Aims: The British Society of Gastroenterology (BSG) guidelines state that definitive management of biliary pancreatitis should be achieved within a 2 week period. The aims of our audit were to assess the management of patients with biliary pancreatitis.

Methods: Data was obtained prospectively from all consecutive patients presenting with acute biliary pancreatitis over a nine month period at two district general hospitals within our Health Board.

Results: Between September 2010 to May 2011 there were 52 admissions with acute biliary pancreatitis. 34 were females. Median age 62 years (range 18-97). Median Length of stay was 6 days (range 1-28). 3 patients died (5.7%). 7 patients underwent Endoscopic Retrograde Cholangiopancreatography (ERCP), with a median wait of 6 days (range 1-12 days). For 4 of these patients, ERCP was deemed as their definitive management due to co-morbidities. 35 patients underwent cholecystectomy, with only 13 of those having surgery within 2 weeks of diagnosis. Median wait from diagnosis to surgery was 23 days (range 2-260). We experienced an 11.1% readmission rate for those that did not undergo definitive management of their gallstones within 2 weeks.

Conclusion: There is significant morbidity associated with delayed definitive management of gallstones in those patients with biliary pancreatitis. 0403: COMPLIANCE WITH BSG GUIDELINES IN BILIARY PANCREATITIS IN A LARGE TEACHING HOSPITAL

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Aim: BSG guidelines state: 1) All patients presenting with severe biliary pancreatitis should undergo ERCP and sphincterotomy within 72 hours of onset of pain; 2) Patients with biliary pancreatitis should receive definitive treatment during the same admission, or within two weeks of discharge.

This study aimed to determine compliance with BSG guidance on biliary pancreatitis in a large teaching hospital.

Methods: Retrospective analysis was conducted on all (19) patients admitted to the surgical unit with biliary pancreatitis over 6 months (Dec 2010-July 2011).

Results: Pancreatitis was graded severe in 9 (47%) patients and mild in 10 (53%) patients. Six (32%) patients underwent ERCP, none complying with BSG guidelines. Five (26%) patients underwent definitive treatment, 4 (21%) meeting BSG guidelines. There was one mortality in our cohort.

Conclusion: Compliance with BSG guidelines was extremely poor. All patients in our series waited longer than 72 hours for ERCP and 85% waited longer than two weeks for definitive treatment. Indeed, most patients (70%) waited longer than six months for laparoscopic cholecystectomy.

Evidence shows that these patients are at significant risk of further episodes of acute pancreatitis, which may be life threatening. We must direct resources toward ensuring adequate access to emergency ERCP and expedited surgical treatment.

0599: THOROUGH PRE-OPERATIVE ASSESSMENT MUST BE CARRIED OUT PRIOR TO LAPAROSCOPIC CHOLECYSTECTOMY

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Aims: Up to 20% of patients who have undergone cholecystectomy continue to experience symptoms. Our aim was to identify the symptoms for which laparoscopic cholecystectomies (LC) were carried out and then determine the prevalence and the nature of persistent symptoms following the procedure.

Method: A validated pre-operative symptoms survey was completed at the time of listing of 500 consecutive LC, followed by a follow up phone survey 12 weeks post-operatively to record the nature, severity and frequency of symptoms experienced.

Results: All patients had at least 2 symptoms pre-operatively and 337 (67.4%) had 3 or more. The most common symptoms pre-operatively were abdominal pain (93.8%) and nausea (65.8%). A total of 90 patients were symptomatic postoperatively. Eighty one patients (16.2%) complained of abdominal pain, while 63 (12.6%) patients also experienced associated dyspeptic symptoms. Sixty patients underwent further investigation following LC; 36 patients went on to have a secondary diagnosis made, the most common (13/36) being hiatus hernia.

Conclusions: A significant number of patients continue to experience symptoms following LC. A careful biliary history, focused physical examination and a thorough pre-operative assessment must be carried out prior to LC to rule out conditions that masquerade as gallbladder disease.

0615: IS ULTRASOUND ALL WE NEED? A REVIEW OF BILIARY IMAGING AT FRENCHAY HOSPITAL

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Aim: Modern management of symptomatic gallstones needs to be streamlined with appropriate investigations and early intervention. We reviewed biliary radiology for emergencies admitted with suspected gallstone disease, assessing the efficiency of our radiology service.

Methods: A retrospective review was conducted of all acute surgical admissions to Frenchay in September 2011. Radiology records were obtained from ICE and WebPACS for patients referred as: right upper quadrant pain, jaundice or pancreatitis. Patients without gallstones or those not needing imaging were excluded.

Results: 43 admissions met the referral criteria, 36 of which were suitable for review. 34 ultrasound scans (USS) and 13 MRCP were requested. Of weekday USS requests, 93% were scanned and 85% reported within 24 hours. 43% of weekend USS were performed and reported within 24 hours of request. 24% of USS were deemed inadequate mainly due to poor CBD views. 44% of inpatient MRCP requests were reported within 5 days with only 1 of 13 adding new information from USS.

Discussion: This study highlights the efficiency of our weekday USS service. MRCP introduced significant delays and added little diagnostic information. The increasing use of intra-operative imaging compensates for discrepancies in USS and may render MRCP redundant in the emergency management of gallstones.

0784: DO LIVER FUNCTION TESTS OR MRI FINDINGS PREDICT COAGULOPATHY IN OBSTRUCTIVE JAUNDICE?

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Aims: Clotting abnormalities in obstructive jaundice are well documented but it is unclear which patients are most likely to be at risk. This study aims to investigate possible predictive factors of coagulopathies in obstructive jaundice.

Methods: Patients undergoing Magnetic Resonance Cholangiopancreatography (MRCP) between March and August 2010 were identified retrospectively. The relationship of serum bilirubin, alkaline phosphatase (ALP), aspartate transaminase (AST) and common bile duct diameter to clotting was investigated.

Results: 72 patients were included. 9.7% had an INR of 1.3 or greater. The mean bilirubin was 90 μg/L, mean ALP was 269μL and the mean INR was 1.17. CBD diameter ranged from 5.22-5mm with a mean of 10mm. There was no significant correlation of any parameters to INR.

Conclusion: None of the factors investigated predict the likelihood of coagulopathy in obstructive jaundice. Clotting impairment in jaundice is complex and multifactorial, making it difficult to identify patients at risk of bleeding complications. Our results fail to justify the routine administration of vitamin K in all jaundiced patients. We suggest that all patients should have coagulation studies performed but vitamin K should be reserved for those with abnormal results.

0823: ANALYSIS OF ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHIC (ERCP) MANAGEMENT OF COMMON BILE DUCT STONES IN THE LAPAROSCOPIC ERA

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Aims: Common bile duct stones (CBDs) are frequent. Current management trends are to perform laparoscopic cholecystectomy and therapeutic endoscopic retrograde cholangiopancreatography (ERCP) separately, necessitating co-operation of surgeons and gastroenterologists.


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ABSTRACTS