protection. Development of new appliance for dental protection is required, with the aim to minimise iatrogenic injury and maximise endoscopic outcomes.

HEPATOPANCREATOBILIARY

0060: PREOPERATIVE EVALUATION OF PATIENTS WITH POTENTIALLY RESECTABLE HILAR CHOLANGIOCARCINOMA

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Background: preoperative evaluation of patients with hilar cholangiocarcinoma is a frequent source of morbidity that may preclude patient from undergoing curative resection. This study set out to determine the morbidity associated with preoperative evaluation of patients with potentially resectable hilar cholagiocarcinoma referred to our institution.
Methods: A retrospective review of all patients referred to our institution over a 12 month period was performed. All patients were discussed in the regional liver case conference. Demographics, imaging, interventions and complications (Clavien-Dindo) were recorded.
Results: 20 patients (median age 66.5, interquartile range 15, M:F = 1.2:1) with potentially resectable hilar cholagiocarcinoma were referred between January 2011 and December2011. Preoperative investigations included percutaneous transhepatic cholangiography (45%), internal/external biliary drainage (55%) and endoscopic retrograde cholangiopancreatography (45%) and laparoscopy (25%). There were 3 grade I, 7 grade IIa and 3 grade IIb complications. The most common were sepsis (50%) and renal failure (15%). There were no deaths.
Conclusion: Preoperative evaluation of patients with potentially resectable hilar cholangiocarinoma is a major source of morbidity. Future studies will evaluate the impact of a fast track pathway.

0183: EARLY CT EVALUATION IN ACUTE PANCREATITIS: A COMPLETE AUDIT CYCLE

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Aim: Current consensus is that contrast-enhanced computer-tomography (CE-CT) performed within 4 days of the onset of acute pancreatitis neither predicts disease severity nor alters management. Early CE-CT is therefore not routinely advocated unless used to exclude other intra-abdominal pathology or early complications. The day of CE-CT, indication for CE-CT and effect on clinical management were investigated at our institution before and after an update of local policy to bring practice in line with current guidelines.
Method: Data were collected before and after the intervention. Comparisons of the day of CE-CT, indication on CE-CT request forms and impact on management were made between the two cohorts.
Results: 67% of patients underwent early CE-CT in the initial cycle compared to 38% in the re-audit. The mean day of CE-CT was significantly later in the second cycle (p=0.02). Following intervention early CE-CTs requested to confirm a diagnosis of acute pancreatitis decreased from 35% to 0%. Of all CE-CTs requested those that did not alter management reduced from 84% to 18%.
Conclusions: The intervention resulted in a substantial reduction in the number of early CE-CTs performed in acute pancreatitis without clinical rationale, reflecting current guidelines.

0314: SELECTIVE HEPATIC ARTERY EMBOLISATION FOR THE TREATMENT OF LIVER METASTASES FROM NEURO-ENDOCRINE DISEASE

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Aim: At our institution selective hepatic artery embolisation (HAE) is offered to symptomatic patients with hepatic gastroenteropancreatic (GEP) neuroendocrine metastases. We aimed to assess the effectiveness of HAE in neuroendocrine tumour and to establish any parameters which may predict a response to treatment.
Methods: We reviewed the demographics, disease distribution and response to treatment of patients with GEP hepatic metastases undergoing HAE from 2008-2012. Response to treatment was evaluated biochemically (reduction in urine 5-HIAA), radiologically (contrast CT) and clinically (patient reported symptoms).
Results: 64 procedures (range 1-7) were performed in 31 patients. 97% of patients were receiving pre-operative somatostatin analogue treatment. 48% had an identified small bowel primary and 87% had >5 hepatic metastases. A biochemical, radiological or clinical response was reported in 61%, 62% and 65% respectively. 86% of patients had a response in at least one domain whilst 13% had progression in all domains. 29% had procedure related complications and no patients died within 30 days of procedure. We could not identify any specific pre-procedural factors predictive of response.
Conclusions: HAE is a relatively well tolerated procedure and can reduce symptoms as well as biochemical and radiological markers of disease for patients with hepatic GEP neuroendocrine metastases.

0390: RE-AUDIT ON THE MANAGEMENT OF PANCREATITIS AT A DISTRICT-GENERAL-HOSPITAL

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Aim: The BSG have a number of audit standards with respect to the management of acute pancreatitis. Our objectives were that all patients should: 1) receive a gallbladder USS within 24 hours of admission 2) be severity scored on admission 3) have ERCP if fulfilling criteria 4) have Laparoscopic cholecystectomy booked before discharge for those with Gallstone Pancreatitis.
Methods: Retrospective analysis of patients between April 2011 and April 2012. An early morning Ultrasound slot for surgical patients was introduced in January 2012 and a management proforma created in April 2012. Prospective data was collected from April 2012 - December 2012.
Results: > 165 cases between April 2011 and December 2012. Delay in USS of >24 hours reduced from 26% (April 2011-January 2012) to 4% (January 2012- July 2012) following introduction of USS slot; further reduction to 3% also demonstrated (July 2012- December 2012). Following introduction of proforma: 100% (77% pre-proforma) of those fulfilling criteria received an ERCP (not sustained on re-audit), and a sustained 100% of patients had laparoscopic cholecystectomy booked on discharge (85% pre- proforma). Severity stratification documentation remained poor.
Conclusion: Compliance with BSG guidelines can improve by introducing a dedicated early morning surgical ultrasound slot.

0490: COMPARATIVE ASSESSMENT OF SURGICAL MEANS OF THE BILIARY DECOMPRESSION AT PATIENTS WITH THE CRITICAL AND UNCRITICAL FORMS OF THE NONNEOPLASTIC OBTURATIVE JAUNDICE

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Introduction: Unsatisfactory results of the early postoperative period of surgical treatment of the nonneoplastic obturative jaundices (NPOJ) are specified with the postdecomprssive development and progression of the hepatic failure on the basis of systemic metabolic malfunctions.
Aim: assessment of influence of surgical means of the billiary decompression on the systemic metabolic malfunctions and the risk of postoperative complications at the patients with critical and uncritical NPOJ for the choice of optimal surgical tactic and principles of postoperative intensive therapy.
Materials and Methods: The results of surgical treatment of 510 patients with NPOJ were analyzed. The changes of the endotoxicosis and the functional condition of the liver were made under the impact of biliary decompression methods: external laparotomic undosed, internal: biliary-enteric anastomosis with the duodenum, with the small intestine and combined external-internal. External laparoscopic measured: EPST with the nasobiliary drainage, laparoscopic cholangiostomy, PTMS.
Conclusions: The dosage of laparoscopic cholangiostomy and PTMS decrease the risk of HF and the using of EPST with the nasobiliary drainage, is accompanied with the risk decreasing and number of postoperative complications. Internal decompression with the way of combined methods is priority in the radical treatment choice of NPOJ.