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CONFERENCE MANAGEMENT

Mrs Jennifer Treglohan, Executive Director
E: jtreglohan@alsgbi.org Tel: +44(0)20 7869 6941

Mrs Sarah Williams, Director of Fundraising
E: swilliams@alsgbi.org Tel: +44(0)20 7869 6940

Association of Laparoscopic Surgeons of Great Britain & Ireland @ The Royal College of Surgeons of England
Room 306, 3rd Floor, 35-43 Lincoln's Inn Fields, London WC2A 3PE

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XX-ALSGBIP-08-17

DVD01 (09:15-09:23: 06.12.18)

PILOT TRAINING INITIATIVE FOR TRANSANAL TME (TATME): OUR EXPERIENCE

Presenter: B Mahendran
Author(s): B Mahendran, A Sale, M Coleman, R Kochupapy
Institution: University Hospitals Plymouth NHS Trust, United Kingdom

Aims: TATME has been practiced worldwide since 2014. To gain experience in the UK, a national training program was established in 2017. 5 centres in UK were selected through a national selection process. Here we are to show our experience in this program with a video presentation of a TATME case.

Methods: Two surgeons were involved in this training program. With completion of the dry and wet lab training 5 proctored operations were performed in our centre. 5 carefully selected low rectal cancer patients were involved in this training program. The full unedited video was sent to the committee for assessment.

Results: With the support of industry and ACPGBI, national proctors came to our centre to train us in TATME. After obtaining informed consent, these patients underwent TATME. All 5 patients did not have any immediate postoperative complications. The TATME steps were standardized with initial abdominal approach followed by transanal steps.

Conclusion: This is the first outcome-based training in the world and the progress by Cusum scores were impressive. The abdominal surgeon scored 6/6 in all cases and the transanal surgeon scored 3/6 in the first case to 5/6 in the fifth. Final score was 5.5/6 overall.

Key statement: Structured training programme is needed for a good outcome in lower rectal cancers. TATME is the answer for obese male patients with low rectal cancer.

DVD02 (09:23-09:31: 06.12.18)

LAPAROSCOPIC ADHESIOLYSIS AND COMBINED LAPAROSCOPIC/CYSTOSCOPIC APPROACH FOR REMOVAL OF BLADDER EROSION AND MESH

Presenter: E Tokidis
Author(s): L Onos, E Tokidis, M Hilmy, P Chitsabesan
Institution: York Teaching Hospitals NHS Trust, United Kingdom

Aims: To present a DVD case report of an advanced combined laparoscopic/cystoscopic case of salvage vaginal mesh at York Teaching Hospital, a national vaginal mesh salvage centre in the UK.

Methods: A 44-year old female with a background of autoimmune disease and chronic incontinence underwent multiple failed supportive and reconstructive urethral procedures throughout an 11-year period. She presented at York with recurrent urinary tract infections, urge incontinence, haematuria and bladder stones. She was diagnosed with bladder erosion due to mid-urethral sling.

Results: The patient was managed on an elective urological/general surgical list on March 2018. She underwent a combined laparoscopic/cystoscopic excision of bladder erosion and mesh after adhesiolysis, under a general anaesthetic. Her recovery was uneventful and her symptoms resolved completely.

Conclusion: Complications related to mid-urethral sling procedures carry significant morbidity and patients require multiple approaches and interventions to improve their symptoms. Such complications require specialised and flexible multi-disciplinary approaches within a Pelvic Floor service to resolve such complex problems.

Key statement: Advanced combined laparoscopic/cystoscopic skills can achieve in good outcomes in the management of bladder erosion due to mid-urethral slings.

DVD03 (09:31-09:39: 06.12.18)

MINIMISING THE IMPACT OF A FAILED BANDED BYPASS: REMOVAL OF AN ADJUSTABLE GASTRIC BAND AND PLACEMENT OF MINIMIZER RING

Presenter: S Korambayil
Author(s): S Korambayil, S Wardle, S Small, P Jethwa, S Monkhouse
Institution: East Surrey Hospital, Redhill, United Kingdom

Aims: To demonstrate a safe and effective technique to reverse severe adverse symptoms and aid continued weight loss from a failed banded gastric bypass, due to erroneous placement of a standard adjustable gastric band, by the replacing it with a MiniMizer ring.

Methods: We demonstrate a two-stage completely laparoscopic operation; the first to remove the erroneously used standard adjustable gastric band and the second to place a MiniMizer ring to provide adequate pouch restriction.

Results: This patient who previously experienced no weight loss with the adjustable gastric band with debilitating adverse side effects (persistent dysphagia, vomiting and gastro-oesophageal reflux successfully lost a significant proportion of excess body weight and has had complete resolution of the adverse symptoms after replacing it with a MiniMizer ring.

Conclusion: The standard adjustable gastric band does not provide enough restriction of the gastric pouch and is likely to cause adverse symptoms in patients who have undergone a gastric bypass. Removal and replacement of these with a specifically designed MiniMizer ring is a safe procedure that results in an excellent outcome.

Key statement: The Minimizer ring should be the gold standard for patients undergoing a banded gastric bypass. In the case of erroneous application of a standard gastric band and development of complications, this two-stage approach to correct it, is a technically safe and a surgically sound procedure with a far superior outcome.

DVD04 (09:39-09:47: 06.12.18)

ROBOTIC PERINEAL HERNIA REPAIR

Presenter: A Macleod
Author(s): A Macleod, S Dixon, W Sing Ngu, G Farook, S Holtham
Institution: Sunderland Royal Hospital, United Kingdom

Aims: Robotic Surgery is increasingly used in colorectal cancer. It is particularly beneficial when tackling low pelvic dissections in a difficult pelvis. We present a case of robotic repair of a post-operative perineal hernia, in which the benefits of robotic approach in benign pelvic surgery is seen.

Methods: A 70-year old female, who underwent a successful Laparoscopic Extra-Levator Abdomino-Perineal resection in 2016, for a T3N0M0 presented 6 months post operatively with a symptomatic perineal hernia. Herniation was confirmed on imaging and decision to proceed to robotic repair was made.

Results: Robotic repair of hernia using a double mesh technique was successfully carried out. Permacol mesh inserted at original operation was seen, floating free in the pelvis having become detached from its lateral attachments. New meshes were secured anteriorly using 2-0 vicryl suture; and tacked posteriorly to the sacral hollow.

Conclusion: The angulation of robotic instruments, as well as the stereotactic 3-D vision, eases the notoriously difficult securing of the anterior margin in the repair of perineal hernias. It allows for a safer operation; with reduced risk to inadvertent damage to surrounding structures.

Key statement: While the use of robotic surgery in colorectal cancer is widely appreciated; its benefits in benign pelvic surgery must be considered. In this robotic perineal hernia repair – a successful, confident and precise attachment of mesh to the pelvic walls was completed, with no evidence of recurrence at 6-month follow up.

DVD05 (09:47-09:55: 06.12.18)

LAPAROSCOPIC REPAIR OF A HIATUS HERNIA IN TOTAL SITUS INVERSUS

Presenter: C Gilbert
Author(s): C Gilbert[1], S Froghi[2], S Monkhouse[1], P Jethwa[1]
Institution: [1]Surrey and Sussex NHS Trust, Redhill, United Kingdom
[2]Royal Free Hospital, London, United Kingdom

Aims: A 40-year old patient with known total situs inversus and Kartageners's syndrome was referred by the local respiratory team with worsening lung function and symptoms of GORD. The aim of the surgery was to treat her hiatus hernia and, thus improve her lung function and GORD.

Methods: The surgery performed with full ITU back up. A conventional laparoscopic repair was performed, the large hiatal defect reinforced with a Gore Bio-A mesh and, a 360 degree wrap fashioned. Postoperative recovery was slow due to the need for intensive respiratory physiotherapy. The patient was discharged on day 6.

Results: The patient was reviewed clinically and radiologically at two months. She reported a significant increase in her exercise tolerance, has had no GI side effects, has successfully discontinued her PPI medication and weaned down her respiratory support. Her contrast swallow showed a normally positioned GOJ with no reflux.

Conclusion: Surgical repair of large symptomatic hiatus hernia are technically challenging operations with, a potential of significant morbidity and hernia recurrence. This case demonstrates a success repair with mesh augmentation in a patient with unconventional anatomy.

Key statement: Operative strategies in cases of situs inversus need to carefully planned to ensure optimal outcomes. This group of patients frequently have associated lung dysfunction and access to high dependency facilities are mandatory.

DVD06 (09:55-10:03: 06.12.18)

INTRALUMINAL BLEEDING WITH JEJUNO-JEJUNAL OBSTRUCTING CLOT FORMATION POST ROUX-EN-Y GASTRIC BYPASS (CASE REPORT)

Presenter: B Bereczky M.D., Ph.D.
Author(s): B Bereczky M.D., Ph.D., S Awad M.D., Ph.D., FRCS, C Neophytou M.D., MRCS, A Awan M.D., FRCS
Institution: Royal Derby Hospital, United Kingdom

Aims: Raise awareness of possible early, severe complications post laparoscopic Roux-en-Y gastric bypass (LRYGB), especially in high-risk patients. Low threshold for performing of urgent CT scan in case of deterioration of the patient and early differential-diagnosis is crucial.

Methods: 55-year old male patient (BMI: 37.7/weight:116kg; baseline BMI:42.2/weight:132.2kg) with high-risk comorbidities underwent successful LRYGB for morbid obesity. Initially he was stable, but 36 hours postoperatively he has deteriorated rapidly with acute abdomen, hematemesis, hiccups, fever of 38.5C. Hemoglobin dropped to 108g/L and lactate raised to 2.4mmol/L.

Results: Urgent CT confirmed intraluminal hematoma at the J-J anastomosis site, small bowel obstruction (SBO) and distended remnant stomach. During emergency laparoscopy a large blood clot was evacuated causing obstruction in the J-J anastomosis and small stapler line bleeding controlled. G-J anastomosis looked patent. The patient was discharged on 12thpostoperative day.

Conclusion: Postoperative bleeding from staple line potentially exacerbated by routine perioperative thromboprophylaxis use can cause life-threatening, early proximal SBO at the J-J anastomosis after LRYGB. Continuous monitoring of vitals, detection of clinical symptoms (hiccups, hematemesis, increasing abdominal pain) and early recognition of SBO post LRYGB is imperative to avoid serious sequelae.

Key statement: SBO following LRYGB can occur in up to 5% of patients and may be caused by adhesions, internal- or abdominal wall hernias, stricture at J-J anastomosis, intussusception and intraluminal bleed. Jejuno-jejunal obstruction due to intraluminal haematoma carries the risk for perforation unless urgent intervention is instituted.

FP01 (12:25-12:35: 06.12.18)

ANASTOMOTIC LEAK AFTER COLORECTAL SURGERY: AN INSIGHT OF RISK FACTORS

Presenter: H Younus
Author(s): H Younus, J Nunoo Mensah, L Barker, A Haji, A Haq
Institution: King's College Hospital, London, United Kingdom

Aims: The aim of this study was to evaluate different risk factors associated with the development of anastomotic leak after colorectal surgery.

Methods: A cohort of 1592 patients who had undergone colorectal surgery between 2009 and 2015 were studied their medical notes were reviewed for preoperative demographics, co morbidities, biochemical markers, type of surgery, degree of contamination and stage of cancer. We studied the relationship of these factors in the development of anastomotic leak (AL).

Results: Out of 1592 patients, 2%developed anastomotic leak. These patients had significantly higher BMI, higher percentage of major and complex major procedures($p<0.05$). There was no significant difference in terms of age, gender, Ppossum mortality risk, cardiac comorbidities, ASA-score, biochemical markers, type of surgery, peritoneal contamination, Dukes staging and operating surgeon.

Conclusion: High BMI and complex colorectal surgery may be associated with higher anastomotic leak based on our studied cohort. Such cases should be carefully monitored for early detection of this complication to improve patient outcome.

Key statement: Anastomotic leak is one of the most concerning complications following colorectal surgery due to high mortality rate of up to 39%. The understanding of risk factors may help us improve patient outcome. High BMI and complex colorectal surgery may be associated with higher anastomotic leak based on our studied cohort.

FP02 (12:35-12:45: 06.12.18)

IMPACT OF ROBOTIC PLATFORM ON RECOVERY AFTER RECTAL CANCER SURGERY

Presenter: T Petropoulou
Author(s): T Petropoulou, S Amin
Institution: Sheffield Teaching Hospitals, United Kingdom

Aims: The aim of this study is to investigate whether the robotic platform can have a positive impact on patient recovery and improve short and long term outcomes after elective rectal surgery.

Methods: A prospectively collected robotic database was reviewed and compared with the trust and the national data. This includes all rectal resections which were performed with the robotic platform, over a period of 4 years, versus the trust data. The data were analyzed for short and long-term outcomes.

Results: 270 patients were analyzed. Groups were matched for distance from the anal verge. Demographics for the two groups (sex, age, BMI) were similar. Median LoS, complication rate, APER rate, CRM (+) rate, for the robotic group was statistically significant lower in all subgroup analyses.

Conclusion: Robotic surgery for rectal cancer is safe and feasible, and can have a positive impact on recovery after rectal surgery.

The robotic platform could help surgeons perform ultra low rectal resections and save patients sphincters. CRM (+) rate is low, which could lead to improved oncological outcomes.

Key statement: This is one of the biggest databases for robotic rectal cancer resections in UK (awaits publication in peer reviewed journal). Our data for short term outcomes are favourable over previously published data. Specimen quality and long-term outcomes were better which could lead to improved oncological outcomes.

FP03 (12:45-12:55: 06.12.18)

LAPAROSCOPIC TOTAL ADVENTITIAL RESECTION OF THE CARDIA PROVIDES IMPROVED SURVIVAL FOR PATIENTS WITH CANCER AT THE OESOPHAGO-GASTRIC JUNCTION

Presenter: A Botha
Author(s): A Botha, W Knight, R Bott, N Maisey, H Deere
Institution: Guy's and St Thomas' Hospitals, London, United Kingdom

Aims: We have previously proposed total adventitial resection of the cardia (TARC) as an optimal local resection technique for oesophago-gastric junction (OGJ) cancers. We have also reported a learning curve for laparoscopic resection. The purpose of this study was to assess the long-term survival when converting from open to laparoscopic TARC.

Methods: Data was collected prospectively of consecutive oesophago-gastrectomies for OGJ cancer performed by a single surgeon from 2003-2013. Laparoscopic oesophagectomy was commenced in 2005. The learning curve progressed through 4 main steps of open surgery, laparoscopic lymphadenectomy, thoracoscopy and laparoscopic TARC. Data analysis by logistic regression and t-testing with GraphPad software.

Results: 204 resections were performed. Laparoscopy, thoracoscopy and laparoscopic TARC were introduced sequentially. The 5 year survival during the 4 steps of the learning curve were 41%, 39%, 41% and 55% respectively. The survival of the last 51 patients who had laparoscopic TARC were higher than the first 153 ($p=0.0739$).

Conclusion: Surgical resection of cancers of the OGJ is complex and requires a long learning curve. Optimal selection of patients for neo-adjuvant chemotherapy combined with optimal surgical techniques such as laparoscopic total adventitial resection of the cardia result in improved long-term survival for patients with OGJ cancer.

Key statement: The learning curve of a complex operation such as laparoscopic oesophagectomy can be broken into multiple steps and phases. Gaining proficiency in the whole operation improves short term outcomes and also has long-term survival benefit for the patients.

FP04 (12:55-13:05: 06.12.18)

LAPAROSCOPY IN EMERGENCY GENERAL SURGERY (LEGS): A NATIONAL MULTI-CENTRE REVIEW OF CURRENT CONSULTANT PRACTICE IN THE UK

Presenter: P Sodde
Author(s): P Sodde[1], K Parmar[1], N Heywood[1], M Stott[1], J Lim1, D Doherty[1], A Sharma[2]
Institution: [1]North West Deanery, United Kingdom
[2]Manchester University NHS Foundation Trust, United Kingdom

Aims: Despite consensus guidelines which suggest laparoscopic approaches to emergency general surgery (EGS) are safe; current National Emergency Laparotomy Audit (NELA) data suggests only 13-14% of cases are approached laparoscopically each year.

Methods: The LEGS Study Group utilised a trainee collaborative model to distribute and collate data from questionnaires sent to consultant surgeons performing EGS across UK centres. Current practice was assessed through a series of procedure based questions and case scenarios for various emergency surgical conditions using a 5-point Likert scale.

Results: 152 consultants from 22 centres returned questionnaires. Consultants were more likely to use an open approach for all conditions save appendicectomy and cholecystectomy. UGI surgeons were more likely to approach perforated duodenal ulcers laparoscopically than colorectal surgeons whom conversely were more likely to manage complications following anterior resection laparoscopically ($p<0.05$).

Conclusion: Overall, consultant surgeons are less likely to approach most emergency general surgery procedures laparoscopically with Upper GI and Colorectal surgeons more likely to perform laparoscopic EGS within their own subspecialties.

Key statement: The provision of laparoscopy in emergency general surgery is influenced by many surgeon factors including subspecialty interest, laparoscopic experience and the underlying surgical pathology to be treated.

FP05 (15:00-15:10: 06.12.18)

OUTCOMES OF LAPAROSCOPIC PANCREATICODUODENECTOMY (LPD) FROM A TERTIARY CENTRE

Presenter: S Patel
Author: S Patel, S Iype, S Van Laarhoven, SS Liau, S Harper, A Jah
Institution: Addenbrookes Hospital, Cambridge University Hospitals NHS Foundation Trust, United Kingdom

Aims: There is increasing evidence to suggest the benefits of laparoscopic pancreatic resections in length of stay and early recovery without compromising oncological clearance. Laparoscopic-Assisted Pancreaticoduodenectomy (LAPD) and Totally Laparoscopic Pancreaticoduodenectomy (TLPD) are complex techniques. We have evaluated experiences of benefits and outcomes of LPD from our tertiary centre.

Methods: The following data was obtained from electronic records of patients undergoing LPD from November 2012 to July 2018: demographics (M:F ratio 2.4:1, median age 68y, median BMI 22kg/m2), indications, procedure (totally laparoscopic-TLPD, laparoscopic-assisted-LAPD or converted to open-LCO), intra/post-operative events (e.g. delayed gastric emptying- DGE) and oncological outcomes.

Results: The 17 LPD comprised 1-TLPD, 8-LAPD and 8-LCO (4-advanced lesions,3-vascular,1-technical). 5/17 were R1 resections.Median operating time was 513min, tumour size was 25mm and LN retrieval was 20.Median hospital stay was 10days. Surgical complications included DGE-4, pancreatic leak-4, GJ stenosis-1 but no peri-operative mortality. Re-operation was required in 2/17.

Conclusion: The conversion to open in almost 50% of LPD was high compared to previous reports (0-40%) and was mainly due to advanced stage. LN retrieval rate was good according to NCCN-2017 recommendations. R1 resection rate of 29% was similar to the reported data for open resections.

Key statement: Our experience reveals LPD can be performed successfully and safely with reduced hospital stay. High LN retrieval rate in keeping with national recommendations could be achieved. High conversion rate may be reduced by further experience and improved case selection.

FP06 (15:10-15:20: 06.12.18)

WHAT ARE ACCEPTABLE OUTCOMES AFTER LAPAROSCOPIC FUNDOPLICATION? A COMPARISON OF PATIENTS, GPS AND SURGEONS

Presenter: A Currie
Author(s): A Currie[1,2], S Thompson[3], P Devitt[3], T Bright[1], D Watson[1]
Institution: [1]Flinders University Department of Surgery, Flinders Medical Centre, Adelaide, Australia
[2]Western Sussex Hospitals NHS Trust, Chichester, United Kingdom
[3]Discipline of Surgery, University of Adelaide, Royal Adelaide Hospital, Australia

Aims: Antireflux surgery using fundoplication aims to improve patients' quality of life. However, whether patients and clinicians agree on what is an acceptable outcome following fundoplication is unknown. This study used clinical scenarios to define acceptable outcomes according to patients', surgeons' and general practitioners' following laparoscopic fundoplication for gastro-oesophageal reflux.

Methods: Patients who had previously undergone laparoscopic fundoplication, general practitioners and oesophagogastric surgeons were all invited to rank 11 clinical scenarios of outcomes following laparoscopic fundoplication for acceptability. Clinicopathological and practice variables were collated for patients and clinicians, respectively. Descriptive and multivariate statistical analyses examined for associations with acceptability.

Results: 331 patients, 93 GPs and 60 surgeons completed the questionnaire. Bloating was less acceptable (p=0.014) and dysphagia more acceptable (p=0.001) to patients compared to clinicians. On regression analysis, female patients were associated with finding bloating to be less acceptable (OR:0.51 (95%CI:0.29-0.91); p=0.022), but dysphagia more acceptable (OR:1.93 (95%CI: 1.17-3.21);p=0.011).

Conclusion: Patients and clinicians have different appreciation of an acceptable outcome following antireflux surgery. Female patients are more concerned about wind related side effects than male patients. The opposite holds true for dysphagia.

Key statement: Patients have a different perception of what constitutes an acceptable outcome following laparoscopic fundoplication compared to surgeons and GPs. Female patients appeared to be more concerned regarding bloating and less so about dysphagia postoperatively. Patient expectations should be comprehensively explored in preoperative consultation before laparoscopic fundoplication.

FP07 (15:20-15:30: 06.12.18)

QUANTIFYING TENSION IN TENSION-FREE HIATAL HERNIA REPAIR: A NEW INTRA-OPERATIVE TECHNIQUE

Presenter: L Navaratne
Author(s): L Navaratne, H Ashrafian, P Lung, A Isla
Institution: Northwick Park Hospital, London, United Kingdom

Aims: A technique to measure crural closure tension has not been described before. The aims of this study were to develop a reliable method for measuring the tension of crural closure during hiatal hernia repair and to describe the tension characteristics of crural closure.

Methods: 50 patients underwent crural tension measurement. Hiatal surface area was measured intraoperatively and a Sauter-FH50 Universal Digital Force Gauge was used to measure the tension of crural closure during cruroplasty. Outcome measures included the mean tension of the crural closure and the presence of any muscle splitting during the cruroplasty.

Results: 148 interrupted cruroplasty sutures were performed in all fifty patients. Each interrupted suture had three tension measurements recorded. The mean SD amongst the tension measurements was 0.27. Muscle splitting occurred at higher crural tension (5.3N vs 1.62N, $p<0.0001$). The lowest observed mean crural closure tension causing muscle splitting was 3.52N.

Conclusion: A reliable method for measuring the tension of crural closure has been described. Initial findings suggest that crural closure tension up to ~4N could be the permissible tension threshold for suture cruroplasty and higher tension may benefit from the use of mesh reinforcement.

Key statement: We have developed a technique for measuring the tension of crural closure during laparoscopic repair of hiatal hernia which is reproducible, quick, of low cost and requires only minimal additional equipment. There is now a possibility to optimise this operation with objective measures 100 years after it was first described.

FP08 (15:30-15:40: 06.12.18)

COMPARATIVE ANALYSIS OF OPEN, LAPAROSCOPIC AND ROBOTIC DISTAL PANCREATIC RESECTION: AN ANALYSIS OF A SINGLE CENTRE EXPERIENCE

Presenter: SK Kamarajah
Author(s): SK Kamarajah, J French, D Manas, R Charnley, S White
Institution: Department of Hepatobiliary, Pancreatic and Transplant Surgery
Academic Department of Surgery, Freeman Hospital, Newcastle, United Kingdom

Aims: Laparoscopic distal pancreatectomy (LDP) has advantages over open equivalent (ODP) for body and tail pancreatic disease. Within the UK there is no reported experience describing role of robotic distal pancreatectomy (RDP) over LDP. This study aimed to perform the first UK comparison of perioperative outcomes between ODP, LDP and RDP

Methods: Patients undergoing distal pancreatectomy performed at Department of Hepatobiliary and Pancreatic Surgery at Freeman Hospital between September 2007 and March 2018 were included from a prospectively maintained database. Primary outcome was overall complications graded according to the Clavien-Dindo classification. Secondary outcomes were pancreatic fistula classified according to the ISGPS criteria

Results: Of the 120 patients, median age was 62 years and 45% were male. RDP has lower conversion (12%vs16%,$p=0.041$), operative time (280vs300min,$p<0.001$), and spleen preservation (68%vs98%,$p<0.001$) than LDP. R0 rates were higher in RDP than LDP but lower than ODP (25%vs20%vs56%,$p=0.037$). RDP had shorter hospital stay than LDP/ODP (8vs9vs10 days,$p=0.013$).

Conclusion and key statement: Minimally invasive pancreatic resection offers significant advantages over ODP with RDP appearing to be superior to conventional LDP.

P01

IS OBESITY A PROBLEM FOR LAPAROSCOPIC CHOLECYSTOCTOMY? - A PROSPECTIVE OBSERVATIONAL STUDY

Presenter: KK Dasharathrao
Author(s): KK Dasharathrao, L Kaman, D Dahiya, A Behera
Institution: Postgraduate Institute of Medical Education and Research Chandigarh, Chandigarh, India

Aims: The purpose of this study is to determine prospectively whether body mass index (BMI) has role in the outcome of the patients undergoing laparoscopic cholecystectomy(LC), in terms of operating time, conversion rate, intra-operative and post-operative complications and duration of hospital stay.

Methods: Sixty patients, aged 18 to 70years, undergoing elective LC for symptomatic gall stone disease were included. 2 BMI groups were made (30 patients each); Group NO(NonObese - BMI < 30 kg/m2) and Group O(Obese - BMI ≥ 30 kg/m2). Patients were followed up to first post-operative visit.

Results: In GroupNO and GroupO mean operating time was 58.33±24.4 and 57.87±22 minutes(p=0.917) and mean hospital stay was 1.30±1.14 and 1.83±2.0days(p=0.154) respectively. One in each group required conversion to open cholecystectomy. 22 cases (GroupNO-6); GroupO-16) had intra-operative bile or stone spillage(p=0.007). No post-operative complications were reported.

Conclusion: Hence obesity does not have an adverse outcome for laparoscopic cholecystectomy in terms of operating time, conversion rates, post-operative complications and length of hospital stay. Although a higher rate of intra-operative bile or stone spillage occurred in the obese group indicating technical difficulties involved in obese patients.

Key statement: Obesity does not affect the final outcome of laparoscopic cholecystectomy but intra-operative technical problems can occur frequently.

P02

READMISSIONS FOLLOWING HISTOLOGICALLY NORMAL LAPAROSCOPIC APPENDICECTOMY

Presenter: C West
Author(s): C West[1,2], K Erskine[3]
Institution: [1]Dorset County Hospital NHS Foundation Trust, Dorchester, United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, United Kingdom
[3]Brighton and Sussex Universities NHS Trust, United Kingdom

Aims: Appendicitis is often a clinical diagnosis and the decision to undertake appendicectomy is commonly made without radiological investigation. The national average histologically normal appendicectomy rate is 20.6% (range 3.3-36.8%) [1]. The aim of this study was to determine readmission rates following appendicectomy where the post-operative histology was normal.

Methods: This was a retrospective observational study over a six month period. All patients discharged following laparoscopic appendicectomy were included and their histology reviewed. The proportion of histologically normal specimens was calculated and in this cohort the number representing in a two month period following discharge was recorded.

Results: A total of 220 appendicectomies with histology were performed in 6 months, 61/220 (27.7%) were normal, of these patients 7/61 (11.5%) represented two months following their operation. The subsequent diagnoses were: diverticular perforation (1), adhesional pain (1), biliary colic (2), non-specific abdominal pain (1) and non-specified (2).

Conclusion: The rate of readmission following normal appendicectomy was not insignificant, in addition alternate pathologies were diagnosed in the post-operative period after appendicectomy. Additional pre-operative imaging, longer periods of observation before surgery, thorough diagnostic laparoscopy and senior decision maker selection of patients for theatre may help improve patient outcomes.

Key statement: There are no current standards for the rates of readmission post-appendicectomy with normal histology. Morbidity after this operation is not insignificant and alternative pathology may be present. Units with higher rates of normal histology should take steps to reduce this closer to the national average.

Reference: doi:10.1002/bjs.9201

P03

APPENDICITIS DUE TO INCARCERATION WITHIN A LAPAROSCOPIC UMBILICAL PORT-SITE HERNIA

Presenter: C West
Author(s): C West[1,2], A Lam[3], B Parnell[2], J Black[2]
Institution: [1]Dorset County Hospital NHS Foundation Trust, Dorchester, United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, Brighton, United Kingdom
[3]Surrey and Sussex Healthcare NHS Trust, Redhill, United Kingdom

Aims: Incisional hernias within laparoscopic port-sites are a relatively common occurrence. Presented is a rare complication of laparoscopic surgery where an incarcerated appendix was present in an umbilical port-site hernia which subsequently became acutely inflamed.

Methods: A 37-year-old female presented with abdominal pain initially managed as recurrent pancreatitis and discharged. She represented 12 days later with an erythematous incarcerated port-site incisional hernia from previous laparoscopic sterilisation. Computed tomography showed a 3 cm defect at the umbilicus containing presumed small bowel with surrounding fat stranding.

Results: She underwent incisional hernia repair where an ischaemic appendix was found necessitating appendicectomy. The defect was repaired with an onlay mesh. She developed a wound infection that was managed with antibiotics only. Histology showed acute inflammation of the appendix on a background of changes consistent with chronic incarceration.

Conclusion: Abdominal wall hernias containing the appendix are usually due to sliding variants into the inguinal region or the femoral canal, known eponymously as Amyand's or De Garengoet's hernias respectively. They are usually encountered incidentally, but may present with appendicitis. For this phenomenon to occur in port-site hernias is very unusual.

Key statement: Fascial closure of port-sites over 10mm must be performed before finishing laparoscopic operations to prevent incisional hernias developing, this common general surgical practice must also apply to all laparoscopic gynaecological procedures. It is possible for the appendix to become incarcerated in these hernias.

P04

AUDIT OF PATIENTS REQUIRING ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY FOLLOWING A BILE LEAK POST-LAPAROSCOPIC CHOLECYSTECTOMY

Presenter: C West
Author(s): C West[1,2], A Lam[3]
Institution: [1]Dorset County Hospital NHS Foundation Trust, Dorchester, United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, Brighton, United Kingdom
[3]Surrey and Sussex Healthcare NHS Trust, Redhill, United Kingdom

Aims: In a single month four patients presented with significant bile leaks requiring sphincterotomy and common bile duct stenting by endoscopic retrograde cholangiopancreatography (ERCP) following laparoscopic cholecystectomy. The aim was to investigate cases requiring ERCP for bile leaks to assess the effectiveness of management and review operation notes for causative factors.

Methods: Data was collected retrospectively over 12 months from all patients having ERCP and stenting requested for the purposes of managing a bile leak. These case notes were then reviewed for their operation note from laparoscopic cholecystectomy, additional length of stay and overall number of additional procedures required.

Results: All operation notes (n=11) described cholecystitis, leak aetiologies included: accessory duct, cystic duct injury and subtotal cholecystectomy. Drains were left in 7/11, the others required washout and drain placement. A total 21 ERCPs were required (including stent removal), all leaks dried up. Average additional length of stay was 12.6 days.

Conclusion: Bile leaks that require ERCP place a significant burden on hospital beds and endoscopy departments. Placing a drain after laparoscopic cholecystectomy significantly reduces morbidity. ERCP is an effective intervention for bile leaks, these stents should be removed after discharge as an outpatient.

Key statement: Drain placement following difficult laparoscopic cholecystectomy is essential to lead to early diagnosis of bile leak and reduce the morbidity from these leaks, particularly if cholecystitis is present or iatrogenic injury suspected. If leaks do not dry up after a period of observation ERCP is an effective definitive management option.

P05

MULTI-CENTRE AUDIT REVIEWING POST-OPERATIVE LAPAROSCOPIC APPENDICECTOMY AND CHOLECYSTECTOMY BLOOD TRANSFUSION RATE TO REDUCE NUMBERS OF PRE-OPERATIVE GROUP & SAVE TESTS OBTAINED

Presenter: N Wong
Author(s): N Wong, B Davies, H Cheng, J Lawrence, G Conn
Institution: Mid Essex NHS Trust, Broomfield, United Kingdom

Aims: The audit aim was to ascertain the post-operative blood transfusion rate for laparoscopic appendicectomy and cholecystectomy. This was to establish clarification if mandatory pre-operative group and save is necessary, and if the number of group and saves obtained pre-operatively could be reduced.

Methods: A retrospective review of electronic patient records who underwent laparoscopic appendicectomy or cholecystectomy ± on table cholangiogram at 3 district general hospitals. A total of 1545 patient records were reviewed between January 2015 to July 2017 at Mid Essex Hospital, Basildon and Thurrock Hospital and Southend University Hospital NHS Trusts.

Results: A total of 1545 operations were performed whom all had a valid group and save. 10 patients received post-operative blood transfusions. In each of the hospitals the combined post-operative blood transfusion rate for laparoscopic appendicectomy and cholecystectomy were less than 1%. The overall post-operative blood transfusion rate was 0.65%.

Conclusion: Post-operative blood transfusion rate for appendicectomy and cholecystectomy is low. This multi-centre study indicates patients may undergo unnecessary pre-operative group & save tests, as they are unlikely to require blood transfusion. Routine pre-operative group and save test may be dispensable and potentially save a minimum of £15,032.85 without compromising safety.

Key statement: The very low post-operative blood transfusion rate of 0.65% for laparoscopic appendicectomy and cholecystectomy in this multi-centre study gives credence to a non-mandatory pre-operative group and save policy. This policy would not adversely affect or compromise surgical patient safety whilst reducing clinical and financial burden.

P06

LAPAROSCOPIC COMMON BILE DUCT EXPLORATION: SAFE IN SAFE HANDS

Presenter: N Ali
Author(s): N Ali, J Ockrim, T Farooq
Institution: Yeovil District Hospital, Somerset, United Kingdom

Aims: ERCP has established its role in the management of bile duct stones. The use of laparoscopic approach to treat bile duct stones is still debatable. The aim of this study is to look at the outcome of laparoscopic bile duct clearance.

Methods: Retrospective data analysis of patients who underwent a laparoscopic bile duct clearance at a rural surgical centre.Patient demographics,presentation and procedure outcomes were measured. The data was analysed using mean/median values and percentages.

Results: 67% of the explorations elective while 33% were emergency. The mean operative time was 154 minutes. 18% procedures were converted, stone size and impaction being most common reason. 11% patients had a trans-cystic clearance, 89% required a choledochotomy.Retained stones were seen in 4% and 4% required drainage for bile leak.

Conclusion: Laparoscopic bile duct clearance is an invaluable technique saving time, money and offering a single procedure for the clearance of the bile duct and removal of the gall bladder. The occurrence of procedure related morbidities can be minimized with better patient selection and meticulous surgical technique.

Key statement: Laparoscopic bile duct exploration should be considered early in the management of ductal calculi.

P07

DIAGNOSING ACUTE APPENDICITIS IN PREGNANCY: A CLINICAL CONUNDRUM

Presenter: J Michaels
Author(s): J Michaels, S Shepherd, C Liao
Institution: East and North Herts NHS Trust, Hertfordshire, United Kingdom

Aims: This study aimed at investigating the diagonstic accuracy of ultrasound and magnetic resonance imaging in pregnant patients presenting with possible appendicitis. By auditing hospital data, we aim to distinguish the benefits and limitations of each diagnostic tool whilst also providing solutions to implement appropriate clinical improvements.

Methods: Data was collected on pregnant patients who underwent ultrasound scan and/or MRI scan to investigate RIF pain in Lister hospital, between April 2013 - April 2018. Diagnostic accuracy, sensitivity, and specificity of both USS and MRI scan was calculated based on confirmation of appendicitis following surgery, or resolution of symptoms.

Results: Altogether there were sixty-six patients who underwent imaging. 41 patients had only USS, 5 patients had only MRI scan and 20 patients had both USS followed by MRI scan. The sensitivity and specificity of USS was 62.5% and 98% respectively, for MRI scan it was 75% and 100% respectively.

Conclusion: MRI appears to be a better diagnostic tool in our small group of patients, compared to USS, although this is not significant due to a small sample size. However the significance of missed appendicitis or delay in diagnosis must be taken into consideration.

Key statement: MRI continues to be a vital diagnostic tool when investigating pregnant patients who present with possible appendicitis. As such, a great emphasis should be made to consider the use of MRI as a means of avoiding a missed or delayed diagnosis in this high-risk cohort.

P08

ROBOTIC VERSUS CONVENTIONAL LAPAROSCOPIC LIVER RESECTION: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: SK Kamarajah
Author(s): SK Kamarajah, SM Robinson, JJ French, G Sen, DM Manas, SA White
Institution: Department of HPB Surgery, The Freeman Hospital, Newcastle Upon Tyne, United Kingdom

Aims: Robotic surgery is gaining popularity as it offers several theoretical advantages to conventional laparoscopic surgery including improved instrument dexterity, 3D visualization and better ergonomics. This systematic review and meta-analysis aims to evaluate a comparison of robotic versus laparoscopic liver resection.

Methods: A systematic literature search was conducted for studies reporting robotic and laparoscopic liver resection. Meta-analysis of intraoperative (operating time, blood loss, transfusion rate, conversion rate), postoperative (complications, bile leaks, length of hospital stay) and oncological outcomes (R0 resection) was performed using a random effects model. Cost analysis was excluded.

Results: Twenty-one non-randomised studies included 1753 patients (652 robotic, 1016 laparoscopic). Patients undergoing robotic surgery had longer operating time (283 vs 209min, $p<0.001$) and higher blood loss (289 vs 267min, $p=0.02$). There were no significant differences in transfusion and conversion rates, overall (OR: 0.83, $p=0.3$) or major (OR: 1.19, $p=0.6$) complications and R0 rates, although a trend for benefit with robotic surgery (OR: 0.69, $p=0.1$).

Conclusion: Robotic liver resections do not offer statistically significant advantage although trends towards benefit for overall complications and R0 rates were apparent. This is likely due to heterogeneity of studies with small sample sizes and associated learning curves and introducing new techniques with limited surgical adjuncts available for robotic liver resection.

Key statement: This review aims to evaluate the current literature on robotic versus open or laparoscopic pancreaticoduodenectomy. Robotic pancreaticoduodenectomy offers a significantly shorter stay less blood loss and transfusion rates but no difference in postoperative complications.

P09

ROBOTIC VERSUS CONVENTIONAL AND LAPAROSCOPIC PANCREATICODUODENECTOMY: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: S Kamarajah
Author(s): S Kamarajah, SM Robinson, JJ French, G Sen, DM Manas, SA White
Institution: Department of HPB Surgery, The Freeman Hospital, Newcastle Upon Tyne, United Kingdom

Aims: Minimally invasive pancreaticoduodenectomy (MIPD) is a demanding operation such that it has not gained popularity amongst HPB surgeons in the UK. Three main advantages of robotic pancreaticoduodenectomy are improved dexterity, 3D vision less surgical fatigue. This review aims to evaluate current literature on robotic versus open or laparoscopic pancreaticoduodenectomy.

Methods: A systematic literature search was conducted for studies reporting robotic and open/laparoscopic surgery for pancreaticoduodenectomy. Meta-analysis of intraoperative (operating time, blood loss, transfusion rate), postoperative (overall and major complications, pancreatic fistula, delayed gastric emptying, length of hospital stay) and oncological outcomes (R0 resection, lymphadenectomy) were performed using random effects models.

Results: Seventeen non-randomised studies included 4878 patients (1262 robotic, 1718 laparoscopic, 1898 open), of which 14 studies compared robotic and open surgery. Patients undergoing robotic surgery had longer operating times (459 vs 370min, p=0.002) but less blood loss(354 vs 536mL, p<0.001), transfusion rates(p=0.01) and hospital stay(12.5 vs 15.4days,p=0.001). Only 3 studies compared robotic versus laparoscopic surgery limiting meaningful data for analysis.

Conclusion: Robotic pancreaticoduodenectomy offers a significantly shorter stay less blood loss and transfusion rates but no difference in postoperative complications. These results are encouraging given its recent introduction. However, further studies are needed to assess improvement in patient survival, cost-effectiveness and uptake amongst surgeons who otherwise would not consider MIPD.

Key statement: Robotic pancreaticoduodenectomy offers a significantly shorter stay less blood loss and transfusion rates but no difference in postoperative complications. These results are encouraging given its recent introduction. However, further studies are needed to assess improvement in patient survival, cost-effectiveness and uptake amongst surgeons who otherwise would not consider MIPD.

P10

LAPAROSCOPIC CHOLECYSTECTOMY COMPLICATIONS: ARE WE CONSENTING FOR DIARRHOEA?

Presenter: M Hanks
Author(s): M Hanks
Institution: Kingsmill Hospital, Mansfield, United Kingdom

Aims: The 2015 Montgomery v Lanarkshire judgement revised informed consent guidance; complications previously seldom discussed should be considered during the consent process. Current literature reports post-cholecystectomy diarrhoea prevalence at 9.1%; patients reveal this is the most distressing post-cholecystectomy complication; we aimed to assess whether current practice follows this new national guidance.

Methods: A retrospective analysis of cholecystectomy consent forms for emergency and elective procedures performed between 1stNovember 2017 – 31stDecember 2017 to assess if diarrhoea or change in bowel habit was documented in the consent risks section or consultation notes. 78 patients underwent cholecystectomy and a proforma facilitated consistent data collection.

Results: 29 males and 49 females with a mean age of 52 years were reviewed. 58% were consented by consultants; 29% registrars; 4% clinical fellows and 9% SHOs. 54% of consent forms included diarrhoea. 8 forms recorded risks "As per Leaflet" without any further information recorded. 73 patients received information leaflets.

Conclusion: A large consenter variability is noted for cholecystectomy and diarrhoea. Cholecystectomy information leaflets list diarrhoea as a complication but if not discussed and documented medical defence unions argue simple leaflet issuing does not constitute the required dialogue following the Montgomery Judgement. A pre-printed form may provide a consistent consent process.

Key statement: Laparoscopic cholecystectomy is a commonly performed procedure reflecting the importance of ensuring appropriate consent is obtained; post-cholecystectomy diarrhoea is reported as the most distressing complication and is a source of litigation. Comprehensive discussion throughout the consent process combined with a standardised pre-printed form ensures consistent information is provided to patients.

P11

HYDROURETER FROM AN INFERIOR VENA CAVA OBSTRUCTION: NEW ENDOVASCULAR SOLUTIONS

Presenter: D Smith
Author(s): D Smith[1], C Lim[2], K Steiner[1], M Metcalfe[1]
Institution: [1]Lister Hospital, Stevenage, United Kingdom
[2]Royal Free Hospital, London, United Kingdom

Aims: A case report of a 53 year-old active gentleman presenting with sudden onset bilateral lower limb swelling, vomiting, calf and loin pain. This project aims to summarise an unusual case of inferior vena cava atresia, including investigation, diagnosis and management.

Methods: This was a case report study, requiring knowledge of the case and the patient's outcome.

Results: A 53 year-old gentleman presented with acute bilateral lower limb swelling, calf and loin pain. A CT scan showed a left hydroureter. MRV indicated freshly occluded iliac veins compressing the ureter, with a occluded IVC. The patient was treated with dalteparin, and underwent venous lysis to improve collateral venous drainage.

Conclusion: IVC atresia is a rare but well recognised vascular anomaly with a reported incidence between 0.3 and 10%. It may be asymptomatic and detected incidentally on CT or MRI scanning. It is a risk factor for DVT and patients may present with acute venous thrombosis or chronic venous insufficiency.

Key statement: This case demonstrates how a complex pathology can present in an unusual way, and can mimic two more common diagnoses. This is an unusual presentation of a hydroureter in a young active man. Cross specialty discussions enabled a quick diagnosis and referral for effective treatment.

P12

PROTECTION OF LOWER RECTAL ANASTOMOSIS WITH AN INFLATED URINARY CATHETER

Presenter: K P V R De Silva
Author(s): K P V R De Silva[1], M Nawaz[1], R Ullah[1], W M D Fernado[2], T Gamage[3]
Institution: [1]Diana Princess of Wales, Grimsby, United Kingdom
[2]Broomfield Hospital, Chelmsford, United Kingdom
[3]National Hospital of Sri Lanka, Colombo, Sri Lanka

Aims: Leaking of lower rectal anastomosis is a nightmare of a surgeon. Further, which contributes to high mortality and morbidity. Therefore, protection of lower rectal anastomosis from leaking is of paramount importance.

Methods: 68 patients from 42 to 85 years of age who had lower rectal malignancies underwent open or laparoscopic anterior resection. All patients received a 20F urinary catheter administered rectally beyond the anastomosis. After inflation of catheter bulb, urinary catheter fixed to perianal skin. Catheter was removed on post OP day four.

Results: Except six patients those who had small pelvic collections, rest did not have post-surgical complications following insertion of urinary catheter beyond the anastomosis. 62 out of 71 patients with ileostomy recovered uneventfully. Two developed anastomotic leakage, needed surgical intervension.7 patients have developed small pelvic collections, treated with antibiotics

Conclusion: Thus, inflated urinary catheter alone has shown statistically significance (Chi test 109.1 ; $p<0.1$)

Key statement: Therefore, it has been confirmed that, inflated urinary catheter has improved the outcome of lower rectal anastomosis and prevent the need of creation of ileostomy as well as closure of loop ileostomy as the second surgical procedure.

P13

ACUTE GALLSTONE PANCREATITIS AND MODIFIED INDEX LAPAROSCOPIC CHOLECYSTECTOMY: MERGING STANDARD MANAGEMENT PATHWAY WITH SURGICAL HOT CLINIC – FACING THE CHANGE

Presenter: AA Dhahri
Author(s): AA Dhahri, O Khan, E Mohammed, B Ivanov
Institution: The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom

Aims: British Society of Gastroenterology (BSG) advises laparoscopic cholecystectomy within 2 weeks of admission unfolding concept of index admission surgery. With recent admission pressure building up on NHS, we aim to assess the efficacy of incorporating surgical hot clinic pathway to BSG guidelines while modifying index admission laparoscopic cholecystectomy.

Methods: Prospective data was collected about acute mild to moderate gallstone pancreatitis patients after taking approval from the local audit department. All such patients managed and offered scheduled laparoscopic cholecystectomy via surgical hot clinic within 2 weeks target. Post-operative complications and patient satisfaction assessed and analyzed.

Results: Over a period of 18 months since starting surgical hot clinic at our hospital, selected willing patients underwent laparoscopic cholecystectomy through surgical hot clinic admissions. Post-operative complications comparable to index admission surgery. Patient satisfaction was satisfactory with regards to surgical hot clinic pathway.

Conclusion: Modifying index admission laparoscopic cholecystectomy through surgical hot clinic pathway is effective, safe and reliable treatment option in mild to moderate gallstone pancreatitis with better patient satisfaction.

Key statement: Incorporating surgical hot clinic pathway, to bring back stable post-gallstone pancreatitis patients for scheduled surgery within 2 weeks, can be very useful during moderate to high pressure times in Trusts.

P14

SETTING UP AN ADVANCED LAPAROSCOPIC SERVICE IN FIJI ISLANDS - EXPERIENCE AND RESULTS OF A QUALITY IMPROVEMENT PROJECT

Presenter: K Maruthachalam
Author(s): K Maruthachalam[1,2], S Vudiniabola[2], P Mohandas[1,2]
Institution: [1]MIOT International Hospital, Chennai, India. [2]MIOT Pacific Hospital, Suva, Fiji

Aims: The surgical practice in Fiji has been limited to open surgery with minimal use of basic laparoscopy. Aim of this study is to evaluate the preliminary experience in the establishment of a specialist laparoscopic service in Fiji.

Methods: A dedicated laparoscopic stack system along with procurement of instruments was done. Patients were chosen for laparoscopic surgery based on their ASA status, co-existing disease, previous surgery and mode of presentation.

Results: 34 laparoscopic operations were performed between February 2017 and September 2018 including Appendicectomy (9), Cholecystectomy (20), Groin hernia repair (2), Right hemicolectomy (1), Paraoesaphageal hernia repair (1) & Incisional hernia repair (1). One conversion was made (CBD stone). No deaths nor complications were reported. Average length of stay is 3 days.

Conclusion: A safe introduction of advanced laparoscopy is feasible by a trained surgeon with systematic structured education of health care professionals and rigorous case selection. Addition of advanced infrastructure ensured the procedures are performed with minimal complications.

Key statement: Advanced laparoscopy provides improved short-term outcomes and can be implemented in low income set up by a trained surgeon following systematic education and optimal case selection. This ensures patients return to normal living soon after surgery with minimal disruption to quality of life.

P15

DELAY IN INITIATION OF ADJUVANT CHEMOTHERAPY IN COLORECTAL CANCER: OUTCOMES BETWEEN LAPAROSCOPIC AND OPEN SURGERY

Presenter: B Mahendran
Author(s): B Mahendran, R Wee, S Smolarek
Institution: University Hospitals Plymouth NHS Trust, United Kingdom

Aims: The treatment of colorectal cancer involves the use of adjuvant chemotherapy. The delay to the initiation of adjuvant chemotherapy is associated with worse overall survival (OS). This study looks to investigate the difference in the time to adjuvant chemotherapy between patients undergoing laparoscopic (LS) or open primary resection (OPR).

Methods: A retrospective review of patients undergoing an operative management of colon cancer between 2012-2018 was undertaken. Patients undergoing endoscopic treatment, resections for appendiceal and small bowel tumours were excluded, . Statistical analysis was undertaken using Kaplan-Meier curves, and Mann-Whitney test for non-parametric data.

Results: A total 340 patients' records were reviewed. 196 had a laparoscopic resection, whilst 140 had an open resection. The average time delay between the LS and OPR group was 161:182 days (p=0.0573). There was no difference between the overall survival between the two groups.

Conclusion: There is a strong trend towards the earlier initiation of adjuvant chemotherapy in the laparoscopic group. Whilst there is no difference in OS between the groups, this might be in relation to the sample size and length of follow up for these patients.

Key statement: Laparoscopic resection of colorectal cancer leads to earlier initiation of adjuvant chemotherapy.

P16

SURGICAL ATTITUDES TO TECHNOLOGY AND SURGERY

Presenter: D Menzies
Author(s): E Menzies[1], D Menzies[2]
Institution: [1]Ipswich School, United Kingdom. [2]Colchester Hospital, United Kingdom

Aims: The increasing use of technology in laparoscopic surgery advances exponentially. These advances seem driven by industry with little attention to the impact these advances have on how general clinicians respond, adopt and approach technology

Methods: A questionnaire was circulated to members of the ALSGBI asking about laparoscopic experience, current technology adoption and future expectations. The questionnaire was an on-line survey

Results: 87 responded. Most experienced laparoscopic surgeons. 1.5% used SILS. 58% did not use any advanced technology, 7% used DaVinci. More than 60% considered technology made surgery safer but also more expensive. 79% believed technology made surgery harder. Despite this surgeons were comfortable with technology and looked forward to future developments.

Conclusion: Surgeons consider technology in surgery as exciting and look forward to development but accept that it makes surgical practice harder. Despite this the uptake of technology in surgery is low.

Key statement: Surgeons are enthusiastic about technology but do not readily adopt it.

P17

A RARE CAUSE OF LOWER GASTROINTESTINAL BLEEDING: A CASE REPORT OF INTESTINAL MALROTATION IN AN ADULT PATIENT

Presenter: M Aradaib
Author(s): M Aradaib, D O'Riordain
Institution: Beacon Hospital, Dublin, Ireland

Aims: Intestinal malrotation(IM) is rare in adults with an estimated incidence of 0.2%-1%. It could present acutely as small bowel volvulus or an internal hernia or with chronic non-specific symptoms. Gastrointestinal bleeding due to IM is extremely rare. We present this unusual case of lower GI bleeding secondary to IM.

Methods: We present a case of a 28-year-old female who presented to our service with rectal bleeding secondary to IM and we compare our patient to some of the reported literature.

Results: A 28-year-old female presented with rectal bleeding. Colonoscopy showed haemorrhoids and ascending-colon vascular engorgement. CT-abdomen confirmed the IM and revealed narrowing at the SMV confluence and mesenteric venous congestion. Elective laparoscopic Ladd's procedure was performed. Symptoms settled completely and a follow-up CT scan showed resolution of the venous congestion.

Conclusion: Despite its rarity, intestinal malrotation could cause lower GI bleeding in adults. Familiarity with this condition and its management would be beneficial when dealing with lower GI bleeding of obscured aetiology

Key statement: Intestinal malrotation in adults is rare and it can present with lower gastrointestinal bleeding.

P18

PORT-SITE HERNIA – A DARK FORCE IN TRANS-ABDOMINAL PRE-PERITONEAL (TAPP) REPAIR: SYSTEMIC LITERATURE REVIEW & META-ANALYSIS

Presenter: AA Dhahri
Author(s): AA Dhahri[1], D Kumar[2], M Adeel Dhahri[1], A Rao[1], N Kirmani[1]
Institution: [1]The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom
[2]North Tees University Hospital, Stockton-on-Tees, United Kingdom

Aims: Despite many controversies, very few literature in past have compared both TAPP and totally extra-peritoneal (TEP) techniques in terms of port-site hernia. In this study we aimed to compare incidence of port-site hernia between TAPP and TEP in literature to determine safe outcome.

Methods: Electronic database including Medline, EMBASE, Cochrane review register and Google scholar services was searched using MeSH term. Meta-analysis was performed using Revman 5.2 statistical software. Out of 40,000 search results, we included randomized (RCTs) as well as non-randomized controlled trials scratching data for port-site hernia mainly.

Results: 12 studies included. Incidence of early or later stage port-site hernia was as much as 5.2% after TAPP. Mean follow-up was not same. Parallel variable results in our study also included shorter operative time, scrotal hematoma, and thermal injury in less than 1% in TAPP.

Conclusion: Both TAPP and TEP are safe with overall same outcome. Although TAPP easier to learn and perform, literature has shown that TEP has an edge in avoiding port-site hernia in nearly most of the time and suggested to adequately closure of 10mm trocar ports in TAPP.

Key statement: Due to very less number of RCTs defining port-site hernia following TAPP, this can only be reliably addressed by multi-centre well –designed RCT.

P19

NEEDLESCOPIC CHOLECYSTECTOMY (NC): INVENTIVENESS TO REIGN

Presenter: AA Dhahri
Author(s): AA Dhahri[1], D Kumar[2], A Rao[1], N Kirmani[1]
Institution: [1]The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom
[2]North Tees University Hospital, Stockton-on-Tees, United Kingdom

Aims: Needlescopic Cholecystectomy (NC) is hone form of conventional laparoscopic cholecystectomy (LC) using smaller ports and instruments as small as 2mm. We systematically analyzed clinical efficacy of both NC and LC to ascertain practicability of these techniques in one of the most common operations of world.

Methods: Following search databases were used: EMBASE, MEDLINE, Web of Science, NICE guidelines, and Cochrane Hepato-Biliary Group Controlled Trials Register. MeSH terms were combined. Meta-analysis was performed on various outcomes using Revman 5.2 statistical software. The primary outcomes were operative time, complications, postoperative pain, hospital stay, and cosmesis.

Results: 21 studies (n=1110) included in the review. Mean operative time in NC was 60.12 minutes comparable to LC. Postoperative pain was less in NC but one study showed higher conversion rate to open in NC. There was no significant difference in hospital stay between NC and LC.

Conclusion: In properly selected patients, NC is safe and practical replacement of LC with similar incidence of post-operative complications. For early postoperative pain NC is much superior. Patient satisfaction was better with cosmetic results.

Key statement: Needlescopic Cholecystectomy is superior to laparoscopic cholecystectomy in terms of postoperative pain and cosmetic results.

P20

RATES OF BILE ACID DIARRHOEA DIAGNOSIS IN PATIENTS FOLLOWING CHOLECYSTECTOMY

Presenter: A Farrugia
Author(s): A Farrugia, S Khan, N Williams, R Arasaradnam
Institution: University Hospitals of Coventry and Warwickshire, Coventry, United Kingdom

Aims: Post cholecystectomy diarrhoea may occur in up to 35% of patients and may be due to disruption of the enterohepatic circulation postoperatively. The rate of bile acid diarrhoea postoperatively is unknown, and we sought to determine this as well as the time from surgery to diagnosis.

Methods: Cross-referencing of a prospective electronic database of patients who underwent laparoscopic cholecystectomy (LC) and a 75SeHCAT test at a tertiary centre between 2013 and 2017 was performed. A 7-day retention time of <15% was deemed positive.

Results: 34 of 2381 patients undergoing LC were investigated via endoscopy and 75SeHCAT test for chronic diarrhoea postoperatively. 20 (59%) had a 75SeHCAT retention of 75SeHCAT testing was 564 days (SD=371), and women were tested significantly later than men (660 vs 287 days, p=0.006).

Conclusion: Only a small proportion of post-cholecystectomy patients were investigated for BAD (1.4%), and of these 59% were positive. There was also a significant time delay to diagnosis. This may be partly due to that cholecystectomies are now undertaken as a day case and routine follow-up is rarely offered.

Key statement: 59% of patients with diarrhoea post LC developed BAD. There are significant time delays to diagnosis and the true prevalence of BAD post cholecystectomy may be much higher, as it is grossly under-investigated. Clinicians need to have an increased awareness of this condition as it is easily treatable.

P21

LAPAROSCOPIC APPENDICECTOMIES WITHOUT CONVERSION TO OPEN IS FEASIBLE FOR ALL SIMPLE AND COMPLEX APPENDICITIS- OUR EXPERIENCE IN 71 CONSECUTIVE CASES

Presenter: K Tong
Author(s): J Gan[1], K Tong[1], R Doshi[1], D Larkin[2], A Warsi[1]
Institution: [1]University Hospitals of Morecombe Bay NHS Foundation Trust, Barrow-in-Furness United Kingdom
[2]Stepping Hill Hospital, Stockport, United Kingdom

Aims: Although laparoscopic appendicectomy (LA) is increasingly performed over the last 40 years, complicated appendicitis may need conversion to open in up to 15%. We present our data of 71 consecutive laparoscopic appendicectomies with no conversion.

Methods: We reviewed a single consultant's prospectively maintained database of Las at our trust from 01/03/2012 to 13/02/2018 (72 months). Patient demographics, investigations, intraoperative findings and postoperative results were recorded and analysed. Complicated appendicitis was defined as appendix mass, abscess or mass + abscess, and perforation with peritonitis.

Results: Median patient age was 28(range 10-89). True positive rates for USS and CT were 25% and 81% respectively. Negative appendicectomy rate was 10%. 47% of patients had complicated appendicitis. 85% of cases were performed by registrars supervised with the consultant physically present. There were no conversions to open surgery.

Conclusion: Despite the high rate of complicated appendicitis in our trust, LA was possible in all cases without needing to convert to open surgery with good post-operative results: 91% of patients were discharged within 48 hours (30% within day 1) with no complication within 30 days.

Key statement: LA without conversion is feasible in simple as well as complex appendicitis, including perforated appendicitis with peritonitis, with very good outcomes.

P22

DELAYED MANAGEMENT OF BILIARY EMERGENCIES RESULTS IN MORE DIFFICULT LAPAROSCOPIC CHOLECYSTECTOMIES

Presenter: HJ Ng
Author(s): HJ Ng[1], A Nassar[2]
Institution: [1]NHS Greater Glasgow and Clyde, Glasgow, United Kingdom
[2]NHS Lanarkshire, Lanarkshire, United Kingdom

Aims: Despite evidence and guidelines, majority of centres adopt a two-stage approach to biliary emergencies, perceiving index admission laparoscopic cholecystectomy (LC) to be more difficult. This is mostly due to logistic obstacles but is in part the result of sub-specialisation and skills issues. Is either approach associated with increased operative difficulty?

Methods: A prospectively maintained database including 5308 consecutive LC performed by a single surgeon was analysed. 2294 emergency admissions including previous episodes (up to 16weeks) were reviewed comparing index (IC) vs delayed (DC) cholecystectomies. Outcomes evaluated include operative difficulty grade, duration of surgery, length of hospital stay (LOS) and complication rate.

Results: 71% female, median age 53years.

	IC	DC	
Total	82.3%	17.7%	
Operative Difficulty Grade			
I	24.2%	20.5%	
II	29.4%	23.5%	
III	22.5%	25.5%	
IV	21.6%	26.0%	
V	2.3%	4.5%	
			P-value 0.002769
Common bile duct exploration	29.5%	40.4%	
Median duration of surgery	70min	80min	
Median LOS	7days	7days	
Complication rate	2.4%	2.8%	

Conclusion: Contrary to common belief, index admission management of biliary emergencies is associated with less operative difficulty, shorter duration of surgery despite common bile duct exploration and lower complication rate. The LOS are similar. Targeted service design including referral protocols, sub-specialisation and logistic support can optimise the outcomes of biliary emergencies.

Key statement: This study showed that index admission management of biliary emergencies should be incorporated and logistic obstacles addressed to optimise management. Until such protocols are widely adopted, delayed LC should be performed by experienced surgeons as such cases are associated with an increased, rather than decreased, operative difficulty.

P23

THE VALUE OF PERITONEAL LAVAGE IN APPENDICECTOMY: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: E Gammeri
Author(s): E Gammeri, T Petrinic, G Bond-Smith, A Gordon-Weeks
Institution: Oxford University Hospital, United Kingdom

Aims: The use of peritoneal lavage in complicated appendicitis to prevent post-operative intra-abdominal abscess (IAA) has been widely debated. We conducted a systematic review and meta-analysis of suction alone versus lavage for appendicitis in order to determine the relative benefit of lavage, focusing particularly on post-operative IAA and wound infection (WI).

Methods: The meta-analysis was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Metaanalysis (PRISMA) guidance. In total 8 studies reported post-operative intra-abdominal collection, 5 studies reported wound infection rate and length of hospital stay and 3 studies reported operating time. Only 3 were randomized-controlled trials.

Results: The rate of IAA were1.0% to19.5% in patients receiving suction alone and 1.5% to 18.6% in those receiving lavage, whilst WI rates were 1.0% to 29.2% and 0.8% to 20.5%. The pooled risk difference for IAA was 0.01 (95% CI: -0.03-0.06, P=0.5) and for WI was 0.00 (95%CI: -0.05-0.05, P=0.98)

Conclusion: The key finding from the pooled analysis presented here is that there is no evidence of benefit from lavage over suction for post-operative infective complications and importantly, no single study demonstrating significant benefit for patients receiving lavage.

Key statement: This trial was small and more expansive trials are required to confirm this, however, our meta-analysis provides the best available evidence to date that lavage does not reduce septic complications in patients undergoing appendicectomy.

P24

HEPATIC – PORTAL VENOUS GAS IN PATIENT WITH SIGMOID PERFORATION: A CASE REPORT OF MALE PATIENT

Presenter: AA Dhahri
Author(s): AA Dhahri[1], M Hoff[2], F Hatem[1], MS Das[1], A Ahmed[1]
Institution: [1]The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom
[2]Addenbrooke's Hospital, Cambridge, United Kingdom

Aims: Hepatic – portal venous gas (HPVG) is rare ominous condition with poor clinical prognosis. Diverticulitis is one of the most common causes of HPVG after ischemic bowel disease. CT has higher sensitivity to detect HPVG. Although can be treated conservatively, emergency laparotomy is recommended in associated intra-abdominal abscess and tumors

Methods: We present a case of 52 year old male patient with background of diverticulosis, admitted and initially treated conservatively for concealed sigmoid micro-perforation. Later after 3 days, because of sudden clinical deterioration and new CT-findings of minimal free fluid & extensive HPVG, emergency Hartman's procedure was performed.

Results: Post-Hartmann's procedure, patient had good postoperative recovery & subsequent resolution of HPVG. Colorectal clinical follow up arranged and patient later had laparoscopic assisted reversal of colostomy with good overall patient outcome and satisfaction.

Conclusion: In HPVG, conservative management is option but with low threshold for surgery as the patient survival can be unexpected

Key statement: Hepatic – Portal Venous Gas is rare diagnostic entity in patients with acute surgical abdomen that may confound patient management.

P25

APPENDICULAR NEOPLASMS: A RARE DISEASE AND DIAGNOSTIC CHALLENGE

Presenter: B Mahendran
Author(s): R Wee[1], A Atef[2], B Mahendran[1], B Amr[2]
Institution: [1]University Hospitals Plymouth NHS Trust, United Kingdom
[2]Royal Cornwall Hospitals Trust, Cornwall, United Kingdom

Aims: Appendicectomy is the most common surgical procedure performed worldwide. The prevalence of appendicular neoplasms is rare in the general population. Common malignancies include carcinoid, adenocarcinoma, and mucinous neoplasms. Preoperative diagnosis is challenging. We aim to present our current experience in diagnosis and managing common appendicular neoplasms.

Methods: Retrospective review of all patients who underwent appendicectomies with the intention to treat clinically suspected appendicitis was undertaken across two sites. Preoperative presentation, operative findings, and post-operative follow-up were reviewed for patients with confirmed histological diagnosis of appendicular neoplasms.

Results: 5683 appendicectomies were performed during the study period. 56 patients were found to have neoplastic lesions including 27 patients found to have carcinoid tumours, 12 with adenocarcinoma. Mucinous tumours were histologically confirmed in 17 patients.

Conclusion: Appendicular tumours are challenging due to the rarity of the disease as well as its incidental diagnosis. A careful histopathological assessment of all appendicectomy specimens is a powerful diagnostic tool. Surgical treatment ranges from a simple appendicectomy to hemicolectomy.

Key statement: Preoperative and intraoperative diagnosis of appendicular neoplasms is difficult hence precise histological examination of appendicectomy specimens is mandatory to rule out rare appendicular neoplasms, which might require further intervention.

P26

EARLY VERSUS DELAYED LAPAROSCOPIC CHOLECYSTECTOMY FOR ACUTE GALLBLADDER DISEASE: A CLINICAL AND COST ANALYSIS

Presenter: JA Attard
Author(s): JA Attard[1], R Seth[1], D Hariharan[2], EA Griffiths[3], RP Sutcliffe[1]
Institution: [1]Liver Unit, Queen Elizabeth Hospital, Birmingham, United Kingdom
[2]HPB unit, Royal London Hospital, United Kingdom
[3]General and Upper GI surgery unit, Queen Elizabeth Hospital, Birmingham, United Kingdom

Aims: In our tertiary HPB centre, there was no pathway for early laparoscopic cholecystectomy (ELC) for acute gallbladder disease (AGD). The Chole-Quic project aimed to increase uptake of ELC. Our aim was to compare outcomes and costs in patients with AGD who underwent early or delayed laparoscopic cholecystectomy (DLC) within Chole-Quic.

Methods: A prospective cohort of 171 consecutive patients with AGD over one year were assessed for ELC-eligibility (cholecystectomy within 8 days of admission) using Chole-Quic criteria. Conversion to open cholecystectomy, short-term outcomes, unplanned readmissions and costs were compared between eligible patients who either underwent ELC or were initially treated conservatively for DLC.

Results: Of 64 eligible patients, 19 (30%) underwent ELC a median of 5 days after admission. Forty-five patients underwent DLC. Open conversion was more frequent during ELC (32% vs 3%;p=0.005). Unplanned readmissions (pre/postop) were more likely with DLC (49% vs 5%;p=0.001), but median LOS, complications and overall costs were similar.

Conclusion: Early laparoscopic cholecystectomy for acute gallbladder disease is associated with fewer readmissions than delayed surgery, with no impact on postoperative complications. However, any potential cost benefit associated with ELC may be offset by a higher conversion rate.

Key statement: Early laparoscopic cholecystectomy for acute gallbladder disease is safe and potentially cost effective if conversion rates to open cholecystectomy can be reduced. Dedicated theatre resources and a coordinated pathway may reduce conversion rates, potentially reducing costs of early cholecystectomy for acute gallbladder disease.

P27

MARGINAL CHANGES AND GREAT GAINS: INCREASING SAME DAY DISCHARGE OF LAPAROSCOPIC CHOLECYSTECTOMY MAY BE A FEW CLICKS AWAY

Presenter: P Cunha
Author(s): P Cunha, D Anderson, L Sheehan, H Arunachalam
Institution: Homerton University Hospital NHS Trust, London, United Kingdom

Aims: A majority of patients can be safely discharged on the same day after laparoscopic cholecystectomy. In the NHS rates of at least 60% are expected to be easily achieved and in the literature much higher rates have been reported. We audited our practice and implemented changes to improve our performance.

Methods: An audit of 405 operations revealed 59% rate of same day discharge. Risk factors for failed discharge were identified through univariate analysis. One modifiable risk factor, time of start of surgery, was selected for change. Rate of same day discharge of groin hernia repair was monitored as balancing measure.

Results: We arranged for the lap. cholecystectomies to be put on the top of the list sent to surgeons for approval. Complying with the order wasn't mandatory and the operating team could change the order at any time. The rate of same day discharge increased to 71%, sustained for one year.

Conclusion: Ordering laparoscopic cholecystectomy cases first on the list has achieved a significant improvement on the rate of successful day cases. This is a classic example of low effort great impact change in quality improvement science.

Key statement: Same day discharges have great benefits to patients and health systems. High rates are reported on literature. In the reality of an ordinary operating day on the NHS, many hospitals struggle to replicate those rates. We have managed to achieve a significant gain with a simple, non-clinical and costless measure.

P28

LAPAROSCOPIC HELLER MYOTOMY WITH PARTIAL FUNDOPLICATION FOR ACHALASIA CARDIA: INITIAL EXPERIANCE FROM SINGLE GASTROINTESTINAL SURGICAL UNIT IN A DEVELOPING COUNTRY

Presenter: D Subasinghe
Author(s): D Subasinghe[1,2], A Priyantha[1]
Institutional: [1]Gastrointestinal Surgical Unit, Colombo South Teaching Hospital, Kalubowila, Colombo, Sri Lanka
[2]Department of Surgery, Faculty of Medicine, University of Colombo, Colombo, Sri Lanka

Aims: Achalasia cardia is debilitating oesophageal motility disorder of unknown aetiology. The goal of treatment is to improve symptoms by relieving functional obstruction. Laparoscopic Hellers myotomy with fundoplication is the gold standard treatment. The aim was to evaluate patients underwent laparoscopic Hellers myotomy for achalasia and to assess their surgical outcomes.

Methods: Patients underwent laparoscopic surgery for achalasia 2016-2018 were included. Barium swallow, oesophagogastroscopy, oesophageal manometry to exclude carcinoma and to confirm achalasia. The surgical design involved a 7-cm myotomy, which extended 2 cm onto stomach, a Dor fundoplication. All data on demographic, operative, surgical morbidity, hospital stay were recorded.

Results: The M:F ratio was 8:7. Mean age was 44.6 years (range,16-71). The mean operating time was 118 minutes (range=100–240). The median hospital stay was 4 (range,2-8days). Intra/postoperatively, oesophagealmucosalperforation (n=3), pneumothorax (n=1), anteriorvagusdamage (n=1), bile leak from liver retractor site (n=1) were noted. The average follow-up period is 6.1months (range, 1- 22)

Conclusion: Laparoscopic Heller myotomy is feasible in our setting with satisfactory outcomes. In view of its equal safety and efficacy with added advantage of less morbidity and mortality.

Key statement: Laparoscopic Heller myotomy can be safely performed with satisfactory outcomes in carefully selected patients with experienced surgical hands. However larger case series and long term follow up would be warranted.

P29

ANNUAL VARIATION IN SUBTOTAL CHOLECYSTECTOMY RATES SINCE IMPLEMENTATION OF CG188 IN A DISTRICT GENERAL HOSPITAL

Presenter: D Ghosh[1], S Andrews[2]
Author(s): D Ghosh[1], S Andrews[2]
Institution: [1]Homerton University Hospital, London, United Kingdom
[2]Torbay District Hospital, Torquay, United Kingdom

Aims: To identify any significant changes in the rate of Laparoscopic Subtotal Cholecystectomy (STC) since implementation of Nice Guidance CG 188 in our DGH.

Methods: All laparoscopic cholecystectomies (LCs) performed as index operations were included from October 2012 till August 2017. The outcome measures were number of Elective vs Emergency LCs, STCs in elective (EISTCs)/ emergency (EmSTCs) operations, post-operative ERCPs in the STC group and 30-day readmission rates.

Results: 1619 LCs --- October 2012 - 2017 (1003 EILCs /616 EmLCs).

EmLCs increased from October 2014 (72/year to 171/year).

25 (2.4%) EISTCs done vs 42(6.8%) EmSTCs.(p=0.00022).

Post- operative ERCPs more after EmSTCs (12% vs 42%) -- (p = 0.008).

30-day readmission rate higher for EmSTCs higher (25% vs 7.5%).

Conclusion: Emergency LCs can be difficult operations and STCs as a means of Chasing safety as opposed to Chasing anatomy are being advised and performed in increasing numbers. Post-operative ERCPs due to bile leak are expected to come down in the absence of biliary pathology as more experience is accrued.

Key statement: The NICE guidelines have changed practice however in view of the findings it is important that the consent has to be tailored to each patient's situation as per Montgomery standards. The patients need to be informed about the increased risk associated with difficult procedures and need for subsequent interventions.

P30

LAPAROSCOPIC ANTRAL STUNTING SLEEVE GASTRECTOMY – A COMPARABLE PROCEDURE TO LRYGB FOR T2DM IN MORBIDLY OBESE PATIENTS?

Presenter: D Ghosh
Author(s): D Ghosh, Y Koak
Institution: Homerton University Hospital, London, United Kingdom

Aims: Laparoscopic sleeve gastrectomy (LSG) is the most common bariatric surgical procedure over last decade and evidence is accumulating about its efficacy in remission of T2DM in morbidly obese patients.

Methods: We looked at the evidence by retrospectively analyzing the data from a single surgeon practice from June 2010 to January 2015.

Results: June 2010 – Jan 2015, 212 LSGs vs 244 LRYGBs performed.

65 (32%) of LSGs & 118 (48%) of the LRYGBs had T2DM

The mean age, sex, weight, BMI and profile of T2DM treatment preoperatively -- similar in both groups.

In 2 years, the EWL & T2DM (70% vs 40%) remission in LRYGB > LSGs.

Conclusion: LSG can be used appropriately to promote weight loss and reverse or slow down the progress of T2DM in our patient practice.

Key statement: In complex super - obese obesity, LSG can be used as a surgical tool to promote weight loss and improve comorbidities allowing patients to opt for further intervention if need be later on in life.

P31

EVALUATING THE EFFECTIVENESS OF STANDARD OPERATION NOTE PROFORMAS FOR LAPAROSCOPIC CHOLECYSTECTOMIES IN A TERTIARY CENTRE

Presenter: T Bhuvanakrishna
Author(s): T Bhuvanakrishna, A Visan
Institution: Southampton General Hospital, United Kingdom

Aims: Laparoscopic cholecystectomy is a commonly performed minimally invasive surgical procedure. It can have high complication rates. Therefore, clear operative notes are important in the event of post-operative complications. This audit evaluates the effectiveness of introducing operation note proformas in a tertiary centre, based on the Royal College of Surgeons guidelines.

Methods: This study audited the operation notes of all laparoscopic cholecsytectomies undertaken at a tertiary centre from July – August 2018. All notes were evaluated against the 18 standards issued by Royal College of Surgeons (RCS) guidelines, which have already been incorporated into the standard operation note proforma used at the centre.

Results: Of the 70 operation notes evaluated, 15 out of the 18 standards issued by RCS were 100% compliant. The non-compliant standards included names of the operating surgeon and assistant (83% compliant), name of the theatre anaesthetist (98% compliant) and recorded operative diagnosis (70% compliant).

Conclusion: The pre-existing standard operation note proforma incorporating all 18 standards as described on the RCS guidelines ensure medico-legally robust operation notes. Despite the presence and usage of this standard proforma, this audit demonstrates that the operative notes for laparoscopic cholecystectomies do not fully comply with the set standards.

Key statement: Standard operation note proformas have been created to ensure medico-legally robust operation notes. This also ensures consistent quality of operation notes and facilitates clear communication with other healthcare professionals. Therefore, we will aim to identify methods to improve operation notes with a view for re-evaluation at the tertiary centre.

P32

SETTING UP ROBOTIC HPB PROGRAM: COVENTRY EXPERIENCE

Presenter: N Ravichandran
Author(s): M Ali, N Ravichandran, S Khan, G Marangoni, J Ahmad
Institution: University Hospitals Coventry and Warwickshire, Coventry, United Kingdom

Aims: We share our experience of developing Robotic HPB program at our hospital where daVinci® Si Robot (Intuitive® California) was being used for urological and colorectal resections since 2014. HPB surgeons developed interest in Robotic surgery, went through structured training and started the program in April 2018.

Methods: Feasibility, scope and rationale of Robotic HPB surgery were discussed with colleagues and management. New interventional procedure approval was formally obtained and the program started with two consultants working on every major resection. All patients were counselled pre-operatively of the new procedure status and given information leaflets.

Results: Each surgeon was required to undergo in excess of 30-hour console training, followed by online assessments and in-house training session with Intuitive® representative. This was followed by hands-on wet lab practice at European training center. Each surgeon performed 11 cholecystectomies as training cases before proceeding to more complex procedures.

Conclusion: Setting up a new service requires perseverance. Robotic HPB program is feasible and rewarding in the NHS. To date (September 2018) 39 robotic procedures have been performed, including 14 resections (6 distal pancreatectomy, 2 Whipple's, 5 liver resections, 2 gall bladder cancer resections) with good results.

Key statement: Robotic surgery avoids a major laparotomy and has advantages such as 3D vision, tremor filtration and better articulation of instruments. Case observations were organised at high volume European centers before complex resections were performed and appropriately experienced Proctors were present for major resections and for initial training cholecystectomies.

P33

EFFECT ON SHORT-TERM OUTCOMES IN ELECTIVE COLORECTAL SURGERY AFTER OPTIMISING THE ENHANCED RECOVERY PATHWAY; A TERTIARY CARE UNIVERSITY HOSPITAL EXPERIENCE

Presenter: E Tokidis
Author(s): E Tokidis, T Petropoulou, S Amin
Institution: Sheffield Teaching Hospitals NHS Trust, United Kingdom

Aims: To present our short-term elective colorectal surgery outcomes (open, laparoscopic and robotic) after revising and optimising the colorectal Enhanced Recovery programme (ERP) in Sheffield Teaching Hospitals NHS Trust.

Methods: A prospectively collected database was analysed, over a period of 5 months. A standard protocol was set up and ERP instructions were given via an optional standardised operation note. ERP compliance elements, length of stay (LoS) and complication rate were our primary outcomes.

Results: 101 cases were analysed (24 open, 67 laparoscopic attempted, 10 robotic). Median age and BMI were 64 and 26.3 respectively. 77% of operation notes were standardised and those patients achieved higher ERP compliance. The overall median LoS was 6 days and serious complications were reduced to 8%.

Conclusion: As shown in our analysis, the implementation and adherence to a standardised ERAS protocol in colorectal surgery can lead to lower complication rates and reduced length of stay.

Key statement: Compliance to ERAS is staff dependent and requires engagement of the multi-disciplinary team. However, if applied, it leads to improved short-term outcomes in elective colorectal patients.

P34

ROBOTIC HPB SURGERY: THE COVENTRY EXPERIENCE

Presenter: N Ravichandran
Author(s): N Ravichandran, M Ali, S Khan, G Marangoni, J Ahmad
Institution: University Hospitals Coventry and Warwickshire, Coventry, United Kingdom

Aims: Robotic surgery offers the advantages of a minimally invasive operation to the patients who are deemed extremely challenging for standard laparoscopic approach. Robotic HPB surgery is new to the NHS and is challenging to establish due to training and financial implications. We share our initial experience from Coventry.

Methods: New interventional procedure approval was sought and HPB surgeons underwent structured training organised by Intuitive®. The program started in April 2018 with 11 robotic cholecystectomies as training cases for each surgeon followed by major resections. To date HPB team has performed 39 Robotic cases including 13 resections.

Results: 2 radical cholecystectomies, 3 atypical liver resections, 6 distal pancreatico-splenectomies and 2 pancreatico-duodenectomies were performed. Mean operative times were 285, 212, 210 and 540 minutes respectively. Median post-operative stay was 3 days. Two patients had grade 3a (Clavien-Dindo) complications and one amongst them required re-admission within 30 days.

Conclusion: Robotic HPB surgery is well established and is common practice in many Western countries. UK has been slow to adopt this promising approach mostly due to lack of financial, access and training opportunities. However, setting up a HPB Robotic program in the NHS is feasible and rewarding.

Key statement: Robotic surgery facilitates enhanced recovery and early discharge which would expedite commencement of adjuvant therapy. It is safe, effective and has comparable oncological outcomes to open surgery. One of the two complications we reported was due to pancreatitis of the remnant pancreas.

P35

PROSPECTIVE COMPARATIVE COHORT STUDY COMPARING MORPHINE PATIENT CONTROLLED ANALGESIA WITH COMBINED OXYCODONE-NALOXONE (TARGINACT) FOR POSTOPERATIVE PAIN FOLLOWING LAPAROSCOPIC COLORECTAL RESECTIONS

Presenter: K Hashmi
Author(s): K Hashmi, S Ul-Hassan, M Jonas-Obichere
Institution: Luton & Dunstable University Hospital, Luton, United Kingdom

Aims: This study compares a morphine PCA with Targinact for postoperative analgesia following laparoscopic colorectal resections in our patient population. Primary end points were length of stay, and return of gut function determined by time to flatus and first bowel movement. Secondary endpoints were complication rates, adverse events, and compliance.

Methods: A prospective comparative cohort study included consecutive laparoscopic colorectal resections by a single surgeon over 3 years. A protocol was agreed. Daily pain scores, analgesia usage, time to flatus and first bowel movement, hospital stay, and complications were recorded prospectively. Data was analysed using SPSS version 22.

Results: Sixty patients participated. Targinact group had significantly less pain on day 1 and 2, better tolerated diet at day 3 and 4, and had significantly higher rates of flatus on day 3 and 4. There was no difference for ileus, time to bowel movement, additional analgesia requirements, or hospital stay.

Conclusion: Targinact appears to be effective postoperative analgesia, with no adverse effects. Return to normal gut function may be earlier with Targinact versus morphine PCA. Compliance was 100% with the easily administered tablet formulation. These results support the use of Targinact for postoperative analgesia, and form a basis for further studies.

Key statement: Postoperative ileus may complicate bowel surgery, causing discomfort and prolonged hospital stay. Opioid analgesia impairs gut motility and may cause ileus. Targinact appears to be an ideal analgesic agent which is highly effective with minimal adverse effects on bowel function hence, appears to enhance recovery of laparoscopic bowel resection patients.

P36

LAPAROSCOPIC VERSUS OPEN CYTOREDUCTIVE SURGERY WITH HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY FOR PERFORATED LOW GRADE APPENDICEAL MUCINOUS NEOPLASMS

Presenter: H Abudeeb
Author(s): H Abudeeb, C Selvasekar, M Wilson, S O'Dwyer, O Aziz
Institution: The Christie NHS Trust, Manchester, United Kingdom

Aims: Cytoreductive surgery with HIPEC (CRS/HIPEC) is an established treatment for PMP resulting from LAMN II. In selected patients CRS/HIPEC can be performed laparoscopically (L-CRS/HIPEC), however the outcomes are unclear. This study reports findings from a L-CRS/HIPEC group and compares outcomes to open surgery (O-CRS/HIPEC).

Methods: The study group underwent L-CRS/HIPEC for LAMN II lesions and were compared to a group of O-CRS/HIPEC with low volume PMP. The two groups were compared with regards to operative time, critical care unit (CCU) admission, and length of stay.

Results: Between 2003-2017, 55 L-CRS/HIPEC vs 290-CRS/HIPEC. Median operative time 8.8 for LS versus 7.3 hrs for OS. CCU admission rate 97% for O-CRS/HIPEC versus 56%L-CRS/HIPEC. Median length of hospital stays 6 days L-CRS/HIPEC versus 10 days O-CRS/HIPEC. No recurrence observed over 38 months follow-up.

Conclusion: Laparoscopic CRS/HIPEC can be safely performed in patients with LAMN II and has significant benefits with regards to CCU admission and length of stay, whilst maintaining equivalent medium-term outcomes.

Key statement: Laparoscopic CRS/HIPEC can be safely performed in patients with LAMN II.

P37

THE YIELD OF COLO-RECTAL CANCER AMONG FAST TRACK PATIENTS WITH IRON DEFICIENCY ANAEMIA. SERVICE EVALUATION AND MEASUREMENT OF DIAGNOSTIC YIELD

Presenter: T Majeed
Author(s): T Majeed, S Sakpal, P Chitsabesan
Institution: York Hospital, United Kingdom

Aims: To assess the appropriateness of fast track (FT) referrals for Iron deficiency anemia (IDA) from primary care, by evaluating them against the guidelines set by Department of Health and to assess the diagnostic yield of the screening service and factors affecting it.

Methods: Retrospective clinical review over 2 years (2016-18). Data was extracted from electronic patient database. Diagnostic yield was measured and specificity, sensitivity, number needed to test and positive predictive value were determined by using relevant statistical tests. Appropriateness of referrals was checked against guidelines set by ACPGBI, MOH and NICE.

Results: 950(total 4177) patients with anaemia, divided into groups (asymptomatic, bowels symptoms, generalize symptoms and PR bleeding). 96 (70 GI and 26 non GI) with cancer with overall yield of 10.10% with highest yield in symptomatic group(O.R 2.032 and PPV of 15.45). 41.7% referrals were found inappropriate or incomplete.

Conclusion: FT diagnostic criteria for anaemia patients should be revised to increase the diagnostic yield of the screening service. Asymptomatic patients should have Iron therapy, screened further and put straight to scans rather than scopes. High incidence of non-curative GI and non GI cancers warrants Multi-disciplinary common anaemia referral pathway.

Key statement: High yield in symptomatic patients means they should be prioritized. Highest presentation is of asymptomatic patients but with low yield (comparable to routine clinics), depicts that they need either further evaluation (FOB), trial of iron therapy (56.6% did not have) or straight to scan rather than scopes (42% were diagnosed).

P38

LAPAROSCOPIC RESECTION OF T4 COLORECTAL CANCER IS A SAFE AND FEASIBLE APPROACH

Presenter: CY Tan
Author(s): CY Tan, A Sivakkolunthu, K Aryal
Institution: James Paget University Hospital, Great Yarmouth, United Kingdom

Aims: Laparoscopic resection of colorectal cancer (CRC) had become standard practice due to its favorable oncological outcome and perioperative morbidities. However, experts still regard T4 CRC as an absolute contraindication to laparoscopic resection. The aim of this paper is to compare the outcomes of T4 CRC undergoing laparoscopic and open approach.

Methods: Between April 2014 and March 2018, histologically proven T4 CRCs that were resected on both elective and emergency basis were included in this study. Primary outcome is the resection margins (R0). Secondary outcomes are 90 days mortality rate, length of hospital stay (LOS) and post-operative complications.

Results: 97 cases were identified during study period. 3 cases (3.1%) converted to open. R0 rate was higher in laparoscopic group but not significant (83.7% vs 68.8%, p=0.099). Open group had significantly higher 90-days mortality (14.6% vs 2%, p=0.0307), LOS (20.6 vs 11.6, p=0.003759) and post-op complications (26 vs 10, p=0.00058).

Conclusion: Laparoscopic resection of T4 CRCs appeared to have significant benefits in lower mortality rates, LOS and post-op complications among our study population. R0 resection rate is higher in laparoscopic group but the result is not significant. Our results showed that it's feasible to perform laparoscopic resection in T4 CRCs.

Key statement: Our paper had shown that laparoscopic resection of T4 CRCs appears to be a feasible and safe approach with low conversion to open rate (3.1%). This approach still needs to be applied with cautions. Future studies should focus on identifying factors that favour this approach to improve outcomes.

P39

COMPARING OUTCOMES OF DIFFERENT GRADES OF SURGEONS PERFORMING LAPAROSCOPIC AND OPEN APPENDICECTOMIES AT A SINGLE CENTRE OVER A TEN-MONTH PERIOD

Presenter: A Talbot
Author(s): A Talbot, P Asaad, N Iqbal
Institution: Royal Albert Edward Infirmary, Wigan, United Kingdom

Aims: Assess whether laparoscopic appendicectomies (LA) are a superior option to open appendicectomies (OA).Specifically, comparing the time taken, complication rates and whether it is more appropriate to perform an LA overnight, as opposed to OA. Finally, to find out how a range of outcomes differs between different grades of surgeon.

Methods: An information request was sent to the clinical coding department to derive patient identification numbers for all appendicectomies over a ten-month period (180 total surgeries). These numbers were then inputted into the hospital information system where the electronic operation note is present, and specific outcomes were derived and analysed.

Results: 68% of operations were OA and 32% LA. Mean LA times for consultants, SAS and SpR were 88.4, 78 and 92 minutes respectively and OA 63, 57 and 59 minutes respectively. Their respective conversion rates were 27%, 16% and 0%. OA had a complication rate of 16.3%, LA was 10.2%.

Conclusion: OA are performed more than LA. SpR doctors had the slowest completion times for LA but the lowest conversion rates. SAS doctors had the fastest completion times for LA and OA but higher conversion. LA takes longer than OA but has lower complication rates; key factors when performing at night.

Key statement: Laparoscopic appendicectomies require more surgeon-hours and have the potential to be converted to open, however the rates of complications and serious complications are significantly lower.

P40

ANASTOMOTIC LEAKS IN MALIGNANT COLORECTAL RESECTIONS: A SINGLE CENTRE EXPERIENCE

Presenter: MA Gok
Author(s): MA Gok, CJ Smart, SJ Ward, MM Sadat, UA Khan
Institution: East Cheshire NHS Trust, Macclesfield, United Kingdom

Aims: Anastomotic leaks is a serious complication that is reported to occur in < 10% of restorativecolorectal surgery. Anastomotic leaks is believed to adversely affect long term survival. The aim of the study is to assess the management of colorectal anastomotic leaks at a single centre.

Methods: A retrospective study was carried out at East Cheshire NHS Trust from November 2008 to August 2018. Patient demography & and post-operative features were collected for malignant colorectal resections with anastomotic "leaks", and "non-leaks" were recruited as controls.

Results:

	Leaks (n=48)	Non Leaks (n=964)	p value
Time to leak (days)	7		
Type A antibiotics	20		
Type B drainage	6		
Type C surgery	22		
Op time (mins)	155.2	161	NS
LOS (days)	13	9	<0.0005
Survival rates (%)			
1st year	84.9	87.7	Logrank p=NS
5th year	68.3	67.8	

Conclusion: Anastomotic leaks occurred in 4.7 %, with surgical intervention in 2.2 %. Median post-op time to leak was 7 days. Anastomotic leaks did not adversely affect patient survival (Logrank p = NS). Diversion stoma reduces the rate & severity of anastomotic leakage. Early diagnosis is crucial in the management of anastomotic leaks.

Key statement: Early diagnosis is crucial in the management of anastomotic leaks.

P41

QOL FOLLOWING LAPAROSCOPIC MESH VENTRAL RECTOPEXY (LVR) AT A SINGLE CENTRE

Presenter: MA Gok
Author(s): MA Gok, MM Sadat, UA Khan
Institution: East Cheshire NHS Trust, Macclesfield, United Kingdom

Aims: Rectal prolapse is an important cause of obstructed defecation. LVR has evolved as a treatment modality for rectal prolapse. LVR produced good anatomic results, low recurrence rates, few complications, improvements of both constipation & faecal incontinence. Aim of the study is to assess the outcomes of LVR at a single centre.

Methods: A retrospective study was carried out on all LVR carried out since 2012 at East Cheshire NHS Trust. Pre-operative & post-operative QOL was assessed using the East Cheshire "Pelvic Floor Unit QOL" survey (a modified Wexner faecal incontinence grading system).

Results:

	Pre op (n = 65)	Post op (n = 65)	p value
Peri-anal lump	36	1	< 0.05
Tenesmus	53	2	< 0.05
Incomplete defecation	27	1	< 0.05
Prolonged toilet	23	1	< 0.05
Rectal pain	9	1	< 0.05
Digitation	33	2	< 0.05
Faecal incontinence	27	10	< 0.05
Constipation	25	12	NS

Conclusion: LVR is a safe procedure with low mortality rate, shorter hospital stay and few complications. Outcomes of surgery as measured by East Cheshire Pelvic Flow QOL survey showed improvement of obstructive defecation symptoms.

Key statement: Laparoscopic ventral rectopexy is a safe procedure with low mortality rate.

P42

FIRST NATIONAL TRAINING INITIATIVE FOR TRANSANAL TOTAL MESORECTAL EXCISION (TATME): UK EXPERIENCE

Presenter: S El Falaha
Author(s): N Francis[1], S El Falaha[1], M Penna[2], F Carter[1], R Hompes[3]
Institution: [1]Yeovil District Hospital, United Kingdom. [2]Imperial College, London, United Kingdom [3]Academic Medical Center Amsterdam, Netherlands

Aims: Transanal total mesorectal excision (TaTME) has attracted world-wide interest but technical challenges have been acknowledged by early adopters. The aim of this study was to report on the feasibility and development of the first national pilot training initiative to ensure its safe introduction and wider adoptions in the UK.

Methods: A UK national pilot training programme has been was established and consisted of: (i) Set up stage including securing funding and endorsement of the programme; (ii) Selection of pilot sites and (iii) Formal proctorship programme with quality assurance mechanism to ensure safe implementation, monitor training and measure outcomes.

Results: A collaborative training initiative launched in in the UK in 2017 supported by a cohesive multi-modal training curriculum. 10 consultant surgeons from five pilot centres were selected and underwent formal proctorship programme. Specifically designed assessment tools were applied to monitor and appraise training of 25 TaTME cases.

Conclusion: A multi-modal training programme for transanal total mesorectal excision that is competency-based is feasible and achievable to support safe introduction of this technique in the UK.

Key statement: Evidence from previous surgical training initiatives suggests that a structured proctorship programme can shorten the learning curve andreduce complications. This study is reporting on the first national training initiative to support training for Transanal total mesorectal excision in the UK.

P43

EMERGENCY LAPAROSCOPIC COLORECTAL RESECTIONS: SHOULD THIS BE THE PREFERRED APPROACH?

Presenter: A Jha
Author(s): D Garg, M Jha, A Jha
Institution: James Cook University Hospital, Middlesborough, United Kingdom

Aims: Colorectal pathology accounts for one third of all emergency admissions and 30% of patients with colorectal cancer present as emergency. We plan to evaluate the laparoscopic colorectal resections in the emergency setting and can the benefits of elective colorectal resection be translated into the emergency setting.

Methods: Retrospective review of non randomised colorectal resections carried out in the emergency setting over a 8 year period. Data obtained from patient notes, theatre records and pathology database.155 patient had an emergency laparoscopic colorectal resection by a single surgeon. The laparoscopic cohort were standard multiport surgery or single port surgery.

Results: Average age was 59 and ASA grade 2. Average length of stay 7 days, morbidity 30%, anastomotic leak rate 1.7% and mortality 2.6%. Operating time 164 minutes. Complication rates of post op ileus 3.5%, respiratory 7%, wound infection 3%, intrabdominal collection 4%, return to theatre 3%.

Conclusion: Laparoscopic colorectal resections in the emergency setting is a safe and feasible option for a variety of pathologies (colorectal cancers, IBD, diverticular disease) with improved patient outcomes, reduced post op stay and mortality. The results are comparable to elective colorectal resection data.

Key statement: Emergency colorectal resections are generally carried out on sickest of patients. Majority of these resections can now be carried out by Laparoscopic approach resulting in improvement of the post-operative results in these high risk patients. This should now be considered the preferred approach and offered to all suitable patients.

P44

RATES AND PREDICTIVE FACTORS FOR LAPAROSCOPIC SUBTOTAL CHOLECYSTECTOMY IN AN HPB UNIT

Presenter: A Farrugia
Author(s): A Farrugia, N Ravichandran, M Ali, J Ahmad, G Marangoni
Institution: University Hospitals Coventry and Warwickshire, Coventry, United Kingdom

Aims: Laparoscopic subtotal cholecystectomies (LSC) are occasionally performed for difficult gallbladder surgery. The aim of this study was to determine the rate of subtotal cholecystectomy and their outcomes i.e. readmission, reoperation, morbidity rates in an HPB unit and whether any predictive factors could be found.

Methods: A 5-year review of laparoscopic cholecystectomies (LC) performed by HPB team at a tertiary centre. Demographic, operative and postoperative data were identified for 102 LSC patients. A randomised group (using Research Randomizer) of 102 LC had the same data recorded for comparison. Significance level was set at $p<0.05$.

Result: 1613 patients underwent LC, of which 102(6.3%) had LSC.

Procedure	LSC	LC
Complications	13(12.7%)	5(4.9%)
Bile leak	4(3.9%)	1(0.98%)
Collection (with drainage)	1(0.98%)	0
Other	7(6.86%)	4(3.92%)

LSC more likely with previous cholecystitis, thickened gallbladder wall on imaging and previous ERCP ($p<0.01$).

Conclusion: Subtotal cholecystectomy is a safe procedure and can avoid bile duct injury or conversion to open surgery in difficult circumstances. Complications were comparable between the two groups although the LSC group had higher median length of stay (2 days vs 0 days) and slightly higher readmission rate (8.8% vs 3.92%).

Key statement: Patients who had previous episodes of cholecystitis, thickened gallbladder wall and had previous ERCPs were more likely to require a subtotal cholecystectomy. There was one bile duct injury in the LC group which may be a reflection of the fact that we need to perform more LSC in difficult cases.

P45

SUBJECTIVE OUTCOMES FOR PATIENTS WITH TYPICAL AND ATYPICAL GORD SYMPTOMS UNDERGOING LAPAROSCOPIC TOUPET FUNDOPLICATION

Presenter: C Izard
Author(s): C Izard, L Navaratne, A Isla
Institution: Northwick Park Hospital, London, United Kingdom

Aims: Gastro-oesophageal reflux disease (GORD) can present with typical (heartburn and indigestion), atypical (cough and dysphonia) or mixed symptoms. There is little evidence quantifying which symptom complexes respond to Laparoscopic Toupet Fundoplication (LTF). This study aims to investigate how typical versus atypical symptoms responded to LTF.

Methods: A prospective observational study of 100 patients undergoing LTF between February 2015 and May 2018 was conducted. All patients completed pre and post-operative triple assessment questionnaires and were allocated to groups based on their symptoms: typical, mixed or atypical. Median follow up time was 7.65 months post-operatively.

Results: The median % reduction in RSI in typical, mixed and atypical groups was 84.1%, 71.9% and 66.7% respectively ($p<0.05$). The proportion of patients with a reduction in RSI >50% was 30/32, 33/45 and 16/23 respectively ($p<0.05$). The median % reduction in VHI was 100, 88.75 and 50 respectively ($p<0.05$).

Conclusion: Despite similar pre-operative investigation findings, patients with predominantly typical symptoms when compared with mixed or atypical groups, tend to respond better across all three questionnaires (reflux, swallowing and voice) to LTF. Patients with predominantly atypical symptoms report less improvement in their atypical symptoms when compared to patients with typical symptoms.

Key statement: The type of GORD symptoms may impact on the success of LTF. The type of symptom complex may be able to predict which patients may have better outcomes and which symptoms in particular may improve. This information can be used to counsel patients prior to surgery and help manage expectations.

P46

PRE-OPERATIVE CLINICAL JAUNDICE DOES NOT INCREASE COMPLICATION RATE IN LAPAROSCOPIC COMMON BILE DUCT EXPLORATION (LCBDE)

Presenter: L Navaratne
Author(s): L Navaratne, C Izard, A Isla
Institution: Northwick Park Hospital, London, United Kingdom

Aims: Jaundice with or without cholangitis was a feature in one-fifth of the presentations in a recently published series of over four thousand laparoscopic cholecystectomies. The aim of this paper is to determine whether the presence of clinical jaundice at the time of LCBDE increases the complication rate of this procedure.

Methods: 382 patients underwent LCBDE between February 1998 and September 2018. A pre-operative bilirubin level of 42 µmol/L was used as a biochemical threshold to identify patients with jaundice at the time of their operation. Outcome measures were 30-day in hospital mortality, post-operative morbidity and post-operative length of hospital stay.

Results: 129 patients (33.8%) were included in the jaundice group and 253 patients (66.2%) in the non-jaundiced group. There was no statistical difference in mortality, post-operative morbidity or length of hospital stay between the two groups ($p=0.2645$, $p=0.0509$ and $p=0.7103$ respectively).

Conclusion: Single stage management of choledocholithiasis and its acute complications is becoming more widely available and the presence of jaundice does not appear to increase the incidence of post-operative mortality, complications or length of post-operative stay.

Key statement: Laparoscopic common bile duct exploration appears to be a safe procedure even in the presence of jaundice and in our opinion should be considered the first line treatment of common bile duct stones when the gallbladder is in situ.

P47

WELL LEG COMPARTMENT SYNDROME IN ROBOTIC SURGERY – A CASE REPORT AND MULTIMODAL APPROACH TO MANAGEMENT

Presenter: A Macleod
Author(s): A Macleod, WS Ngu, G O'Dair, S Holtham, G Farook
Institution: Sunderland Royal Hospital, Sunderland, United Kingdom

Aims: Robotic surgery is becoming increasingly established in colorectal surgery. Recently, we experienced our first case of Well Leg Compartment Syndrome (WLCS) following robotic anterior resection. WLCS is compartment syndrome in the absence of trauma; it is a rare but recognized complication. We have created a multimodal approach to managing this.

Methods: Data was analyzed from our prospective robotic colorectal database. Literature review was performed of WLCS in laparoscopic or robotic surgery. Management strategies were discussed at departmental meetings and a pathway was formed.

Results: 92 robotic procedures were performed from July 2015-September 2019. Our case was a muscular 58-year old male (BMI:47.6) who underwent ultra-low anterior resection for rectal adenocarcinoma in modified Lloyd-Davies position. The operation took 8-hours with 15 minute breaks every 4 hours. In recovery, patient reported severe leg pain and underwent prompt fasciotomies.

Conclusion: Patients undergoing robotic surgery should have their legs positioned supine for 15 minutes every 3-hours; increased to every 2-hours for high-risk patients. "High risk" includes muscular patients, high BMI or patients with cardiac/respiratory compromise. Only intermittent pneumatic compression devices are used intra-operatively and replaced post-operatively with compression stockings.

Key statement: WLCS is a rare but serious complication of robotic surgery. All patients with lower limb pain after robotic surgery should be assumed to have WLCS and assessed promptly. We have identified risk factors and developed management strategies to reduce the risk of this in our patients.

P48

LAPAROSCOPIC EXTENDED RIGHT HEMICOLECTOMY AND LAPAROSCOPIC LEFT HEMICOLECTOMY FOR DISTAL TRANSVERSE AND PROXIMAL DESCENDING COLON CANCERS

Presenter: SY Choo
Author(s): SY Choo, E Xing, A Ghosh, J Nunoo-Mensah, A Haji
Institution: Kings College Hospital, London, United Kingdom

Aims: The aim of this study was to compare Laparoscopic Extended Right Hemicolectomy (LERH) and Laparoscopic Left Hemicolectomy (LLH) for the treatment of cancers in the distal transverse and proximal descending colon.

Methods: Data was acquired retrospectively from a single establishment over 9 years, from patients on the Enhanced Recovery After Surgery (ERAS) Pathway. 97 patients underwent either an Extended Right Hemicolectomy or a Left Hemicolectomy. After excluding benign conditions and tumours originating from other locations, 24 LERH and 15 LLH were isolated.

Results: Mean procedure times for LLH and LERH were 269 and 230 minutes respectively (P=0.045). Post-operative anastomotic leak rates for LERH were 12.5% and 0% for LLH. Re-operative rates for LERH were 16.7% and 6.7% for LLH. Overall survival rates for LERH were 83.3% and 86.7% for LLH (P=0.786).

Conclusion: Operating times for LLH were significantly longer than LERH, this could be due to the increasing technical challenge that the surgery poses. In our study, LLH had better post-operative outcomes compared to LERH, though there were no significant differences to the overall survival rates.

Key statement: Laparoscopic Extended Right Hemicolectomy (LERH) and Laparoscopic Left Hemicolectomy (LLH) produced similar oncological outcomes for distal transverse and proximal descending colon cancers. LLH may be associated with fewer post-operative complications compared to LERH.

P49

ROLE OF ROBOTIC RECTAL RESECTIONS IN LOCALLY ADVANCED CANCERS – SIX YEAR EXPERIENCE AT A TERTIARY CANCER CENTRE

Presenter: CN Khanna
Author(s): S Wijerathne, CN Khanna, C Selvasekar, O Aziz, S O'Dwyer
Institution: The Christie NHS Foundation Trust, Manchester, United Kingdom

Aims: Laparoscopic rectal cancer surgery has not shown benefits compared to open surgery. It is believed robotics may provide improved outcomes. We analysed the short and medium term outcomes of the robotic rectal resections over a 6 year period (2012-18)

Methods: Data collected from a prospective data base, were analysed. Procedures included standard and extended rectal cancer resections, initially performed with the da Vinci S and later with Si systems.

Results: 76 procedures (54% males). Ages 31-82 years, mean 61.9. BMI 17-42.4, mean 26.

Mean hospital stay 8 days.

63 rectal cancers, 70.9% had chemoradiotherapy.

41 Abdominoperineal excisions, 16 anterior resections, 13 posterior exenterations performed.
77.4% R0 resections with no mortality.

15.8% T4 and 50.8% T3 stages. 11 developed local recurrence.

Conclusion: We have demonstrated, in locally advanced rectal cancer, robotic rectal resections can be safe and effective with acceptable short and medium term outcomes.

Key statement: Case selection and expertise contribute to safe and effective robotic rectal surgery.

P50

PROSPECTIVE, MULTICENTRE COHORT STUDY OF WOMEN WITH ACUTE RIGHT ILIAC FOSSA PAIN IN THE UK & EXTERNAL VALIDATION OF RISK SCORES

Presenter: J Clements
Author(s): RIFT Study Group
Institution: West Midlands Research Collaborative, Birmingham, United Kingdom

Aims: The diagnosis of appendicitis remains challenging, particularly in women. We aimed to determine whether existing risk prediction models can identify patients with acute right iliac fossa (RIF) pain who are at low risk of appendicitis

Methods: A systematic search identified all existing appendicitis risk prediction models. Models were validated in a multicentre prospective observational cohort study in the UK. Consecutive patients aged 16-45 years with RIF pain were included between March-June 2017. The primary outcome was to determine best achievable model specificity (failure rate <5%)

Results: 5345 patients were included across 154 hospitals (67.6% female). Women were less likely to undergo surgery than men (32.0% versus 59.8%, RR 0.53 [95% CI 0.50-0.57], p<0.001).

Conclusion: Of 15 validated risk prediction models, the Adult Appendicitis Score achieved highest specificity in women. Women have a disproportionate burden of admission without surgery but have higher incidence of normal appendicectomy. We identified the best risk prediction model to support shared decision making and low risk stratification for appendicitis.

Key statement: Women have a disproportionate burden of admission without intervention and are subjected to high rates of normal appendicectomy. We identified the best risk prediction models to support shared decision making by identifying patients at low risk of appendicitis.

P51

THE USEFULNESS OF BIOCHEMICAL TESTING IN RADIOLOGICALLY CONFIRMED NON-PHEOCHROMOCYTOMAS: A CASE SERIES

Presenter: A Anton
Author(s): A Anton[1], P Sedman[2]
Institution: [1]Hull York Medical School, Hull, United Kingdom
[2]Castle Hill Hospital, Cottingham, United Kingdom

Aims: To review the need for 24-hour urine free catecholamines and plasma metanephrines testing in patients with benign adrenal masses confirmed on CT or MRI.

Methods: Retrospective analysis of case notes from 96 patients undergoing adrenalectomy for adrenal lesions between 2009 and 2018. Histologically, there were 25 cases of pheochromocytoma, 37 cases of benign adrenal tumours and 34 cases of primary malignant or metastatic lesions to the adrenal gland.

Results: In 73% of patients with benign tumours (the majority were adenomas) there was a positive CT/MRI diagnosis of incidentaloma and normal levels of urine catecholamines and/or plasma metanephrines. In 27% of patients, surgery was performed successfully based on radiological diagnosis alone, without the need for preoperative biochemical testing.

Conclusion: For benign asymptomatic adrenal tumours, confidently diagnosed on CT / MRI, biochemical testing may not be warranted preoperatively.

Key statement: In radiologically confirmed non-pheochromocytomas, biochemical testing with 24-hour urine catecholamines and/or plasma metanephrines may not be justified.

P52

FIRST EVER META-ANALYSIS OF RCTS EXPLORING ROLE OF SINGLE INCISION LAPAROSCOPIC SURGERY VERSUS CONVENTIONAL MULTIPORT LAPAROSCOPIC SURGERY FOR COLORECTAL RESECTIONS

Presenter: AA Sokker
Author(s): AA Sokker[1], MI Bhatti[1], MK Baig[2], P Sains[2], MS Sajid[2]
Institution: [1]Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust, Kings Lynn, United Kingdom
[2]Brighton and Sussex Hospitals NHS Trust, Brighton, United Kingdom

Aims: The objective of this article is to evaluate the surgical outcomes in patients undergoing single incision laparoscopic surgery (SILS) versus conventional multi-incision laparoscopic surgery (MILS) for colorectal resections

Methods: The data retrieved from the published randomized, controlled trials (RCTs) reporting outcomes in patients undergoing SILS versus MILS for colorectal resections were analysed using the principles of meta-analysis. The combined outcomes of dichotomous data were represented as risk ratio (RR) and continuous data was shown as standardized mean difference (SMD).

Results: Five RCTs on 525 patients reported the colorectal resections by SILS versus MILS. Operation time, length of in-patient stay,and lymph node harvesting were comparable. Furthermore, post-operative complications, post-operative mortality, surgical site infection rate, anastomotic leak rate, conversion rate and re-operation rate were also statistically similar.

Conclusion: SILS failed to demonstrate any superiority over MILS for colorectal resections in all post-operative surgical outcomes.

Key statement: Single Incision Laparoscopic Surgery has similar outcomes to Conventional Multiport Laparoscopic Surgery

P53

AN UPDATED META-ANALYSIS OF RANDOMIZED, CONTROLLED TRIALS REPORTING THE EFFECTIVENESS OF STAPLED HAEMORRHOIDOPEXY VERSUS TRANS-ANAL HAEMORRHOIDAL DE-ARTERIALIZATION FOR HAEMORRHOIDAL DISEASE

Presenter: MI Bhatti
Author(s): MI Bhatti[1], A Sokker[1], P Sains[2], M K Baig[2], M S Sajid[2]
Institution: [1]Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, Kings Lynn, United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, Brighton, United Kingdom

Aims: The objective of this article is to compare the role of stapled haemorrhoidopexy (SH) versus trans-anal haemorrhoidal de-arterialization (THD) for the management of haemorrhoidal disease

Methods: The data retrieved from published randomized, controlled trials (RCTs) reporting role of SH versus THD in the management of haemorrhoidal disease was analysed using the principles of meta-analysis. The summated outcome of continuous variables was expressed as standardized mean difference (SMD) and dichotomous data was presented in odds ratio (OR).

Results: Nine RCTs on 1041 patients with known haemorrhoidal disease of various grades underwent either THD or SH as per trial protocol. THD was associated with reduced post-operative pain (P=0.008) compared to SH. However, treatment success rate, complications, procedure time, and recurrence rates were similar. There was significant heterogeneity among included trials.

Conclusion: This study demonstrates that THD is equally effective but less painful procedure compared to SH

Key statement: Trans-anal Haemorrhoidal De-arterialization (THD) is equally effective but less painful procedure compared to Stapled Haemorrhoidectomy.

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DVDS

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B Mahendran, A Sale, M Coleman, R Kochupapy
University Hospitals Plymouth NHS Trust, United Kingdom

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L Onos, E Tokidis, M Hilmy, P Chitsabesan
York Teaching Hospitals NHS Trust, United Kingdom

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S Korambayil, S Wardle, S Small, P Jethwa, S Monkhouse
East Surrey Hospital, Redhill, United Kingdom

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C Gilbert[1], S Froghi[2], S Monkhouse[1], P Jethwa[1]
[1]Surrey and Sussex NHS Trust, Redhill, United Kingdom
[2]Royal Free Hospital, London, United Kingdom

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B Bereczky M.D., Ph.D., S Awad M.D., Ph.D., FRCS
C Neophytou M.D., MRCS, A Awan M.D., FRCS
Royal Derby Hospital, United Kingdom

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[1]North West Deanery, United Kingdom
[2]Manchester University NHS Foundation Trust, United Kingdom

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Addenbrookes Hospital, Cambridge University Hospitals NHS Foundation Trust, United Kingdom

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A Currie[1,2], S Thompson[3], P Devitt[3], T Bright[1], D Watson[1]
[1]Flinders University Department of Surgery,Flinders Medical Centre Adelaide, Australia.
[2]Western Sussex Hospitals NHS Trust, Chichester, United Kingdom
[3]Discipline of Surgery, University of Adelaide, Royal Adelaide Hospital Australia

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L Navaratne, H Ashrafian, P Lung, A Isla
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SK Kamarajah, J French, D Manas, R Charnley, S White
Department of Hepatobiliary, Pancreatic and Transplant Surgery
Academic Department of Surgery, Freeman Hospital, Newcastle
United Kingdom

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Postgraduate Institute of Medical Education and Research Chandigarh Chandigarh, India

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C West[1,2], K Erskine[3]
[1]Dorset County Hospital NHS Foundation Trust, Dorchester United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, United Kingdom
[3]Brighton and Sussex Universities NHS Trust, United Kingdom

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[1]Dorset County Hospital NHS Foundation Trust, Dorchester United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, Brighton United Kingdom
[3]Surrey and Sussex Healthcare NHS Trust, Redhill, United Kingdom

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C West[1,2], A Lam[3]
[1]Dorset County Hospital NHS Foundation Trust, Dorchester United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, Brighton United Kingdom
[3]Surrey and Sussex Healthcare NHS Trust, Redhill, United Kingdom

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Department of HPB Surgery, The Freeman Hospital
Newcastle Upon Tyne, United Kingdom

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Department of HPB Surgery, The Freeman Hospital
Newcastle Upon Tyne, United Kingdom

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Kingsmill Hospital, Mansfield, United Kingdom

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[1]Lister Hospital, Stevenage, United Kingdom
[2]Royal Free Hospital, London, United Kingdom

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[1]Diana Princess of Wales, Grimsby, United Kingdom
[2]Broomfield Hospital, Chelmsford, United Kingdom
[3]National Hospital of Sri Lanka, Colombo, Sri Lanka

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The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom

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[1]MIOT International Hospital, Chennai, India
[2]MIOT Pacific Hospital, Suva, Fiji

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[1]Ipswich School, United Kingdom
[2]Colchester Hospital, United Kingdom

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Beacon Hospital, Dublin, Ireland

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AA Dhahri[1], D Kumar[2], M Adeel Dhahri[1], A Rao[1], N Kirmani[1]
[1]The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom
[2]North Tees University Hospital, Stockton-on-Tees, United Kingdom

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AA Dhahri[1], D Kumar[2], A Rao[1], N Kirmani[1]
[1]The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom
[2]North Tees University Hospital, Stockton-on-Tees, United Kingdom

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A Farrugia, S Khan, N Williams, R Arasaradnam
University Hospitals of Coventry and Warwickshire, Coventry United Kingdom

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[1]University Hospitals of Morecombe Bay NHS Foundation Trust Barrow-in-Furness, United Kingdom
[2]Stepping Hill Hospital, Stockport, United Kingdom

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HJ Ng[1], A Nassar[2]
[1]NHS Greater Glasgow and Clyde, Glasgow, United Kingdom
[2]NHS Lanarkshire, Lanarkshire, United Kingdom

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AA Dhahri[1], M Hoff[2], F Hatem[1], MS Das[1], A Ahmed[1]
[1]The Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom
[2]Addenbrooke's Hospital, Cambridge, United Kingdom

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R Wee[1], A Atef[2], B Mahendran[1], B Amr[2]
[1]University Hospitals Plymouth NHS Trust, United Kingdom
[2]Royal Cornwall Hospitals Trust, Cornwall, United Kingdom

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JA Attard[1], R Seth[1], D Hariharan[2], EA Griffiths[3], RP Sutcliffe[1]
[1]Liver Unit, Queen Elizabeth Hospital, Birmingham, United Kingdom
[2]HPB unit, Royal London Hospital, United Kingdom
[3]General and Upper GI surgery unit, Queen Elizabeth Hospital Birmingham, United Kingdom

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D Subasinghe[1,2], A Priyantha[1]
[1]Gastrointestinal Surgical Unit, Colombo South Teaching Hospital Kalubowila, Colombo, Sri Lanka
[2]Department of Surgery, Faculty of Medicine, University of Colombo Colombo, Sri Lanka

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[1]Homerton University Hospital, London, United Kingdom
[2]Torbay District Hospital, Torquay, United Kingdom

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University Hospitals Coventry and Warwickshire, Coventry
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[1]Yeovil District Hospital, United Kingdom
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[1]Hull York Medical School, Hull, United Kingdom
[2]Castle Hill Hospital, Cottingham, United Kingdom

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[1]Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust
Kings Lynn, United Kingdom
[2]Brighton and Sussex Hospitals NHS Trust, Brighton, United Kingdom

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[1]Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
Kings Lynn, United Kingdom
[2]Brighton and Sussex University Hospitals NHS Trust, Brighton
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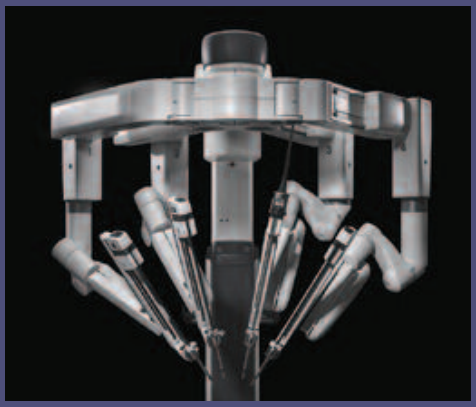

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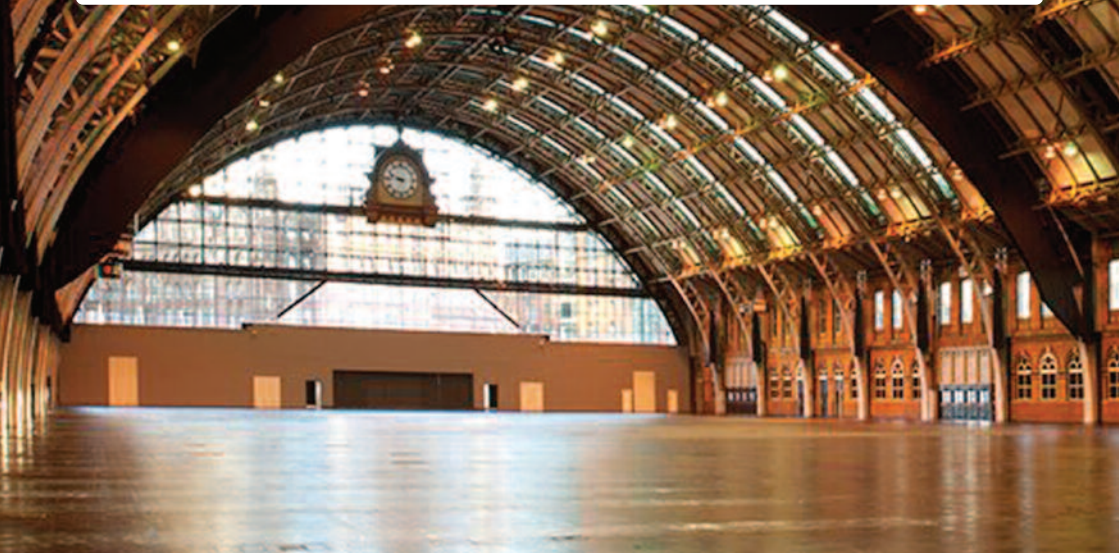

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