



# The Association of Surgeons in Training

**Results:** 286 transplants between 1st January 1992 and 31st March 2009 were investigated. The male:female ratio was 4.2:1. Median age at transplant was 51 years 7 months. Median survival was 3502 days (95% C.I. 2798.78–4205.22 days). Our data showed 79.9% survival at 1 year, 67.2% at 5 years, 48.6% at 10 years and 37.7% at 15 years. Excluding non-melanomatous skin cancer, 21 patients developed cancer. These included Lymphoma (n = 9), Colorectal (n = 3), Lung (n = 2), Gastric (n = 2), Pancreatic (n = 1), Cholangiocarcinoma (n = 1), Brain (n = 1), Testicular (n = 1), Metastatic skin (n = 1). Median time from transplant to diagnosis was 1073 days (95% C.I. 538.72–1607.28).

**Conclusion:** Advances in medicine have improved long-term survival of cardiac transplant patients. In this population, cancer limits long-term survival, and is thought to be a complication of immunosuppression. As transplanted patients survive longer, the incidence of cancer may increase. Further research may elucidate the exact mechanism underlying carcinogenesis post-transplantation.

## INTRA-OP SPECIMEN RADIOGRAPHY FOR MARGIN ASSESSMENT IN BREAST CONSERVING SURGERY: THE NEED FOR SURGEON AND RADIOLOGIST

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**Background:** Wire guiding and ultrasound marking are used to assist the surgeon for clinically impalpable lesions in breast conserving surgery. Specimen radiography is a widely used intra-op adjunct to aid margin assessment. In many surgical units surgeon intra-op assessment but not radiologist is routine.

**Aims:** 1. Determine accuracy of radiological intra-op margin assessment by surgeon and radiologist against gold standard histological assessment. 2. Determine the agreement between surgeon and radiologist assessment. **Methods:** All clinically impalpable breast lesions requiring excision (n = 37), utilising either ultrasound or wire guided localisation, were prospectively recruited between Oct 2008 to Oct 2009 from a single district general breast unit. Specimen radiographs were independently assessed by radiologist and surgeon for adequacy of margins and compared to histological assessment.

**Results:** Surgeon compared to Radiologist assessment had sensitivity of 24% versus 50%, specificity of 90% versus 90% and the K-coefficient of 0.14 versus 0.41. There was moderate agreement between surgeon and radiologist (K-coefficient = 0.54).

**Discussion:** Intra-op radiological assessment can reduce need for re-operation for positive margins. However such assessment is not always reliable with our sensitivity and specificity results similar to current literature. This study suggests that if all intra-op specimens are assessed by a radiologist this may improve accuracy of margin assessment.

## SURGICAL SITE INFECTION IN KIDNEY TRANSPLANT RECIPIENTS: A RETROSPECTIVE ANALYSIS OF A SINGLE-CENTRE EXPERIENCE

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**Introduction:** Post-transplant bacterial infections are important because of their influence on patient and graft outcomes. A surgical site infection

(SSI) is a common post-operative complication that leads to significant morbidity, and length of hospital stay.

**Objectives:** The purpose of this study was to systematically determine the epidemiological characteristics and risk factors for surgical site infections associated with kidney transplantation.

**Methods:** We conducted a retrospective review of all adult kidney-only transplants performed in Addenbrooke's Hospital (Cambridge University Hospitals NHS Foundation Trust, UK) between June 2007 and July 2009.

**Results:** In total 270 recipients were studied. Of our patients 64 (23.7%) had at least one episode of infection. The most frequently isolated pathogens were coagulase negative staphylococci (40.5%), Escherichia Coli (24.3%), Enterococci spp. (13.0%) and Pseudomonas aeruginosa (8%). Patients with BMI >30 (P < 0.0001), positive donor ureter microbiology (P = 0.0006) and postoperative weight gain (P = 0.0019) were identified in the analysis as risk factors for SSI.

**Conclusions:** Patients with high BMI, those who showed higher weight gain postoperatively, and those receiving kidneys that were ureter microbiology positive showed an increased risk of developing SSI after kidney transplantation.

## THE USE OF DC CARADIOVERSION FOR REFRACTORY ATRIAL FIBRILLATION FOLLOWING CARDIAC SURGERY

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**Objective:** To determine the efficacy of electrical DC cardioversion(DCCV) in post-operative atrial fibrillation(AF) refractory to medical management in the short/medium-term.

**Methods:** Retrospective review over a two-year period in an adult cardiac unit. Patients with prior history of AF and emergency cardioversions for haemodynamic compromise were excluded.

**Results:** Following 3387 procedures, 117 patients required DCCV(mean age 70.8, 70.9% male). Median onset of AF was 3 days post-operatively. Initial management was with Amiodarone(68.4%), Digoxin(17.9%), Amiodarone and Digoxin(6.8%), or beta-blockers(6.8%). Patients remaining in AF underwent DCCV at 4 days(median) after onset. DCCV successfully restored sinus rhythm(SR) in 83.8% of cases with 70.9% requiring a single shock.Serum potassium was not significantly different between successful and unsuccessful groups. At discharge 87.8% of patients successfully cardioverted remained in SR, increasing to 92.7% at six weeks follow-up. Patients who required more than a single shock were significantly more likely to relapse into AF by discharge(OR 7.6 95%CI 2.1–28.2, p<0.01). Of failed cardioversions, 73.7% had reverted to SR at six weeks with continued medical treatment and anticoagulation.

**Conclusions:** Cardioversion is effective at restoring SR if antiarrhythmic or rate-limiting therapy fails. The majority of patients with new AF following cardiac surgery will be in SR at six weeks, but earlier cardioversion obviates the need for interim anticoagulation.

## USE OF FIBRIN GLUE AND QUILTING IN REDUCING DRAINAGE IN ELD FLAP DONOR SITE

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**Background:** Significant seroma rates are quoted in literature for ELD flap donor site. These rates are considerably reduced with the use of quilting technique. Nevertheless the drains are still required to be left in flap donor site for number of days. Drains are potential source of infection, cause pain, and requires patient to be kept in hospital.

**Material & Method:** Comparison of drainage and duration of drains in ELD donor site in 11 consecutive prospective patients in which flap donor site was closed using fibrin glue and quilting vs. 24 consecutive retrospective patients, in which only quilting was used.

**Result:** Total amount of drainage in control group 645 mls (330-973) vs. Fibrin group 330 mls (210-430) ( $p = 0.018$ ). Number of days drain left in situ in control group 5 (4.25-6) vs. Fibrin group 4 (4-5) ( $p = 0.022$ ).

**Conclusion:** Fibrin glue and quilting significantly reduce the amount of drainage and the numbers of days the drains are left in situ following ELD flap based breast reconstruction. Fibrin glue can potentially reduce the number of days drains are left in situ or reduce the drainage to such an extent that drains are no longer required.

## LAPAROSCOPIC STOMA FORMATION – A SUITABLE TRAINING PROCEDURE?

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**Introduction:** Diverting stoma formation is a common procedure indicated in a number of acute and elective clinical settings. The laparoscopic approach is increasingly being favoured: it can be utilised to aid development of trainee skills including creation of pneumo-peritoneum, basic bowel mobilisation and instrument handling.

**Methods:** A retrospective survey of diverting stomas created over an 18-month period was performed to determine demographics, indication for procedure, operating surgeon and time taken, time to return of bowel function and length of stay. Laparoscopic (Lap) and open (Op) procedures performed by trainees and consultants were compared.

**Results:** 46 (20M, 26F) patients with a mean age of 66.1 (range 21-95) years underwent stoma formation (27 Lap, 19 Op). Indications included pre-treatment rectal and anal carcinoma (54%), palliative bypass (15%), complex fistula (17%), large bowel obstruction (11%) and incontinence (2%). 61% were trainee-led cases and 30% were consultant-led cases. Mean operating time (111mins Lap, 94mins Op) and time to return of bowel function (2.11days Lap, 2.47days Op) was not statistically significant between the groups. Excluding outliers, inpatient stay was 7 days (Lap) and 9.4 days (Op).

## USE OF ENTONOX FOR COLONOSCOPY: A SYSTEMATIC REVIEW

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**Objective:** Colonoscopy is an invasive procedure requiring adequate analgesia and sedation for successful completion. Current UK practice involving a benzodiazepine/opiate combination may produce more cardiorespiratory adverse effects compared to Entonox (N<sub>2</sub>O/O<sub>2</sub>), which is a shorter-acting inhalational analgesic agent. We aimed to systematically review the published randomised evidence comparing Entonox with other methods for analgesia and sedation in colonoscopy.

**Methods:** PubMed, EMBASE & the Cochrane Library were searched to identify studies. All uncontrolled, non-randomised, retrospective studies or duplications were excluded. The included trials were reviewed in terms of study design, risk of bias and quantitative outcomes.

**Results:** Seven randomised controlled trials (RCTs) were identified after exclusions, with 507 patients (258 Male, 249 Female). Equivalence in pain control to benzodiazepine/opiate was demonstrated in 5 of 6 studies. Completion rates of colonoscopy were not significantly different between the two groups in 6 of 7 studies. Time to discharge was significantly less in the Entonox group compared with the standard regimen in all studies. Risk of bias assessment demonstrated inadequate blinding in 4/7 studies with randomisation methods clearly demonstrated in only 4/7 studies.

**Conclusions:** Use of Entonox allows analgesia during colonoscopy which is no worse than benzodiazepine/opiate agents but allows earlier discharge from hospital

## CARCINOID TUMOURS OF COLON AND RECTUM – MANAGEMENT AND LONG TERM OUTCOME

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**Aim:** Presenting our experience in managing carcinoid tumours of colon and rectum (CTCR) and long term outcome.

**Method:** Patients diagnosed with CTCR (2000-2009) were identified from our database.

**Findings:** Twenty-two patients were identified with CTCR. Seventeen were tumours (15 right colon, 1 rectosigmoid, 1 rectal), while 5 were incidental polyps (1 transverse colon, 4 rectum). At presentation 9 patients had nodal disease, 9 liver metastases including 3 concurrent nodal disease and 1 disseminated disease. Two patients developed delayed metastases after colectomy. Three patients had inoperable disease at diagnosis. Surgical intervention was 13 right colectomies (59%), 1 anterior resection, 2 TEMS and one hepatic resection for delayed metastasis. Four incidental polyps had clear margins. Three patients received chemotherapy, 2 patients received MIBG therapy and 4 patients required sandostatin therapy. Majority of tumours were well-differentiated (60%). Four people have since succumbed to the disease with remainder alive at present. Only 4 patients have had five year disease free survival.

**Conclusion:** CTCR is rare with predilection for right colon. It's infrequent in comparison with small bowel carcinoids. Nodal and/or liver involvement at presentation is frequent, but tumour resection prolongs survival (12/13 colectomies). Incidental finding in polyps need no further intervention if completely excised.

## EARLY COMPLICATIONS FOLLOWING STOMA FORMATION

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**Aims:** Stoma formation is a common procedure that is associated with substantial morbidity when performed badly. Stoma related complications may occur immediately or many years post operation. Our previous audit found that early stoma-related complications did not improve over time with subsequent chronic morbidity. Our aim was to calculate our day 10 complication rate and identify risk factors.

**Methods:** We analysed our prospective stoma database to characterise complications at day 10 (including stenosis, retraction, hernia, prolapse). Stoma care nurses had collected data on a standard proforma at the day 10 assessment which was repeated at regular intervals up to 5 years post procedure.

**Results:** During the 10 year audit, 1846 consecutive patients had stomas formed in three regional centres. Of these, 1827 were gastrointestinal stomas suitable for analysis. There were 292 early complications (16% of all