assess how the LEV in Plastic Surgery has changed from 2003 to 2013, compared with five other specialties.

Methods: Articles in 2003 and 2013 of the top three general plastic surgery journals (by 2013 Impact Factor-IF) were systematically labeled as LEV 1–5, defined by the American Society of Plastic Surgeons. Comparisons were made with five other surgical specialties.

Results: The mean LEV for plastic surgery improved by 4.1% from 3.86 to 3.70 in 2003 to 2013. Journals representing all six specialties included in this study have improved their mean LEV (range 3.7%–10.9%). Plastic Surgery ranks 5/6 of specialties in order of the mean LEV achieved in both 2003 and 2013. All specialties reduced the proportion of level five evidence published. There was a slight trend towards higher LEV with higher weighted or mean IF but this did not reach significance (p = 0.065 and 0.079 respectively).

Conclusion: Plastic Surgery is tending towards higher levels of evidence albeit at a slow pace. The specialty must continue to drive towards higher LEV to improve the corpora of research for evidence-based decision-making.

0824: THE NEED FOR CORE OUTCOME REPORTING IN AUTOLOGOUS FAT GRAFTING FOR BREAST RECONSTRUCTION

G. Wellstead 2, 3, R. Agha 3, A. Fowler 2, T. Pidgeon 4, D. Orgill 5. The Academic Surgical Collaborative. 1 The Academic Surgical Collaborative, UK; 2 Barts and The London School of Medicine and Dentistry, UK; 3 Mid-Yorkshire Hospitals NHS Trust, UK; 4 University Hospital Coventry and Warwickshire NHS Trust, UK; 5 Brigham and Women’s Hospital Boston, USA

Aim: There is growing interest in the potential of autologous fat grafting (AFG) for breast reconstruction. This follow-on work from our recent systematic review of this area looks at the range of outcomes used, their definition and whether there is a need for a core outcome set to aid reporting.

Methods: Following on from prior work involving a search of 20 databases from 1986 to March 2014, 35 studies meeting the inclusion criteria for our systematic review were assessed.

Results: A total of 51 different outcomes were reported across the 35 studies. Each study reported a median of 5 separate outcomes (range 2–14), of which a median of 3 outcomes was defined (range 0–14). A median of 2 outcomes per paper were pre-specified in the methods (range 0–12), with a median of only 2 outcomes both defined and pre-specified (range 0–12). The most commonly reported outcome, reported by 26 studies, was “Operative details”, however 8 different definitions were used. Overall, there was a poor proportion of defined and pre-specified outcomes, employing a wide range of different definitions.

Conclusion: There is a need for a core outcomes set for AFG to minimise outcome and reporting bias and aid evidence synthesis.

Posters: Coloproctology

0032L: THE CORRELATION OF SURGEONS’ AGE TO POST-OPERATIVE MORTALITY

R. Edmonds a, 1, D. Nepogodiev b, 1, T. Pinkney b, 1. King’s College London, UK; 1 University of Birmingham, UK

Aim: This study aimed to identify whether surgeon’s age is related to colorectal cancer mortality rates.

Methods: Mortality rates for surgeons who performed >10 elective resections for bowel cancer in 2010–2012 were extracted from data published by the Association of Coloproctology of Great Britain and Ireland. Surgeons’ ages were estimated based on year of graduation, extracted from the General Medical Council register. Surgeons were split in to three age groups for analysis (<42, 43–49 and ≥50 years).

Results: Outcomes were available for 25,827 procedures performed by 615 surgeons. Overall pooled unadjusted mortality was 2.9% (745/25827). For surgeons aged <42 years it was 2.27% (from 225 surgeons), it was 3.16% (n = 192) for ages 43–49 years, and 3.28% (n = 127) for those ≥50 years. Surgeons aged <42 had significantly lower rates versus both surgeons aged 43–49 (odds ratio (OR) 1.39, p < 0.001) and ≥50 (OR 1.45, p < 0.001). There were no significant differences between surgeons aged 42–49 and ≥50 years. Analysis of adjusted mortality rates replicated these findings.

Conclusion: Surgeons aged <42 years have lower post-operative colorectal cancer mortality rates than surgeons aged ≥42 years. However, risk-adjustment may have been incomplete and senior surgeons may undertake more complex and high-risk procedures.

0145: THE YIELD OF PATHOLOGY FROM DIAGNOSTIC FLEXIBLE SIGMOIDOSCOPY IN PATIENTS UNDER 40 YEARS

P. Orchard 1, R. Mustafa, C. Thorn, R. Alexander. Great Western Hospital, UK

Aim: Flexible sigmoidoscopy (FS) allows both macroscopic and histological assessment of the left colon and rectum. Current guidelines define the need for FS in patients over 40 yrs, but is lacking in those under 40yrs.

Methods: Data was analysed from our prospectively collected database over a one-year period (April 2013–14). Patients undergoing diagnostic FS under 40yrs were included (n = 136). Fisher’s exact and Chi squared were used for analysis.

Results: 38 patients (28%) yielded pathology: 29 (21%) had a politis, 5 (4%) had polyps, and 4 patients had other benign pathology. No patients had a cancer. Analysis of indication for FS indicated a non-significant (p = 0.09) propensity of finding pathology in patients with rectal bleeding and abdo pain or change of bowel habit (46%). Our data supports a smaller published series (Mittapalli et al 2008) for pathology yield (p = 0.33).

Conclusion: This study provides evidence that FS in the under 40’s identifies pathology in approximately 1 in 4 patients. Presenting with a PK bleed in addition to other symptoms is, perhaps more likely to yield pathology.

0161: WHAT HAPPENS TO PILONIDAL ABSCESSES AFTER EMERGENCY INCISION AND DRAINAGE?

A.O. Rae 1, M.J. Lee, A. Harikrishnan. Northern General Hospital, UK

Aim: Pilonidal abscess is a common condition, which is managed by the on-call team. It is recognised that some patients will recur after incision and drainage (I&D) and will require further treatment. Our aim was to identify what proportion of patients undergoing I&D required subsequent intervention, with the aim of informing our follow-up policy.

Methods: Patients undergoing I&D of pilonidal abscess over a four-year period were identified through theatre registers. Dates of procedures, intervals between procedures and follow-up data were recorded.

Results: I&D was performed 311 times over four years. Median duration of follow-up was 679 days. The risk of recurrence after first I&D was 10.9%, increasing to 20.5%, 42.8% and 66.6% after the 2nd, 3rd and 4th events respectively. Median time to recurrence was 163, 165, 127 and 39 days for 1st, 2nd, 3rd and 4th episode respectively. After the first recurrence, 65% of patients were followed-up. One patient was offered follow-up after third recurrence and none of those with a 4th recurrence had follow-up. Conclusion: 90% of patients had index drainage only. The risk of recurrence increases with each episode of abscess requiring a drainage procedure and the associated interval decreases. We should follow-up patients after their first recurrence.

0184: AUDIT TO ASSESS EFFECTIVE REPORTING AND IMPROVE EARLY DETECTION OF SURGICAL SITE INFECTIONS IN COLORECTAL SURGERY AT A DISTRICT GENERAL HOSPITAL

A. Lai 1, C. Thorn, S. Moseley, J. Gorham, F. Gooding, N. Earl. Great Western Hospital, UK

Aim: Surgical site infections (SSIs) affect patient morbidity and have significant financial implications through extended hospital stay. Accurate reporting of SSI is essential for surveillance and early detection of SSIs allows timely intervention. Our aim was to assess effectiveness of
reporting of SSIs in General Surgery. Development of a new scoring system to actively detect SSIs and its effectiveness is compared with an established system.

Methods: Retrospective study of 76 patients who underwent colorectal resections between 1st June and 31st August 2014. Prospective study of 43 patients operated on from 1st October to 15th November 2014. Surgical wounds were assessed by 2 independent assessors twice weekly using 2 scoring systems.

Results: SSI rate from the retrospective study was 6.6%. 80% of SSI cases were reported in discharge summaries. 5.2% of patients were coded as SSIs. SSI rate in the prospective study was 9.3%. 25% of these cases were diagnosed as SSIs on both scoring systems. 75% cases were detected as high risk for SSIs on both scoring systems before a diagnosis of SSIs was made.

Conclusion: There is under-reporting and discrepancy between coding and actual rate of SSIs. The new scoring system showed promise in detecting early signs of SSIs for early intervention.

0204: THE SUPERIOR MESENTERIC ARTERY STENOSIS IN COLORECTAL CANCER PATIENTS: RADIOLOGICAL REPORTING AND CLINICAL OUTCOMES

J. Kaczynski, P. Hrobar, J. Sathianathan, I. Muir. Dumfries and Galloway Royal Infirmary, UK

Aim: Anastomotic leakage (AL) remains the most serious complication following restoration of bowel continuity. The primary aims were to assess radiological reporting of the Superior Mesenteric Artery (SMA) stenosis and to correlate the severity of the SMA stenosis with an AL rate. Secondary objective was to formulate management plan of the SMA revascularisation in patients with the concurrent colorectal cancer.

Methods: Retrospective audit of all patients listed at the colorectal multidisciplinary team meeting between February 2010-March 2012. Computed tomography scans reports were checked for diagnosis of the SMA stenosis. Relevant case notes were examined for an AL rate.

Results: 407 patients with median age of 78 (range 43-92), 240 were males. The SMA stenosis was reported in 7 cases. It was unreported in 70 cases and these included 24 cases with the SMA stenosis <30%, 26 (30-50%), 15 (50-70%) and 5 cases >70% stenosis. There were no anastomotic leaks in either of the groups.

Conclusion: Although no correlation between the severity of the SMA stenosis and AL rate following colorectal cancer surgery was found, reporting guidelines that define the aspects of radiological good medical practice should be followed. Revascularisation of the <70% SMA stenosis is not indicated.

0294: EXERCISE TOLERANCE IS THE ONLY MODIFIABLE LIFESTYLE FACTOR THAT PREDICTS POST-OPERATIVE OUTCOMES IN AN ERAS POPULATION

E. McLennan, R. Oliphant, C. McCutcheon, S. Moug, University of Glasgow, UK, Royal Alexandra Hospital, UK

Aim: Enhanced recovery after surgery (ERAS) programmes aim to standardise peri-operative care to improve patients outcomes. However, individual lifestyle factors can also significantly influence outcomes. This study explores the influence of such factors on short-term outcomes after colorectal surgery.

Methods: Consecutive patients enrolled on an ERAS pathway after elective colorectal surgery at one hospital site (June 2013 – March 2014) were included. Prospectively collected data from an ERAS departmental database were linked to computerised hospital records that recorded lifestyle factors and analysed for their influence on post-operative complications and length of stay.

Results: 138 patients (55.1% male) were included. Patients with limited pre-operative exercise tolerance (self-reported by patient as ‘unable to climb 2 flights of stairs without stopping’) were associated with a significant increase in post-operative complications (Clavien-Dindo I-II) OR 5.1 (95% CI 1.12, 21.03; P = 0.024) and almost 3 times more likely to have prolonged hospital stay [OR 2.87 (95% CI 1.02, 9.80; P = 0.047)] compared to those with good exercise tolerance. Age, gender, deprivation, smoking status, alcohol intake, BMI or level of co-morbidity were found not to be significant.

Conclusion: Limited exercise tolerance adversely influenced post-operative outcomes, creating a potential role for prehabilitation in colorectal surgery.

0304: SIX MONTH CLINICAL OUTCOMES IN PATIENTS WITH INTERMEDIATE RAISED FAecal CALPROTECTIN LEVELS

M. McFarlane, S. Chambers, A. Dhalliwal, A. Patel, C. Nwokolo, R. Arasaradnam. University Hospital Coventry & Warwickshire, Coventry, UK

Aim: A recent systematic review has confirmed the value of Faecal Calprotectin (FC) in distinguishing between organic and non-organic GI disease. We aimed to determine clinical outcomes in patients with intermediate FC levels, 50–250 mcg/g.

Methods: 444 patients were identified between June 2012 – October 2013: 351 normal (<50 mcg/g), 55 intermediate (50–250 mcg/g) and 34 raised (>250 mcg/g). 12 month clinical outcome data was analysed.

Results: Of those with normal FC results, only 18% were referred to secondary care, with a third of these in secondary care at 6 months. None were diagnosed with IBD.

Of those with raised FC, 17% were known IBD with a further 37% newly diagnosed with IBD. 40% remained in secondary care at 6 months.

Of the intermediate patients, 2% were known IBD and 10% were newly diagnosed, 16% were diagnosed with another organic GI condition (e.g. Diverticular disease). 22% were in secondary care at 6 months.

Conclusion: 1) 79% of FC requested were normal, with similar proportion managed in primary care without diagnosis of IBD. 2) Newly diagnosed IBD approximately 4 times more common with FC values >250 mcg/g. 3) 22% with intermediate FC levels remained in secondary care at 6 months.

0319: COLONOSCOPY: TO SCOPE OR NOT TO SCOPE?

I. Sama*, S. Kurrimboccus. Pennine Acute Hospitals NHS Trust, Manchester, UK

Aim: Same-day colonoscopy cancellations have a large financial impact on the NHS and a clinical impact on the patient and those waiting. We set out to evaluate same-day colonoscopy cancellations and determine reasons for cancellations with the aim of identifying shortfalls and improving services.

Methods: A retrospective review identified 52 patients with same-day colonoscopy cancellations from February 2012 to July 2014 from a single endoscopist’s list. Colonoscopy reports from Unisoft were obtained and analysed for indications and reasons for cancellation. Hospital databases were used to access previous colonoscopy and histology reports.

Results: 8.9% of all requested colonoscopies were cancelled on the day of the procedure over a 2.5-year period. 34.6% of patients were cancelled as a result of the procedure not being indicated, with 77.7% due to inappropriate follow-up for polyp surveillance, against BSG guidelines. 26.9% of patients were cancelled due to inadequate bowel preparation.

Conclusion: Colonoscopy remains the gold-standard investigation of choice for a number of colorectal symptoms. It is however resource intensive and expensive, with demand for services currently outweighing supply.

We highlight poor adherence to BSG guidelines with regard to polyp surveillance in this study with potential for improvement.

0381: EARLY WARNING SCORE PREDICTS RECOVERY AFTER MAJOR COLORECTAL SURGERY

S. Liptrot*, C. Walter, C. Harber. Nottingham University Hospital NHS Trust, Nottingham, UK

Aim: The early warning score (EWS) is an established tool that helps to identify patients at risk using a set of routine observations. The aim of this study was to determine if there was a relationship between an early abnormality in the EWS after major colorectal surgery and patients’ recovery.