West Midlands Surgical Society

Autumn Meeting 2015

University Hospital Coventry and Warwickshire,

Coventry

Thursday 3rd December 2015

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ENDOLOGIX

Programme

09.00 **REGISTRATION AND COFFEE**

09.30 **WELCOME**

Mr Stan Silverman – President WMSS

Scientific Short Papers

09.35 ***Are we calling it right. The accuracy of preoperative radiological staging in rectal cancer***

A.Brookes[1], K.Jones[1], L.Meecham[1], T.Stone[2], M.Cheetham[1] 1. Department of Colorectal Surgery, Royal Shrewsbury Hospital 2. Department of Radiology, Royal Shrewsbury Hospital

09.44 ***Consultant reporting of diagnostic radiological tests for emergency general surgical patients***

J.Ward, U. Shariff, K. McArdle, T. Raju General & Colorectal Surgery, Good Hope Hospital, Heart of England NHS Foundation Trust, Sutton Coldfield, West Midlands

09.53 ***Does alignment of total knee replacement affect patient reported outcome measures?***

Imran Ahmed, Tim Barlow, Bhanu Mishra, Dveej Bhatt, Damian Griffin, Institution University Hospital Coventry and Warwickshire

10.03 ***Does prescribing mechanical venous thrombo-embolism (VTE) prophylaxis improve compliance with their use in surgical inpatients?***

Miss P Kaur[1], Dr F Colombo, Mr P Thomas 1 - Burton Hospital Foundation Trust,

10.12 ***Early outcomes of volume maximised Glycerol rhizolysis***

Girish Kulkarni, Ravi Vemaraju, Ramesh Chelvarajah Department of Neurosurgery Queen Elizabeth Hospital Birmingham, Mindelsohn Way, Edgbaston B15 2WB.

10.21 ***Endovascular repair of asymptomatic thoraco-abdominal aortic aneurysms with fenestrated and branch devices a single centre experience***

MCR Houlihan, A Koutsoumpelis, PFJ Clift, AM Ranasinghe, JG Mascaro, MW Claridge, DJ Adam , Birmingham Complex Aortic Team Vascular and Endovascular Unit, Heart of England NHS Foundation Trust. Adult Congenital Heart Unit, University Hospital Birmingham NHS Foundation Trust. Cardiothoracic Aortic Unit, University Hospital Birmingham NHS Foundation Trust

10.30 ***Exploring morbidity assessment for trauma patients a pilot study of the Adapted Clavien Dindo for Trauma (ACT) classification system***

David N Naumann[1,2], Nicola Pearson[2], Iain M Smith[1], Keith Porter[2], Mark J Midwinter[1,2] **Affiliations** 1. National Institute for Health Research, Surgical Reconstruction and Microbiology Research Centre, Queen Elizabeth Hospital, Birmingham, B152TH, United Kingdom 2. University Hospitals Birmingham NHS Foundation Trust, Birmingham, B152TH, United Kingdom

10.39 ***Infective complications of military craniectomy and cranioplasty Iraq and Afghanistan***

E Toman[1], S Roberts[2], M Midwinter[1], T Belli[1] NIHR/SRMRC Queen Elizabeth Hospital Birmingham, UK' 2. NIHR/SRMRC Imperial College London & Queen Elizabeth Hospital Birmingham, UK

10.48 ***Is artery diameter or vein diameter the most important determinant of the gender bias in primary arteriovenous fistulae failure***

Maria Corte-Real Houlihan, Sarah Powers, Tami Stephenson, Jyoti Baharani, Teun Wilmink Institution: Department of Vascular Surgery and Renal Medicine, Heart of England Foundation Trust, Birmingham.

10.57 ***One stop emergency clinic***

Miss Christina Macano, Dr Marcus Taylor, and Mr Robert Clarke Institution**:** The Shrewsbury and Telford hospital NHS trust

11.06 **MORNING COFFEE**

Plus visit to trade stands

11.30 ***Outcomes and satisfaction with semi-elective day case hand trauma surgery***

Miss Felicity Page, Mr Darren Chester, Queen Elizabeth Hospital, Birmingham, B15 2TH,

11.39 ***Outcomes following lower limb angioplasty for patients with diabetes compared to***

patients without

Danielle Lowry, Alok Tiwari, Vascular Surgery Department, Queen Elizabeth Hospital Birmingham,

11.48 ***Popliteal Artery Aneuysm Stenting***

M Walls, V Summerour, R Pathak, Russells Hall Hospital, Dudley, UK

11.57 ***Post traumatic stress disorder amongst surgical trainees an unrecognised risk?***

Christopher V Thompson[1], David N Naumann[1,2], Jodie L Fellows[3], Douglas M Bowley[2], Nigel Suggett[1] **Affiliations :** University Hospitals Birmingham NHS Foundation Trust, Queen Elizabeth Hospital, Birmingham, UK 2. Academic Department of Military Surgery and Trauma, Royal Centre for Defence Medicine, Birmingham, UK 3. Birmingham and Solihull Mental Health Foundation NHS Trust, Birmingham, UK

12.06 ***Reoperation rates and influencing factors in below knee amputation***

A Anandakumar, New Cross Hospital. R Faulconer, Royal Shrewsbury Hospital. A Garnham, New Cross Hospital.

12.15 ***Short term perineal wound outcomes following extralevator abdomino-perineal excision (ELAPE) compared to standard abdomino-perineal excision (SAPE)***

Miss P Kaur, Mr P Thomas, Mr P Kumar 1 - Burton Hospital Foundation Trust, contact number 07711951518

12.24 ***TEO procedure for low rectal lesions***

N A Yassin A Mistry A Adeyemo

12.33 ***The use of pre-operative blood grouping and saving in appendicectomies***

Authors: Dr Margaret Senbanjo (Russells Hall Hospital), Dr Sarah Lort (Russells Hall Hospital), Mr Raj Patel (Russells Hall Hospital),

12.42 ***Use of perioperative glucocorticoid therapy***

Gaunt A, Green N, Bowley D, Heartlands Hospital, Heart of England NHS Foundation Trust

12.51 ***West Midlands Diabetic Foot Service***

Authors: HC. Travers[1], West Midlands Vascular Research Collaborative,

Collaborators: T. Baker[2], M. Claridge[3], N. Dattani[4], H. Davies[3], R. Faulconer[5], A. Garnham[2], HS Khaira[3], A. Murray[1], S. Premaratne[6], R. Sam[7], **Institutions:** 1. Worcestershire Royal Hospital, Worcester, 2. Russel's Hall Hospital, Dudley, 3.Heartlands Hospital, Birmingham, 4.University Hospital Coventry and

Warwickshire, Coventry, 5. Royal Shrewsbury Hospital, Shrewsbury, 6.Royal Stoke University Hospital, Stoke –on –Trent, 7. University Hospital Birmingham, Birmingham

13.00 **LUNCH**
Plus visit to trade stands and posters

13.50 **AGM**

Symposium: Emergency Surgery

14.00 **National Emergency Laparotomy Audit (NELA) and EPOCH respectively**
Dr Andrew Thacker, Consultant Anaesthetist, UHCW
Dr Anne Scase, Consultant Anaesthetist, UHCW

14.30 **Emergency Neurosurgical TARN data Audit**
Mr Ronan Dardis, Consultant Neurosurgeon, UHCW
Mr Shahid Siddique, Consultant Neurosurgeon, UHCW

14.50 **The West Midlands Blunt Trauma Audit**
Mr Thanos Saratzis, General and Vascular Surgery; NIHR Academic Clinical Lecturer, Leicester

15.15 **Question and Answer Session**

15.50 **TRAINING UPDATE**
Mr Mike Hallissey

16.10 **WEST MIDLANDS RESEARCH COLLABORATIVE**
Marianne Johnstone

16.30 **TEA AND AWARD OF REGISTRARS' PRIZES**
Please note prizes will not be awarded in absentia

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Abstracts

Are we calling it right? The accuracy of preoperative radiological staging in rectal cancer?

A.Brookes[1], K.Jones[1], L.Meecham[1], T.Stone[2], M.Cheetham[1]

1. Department of Colorectal Surgery, Royal Shrewsbury Hospital

2. Department of Radiology, Royal Shrewsbury Hospital

Contact: 07812538087 (AB)

Introduction:

Preoperative radiological staging is critical to decisions regarding treatment in rectal cancer. We investigated the accuracy of radiological TN staging with MRI.

Methods

We retrospectively reviewed rectal cancer resections performed over 1 year. Data were obtained from the electronic record system. The pre-operative staging on MRI was compared to subsequent histology.

Results:

71 patients data were reviewed. 12 patients were excluded. 1 patient only had histological T staging data having undergone an Altemeiers.

Radiological staging and histology were concordant in 52.5% and 51.7% for tumour and nodes respectively. Tumour and nodal staging was overcalled in 37.3% and 22.4%. Nodal disease presence was correctly identified with in 62.9%.

MRIs following long course chemoradiotherapy (LCCRT) were not formally re-staged but reported changes correlated with the histology.

If patients receiving LCCRT were excluded radiological staging was concordant with histology in 60.4% and 55.3% for tumour and nodes respectively. Tumour and nodal staging was overcalled in 27.1% and 17.0%. Accuracy for presence of nodal disease was 76.6%

Conclusion:

MRI yields acceptable accuracy with regard to tumour and nodal staging. From a surgical perspective the reliability of radiological reporting for clinical decision making is enhanced by the tendency of radiologists to overcall any uncertainty.

Consultant reporting of diagnostic radiological tests for emergency general surgical patients

J.Ward, U. Shariff, K. McArdle, T. Raju

General & Colorectal Surgery, Good Hope Hospital, Heart of England NHS Foundation Trust, Sutton Coldfield, West Midlands

Contact: Umar Shariff 07976428770

Introduction

Following publication of "NHS Services, Seven Days a Week Forum Clinical Standards" for diagnostic radiological services, this audit aim was to assess times from test completion to consultant reporting for diagnostic radiological services performed for emergency general surgical patients in our DGH.

Methods

A prospective audit was performed (1/12/14 – 31/12/14) using a proforma to collect data for all emergency general surgical patients requiring diagnostic imaging. Data was collected on: type of test, categorisation into critical, urgent, non-urgent, time booked and reported for each test.

Results

114 patients underwent diagnostic imaging. Median age 58.8 (range 17-92); 31 male: 83 female. Diagnostic tests included: Ultrasound (USS) 56 (49.1%), CT 51 (44.8%), CT-KUB 4 (3.5%), MRI/MRCP 3 (2.6%). Overall median time between booking and reporting tests was 11 hours 41 minutes. Overall median time from test completion to reporting: 1hour 22minutes. Median time from test completion to consultant reporting: USS: 1hour, CT: 1hour 39minutes, CT-KUB: 1hour 47minutes, MRI: 5hours 56minutes. 44/94 urgent patients (46.8%) did not meet standard for reporting within 12 hours.

Conclusions

Although consultant reporting is completed within reasonable times, this audit highlights the importance of arranging tests efficiently to ensure that urgent patients have tests reported within recommended times.

Does alignment of total knee replacement affect Patient reported outcome measures?

Imran Ahmed, Tim Barlow, Bhanu Mishra, Dveej Bhatt, Damian Griffin

Institution University Hospital Coventry and Warwickshire

Contact: 07845269614, imranahmed08@hotmail.com, imran.ahmed4@nhs.net

Introduction: Total knee replacement (TKR) is an effective means of alleviating the symptoms of knee arthritis. However, 20% of patients report dissatisfaction post operatively. Factors leading to

dissatisfaction include persistent pain and reduced postoperative function both of which can be assessed by Patient Reported Outcome Measures (PROMs). Studies have demonstrated conflicting evidence on the association between alignment of TKR components and PROMs.

Aim: To investigate the association between alignment and PROMs.

Method: A multicentre cohort study was performed at six centres. Blinded assessment of postoperative coronal and sagittal radiographs was carried out and Oxford Knee Score (OKS) was measured six months postoperatively.

Results: 461 patients were available for analysis with a mean age of 68 and a mean BMI of 34. There was no significant difference between alignment and OKS score at six months (independent t-test)($p>0.05$). A multivariate regression model taking into account age, gender, BMI, arthritis severity, deprivation score and baseline OKS demonstrated no significant difference ($p>0.05$).

Conclusion: In conclusion, our study suggests that if PROMs is the outcome of interest for operating surgeons then alignment does not significantly affect outcome scores. As a result alignment is unlikely to be the cause of the high rates of dissatisfaction.

Does prescribing mechanical venous thrombo-embolism (VTE) prophylaxis improve compliance with their use in surgical inpatients?

Miss P Kaur[1], Dr F Colombo, Mr P Thomas

1 - Burton Hospital Foundation Trust, contact number 07711951518

Introduction

Current guidelines in the UK suggest that all surgical inpatients should have mechanical VTE prophylaxis.

A recently conducted audit in our department showed there was a lack of compliance with the use of mechanical VTE prophylaxis in surgical inpatients.

Our study aimed to show that prescribing mechanical VTE prophylaxis would improve compliance with its use in surgical inpatients.

Method

Mechanical VTE prophylaxis was made available to be prescribed throughout the trust via the electronic prescribing system. Furthermore a daily alert for the ward nurses administering medications was set for all patients with prescribed mechanical VTE prophylaxis.

A month later, a retrospective study was performed to determine if compliance mechanical VTE prophylaxis use had improved.

Results

33 patients were included in our study. In total mechanical VTE prophylaxis had been prescribed for 24 (73%) of our patients with it being contraindicated in a further 3 (9%) of patients.

Of the 30 patients, without contraindications, it was in use for 23 (77%) of patients. Of the 7 patients not using mechanical VTE prophylaxis 4 of the patients had refused its use.

Conclusion

Prescribing of mechanical VTE prophylaxis improves compliance with its use in surgical inpatients from 33% to 77%.

Early outcomes of volume-maximised Glycerol rhizolysis for Trigeminal Neuralgia

Girish Kulkarni, Ravi Vemaraju, Ramesh Chelvarajah

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Queen Elizabeth Hospital Birmingham, Mindelsohn Way, Edgbaston B15 2WB.

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Senior author / Sponsor: Ramesh Chelvarajah

Introduction:

Trigeminal neuralgia, amongst the worst pains experienced by humans, is occasionally intractable to best medical management. Percutaneous ablative &/or operative procedures can offer more efficacious & longer duration of pain relief.
We present early results of our **volume-maximised** Glycerol rhizolysis technique by a single surgeon.

Objectives: Determine

- Post-procedure duration of pain relief
- Incidence of facial numbness
- Compare duration of pain relief in patient subgroups with & without numbness
- Complications from this new technique

Method:

Operation notes analysis & prospectively recorded follow-up between 2012 to 2014.
Comparison of duration of pain-relief & incidence of post-injection facial numbness.

Results:

30 patients underwent **volume-maximised** Glycerol injections for TGN.
22/30 (73%) benefitted from pain-relief.
All 22 had pain-relief immediately; 83% @ 6-months post-injection; 50% @ 12-months; 33%@ 18-months; 33% @ 24-months; 8% @ 30-months.

About half the cohort(14/30) experienced numbness post-procedure, lasting an average of 14.6 months before resolving. All these benefitted with pain relief lasting an average of 30 months.

Conclusions:

Volume-maximised Glycerol rhizolysis is a safe method.
Pain relief lasts 12 - 36 months.
Induction of facial numbness appears to prolong duration of relief from TGN.
Our **volume-maximised** Glycerol injection technique appears to be positively implicated with the induction of facial numbness.
No serious complications noted.

Endovascular repair of asymptomatic thoraco-abdominal aortic aneurysms with fenestrated and branch devices: a single centre experience

MCR Houlihan, A Koutsoumpelis, PFJ Clift, AM Ranasinghe, JG Mascaro, MW Claridge, DJ Adam

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Endovascular repair (EVAR) of thoraco-abdominal aortic aneurysms (TAAA) is a complex procedure. We analysed early outcomes of elective fenestrated and branch EVAR (FEVAR/BEVAR) for TAAA. Between June 2007 and September 2015, 163 patients underwent elective FEVAR/BEVAR for TAAA [median diameter 72 (range 51-110) mm]. Aneurysms were classified according to anatomical extent (65 anatomical extent I-III, 76 extent IV, 22 juxtarenal with supracoeliac coverage) and to endovascular repair extent [104 extent I-III aortic coverage, 59 extent IV coverage (defined as up to 35mm above the coeliac)].

Of 620 target vessels, 579 (mean 3.6/patient) were stent-grafted and 5 (3 main renal, 1 accessory renal, 1 coeliac) were lost intra-operatively. 30-day mortality was 0.6% (n=1), 4.9% (n=8) required early re-operation and 0.6% (n=1) required unplanned permanent renal dialysis. Five (3.1%) patients developed spinal cord ischemia (SCI) [5/104 (4.8%) extent I-III aortic coverage vs. 0/59 extent IV coverage]. The incidence of SCI decreased with the introduction of a spinal cord protection protocol (SCPP) for extent I-III aortic coverage [4/22 (18%) pre-SCPP vs. 1/82 (1.2%) with SCPP].

Elective endovascular TAAA repair can be performed with high technical success and low risk of adverse outcome in a supraregional high-volume complex aortic centre.

Exploring morbidity assessment for trauma patients: a pilot study of the Adapted Clavien-Dindo for Trauma (ACT) classification system

Authors

David N Naumann[1,2], Nicola Pearson[2], Iain M Smith[1], Keith Porter[2], Mark J Midwinter[1,2]

Affiliations

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Background

Trauma outcomes are often limited to mortality. No validated tools for the assessment of post-traumatic morbidity exist. We describe initial experience with the "Adapted Clavien-Dindo for Trauma" method (ACT)—a derivative of an established tool for grading elective surgical complications.

Methods

An observational, prospective pilot study tested ACT in patients admitted to critical care at a UK Major Trauma Centre. Demographics, patterns of injury, critical care and hospital lengths of stay, organ dysfunction and 30-day mortality were compared between patients with and without complications.

Results

51 patients were included. Median age was 37.5 (26.6 – 53.2) years; 76.5% were male. Median ISS was 16 (11.5 – 24.5). Median Sequential Organ Failure Assessment scores on Days 1 and 4 were 4 (2 – 7) and 1 (0 – 5.5) respectively. 30-day mortality was 11.8%. 9/51 patients suffered complications. ACT grades were successfully assigned to all of these. Patients with complications had longer critical care stays than patients without (10 (7 – 18) days *vs.* 3 (2 – 7) days; p=0.004), and had higher SOFA scores on day 4 (5 (2 – 9) vs. 0 (0 – 3.75); p=0.038).

Conclusion

This initial exploration suggests that ACT may be useful for grading post-traumatic complications. Further prospective multi-centre validation is required.

Infective complications of military craniectomy and cranioplasty; Iraq and Afghanistan

E Toman[1], S Roberts[2], M Midwinter[1], T Belli[1]

1. NIHR/SRMRC Queen Elizabeth Hospital Birmingham, UK
2. NIHR/SRMRC Imperial College London & Queen Elizabeth Hospital Birmingham, UK

Objectives

To describe the indications, infective complications and outcomes in UK military personnel requiring craniectomy in recent conflicts

Design

Retrospective audit

Subjects

14 UK military personnel

Methods

JTTR search: UK survivors who underwent craniectomy and cranioplasty from mechanisms of explosion, blunt trauma and gun shot-wound from 2004 -2014. Notes from Role 3 and 4 hospitals

Results

All male, mean age 24 (18-37), 79% with open cranial injury and penetrating fragments. Mechanism of injury was 50% blast, 50% gunshot wound. 10 patients had an ISS of 75. Median time to cranioplasty 9 months. Infective complication rate of 43%. Most common causative organism was acinetobacter. Glasgow outcome score ranges from 3-5

Conclusions

This is the largest study to date evaluating the UK military population that have undergone decompressive craniectomy. The infective complication rate is likely related to the initial injury pattern, predisposing these patients to infection. Complication rates are comparable to UK civilian and US military data. There was an unexpected survival rate for those with an ISS of 75. It is clear that access to neurosurgical intervention in theatre remains imperative for good long-term outcomes in this cohort of patients.

Is artery diameter or vein diameter the most important determinant of the gender bias in primary arteriovenous fistulae failure?

Authors:

Maria Corte-Real Houlihan, Sarah Powers, Tami Stephenson, Jyoti Baharani, Teun Wilmink

Institution: Department of Vascular Surgery and Renal Medicine, Heart of England Foundation Trust, Birmingham.

Introduction: Ultrasound (US) vessel size criteria, and whether artery or vein diameter determines primary failure (PF) of AVF, are not well established.

Methods: Review of AVF databases and dialysis sessions. Primary failure (PF) is defined as failure to achieve 6 consecutive dialysis sessions with 2 needles on the AVF. Artery and vein diameters were measured by US according to a standard protocol. Radio-cephalic (RCAVF) are created if artery and vein are ≥2 mm. Elbow AVF are created if artery and vein are ≥ 3 mm.

Results: 213 AVF operations with known vessel sizes and outcomes were analysed: 132 RCAVF (62%), 61 BCAVF (29%) and 20 BBAVF (9%). Women had more PF for RCAVF than men (32% v.11%; p = 0.004) but not for elbow AVF (28% v 22% p= 0.56). Women had smaller mean radial artery diameter

(2.4 mm v. 2.6mm; p=0.02) and brachial artery diameters (mean diameter: 4 mm v. 4.5 mm; p= 0.01). Elbow vein diameters did not differ.

	PF	***Dialysis use***	***p***
Artery below size	4 (36%)	7 (64%)	0.22
Artery meets size	35 (20%)	84 (80%)	
Vein below size	4 (22%)	14 (78%)	0.94
Vein meets size	35 (21%)	128 (79%)	
Total	*39*	*142*	

Discussion: Preliminary results suggest that artery size is a more important in PF. This has to be confirmed in a larger dataset.

Conclusion: Higher PF in women could be related to smaller arteries. Vein size may not influence outcome.

Authors: Miss Christina Macano, Dr Marcus Taylor, and Mr Robert Clarke

Institution: The Shrewsbury and Telford hospital NHS trust

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One stop emergency clinic; rapid assessment, reduced admissions and improved acute surgical service.

There is increasing pressure on emergency services to provide efficient assessment and management of patients that reduce admissions. By setting up a consultant led, registrar delivered emergency clinic, we bridge the gap between patients that fall between the extremes of urgency of care, which can be managed acutely, on an outpatient basis, therefore preventing admissions.

Methods: We reviewed our initial practice as an emergency clinic, assessing referrals and patient out-comes. Guidelines were distributed to the care co-ordinating centre. 6 weeks later we audited to assess compliance and improvements in clinical practice.

Results: Having reviewed our initial practice and by introducing strict guidelines, we significantly improved suitability of patients attending clinic (42.9% to 79.4%). The majority (75.8%) of appropriate referrals were successfully managed on an outpatient basis. Admitted appropriate referrals had either abnormal results on assessment or required surgery. 97.8% of inappropriate referrals will be admitted for inpatient management.

Conclusion: By providing suitable guidelines, we have optimised our clinic use significantly. We have reduced admissions, provided rapid treatment and are adapting our medical care for the ever-increasing trends of negative defensive medicine and rising referral numbers.

Outcomes and Satisfaction with Semi-elective Day Case Hand Trauma Surgery

Miss Felicity Page, Mr Darren Chester

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Introduction and Aims

In 2003, the University Hospital Birmingham introduced a day case emergency hand trauma operating system[1]. Appropriate patients are identified at assessment in accordance with strict selection criteria and return for their operation on dedicated hand trauma theatre lists. The service has been shown to improve efficiency and reduce patient complaints[2].

The aim of the study was to assess clinical outcomes and patient satisfaction with the service.

Material and Methods

Feedback questionnaires were distributed prospectively to patients on emergency hand trauma operating lists. Patients were contacted by telephone and case notes were reviewed at 30 days post operatively. Analysis included patient demographics, injury sustained, operative management, complications and satisfaction results.

Key Results

Results were collected for 100 patients. Overall 93% would recommend the service. There were high levels of satisfaction with all aspects, including information provided (93%), pain management (83%) and comfort going home (86%).

99% were supplied with antibiotics in accordance with management protocols. 2.3% of patients were treated for a post-operative infection.

Conclusion

This study has shown that semi-elective day case hand trauma surgery is safe and effective as demonstrated by the low infection rates and high levels of patient satisfaction.

Outcomes following lower limb angioplasty for patients with diabetes compared to patients without.

Danielle Lowry, Alok Tiwari

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Introduction: Patients with diabetes mellitus (DM) are generally considered to have poorer outcomes following lower limb angioplasty (LLA) compared to patients without DM. However this conclusion is based on cohorts who are poorly matched for potential confounding factors. To address this we have compared two impeccably matched cohorts.

Method: All patients who underwent LLA between July 2010 and May 2015, at our institution, were identified. Those with DM were matched, for age, sex, ethnicity, smoking, hypertension, hypercholesterolaemia and renal status, with a patient without DM. Further LLA, revascularisation surgery, minor amputation (MiA), major amputation (MaA) and all-cause mortality were the outcome measures.

Results: After matching there were 153 perfectly matched patients in each cohort. A higher proportion of DM pts had MiA (8.5% vs 2.0% p 0.018) or MaA (8.5% vs 2.0% p 0.018) and a lower rate of amputation free survival (81.7% vs 68.0% p 0.008). Log-rank tests demonstrated survival was worse in the DM group for MiA, MaA and mortality (p 0.01, 0.017 and 0.037 respectively).

Conclusion: In well matched cohorts DM remains a significant risk factor for amputation and all-cause mortality. The presence of DM does not have an impact on the rate of revascularisation procedures.

Popliteal Artery Aneurysms: Endovascular Treatment – A Case Series

M Walls, V Summerour, R Pathak

Russells Hall Hospital, Dudley, UK

Introduction

Popliteal artery aneurysms are the most common peripheral artery aneurysm. Symptoms range from pain, palpable mass, claudication and acute lower limb ischaemia, with 33-50% asymptomatic at diagnosis. Endovascular repair with flow diverting stent grafts has been established but long term patency rates have not with many studies following up for 12-24 months showing comparable patency rates with open surgery. We present our units data covering 13 aneurysm repairs using flexible endovascular stents in 12 patients over 6 years.

Method

Patients were identified retrospectively from theatre dairies and theatre coding records with clinical details found from the electronic record.

Results

Median patency rates were 34 months clinically and 25.4 months radiologically. 2 stents were occluded at follow up at 5 and 34 months clinically and the later radiologically as well, one stent showed 50% stenosis at 55 months radiologically which required no intervention. There was no claudication, bypass nor amputations following stenting.

Conclusion

We find popliteal artery stenting for exclusion of aneurysmal disease a viable method. We are expanding our analysis by directly comparing exclusion bypass to stenting using matched in terms of long term patency and function.

Correspondence to Martin Walls, martin.walls@doctors.org.uk, 07921061624

Post-traumatic stress disorder amongst surgical trainees: an unrecognised risk?

Authors

Christopher V Thompson[1], David N Naumann[1,2], Jodie L Fellows[3], Douglas M Bowley[2], Nigel Suggett[1]

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Background

Experiences of actual or threatened death or serious injury to patients are commonplace in surgery. Following this, pathological symptoms may develop, leading to Acute Stress Reaction (ASR) and Post Traumatic Stress Disorder (PTSD). The estimated rate of PTSD in the general population is 5.6%

Methods

A web-based pan-specialty survey of UK surgical trainees based upon the Impact of Events Scale-Revised (IES-R) was distributed using social media platforms and email. A score of ≥ 33 was indicative of ASR or PTSD (dependent on chronicity). Chronicity of symptoms and sources of support were also explored.

Results

167 returned surveys; mean age of 32.7 ±3.6 years; 61.4% male. Mean training duration 6.1 ±3.6 years. Median IES-R score was 14 (IQR 7 – 23.5).

23 (16%) had IES-R score ≥ 33; 6/23 (26%) of these had symptoms <1 month (ASR); 17/23 (73.9%) had symptoms lasting >1 month (PTSD).
Those in the IES-R ≥ 33 group were more likely to be female, have repeated a year of training, and have witnessed severe pain, traumatic injury, and acute haemorrhage.
Seven trainees (29.2%) with score ≥ 33 had sought support.
Conclusion
Occult psychological morbidity amongst surgical trainees is higher than that of the normal population.

Reoperation rates and influencing factors in Below Knee Amputation.

A Anandakumar, New Cross Hospital. R Faulconer, Royal Shrewsbury Hospital. A Garnham, New Cross Hospital.

Introduction

Complications following below knee amputation (BKA) may lead to poorer outcomes and longer hospital stays. A significant complication is the need for revision. We aim to identify factors influencing reoperation following BKA.

Method

A retrospective review of major lower limb amputations over 13 months at a single vascular network.

Results

72 amputations were identified. Median age was 69 years. Mean length of stay was 19.4 days.

38 patients underwent a BKA. 34% (n=13) had a reoperation and 26% (n=10) required conversion to an above knee amputation (AKA).

Presentation leading to BKA was critical limb ischaemia (CLI) in 53% (n=20) and infection in 32% (n=12). 50% (n=10) of the CLI group and 33% (n=4) of the infection group required reoperation.

In BKA patients with previous ipsilateral revascularisation, 28% (n=5) required reoperation compared with 38% (n=8) who had not. Patients who had previous revascularisation had shorter in-patient stays, 17.6 versus 19.8 days.

Conclusions

The majority of patients requiring reoperation presented with CLI and had not had previous revascularisation. This suggests patients presenting with CLI may have improved outcomes with a reconstruction initially even if they ultimately require an amputation. Those not receiving revascularisation need more consideration of primary amputation level.

Short term perineal wound outcomes following extralevator abdomino-perineal excision (ELAPE) compared to standard abdomino-perineal excision (SAPE)

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Introduction

Data related to wound morbidity following ELAPE as compared to SAPE remains unconvincing.

We aimed to show improved short term outcomes in patients undergoing ELAPE with a biological mesh perineal reconstruction compared to SAPE

Method

Data was collected on patients undergoing either SAPE or ELAPE, with biological mesh perineal reconstruction, for low rectal cancers. Comparisons were made on the following outcomes

1. Length of hospital stay
2. 90 day mortality
3. Perineal wound morbidity
    a. Infection
    b. Need for packing
    c. Return to theatre within 30 days

Results

37 patients underwent a SAPE and 22 underwent ELAPE. Patients undergoing an ELAPE had a shorter length of stay (8.7 days vs 10.6 days). 90 day mortality was greater in patients undergoing a SAPE (8% vs 0%). The rate of perineal wound infections were not different between the two cohorts with 27% of patients in both cohorts developing a wound infection. More patients undergoing a SAPE required packing of the perineal wound (37% vs 18%), however more patients in the ELAPE cohort required a return to theatre for their perineal wound (22% vs 5%)

Conclusion

With a biological mesh perineal reconstruction during ELAPE perineal wound morbidity is comparable to SAPE.

TEO procedure for low rectal lesions

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Background

Transanal endoscopic microsurgery (TEMS) and Transanal minimally invasive surgery (TAMIS) procedures have been undertaken by specialist centres. The learning curve for both can be steep. The TEO procedure (Transanal Endoscopic Operation) has evolved as a new technique. We aimed to assess the feasibility and clinical outcomes of patients undergoing the TEO procedure within a District General Hospital (DGH) setting.

Methods

All TEO procedures were conducted by a single surgeon between June 2012 and June 2015. A retrospective study was conducted and data were collected from clinical and histological databases.

Results

A total of 22 procedures were performed in 19 patients. M:F ratio was 2:1. Median age was 70 years (range 50-82). Median length of stay was 1 day (range 1-14). The histology revealed benign lesions in all but 4 cases. Of the malignant lesions, one required 2 further TEO excisions. One patient required a low anterior resection. Surgical complications were 4 post-operative bleeds which settled conservatively with only 1 requiring a repeat EUA.

Conclusion

The TEO procedure is feasible and safe to use for elderly and comorbid patients within a DGH setting. Using these strict criteria for patient selection one can expect good outcomes and avoid major colonic resections.

The use of pre-operative blood grouping and saving in appendicectomies

Aims: To assess the necessity of preoperative blood grouping and saving before performing emergency appendicectomies based on the risk of red blood cell (RBC) transfusion.

Methods: A computerised retrospective search of a District General Hospital patient database using the relevant OPCS-4 Codes for appendicectomies was performed for the period January 2012 to December 2014. This data was then cross referenced against the Hospital blood bank database to identify patients who received blood products post-operatively.

Results: 1098 patients had an appendectomy over the 2-year period. Of these, 564 (51.4%) patients were male and the mean age was 29.6 years. In total, only one patient (0.09%) required RBC transfusion. The risk of requiring RBC transfusion for open and laparoscopic appendicectomies was 0.12% and 0% respectively.

Conclusions: In this Hospital, the risk of requiring RBC blood transfusion when undergoing appendicectomy was extremely low (0.09%). Current local policy requiring all patients undergoing this operation to have routine preoperative blood grouping and saving requires amendment. A

change of policy will support efficient use of emergency operation theatres by reducing delays caused by incorrect/insufficient blood samples and also reduce fiscal expenditure on clinically unindicated tests.

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Use of glucocorticoid therapy in patients undergoing colorectal surgery

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Introduction

Long term steroid therapy can suppress the hypothalamic-pituitary-adrenal (HPA) axis and native hormone production may not be adequate at times of surgical stress. High dose peri-operative steroids are commonly prescribed; however, high-dose steroid therapy increases risk of complications and recent systematic reviews have questioned the need for supplemental perioperative stress-dose glucocorticoids.

Methods

Retrospective review of patients on glucocorticoid therapy who underwent major colorectal surgery between 01/12/2014 to 31/05/2015.

Results

15 patients (9M: 6F): Crohn's (9), UC (5) and other (1). 11/15 patients were taking steroids prior to admission. Patients stratified into "high risk" for HPA axis suppression (>3/52 prednisolone 20mg) and "low risk" (remainder). Of "high risk" group, 38% received correct dose IV hydrocortisone at induction and 25% post-operatively (50% received a higher dose). Of the "low risk" group 29% received correct dose at induction and 29% post-operatively. A variety of steroid weaning regimens were prescribed.

Conclusions

Current practice in our hospital shows an unacceptable degree of variation. >60% of patients at high risk of HPA suppression were incorrectly treated peri-operatively and only a minority of patients are prescribed an appropriate post-operative regimen. Increased awareness of peri-operative glucocorticoid therapy in these patients and dissemination of appropriate guidelines is required.

West Midlands Diabetic Foot Service

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Background: Diabetic foot problems are a significant burden on the NHS and contribute to the estimated 80% of preventable amputations. NICE published guidance in 2011 and Diabetes UK released the Foot First Campaign in 2013 detailing standards for management of patients with diabetic foot problems with particular reference to services that are available.

Aim: To establish the provision of integrated diabetic foot services across the West Midlands.

Methods: A questionnaire was conducted based on the NICE quality statements to establish the provision of diabetic foot services across the seven vascular centres in the West Midlands.

Results: There is local guidance for the management of diabetic foot problems in 71% (5/7) of the vascular units. 71% have an integrated care pathway and 57% (4/7) have a local risk stratification system. Only 57% have a foot protection team and 57% have a multidisciplinary foot care team. 71% have a rapid access clinic. Only one centre has all services. Inpatient integrated multi-professional care is also poor across the West Midlands.

Conclusion: Significant variability exists in the provision of diabetic foot care services across the West Midlands with poor compliance with NICE guidance. There is substantial scope for improvement and standardisation.

POSTER LIST

Analysis of how complaints are handled

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Are we over treating axillae following positive axillary lymph node biopsy

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Blood Transfusion in Oesophagectomy

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Does routine duplex surveillance for restenosis post carotid endarterectomy have any benefit

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Operative waiting times for lower limb amputations and foot debridements a single centre audit

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The effect of expectation on satisfaction in total knee replacements a systematic review

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West Midlands Higher Surgical Trainees Operative Logbook Audit 2013- 2014

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