

**Methods:** Patient records were interrogated between January 2006 and April 2011. All patients who underwent ERCP were included. Those who presented with CBDS were specifically identified.

**Results:** Of 1229 patients identified, 736 underwent ERCP for CBDS. In those, stones were directly visualised on ERCP in 539 cases with the remaining 197 showing the presence of sludge or evidence of passed stones. Of the 539 patients, 390 patients had successful stone removal on first ERCP, whereas 149 patients required repeated ERCPs and placement of CBD stents. Of these, 124 eventually had successful CBDS clearance (median of 2 ERCPs: range 1–12). However, 25/149 patients proceeded to surgical CBD exploration following unsuccessful ERCP. Overall, endoscopic CBDS clearance was achieved in 95.4%, though 23% of these required two or more ERCPs.

**Conclusions:** The proportion of patients requiring repeated ERCP remains significant. Therapeutic ERCP is gaining popularity but carries specific risks. With improving laparoscopic techniques, it may be appropriate to consider early referral for laparoscopic bile duct exploration following inability to clear the CBD following ERCP.

## MAXILLOFACIAL SURGERY

### 0253: REVIEW OF RECURRENT OR SECOND PRIMARY TUMOURS IN PATIENTS PREVIOUSLY TREATED FOR HEAD AND NECK CANCER- IS ROUTINE REVIEW NECESSARY

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In the UK, healthcare purchasers are undergoing a rationalisation of spending. The aim of this review was to examine the need for regular review by a specialist multi-disciplinary team with respect to head and neck cancers.

Patients were identified who had developed a recurrence or second primary head and neck cancer over a five year period (2005–2010). Assessment was made of where these patients presented to.

Case notes of thirty-eight patients were reviewed. Of these 23 were deemed to have a second oro-pharyngeal tumour. Four of these were excluded: two were followed up at another trust and two second primaries were discovered incidentally at operation.

Seventeen of the nineteen patients included presented to a routine hospital appointment. One patient attended their general medical practitioner and one their dentist.

The importance of regular review for head and neck cancer patients by a specialist multi-disciplinary team is emphasised.

### 0320: CONCURRENT BILATERAL TOTAL TEMPOROMANDIBULAR JOINT REPLACEMENT SURGERY AND CONVENTIONAL MAXILLARY OSTEOTOMY UTILISING VIRTUAL PLANNING WEB-BASED TECHNOLOGY

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**Background:** We describe the case of a 31 year-old lady who presented with significant temporomandibular joint (TMJ) dysfunction following a previous vertical sub-sigmoid osteotomy in 1999. Previous surgery had resulted in both condyles being displaced from their glenoid fossae and a persistent malocclusion. Though initially managed conservatively, both condyles remained out of their fossae and she re-presented 10 years later. On presentation, she had significant progressive right TMJ dysfunction with severe pain. A Class III malocclusion was apparent with a 5mm anterior open bite and jaw deviation to the right on mouth opening. Her maximal inter-incisal opening was 32mm.

**Method:** The case was prepared using conventional orthodontic treatment, with surgery being remotely planned by a design facility using a web-based virtual planning and design process. Definitive surgery consisted of bilateral condylectomy, coronoidectomy and placement of bespoke TMJ replacement prostheses. A simultaneous Le Fort I osteotomy was performed with 4mm maxillary advancement.

**Results:** A Class I occlusion was achieved with full range of movement, good functional and aesthetic outcomes.

**Conclusion:** This documents one of the first reported cases of bilateral total TMJ replacement surgery performed with a concurrent maxillary osteotomy. It demonstrates the viability of simultaneous procedures and the potential of virtual planning.

### 0461: THE IMPORTANCE OF CODING SURGICAL PROCEDURES - THE MAXILLOFACIAL EXPERIENCE

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**Aim:** Coding of surgical procedures in NHS hospitals is carried out using OPCS-4 and HRG4 systems, which rely upon correct initial documentation and coding of procedures by the surgical team. The transfer of these important details can result in incorrect labelling of set procedures resulting in loss of earnings to the surgical departments. We aimed to audit the coding system at Kings Maxillofacial Department.

**Method:** Audit of surgical case coding over a two month period at Kings College maxillofacial department. Data was collected from the maxillofacial departmental database, theatre galaxy database, admissions, EPR and coding department. Actual surgical procedures performed were compared to procedures coded in order to calculate the difference in cost.

**Result:** Of 148 patients who underwent a total of 175 procedures, 97.8% were coded correctly. The potential loss of earning to the department from incorrectly coded procedures was calculated as £6,636 over the 2 month period, which annually amounts to £39,816.

**Conclusion:** Accurate coding of surgical procedures is very important in order to avoid miscalculations in payments to departments. Increasing the awareness of correctly coding procedures and re-auditing data is a step forward in ensuring surgical departments are correctly paid.

### 0708: LE FORT 1 OSTEOTOMY - USA VS UK - WHY THE DIFFERENCE?

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**Introduction:** Maxillary osteotomy is a common maxillofacial procedure for correction of facial skeletal deformities beyond the scope of orthodontics alone. This can be performed via a single piece or segmental Le Fort I osteotomy.

**Aim:** We aim to compare the practice of 2 maxillofacial units in the UK and US in terms of preference for single piece or segmental osteotomies. We present the current literature comparing the techniques.

**Method:** We recorded and compared the techniques used for maxillary osteotomies performed during 2010 at the University of Maryland Medical Center and University Hospital of Wales. The differences in surgical preference were highlighted, and supporting literature was reviewed, looking specifically at stability, blood loss, vascularity of the osteotomised segment and combined orthodontic and surgical treatment time.

**Results:** Fewer segmental osteotomies were performed in UHW than UMMC. According to the literature the two techniques are generally comparable. Segmentalisation may expedite overall treatment time but is associated with increased intra-operative blood loss and other minor morbidities.

**Conclusion:** There is variation in preferred orthognathic techniques between units. A literature review did not reveal a significant advantage to either technique.

### 1001: A SIX-YEAR RETROSPECTIVE REVIEW OF DISTANT FREE TISSUE FLAP RECONSTRUCTIONS IN A REGIONAL MAXILLOFACIAL UNIT

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**Aims:** To determine predictive factors of success, complications and survival of donor flaps in head and neck reconstruction.

**Methods:** A review of 116 flaps-66 radial forearm free-flaps (RFFF), 31 fibular free-flaps (FFF) and 19 anterolateral thigh (ALT) flaps was performed. Patients' age, American Society of Anesthesiologists (ASA) status, creatinine (Cr) and haemoglobin (Hb) levels and intensive care unit (ITU) admission duration were recorded.

**Results:** Results show success rates of 94% for RFFF (n=62); 90% for FFF (n=28) and 89.5% for ALT-flaps (n=17). Patients had 4.4 days longer average admissions following FFF with shorter ITU admission (22% vs 26.5% of hospital stay). Cr and Hb fall was greatest following ALT-flaps, 41.7umol/L and 3.83g/dL respectively. Hb reduction following RFFF was 3.6g/dL and 3.2g/dL following FFF. 55% and 56% of patients undergoing FFF