0962: SURGICAL REFERRALS FROM NURSING HOMES; MORE EVIDENCE FOR A GERIATRIC MEDICINE LIASON SERVICE

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Aims: To assess outcomes of inpatient stay in patients referred to acute surgical unit from residential homes, comparing with non-institutionalised patients with similar presenting complaints.

Methods: 40 patients admitted from homes over six months were matched with following emergency surgical admission living independently aged ≥70. Data gathered via ‘take’ lists and discharge summaries.

Results: Dementia was more prevalent in the residential care (45 vs 28%), who also had more co-morbidities (4.4 vs 2.6). Presenting complaints between groups were similar, abdominal pain and haematemesis being leading causes. Larger proportion of community residents underwent surgery during admission (28 vs. 5%) whilst greater proportion of residential care died during admission (15 vs. 2.5%). Residential care patients had a slightly longer average duration of stay in this study (5.5 vs 4.2 days).

Conclusions: Whilst presenting with similar complaints, residential care patients are less often surgical candidates; fewer undergo surgery and a larger proportion die during admission. This supports value of geriatric liaison, particularly discharge planning, including in those patients palliative needs, as well as medical optimisation of co-morbidities when surgery is considered. Presented to the surgical and elderly care department: a new admission pathway for this group of patients was proposed to the trust, suggesting referral via the geriatric team.

1045: OUTCOMES FOLLOWING EMERGENCY GENERAL SURGERY IN NONAGENARIANS

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Aim: In 2010 NCEPPOD highlighted concerns over outcomes of elderly patients undergoing emergency surgery. This study aimed to investigate outcomes in nonagenarians undergoing emergency surgery and identify predictive risk factors for mortality and the impact on care requirements.

Method: All nonagenarian patients who underwent emergency general surgery operations between June 2005 and June 2010 within one NHS Trust were retrospectively reviewed. Risk factors analysed included age, sex, ASA grade, clinical parameters, preoperative blood tests (including C-reactive protein (CRP), preoperative care dependence, operation factors and surgeon factors. Kaplan-Meier survival analysis was performed using one year mortality rates.

Results: Forty six patients (30 female) underwent surgery with an inpatient mortality of 32.6% and one year mortality of 54.3%. Patients undergoing major index surgery, a CRP > 100 or who required any form of preoperative social care had significantly reduced survival (P = 0.013, P<0.001 and p = 0.0024 respectively). Upon discharge 59.3 % of patient required no change in social care, 29.6% a temporary change and 11.1% a permanent change.

Conclusion: Emergency surgery in the nonagenarian is feasible with little long term change in social care requirements. Predictors of mortality are CRP > 100, requirement for social care preoperatively and major index surgery.

1096: LAPAROSCOPIC APPENDICECTOMY – A NEGATIVE IMPACT ON EMERGENCY OPERATING?

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Background: Acute appendicitis is commonly managed with laparoscopic appendicectomy. However, there is a perception that it takes longer than an open operation and may, therefore, impact on the efficiency of emergency operating lists. The purpose of this study was to 1) evaluate the increase in laparoscopic appendicectomies over a five year period; 2) assess whether operating times are increased and 3) identify how this affects the provision of emergency operating lists.

Methods: Data was collected retrospectively for all appendicectomies performed in a single NHS trust from 2006 to 2011 and analysed over three time periods.

Results: The total number of appendicectomies performed annually ranged from 336 to 399. The percentage performed laparoscopically has progressively increased from 9% in 2006 to 56% in 2011. The average time taken to perform a laparoscopic appendicectomy was eight minutes longer than for an open procedure (p<0.001). The average duration of laparoscopic appendicectomy has not changed since 2006.

Conclusion: Although laparoscopic appendicectomies took consistently more time than open appendicectomies, the average difference was only eight minutes. Given the average number of appendicectomies performed per day is one, it is unlikely this increased operating time will negatively impact on the provision of emergency surgery.

1129: IS THE USE OF LAPAROSCOPY LEADING TO A RISE IN THE NEGATIVE APPENDICECTOMY?

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Aim: Studies have shown that negative appendicectomy rates are not significantly reducing and that laparoscopy is possibly lowering the threshold for intervention in patients with suspected appendicitis. Our aim was to establish the rate of negative appendicectomy in our institution and identify related factors.

Methods: A retrospective review of patients undergoing an appendicectomy over 12 months was performed. Data on the pre-operative assessment, investigation, operative management and final pathology of patients were collected. Chi squared test was used to identify any factors associated with a negative appendicectomy.

Results: 95 patients underwent an appendicectomy. The median age was 30yrs. 51 (54%) of patients were male. 19% of patients underwent preoperative computed tomography (CT). 29 patients underwent open appendicectomy, 65 laparoscopic and of these 6 were converted to open. Appendicitis was significantly more likely in patients undergoing open surgery compared with laparoscopic surgery (93% vs. 63%, p=0.004). Women were significantly more likely to undergo laparoscopy (78% vs 50%, p=0.02). 93% of patients with CT findings suggestive of appendicitis had appendicectomy.

Conclusions: The use of laparoscopy appears to be associated with an increased rate of negative appendicectomy. Increased use of CT may be preferable to initial laparoscopy.

1177: THE EFFECT OF CENTRALISING THE TRAUMA SERVICE ON GENERAL SURGERY EMERGENCY OPERATIONS: CLOSING THE LOOP ON AN AUDIT OF TIME WAITING FOR SURGERY

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Aims: Following the centralisation of trauma services to a single unit there were concerns that this would increase pressure on emergency general surgery provision and theatre access. Therefore, time to theatre was audited before and after centralisation against guidelines set by the Royal College of Surgeons.

Methods: Data was collected from 471 patients; January-June 2009 before and January-June 2011 after the addition of the trauma unit. The waiting time from booking emergency general surgery to operation for admissions was audited using the theatre database.

Results: The median waiting time was 6.6 hours (0.3-61.1) for procedures before trauma centralisation compared with 12.5 hours (0.0-120.3) for procedures after trauma centralisation. For laparotomy, appendicectomy and incision and drainage of abscess waiting times were 3.6 hours (0.3-26.6), 5.7 hours (0.4-37.4) and 15.1 hours (0.4-61.1) respectively before centralisation and 6.5 hours (2.39), 7.8 hours (0.7-58.3) and 16.7 hours (1.3-120.3) respectively following centralisation. 37% of appendicectomies breached the 18-hour sepsis target following centralisation compared with 17% prior to centralisation.

Conclusions: Centralisation of trauma services has resulted in increased waiting times for general surgery emergencies. Following this audit general emergency theatre provision has been increased and protected from other service demands.

UPPER-GASTROINTESTINAL SURGERY

0036: STOPPING PPIs PRIOR TO ENDOSCOPY

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Background: NICE recommends that patients undergoing endoscopy should cease treatment with a PPI or H2 receptor antagonist for a minimum of 2 weeks prior to endoscopy to prevent false negative tests. Aim: To determine the extent to which these NICE guidelines are being followed in our Trust. Method: This study analysed data obtained from questionnaires filled in by endoscopists at a district general hospital between October, 2010 and January, 2011. Results: 67 questionnaire’s were analysed. Median patient age was 80 years (male 48%, female 46%). Of the referrals analysed 62.7% were requested as a 2 week wait[1]. Of this 2 week wait group, over 4 in 10 patients had been taking a PPI at referral. 24% of those patients on a PPI did not stop their PPI 2 weeks before endoscopy (of this group, a third were not verbally advised to stop PPI prior to endoscopy and 46% received the endoscopy information leaflet less than 2 weeks before endoscopy). Conclusions: Lack of patient information may lead to the need for repeat procedures and potentially false negative endoscopies. This study highlights the importance of giving information leaflets during the consultation and verbally reinforcing the information.

0073: COMPLICATIONS OF LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING (LAGB) PERFORMED BY ONE SURGEON OVER A 10-YEAR PERIOD
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Background: Between November 2001 and September 2011, 1100 laparoscopic adjustable gastric banding operations (LAGB’s) were performed by one surgeon. Our study examined the long-term complication rate.
Methods: All available medical notes (1079 patients) were reviewed.
Results: Mean weight was 120 kg, BMI 43.3. After 10 years of follow-up, complications occurred in 347 patients. 143 patients experienced band slippage; re-operation was required in half of these cases. 82 patients had their band removed due to complications, slippage in 60, erosion in 17 and band intolerance in 5. 136 patients experienced port problems; 37 were flipped on clinical or radiological fills, 17 patients had port infection. 50 ports required repositioning due to discomfort or difficulty with clinical fills; 16 were removed or replaced, including 5 for cutaneous erosion. 4 patients required other procedures to deal with intra-operative complications. 18 patients had a concurrent procedure. The only post-operative death was due to biliary peritonitis in a patient who had undergone simultaneous cholecystectomy.
Conclusion: Complication rates reflect the literature. Slippage rate may appear higher in our patients, but this is because most patients undergo radiological band fills hence many non-symptomatic slippages are detected. Only half of our slippages were clinically apparent or needed any intervention.

0138: POST-OPERATIVE RECOVERY FROM CHOLECYSTECTOMY AT A DISTRICT GENERAL HOSPITAL
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Laparoscopic cholecystectomy is one of the most common general surgical operations; however the majority of patients undergoing this procedure receive no routine surgical follow-up. Descriptions of the recovery period and quoted rates of potential complications when counselling patients for this procedure are hence potentially inaccurate.
We sent a postal questionnaire to all patients who had undergone a cholecystectomy at our institution over a 6 month period (median 5 months post op) in order to investigate patients’ recovery from this procedure. 60% of 100 patients contacted returned the questionnaire. Median time to return to work and driving was 2 weeks. 48% of patients reported having a post-operative problem that they consulted their GP or A&E regarding; 50% of these were prescribed antibiotics. Reported complications included LRTI in 3.5% of responders, and surgical site infection in 22%. A single patient required re-operation, and 6 patients (10%) reported re-admission to hospital. Little information specific to our unit has previously been available to aid in counselling patients undergoing cholecystectomy. Rates of surgical site infection and post-operative antibiotic requirements were much higher than our estimates. Knowledge of this may have an impact upon the way in which we practice and perform this operation in the future.

0183: CENTRALISATION OF UPPER GI CANCER SERVICES – IS THE HUB BETTER THAN THE SPOKE?
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Aims: To assess whether patients diagnosed with oesophageal or gastric cancer at a local district general hospital (the “spoke”) have a similar temporal pathway through the decision making and treatment process compared to those patients presenting at the centralised, tertiary hospital (the “hub”).
Methods: Between April 2010 and April 2011, patients with a new diagnosis of oesophage-gastric cancer from both the hub and spoke hospitals were included. Data regarding diagnosis, time from diagnosis to multidisciplinary (MDM) discussion and time from MDM decision to first treatment were all recorded and prospectively analysed.
Results: There was a statistically significant increase in the time from diagnosis to MDM discussion at the spoke hospital compared to the hub. (13.3 days vs.+ 25.67 days; P=0.001). However, time to first was significantly increased in the hub hospital compared to the spoke (43.4 days vs 25.5 days; P=0.023).
Conclusions: Withholding its limitations, this study is the first of its kind to show that there is a disparity in the management pathways of patients who present to a regional hospital rather than the tertiary centre. Patients at the spoke hospital have a longer lead time into MDM but non-operative treatment appears to be delivered more quickly locally.

0203: OUTCOMES AT ONE YEAR FOLLOWING LAPAROSCOPIC SLEEVE GASTRECTOMY IN WALES
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Aim: Seven of the UK’s ten worst areas for morbidity obesity occur within Wales and bariatric surgery is the only proven treatment strategy. This study aimed to compare percentage excess weight loss (%EWL) and comorbidity resolution following laparoscopic sleeve gastrectomy (LSG) against UK National Bariatric Surgery Registry 2010 (NBSR) figures.
Methods: Retrospective analysis was performed on patients undergoing LSG at a single centre. Weight and Body Mass Indices (BMIs) were measured pre-operatively, at 3-6 months (n=28) and at 12 months (n=20). Obesity-related comorbidities of type-II diabetes mellitus (T2DM), hyper tension and obstructive sleep apnoea (OSA) were recorded preoperatively and at 12 months.
Results: Twenty-eight patients (median age 45.5 years [17-63yrs], m/f=7:21) were studied. At 3-6 months median %EWL was 28.0% (9.2-67.2%); median BMI reduced from 46.5kgm-2 to 37.8kgm-2. At 12 months (20 patients), median %EWL was 55.7% (24.4-88.0%); median BMI reduced from 45.0kgm-2 to 32.3kgm-2. At 12 months, 100% of patients (7 pts) with T2DM, 100% (6 pts) with hypertension and 80% (5 pts) with OSA demonstrated improvement or complete resolution of comorbidity.
Conclusion: Percentage EWL and comorbidity resolution at twelve months compare favourably with those of the NBSR (%EWL=56% vs. 54%; T2DM resolution=100% vs. 50%) after LSG.

0231: A 10 YEAR RETROSPECTIVE ANALYSIS OF OUTCOMES FOLLOWING PERFORATED GASTRIC OR DUODENAL ULCER
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Aim: Despite improved medical management for peptic ulcer disease, incidence of perforated ulcer remains unchanged, resulting in high mortality and morbidity. This study aims to establish outcomes following surgery for perforated ulcer and identify factors predicting mortality and morbidity.
Method: Records of 48 patients undergoing surgery for perforated peptic ulcer from 2001 to 2010 were retrospectively reviewed. Factors significantly increasing mortality and morbidity were determined with multivariate logistic regression. Factors analysed included: age; ASA grade; pre-operative shock; co-morbidities and delayed presentation.
Results: There were 36 male and 12 female patients with mean age of 55 (range 20-89). 44 patients had a duodenal perforation. Only 2 perforations