0898: A RETROSPECTIVE STUDY OF POST-SURGICAL UROLOGICAL COMPLICATIONS FOLLOWING RENAL TRANSPLANT ACCORDING TO PATIENT BODY MASS INDEX

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Aim: Historically for renal transplants, recipient Body Mass Index (BMI) ≥30kg/m² (obese) was considered to be associated with increased risk of perioperative morbidity and mortality. This study aims to determine the incidence of perioperative urological complications with potential intervention requirement following renal transplantation and relate this to recipient BMI.

Method: A consecutive series of 634 renal transplants (2008-2013) were audited with patients divided into three cohorts based on BMI (kg/m²) [Cohort A-25, B 25-29.99, C≥30]. We recorded all perioperative urological complications (90 days) per patient.

Result: Study sample=610 transplant recipients [Cohort A-294, B-224, C-92, excluded-24]. Three types of urological complications were assessed: Urinary Tract Infection, Urinoma and Ureteric Stricture. All of these complications were experienced by a higher rate of obese patients (Cohort C) in comparison other patients. However, chi-square analysis found no significant relationship between BMI and type of urological complication. Incidence rates for actual intervention were all related to ureteric stricture: [Cohort A-0.2%, B-0.7%, C-0.3%, TOTAL-1.1%].

Conclusion: Incidence of post-surgical urological complications following renal transplant is not determined by BMI of the patient. The only urological complication requiring surgical intervention was ureteric stricture.

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1239: RECIPIENT HYPERTENSION AND PROLONGED COLD ISCHEMIA TIME IS A SIGNIFICANT PREDICTIVE FACTORS OF RENAL TRANSPLANT FIBROSIS AT ONE MONTH POST LIVE DONOR RENAL TRANSPLANTATION

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Background: Renal transplantation is the therapeutic option of choice in the appropriate patient with end-organ disease. Donor characteristics and its relations to post transplant fibrosis was not clearly assessed in the past.

Method: The study has been designed to identify recipients co-morbidities prior to live donor renal transplantation. 300 live donor renal transplant recipients over 12 years (1997-2009) has been assessed.

Statistical analysis: Multivariable linear regression analysis was performed to explore the association between fibrosis at one month and donor characteristics. Cold ischemia and HTN were included in this analysis. The age of the donor, their relation to the patient, the pre-op creatinine, number of arteries, kidney weight and warm ischemia time were not found to be significantly associated with fibrosis at one month.

Result: In this complex model; HTN in the recipient and cold ischemia time were found to be strong predictive factors of fibrosis at one month (HTN: p<0.001, 95% CI -0.08 to -0.02, Coefficient -0.05), (Cold ischemia time: p=0.003, 95% CI -0.1 to -0.04, Coefficient -0.5 ).

Conclusion: Hypertension and prolonged cold ischemia time in live donor renal transplant recipients is a significant predictive factor of kidney fibrosis at one month post transplantation.

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Trauma and orthopaedics

0038: HIP FRACTURE QUALITY IMPROVEMENT IN A DISTRICT GENERAL HOSPITAL – EARLY SURGERY IS ACHIEVABLE AND SAVES LIVES


70,000 Hip Fractures occur annually in the UK carrying a one-month mortality of 10%. Delayed Time-to-Surgery is recognised in increasing mortality. Our aim was to identify the proportion of patients undergoing surgery within 36 hours of admission, and to investigate the causes of delays and their effects on mortality.

Retrospective analysis of a three-month snapshot of data from National Hip Fracture Database, with a re-audit following an education programme and appointment of a ‘hip champion’ – a member of staff who advocated for the expediting of hip fracture patients. Local data was compared to NHFD Standards and National Averages.

Overall, 52% of delayed surgeries were attributed to logistics, compared to medical reasons or further investigations (41% and 7% respectively). This was reduced from 70% to 11% in the re-audit with the ‘hip champion’. Logistically delayed surgery carried a higher mortality rate of 21%, compared to medical delays (17%) and timely surgeries (11%).

The percentage of patients having surgery within 36 hours remains lower than the national average, however our data suggests a re-education programme can reduce logistic delays and mortality. This could be further improved by having a dedicated trauma list with prioritisation of Hip fractures over less urgent fractures.

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0048: PATIENT REPORTED OUTCOME AND EXPERIENCE MEASURES FOR HALLUX-RIGIDUS. CHEILECTOMY VS. FUSION

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Introduction: PROMS/PREMS are a fundamental part of the NHS. PROMS2.0, a web-based system, allows collection and analysis of outcomes

Objective: We compare PROMS/PREMs for cheilectomy/fusion at UHSM.

Method: 1st MTPJ cheilectomy-10 patients (4Female,6Male) (9Right,1-Left). Average age- 47.3 (34-70). 1st-MTPJ fusion-16 patients (12Female,4Male) (9Right,7Left). Average age-60.3yrs (19-83) PPE-questionnaire-17 patients (10 fusion/7 cheilectomy). OA graded with Hattrup and Johnson classification. Data significant if p<0.05.


Result: Cheilectomy- Averag EQ5QF improved- Pain: 33.5-25.0 (p=0.084), VAS-68.8-80.4 (p=0.158) Fusion- Averag MOXQF improved- Pain: 50.7-9.7 Walking/standing: 49.1-16.1. Social interaction: 48.4-20.1 (all p<0.001) Average EQ-5D improved: Index: 0.68-0.83 (p=0.003). VAS-72.5-83.6 (p=0.014) Fusion outcomes with OA grades- 4/4 patients with grade 2 OA improved, 11/12 with grade 3. Cheilectomy, 2/2- grade one improved, 3/7 with grade 2 and 0/1 with grade 3. (p<0.0001)17 patients (10 fusion/7 cheilectomy) did PPE-questionnaire- satisfactory experience for both groups

Conclusion: Both procedures show improved outcomes. Fusions have greater improvements than cheilectomy based on reported outcomes. Higher grades of OA better with fusion. Both patient sets have satisfactory experience.

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0064: EVALUATING THE EFFECT OF TRANEXAMIC ACID ON BLOOD LOSS AND TRANSFUSION RATES IN HIP HEMIARTHROPLASTIES. A RETROSPECTIVE AUDIT

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Introduction: Hip hemiarthroplasty is an increasingly common surgical procedure which can lead to excessive blood loss and therefore adversely affect patient outcomes. A 1g intravenous dose of tranexamic acid (TXA)