wiring. We found no correlation between glove perforation and sternal wound infection.

0153: DOES EXPLORATIVE THORACOTOMY FOR NON-SMALL CELL LUNG CANCER (NSCLC) ADVERSELY AFFECT PATIENTS' OUTCOME POSTOPERATIVELY?

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Aims: To determine our incidence of explorative thoracotomy for NSCLC and its influence on further management of patients & their survival.

Methods: Retrospective review of patients referred for lung cancer surgery over 2.5 years. Clinical data were collected on radiological/pathological staging and post-operative management including survival status.

Results: Between January 2008-August 2011, 418 patients underwent thoracotomy for primary lung cancer, of which 27 patients (6%) had inoperable disease. Of the inoperable cases, 4 (15%) had a pre-explorative mediastinoscopy and 22 (81%) were investigated with PET studies. Sixteen patients (59%) had radiological-advanced stage (IIA). Inoperability was due to stage migration, N2 disease, tumour invasion or poor physiological status intra-operatively. Subsequent treatments included adjuvant (chemotherapy/ radiotherapy /combined) in 16 patients (59%) of which 12 (75%) are still alive with an average length of survival of 9 months.

Conclusion: Our incidence of explorative thoracotomy is well within those reported in the literature. Over half of patients were still suitable for radical adjuvant treatment and 44% survived for an average 9 months post-surgery.

Sternotomy should not be denied for advanced NSCLC to avoid depriving patients the benefit of curative resection and if resection cannot be achieved then some patients are suitable for adjuvant treatments.

0308: THE USE OF HOMOGRAFTS IN THE OPERATIVE MANAGEMENT OF INFECTIVE ENDOCARDITIS HAS LOWER SHORT AND MEDIUM-TERM MORTALITY AND IMPROVED OVERALL OUTCOME COMPARED TO PROSTHETIC VALVES

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Aim: Infective endocarditis remains a challenging clinical entity, particularly with changing causative organisms. We aim to characterize the operative management, microbiology, operative mortality and long-term survival in a contemporary cohort of patients having surgery for IE.

Methods: We reviewed the records of 125 consecutive patients who had surgery for IE over five years (2006-2011), at a large tertiary cardiothoracic centre. The valve prosthesis, causative organism, in-hospital mortality, long-term survival and need for repeat surgery were examined.

Results: Cumulative Kaplan-Meier survival was 86.8% at one-year and 67.8% at five years. 101/125(80.8%) patients had isolated valve surgery, 13/125(13.6%) two valves and 7/125(5.6%) three valves. Of the aortic valve IE, 24/66(36.3%) patients had aortic homograft (LES 44.7%), 33/66(50%) had tissue valve (LES47.7%) and 9/66(13.6%) mechanical prosthesis (LES 23.3%). The use of Homograft as a valve substitute was more common in patients with annular involvement and intracardiac abscesses. In-hospital mortality for homograft was 4.5% vs. 8% for prosthetic valve p<0.01. There were no re-infections in the homograft group vs. 4.5% for prosthetic valve p=0.01.

Conclusion: In patients having operation for infective endocarditis, homograft valve replacement provided excellent short and medium-term outcomes with superior survival and freedom from re-intervention compared with prosthetic valve replacement.

0308: THE ROLE OF SURGICAL LUNG BIOPSY IN THE MANAGEMENT OF UNDEFINED PARENCHYMAL LUNG DISEASE

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Aim: To examine whether surgical lung biopsy (SLB) is worthwhile while in the diagnosis of undefined parenchymal lung disease (UPLD).

Methods: 113 patients over a two year period at a single institution underwent SLB for UPLD. Patient demographics, pre-operative diagnosis and treatment, surgical approach, number and site of biopsies, complications, length of postoperative stay and postoperative diagnosis and treatment were examined.

Results: Fifty six patients were female and 57 were male. The median age was 59 years. Following biopsy, 27% of patients received no clear pathological diagnosis and 73% received a specific diagnosis. Of all patients, 42% had a change in their treatment following the procedure. We observed 5 (4%) perioperative deaths, 7 major complications (6%) and 8 minor complications (8%). The median hospital stay was 4 days.

Conclusions: Surgical lung biopsy is a relatively safe procedure. Although it provides an accurate diagnosis for many patients, SLB can be inconclusive and can fail to provide a consistent change in patient management. It can be associated with a prolonged post-operative stay, resulting in an increased cost to the NHS. SLB should therefore be performed in a select group of patients with UPLD after discussion at a respiratory multidisciplinary team meeting.

0513: WHAT'S THE ROLE OF VENTRICULAR ENDOCARDIAL RECONSTRUCTION SURGERY IN 2017? A SINGLE CENTRE 7 YEAR EXPERIENCE


Aim: Surgical ventricular restoration in patients with coronary artery disease, post infarction left ventricular aneurysm or ischemic dilated cardiomyopathy is a viable treatment option, yet conflicting data currently exists. We evaluated the 7-year clinical experience of this procedure in our institution.

Methods: From 2003 to 2010, surgical ventricular restoration was performed in 86 patients (M2.3:1F), mean age 64.5 years. All patients presented with angina, heart failure and/or ventricular tachycardia. Post-infarction left ventricular aneurysm was present in all patients and ischemic dilated cardiomyopathy with a large akinetic left ventricle in 11.6%. The preoperative left ventricular ejection fraction was 33.1±10.4%. Multi-vessel disease was present in 93% patients.

Results: All patients underwent endoventricular or circular patch repair. 94% had concomitant coronary revascularisation, median of 2 grafts and 5% had mitral valve repair. Intra-aortic balloon pump was placed pre-operatively in 18.6% while 16.2% needed inotropic support for more than 24h. Postoperative stroke occurred in 1 patient. In-hospital mortality was 4.6%. All cause cardiovascular mortality at five years was 8.1%. Mean follow-up in operative survivors was 4.4±2.8years. Actuarial survival at 1.2 and 5 years was 90.6%, 87.9% and 79.1%.

Conclusions: Early and long-term results are good in terms of survival and better when compared to ventricular resynchronisation therapy and medical management.

0567: A FIVE YEAR AUDIT STUDY ON DEEP STERNAL WOUND INFECTIONS AND ASSOCIATED DEHISCENCE POST MEDIAN STERNOTOMY: AN ANALYSIS OF PATIENT OUTCOME, RISK FACTORS AND A PROPOSED MANAGEMENT STRATEGY

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Aims: To audit risk factors, outcome and management of patients who developed post median sternotomy wound infections and associated dehiscence.

Methods: In a five year retrospective study 6335 consecutive patients who underwent median sternotomies for coronary artery bypass grafts and aortic valve replacements were examined.

Results: There were 166 sternal wound infections (2.6%). 48 patients (0.76%) underwent treatments such as vacuum therapy and debridements for sternal dehiscence. Increased age, BMI, a lower ejection fraction and diabetes were risk factors for developing sternal wound infections requiring more radical treatments. 18 patients required sternal reconstruction in the form of a flap and on average were seen by plastic surgeons 13 days after the onset of dehiscence. In the reconstruction group each patient received on average 27 days of vacuum therapy and 3 debridements.
Conclusions: All patients should be risk stratified for post median sternotomy wound infections.

In patients with significant risk factors and infected sternal wound dehiscence combined plastic and cardiothoracic surgical input should be undertaken from the outset.

Aggressive and early one stage debridement and flap coverage should be considered in serious sternal wound infections associated with dehiscence as it may negate the need for multiple debridements and prolonged vacuum therapy.

0614: SYNCHRONOUS CAROTID ENDARTERECTOMY FOR ASYMMPTOMATIC CAROTID STENOSIS AND CORONARY ARTERY BYPASS GRAFTING IN PATIENTS WITH CONCOMITANT DISEASE - A LITERATURE REVIEW
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Aims: This literature review investigates the outcomes of synchronous coronary artery bypass grafting (CABG) and carotid endarterectomy (CEA) for concomitant disease in neurologically asymptomatic patients.

Methods: An electronic OVID Medline® database search using the following criteria: “asymptomatic”, “carotid stenosis”, “carotid endarterectomy”, “CEA”, “coronary artery bypass”, “CABG” gave a total of 56 articles. Stroke and mortality rates were calculated and compared to CABG alone in patients with carotid stenosis. Fishers exact test was used to calculate significance.

Results: Incidence of stroke was significantly less in asymptomatic patients undergoing synchronous surgery compared to symptomatic patients. 1.7% versus 12.2%, risk 0.13 (95% confidence interval 0.00-0.21, P = 0.001). There was a small significant decrease in stroke risk in patients undergoing synchronous surgery compared to CABG alone, 3.4% versus 5.8%, risk 0.92 (CI = 0.86-0.99, P = 0.0123), but this was insignificant when limited to asymptomatic patients. There was a trend of increased mortality in symptomatic patients and in synchronous surgery which was not statistically significant.

Conclusions: This study suggests synchronous surgery decreases stroke risk in patients with carotid stenosis compared to CABG alone, but mortality benefit and benefit to asymptomatic patients remains unclear.

Neurologically asymptomatic patients have worse outcomes compared to those with asymptomatic carotid stenosis.

0892: WEIGHT REDUCTION PRIOR TO ELECTIVE CORONARY REvascularization IN extremely OBBESE PATIENTS IMPROVES CLINICAL OUTCOMES
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Introduction: 20% of patients undergoing coronary revascularization [CABG] in the UK are obese, with associated co-morbidities including diabetes, hypercholesterolaemia poor mobility, and smoking. They present a high risk for CABG. We examined the impact of diligent preoperative risk modification on postoperative outcomes.

Methods: We instituted a closely monitored regimen of risk reduction focusing on weight loss, cessation of smoking and diabetic control, in extremely obese patients [BMI>40] requiring elective CABG [Group WL] and examined their outcome compared to less obese patients outside the study group [Group OE]. Kruskal Wallis and Anova method was used for statistical analysis.

Results: A 8.9% weight loss was achieved safely in the 13 patients [Group WL] over 202 days, with a fall in BMI from 43.9 [+ 3.7] to 40.1[+3.4]. Four patients quit smoking and tight glycemic control was achieved in 8 diabetics before surgery. In spite of the poorer patient profile, patients in group WL did better with lower incidence of mediastinitis, wound infection, early mobilization and hospital stay compared to Group OE.

Conclusion: Weight loss was safely achieved in extremely obese patients before planned CABG with tangible reduction of adverse postoperative outcomes and promises a better result in this high risk cohort of patients.

0983: THE OUTCOME OF CARDIAC SURGERY IN OCTOGENARIANS: A 13 YEAR EXPERIENCE
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Aim: Advanced age is associated with increased risk in cardiac surgery and more octogenarians are being referred for interventional procedures for structural and ischemic heart disease. The aim of this study is to evaluate our surgical outcome in octogenarians following cardiac surgery.

Methods: Between January 1998 and May 2011, we identiﬁed 530 octogenarians who underwent cardiac surgery. The mean age was 82.3 +/- 2.4 years with a logistic EuroSCORE of 16.39 +/- 14.63. 135 patients (25.5%) underwent isolated coronary artery bypass grafting (CABG), 357 patients (67.3%) had aortic or mitral valve procedures.

Results: The in-hospital mortality was 6.0%. Major complications included stroke in 0.8%, new haemofiltration in 9.1% and permanent pace maker insertion in 5.8% of patients respectively. Median postoperative stay was 13 days. The overall actuarial survival at 1, 3 and 5 years was 87.4%, 80.0% and 75.2% respectively. The actuarial survival at 5 years for the isolated CABG group, aortic valve replacement group and mitral valve group was 82.8%, 74.7% and 74.0% respectively.

Conclusion: In our experience, cardiac surgery in octogenarians has excellent early and long-term survival. Morbidity rates are acceptable. We conclude that cardiac surgery should not be discounted in octogenarians on the basis of age alone.

1004: CORONARY ARTERY BYPASS GRAFTING ON DIALYSIS-DEPENDENT CHRONIC RENAL FAILURE PATIENTS: SHORT AND LONG-TERM OUTCOMES, A 12 YEAR EXPERIENCE
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Aim: Performing coronary artery bypass graft surgery (CABG) on dialysis-dependent end-stage renal disease patients is still a subject for debate. This study focuses on the short and long term outcomes of dialysis-dependent patients undergoing CABG.

Methods: Between October 1998 and December 2010, we identiﬁed 65 dialysis dependent patients who underwent CABG in our institution. The mean logistic EuroSCORE was 17.07 +/- 20.62. 38 patients (58.5%) underwent isolated CABG and 27 patients (41.5%) had concomitant procedures.

Results: The total in-hospital mortality was 7.7%. Major complications included reintubation in 4.6% of patients. None of the patients had new post-operative stroke. The median postoperative stay was 14 days. The overall actuarial survival at 1, 3 and 5 years was 80.0%, 64.3% and 49.8% respectively. The actuarial survival at 5 years for the isolated CABG group, aortic valve replacement group and mitral valve group was 51.8%, 52.5% and 40.4% respectively.

Conclusion: Cardiac surgery can be performed in end stage renal disease with acceptable morbidity and mortality. The relatively decreased long term survival is only a reﬂection of their high natural attrition state and cardiac surgery should not be discounted solely on this foundation.

1065: ANTIPLATELET THERAPY FOLLOWING CORONARY ARTERY BYPASS GRAFT SURGERY
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Aim: The most recent American College of Cardiology Foundation/American Heart Association guidelines for coronary artery bypass graft surgery (CABG) recommend the initiation of Aspirin (100-325mg) within 6-hours post-operatively and indefinite continuation, supported by class 1A evidence. This study aimed to evaluate adherence to these guidelines in our cardiac unit.

Method: A retrospective analysis of 100 consecutive patients undergoing CABG was conducted, analysing antiplatelet agents, dosing and timing of administration. The findings and recommendations were presented at local level. A prospective analysis of a further 100 consecutive patients undergoing CABG was conducted, analysing the above primary outcomes.

Results: The retrospective analysis revealed the following therapies: Aspirin 75mg-73%, Clopidogrel 75mg-5%, Aspirin+Clopidogrel 75mg-15% and Aspirin 300mg-7%. Initiation of therapy within 6-hours was not observed in any patient. The prospective analysis revealed the following therapies: Aspirin 75mg-61%, Clopidogrel 75mg-4%, Aspirin+Clopidogrel 75mg-7% and Aspirin 300mg-28%. Initiation of therapy within 6-hours was observed in 16%.