Conclusion: A large proportion of children underwent surgery which revealed, histologically, a non-inflamed appendix. Discrepancies remain between intra-operative and histological findings, with implications for those arguing for increased use of ‘laparoscopy & proceed’ techniques. Poor adherence to hospital antibiotic protocol was noted.

METHODS: Retrospective study of patient notes from 2000 - 2009 (below 16yrs). Data collected via telephone interview/questionnaire from patient & parents as appropriate. Follow up time calculated by subtracting age at operation from current age.

Results: Of 85 patients were able to provide required data (14 months - 14 years). 33 out of 71 (46.4%) were below 5 yrs, further 27/71 (38%) were above 5 years of age. Median follow up was 7 years with a minimum follow up of at least 1 year. 3 patients (4.2%) developed recurrence at 1, 3 & 4 years from their initial operation. 1 child (1.2%) developed hematoma and wound infection post-operatively.

Conclusions: Hernia surgery in children is associated with very low complications and long term follow up study suggests most recurrences occur within 5 years of original operation. Our study suggests recurrence is more common in above 2 year old repairs. Although this is a small study it opens a debate whether this group needs long term follow up or not.

PLASTIC SURGERY

0037: BREAKING DOWN THE HEALTH CARE LANGUAGE BARRIER: EXPERIENCE OF A REGIONAL BURN UNIT

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Aims: The objectives of this study were to (1) assess the requirement and provision of translation service at a regional burn unit (2) to implement changes based on national guidelines to improve clinical effectiveness.

Method: A prospective study was performed to assess translation requirements of 100 patients attending the burns outpatient department. A questionnaire was designed to collect data on burn distribution, mechanism, complications, native language of patient and person accompanying patient, translation needs and adequacy. Changes were implemented according to the NICE guidelines, including updating translation materials, training interpreters, educating referring hospitals, contacting twenty cultural centres in the region to provide ‘burns first aid and safety in the home’ courses in the native community language. Follow-up study collected data on 85 additional patients following implementation of changes.

Results: The number of patients whose native language is not English in the two cohorts was similar (32% vs 30.5%). Translation needs decreased significantly (32% vs 8%; p = 0.0001) following education to the referring hospitals. Adequacy of translation improved (91.6% vs 100%), and the use of ad hoc interpreters, including family members/relatives and staff, reduced.

Conclusions: Targeted education can improve language service, which is an essential element of patient care in a multi-cultural society such as Britain.

0063: THE TERTIARY MANAGEMENT OF PRETIBIAL LACERATIONS

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Aims: Pretibial lacerations remain one of the commonest yet most neglected conditions facing plastic surgery. Furthermore, these injuries afflict the most vulnerable groups of adults - the elderly and the infrim. This review aims to provide an evidence-based treatment plan, reduce unnecessary surgery and safeguard the at-risk patient.

Method: A MEDLINE search was conducted using the terms (Lacerations OR Laceration) and keywords (pretibial, pre ADJ tibial) to identify high level evidence.

Results: We present an evidence-based approach of these injuries and propose a treatment algorithm that we have utilized to successfully manage 40% of pretibial lacerations conservatively.

Conclusion: The evidence-based algorithm suggested for the management of these wounds is - 1 Linear laceration without skin loss: Manage conservatively; Level of Evidence IV. II Flap laceration viable: Steristrip and manage conservatively; level of Evidence I. III Flap laceration non-viable: Small non-viable flaps: Excise and manage conservatively; larger skin flaps: Excise and skin graft under local anaesthetic; level of Evidence II. IV Skin loss: < 1% TBSA: Manage conservatively; > 1% TBSA: Skin graft under local anaesthetic; level of Evidence V. V Laceration with haematoma: Evacuate haematoma and skin graft; Level of Evidence V