Background: NICE recommends that patients undergoing endoscopy should cease treatment with a PPI or H2 receptor antagonist for a minimum of 2 weeks prior to endoscopy to prevent false negative tests.
Aim: To determine the extent to which these NICE guidelines are being followed in our Trust.
Method: This study analysed data obtained from questionnaires filled in by endoscopists at a district general hospital between October, 2010 and January, 2011.
Results: 67 questionnaire's were analysed. Median patient age was 80 years (male 48%, female 46%). Of the referrals analysed 62.7% were requested as a 2 week wait[s1] . Of this 2 week wait group, over 4 in 10 patients had been taking a PPI at referral. 24% of those patients on a PPI did not stop their PPI 2 weeks before endoscopy (of this group, a third were not verbally advised to stop PPI prior to endoscopy and 46% received the endoscopy information leaflet less than 2 weeks before endoscopy)
Conclusions: Lack of patient information may lead to the need for repeat procedures and potentially false negative endoscopies. This study highlights the importance of giving information leaflets during the consultation and verbally reinforcing the information.

0073: COMPLICATIONS OF LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING (LAGB) PERFORMED BY ONE SURGEON OVER A 10-YEAR PERIOD

Corinne Owers, Sophy Rymaruk, Roger Ackroyd. *Sheffield Teaching Hospitals, Sheffield, South Yorkshire, UK*

Background: Between November 2001 and September 2011, 1100 laparoscopic adjustable gastric banding operations (LAGB's) were performed by one surgeon. Our study examined the long-term complication rate.
Methods: All available medical notes (1079 patients) were reviewed.
Results: Mean weight was 120 kg, BMI 43.3. After 10 years of follow-up, complications occurred in 347 patients. 143 patients experienced band slippage; re-operation was required in half of these cases. 82 patients had their band removed due to complications, slippage in 60, erosion in 17 and band intolerance in 5. 136 patients experienced port problems; 37 were flipped on clinical or radiological fills, 17 patients had port infection. 50 ports required repositioning due to discomfort or difficulty with clinical fills; 16 were removed or replaced, including 5 for cutaneous erosion. 4 patients required other procedures to deal with intra-operative complications. 18 patients had a concurrent procedure. The only post-operative death was due to biliary peritonitis in a patient who had undergone simultaneous cholecystectomy.
Conclusion: Complication rates reflect the literature. Slippage rate may appear higher in our patients, but this is because most patients undergo radiological band fills hence many non-symptomatic slippages are detected. Only half of our slippages were clinically apparent or needed any intervention.

0138: POST-OPERATIVE RECOVERY FROM CHOLECYSTECTOMY AT A DISTRICT GENERAL HOSPITAL

Andrew Hannah, Jake Foster, Michael Terry. *Isle of Wight NHS Trust, Isle of Wight, UK*

Laparoscopic cholecystectomy is one of the most common general surgical operations; however the majority of patients undergoing this procedure receive no routine surgical follow-up. Descriptions of the recovery period and quoted rates of potential complications when counselling patients for this procedure are hence potentially inaccurate.
We sent a postal questionnaire to all patients who had undergone a cholecystectomy at our institution over a 6 month period (median 5 months post-op) in order to investigate patients' recovery from this procedure.
60% of 100 patients contacted returned the questionnaire. Median time to return to work and driving was 2 weeks. 48% of patients reported having a post-operative problem that they consulted their GP or A&E regarding: 50% of these were prescribed antibiotics. Reported complications included LRTI in 3.5% of responders, and surgical site infection in 22%. A single patient required re-operation, and 6 patients (10%) reported re-admission to hospital.
Little information specific to our unit has previously been available to aid in counselling patients undergoing cholecystectomy. Rates of surgical site infection and post-operative antibiotic requirements were much higher than our estimates. Knowledge of this may have an impact upon the way in which we practice and perform this operation in the future.

0183: CENTRALISATION OF UPPER GI CANCER SERVICES – IS THE HUB BETTER THAN THE SPOKE?

Simon Monkhouse, Jana Torres-Grau, Daniel Bawden, Claire Ross, Richard Krysztopik. *Royal United Hospital, Bath, UK*

Aims: To assess whether patients diagnosed with oesophageal or gastric cancer at a local district general hospital (the "spoke") have a similar temporal pathway through the decision making and treatment process compared to those patients presenting at the centralised, tertiary hospital (the "hub").
Methods: Between April 2010 and April 2011, patients with a new diagnosis of oesophago-gastric cancer from both the hub and spoke hospitals were included. Data regarding diagnosis, time from diagnosis to multidisciplinary (MDM) discussion and time from MDM decision to first treatment were all recorded and prospectively analysed.
Results: There was a statistically significant increase in the time from diagnosis to MDM discussion at the spoke hospital compared to the hub. (13.3 days vs.+ 25.67 days; P=0.001). However, time to first was significantly increased in the hub hospital compared to the spoke (43.4 days vs 25.5 days; P=0.023).
Conclusions: Witholding its limitations, this study is the first of its kind to show that there is a disparity in the management pathways of patients who first present to a regional hospital rather than the tertiary centre. Patients at the spoke hospital have a longer lead time into MDM but non-operative treatment appears to be delivered more quickly locally.

0203: OUTCOMES AT ONE YEAR FOLLOWING LAPAROSCOPIC SLEEVE GASTRECTOMY IN WALES

Andrew J. Beamish, Jessica J. Foster, Nia Eyre, William Beasley, Scott Caplin, John Baxter, Jonathan Barry. *Welsh Institute of Metabolic and Obesity Surgery, Morriston Hospital, Swansea, Wales, UK*

Aim: Seven of the UK's ten worst areas for morbid obesity occur within Wales and bariatric surgery is the only proven treatment strategy. This study aimed to compare percentage excess weight loss (%EWL) and comorbidity resolution following laparoscopic sleeve gastrectomy (LSG) against UK National Bariatric Surgery Registry 2010 (NBSR) figures.
Methods: Retrospective analysis was performed on patients undergoing LSG at a single centre. Weight and Body Mass Indices (BMIs) were measured pre-operatively, at 3-6 months (n=28) and at 12 months (n=20). Obesity-related comorbidities of type-II diabetes mellitus (T2DM), hypertension and obstructive sleep apnoea (OSA) were recorded preoperatively and at 12 months.
Results: Twenty-eight patients (median age 45.5 years [17-63yrs], m:f=7:21) were studied. At 3-6 months median %EWL was 28.0% (9.2–67.2%); median BMI reduced from 46.5kgm^{-2} to 37.8kgm^{-2}. At 12 months (20 patients), median %EWL was 55.7% (24.4-88.0%); median BMI reduced from 45.0kgm^{-2} to 32.3kgm^{-2}. At 12 months, 100% of patients (7 pts) with T2DM, 100% (6 pts) with hypertension and 80% (5 pts) with OSA demonstrated improvement or complete resolution of comorbidity.
Conclusion: Percentage EWL and comorbidity resolution at twelve months compare favourably with those of the NBSR (%EWL=56% vs. 54%; T2DM resolution=100% vs. 50%) after LSG.

0231: A 10 YEAR RETROSPECTIVE ANALYSIS OF OUTCOMES FOLLOWING PERFORATED GASTRIC OR DUODENAL ULCER

Kathryn Lynes, Sobana Vicknesvaran, Ali Al-Temimi, Kislaya Thakur. *Queen Elizabeth Hospital; South London Healthcare NHS Trust, Woolwich, London, UK*

Aim: Despite improved medical management for peptic ulcer disease, incidence of perforated ulcer remains unchanged, resulting in high mortality and morbidity. This study aims to establish outcomes following surgery for perforated ulcer and identify factors predicting mortality and morbidity.
Method: Records of 48 patients undergoing surgery for perforated peptic ulcer from 2001 to 2010 were retrospectively reviewed. Factors significantly increasing mortality and morbidity were determined with multivariate logistic regression. Factors analysed included: age; ASA grade; preoperative shock; co-morbidities and delayed presentation.
Results: There were 36 male and 12 female patients with mean age of 55 (range 20-89). 44 patients had a duodenal perforation. Only 2 perforations

were repaired laparoscopically. ASA grade and pre-operative shock independently predicted mortality ($p < 0.01$). ASA grade predicted morbidity ($p < 0.01$). Patients with Boey Score of 0, 1, 2 and 3 had 0, 6, 55 and 100% mortality respectively.
Conclusions: Our 30-day mortality of 14.6% compares to published figures of 4-31%. Morbidity of 50% was higher than expected which may be due to definition or case mix. The development of guidelines for managing perforated ulcer would permit comparison of outcomes between centres. Future directions for improving care include management of sepsis and use of laparoscopic surgery.

0482: DOES A RELATIONSHIP EXIST BETWEEN BLOOD GROUPS AND GASTRO-OESOPHAGEAL JUNCTIONAL TUMOURS?

Rachel Barnes, Rhiannon Bowen, Timothy Havard, Xavier Escofet. *Royal Glamorgan Hospital, Llantrisant, UK*

Aims: Many studies have been carried out to investigate the association of blood group antigens and disease. Cancers in general appear to be associated with group A and to a lesser extent group B. This study aimed to establish whether there is a positive association between inherited blood group antigens and the development of Gastro-oesophageal junctional (GOJ) tumours.
Methods: A retrospective analysis of a prospectively maintained database to identify all patients with GOJ tumours from 2000-2010. The blood groups and data on other risk factors were collected and compared with information from the Welsh Blood Service on the relevant catchment area. Statistical analysis was performed using the Chi squared test.
Results: 210 patients were diagnosed with GOJ tumour (79% male). Age range 31- 89 years (mean 68 years). All patients were Caucasian. The distribution of blood groups within the patient cohort was comparable to that of the general population within the catchment area ($p = 0.062$- 0.9).
Conclusion: There appears to be no association between blood groups and the development of gastro-oesophageal cancer. Larger scale studies will be required.

0530: FAST TRACK UPPER GASTROINTESTINAL SURGERY – A SYSTEMATIC REVIEW

Dilan Dabare, Vanash Patel, Emmanouil Zacharakis. *Queen Alexandra Hospital, Southsea, Portsmouth, UK*

Aims: The aim of this systematic review was to evaluate the feasibility of fast track surgery in upper gastrointestinal surgery.
Methods: A systematic review was performed by searching EMBASE, Medline, PsycINFO and Cochrane Library. The search strategy included the keywords: fast track, enhanced recovery and multimodal rehabilitation/optimization/perioperative care. We included all original studies and classified them according to the 17 fast-track interventions proposed by the Enhanced Recovery After Surgery Group. The primary endpoints were median length of hospital stay (LOS), readmissions, morbidity and mortality.
Results: 13 studies reporting on a total of 1621 patients were found: 2 randomised control trials and a case-series in gastric surgery; 2 case-control studies and a case-series in hepatic surgery; 2 case-series in oesophageal surgery; 2 case-control studies and 3 case-series in pancreatic surgery. The highest number of interventions implemented in gastric, hepatic, oesophageal and pancreatic surgery were 13, 15, 5 and 12 respectively. In all types of upper gastrointestinal surgery studies demonstrated a reduction in median length of stay ranging from 2-6 days, without an increase in readmission rates, morbidity and mortality.
Conclusions: Initial studies show that fast-track surgery is feasible and may reduce length of stay. However, high quality studies are required.

0552: AN AUDIT OF THE USE OF PET-CT AND FITNESS ASSESSMENT IN PATIENTS WITH OESOPHAGO-GASTRIC CANCER

Emily Hotton, Srikant Ganesh, Natalie Blencowe, Robert Whistance, Sean Strong, Jane Blazeby. *University of Bristol, Bristol, UK*

Aim: Accurate staging in oesophago-gastric (OG) cancer is essential for patients considered for radical treatment. National guidelines recommend that Positron Emission Tomography Computed Tomography (PET-CT) be performed in all OG cancer patients without CT evidence of metastatic disease and who are deemed fit for curative treatment. This study assessed adherence of the upper gastrointestinal (UGI) cancer multi-disciplinary team (MDT) to this audit standard.
Methods: A retrospective review of prospectively kept MDT records was performed for consecutive patients with OG cancer discussed at the central MDT between July 2008 and July 2010. Data collection included investigations performed, treatment outcomes and patient fitness.
Results: 102 MDT meetings discussed 460 patients with OG cancer of whom 241 were primarily considered for curative treatment. Of these, 3 patients did not undergo PET-CT and reasons for this were unknown. 24 patients (10.0%) were subsequently considered unfit for curative treatment. The audit target was met in 214 patients (88.7%).
Conclusion: Adherence to national PET-CT guidelines by the UGI MDT was good. Unnecssary PET-CT staging was performed in a number of patients ultimately deemed unfit for curative treatment. Early fitness assessment in the treatment pathway could improve compliance with national guidelines.

0553: AN AUDIT OF STAGING INVESTIGATIONS FOR PATIENTS UNDERGOING CURATIVE TREATMENT IN OESOPHAGO-GASTRIC CANCER

Srikant Ganesh, Emily Hotton, Natalie Blencowe, Robert Whistance, Jane Blazeby, Sean Strong. *University of Bristol, Bristol, UK*

Aim: Current guidelines recommend the use of Positron Emission Tomography Computed Tomography (PET-CT) in all fit patients with oesophago-gastric cancer (OGC), as part of the staging process. This study assessed investigations performed on recommendation of the upper gastrointestinal (UGI) cancer multi-disciplinary team (MDT) in patients scheduled for curative treatment. Unnecessary investigations were defined as those undertaken in patients ultimately deemed unfit for curative treatment.
Method: A review of MDT records was performed for consecutive patients with OG cancer discussed between 2008 and 2010. Details of all staging investigations and final management decisions were evaluated.
Results: 460 OGC patients were discussed. 241 were initially considered for curative treatment of which 24 were subsequently considered unfit. In these patients, 31 unnecessary investigations were performed including 18 endoscopic ultrasounds (75.0%), 4 second CT scans (16.7%), 5 staging laparoscopies (20.8%) and 4 additional investigations (16.7%).
Conclusion: Unnecessary staging investigations could have been avoided in approximately 10% of patients with cost saving implications.

0581: COMPLICATIONS AFTER BARIATRIC SURGERY

Michail Chatzikonstantinou, Tereza Remesova, Cemal Kavasogullari, Pratik Sufi. *Whittington Hospital NHS trust, London, UK*

Aim/Objective: To audit outcomes of bariatric surgery at North London Obesity Surgery Service (NLOSS). Participants: All patients who underwent elective bariatric surgery at NLOSS between January 2007 and October 2011
Main Outcome Measures. Mortality, overall un-planned readmission, median length of stay in hospital according to type of operations, gender and age.
Methods and data collection: A retrospective analysis of patient outcomes was performed using 4-year discharge data. Of 463 patients, 313 were Laparoscopic Roux-en Y Gastric Bypass (67,6%), 129 Gastric Band (57,8%) and 21 sleeve gastrectomy (5,4%). The patients for every procedure were divided into three age groups, 17-40 years, 41-60 and older than 60 years old. We examined these three procedures separately and compared mortality rates, median length of admission, and readmissions by age and gender.
Results: The overall mortality rate was 0.86. The median length of stay for gastric bypass and band was 4 days (0-34) and 2 (0-7) respectively and the unplanned 28 day readmission rate was 10.8% and 8.7% respectively.
Conclusions: Our statistical results were similar to international guidelines, with no significant difference with literature references.

0758: REMISSION OF TYPE 2 DIABETES FOLLOWING ROUX-EN-Y GASTRIC BYPASS ACCORDING TO NEW GUIDELINES

Haritharan Nageswaran, Martin Nnaji, Dimitri J. Pournaras, David Mahon, Richard Welbourn. *Taunton and Somerset Foundation Trust, Taunton, Somerset, UK*

Aim: Bariatric surgery is considered a long-term solution to the rising incidence of Type 2 Diabetes (T2DM) secondary to obesity, with a meta-