MDT. Phase II demonstrated the feasibility to routinely collect co-morbidity data using ACE-27.

1119: DIFFERENTIAL EXPRESSION AND FUNCTION OF MONOCARBOXYLATE TRANSPORTER 1 (MCT1) IN HUMAN COLON
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Introduction: Butyrate, a short-chain fatty acid, is produced by fermentative bacteria in the colon, and is the primary energy source for colonocytes. It is transported across the colonic epithelium by monocarboxylate transporter 1 (MCT1). Optimal butyrate production and transport is imperative for maintenance of gut health.

Methods: Western blot studies and immunohistochemistry detected expression of MCT1 transporters in the human colon. Butyrate flux studies were carried out by mounting fresh human colon samples in Using Chambers. Bidirectional flux was investigated using radiolabelled butyrate (C14) and Papp determined by using a scintillation counter.

Results: Immunohistochemistry and Western blotting showed differential expression of MCT1 throughout the colon. There was stronger expression in the ascending colon compared to the descending colon (p<0.01, n=3). Butyrate flux was bidirectional and was significantly greater in the ascending colon compared to the descending colon (p<0.05, n=6). Flux was inhibited by the known butyrate inhibitor Resveratrol.

Conclusions: These results illustrate differential expression of MCT1 in the human colon, strongly correlating to regions that contain the largest populations of intestinal bacteria.

1126: COLORECTAL CANCER OPERATIVE NOTES: PRELIMINARY AUDIT RESULTS
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Introduction: Structured operative notes are imperative to provide clear documentation of intraoperative events. In colorectal cancer they are vital to plan post-operative management and future follow-up as well as aiding data collection. This audit will assess colorectal cancer operative note documentation in accordance with Association of Coloproctology (ACP) Guidelines.

Methods: 50 colorectal resections performed between September 2012 and September 2013 were randomly selected for audit and operative notes reviewed retrospectively. From these results an operative note proforma was produced in accordance with ACP guidelines. A re-audit is ongoing auditing all resections performed since November 2013 with this proforma in use. Preliminary second cycle results are presented (n=15).

Results: Full name, DOB and hospital number documentation improved from 51%, 31% and 39% respectively to 100% each in the second cycle. Surgeon name was 100% in both cycles though surgeon grade improved from 61% to 87%. Extent of malignancy improved from 61% to 87%.

Conclusions: Preliminary results show that an operative note proforma has improved documentation in all domains. On-going audit is required to confirm this.

1139: THE ADDITIONAL YIELD OF WHOLE COLONIC IMAGING TWO WEEK RULE (TWR) COLORECTAL ASSESSMENT
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Introduction: Whole Colonic Investigation (WCI) following negative Flexible Sigmoideoscopy (FS) in symptomatic patients is thought to have a low diagnostic yield. We assessed the adequacy of FS in symptomatic TWR patients and additional yield of neoplasia gained with WCI.

Methods: 2151 TWR patients from January 2012 to June 2013 were analysed, 404 excluded for non-attendance and anaemia. Endpoints were age-stratified FS outcomes and additional colonic/extra-colonic neoplastic yield of WCI.

Results: 1747 symptomatic patients were included (median age 65) with 91 colorectal cancers. WCI was undertaken in 974(55.8%) patients following FS. FS initially identified 285 patients with colorectal neoplasia. Subsequent WCI identified 112 additional patients. The additional yield of WCI compared to FS was significantly greater, 29 in the 70-79year group (p=0.006), 41 in the 60-69year group (p=0.001) and 28 in the 50-59 year group (p=0.01) (Chi-square). In >80year and <49year groups, WCI did not confer significant benefit. 15 missed colorectal and 40 extra-colonic primary were identified by WCI.

Conclusions: WCI identified significant numbers of patients with colorectal neoplasia following negative FS. Investigating with FS alone results in unacceptable high missed colonic and extra-colonic cancers. The role of FS alone in colorectal TWR workup needs reassessment.

1157: COLORECTAL CANCER IN THE ELDERLY AND THE INFLUENCE OF LEAD TIME BIAS: BETTER SURVIVAL DOES NOT EQUAL IMPROVED LIFE EXPECTANCY
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Introduction: To define outcomes in all patients presenting with colorectal cancer aged ≥80 years at time of diagnosis based on treatment received.

Methods: Patients aged ≥80 diagnosed with colorectal cancer in one acute hospital trust between 1998 and 2011 were identified from a prospectively maintained database. Primary endpoints were age at diagnosis, age at death/censor and mortality at 30, 90 and 365 days.

Results: Of 668 patients, 412 (61.7%) underwent surgery. 44 (6.6%) received endoscopic therapy and 212 (31.7%) had no active treatment. Mean age at diagnosis was younger in those undergoing surgical resection (83.7 years) compared to those having defunctioning surgery (84.9 years; P=0.043), endoscopic therapy (85.1 years; P=0.008) or those managed non-surgically (85.6 years; P<0.001). There was no significant difference in mean age of death or censor between groups. 1-year mortality in those undergoing surgical resection was 30.1% compared to 67.7% in the defunctioning group, 76.3% after bypass surgery and 63.2% in those who had no active treatment (Log rank P<0.001).

Conclusions: There was no significant difference in age at death or censor between treatment groups among patients aged ≥80 presenting with colorectal cancer, suggesting that differences in observed survival time are heavily influenced by lead-time bias.

1233: I’D RATHER TAKE THE STAIRS – AN ALTERNATIVE TO CARDIOPULMONARY EXERCISE TESTING
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Introduction: To investigate whether a short exercise test and peak expiratory flow rate (PEFR) can predict post-operative complications in elective major abdominal surgery.

Methods: 58 patients scheduled for major abdominal surgery aged over 40 were recruited. In addition to the normal preoperative evaluation, patients’ rates of heart rate recovery (HRR) were recorded for two minutes following a rapid climb of two flights of stairs. Preoperative and postoperative PEFR, incidence of complications and length of stay (LOS) were recorded.

Results: 48 patients were suitable for analysis; 40 had valid HRR data. Complications occurred in 24/48 patients (50%). The mean rate of HRR was significantly lower in those who subsequently developed complications (2.88±1.577 b.p.m/15secs) compared to those who did not (4.49±3.106 b.p.m/15 secs) ( t (38)=3.473, p<0.001), a mean difference of 1.614 (95%CI 0.637-2.554). When adjusted for severity of complication, the R² value of association was 0.371 (p<0.001). In patients with co-morbidities, preoperative PEFR was 29.7% lower in those who developed complications (p=0.002, 95% CI 5.09%-54.31%).

Conclusions: The HRR rate is a quick and cheap alternative to cardiopulmonary exercise testing to screen for post-operative complication risk. More data is needed to assess the impact on LOS. PEFR was predictive of complications in those with co-morbidities.

1248: SURGEON VERSUS GASTROENTEROLOGY COLONOSCOPISTS – DO SURGEONS NEED TO BE HAVING COLONOSCOPIES??
Qamar Zaman 1, Aftab Khan 2, Daniel Thomas 1, Rajab Kerwat 1, Hamid Khawaja 1, John Payne 1. 1Queen Mary Hospital, London, UK; 2University College London, London, UK.

Introduction: To compare the colonoscopy service provision between gastroenterologists and surgeons at a district general hospital.
Methods: We compared all colonoscopy procedures performed by joint advisory group (JAG) on GI endoscopy approved surgical and gastroenterology endoscopists during the period January 2008 till June 2013.

Results: A total of 6718 colonoscopies were performed by 6 gastroenterology and 8 surgeon endoscopists with comparable completion rates. The surgeons performed twice more colonoscopies (n=4611) with statistically significant difference in patient’s age (62.3 years vs. 57.6 years, p <0.001). The surgeons also performed more therapeutic procedures (1529 vs. 442, p <0.001) with higher polyp excision rates (p 0.001). During the procedures, surgeons used less sedation (mean dose: Fentanyl dose 55.31 mcg vs. 61.53 mcg, p <0.001; Midazolam 2.6mg vs. 2.7mg, p <0.001) but high dose of Buscopan (9mg vs. 1.5 mg, p <0.001) resulting in overall less patient discomfort levels (p 0.001).

Conclusions: The study demonstrates a high volume of diagnostic and therapeutic colonoscopy service provided by surgeons. This study highlights the need for incorporation of endoscopy training into surgical curriculum.

1252: STAPLED ANOPEXY: AN EFFECTIVE TREATMENT FOR SYMPTOMATIC HAEMORRHOIDAL DISEASE – A DISTRICT GENERAL HOSPITAL EXPERIENCE

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Method: Data was collected prospectively. Clinical information was obtained from all patients. Patient demographics, symptoms, indications for surgery and short-term outcomes were evaluated.

Results: 74 patients with symptomatic haemorrhoidal disease underwent stapled anopexy, with a male: female ratio of 35:39, mean age of 50 range (25-85). Pre-operative symptoms included rectal bleeding (84%), perianal irritation (43%), prolapsing haemorrhoids (30%) and skin tags (7%). Surgery was performed as a day case procedure. There were no intra-operative complications. Post-operatively, minor bleeding or discomfort was the most common complication. No faecal incontinence was noted. 70% of patients were discharged following 1 routine outpatient appointment, increasing to 90% after 3 appointments. Of the remaining 10% (8 patients); 4 had underlying obstructive defecation syndrome, 1 had urgency that settled after 4 months, 1 had delayed wound healing and 2 had painful defecation of which 1 required excision of a painful suture neuroma.

Conclusions: Multiple treatment modalities exist for symptomatic haemorrhoidal disease. Our short-term results demonstrate stapled anopexy to be an effective treatment with low associated morbidity and a high level of patient satisfaction.

1259: ASSESSING THE MOST EFFECTIVE UPPER LIMIT OF NORMAL FOR CEA IN THE FOLLOW UP OF CURATIVE COLONRECTAL CANCER RESECTIONS

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Introduction: carcino-embryonic antigen (CEA) is a marker for recurrent disease following curative resections of colorectal cancer. Not all colorectal tumours express CEA and it may be raised for other reasons. A raised CEA requires investigation but slight rises in CEA frequently fail to demonstrate recurrent disease and carry risks and promote anxiety. We reviewed CEA levels at their first check post-curative resection and correlated this with recurrence.

Methods: Retrospective case-note review of 418 patients having curative resections between 4/9/08 and 24/12/12.

Results: 130 patients developed recurrent disease (first CEA range was 0.2 – 11563ng/ml, median 9.2). 288 patients had no recurrent disease (first CEA range 0.5– 112.9ng/ml, median 2.6). Using an upper limit of normal as 3.5ng/ml for CEA the sensitivity and specificity for recurrent disease is 55% and 75% however at 4.0ng/ml it is 52% and 83%.

Conclusions: The upper limit of normal is effective in reducing the number of disease-free patients having needless investigations for recurrent disease (6% of patients) however the cost of missing three recurrent carcinomas is too high. The best value for the upper limit of normal of CEA is 3.5ng/ml.

1298: ERECTILE DYSFUNCTION AND FAECAL INCONTINENCE AFTER PELVIC RECTAL CANCER SURGERY

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Introduction: Erectile dysfunction (ED) and faecal incontinence (FI) can affect 75% of men after pelvic rectal cancer surgery. There is paucity of data, especially ED as what is accessible is extrapolated from prostate cancer studies. The aim was to gauge trust practice and obtain data for prospective questionnaire planning.

Methods: A retrospective questionnaire (Wexner score and International Index of Erectile dysfunction (IIEF-5)) was sent to 71 male patients from January 2011 to December 2012.

Results: Response rate was 47.9%. Patients who felt inappropriately counselled about ED risk post-operatively was 47%. Of these, 68.8% would have preferred a discussion regarding ED pre-operatively. On the IIEF-5, 31.2% patients had moderate ED, 12.5% had mild to moderate ED, 25% had mild ED whilst 31.2% had no ED. In contrast, 35.2% felt inappropriately counselled about FI risk post-operatively and 83.3% would have preferred to have had this discussion. Prior to surgery, 58.8% never suffered from FI. After surgery, 15.2% patients scored 0 or more on the FI score (0 no incontinence and 20 severe incontinence).

Conclusions: ED and FI are issues that need to be addressed more comprehensively and patients should be counselled regarding these risks in a timely manner whilst dealing with the diagnosis of cancer.

1357: THE INDIVIDUAL SURGEON’S PERFORMANCE: 10 YEARS OF LAPAROSCOPIC COLORECTAL SURGERY

Sina Hossaini1, Balamuruli Bhatharun, Charles Maxwell-Armstrong. Queen’s Medical Centre, Nottingham, UK.

Introduction: To evaluate individual surgeon performance for laparoscopic colorectal operations from UK national laparoscopic training centre.

Methods: Data analysis was conducted from prospectively validated colorectal database for the individual consultant surgeon from July 2003.

Results: 325 patients (172 male, 153 female) of mean age 65.9 years and mean BMI of 26.5. The majority were ASA grade 2 (57.5%), 102 procedures were right-sided, 65 left-sided, 15 involving right and left, and 143 rectal operations. 21% were for malignancy (65.5%). The commonest stage was Dukes’ B and 92% were of curative intent with mean lymph node harvest of 12.5.

Conclusions: The study demonstrates a high volume of diagnostic and therapeutic colorectal surgery. Laparoscopic training can be achieved with good clinical outcomes despite the pressures for disclosure of individual surgeon-level data.

1364: THE EFFECT OF MOVIPREP ADMINISTRATION TIMING ON THE ADEQUACY OF BOWEL PREPARATION FOR COLONOSCOPY


Introduction: Colonoscopy is limited by a small but significant incidence of missed lesions due in part to inadequate bowel preparation. At our endoscopy unit, bowel preparation (Moviprep) is administered 12-16 hr prior to endoscopy for morning lists but only 6-9 hr before afternoon lists. We aimed to investigate the effect of moviprep administration timing on the adequacy of bowel preparation.

Methods: Data was collected for colonoscopy patients over two months. Adequacy of bowel preparation was compared between morning and afternoon lists. The effect of various independent factors on the adequacy of bowel prep including age, gender and operator were also tested.

Results: 199 patients were included. 102 patients were scheduled on a morning list. Within this group, the incidence of good, satisfactory and poor bowel preparation respectively was 23.5%, 50% and 26.5% compared to 57.7%, 24.8% and 17.5% on afternoon lists (P<0.0001). The adequacy of