

not affect the proportion reviewed by a registrar within 60 minutes. Mortality did not appear to be associated with the timing of senior review.

Conclusions: Achieving these standards would require major re-modeling of working patterns; while they may be desirable, this audit does not provide any supporting evidence that review within these time frames is essential.

1047: THE EMERGENCY APPENDICECTOMY – NO LONGER A TRAINING OPERATION FOR CORE TRAINEES

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Aim: Training of core surgical trainees (CT's) within the elective setting is extremely good at our hospital. However, as CT's, we have observed that it is often difficult to receive training in the emergency setting, due to the pressures of the acute surgical take. We audited a traditionally "SHO" procedure, the emergency appendicectomy, to identify the proportion in which an F2/CT was the primary surgeon.

Methods: This was a retrospective audit of 100 consecutive emergency appendicectomies. We collated data related to patient age, type of procedure (laparoscopic / open/ converted), time of day, primary surgeon and most senior surgeon in theatre.

Results: Our results indicate that the emergency appendicectomy is no longer an "SHO" operation in our hospital. The majority (60%) are performed by a registrar, irrespective of time of day. However there is an association between the presence of a consultant in theatre and documentation of the F2/CT as primary surgeon.

Conclusion: As the emergency take becomes increasingly pressured, junior trainees are finding it increasingly difficult to access traditional training operations, as reflected by a shift towards registrar performed appendicectomies. The presence of a consultant in theatre increases training of junior trainees.

1075: OPTIMISING OUTCOMES – EMERGENCY SURGERY IN THE OVER 80'S

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Aim: Advancing age is a risk factor for post-operative morbidity and mortality. The peri-operative pathway and outcome of patients over 80 years old undergoing emergency laparotomy was reviewed.

Method: A retrospective analysis of all General Surgical patients undergoing emergency laparotomy over a 9 month period was performed. Patients were identified from Theatre Database and data were collected from case notes, anaesthetic charts and operation notes.

Results: 101 patients were identified and 57 met our inclusion criteria. 17 patients were over 80 years old with a median age of 89 (range 81–93). The mean time from decision to operate to anaesthetic room was 124 minutes. 16 patients (94%) were operated on before midnight. The average ASA grade was 3.1. 82% of patients went to ICU post-operatively (compared with 55% of those under 80). In-hospital mortality was 29% (compared to 15% in those under 80) and all but one of these patients died on ICU.

Conclusions: Mortality from emergency laparotomy in the over 80's is almost twice that of those under 80. However good patient selection and intensive peri-operative care may improve outcomes, with survival of over 70%.

1101: AN AUDIT CYCLE OF MAJOR TRAUMA PATIENTS TIME TO COMPUTED TOMOGRAPHY SCAN IN A DISTRICT GENERAL HOSPITAL

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Aim: To establish if guidelines set by the strategic health authority were met. All Major Trauma Patients (MTP) (injury severity score >8) in level 2 trauma centres require a Computed Tomography (CT) scan within thirty minutes of arrival to Accident & Emergency (A&E).

Methods: A retrospective audit cycle of patients at a level 2 trauma centre. The first cycle was in September 2011. MTP were identified using A&E logbooks. Our intervention was a lecture incorporated at induction of A&E staff emphasising the guidelines. Time for CT was reviewed using online radiology systems. We re-audited the intervention in December 2012.

Results: First audit (n=7); 57% required CT with the average time to CT being 40 minutes. In the second cycle (n=12); 75% required CT and the

average time to CT was 45minutes. There was great variation in time; the quickest at 22 minutes to the longest at 58 minutes.

Conclusion: The 30 minute guidelines were not met. The longer CT time in the second cycle coincided with a new policy by the trust imposing all trauma CT's should be discussed on a consultant basis. All members of trauma team, including consultants must think of time to CT for all MTP.

1118: ULTRASOUND SCANNING OF RIF PAIN MAY INCREASE TIME TO SURGERY AND INPATIENT LENGTH OF STAY

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Aims: Patients presenting with RIF pain can be investigated by ultrasound scanning (US). We evaluated whether use of US in this patient group delayed time to surgery and in addition, increased length of stay.

Methods: Using histology data from 2009–2012, we assessed 100 index cases per year, including only emergency surgeries for RIF's pain (laparoscopic and open). PACS and electronic records were assessed for length of stay (LOS) and day of operation (DOP). Day of admission = Day0 (D0).

Results: Of 365 patients included, 102 had US pre-operatively: 18% DOP on D0, 41% D1 and 25% D2. Of 263 without US: 52% DOP on D0, 44% D1 and 3% D2. Of the US group, 2% had a LOS of 1day, 12% 2days, 27% 3days, 26% 4days, and 42% >4days. Of the without US group, 5% had a LOS of 1day, 28% 2days, 34% 3days, 17% 4days and 16% >4days.

Conclusions: We showed patients undergoing pre-operative US have surgery later and have longer lengths of stay than those who do not. Accepting that this is not a prospective or randomised study, we feel that in the age of diagnostic laparoscopy, US may be delaying surgery and increasing inpatient length of stay.

1122: CT GUIDED MINI-LAPAROTOMY FOR ADHESIONAL SMALL BOWEL OBSTRUCTION – A NOVEL SURGICAL APPROACH

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Introduction: Adhesional small bowel obstruction (ASBO) that does not resolve with conservative management presents an operative dilemma. Laparotomy and extensive adhesiolysis carries significant risk and morbidity along with high rates of recurrent adhesions. In cases where laparoscopic adhesiolysis is not safe or feasible, an alternative minimally invasive operative technique with pre-operative Computer Tomography (CT) guidance is proposed.

Method: This technique utilises CT to identify the presence of a definitive single transition point. Localised mini-laparotomy is undertaken with selective division of only the obstructing adhesions. From 9 patients admitted under a single surgeon and requiring surgical intervention for ASBO over a 2 year period, 3 were identified by CT imaging as suitable for this technique. 2 patients had transverse incisions away from the previous scar site and 1 underwent a limited midline incision over a small part of the previous scar. Recovery was uneventful and all patients were well at 6-month follow-up with no further adhesion related presentations.

Discussion: High rates of recurrence, risk of enterotomy and morbidity following extensive adhesiolysis for ASBO favours a judicious approach with division of only pathological adhesions. Using pre-operative CT guidance, this technique of focused mini-laparotomy is safe and beneficial for a selected patient group.

1185: SYSTEMIC REVIEW AND META-ANALYSIS OF RANDOMISED CONTROLLED TRIALS COMPARING PRIMARY VERSUS DELAYED PRIMARY SKIN CLOSURE IN CONTAMINATED AND DIRTY ABDOMINAL INCISIONS

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Aims: Surgical site infection (SSI) following abdominal surgery is associated with morbidity and increased health related costs. This study aimed to determine whether delayed primary skin closure (DPC) of contaminated abdominal incisions reduces SSI compared to primary skin closure (PC).

Methods: Systematic review of published randomised controlled trials comparing DPC and PC. Risk of bias was assessed using the Cochrane's Collaboration's tool. The primary endpoint was the rate of SSI.