Conclusion: Old age increases post-operative stay but this is not due to an independent effect on calcium metabolism. The pre-operative calcium and PTH levels were higher in the elderly so appeared to fall more slowly. Elevated serum calcium <24 hours after surgery does not imply the patient is not cured.

0566 **CAROTID ARTERY BALLOON OCCLUSION TESTING: IS IT A RELIABLE TEST PRIOR TO RESECTION IN ADVANCED HEAD AND NECK MALIGNANCY?**

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Introduction: Advanced head and neck cancer may very rarely require resection of the common or internal carotid artery to achieve local disease control. Extended radical neck dissection may include the carotid tree but may precipitate neurological sequelae. Balloon occlusion testing (BOT) can be used to assess tolerance of acute occlusion of an internal carotid artery.
Aims: To report the outcomes of our series of BOT in head and neck malignancy to highlight a useful test that potentially allows surgical clearance through extended radical neck dissection.
Methods: Retrospective review of case notes identified four patients had passed BOT prior to carotid tree excision.
Results: Of the four patients identified that successfully passed BOT without neurovascular compromise, two patients had uncomplicated post-operative courses. Two patients had neurovascular complications of which one developed a temporary neurological deficit due to a cerebrovascular accident (CVA) postoperatively from which he made a complete recovery. The fourth patient died post-operatively from a CVA that was identified as embolic.
Conclusion: In this challenging patient group BTO can be used to assess the patient's ability to tolerate carotid artery resection successfully although caries risk. We describe the technique used at our institution and review the available evidence.

0567 **SPINAL CORD INJURY PATIENTS BENEFIT FROM LAPAROSCOPIC HARTMANN'S PROCEDURE, FOR BOWEL DYSMOTILITY DISORDER**

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Bowel dysfunction (BD) is almost universal among patients with spinal cord injury (SCI). Bowel management is one of the most important factors in determining quality of life. We present the first series combining laparoscopic bowel resection and end colostomy formation as a method of management of BD in SCI patients who have failed conservative measures in a national spinal injury unit.
The notes of 22 consecutive patients over 5-year period were reviewed. Their demographic data, cause of SCI, pre-operative bowel care regime and peri-operative details were recorded. At telephone follow-up, patients reported their satisfaction with their stoma and any stoma-related problems.
Two patients had simple end colostomies while twenty had laparoscopic Hartmann's procedure. One patient died of respiratory failure in the immediate post-operative period and three patients had post-operative complications (haematoma, cardiac event, pneumonia). At follow-up (average 14 months), 71 % of patients (15/21) were very satisfied, 29% were satisfied (6/21) and none was dissatisfied with their stoma. Troublesome rectal discharge was reported by 2 patients while 1 had associated perineal ulceration.
Laparoscopic Hartmann's procedure is an effective option for SCI patients with BD where conservative management has failed, has an acceptably low incidence of complications and a reduced incidence of diversion proctitis.

0569 **IMMEDIATE VERSUS PLANNED TURP FOLLOWING ACUTE RETENTION. ARE WE DOING THE RIGHT THING?**

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Introduction: Acute urinary retention (AUR) is a common urological emergency. Many patients will require TURP but there is no consensus on the exact timing of the procedure.
Material and Methods: We retrospectively (April 2009 - March 2010) evaluated men who had undergone TURP following AUR either during the same admission or after an interval.
Results: 126 TURPs were performed for AUR in our unit during this 12-month period. This was 42.4% (126/297) of all TURPs. Three out of 126 patients had inadequate notes and were excluded. 72 had TURP as an inpatient (Group 1) and 51 electively after an interval at home [range: 8 - 160 days] (Group 2). Group 1 had significantly higher total hospitalisation days (mean 13 days [range: 4-35 days]) compared to group 2 (mean 3.8 days [range: 1-12 days]). Successful TWOC rates were higher in group 2 compared to Group 1 in the days following TURP (78% and 43.8% respectively) and at a six weeks interval (84% and 68% respectively). There were no differences in the complication rates between the two groups.
Conclusion: Deferred TURP provided better outcomes in terms of total hospital stay and successful TWOC with no difference in perioperative complications.

0570 **POST-TONSILLECTOMY DISCHARGE AT 4 HOURS – IS IT SAFE?**

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Background: Tonsillectomy carries an inherent risk of post-operative haemorrhage. Historically routine tonsillectomy has required overnight stay for observation. This practice is still widespread throughout the UK although in some institutions six hours is used as a cut-off for discharge. There are inevitable consequences for bed management; hospital finance and staffing. The majority of post-operative complications occur within four hours. At Bart's and The Royal London Hospital 75% of elective ENT paediatric lists were allotted to afternoon theatre sessions, necessitating overnight stay.
Method: 48 day case patients were followed postoperatively to assess the adherence to selection criteria, duration of inpatient stay, and monitor for the frequency and timing of any postoperative complications.
Result: 28 (58.3%) patients had an overnight stay following a 6 hour post-operative observation period. Of those patients staying overnight, 27/28 (96.43%) had been operated on an afternoon list 23/28 (82.14%) patients staying overnight satisfied all discharge criteria with the exception of the 6-hour postoperative observation period. The remaining 5 patients had other postoperative concerns, all of which became apparent within 4 hours.
Conclusion: A four-hour post-tonsillectomy observation period is safe, cost effective and gives better patient satisfaction. We suggest that this should be implemented nationally in appropriate cases.

0572 **COMPLIANCE WITH EUROPEAN ASSOCIATION OF UROLOGY GUIDELINES FOR PRIMARY NON-MUSCLE INVASIVE BLADDER CANCER?**

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Introduction: Treatment of primary non-muscle invasive bladder cancer (NMIBC) is guided by the European Association of Urology (EAU) clinical guidelines. We evaluated compliance with EAU guidelines in term of risk stratification, first check cystoscopy and further cystoscopy follow up in a University Teaching Hospital.
Material and Methods: We performed a retrospective review of consecutive cases with primary NMIBC between January 2009 and January 2010.
Results: All cases (109 patients) were discussed in a local multi-disciplinary team meeting and 81.6% of cases were not clearly stratified according to EAU risk stratification for disease recurrence/progression (retrospective review revealed 59 with high risk, 40 intermediate and 10 patients with low risk). All were recommended to have their first check cystoscopy in 3 months. The mean time to first surveillance cystoscopy was 4.9 months; only 29% of patients had their cystoscopy performed at the recommended 3 months. Administration of intravesical treatment further delayed the first surveillance cystoscopy (5.4 vs 4.5 months). Further cystoscopy follow up was delivered on time, according to the risk profile, in 25.6% of patients.