

laparoscopic resections(85%), 56 open(15%). 266 were ASA grade 1–2(85%), 58 ASA>3(85%). 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?

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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 colonic versus rectal surgery.

Method: Patients undergoing colorectal surgery on ERAS over 1year 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 colonic ERAS patients compared to 62 rectal ERAS patients. Similar median age between groups (69 versus 67years, $p=0.5$) 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 7.36days, $p=0.8$). 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($p=0.8$), intraabdominal 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

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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?

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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 decompression 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

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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 ($p = 0.72$)

Conclusions: 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 ABSCESS PREDICTIVE OF FISTULA FORMATION?

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

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 ($p < 0.005$).

Conclusions: These results suggest that patients found to have peri anal abscesses due to gram negative organisms should be examined and followed up in out 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

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