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Methods: A prospectively collected database from a District General Hospital was interrogated, identifying patients who underwent appendicectomy within two time frames (1999 & 2009). Notes were examined for key history & examination findings, investigations, operative & post-operative details, including histological findings.
Comparing these groups, there were 63 appendicectomies in 2009 compared with 93 in 1999 (32% reduction). There were no significant differences between groups in terms of age or sex ratio.
Results: Both cohorts showed no discriminating clinical signs or symptoms which were useful in differentiating between histological findings. The usage of pre-operative CRP increased from 16.1% to 100%. The use of CT performed also rose from 8.6% to 14.3%. There was increased utilisation of diagnostic laparoscopy from 4 in 2000 (4.3%) to 28 in 2010 (44.4%). Overall negative appendicectomy rates fell from 19.4% to 12.7%.
Conclusion: Although clinical acumen has long been determined the arbiter of appendicitis, this study appears to show that diagnostic tests alone have altered the negative appendicectomy rate.

0871 BASIC SURGICAL SAFETY SKILLS TEACHING IN UK MEDICAL SCHOOLS

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Background: Surgical safety is a global health issue, with the majority of in-hospital adverse events occurring in the operating theatre (1). In order to create a safe generation of surgeons, undergraduate training in surgical safety is essential. This national study quantified undergraduate surgical safety education in the UK.
Methods: All UK medical schools (n=32) were invited to complete a questionnaire through Royal College of Surgeons of England (RCS). The questionnaire quantified whether the principles of the World Health Organisation (WHO) surgical safety initiatives were taught to medical students.
Results: 23 universities responded (72%). The WHO documents were formally taught by just 17.4% of UK medical schools. Individual components of the documents were taught in greater frequency, with 43.5% of the WHO Surgical Safety Checklist being taught. University curricula were responsible for significantly more surgical safety teaching compared to surgical societies (P<0.001).
Conclusion: Surgical safety teaching is absent from many medical curricula and surgical societies. In order to create a safe surgical future, we suggest a formalised patient safety curriculum.
(1) de Vries EN, Ramrattan MA, Smorenburg SM et al. The nature and incidence of in hospital adverse events: a systematic review. Qual Saf Health Care. 2008;17:216-400

0878 THE POTENTIAL DANGERS OF THE LONDON CYCLE HIRE SCHEME

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Aims: The Mayor of London introduced a bicycle hire scheme in July 2010. Since its introduction many novice cyclists have taken to the streets of London. According to the Royal Society for the Prevention fo Accidents 3,674 cyclists were injured or killed in London in 2009. Many of the users enjoy the convenience and nature of the scheme and do not use safety precautions whilst using the bicycles. This study was conducted to assess the use of helmets and safety precautions in cyclists in the capital. The study aimed to compare cyclists with those using the cycle hire bikes with other cyclist. The study was conducted at random locations, times and weather conditions in a two month period in London.
Method: Over 650 cyclists were observed at 10 London locations.
Results: Only 33% of cyclist using the hire bikes wore helmets compared with 70% of other cyclist, showing a statistical difference between the groups (p<0.01).
Conclusion: A study in the US found that riders with helmets have an 88% reduction in their risk of brain injury. The authors' advocate that more should be done to improve the safety of the cycle hire scheme. The users should become more aware of the life-saving benefits of helmets.

0881 AAA SURVEILLANCE IN OCTOGENARIANS: SHOULD CRITERIA FOR TREATMENT BE MODIFIED?

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Aims: Octogenarians are considered to be high risk for AAA surgery. Optimum surveillance and treatment for this group is still uncertain. We aim to analyse intervention and outcome of octogenarians entered into AAA surveillance.
Methods: A single-centre prospective database of patients under AAA surveillance was interrogated. AAA scan intervals followed unit protocol. Decision to treat was based on patients' surgical risk.
Results: From May 1997 to April 2010, 1112 patients entered AAA surveillance. 269(24.2%) were octogenarians. Octogenarians presented with larger aneurysms (4.42cm vs 4.12cm,p<0.001). 26(9.7%) octogenarians underwent elective repair compared to 162(19.2%) non-octogenarians (p<0.001). AAA size between the two groups when listed for intervention differed (6.16cm vs 5.81cm,p=0.004). A similar proportion of octogenarians to non-octogenarians (7(2.6%) vs 2 (2.5%), p>0.05) ruptured during surveillance. 30-day elective mortality was comparable (1(3.8%) vs 3(1.9%),p=0.513), but a significant difference in 1-year mortality was demonstrated(4(18.2%) vs 7(4.9%),p=0.019).
Conclusions: Comparable 30-day elective mortality between the two groups suggests AAA repair in octogenarians is safe. Octogenarians were no more likely to rupture, despite undergoing fewer elective procedures with larger aortas, suggesting that these patients are dying with intact AAAs and it may be safe to operate at a larger diameter. The higher 1-year mortality questions the survival advantage conferred to this group.

0885 HAVE WE CLOSED THE GAP ON GENDER DIFFERENCES IN AAA?

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Aims: Studies suggest that women with AAA have unfavourable outcomes, with high rupture rates and poor post-operative survival. AAA diameter of 5.0cm is the current threshold for consideration of surgery in women. We evaluate the presentation, treatment and outcomes of women in AAA surveillance.
Methods: A single-centre prospective database of patients under AAA surveillance was interrogated. AAA scans followed unit protocol. Treatment was based on surgical risk.
Results: From May 1997 to April 2010, 1112 patients with AAA were entered into AAA surveillance, of which 263(23.7%) were female. Women presented with smaller aneurysms compared to men (4.06cm vs. 4.23cm,p<0.05). Women were older entering surveillance (mean 75.3 years vs 73.3,p<0.001). Women had higher rupture rates (15(5.7%) vs 13(1.5%),p<0.001) and received fewer elective procedures(32(12.1%) vs 156(18.4%),p<0.005). Women received surgery at a smaller AAA size (mean 5.58cm vs 5.91cm,p<0.05). 30-day elective mortality was comparable (1(3.1%) vs 3(1.9%),p=1.8). 1-year mortality was higher in women(2(7.1%) vs 9(6.5%),p=0.02).
Conclusions: Women enter AAA surveillance at an older age with smaller aneurysms. Although 30-day elective mortality rates are comparable, women were still less likely to receive surgery for AAA for an unclear reason. The mean diameter of AAA for women at surgery was 5.58cm. These factors may contribute to higher rupture rates.

0888 USE OF BIOBRANE IN CHILDREN

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