or a mean excess percent BMI loss (EBL) of 7.4 kg/m². At 1 year, the mean reduction in BMI was 11.1 [EBL of 33.6 kg/m²]. At 2 years, the mean reduction in BMI was 13.29 [EBL of 41.5 kg/m²]. Correlation between pre-operative weight loss versus weight lost at 1 and 2 years was performed. At 1 year & 2 years post-operatively, the Spearman Rank Correlation was 0.154 [p = 0.208] and 0.069 [p = 0.575] respectively (no statistical significant correlation).

Conclusion: In this study, pre-operative dietary weight loss does not correlate with better outcomes following laparoscopic adjustable gastric banding.

1046: HOW DOES A NORTHERN TRUST WITH UNIQUE GEOGRAPHICAL CHALLENGES COMPARE WITH SCOTTISH NATIONAL DATA FOR ALL CANCERS IN KEEPING TERMINALLY ILL UPPER GI CANCER PATIENTS OUT OF HOSPITAL – TO DIE AT HOME?
Angharad Jones 1, Ron Coggins 1, Jen Godsm an 2, 1 Raigmore Hospital, Inverness, UK; 2 NHS Highland, North of Scotland, UK

Aim: To study end of life care for Upper GI cancer patients diagnosed within geographically diverse northern NHS Highland.

Methods: Four national databases were searched using ICD10 codes for Upper GI cancer for years 2005-2010. For patients diagnosed in this region, place of death (home, hospital, hospice or ‘other institution’) was recorded and compared with Scottish national data for all cancers.

Results: 978 Upper GI cancer patients were diagnosed within the study period. 298 were excluded as place of death was unknown. Of the remaining 680 patients 237 (34.9%) died at home, 295 (43.4%) died in hospital, 96 (14.1%) died in hospice and 49 (7.2%) died in another institution. Of 75522 680 patients 237 (34.9%) died at home, 295 (43.4%) died in hospital, 96 (14.1%) died in hospice and 49 (7.2%) died in another institution. Of 75522 cancer deaths in Scotland between 2004-2008 equivalent percentages were 24.3% (home), 51.9% (hospital), 17.6% (hospice) and 6.2% (‘other’). Highly significant differences between NHS Highland and national data were found in both ‘at home’ and ‘in hospital’ deaths (p<0.0001).

Conclusions: Over half of cancer patients in Scotland die in hospital and a quarter die at home. In our study group, fewer patients die in hospital with over one third dying at home. Despite Highland geographical challenges, ability to deliver end of life care for Upper GI cancer patients is uncompromised.

1155: ONE-STOP CHOLECYSTECTOMY CLINIC: A WAY FORWARD FOR THE FUTURE?
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Objective: To assess whether a ‘one stop cholecystectomy clinic’ had an impact on the waiting time, pre-operative visits and admissions for patients with gallbladder diseases and thus improved their 18 week pathway.

Patients and Method: A retrospective observational study of patients attending the ‘one stop cholecystectomy clinic’ (Group A) and the traditional routine clinics (Group B) for patients with gallbladder diseases during 2010 was completed. Patients were preassessed & wait listed for surgery. Primary outcome measured was the waiting time, secondary outcome measured were the pre-operative visits & the emergency hospital admissions whilst awaiting surgery.

Results: Study included 129 patients with a mean age of 49 (SD ±16) years & female to male ratio of 101:28. Of the 129, 59 (46%) belonged to Group A and had a waiting time of 7.3* (95% CI 6.2 – 8.5) weeks compared to 16.6 (95% CI 14.0 – 19.2) weeks for the 70 (54%) belonging to Group B (p-value <0.001).

One unnecessary hospital visit for pre-assessment was avoided in all Group A compared to Group B patients and 9 (15%) Group A patients needed emergency admission compared to 19 (27%) Group B patients meaning significant cost implications.

Conclusion: One-stop cholecystectomy clinic achieves improved patient journey through reduction in emergency admissions, waiting times and unnecessary hospital visits.

1185: SHOULD CT COLONOSCOPY REPLACE FLEXIBLE SIGMOIDOSCOPY?
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Aims: It is recommended that all patients undergoing barium enema have a flexible sigmoidoscopy (FS) to exclude disease distal to the rectosigmoid junction. With the introduction of CT colonoscopy (CTC) is sigmoidoscopy still required for the investigation of suspected colorectal cancer (CRC).

Methods: The findings of CTC in 520 consecutive patients were reviewed by a GI radiologist blinded to the findings at FS. Patients with not adequate bowel preparation for FS, colonoscopy, polypectomy, abnormal MRI or CTC as first line investigation, more than six months period between CTC and FS were excluded. Statistical analyses were performed with Chi-Squared and Fisher test.

Results: 306 patients were excluded. In 188(88%) patients there was concordance between the findings on FS and CTC. Sensitivity and specificity of FS was 74% and 99% respectively (p<0.001), PPV 93.9%, NPV 99.4%. FS did not identify 6 cancers when CTC missed only 2 malignant pathologies classified as inadequate picture due to collapse colon, further investigation has been advised. We could identify statistically significant (p<0.05) dependence between bowel symptoms like PR bleeding and iron deficiency anaemia and diagnosis of bowel cancer in patients undergo FS.

Conclusions: A negative CTC excludes the presence of colorectal cancer.

1208: ANAEMIA AND BARIATRIC SURGERY: A DOUBLE WHAMMY
Mustafa Khanbhai 1, Karishma Patel 2, Sukhpreet Dubb 2, Ahmed Ahmed 1, Toby Richards 1, 1 University College London, London, UK; 2 Imperial College London, London, UK

Background: As bariatric surgery rates continue to climb, anaemia will become an increasing concern. We assessed the prevalence of anaemia and length of hospital stay in patients undergoing bariatric surgery.

Methods: Prospective data (anaemia [Haemoglobin < 12 g/dl], haematinics and length of hospital stay) was analysed on 400 hundred patients undergoing elective laparoscopic bariatric surgery. Results were compared to a prospective database of 1530 patients undergoing elective general surgery as a baseline.

Results: Fifty-seven patients (14%) were anaemic pre-operatively. Median MCV (fL) and overall median Ferritin (µg/L) was lower in anaemic patients (83 vs. 86, p=0.001) and (28 vs. 61, p=0.0001) respectively. Compared to elective general surgery patients, prevalence of anaemia was similar (14% vs. 16%) but absolute iron deficiency was more common in those undergoing bariatric surgery; microcytosis p<0.0001, Ferritin <30 p=0.0001. Mean length of stay (days) was increased in the anaemic compared to in the non-anaemic group (2.7 vs. 1.9). Interestingly, patients who were anaemic immediately post-operatively, also had an increased length of stay (2.7 vs. 1.9), p<0.05.

Conclusion: Absolute iron deficiency was more common in patients undergoing bariatric surgery. In bariatric patients with anaemia there was an overall increased length of hospital stay, suggesting a role in pre-optimisation.

UROLOGY

0016: MANAGEMENT OF ACUTE EPIDIDYMO-ORCHITIS: SHOULD WE CHANGE OUR PRACTICE?
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Aim: The latest antibiotic guideline for epididymo-orchitis from the British Association of Sexual Health and HIV was released in June 2010. We reviewed the management of patients presenting with epididymo-orchitis over a 2 year period to see if the new guideline should be incorporated locally.

Method: Data was collected retrospectively looking at all patients presenting to hospital with a diagnosis of epididymo-orchitis from July 2008 to August 2010. Information collected included; patient age; admission date; mid-stream urine for routine culture and/or Chlamydia PCR; scrotal ultrasound findings; treatment and re-presentation to hospital.

Results: 66 patients were identified. The mean age was 47.29 years with twenty patients being below 35 years. Antibiotic treatment regimes used included Gentamicin and Ciprofloxacin (15.2% of cases), Ciprofloxacin alone (48.5%) and Doxycycline +/- Ciprofloxacin (15.2%). 9 patients had operative intervention. 3 cases were untreated. 3 patients re-presented to hospital with unresolved symptoms or complications.

Conclusion: Our current antibiotic policy seems to be successful as indicated by the few re-presentations and complications. Similar regimes are in use region wide. The 2010 guideline would suggest changing practice. However,
we feel that this is currently not indicated as our hospital regime appears to be effective in managing patients with acute epididymo-orchitis.

0024: PRIMARY HYPERPARATHYROIDISM AND UROLITHIASIS: OUR EARLY EXPERIENCE
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Background: Hyperparathyroidism is associated with an increase risk of developing renal calculi. The aim of this study was to quantify the incidence of renal calculi in patients undergoing parathyroidectomy.

Method: A retrospective study of 38 patients that have undergone parathyroidectomy between 2002 and 2009 was performed. Patient age, mode of discovery, serum levels of biochemical markers and types of renal imaging were evaluated.

Results: 38 patients (7 male), median age 59 (range 31-79) were reviewed. All patients were diagnosed with primary hyperparathyroidism incidentally. Histology of parathyroids showed 9 nodular hyperplasias and 29 parathyroid adenomas. Median adjusted calcium is 2.87 (range 2.62 – 5.3), median parathyroid hormone level is 15.2 (range 6.6 - 114.8). 6 (15%) had a 24 hour urine calcium level test and 4 (10%) had renal stone. 13 (31%) out of 18 patients (US±5, CT KUB=3, IVU=3, abdominal x-ray=2) who have undergone renal imaging had renal calculi. 6 (16%) had renal calculi detected before confirmatory blood test for hyperparathyroidism.

Conclusion: Ultrasound scan of the kidneys could be recommended for all parathyroidectomy patients. A prospective study with 24 hours urinary metabolic work up might help to answer the relationship between primary hyperparathyroidism and urolithiasis.

0052: THE NATURAL HISTORY OF UNTREATED PROSTATE MRI LESIONS IN AN ACTIVE SURVEILLANCE PROSTATE CANCER POPULATION – 260 PATIENT-YEARS
Daniel J. Stevens, Caroline M. Moore, Hashim U. Ahmed, Clare Allen, Alex Kirkham, Jan van der Meulen, Mark Emberton. UCL Division of Surgery and Interventional Science, London, UK

Aim: Lesions detected by multi-parametric (mpMRI) are positively associated with higher volume and higher grade of prostate cancer. This attribute of mpMRI makes it an ideal candidate as a tool in active surveillance (AS) to identify disease progression.

Method: Men in an AS programme were eligible provided they had 2 mpMRIs at least 3 months apart without any prostate cancer treatment. Images were assessed for the presence of a visible lesion (on T2, DCE or ADC map), and progression (by size/intensity of an existing lesion or detection of a new lesion).

Results: 98 men with histologically proven prostate cancer and a combined follow-up of 260 patient years were eligible. 51 men demonstrated no MRI progression during follow-up and all continued on active surveillance. 14/98 men underwent treatment. 11/14 either had a visible baseline lesion or developed one during follow-up.

Conclusions: Those men who did not radiologically progress at any point remained on active surveillance. The role of mpMRI in active surveillance merits further investigation.

0068: OUTCOME OF NEPHRECTOMIES IN THE OVER-EIGHTIES IN A LARGE DISTRICT GENERAL HOSPITAL
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Purpose: We investigated the morbidity and outcome of open and laparoscopic nephrectomies in patients 80 years old and over.

Materials and Methods: The records of octogenarians who underwent a nephrectomy from 1983 to 2009 were reviewed. Of 410 nephrectomies, 61 patients were originally identified, but 33 met our inclusion criteria. Patient records were analysed for morbidity and outcome.

Results: 33 patients were included with a median age of 82 years (range 80-89), (20 M; 13F). 21 patients had significant co-morbidities, including 5 with 2 or more medical problems. Indications for surgery included malignant disease in 31 patients and benign disease in two patients. There was a 58% complication rate, including 18 intraoperative, 36% cardiovascular and respiratory and 12% renal complications. Of 13 laparoscopic cases one was converted to open. There were no returns to theatre.

30-day mortality was 3%. Overall median survival was 36 months, with a urological cancer related death rate of 32%.

Conclusion: The overall benefit of nephrectomies in patients over 80 years of age outweighs the risks of surgery. Although the morbidity rate is 58%, the overall median survival of 36 months suggests that surgery remains justified.

0208: ROLE OF EXTERNAL SPHINCTEROTOMY IN THE LONG TERM MANAGEMENT OF PATIENTS WITH SPINAL INJURY
Vijay Rao Gudla, Meena Agarwal. Cardiff and Vale NHS trust, Cardiff, UK

Introduction: Urological problems are the second most common cause of death in spinal injury patients. The optimal bladder management methods should preserve renal function and minimize urinary tract complications. Clean intermittent catheterisation is a gold standard. External sphincterotomy is also one of the methods to keep the patients free from catheter. The aim of this study is to look at the catheter free period and associated long term complications.

Methods: A database review of the patients undergoing external sphincterotomy in our hospital was done.

Results: A total of 24 patients were included in the study (12 with paraplegia, 11 with tetraplegia). The mean follow up after the first sphincterotomy was 13.75 years (range 1- 36). Sixteen (67%) patients during the follow up needed the repeat sphincterotomy. Sixteen (67%) patients with the average duration of 16 (1-30) years were catheter free. Three (13%) patients needed to have an ileal conduit diversion, 5(20%) patients were converted into long term catheters.

Conclusion: External sphincterotomy has an important role in the treatment of the spinal cord injury patients with a neuropathic bladder. It is the treatment of choice for patients with a hyperreflexic bladder who are unable to catheterize themselves but can use condom drainage.

0285: PROSPECTIVE STUDY COMPARING WHITELIGHT CYSTOSCOPY VERSUS BLUELIGHT FLUORESCENCE CYSTOSCOPY IN DETECTING HIGH GRADE BLADDER TUMOUR
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Aims: Fluoroscopic-assisted (e.g. Hexvix) cystoscopy improve diagnostic yield primary transitional cell carcinoma in situ (CIS), detection rates for superficial bladder cancers; but not for the detection of high grade recurrence. The aims of this study were to validate blue light (BL) fluorescence cystoscopy after the intra-vesical application of hexaminolevulinate hydrochloride against conventional white light (WL) cystoscopy.

Methods: Prospective data from April to October 2010 was collected for primary high grade transitional cell bladder carcinoma (TCC), which were initially managed with transurethral resection of bladder tumour and/or chemotherapy.

Results: There was histopathologically confirmed recurrence in nine patients. WL and BL both detected recurrence in eight patients but also missed a CIS recurrence within random scar biopsy. There was no statistically significant difference between WL and BL in terms of sensitivity (89% and 86%), specificity (62% and 50%), false positive rates (38% and 47%) or false negative rates (14.3% and 11%).

Conclusions: WL and BL cystoscopy utilised for the surveillance of high grade bladder TCC demonstrated no significant difference. BL adjuvant does not impart an improved diagnostic yield. The one false negative case for recurrent CIS disease with CIS recurrence is clinically significant and does demonstrate the importance of random biopsies in suspected CIS.

0287: CURRENT STATUS OF VALIDATION FOR ROBOTIC SURGERY SIMULATORS – A SYSTEMATIC REVIEW
Hamid Abboudi, Mohammed Shamim Khan, Omar Aboumarzouk, Khurshid Guru, Ben Challacombe, Prokar Dasgupta, Kamran Ahmed. Guy's Hospital, London, UK

Objectives: We analyzed studies validating the effectiveness of robotic surgery simulators.

Materials and Methods: The MEDLINE®, EMBASETM and PsycINFOTM databases were systematically searched until September 2011. Simulator name, training tasks, participant level, training duration and evaluation scoring were extracted.