Partnership in their contracts with secondary care providers.

Aims: To establish the number of ENT procedures affected, and to compare local access to these procedures with SIGN and NICE guidance. Objectives: To determine numbers of patients listed for tonsillectomy, grommets, pinnaplasty or rhinoplasty, and the proportion in which exceptional funding was granted, with reference to local and national guidelines.

Methods: Retrospective data collected from admissions databases, theatre lists and clinic letters was analysed for three months from August 2010.

Results: Only 4 of the 38 LVPs are ENT procedures, but these comprised 27% (160/601) of ENT procedures, and 70% of all LVPs in the Trust. Some 28% (44 patients) did not receive their procedures, either due to funding refusal, or due to an arbitrary cut-off date being reached whilst awaiting funding.

Conclusion: The funding process for "low value procedures" needs to be amended to minimise inequalities in access, in particular for ENT procedures. We must ensure our correspondence explicitly highlights where patients meet national guidelines for exceptional funding. Re-audit at three months is planned.

0897 DAY CASE UNIT OUTCOMES
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Aims: Fiscal constraints require the NHS to work cost-effectively whilst providing safe patient outcomes and care. Free standing day case units have an overnight stay rate of 2.4%. We audited our overnight stay rates in order to identify ways of improving the efficiency of our service.

Methods: All patients undergoing day case surgery for the major surgical specialties from January 2009 to June 2009 were identified from the day case departments admission lists. Rates of overnight stay and reasons for this were then audited.

Results: We identified 3128 day cases; 306 (9.8%) cases were unplanned overnight stays. 185 (60.5%) notes were available for review, median age 58years (range 44-68). 71 (38.3%) cases were predictable overnight stays and 111 (62.7%) were due to surgical reasons, mainly routine post-operative care instructions from the surgeon.

Conclusion: Our unit's rate lies within the limits published for day case units which utilise inpatient theatres (2-14%). However, results suggest that better pre-operative selection of patients for daycase lists would improve our unit's overnight stay rates and overall efficiency of the service. Improved case selection would prevent the frequent cancellation of elective procedures due to bed shortages.

0899 WHAT PATHOLOGIES ARE ADMITTED ON THE 'GENERAL SURGICAL TAKE' AND WHO WILL MANAGE THESE PATIENTS?
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Aims: There has been a trend towards sub-specialisation for elective surgery over the past ten years. This paper looks at non-elective admissions to a 'general surgical take' over this period of time.

Methods: Prospective data relating to non-elective admissions, under the care of a single consultant general surgeon, was collected from 1 January 2000 – 31 December 2009. This included recording the sub-speciality pathology for each patient, along the lines of the ISCP logbook.

Results: 4266 patients were admitted during the 10 year period; general (45%), colorectal (13%), HPB/U&I (13%), paediatrics (11%), urology (9.7%), vascular (4.4%), gynaecology (2%), breast (1%). Over the study period, the proportion of urological cases admitted rose from 2% to 19% whilst the percentage of vascular cases fell from 9% to zero, the latter coinciding with the introduction of a specialist vascular rota. There was little change in the proportion of admissions with regard to the other sub-speciality pathologies.

Conclusions: Despite the evolution of elective sub-speciality surgery, non-elective admissions continue to cover a broad range of pathologies. The non-elective (on call) surgeon needs to maintain a breadth of knowledge and skill to manage these patients.

0902 PRE-OPERATIVE STAGING OF THE AXILLA IN BREAST CANCER – AN ACCURATE APPROACH THAT SAVES TIME AND RESOURCES?
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Introduction: Pilot studies have suggested that a combined technique of ultrasonography (US) and fine needle aspiration cytology (FNAC) is useful in detecting axillary lymph node metastasis in breast cancer patients.

Aims: Assess the accuracy of this approach; assess how often sentinel lymph node mapping could be avoided; estimate the cost saving

Methods: Between February 2008 and November 2010, 385 newly diagnosed breast cancer patients underwent axillary US examination. FNAC was carried out if suspicious lymph nodes were detected on US. Patients proceeded to sentinel lymph node mapping if they had a normal US or a negative FNAC. Patients with a positive FNAC proceeded to have a level two axillary node clearance.

Results: Axillary ultrasound examination revealed 112 axillae with suspicious features. Subsequent FNAC was positive for malignant cells in 79 of the 112 axillae. Sentinel lymph node mapping was thus spared in 79 patients which represents 20.6% of the total eligible population in the study. The sensitivity and specificity of combined ultrasound and FNAC was 89% and 99% respectively.

Conclusions: The combination of US and FNAC is an accurate method of assessing the axilla for metastatic breast disease and avoiding unnecessary sentinel lymph node mapping, saving time and resources.

0907 VARIATION OF RATES, ACCURACY OF CLINICAL CODING AND PREDICTIVE VALUE OF INFLAMMATORY MARKERS FOR REMOVAL OF A NORMAL APPENDIX IN 1210 APPENDECTOMIES
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Aims: To study the rates of surgery, accuracy of clinical coding and diagnostic efficacy of inflammatory markers for removal of a normal appendix.

Methods: Retrospective review of all emergency appendicectomy patients over a 5-year period. Pathology reports were gold standard for diagnosis. Clinical coding lists were obtained for comparison. Inflammatory markers (WCC and CRP) were taken at highest pre-operative levels.

Results: Appendicectomy was performed in 1210 patients. Normal rates were higher in females (31% versus 18% in males, p<0.001). There was no significant difference in normal rates between adults and children. There was moderate agreement between histology and clinical coding (Kappa 0.421). Increasing WCC and CRP significantly increased likelihood of appendicitis (versus normal) and complex appendicitis (versus simple appendicitis) for all genders and ages (all p<0.001).

Conclusions: Normal appendicectomy rates were stable in males, but variable and higher in females. Age is not as important as gender in determining normal rates. Clinical coding for normal appendicectomy is unreliable so national analyses based on such data should be guarded. Inflammatory markers are useful for supporting a diagnosis of appendicitis and differentiating complex appendicitis. Contrary to existing literature, if neither inflammatory marker was raised, appendicitis could not be ruled out.

0910 RE-EXCISION RATE FOR BREAST CONSERVING SURGERY (BCS): A RETROSPECTIVE STUDY
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Introduction: BCS is one of the most performed operations nowadays, especially with the increased number of early breast cancer detected with screening program. Different studies have shown different rates of re-excision associated with this operation. This study has shown the re-excision rate in the breast unit of a teaching hospital with some risk factors contributing to this rate.

Method: Retrospective review of 273 patients’ data for those underwent BCS in 2007. SPSS software is used for data analyses.
Results: Mean age at surgery is 58.7; our rate of re-excision is 24.5% (67 patients). 3 independent risk factors with a p value less than 0.05 have been identified to contribute to this rate. The factors are: Presence of insitu disease (p value = 0.036), multifocal disease (p value = 0.001) and referral source whether screening or symptomatic (p value = 0.008).

Summary and recommendations: Our rate of re-excision following BCS is 24.5%. Symptomatic patient have higher re-excision rate compared to screening patients. Re-excision rate increased with the presence of DCIS and multifocal disease.

0914 A PROSPECTIVE ANALYSIS OF BLOOD-STREAM INFECTION POST-TRANSRECTAL ULTRASOUND GUIDED BIOPSY OF THE PROSTATE IN A NATIONAL RAPID ACCESS PROSTATE CLINIC

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Aims: To develop a process for prospective clinical and laboratory surveillance of BSI following TRUS biopsy and also develop a protocol for management of BSI post TRUS.

Methods: Prospective data was collected from all patients attending a prostate screening clinic at a mean of 30 days post biopsy and from all patients admitted with post-TRUS sepsis. A protocol for the investigation and management of cases has been developed.

Results: Of 387 TRUS biopsies performed, ten patients were admitted for management of post-TRUS sepsis. BSI was confirmed in eight patients; E. coli (7) and Bacteroides spp (1). Of the E. coli, 5, 4 and 2 were resistant to amoxicillin, ciprofloxacin and gentamicin respectively. ESBL producers were not detected in this group. The levels of resistance are comparable to that in other BSI isolates of E. coli. The rate of BSI post TRUS biopsy for this hospital was 0.5% (2 of 387 patients biopsied).

Conclusions: Post-TRUS biopsy BSI accounted for approximately 10% of all confirmed E.coli blood stream infection presenting to this tertiary centre. The rate of BSI post TRUS biopsy (0.5%) is within the reported range. We found that Piperacillin/tazobactam is appropriate for empirical therapy.

0919 SUB CUTICULAR NON ABSORBABLE SUTURES HAVE BETTER OUTCOME IN FEMALES THAN METALLIC CLIPS IN ELECTIVE OPEN COLORECTAL SURGERY

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Material: Data was collected prospectively on female patients who underwent elective colorectal surgery via open abdominal approach. A questionnaire was sent to all the patients enquiring about the quality of the scar, infection, use of antibiotics, pain and the appearance of the scar.

Results: Our cohort included n= 90 patients with median age of 67 years (IQR 51, 77). There were n= 56 patients in skin suture (SS) group and n= 34 in skin clips (SC) group.

18% of females developed wound infection in SC group as compared to 19% in SS group (p=0.5). 15% of females of SC group developed infection while in the hospital as compared to 9% with SS group (p=0.3). 25% of females in SC group complained of scar thickness as compared to 11% in SS group (p=0.08).

Over all 72% of patients who had sutures were satisfied with outcome of the scar as compared to 51% who had clips (p=0.043).

Conclusion: Our results indicated fewer rates of complications among female patients, when sub-cuticular sutures were used to close the skin than metallic clips. The cosmetic results were better in suture group compared to the clips group.

0923 INCREASED SURGICAL SITE MORBIDITY AFTER DABIGATRAN ETEXILATE: THE WARWICK EXPERIENCE OVER ONE YEAR

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Introduction: NICE technology appraisal guidance 157 suggests that the oral anticoagulation medication Dabigatran etexilate can be used for the primary prevention of venous thromboembolic events (VTE’s) in adult patients who have undergone elective total hip or knee replacement surgery.

Method: The NICE guidance reports that 13.8% of patients receiving recommended doses of Dabigatran experienced adverse bleeding events. In the pivotal hip and knee VTE trial, wound secretion only accounted for 4.9% of patients treated with Dabigatran (cf 3.0% of patients treated with Enoxaparin).

Results: We report our wound secretion experience after Dabigatran use at Warwick Hospital from March 2009 to March 2010. Of the 788 lower-limb arthroplasties performed, 55 patients (6.9%) had oozing wounds after discharge (Mean=8 days, Range=1–39 days). This resulted in 226 extra home-visits by discharge nurses, 26 positive microbiology cultures and 5 confirmed wound infections needing antibiotic treatment and/or surgical intervention. Incidentally, there were also 2 known cases each of deep vein thrombosis and pulmonary embolus in this cohort. The number of complications was markedly increased from previous years when LMWH was the VTE prophylaxis used.

Conclusion: This data suggests that the use of Dabigatran in Warwick Hospital, may significantly increase surgical site morbidity and resource output after lower limb arthroplasty.

0927 SUB-CUTICULAR NON ABSORBABLE SUTURES IN ELECTIVE OPEN COLORECTAL SURGERY GIVE BETTER RESULTS THAN METALLIC CLIPS AMONG MALES

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Background: We compared the outcome of abdominal skin closure by clips and sutures following elective colorectal surgery among males.

Methods: Prospective data was collected on all male patients who underwent elective colorectal surgery via open abdominal approach. Patients were divided into two groups: skin sutures (SS) and skin clips (SC). A questionnaire was sent to all the patients enquiring about the quality of the scar, pain and cosmetic outcome.

Results: Our cohort included 128 males. n= 78 who had skin closure by using suture SS and n= 50 who had skin closed by metallic clips SC. (11/50) in SC group had wound infection as compared to 11% (9/78) of SS group. Most of the patients had wound infection while they were in hospital. (p=0.042). SC group patients had significantly more discharge (not infected) from their wounds as compared to SS group (P=0.05). Majority of patients in SS group 68% claimed excellent results as compared to SC group 49% (P= 0.026).

Conclusion: Our results showed that male patients who underwent open elective colorectal surgery developed fewer complications when sub-cuticular suture were used for skin closure. In this group the patients were more satisfied with resultant outcome.

0928 THE USE OF ENHANCED RECOVERY AFTER SURGERY (ERAS) IN COLORECTAL SURGERY – IS AGE AN IMPORTANT FACTOR TO CONSIDER?


Aim: ERAS was introduced to improve patient care and shorten hospital stay. The aim was to look at age as a factor in determining the effectiveness of ERAS in reducing the length of stay (LOS).

Method: Data for all patients who underwent a right hemicolectomy over 20 months was collated and the outcome was assessed by the average post-operative LOS.

Results: 58 patients included, 38 right hemicolectomies were carried out laparoscopically. Ages 40–60 averaged ERAS LOS of 5.9 days versus non-ERAS LOS of 5 days; ages 60–80 averaged ERAS LOS of 5.3 days versus non-ERAS LOS of 18 days; and ages 80 plus averaged ERAS LOS of 11.3 days versus non-ERAS LOS of 8.5 days. Of the remaining 20 patients who underwent open right hemicolectomies: ages 60–80 ERAS LOS of 7.3 days versus non-ERAS LOS of 12.5 days; and ages 80 and above ERAS LOS of 42.3 days versus non-ERAS LOS of 17.7 days.