West Midlands Surgical Society

Autumn Meeting

Education Centre, Solihull Hospital

Friday 10th November 2017

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WEST MIDLANDS SURGICAL SOCIETY AUTUMN MEETING

FRIDAY 10TH NOVEMBER 2017 AT SOLIHULL HOSPITAL

Programme

09.00 **REGISTRATION AND COFFEE**

09.30 **WELCOME**
Christine Hall – President WMSS

Scientific Short Papers

09.35 ***A review of postoperative complications for Crohn's and cancer patients undergoing right-sided bowel resections***
Priyesh Chauhan, Dmitri Nepogodiev, Thomas Pinkney
University Hospitals Birmingham

09.44 ***A study comparing discharge letters completed by junior doctors and nurse practitioners to letters completed by consultants***
A R Banks, R Hope, T F Bullen
University Hospital of North Midlands

09.53 ***Angioplasty of infrainguinal vein graft stenosis: long term outcome***
Sejung Park, Lisa Shelswell, Saima Ehsan, Robert Davies
University Hospital Leicester

10.02 ***Body mass index and complications following major gastrointestinal surgery: A prospective, international cohort study***
D Nepogodiev
EuroSurg Collaborative

10.11 ***Clinical outcomes with biological compared to synthetic mesh for laparoscopic ventral mesh rectopexy.***
Abhilasha Patel, Anne Gaunt, Deanna Latham, Robert Padwick, Martin Farmer, Veerabhadram Garimella
University Hospitals of North Midlands NHS Trust

10.20 ***Right Iliac Fossa Treatment (RIFT) study: UK results***
RIFT Collaborators on behalf of the West Midlands Research Collaborative
Dmitri Nepogodiev, West Midlands Research Collaborative,

10.29 ***Cardiopulmonary Exercise Test (CPET) performance in patients with Screen Detected and Non-Screen Detected AAA's***

Faith Protts, Anna Murray, Adrian Jennings, Jeremy Newman, Michael Wall
Dudley Group of Hospitals

10.38 ***Incidence of anastomotic stricture after Ivor-Lewis oesophagectomy using a circular stapling device***

R Tyler, A Nair, M Lau, J Hodson, R Mahmood, J Dmitrewski
Queen Elizabeth Hospital, Birmingham

10.47 ***Evaluation of symptomatic recurrence after laparoscopic ventral mesh rectopexy using the defecating proctogram***

Abhilasha Patel, Anne Gaunt, Deanna Latham, Robert Padwick, Martin Farmer, Veerabhadram Garimella
University Hospitals of North Midlands NHS Trust

10.56 ***Deteriorating eGFR in patients being surveyed for AAA***

Mohamed Amirali Gulamhussein, Mr Michael Wall, Andrew Garnham
Russells Hall Hospital, Dudley Group NHS Trust

11.05 **MORNING COFFEE**

Plus visit to trade stands

11.30 ***Lessons Learnt from the First 5-years Experience from a Cytoreductive Surgery and Heated Intraperitoneal Chemotherapy unit for Colorectal Peritoneal Metastases***

Authors: S Hallam[1], S Fallis, R Tirumularaju, H Youssef
Good Hope Hospital

11.39 ***Nutritional Assessment and Management in Patients who undergo Emergency Laparotomy***

A. Gaunt. A. Patel, T. Bullen
University Hospital North Midlands, Stoke on Trent

11.48 ***The development and validation of a scoring tool to predict the operative duration of elective laparoscopic cholecystectomy***

Reshma Bharamgoudar[1] BSc, Aniket Sonsale[1] BSc, James Hodson[2] BSc, Ewen Griffiths MD[3,4],
on behalf of the CholeS study group, West Midlands Research Collaborative
College of Medical & Dental Sciences, University of Birmingham, Birmingham, UK
Institute of Translational Medicine, Institute of Cancer and Genomic Sciences, College of Medical and Dental Sciences, Department of Upper Gastrointestinal Surgery, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK

11.57 ***Is direct referral for flexible sigmoidoscopy appropriate for excluding colorectal cancer?***

Peleki A[1], Nahari Y[1], Jamjoom H[1], Vazirian-Zadeh M[1], Kawesha A[1], Fisher N[2]
Department of General and Colorectal Surgery, Russells Hall Hospital, Dudley, West Midlands, UK,Department of Gastroenterology, Russells Hall Hospital, Dudley, West Midlands, UK

12.06 ***The Surgical Training Week: Encouraging Surgeons of the Future***

Georgia Layton[1], Siobhan McKay[1], James Archer[1], Sarah Addison[1]
General Surgery Department, Walsall Healthcare NHS Trust

12.15 ***Surgical site infection after gastrointestinal surgery in high, middle, and low income countries: prospective, international cohort study***

S Kamarajah
GlobalSurg Collaborative

12.24 ***Routine blood group and antibody screening prior to emergency laparoscopy: is it a worthwhile use of resources?***

M. Vazirian-Zadeh[1] J. Barrett-Lee[1], J. Vatish[1], , P. Waterland[1]
The Dudley Group NHS Foundation Trust, Russell's Hall Hospital

12.33 ***Effect of Formalin Fixation on Volume of Breast Conserving Surgery Specimens***

Ahmed Salman Bodla[1]; Soni Soumian[1]
[1]University Hospitals of North Midlands

12.42 ***Severity Scoring should not be used in isolation in assessing patients to surgery with ruptured abdominal aortic aneurysms***

Siobhan McKay, Sarah Lort, Awais Habeebullah, Pooja Prasad, Rajiv Pathak.
Department of Vascular Surgery, Dudley Group NHS Foundation Trust

12.51 ***UK and Thai cholangiocarcinoma are genetically different diseases: a call for increased UK based research***

McKay SC [1,2,4], Unger K [1], Sriraksa R [5,3], Zeller C [3], Pericleous S [1,2,4], Limpaiboon T [5], Hutchins RR [4], Spalding DR [2], Brown B [3], Thomas G [1]
1. Human Cancer Studies Group, Imperial College London, UK.
2. HPB Surgery, Imperial College London, UK.
3. Translational Oncology, Imperial College London, UK.
4. Digestive Diseases Clinical Academic Unit, Barts and The London, UK.
5. Centre for Research and Development of Medical Diagnostic Laboratories, Khon Kaen University, Thailand.

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

13.45 **INAUGURATION OF NEW PRESIDENT**
PRESIDENT ELECT – MR MARK GANNON

13.50 **AGM**

14.00 SYMPOSIUM:

Conflict Surgery
MR DAVID NOTT, OBE
THE DAVID NOTT FOUNDATION

15.00 **Presidential Ambitions for the Next 3 Years**
PROFESSOR DEREK ALDERSON
PRESIDENT OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

16.00 **TRAINING UPDATE**
MR MIKE HALLISSEY

16.15 **WEST MIDLANDS RESEARCH COLLABORATIVE**
MR RICHARD WILKIN

16.30 **TEA AND AWARD OF PRIZES**
(please note prizes will not be given in absentia)

A review of postoperative complications for Crohn's and cancer patients undergoing right-sided bowel resections

Authors: Priyesh Chauhan, Dmitri Nepogodiev, Thomas Pinkney
University Hospitals Birmingham

Aim: To review the postoperative course of Crohn's and colonic cancer patients undergoing right hemicolectomies/ileocolic resections at a tertiary centre.

Methods: All Crohn's patients (n=106) who underwent right-sided resections between 01/2012- 10/2016 were compared to a cohort of consecutive colon cancer (n=106) patients undergoing right hemicolectomies; the sample size of the two groups was matched. Both open/laparoscopic procedures and emergency/elective procedures were included. The primary outcome was 30-day Clavien-Dindo major complications (grade III-V). Secondary endpoint data on anastomotic leaks, intra-abdominal collections and pneumonias was collected.

Results: Average age in the Crohn's group was 38.3 years (cancer group: 69.3 years). 10.4% of Crohn's patients versus 19.8% of cancer patients were ASA grades III-V. The major postoperative complication rate in the Crohn's group was 7.5% (cancer group: 8.5%; p=0.80). The incidence of anastomotic leakage was 8.1% in the Crohn's group (cancer group: 7.1%; p=0.80). 15.1% of Crohn's patients versus 12.3% of cancer patients were diagnosed with intra-abdominal/pelvic collections (p=0.55). Cancer patients were at significantly greater risk of pneumonia than Crohn's patients (13.2% versus 2.8%, p=0.005).

Conclusions: Despite Crohn's patients undergoing right-sided resections being younger and having fewer co-morbidities than colon cancer patients undergoing similar procedures, both groups had comparable postoperative complication profiles.

A study comparing discharge letters completed by junior doctors and nurse practitioners to letters completed by consultants

Banks, A.R[1]., Hope, R[2], Bullen T.F[3]

Introduction

Discharge summaries serve to communicate with primary care and provide remuneration. This study looks at their quality and accuracy.

[1] Department of Colorectal Surgery UHNM

[2] Department of Clinical Coding, UHNM

[3] Department of Colorectal Surgery UHNM

Methods

Over 46 days (20.11.16 to 5.1.17) 43 summaries (9 elective: 34 emergency) were completed both by the consultant and team - 25 by Foundation Year 1 (F1), 11 by Senior House Officers (SHO), 5 by Nurse Practitioners (NP), 1 by both Registrar & another Consultant (as sample size small, excluded from analysis). Summaries were reviewed by a GP for 5 criteria using a 5-point scale, & remuneration for each summary was calculated using HRG4.

Results

Discharge diagnosis differed with the consultant diagnosis in: NP 40%, F1 38%, SHO 19%.

GP mean ratings:	NP (5)	F1 (25)	SHO (11)	Cons (43)
Conciseness	3.6	4.68	5	4.98
Clarity of follow up	2.8	4	3.64	3.88
Completeness	4	3.48	3.64	4.3
Information relayed to patient	1.2	1.74	1.91	4.37
Comprehension	3.4	4.32	4.36	4.6

There was no significant difference in remuneration rates between discharges, when using HRG 4.

Discussion

Overall consultants appear to produce the best summaries but are unlikely to have the time necessary to produce them. The best performing junior is the SHO, but there are clear areas for improvement.

Angioplasty of infrainguinal vein graft stenosis: long term outcome

Sejung Park (FY2, University Hospital Leicester),

Lisa Shelswell (medical student, Leicester University)

Saima Ehsan (specialist registrar, University Hospital Leicester)

Robert Davies (Consultant vascular surgery, University Hospital Leicester)

Aim:

To evaluate the long term outcome of infrainguinal vein graft stenosis management and to examine the efficacy of graft surveillance programme.

Methods:

A retrospective study of 55 cases from 2013 to 2016, with a follow up period of at least 6 months. Data regarding graft patency and subsequent interventions were collected using arterial scan surveillance; discharge summaries; and the radiological PACS system. The collated data was processed and analysed using Excel.

Results:

55 patient cases included 16 female (mean age 75) and 39 male (mean age 73) patients. 8 patients passed away before the first surveillance. 43 patients remained alive at the end of the audit period.

19 patients underwent no revision, 9 needed one further intervention, 6 required multiple interventions and 11 required amputation.

Conclusion:

This study showed that graft surveillance is an effective long term method of monitoring the patency of infrainguinal grafts.

19/55 grafts remained patent with no intervention whilst 20 required further intervention. 17 initially underwent angioplasty, 8 of whom required further interventions. Of three patients who underwent bypass revision, one remained patent, one required further multiple angioplasties and one patient proceeded to have an amputation.

Body mass index and complications following major gastrointestinal surgery: A prospective, international cohort study

EuroSurg Collaborative

Corresponding author: Dmitri Nepogodiev, EuroSurg Collaborative,

Aim: Previous studies have reported conflicting findings regarding the effects of obesity on postoperative outcomes. DISCOVER is a recent prospective, multicentre study that reported obesity is associated with an increased risk of major complications in patients undergoing gastrointestinal surgery for cancer, but nor for benign indications. The aim of this study was to validate these findings in an international cohort of patients.

Methods: This prospective multicentre study included adults undergoing both elective and emergency gastrointestinal resection, reversal of stoma, or formation of stoma. The primary endpoint was 30-day major complications (Clavien-Dindo grades III-V).

Results: This study included 2519 patients across 127 centres in the Czech Republic, Republic of Ireland, Italy, the Netherlands, Spain, Turkey, and the United Kingdom. Of 2519, 560 (22.2%) patients were obese. Although unadjusted major complication rates were lower in obese versus normal weight patients (13.0% versus 16.2%, respectively), there were no significant differences in either patients undergoing surgery for malignant or benign conditions in multivariate analysis.

Conclusions: This international multicentre study has failed to identify obesity as a risk factor for major complications following gastrointestinal surgery.

Clinical outcomes with biological compared to synthetic mesh for laparoscopic ventral mesh rectopexy.

Authors:Abhilasha Patel, Anne Gaunt, Deanna Latham, Robert Padwick, Martin Farmer, Veerabhadram Garimella

Institution: University Hospitals of North Midlands NHS Trust

Aim

Choice of mesh for laparoscopic ventral mesh rectopexy remains controversial. The aim of this study was to determine clinical outcomes with biological and synthetic mesh.

Method

Retrospective review of all patients undergoing LVR by a single surgeon at our institution between 2009 and 2014. Synthetic (polypropylene) mesh was utilised between 2009-2012 and biological mesh thereafter. Outcomes for the first 36 months after surgery are given.

Results

Overall, 187 patients were included (M:F 11:179, median age 58 yrs (44-69 yrs), of which, 17 (9 %) developed early symptomatic recurrence. There was no difference in the recurrence rate with indication for surgery (obstructed defecation - 10/81, rectal prolapse -4/33, $p>0.05$). Use of biological mesh was associated with a lower recurrence rate (3/66 versus 17/124, $p=0.038$), however, there was no difference in the number of patients achieving functional improvement in their symptoms (51/60 versus 94/118, $p=0.423$). There was a single patient with synthetic mesh who required surgical excision of the mesh as it had eroded through the vagina.

Conclusions

A significantly higher rate of symptomatic recurrence precludes the use of synthetic mesh in laparoscopic ventral mesh rectopexy.

Right Iliac Fossa Treatment (RIFT) study: UK results

RIFT Collaborators on behalf of the West Midlands Research Collaborative

Corresponding author: Dmitri Nepogodiev, West Midlands Research Collaborative,

Aim: In 2012 the National Appendicectomy Study identified that the 66.3% of appendicectomies were performed laparoscopically, with a 20.6% negative appendicectomy rate (NAR, removal of a histologically normal appendix). Updated international guidance reccomends that all appendicectomies should be performed laparoscopically unless contraindicated, and that the NAR should be under 20%. The aim of RIFT was to re-audit the findings of the 2012 study.

Methods: Prospective, multicentre trainee-led cohort study enrolling all patients that presented with right iliac fossa pain or suspected appendicitis.

Results: A total of 11,079 patients were enrolled across 283 surgical units in the UK, Republic of Ireland, Spain, Italy, and Portugal. In the UK and Ireland 41.8% (3853/9208, 184 units) of patients underwent surgery within 30 days of admission. Of these, 90.3% (3479/3853) underwent appendicectomy. Overall 88.8% of appendicectomies were performed laparoscopically. The commonest reason for planned open appenedicectomy was consultant preference, followed by anticipated severe disease. The NAR was 16.2%. This was higher in females than males in all age groups. In males NAR was greatest in those under 16 years (13.3%), whereas the rate was greatest in females aged 16-29 years (34.2%).

Conclusion: Although rates of laparoscopy have substantially improved, the NAR remains high.

Cardiopulmonary Exercise Test (CPET) performance in patients with Screen Detected and Non-Screen Detected AAAs

Faith Protts, Anna Murray, Adrian Jennings, Jeremy Newman, Michael Wall

Objectives:

We aimed to identify significant differences between the cardiopulmonary function of patients with screen detected and non-screen detected Abdominal Aortic Aneurysms (AAA).

Methods:

All patients with newly diagnosed AAAs, screen and non-screen detected, were identified prospectively over a 3 year period. Two-Tailed T-Tests were applied to assess for differences in Anaerobic Threshold (AT), peakVO2, percentage of predicted Forced Vital Capacity (FVC) and Forced Expiratory Volume (FEV1), age and BMI.

Results:

The screen detected group were significantly younger with mean ages of 66 (SD 1.04) and 76 (SD 8.03) years respectively (t-5.34, $p<0.001$). They also had a higher mean BMI (30kg/m² vs. 27kg/m², t2.62 , $p=0.009$), with 44% of screen detected patients being obese or morbidly obese, compared to 26% of non-screen detected patients. There was no significant difference between the groups in AT (mean 11.0 and 10.9ml/kg/min $p=0.341$), peakVO2 (15.54 and 15.7ml/kg/min $p=0.466$) or respiratory parameters (SpO2, FEV1, FVC $p>0.1$).

Conclusion:

Lack of significant differences in cardiopulmonary function between those patients with screen detected and non-screen detected AAA's may reflect worse physiology in the significantly younger screen detected population.

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Michael Wall	Consultant Vascular Surgeon

R Tyler, A Nair, M Lau, J Hodson, R Mahmood, J Dmitrewski

Queen Elizabeth Hospital, Birmingham

Title

Incidence of anastomotic stricture after Ivor-Lewis oesophagectomy using a circular stapling device

Background

Post-oesophagectomy anastomotic stricture rates of 41% have been reported in the literature. We aimed to determine a single surgeons stricture rate in a series of 2-stage Ivor-Lewis procedures, and to identify any independent risk factors in their development.

Methods

Our database comprised a single-surgeon series of open, two-stage Ivor-Lewis oesophagectomies with a circular stapled intra-thoracic anastomosis performed between 2004-2016. Tumour location, histology, neoadjuvant chemotherapy, stapler size, T-stage and R-status were analysed to see if they could predict stricture formation. Patients with anastomotic leaks were excluded on the basis they would develop an anastomotic stricture.

Results

144 patients were eligible for analysis. 15 were excluded on the basis of anastomotic leak, perioperative death and early recurrence. Median follow up time was 6.85 years. 16 patients (11%) developed strictures. The median time to stricture was 103 days. None of the factors considered were found to be significantly associated with strictures.

Conclusions

The stricture rate was 11% comparing well with previously reported literature. Our analysis provides a unique series of circular stapled anastomosis from a single surgeon. No significant independent factors were found in the development of strictures.

Evaluation of symptomatic recurrence after laparoscopic ventral mesh rectopexy using the defecating proctogram.

Authors:

Abhilasha Patel, Anne Gaunt, Deanna Latham, Robert Padwick, Martin Farmer, Veerabhadram Garimella

Institution: University Hospitals of North Midlands NHS Trust

Aim

Laparoscopic ventral mesh rectopexy (LVR) is performed to restore pelvic floor anatomy, however, symptomatic recurrence is multifactorial. This study aimed to determine the utility of a repeat defecating proctogram (DP) in assessment of these patients.

Method

Retrospective review of all patients undergoing LVR by a single surgeon at our institution between 2009 and 2014.

Results

Overall, 196 patients were included (M:F 13:183, median age 58 yrs (44-69 yrs), of which, 26 (13 %) developed symptomatic recurrence. A repeat DP was performed in 20 (74%) patients; 17 had a persistent rectocele with internal rectal prolapse and 2 had an enterocele. The repeat DP showed an improved anatomical configuration compared with pre-operative DP enabling conservative management in 9 patients. Mesh migration with displaced protacs was found in 3 patients, one of which underwent re-do LVR. In the 8 patients who showed no improvement in their DP appearances, 4 underwent a different surgical procedure.

Conclusion

A repeat DP helps to determine the underlying cause of symptomatic recurrence. If findings suggest an improvement or confirm adequate mesh position, DP can be utilised as an adjunct to reassure the patient and clinician that no further surgical intervention is required.

Deteriorating eGFR in patients being surveyed for AAA

Objective

Patients' diagnosed with AAA but not yet requiring treatment will be placed into surveillance. The aim of our study was to identify the decline in their eGFR during this surveillance period as it is known that deteriorating eGFR increases operative risk when AAA reach threshold for repair.

Methods

All patients undergoing AAA surveillance within our trust based surveillance programme had a retrospective review of their eGFR results from (2007-2016). This commenced at the point of entry to surveillance up until their last result recorded in the notes.

Results

276 patients were included with a mean age at diagnosis 73 years (+/- 8) and mean eGFR change 3.4 (+/-12.7). Age at diagnosis and eGFR deterioration significantly correlated, ($p < 0.05$). Moreover eGFR decline was found to be significantly different for those with and without hypertension (48.2 % hypertensives) as well as age at diagnosis (p 0.03 and 0.04).

Conclusions

There was an overall decline in eGFR within our population with positive correlation to their age at diagnosis and hypertension. As the population ages and comorbidities increase, the prediction of the need for intervention will be vital for resource management.

Author information:

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3. **Andrew Garnham**- Consultant Vascular Surgeon, Russells Hall Hospital, Dudley Group NHS Trust.

Lessons Learnt from the First 5-years Experience from a Cytoreductive Surgery and Heated Intraperitoneal Chemotherapy unit for Colorectal Peritoneal Metastases

Authors: S Hallam[1], S Fallis, R Tirumularaju, H Youssef

Institution: Good Hope Hospital

Background:
Cytoreductive surgery and heated intraperitoneal chemotherapy (CRS+HIPEC) is recommended for patients with limited colorectal peritoneal metastases (CPM). We report the first 5 years' experience of a CRS+HIPEC unit, lessons learnt on patient selection, as well as short and long-term outcomes.

Methods:
An analysis of a prospective database was performed. Patients with CPM undergoing CRS+HIPEC were eligible for inclusion. Data was collected on patient demographics, peritoneal disease severity, completeness of cytoreduction, post-operative outcomes and survival. Potential prognostic factors of overall survival were analysed.

Results:
138 consecutive patients were treated with CRS+HIPEC from 2011-2017. PM of non-colorectal origin were excluded (n45), leaving 93 patients for analysis. Complete cytoreduction (CC0/1) was achieved in 93% of patients with a median peritoneal carcinomatosis index (PCI) of 8 (0-39). Median OS 29 months (16-42 95%CI). OS was significantly better for patients with a CC0/1 resection, 38 months (21-29 95%CI) vs. CC2, 16 months (6-26 95%CI) (p0.0001), PCI score <12 (p0.0001) and colonic primary (p0.03). OS for optimally selected patients was 44 months (36-51 95%CI), with Kaplan Meier predicted 5-year survival of 55%.

Conclusions:
CRS+HIPEC in optimally selected patients can result in significant improvements in OS for CPM, resulting in median survival of nearly 4 years.

Nutritional Assessment and Management in Patients who undergo Emergency Laparotomy

A. Gaunt. A. Patel, T. Bullen

University Hospital North Midlands, Stoke on Trent

Background

Nutritional assessment is important when managing patients who undergo an Emergency Laparotomy. We aimed to determine whether nutritional assessment was performed and nutritional team advice sought.

Methods

50 consecutive patients who underwent an emergency laparotomy in a single unit were identified from theatre operating systems. 1 case excluded not a laparotomy.

Results

Of 49 emergency laparotomies (12/06/2017-21/07/2017), mean age 62.25 years, 24M:25F, pre-operative nutritional assessment (MUST score) documented in 68%. Patients last ate normally a median of 3 days (range 1 – 30 days) before admission. Indications for laparotomy - obstruction (n=21), perforation (n=14), post-operative complications (n=4), trauma (n=3), bowel ischaemia (n=2), other (n=5). Post-operative destinations included critical care 22%, HDU 33% or surgical ward 45%. Half of patients re-commenced oral diet 4 days (median) post-operatively. 16% patients were referred for nutritional assessment and 14% (7/49) received parenteral nutrition (PN). Median time to PN 3 days (1-9) post-operatively.

Conclusions

Pre-operative nutritional assessment was not performed in 1/3rd patients. Post-operative nutritional assessments by surgical team did not account for reduced diet prior to admission particularly in those with bowel obstruction. Nutritional assessment should be performed in all surgical patients and potential for PN considered in all patients having an emergency laparotomy.

The development and validation of a scoring tool to predict the operative duration of elective laparoscopic cholecystectomy

Reshma Bharamgoudar[1] BSc, Aniket Sonsale[1] BSc, James Hodson[2] BSc, Ewen Griffiths MD[3,4] , on behalf of the CholeS study group, West Midlands Research Collaborative.

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Background

With laparoscopic cholecystectomy being one of the most commonly performed procedures worldwide, the ability to accurately predict operative duration can optimise theatre efficiency, reducing cost whilst increasing staff and patient satisfaction.

Methods

CholeS study data on patients undergoing cholecystectomy in UK and Irish hospitals between 04/2014 and 05/2014 were used to study operative duration. A multivariable binary logistic regression model identified significant independent predictors of long (>90minute) operations. The resulting model was converted to a risk score, which was validated on second cohort of patients using ROC curves.

Results

After exclusions, CholeS data were available for 7,227 patients. The median operative duration was 60minutes (IQR: 45-85), with 17.7% of operations lasting >90minutes. Ten factors were found to be significant independent predictors of operative durations >90minutes. A risk score was then produced from these factors, and applied to a external validation cohort of 2,405 patients from a tertiary NHS centre. This returned an area under the ROC curve of 0.708 (SE=0.013, $p<0.001$), with the proportions of operations lasting >90minutes increasing more than 8-fold in the extremes of the score.

Conclusion

The scoring tool produced in this study was significantly predictive of long operative durations on validation in an external cohort.

Is direct referral for flexible sigmoidoscopy appropriate for excluding colorectal cancer?

Peleki A[1], Nahari Y[1], Jamjoom H[1], Vazirian-Zadeh M[1], Kawesha A[1], Fisher N[2]

1. *Department of General and Colorectal Surgery, Russells Hall Hospital, Dudley, West Midlands, UK*
2. *Department of Gastroenterology, Russells Hall Hospital, Dudley, West Midlands, UK*

Introduction: Russells Hall Hospital Rapid Access clinic (RA) offers a unique diagnostic service where patients with suspected colorectal cancer (CRC) are directly referred for flexible sigmoidoscopy (FS). The aim of this observational study was to evaluate our service and monitor patient outcomes over a 4-year period.

Methods: A retrospective analysis of electronic records was carried out during a 12-month period (January-December 2013). Demographics, clinical indications, FS diagnosis, further investigations and final diagnosis were analysed. Subgroup analysis was carried out according to clinical presentation and all patients were cross-referenced with the Somerset CRC database.

Results: 1021 patients were identified as eligible. Mean age was 72.5 years, 1.1 F:M ratio. Main referral criteria were altered bowel habit(61.9%), rectal bleeding(36.4%), anaemia(2.9%), weight loss(2.6%). Diagnosis at examination was: normal(24.8%), diverticulosis(32.9%), polyps(17.5%), haemorrhoids(26.8%), malignancy(5.2%). 30% were subsequently referred for barium enema, colonoscopy(21%), abdominal CT(35%) or CTVC(0.5%). A further 1.5%(16 cases) were diagnosed with CRC after full colonic assessment. Discharge rate was 12.9% at initial endoscopy and 76.2% following further investigations. 4 cases of CRC were diagnosed within 3 years of RA assessment.

Conclusion: The RA pathway offers a quick and reliable service for the exclusion of suspected CRC with excellent diagnostic accuracy.

'The Surgical Training Week: Encouraging Surgeons of the Future'

Georgia Layton[1], Siobhan McKay[1], James Archer[1], Sarah Addison[1]

1: General Surgery Department, Walsall Healthcare NHS Trust

Introduction:

The GMC *National Training Survey 2014* reported that surgical trainees are the least satisfied trainees in the NHS today, especially at foundation level. In an effort to positively impact surgical training, our department developed a novel approach to providing non-ward based training and allowing junior doctors to explore future career choices.

Method:

The Surgical Training Week was piloted as five days free from clinical responsibility for all General Surgical FY1s to spend within outpatient and theatre environments. Prior to the week FY1s were provided with a rota, which aimed to highlight learning opportunities within the surgical department.

Results:

Seven doctors, of 18 who piloted the Surgical Training Week, completed the online feedback. Feedback from the survey population was overwhelmingly positive. All respondents said they found their training week helpful. 85.7% reported scrubbing into theatre as the best aspect of this experience. 71.4% also commented that having the opportunity to personalize a rota, being 'bleep free' and having free time for self-directed projects, such as Audit, as other positive outcomes from the week.

Conclusion:

Our feedback is in line with the key options for improving surgical training as published by the Royal College of Surgeons. Trainees cited reduced clinical responsibility and having motivated seniors who are keen to teach, as key ways in which they feel their experience was positively impacted.

Surgical site infection after gastrointestinal surgery in high, middle, and low income countries: prospective, international cohort study

GlobalSurg Collaborative

Background:

Surgical site infection (SSI) is a leading cause of nosocomial infection worldwide. The study aimed to determine the incidence of SSI after gastrointestinal surgery in global health settings.

Methods:

Multicentre, prospective cohort study including consecutive patients undergoing elective or emergency gastrointestinal resection (including cholecystectomy or appendicectomy) from two-week periods during a six-month study window in 2016. Patients were stratified into high, middle, and low-income groups according to the United Nation's Human Development Index (HDI). The primary outcome measure was the 30-day SSI rate (defined by Centre for Disease Control criteria), adjusted within multilevel logistic regression models.

Findings:

12,539 patients from 343 hospitals in 66 countries were included, with 58·5% from high, 31·2% from middle, and 10·2% from low HDI countries. The overall SSI rate was 12·3%, which more than doubled across high, middle, and low HDI countries (9·4%, 14·0%, 23·2% respectively, p<0·001). Following risk adjustment, patients in low-income countries remained at greater risk of SSI (adjusted OR 1·60, 95% confidence interval 1·05-2·37, p=0·030).

Interpretation:

Patients in low and middle-income countries carry a disproportionately high burden of SSI and associated antimicrobial resistance.

Routine blood group and antibody screening prior to emergency laparoscopy: is it a worthwhile use of resources?

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Introduction

Studies show that rates of blood transfusion associated with laparoscopic surgery are low. Currently there are no national guidelines regarding blood group and antibody screening (G&S) for patients undergoing emergency laparoscopy. This study aimed to assess whether routinely using G&S before emergency laparoscopic general surgery is worthwhile by identifying rates of peri-operative transfusion.

Methods

Retrospective data was collected from 1st January 2014 to 31st December 2016 for patients requiring emergency laparoscopic surgery. Records were reviewed to ascertain whether G&S was performed, if antibodies were detected, and if patients were transfused.

Results

562 emergency laparoscopic cases were performed. Mean age was 33 years (range 6 - 95). Laparoscopic appendicectomy (446), diagnostic laparoscopy (47) and laparoscopic cholecystectomy (25) were most common. Four patients had antibodies detected (0.71%). One patient received a transfusion (0.18%). This was for repair of a perforated duodenal ulcer and the patient was transfused for chronic anaemia.

Conclusion

These results demonstrate a low rate of blood transfusion in emergency, laparoscopic surgery. Most these patients had a low risk of intra-operative haemorrhage and we argue that routine G&S is not warranted. We propose a more targeted approach to the requirement for pre-operative G&S.

Effect of Formalin Fixation on Volume of Breast Conserving Surgery Specimens

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Aim:

This single-centre prospective study sought to evaluate the effect of formalin fixation on volume of breast-conserving surgery specimens, and its impact on margin clearance.

Methods:

Between January-August 2017, volumes of 95 WLE specimens were calculated based on length, width and height both intraoperatively (pre-fixation) and in pathology laboratory (post-fixation). Laboratory data about minimum clearance margins, maximum tumour dimension and histological type were also collected.

Results:

94% of specimens underwent significant but bidirectional volume change post-fixation with percent volume change (%VC) ranging from -58% to +133%. Interestingly, 52% of specimens expanded with a median %VC of +35%. Specimen behaviour post-fixation mainly depended upon the initial specimen size; expanding specimens were considerably smaller with a median surgical volume of 63cm^3 as compared to 137cm^3 for shrinking specimens ($p<0.0001$; Mann-Whitney U Test). Significant negative correlation also existed between the two parameters ($r = -0.40$, $p<0.0001$). Neither cancer size nor histological type had any effect on %VC. Eighteen percent (17/95) specimens had involved/inadequate margins; however, specimen shrinking did not significantly affect this (risk ratio 1.55, $p=0.32$).

Conclusions:

Heterogeneous and bidirectional breast tissue volume change post-fixation is partly governed by initial specimen size. However, this does not affect resection margins significantly.

Severity Scoring should not be used in isolation in assessing patients to surgery with ruptured abdominal aortic aneurysms

Authors: Siobhan McKay, Sarah Lort, Awais Habeebullah, Pooja Prasad, Rajiv Pathak.
Institution: Department of Vascular Surgery, Dudley Group NHS Foundation Trust

Aim The Hardman Index and Glasgow Aneurysm Score (GAS) have been proposed for predicting mortality in patients with ruptured abdominal aortic aneurysms (AAA). Our retrospective study aims to assess its utility in our patient population.

Method Retrospective study from 2012-2014. All patients with ruptured AAA presenting to our centre were included. Scores were calculated from OASIS, NVD and the notes (GAS: age, shock, myocardial disease, cerebrovascular disease, renal disease; Hardman Index: age, creatinine, haemoglobin, loss of consciousness).

Results 50 patients were included. Eight patients underwent conservative management, and 42 underwent intervention (surgery or endovascular repair). Overall mortality for patients undergoing intervention was 48.8%.

Glasgow Aneurysm Score	Study Mortality
<85	33% (3/9)
>85 (100%)	70% (26/37)

Hardman Index	Study Mortality	Hardman Index Mortality
0	33% (3/9)	0%
1	57% (13/23)	27%
2	67% (6/9)	36%
3	80% (4/5)	78%

Conclusion

A GAS of greater than 85 is suggested as a cut-off for interventional management predicting 100% mortality, however our study reveals a 30% survival in this group. The Hardman Index underestimated mortality with scores 0-2 in our population. We propose that clinical assessment has greater utility, and these scores should not be used to decline patient's operative management.

UK and Thai cholangiocarcinoma are genetically different diseases: a call for increased UK based research

Authors: McKay SC [1,2,4], Unger K [1], Sriraksa R [5,3], Zeller C [3], Pericleous S [1,2,4], Limpaiboon T [5], Hutchins RR [4], Spalding DR [2], Brown B [3], Thomas G [1]

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5. Centre for Research and Development of Medical Diagnostic Laboratories, Khon Kaen University, Thailand.

Introduction: The prognosis for choangiocarcinoma (CCA) is dismal, necessitating translational research to improve treatment. The worldwide incidence of CCA is highest in Thailand, and thus attracts the majority of translational research. Are UK and Thai CCA genetically similar and therefore findings are transferable?

Methods: DNA was extracted from 70 UK and 24 Thai CCA. Tumour DNA was labelled with Cy3, and sex-mismatched reference DNA with Cy5 fluorescence dye; then hybridised to array CGH slides (1Mb BAC array CGH (UK cases), 180K Oligonucleotide array CGH (Thai cases)). Fluorescence intensities were extracted using Feature Extraction Software and analysed using CBS algorithm for segmentation of profiles and CGHcall package for calling copy number gains and losses.

Results: There were significant differences between the UK and Thai profiles. UK cases exhibited a higher proportion of DNA alterations. In UK cases copy number gain of 8q24.21-24.3 was associated with a poorer prognosis (median survival 14.4 vs 28.3 months, p-value 0.016.). Five Thai cases demonstrated copy number gain at 7p11.2, which was survival-protective (median survival 29 vs 3 months, p-value 0.0018).

Conclusion: Thai CC has a clear aetioligcal factor, however UK CC develops through multiple 'hits' creating a more complex molecular profile. Therefore increased research is required for UK CCA to improve treatment and prognosis.

POSTER LIST

A Review of the Postoperative Course for Patients Undergoing Subtotal Colectomy for Ulcerative Colitis and Left-Sided Resections for Colonic Cancer
Priyesh Chauhan, Dmitri Nepogodiev, Thomas Pinkney
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An audit comparing size of polyps identified on Computer Tomography Colonoscopy with histology
[1]Baker J, [2]Biju T, [3]Bullen T
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Early experience of setting up a Trans-anal Endoscopic Microsurgery (TEMS) service in a tertiary hospital with co-existent advanced polypectomy pathway
MS Cheruvu, A. Patel, A. Gaunt, P. Varghese, A. Tsiamis, V. Garimella
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Exploring Feedback and WBA in surgical communities using Activity Theory
A. Gaunt (1), D.H. Markham (2), TRB Pawlikowska (3)
(1) University Hospital North Midlands, Stoke on Trent, (2) Warwick Hospital, Warwick
(3) Health Professions Education Centre, RCSI, Dublin

Getting it Right first time for AAA Surgery
Sanjay Singh, Mark Gannon
Complex Aortic Unit Heart of England NHS Foundation Trust Birmingham

How does chronic otitis media affect temporal bone anatomy? A comparative radiological study.
Dr. A.Conybeare, Mr V Visvanathan FRCS (ORL-HNS), UHNS

Is there a role of Nellix EVAS in Complex Aortic Unit?
Sanjay Singh, Donald Adam, Martin Claridge
Complex Aortic Unit, Heart of England NHS Foundation Trust

Reasons for delay in transfer of patients with query ruptured abdominal aortic aneurysm to a specialist vascular hub; an audit of service and outcomes
1. Jonathan Johns[1,] 2. Caroline Spillane[1,] 3. Ruth A Benson[2,] 4. Chris E Imray[2,] 5. Dan Higman[2]
[1,] University of Warwick, [2,] University Hospital Coventry and Warwickshire

Single Centre Audit of Laparoscopic Ventral Mesh Rectopexy (LVMR): Comparison with national standards.
Orfanos G, Coupe N, Lacy-Colson JCH, Farquharson AL
Pelvic Floor Service, Department of General Surgery
The Shrewsbury and Telford NHS Trust, Royal Shrewsbury Hospital

Are we meeting commissioning criteria and utilising day case theatres? UHNM practice of Varicose Veins

Dr Alexander Crichton (Foundation Year Two Doctor) & Mr Sriram Rajagopalan (Consultant Vascular Surgeon).
University Hospital of North Midlands

Why are vascular surgical patients who are medically fit for discharge, delayed and implications of delay in a large hub site vascular unit?

Kemi Fabusiwa, Keele medical school, Sis. P. Winnington, Ward sister, vascular unit, UHNM, Gill Onions, discharge facilitator, vascular unit, UHNM, Anita Singh, Rehab Consultant, UHNM, Arun Pherwani, clinical lead and vascular surgeon, UHNM, Sriram Rajagopalan, vascular surgeon, UHNM- corresponding author,
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