

0134: STRICT ADHERENCE TO BSG GUIDELINES REQUIRED FOR CHOLECYSTECTOMY FOLLOWING PANCREATITIS TO PREVENT HIGH READMISSION RATES

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Background: The current British Society of Gastro-enterology guidelines (2005) for the management of acute pancreatitis suggests that patients with gallstone-induced mild pancreatitis should undergo cholecystectomy with operative cholangiography, unless unfit for surgery, in order to prevent recurrence of pancreatitis. Cholecystectomy should be done at the same admission or within two weeks after discharge and delayed in patients with severe acute pancreatitis until systemic disturbance have resolved.

Methods: Data from Patients admitted with acute pancreatitis from January 2010 to December 2010 were collated.

Results: Of the 117 patients admitted with acute pancreatitis, 51 patients had gallstone-related pancreatitis. 21 patients were known to have gallstone disease from previous admissions. Of the 30 admissions with primary gallstone presentation, 20 were placed on the cholecystectomy waiting list. Eleven (55%) patients were re-admitted, and 6 patients underwent emergency cholecystectomy. The overall waiting list time was 18 (2–36) weeks. Of the 21 patients with previous admission for gallstone related complications, 1 had an emergency cholecystectomy while 15 patients were placed on the waiting list. 5 patients (33.3%) re-presented with 3 patients then undergoing an emergency cholecystectomy.

Conclusion: High re-admission rates following gallstone pancreatitis are a result of non-adherence to the BSG guidelines, especially in female patients.

0212 – WINNER OF ALSGBI TRAINEE PRIZE: SINGLE INCISION COMPARED TO STANDARD LAPAROSCOPIC CHOLECYSTECTOMY

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Introduction: Single-incision laparoscopic surgery is gaining momentum in general surgery. The aim of this study was to compare outcomes for day case single-incision laparoscopic cholecystectomy (SILC) with standard laparoscopic cholecystectomy (StdLC).

Methods: Patients scheduled for day case laparoscopic cholecystectomy were block randomized to SILC or StdLC. Patients were prospectively scored for pain, wellbeing, satisfaction with wounds and recovery on a visual analogue scale (VAS) on days one and seven post operatively.

Results: 49 patients were included in the study (SILC=24; StdLC=25). There were no differences in age, sex, ASA grade and BMI. Two patients were excluded from the study, one from the SILC group and one from the StdLC group. There was no significant difference in the VAS on day one. However, on day seven the SILC group rated their cosmesis significantly higher than the StdLC group ($p = 0.03$). There was no difference in pain wellbeing or strength between the groups.

Conclusion: SILC is feasible, safe and comparable with StdLC. SILC is associated with superior cosmesis.

0257: DOES SEQUENTIAL HEPATIC ARTERY EMBOLISATION INCREASE COMPLICATIONS AND MORTALITY FOLLOWING LIVER RESECTION COMPARED TO PORTAL VEIN EMBOLISATION ALONE?

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Aim: To evaluate the feasibility of portal vein embolisation (PVE) and sequential hepatic artery embolisation (HAE) to increase the future liver remnant (FLR) prior to liver resection.

Methods: All patients undergoing PVE and sequential HAE between Jan 2006–May 2011 were identified from a prospectively held database. These patients were discussed at MDT meetings to decide the necessity for FLR augmentation.

Results: 50 patients underwent right PVE with 33 (66%) progressing to resection. The median FLR of those who progressed to resection following PVE, by CT volumetry, was 384.5cc (330–490), significantly more than those who did not, 237cc (110–280) ($p=0.03$). All patients with small FLR following PVE ($n=6$) underwent HAE (with 5 undergoing resection). HAE increased the FLR by a further 99.8cc (80.5–130cc). Following resection after PVE and sequential HAE 9/33 (27%) and 3/5 (60%) respectively suffered serious

complications (Clavien-Dindo 3/4). There were 6 post-operative deaths, 5/33 (15%) after PVE and 1/5 (20%) following sequential HAE.

Conclusion: PVE is an increasingly used technique to augment the FLR, allowing resection in a significant proportion of patients who were initially considered inoperable. Patients who do not achieve adequate hypertrophy may have HAE to increase the FLR but perhaps at the expense of increasing post-operative complications.

0325: DOUBLE BYPASS FOR INOPERABLE PANCREATIC MALIGNANCY AT LAPAROTOMY: SHOULD WE ALWAYS PROCEED?

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Aim: Double bypass, although associated with high risk of postoperative complications and mortality, is an option for those with pancreatic malignancy found to be inoperable at surgery. The aim of this study was to identify pre-operatively which patients undergoing bypass are at high risk of complications/mortality and to assess their long term outcome.

Method: Of the 576 patients undergoing pancreatic resection for malignancy from January 2006–July 2011 identified from a prospectively held database, 50 patients had a double bypass procedure for locally inoperable disease. Demographics, risk factors for postoperative complications and preoperative anaesthetic assessment data including P-POSSUM and Cardiopulmonary Exercise Testing (CPET) results were collected.

Results: 50 (33 male, 17 female) patients were included; median age 64 (39–79) years. The complication rate was 50% and the in-hospital mortality 4%. High P-POSSUM physiology score and low Anaerobic Threshold at CPET were significantly associated with postoperative complications ($P=0.005$, $P=0.016$ respectively). Overall long-term survival was significantly shorter in patients with postoperative complications (9 vs 18 months) and postoperative complications were independently associated with poorer long-term survival ($P=0.003$, OR 3.261).

Conclusions: These findings question whether a palliative bypass should be performed in patients with a high P-POSSUM physiology score or low CPET score due to the high complication rate and poor long-term outcome.

0341: LONG TERM OUTCOMES AFTER PERCUTANEOUS CHOLECYSTOSTOMY FOR ACUTE CHOLECYSTITIS - A MULTI-INSTITUTIONAL REVIEW

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Aim: To analyze the long-term outcomes after Percutaneous Cholecystostomy (PC).

Methods: Retrospective study of all consecutive patients who underwent PC at two university hospitals between 2000–2010.

Results: 53 patients underwent PC. 58% were ASA III and 34% ASA IV. The median duration of symptoms was 1 day (range 1–35). 63% (33/53) had calculus cholecystitis, whilst 37% (20/53) had acalculous cholecystitis. 7% (4/53) had gallbladder perforation. 82% (43/53) had USS-guided drainage while 18% had CT-guided drainage. The median time to PC from admission was 3 days (range 1–15). The median hospital stay was 15.5 days (range 7–120). 13% (7/53) patients developed complications including bile leaks ($n=5$), haemorrhage ($n=1$) and duodenal fistula ($n=1$). The in-hospital mortality was 18%. 34% (18/53) of patients eventually had cholecystectomy. 4/18 were done on the index admission and a majority had interval cholecystectomy (78%). 6/18 (33%) had laparoscopic cholecystectomy and a majority required conversion to open (67%). 22% (13/53) patients were readmitted with recurrent cholecystitis during follow-up. 13/53 (24%) had repeated PC. The median time to representation was 151 days (2–510).

Conclusions: Only a minority of patients undergoing PC proceed to cholecystectomy. The risk of conversion to an open procedure is high and should be emphasized during the consent. A quarter of patients present with recurrent cholecystitis requiring a repeat PC during follow-up.

0379: PROSPECTIVE AUDIT ON THE MANAGEMENT OF BILIARY PANCREATITIS

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