or a mean excess percent BMI loss (EBL) of 7.4 kg/m². At 2 years, the mean
reduction in BMI was 11.1 [EBL of 33.6 kg/m²]. At 1 year, the mean
reduction in BMI was 13.29 [EBL of 41.5 kg/m²]. Correlation between pre-
operative weight loss versus weight lost at 1 and 2 years was performed.
At 1 year & 2 years post-operatively, the Spearman Rank Correlation was
0.154 [p = 0.208] and 0.069 [p = 0.575] respectively (no statistical
significant correlation).

Conclusion: In this study, pre-operative dietary weight loss does not correlate
with better outcomes following laparoscopic adjustable gastric
banding.

1046: HOW DOES A NORTHERN TRUST WITH UNIQUE GEOGRAPHICAL
CHALLENGES COMPARE WITH SCOTTISH NATIONAL DATA FOR ALL
CANCERS IN KEEPING TERMINALLY ILL UPPER GI CANCER PATIENTS
OUT OF HOSPITAL – TO DIE AT HOME?
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Aim: To study end of life care for Upper GI cancer patients diagnosed
within geographically diverse northern NHS Highland.

Methods: Four national databases were searched using ICD10 codes for
Upper GI cancer for years 2005–2010. For patients diagnosed in this region,
place of death (home, hospital, hospice or 'other institution') was recorded
and compared with Scottish national data for all cancers.

Results: 978 Upper GI cancer patients were diagnosed within the study
period. 298 were excluded as place of death was unknown. Of the remaining
680 patients 237 (34.9%) died at home, 295 (43.4%) died in hospital, 96
(14.1%) died in hospice and 49 (7.2%) died in another institution. Of 75522
cancer deaths in Scotland between 2004–2008 equivalent percentages were
24.3% (home), 51.9% (hospital), 17.6% (hospice) and 6.2% ('other'). Highly
significant differences between NHS Highland and national data were found
in both ‘at home’ and ‘in hospital’ deaths (p<0.0001).

Conclusions: Over half of cancer patients in Scotland die in hospital and a
quarter die at home. In our study group, fewer patients die in hospital
with over one third dying at home. Despite Highland geographical chal-
enges, ability to deliver end of life care for Upper GI cancer patients is
uncompromised.

1155: ONE-STOP CHOLECYSTECTOMY CLINIC: A WAY FORWARD FOR
THE FUTURE?
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Objective: To assess whether a ‘one stop cholecystectomy clinic’ had an
impact on the waiting time, pre-operative visits and admissions for
patients with gallbladder diseases and thus improved their 18 week
pathway.

Patients and Method: A retrospective observational study of patients
attending the ‘one stop cholecystectomy clinic’ (Group A) and the tradi-
tional routine clinics (Group B) for patients with gallbladder diseases
during 2010 was completed. Patients were preassessed & wait listed for
surgery. Primary outcome measured was the waiting time, secondary
outcome measured were the pre- operative visits & the emergency
hospital admissions whilst awaiting surgery.

Results: Study included 129 patients with a mean age of 49 (SD ±16) years
& female to male ratio of 101:28.Of the 129, 59 (46%) belonged to Group A
who had a waiting time of 7.3* (95% CI 6.2 - 8.5) weeks compared to 16.6 (95% CI
14.0 - 19.2) weeks for the 70 (54%) belonging to Group B (p-value <0.001).
One unnecessary hospital visit for pre-assessment was avoided in all
Group A compared to Group B patients and 9 (15%) Group A patients
needed emergency admission compared to 19 (27%) Group B patients
meaning significant cost implications.

Conclusion: One-stop cholecystectomy clinic achieves improved patient
journey through reduction in emergency admissions, waiting times and
unnecessary hospital visits.

1185: SHOULD CT COLONOSCOPY REPLACE FLEXIBLE SIGMOIDOSCOPY?
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Aims: It is recommended that all patients undergoing barium enema have a
flexible sigmoidoscopy (FS) to exclude disease distal to the rectosigmoid
junction. With the introduction of CT colonoscopy (CTC) is sigmoidoscopy
still required for the investigation of suspected colorectal cancer (CRC).

Methods: The findings of CTC in 520 consecutive patients were reviewed
by a GI radiologist blinded to the findings at FS. Patients with not adequate
bowel preparation for FS, colonoscopy, polypectomy, abnormal MRI or CTC
as first line investigation, more than six months period between CTC and
FS were excluded. Statistical analyses were performed with Chi-Squared
and Fisher test.

Results: 306 patients were excluded. In 188 (88%) patients there was
 concordance between the findings on FS and CTC. Sensitivity and speci-
ficity of FS was 74% and 99% respectively (p<0.001), respectively
(p<0.05). FS did not identify 6 cancers when CTC missed only 2 malignant
pathologies (classified as inadequate picture due to collapse colon, further
investigation has been advised). We could identify statistically significant
(p<0.05) dependence between bowel symptoms like PR bleeding and iron
deficiency anaemia and diagnosis of bowel cancer in patients undergo FS.

Conclusions: A negative CTC excludes the presence of colorectal cancer.

1208: ANAEMIA AND BARIATRIC SURGERY: A DOUBLE WHAMMY
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Background: As bariatric surgery rates continue to climb, anaemia will
become an increasing concern. We assessed the prevalence of anaemia and
length of hospital stay in patients undergoing bariatric surgery.

Methods: Prospective data (anaemia [Haemoglobin <12 g/dl], haema-
tinics and length of hospital stay) was analysed on 400 hundred patients
undergoing elective laparoscopic bariatric surgery. Results were compared
to a prospective database of 1530 patients undergoing elective general
surgery as a baseline.

Results: Fifty-seven patients (14%) were anaemic pre-operatively. Median
MCV (fl) and overall median Ferritin (µg/L) was lower in anaemic patients
(83 vs. 86, p=0.001) and (28 vs. 61, p<0.0001) respectively. Compared to
elective general surgery patients, prevalence of anaemia was similar (14%
vs. 16%) but absolute iron deficiency was more common in those
undergoing bariatric surgery; microcytosis p=0.0001, Ferritin <30 p<0.0001.
Mean length of stay (days) was increased in the anaemic compared to
the non-anaemic group (2.7 vs. 1.9). Interestingly, patients who were
anaemic immediately post-operatively, also had an increased length of
stay (2.7 vs. 1.9), p<0.05.

Conclusion: Absolute iron deficiency was more common in patients
undergoing bariatric surgery. In bariatric patients with anaemia there was
an overall increased length of hospital stay, suggesting a role in pre-opti-
misation.

UROLOGY

0016: MANAGEMENT OF ACUTE EPIDIDYMO-ORCHITS: SHOULD WE
CHANGE OUR PRACTICE?
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Aim: The latest antibiotic guideline for epididymo-orchitis from the British
Association of Sexual Health and HIV was released in June 2010. We
reviewed the management of patients presenting with epididymo-orchitis
over a 2 year period to see if the new guideline should be incorporated
locally.

Method: Data was collected retrospectively looking at all patients pre-
senting to hospital with a diagnosis of epididymo-orchits from July 2008
to August 2010. Information collected included: patient age; admission
date; mid-stream urine for routine culture and/or Chlamydia PCR; scrotal
ultrasound findings; treatment and re-presentation to hospital.

Results: 66 patients were identified. The mean age was 47.29 years with
twenty patients being below 35 years. Antibiotic treatment regimes used
in our study findings; treatment and re-presentation to hospital.

Conclusion: Absolute iron deficiency was more common in patients
undergoing bariatric surgery. In bariatric patients with anaemia there was
an overall increased length of hospital stay, suggesting a role in pre-opti-
misation.