laparoscopic resections (85%), 56 open (15%). 266 were ASA grade 1-2 (85%), 58 ASA 3 (15%). There were four 30-day mortalities (1%).

Conclusions: Mode of referral influenced CRC incidence but did not influence anatomical location, stage of disease, operative modality, ASA or mortality. The majority underwent laparoscopic colectomy.

1070: IS ENHANCED RECOVERY AFTER SURGERY (ERAS) APPROPRIATE FOR PATIENTS UNDERGOING RECTAL SURGERY?

Background: The suitability of ERAS in rectal surgery has been debated, following reports of increased complications in this cohort of patients.

Aim: To assess the efficacy of ERAS protocols on outcomes in colon versus rectal surgery.

Method: Patients undergoing colorectal surgery on ERAS over 1 year were prospectively entered into a database. Parameters measured included length of hospital stay (LOS), ITU/HDU admission, readmission/re-operation rates, number and type of post-operative complications.

Statistical analysis performed using unpaired t-test and Fishers exact test.

Results: 117 colorectal ERAS patients compared to 62 rectal ERAS patients. Similar median age between groups (69 versus 67 years; p = 0.5) as was the proportion of laparoscopic cases (66% versus 63%; p = 0.7). No difference in LOS between colonic and rectal groups (7.3 versus 7.35 days; p = 0.8). No difference in rates of ITU/HDU admission (p = 0.5), readmission or reintervention (p = 0.4, 0.6 respectively). However rectal ERAS demonstrated greater postoperative complications than colonic (p = 0.003), with significantly higher rates of postoperative urinary retention (p = 0.009). No difference in rates of other complications between the groups: postoperative ileus (p = 0.5), wound infection (p = 0.8), intra-abdominal collection (p = 0.3) or chest infection (p = 0.8).

Conclusion: The ERAS protocol demonstrates comparable efficacy in colonic and rectal surgery. However, greater postoperative complications occur with rectal ERAS. Specifically, urinary retention poses a significant complication if current guidelines are adhered to.

1084: DECISION MAKING IN THE MANAGEMENT OF LOW RECTAL CANCER

Introduction: Management of low rectal cancer is complex and there is variation in abdominoperineal (APR) resection rates, other operative strategies and non-operative/palliative management. There is little information regarding the decision making process for those patients treated with palliative intent. Our aim was to audit 3 years of low rectal cancer in our institution.

Methods: Retrospective audit of low rectal adenocarcinoma less than 8cm from anal verge.

Results: 93 patients, median age 71.5 (36-94), 73 treated operatively with curative intent (40 APR, 30 Anterior resection (AR), 3 TEMS). APR had significantly lower rectal tumours compared to AR, 4cm (2-8) vs 6.7cm (4-8) (p = 0.001) and more likely to receive neoadjuvant therapy 93% vs 63% (p = 0.001). Higher proportion of CRM+ve in APR vs anterior resection 25% vs 17% (not significant). 20 patients were treated with palliative intent (13 conservative, 6 defunctioned, 1 stent). Palliative group had significantly more advanced disease UICC stages 3-4 compared with the operative group 70% vs 39% (p = 0.02)

Conclusion: 22% of all patients are treated with palliative intent, usually due to advanced disease. Patients with lower rectal tumours are more likely to receive neoadjuvant therapy. Our data suggests that tumour anatomy influences margin positivity.

1105: IS A SPECIALIST ENHANCED RECOVERY AFTER SURGERY (ERAS) NURSE ACTUALLY REQUIRED?

Aim: To assess the effect of a dedicated ERAS nurse versus ward based care, on ERAS specific outcomes in colorectal surgery.

Methods: Data was prospectively collected from patients undergoing elective colorectal surgery for benign and malignant disease in our unit over one year.

Outcomes in patients who were allocated an ERAS nurse (Group A) were compared with ERAS delivered by ward staff (Group B). Parameters measured were in accordance with international ERAS guidelines. Statistical analysis performed using unpaired t-test and Fishers exact test.

Results: 77 patients in group A (median age 68 years, IQR 55-81 years) compared to 44 patients in group B (median age 69 years, IQR 56-74 years).

There was no difference in outcomes for most parameters studied: proportion of patients achieving early mobilization (p = 0.7), early nutrition (p = 0.09), avoidance of postoperative nausea and vomiting (p = 0.6), early and appropriate discontinuation of IV fluids (p = 0.8) and avoidance of systemic opiates (p = 0.4). However, significantly fewer patients in group A had postoperative nasogastric decomposition compared to group B (p = 0.001).

Conclusion: Apart from reducing postoperative nasogastric decompression, this study did not demonstrate significant benefits of having a dedicated ERAS nurse over general ward based care in improving ERAS specific postoperative outcomes.

1111: WIDE LOCAL EXCISION OR ABDOMINOPERINEAL RESECTION FOR ANORECTAL MELANOMA?: A SYSTEMATIC REVIEW
Sanjay Harrison 1, Chun Sui Kwok 2, Vickram Joypaul 1. 1 Northern Deanery, Tyne & Wear, UK; 2 South Tyneside District General Hospital, Tyne & Wear, UK.

Aim: The surgical treatment of anorectal melanoma is still controversial. By performing a systematic review of the published literature, we aim to determine whether there is a difference in overall survival following treatment with a wide local excision (WLE) or an abdominoperineal resection (APR).

Method: A pubmed search using the terms ‘anorectal melanoma’, ‘wide local excision anorectal melanoma‘ and ‘abdominoperineal resection anorectal melanoma’ was carried out and the relevant case series selected. Bibliographies were also searched for relevant studies. Only case series that allowed calculation of the overall survival were selected for this analysis.

Results: 22 studies were identified that met the criteria with a total of 619 patients (WLE-285, APR-334). The mean age of the patients was 57.8 with a male:female ratio of 1:1.6 (p = 0.26). The overall survival in the WLE and APR groups were 23.8 months and 20.9 months respectively (p = 0.72)

Conclusion: There is no significant difference in overall survival between the WLE and APR groups. Based on these results, we would advocate that patient factors such as co-morbidities, ability to cope with a stoma and patient wishes take precedence when deciding on the best treatment.

1115: IS THE MICROBIOBIOLOGY OF A PERI-ANAL ABSCES PREDICTIVE OF FISTULA FORMATION?
Sanjay Harrison 1, Chun Sui Kwok 2, Vickram Joypaul 1. 1 Northern Deanery, Tyne & Wear, UK; 2 South Tyneside District General Hospital, Tyne & Wear, UK.

Aim: In this study we aim to determine if the microbiological culture of the abscess can predict the development of anal fistula.

Method: A retrospective study of 200 peri anal abscesses was undertaken and data on the subsequent development of anal fistulae along with the relevant microbiological results was collected. The causative organisms were classified as gram negative or positive and a chi squared test was performed to determine an association with fistula development.

Results: Of the 200 peri anal abscess cases analysed (145 male, 55 female), 152 were found to be due to gram negative organisms and 48 were due to gram positive organisms. 40 gram negative cases went on to develop fistulae whereas in the gram positive group there were only 3. Chi square analysis demonstrated that the gram negative cases were more likely to develop fistulae (p < 0.005).

Conclusion: These results suggest that patients found to have peri anal abscesses due to gram negative organisms should be examined and followed up in our patient clinics to monitor for fistula development. The practice of following up all patients after an incision and drainage of a peri anal abscess may not be justified.

1124: SURGICAL SITE INFECTIONS IN GENERAL SURGERY PATIENTS: A PROSPECTIVE SINGLE CENTRE STUDY
James Manfield 1, Hutan Ashrafian 2, Rakhee Shah 1, Fiona Bailey 1, Pawan Mathur 1. 1 Department of General Surgery, Barnet Hospital, Barnet and Chase Farm Hospitals NHS Trust, Greater London, UK; 2 Department of Surgery and Cancer, Imperial College London, London, UK.
**1129: THE USE OF PORCINE COLLAGEN MESH TO PREVENT PERINEAL HERNIATION AFTER EXTRALEVATOR LAPAROSCOPIC ABDOMINOPERINEAL RESECTION OF THE RECTUM (ELAPR): A CASE SERIES**

Anil Bagul, Nasar Alam, Peter Vaughan, Michael Lamparelli, Dorset County Hospital, Dorchester, UK.

**Background:** Postoperative perineal hernias have been reported as a rare complication following conventional Abdominoperineal resection. Female gender, pelvic irradiation, hysterectomy, small bowel length and perineal infection have been associated with this. The combination of fewer adhesions after laparoscopic surgery and a more radical extralevator/cylindrical approach results in a large perineal defect which potentially could predispose to a perineal hernia.

**Aim:** To evaluate the use of a porcine collagen mesh as an adjunct to primary closure in preventing perineal herniation post ELAPR.

**Material and Methods:** Thirty patients undergoing an ELAPR between January 2005–November 2012 were identified. Seven patients who did not have mesh reconstruction were excluded.

**Results:** Twenty three patients were included. The median age was 72 (42–87). Sixteen (69.5%) patients had preoperative radiotherapy. Median CME resection margin was 10.5 (2–35) mm and hospital stay was 11.5 (5–68) days. Perineal complications* were seen in 10 (43.5%); 4 had superficial wound breakdown with consequent delayed healing and a persistent perineal discharge was seen in a 6 (26 %) patients. Perineal hernia occurrence rate was 1 (4.3%).

**Conclusions:** We saw no increase in post operative perineal hernia* after the more radical eELAPR following the use of Pernacoal as primary repair. We advocate that the use of a mesh for primary repair of a perineal defect is appropriate.

**1131: REDUCING PERFORATION RATES AND LOCAL RECURRENT IN APER'S IN A DGH SETTING**

Rebecca Halas, Jonathan Cowley, Catherine Parchment-Smith. Pinderfields General Hospital, Wakefield, UK.

**Aim:** Abdomino perineal excision of the rectum is required for the surgical treatment of low rectal cancers. LOREC was established to improve operative techniques, oncological outcomes and reduce post operative complications. Within the Mid-Yorks trust LOREC methods were adopted in 2011 with only certain consultants performing APER’s. We reviewed perforation rates and local recurrence in cases performed before and after these changes.

**Method:** A retrospective case note review was performed using electronic databases and case notes for all APER’s performed since 2009. Data was extracted for demographics, histology, perforation rates and evidence of local recurrence.

**Results:** Sixty Seven APER’s were performed within the trust since 2009, 28 (42%) since 2011. Five cases (17%) pre 2011 histologically confirmed perforation and no cases (0%) were perforated following 2011. Two cases pre 2011 had local recurrence detected, both having local perforation at surgery. No local recurrence has been detected in the post 2011 cohort.

**Conclusion:** Perforation rates at APER and local recurrence were reduced in patients undergoing surgery for low rectal cancers following departmental restructuring although follow up remains short term.

**1172: ANAL DYSPLASIA AND ITS PROGRESSION TO SQUAMOUS CELL CARCINOMA OF THE ANUS**

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**Background:** The natural history of anal intraepithelial neoplasia (AIN) is poorly understood and there is no consensus on its management. We aimed to identify the risk of progression to squamous cell carcinoma (SCC) and the factors which increased this risk.

**Methods:** A retrospective analysis of all patients with biopsy-proven anal dysplasia between 1994–2011 in Glasgow was carried out. Changes suspicious of AIN3 (severe dysplasia) are biopsied and excised with localisation of AIN3. More extensive changes are mapped and the majority of patients with extensive severe dysplastic change have this excised with reconstruction.

**Results:** 128 patients were included (29M:99F). 21 Patients presented with SCC (3M:18F). 6 Patients progressed to SCC over follow up, 2 were HIV positive, and 2 were taking immunosuppressant medication. 21% of all patients had an eventual diagnosis of SCC. This proportion was greater in HIV positive (N=4/16, 25%) and immunosuppressed (N=4/13, 31%) patients. 17 patients died (age range 34–85). One patient had anal SCC and three had vulval SCC as a primary cause of death. There was a significant association between immunosuppression and death (p=0.000) and borderline association with progression to anal SCC (p=0.051).

**Conclusions:** These findings demonstrate immunosuppressed and HIV positive patients with anal dysplasia warrant close surveillance.

**1179: HAS THE CHANGE IN TRUST ANTIBIOTIC POLICY LED TO AN INCREASE IN COLORECTAL SURGICAL SITE INFECTIONS?**

Saadia Farooq, Nima Abbassi-Ghadi, Caris Grimes, Neil Smith. East Surrey Hospital, Surrey, UK.

**Aim:** To measure the impact of changes in hospital antibiotic policy on surgical site infections (SSI) in elective colorectal surgery.

**Method:** In July 2012, antibiotic prophylaxis at our hospital switched from cefuroxime and metronidazole to amoxicillin, metronidazole and gentamicin, aiming to reduce the incidence of C.difficile. The incidence of SSI was compared during two 6 month periods immediately before (A) and after (B) this change.

**Results:** 183 consecutive patients (85 males, 98 females) were analysed. The incidence of SSI was 3/82 (period A) and 18/101 (period B), (p=0.0024). 3/3 SSI in period A (2 pseudomonas) involved stoma formation or closure, versus 7/18 in period B during which the commonest organisms were Staph.aureus (6/18), pseudomonas (2/18) and E.coli (1/18). The median length of stay (LOS) for a laparoscopic right hemicolectomy was 7 days and anterior resection with loop ileostomy was 10 days. SSI led to increased median LOS, 10 days and 15.5 days respectively. 2 patients were readmitted with SSI during period B.

**Conclusion:** With surgical practice remaining constant, the change in prophylactic antibiotics for elective colorectal surgery may have led to the increase in post-operative wound infections and subsequent increased LOS, costly to the patients’ recovery and hospital resources.

**1186: ELECTIVE OPERATING OUT OF HOURS – IS IT SAFE?**

Paul Froggatt, Chris Harmston. University Hospital Coventry & Warwickshire, Coventry, UK.

**Aim:** To determine the incidence of morbidity & mortality in elective colorectal procedures which are undertaken outside of normal working hours.