ABSTRACTS


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**5267 NATIONAL SELECTION FOR ST3: WHAT DO YOU REALLY THINK?**
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**Aim:** National Selection for ST3 in Otolaryngology in England was carried out for the first time in April 2010. This was amongst active debate regarding this process of selection to higher surgical training in both ENT and other surgical specialties. Our objective was to formally collate viewpoints of all those involved in single centre national selection.

**Methods:** A nine question survey was distributed to trainees in both ENT and eight other surgical specialties at the annual conference of the Association of Surgeons in Training (ASiT), regional ENT Trainee meetings and an online version was posted on the Association of Otolaryngologists in Training (AoT) members forum.

**Results:** A total of 380 completed surveys were analysed. Only 21% were in favour of Single-Centre National Selection. More than 80% thought that trainers should be involved in selecting the trainees that would be working for them. 67% were in favour of a nationally coordinated application process with multicentre interviews.

**Conclusion:** The results show that there are strong concerns from both trainees and consultants from around the country that the current National Selection system does not allow local trainers to be engaged in recruitment and that a system which allows this input would be preferred.

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**0268 HIP FRACTURE SURGERY AND OBTAINING CONSENT: IS THE PROCESS TRULY INFORMED?**
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**Introduction:** With current trends in life expectancy and the increasing prevalence of osteoporosis, the treatment of fragility fractures places considerable demands on the NHS. Hip Hemiarthroplasty and Dynamic Hip Screw/(DHS) remain the two most common operative procedures for management of hip fractures. An informed patient is one with a clear understanding of the proposed procedure and associated risks/comlications.

**Aim:** To determine adequacy of the consent process for Hip Hemiarthroplasty & DHS.

**Methods:** N=100 (50Hemiarthroplasty/50DHS). Consent forms were analysed and information compared to that included on British Orthopaedic Association (BOA) endorsed protocol for Consent forms.

**Results:** Hip Hemiarthroplasty: Grade of surgeon obtaining consent: SHO86%, Registrar8%, Other6%. Risks/Complications documented: DVT66%, Bleeding94%, Pain40%, LL20%, Dislocation62%, Infection100%, Altered wound healing6%, Nerve injury84%, Fracture26%, Vascular injury58%, PEG62%, Death20%. DHS: Grade of surgeon obtaining consent: SHO78%, Registrar4%, Other18%. Risks/Complications documented: DVT26%, Bleeding94%, Pain50%, Infection100%, Catheterisation0%, LL4%, AVN26%, (46% for Intra-capsular NoF<65yrs), Softness24%, Nerve injury50%, Fracture16%, Vessel injury40%, Death26%.

**Conclusion:** Current documentation of consent for Hip Hemiarthroplasty and DHS does not satisfy BOA endorsed guidelines. It may be argued that in some instances consent is therefore not truly informed.

Addressing this aspect of the consent process will improve patient understanding and expectations. It may also reduce the likelihood of patient dissatisfaction, complaints and litigation.

**0269 DOES ESSENTIAL DISCHARGE INFORMATION OF SURGICAL PATIENTS ARRIVE WITH GENERAL PRACTITIONERS IN A TIMELY FASHION?**
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**Aim:** To establish the most efficient method of discharge letters arriving with general practitioners.

**Introduction:** Patient information from emergency and elective hospitals surgical admissions arriving to general practitioners in a timely fashion is paramount.

**Methods:** All inpatient discharge letters from November 2009 were analysed to compare audit form (EMAS) and standard formulated discharge letters.

**Results:** 126 discharge letters (70 emergencies, 50 elective, 5 ward transfers, 1 unclear) were analysed (M:F 56:70). Inpatient stay ranged from 0 to 39 days. Number of days from discharge to dictation was higher for standard formulated discharge letters (Average 18.9, Min 2, Max 104) than audit form discharge letters (Average 11.04, Min 1, Max 14). EMAS letters had a higher number of days from dictation to typing (EMAS Average 3.94, Min 0, Max 14, Standard formulated Average 3.48, Min 0, Max 10), 15 discharge letters were not completed. Conclusion: There is a significant time delay in discharge letters arriving to General Practitioners and discharge letters not completed. Currently the EMAS system appears to be faster however a new system is required. An electronic discharge system would ensure General Practitioners receive timely, correct, legible patient information including drug changes and improve patient safety.

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**0272 THE ROLE OF PREOPERATIVE DUPLEX ULTRASOUND AS AN ALTERNATIVE TO CONVENTIONAL ARTERIOGRAPHY IN DESIGNING THE SURGICAL STRATEGY IN PATIENTS WITH CRITICAL LIMB ISCHAEMIA UNDERGOING BELOW-KNEE REVASCULARIZATION**
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**Background:** Conventional angiography (CA) is the gold standard for the pre-operative evaluation of the lower limb arterial tree despite well documented associated risks. Duplex ultrasound (DUS) is a non invasive alternative technique.

**Aims:** To investigate the role of DUS as a sole pre-procedural imaging study in patients undergoing below-knee revascularization.

**Methods:** A systematic review was performed using articles published within the last 10 years identified by searching the databases MEDLINE, EMBASE and The Cochrane Library. Selection criteria included cohort studies with good reference standards to quantify the diagnostic ability of DUS in below-knee revascularization.

**Results:** Five studies were included with a total of 528 patients. Two studies showed significant agreement in 389 patients between CA and DUS in mapping the below knee arterial tree (P<0.05). In the remaining 3 studies the calculated overall positive predictive value (PPV) and negative predictive value (NPV) were 95% and 90% respectively in total of 139 patients undergoing DUS.

**Conclusions:** Although DUS has high PPV and NPV, CA is the best diagnostic test in below-knee bypass surgery. DUS can replace CA as long as it can visualize at least one of the crucial arteries which is in continuity of the superficial femoral artery.

**0276 VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS IN ACUTE GENERAL SURGICAL PATIENTS: A 2 CYCLE AUDIT**
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**Background:** Hospital in-patients have a tenfold increased risk of VTE. SIGN guidelines recommend all patients are individually risk assessed and receive thromboprophylaxis.
Aim: To examine the effect of education on compliance with VTE prophylaxis guidelines.
Method: Undertake retrospective (Sept 2009) and prospective (Oct 2009) analysis of hospital records collected over two acute surgical receiving weeks assessing demographics, presenting complaint, VTE risk and prescribing accuracy.
Results: Comparison of VTE risk assessment and prophylaxis guidelines remains poor thus further efforts are needed improve education.

0281 HOW TO IMPROVE THE MANAGEMENT OF HIP FRACTURES: AN EFFECTIVE STRATEGY AT THE WILLIAM HARVEY
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Introduction: Hip fractures are regularly audited and managed with nationwide standards. Audits at the William Harvey revealed 66% of hip fractures were operated within 48 hours (national average 75%). We implemented a strategy to improve this target by introducing the ‘Dawn Hip’ – a hip fracture operation which is prepared for 8am on the Emergency (CEPOD) list.
Methods: For two months after introducing the ‘Dawn Hip’, the number of trauma hip operations and start time, on the CEPOD list, were audited. Performance data were extrapolated from the National Hip Fracture Database (NHFD) and compared nationally.
Results: Three months prior to the ‘Dawn Hip’ the average start time of surgery on the CEPOD list was 9.50am. Since the introduction of the ‘Dawn Hip’, 67% of trauma hip operations were done on the CEPOD list, average start time 8.38am. Data from the NHFD revealed 81% of trauma hip operations were operated within 48 hours (national average 80%).
Conclusion: This is an effective strategy which increases efficiency of existing resources and improves hospital performance. This has implications in improving clinical care for hip fractures and other trauma cases, but also cost incentives provided to the trust for meeting targets in hip fracture management.

0282 INFLUENCE OF SOCIAL DEPRIVATION ON REFERRAL PATTERN AND RATES OF RADICAL PROSTATECTOMY FOR EARLY LOCALISED PROSTATE CANCER IN ENGLAND
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Introduction: Prostate cancer accounts for 25% of new cancers and is the second most common cause of cancer-related death in men in the UK. Referral depends on several factors. Treatments choices are generally offered after the diagnosis of organ-confined prostate cancer. Scrutiny of referral and treatment in England has been prompted by the changing incidence.
Materials and Methods: Incident cases and treatment choices were extracted from the Hospital Episode Statistics and the National Cancer Data Repository for 2000-2007 (England), analysed by social deprivation (department of Communities and Local Government, http://www.communities.gov.uk/publications/communities/indicesdeprivation07) and controlled for age-distribution.
Results: Social deprivation is statistically significantly associated with referral pattern and rates of radical prostatectomy. Patients from the most deprived quintile are significantly less likely to undergo radical prostatectomy, a finding which is unchanged from 2000-2007 despite an overall increase in radical prostatectomy rates from 7% to 11% of incident cases.
Conclusion: In England there is a clear difference in referral pattern and prostatectomy rates for organ-confined prostate cancer between areas of different deprivation. This difference is likely multifactorial. It is similar to the inverse association noted between cardiac surgery and socioeconomic status. These data are important in guiding national policy development.

0284 ENDOVASCULAR TREATMENT OF ISOLATED INTERNAL ILIAC ARTERY ANEURYSMS
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Objective: To evaluate the outcome of endovascular treatments for isolated internal iliac artery aneurysms.
Methods: A systematic review of the literature using public domain databases was undertaken. All studies reporting on treatments of isolated hypogastric artery aneurysms by endovascular means were considered. Experience from our institution was involved in the analysis. The primary outcome measures were technical success, perioperative, 30-day, and overall mortality/morbidity.
Results: Data was extracted from 30 articles fulfilling the selection criteria, and the study cohort consisted of 55 patients having undergone treatment of 59 internal iliac artery aneurysms. Ten patients (18%) were treated on an urgent or emergency basis for a ruptured aneurysm. Technical success was achieved in 71% of the cases. The most common reason for technical failure was incomplete exclusion of the aneurysm sac. Thirty-day mortality occurred in one patient (2%). The 30-day morbidity rate was 20% and was mostly associated with insufficiency of the pelvic circulation. One aneurysm-related death occurred during a mean follow up period of 13 months (range, 0.5-56 months). Open surgical intervention for aneurysm-related complications was required in 5 patients.
Conclusions: Endovascular treatment of isolated internal iliac artery aneurysms is an effective alternative option, with satisfactory early and mid-term results.

0285 PRE-TRANSPLANT SERUM CXCL9 AND CXCL10 LEVELS FAIL TO PREDICT ACUTE REJECTION IN KIDNEY TRANSPLANT RECIPIENTS RECEIVING INDUCTION THERAPY
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Aims: In kidney transplant recipients not treated with induction therapy, pre-transplant serum CXCR3-binding chemokines CXCL9 and CXCL10 levels are associated with acute rejection (AR) and graft loss. Since induction therapy potentially alters cellular responses to CXCR3-binding chemokines post-transplantation, we have tested predictive values of pre-transplant serum CXCL9 and CXCL10 levels for AR in patients receiving either Alemtuzumab or Basiliximab induction.
Method: 64 kidney transplant recipients, 44 receiving Basiliximab and 20 receiving Alemtuzumab, were observed for one year post-transplantation.
Results: 12 patients experienced AR. Pre-transplant serum was assayed for CXCL9 and CXCL10 levels by ELISA. Total leukocyte gene expression was determined using real-time RT-PCR. No significant difference between non-rejecting patients and patients with AR, in CXCL9 levels (296.4±452.9 vs. 150.1±88.4, P = ns) or CXCL10 levels (158.2±91.1 vs. 97.5±376, P = ns) was observed. Analysis of peripheral blood CXCR3 expression showed a profound reduction of CXCR3 mRNA levels in Alemtuzumab-treated patients.
Conclusion: This study shows that pre-transplant serum CXCL9 and CXCL10 levels fail to predict AR in kidney transplant recipients receiving Alemtuzumab or Basiliximab, likely due to depletion or inactivation of