Background: In concordance with the national guidelines, the St. Mark’s Hospital colonoscopy tattooing protocol stated that suspicious lesions should be tattooed, with the exception of those in the caecum and within 20 cm of the anal verge. Three tattoos should be placed (120° apart, close to the lesion) and distal to lesions proximal to the splenic flexure (SpFlx). Left sided lesions should have tattoos placed proximal to the lesion.

Aims: To audit compliance with the tattooing protocol in patients undergoing surgery for colorectal neoplasia.

Methods: We reviewed endoscopy reports for the location of tattoos relative to the lesion and number of tattoos placed in all patients who had surgery over 12 months.

Results: 114 reports were available and full compliance with the protocol was observed in 71 cases (62%), 19 cases (17%) were partially compliant and 24 cases (21%) were non-compliant. Incomplete documentation (22 cases) and inability to place tattoos proximal to obstructing lesions (19 cases) were the major causes of reduced compliance.

Conclusions: Educational intervention is necessary to address poor documentation. However, changes to our protocol are also required. The new protocol recommends that all tattoos should be placed distal to the lesion, regardless of the anatomical position.

0051: DOES RIGID SIGMOIDOSCOPY HAVE A PLACE IN THE MODERN OUTPATIENT COLORECTAL CLINIC?

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Background: Although flexible sigmoidoscopy is now used in most outpatient colorectal clinics, rigid sigmoidoscopy is still used in many other (OP) colorectal clinics. The aim of our study is to assess the efficacy of rigid sigmoidoscopy.

Methods: Retrospective review of 103 patients that attended OP Colorectal clinic who had undergone rigid sigmoidoscopy for colorectal symptoms. Findings as well as requirement of further investigation were recorded.

Results: 103 patients. Presenting symptoms were: change in bowel habit 47 (45.6%), PR bleeding 33 (32%), rectal mass 8 (7.8%), Abdominal pain 4 (3.9%), faecal incontinence 1 (0.9%), tenesmus 1 (0.9%), anaemia 1 (0.9%) and follow up patients 8 (7.8%). Finding were: normal mucosa 62 (60.1%), inflamed mucosa 5 (4.9%), rectal polyp 2 (1.9%) and uninformative 34 (33.1%). Of the 103 patients, 68 (66%) required further investigations. 35 (34%) did not require further investigation. Amongst those who had a normal finding, on further investigation 16 (25%) had different pathology. 3 (42%) out of 7 patients whom had abnormal finding on rigid sigmoidoscopy, no abnormality was detected on further investigation.

Conclusions: Our study showed that rigid sigmoidoscopy was rarely useful in the OP clinic set up. Further investigations were almost always needed to complete the assessment of the patient.

0097: LYMPH NODE HARVEST IN COLORECTAL RESECTIONS: AN AUDIT AT A SOUTH-EAST ENGLAND COLORECTAL SURGERY UNIT COMPARING PERFORMANCE IN 2005 AND 2008 WITH ANALYSIS OF THE INFLUENCE OF KEY OPERATIVE FACTORS

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Lymph node examination is vital in the staging of colorectal cancer and ultimately influencing decisions on post-operative management. The ‘Association of Coloproctology of Great Britain and Ireland’ as well as the ‘National Institute of Clinical Excellence’ recommend that at least 12 lymph nodes are examined per resection.

Aim: This study assesses the performance of a large colorectal surgery unit in England against the above targets between 2005 and 2008 with an analysis of the influence of operator and patient variables.

Method: A hospital database search was used to identify all patients who underwent colorectal cancer resections in the months of October in 2005 (n=51) and 2008 (n=69). Information was extracted manually from notes and computed.

Results: A significant improvement was shown in lymph node clearance from 8.2 to 11.0 between 2005 and 2008 respectively (p=0.0019). No statistically significant difference between elective/emergency or open/ laparoscopic resections was shown. The strongest improvement was found in open resections between 2005 & 2008 cohorts.

Conclusion: The results of the study provide further cause to explore and discuss the reasons behind the apparent improvement in lymph node harvest and to determine the relative importance of surgical technique, histopathological techniques and other possible influential factors.

0115: COLORECTAL RESECTIONS: EVALUATING SHORT TERM POSTOPERATIVE OUTCOMES IN LAPAROSCOPIC VERSUS OPEN SURGERY

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Introduction: Laparoscopic colectomies has become increasingly popular in the recent decade, however reluctance still exists to widely apply it for colorectal resections. This study aims to evaluate the postoperative outcomes of laparoscopic surgery (LS) compared to open surgery (OS) in our centre.

Method: All patients who underwent colorectal resection from June 2010 to February 2011 were reviewed retrospectively from the hospital database. Parameters include length of postoperative stay, infective and non-infective complications.

Result: Between June 2010 and February 2011, a total of 99 patients of median age 69 (range 20-95) underwent colorectal resection. The most common indication was malignancy (66%). 56/99 cases were subjected to LS, and 43/99 to OS, with a number of 5 conversions. Median postoperative stay was 13 days. This was higher in OS (10) compared to LS (7).

Conclusion: LS demonstrated better postoperative outcomes compared to OS. As a result of this study, further reviews were conducted within the General Surgery department to explore the possibility of increasing usage of the laparoscopic method.

0118: THE ROLE OF FDG-PET CT IN COLORECTAL CANCER

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Background: There is limited evidence to support the use of PET-CT in colorectal cancer. The aim of this study is to evaluate the clinical impact of PET scan in management of our patients.

Methods: 1043 patients were identified from SCAN database over a 2 year period, from July 2009. 103 patients underwent a FGD-PET CT in addition to conventional imaging. In this retrospective study, PET CT findings were compared with CT findings and the clinical impact was evaluated.

Results: 27 patients (26.2%) had PET CT for pre-operative staging and 76 patients (73.7%) for disease surveillance. Based on PET findings, the management was altered in 21 (77.7%) patients in pre-operative group with indeterminate CT findings. In the follow-up group, PET had a significant impact on management of 51 patients (67.1%), of which 39 had indeterminate CT findings. 6 patients with a negative CT had recurrent disease and another 6 patients with resectable disease on CT had unresectable metastases on PET.

Conclusion: PET CT plays a significant role in management of colorectal cancer by avoiding unnecessary surgery or identifying recurrent disease at an early stage.

0161: AUDIT OF CT COLONOGRAPHY: DOES IT ANSWER OUR QUESTIONS?

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Aim: CT Colonography (CTC) is being increasingly used instead of colonoscopy as it is less invasive and detects extra-colonic abnormalities. It has 94.9% sensitivity and 99.7% negative predictive value for colorectal cancer. As it is frequently used in our hospital, we aim to assess - appropriateness of requests; bowel preparation adequacy; effectiveness in identifying abnormalities; diagnostic value and possible use as a screening tool and/or gold standard investigation.