Free Paper 01 (11:55 – 12:05)

INTRACORPOREAL VERSUS EXTRACORPOREAL ILEOCOLIC ANASTOMOSIS AFTER LAPAROSCOPIC RIGHT HEMICOLECTOMY IN PATIENTS WITH RIGHT COLON CANCER: A PROSPECTIVE COMPARATIVE STUDY

Presenter: Mr MH Hassan

Author(s): Mr MH Hassan[1,2], Professor A Mourad[2], Professor AA Abdelshafy[2]

Institution: [1]Somerset NHS Foundation Trust, Yeovil, United Kingdom. [2]Ain Shams University Faculty of Medicine, Cairo, Egypt

Aims: This study aimed to evaluate the effects of ECA and ICA techniques on perioperative safety and postoperative recovery following LRH.

Methods: A prospective comparison was conducted involving 40 patients diagnosed with right-sided colon cancer between October 2022 and May 2024.

Results: Operative time was longer in the ECA group (246.91±44.97 min) than in the ICA group (215.94±36.20 min, P=0.025). Anastomosis time was longer in the ECA group (19.48±2.33 min) than ICA (15.35±1.17 min, P<0.01). Postoperative pain, was notably lower in the ICA group during the first 48 h. postoperative ileus was more prevalent in the ECA group (34.8 vs. 5.9%; P=0.03).The results indicate that LRH with ICA is associated with shorter operative times, quicker recovery of bowel function, earlier resumption of oral intake, reduced hospital stays, and lower postop.

Conclusion: The results indicate that LRH with ICA is associated with shorter operative times, quicker recovery of bowel function, earlier resumption of oral intake, reduced hospital stays, and lower postop.

Key statement: Anastomosis, colon cancer, extracorporeal, intracorporeal, laparoscopic right hemicolectomy.

Free Paper 02 (12:05 – 12:15)

TAILORED VERSUS FIXED BILIOPANCREATIC LIMB LENGTH IN REDO ONE-ANASTOMOSIS GASTRIC BYPASS AFTER SLEEVE GASTRECTOMY: A RETROSPECTIVE COHORT STUDY

Presenter: Mr A Aosmali

Author(s): Mr Ahmed Aosmali[1], Mr M Aboshiesha[2], Mr M Abdelglil[3]

Institution: [1]Royal Derby Hospital, United Kingdom. [2]General Surgery Department, Wirral University Teaching Hospital NHS Trust, United Kingdom. [3]Paediatric Surgery, Mansoura University Children's Hospital, Mansoura, Egypt

Aims: To compare tailored biliopancreatic limb length with a fixed 200 cm limb in patients undergoing revisional one-anastomosis gastric bypass after failed sleeve gastrectomy, focusing on weight loss, nutritional outcomes, gastrointestinal symptoms, complications and quality of life.

Methods: This retrospective cohort study included 200 patients undergoing revisional OAGB after sleeve gastrectomy. Patients were divided into tailored BPL and fixed BPL groups, with 100 patients in each. The fixed group had a 200 cm BPL, while the tailored group had BPL length set at 30% of

total measured small bowel length. Follow-up was at 6, 12 and 24 months. Outcomes included weight loss, BMI, micronutrient deficiency, biochemical markers, gastrointestinal symptoms, complications and quality of life.

Results: Weight loss significantly favoured the tailored group at all follow-up points. Mean %EWL at 6, 12 and 24 months was 38%, 71% and 92% in the tailored group versus 31%, 55% and 66% in the fixed group. Mean %TWL was also higher in the tailored group: 18%, 33% and 45% versus 14%, 25% and 33%. Micronutrient deficiency was lower in the tailored group, with better one-year biochemical markers and quality of life, although mild bile reflux was more frequent.

Conclusion: Tailoring the biliopancreatic limb to 30% of total small bowel length in revisional OAGB after sleeve gastrectomy was associated with greater weight loss, fewer micronutrient deficiencies, better biochemical outcomes and improved quality of life compared with a fixed 200 cm limb. This approach may offer a more individualised and balanced strategy for revisional bariatric surgery.

Key statement: In revisional one-anastomosis gastric bypass after failed sleeve gastrectomy, tailoring the biliopancreatic limb to 30% of total small bowel length was associated with superior weight loss, fewer micronutrient deficiencies, better one-year biochemical markers and improved quality of life compared with a fixed 200 cm limb. These findings suggest that an individualised limb-length strategy may provide a better balance between efficacy and nutritional safety in revisional bariatric surgery.

Free Paper 03 (12:15 – 12:25)

INDOCYANINE GREEN FLUORESCENCE ANGIOGRAPHY AND DEFUNCTIONING STOMA FORMATION COLORECTAL SURGERY: SYSTEMATIC REVIEW AND META-ANALYSIS RCTS WITH NARRATIVE SYNTHESIS OF DECISION-MAKING

Presenter: Miss N Widanage

Institution: George Eliot Hospital NHS Trust, Nuneaton, United Kingdom

Aims: Indocyanine green fluorescence angiography (ICG-FA) improves intraoperative assessment of bowel perfusion and has been associated with reduced anastomotic leak following colorectal surgery. Whether improved perfusion assessment influences surgeons' decisions to fashion a defunctioning stoma remains uncertain. We aimed to systematically evaluate the effect of ICG-FA on defunctioning stoma formation in colorectal surgery through a meta-analysis of randomised controlled trials (RCTs). Secondary objectives were to assess anastomotic leak, reoperation, and to explore how defunctioning stoma decisions were reported within published RCTs.

Methods: A systematic review was performed in accordance with PRISMA guidelines. MEDLINE, Embase, CENTRAL and ClinicalTrials.gov were searched for RCTs comparing ICG-FA with conventional visual assessment during elective colorectal resection with primary anastomosis. The primary outcome was defunctioning stoma formation. Secondary outcomes included anastomotic leak, reoperation and intraoperative change in transection level. Random-effects meta-analysis generated pooled risk ratios (RR) with 95% confidence intervals (CI). Statistical heterogeneity was assessed using the I^2 statistic. Risk of bias was evaluated using the Cochrane RoB 2 tool. Narrative synthesis assessed trial-specific approaches to diversion decision-making.

Results: Seven RCTs comprising 3,124 patients met the inclusion criteria. ICG-FA was not associated with a significant reduction in defunctioning stoma formation compared with standard assessment (RR 0.93, 95% CI 0.82–1.06; P=0.29; I^2=12%). However, ICG-FA significantly reduced anastomotic leak (RR 0.69, 95% CI 0.53–0.90; P=0.006; I^2=18%). Reoperation demonstrated a non-significant trend favouring ICG-FA (RR 0.78, 95% CI 0.60–1.02; P=0.07). Narrative synthesis

demonstrated that diversion decisions were predominantly protocol-driven and seldom modified following intraoperative fluorescence assessment.

Conclusion: ICG-FA significantly reduces anastomotic leak but does not appear to influence defunctioning stoma formation. Although perfusion assessment is improved, the decision to fashion a diverting stoma continues to depend on established clinical factors such as tumour height, neoadjuvant therapy and surgeon judgement. This suggests that the benefits of ICG-FA have yet to translate into changes in operative decision-making. Future randomised trials should evaluate whether incorporating perfusion findings into predefined diversion algorithms can safely reduce unnecessary stoma formation without compromising anastomotic safety.

Key statement: Improved perfusion assessment alone does not reduce defunctioning stoma formation. The next step is to determine whether perfusion-guided decision-making can safely reduce unnecessary stomas.

This review shifts the focus from anastomotic leak to surgical decision-making, demonstrating that improved perfusion assessment has yet to translate into fewer defunctioning stomas.

Free Paper 04 (12:25 – 12:35)

STANDARDISED LEVOBUPIVACAINE PORT-SITE AND INTRAPERITONEAL INFILTRATION IN DAY-CASE LAPAROSCOPIC CHOLECYSTECTOMY: A PROSPECTIVE COMPARATIVE STUDY OF POSTOPERATIVE PAIN

Presenter: Mr M Sakr

Authors: Mr M Sakr, Mr E Elshaikh, Mr K Toe

Institution: Milton Keynes University Hospital NHS Foundation Trust, United Kingdom

Aims: Postoperative pain remains a common barrier to same-day discharge after elective laparoscopic cholecystectomy. PROSPECT and BADS both recommend port-site infiltration and intraperitoneal local anaesthetic as part of multimodal, opioid-sparing analgesia, but in practice the dose, volume and technique vary between surgeons. We compared postoperative pain in patients receiving a standardised, weight-based levobupivacaine regime, combining port-site infiltration with intraperitoneal spray, against patients receiving our standard local anaesthetic practice. We also compared the groups at baseline and during surgery, and recorded intraoperative and discharge analgesia, so that the pain findings could be interpreted in context.

Methods: Prospective non-randomised comparative study of 50 elective day-case laparoscopic cholecystectomies, allocated by operating consultant (25 per group). Levobupivacaine 0.25% at 2mg/kg was diluted with 0.9% sodium chloride to 100mL. We gave 40mL as pre-incisional port-site infiltration (15mL per 10mm port, 5mL per 5mm port), including deep infiltration of the rectus sheath; 20mL sprayed over the gallbladder fossa using oxygen at 4L/min from the anaesthetic machine; and 40mL into all wounds at closure, again including the rectus sheath. Pneumoperitoneum was 10mmHg, raised to 12mmHg only if the view required. Pain (0–10 VAS/NRS) was recorded at 1, 4 and 24 hours.

Results: Groups were similar in age (53 vs 52 years), sex and ASA grade; bile spillage, consultant operating and antibiotic use did not differ (all p=1.00). Operations took longer in the intervention group

(73.4 vs 60.6 minutes) and mean BMI was higher in controls (31.8 vs 28.2kg/m²). Mean pain was lower with the standardised regime at 1 hour

(1.97 vs 4.44; −56%), 4 hours (1.93 vs 4.80; −60%) and 24 hours (2.23 vs 3.64; −39%). Pain data were group summaries, so differences are given as absolute and relative reductions. More intervention patients were discharged on paracetamol-ibuprofen (68% vs 12%, p=0.0001).

Conclusion: A standardised, weight-based levobupivacaine regime was associated with pain scores less than half those of standard practice at 1 and 4 hours after day-case laparoscopic cholecystectomy. The difference held even though these operations took longer and the patients received less intraoperative opioid. Discharge analgesia in this group was also closer to current guidance. We believe these results support a single local pathway for elective day-case

cholecystectomy: a set local anaesthetic dose with defined volumes at each site, low-pressure pneumoperitoneum, and regular paracetamol with an NSAID on discharge.

Key statement: Uncontrolled early pain is still a leading reason why a planned day-case cholecystectomy becomes an overnight stay. In our series, a simple weight-based levobupivacaine regime (2mg/kg diluted to 100mL; 15mL into each 10mm port and 5mL into each 5mm port including the rectus sheath, 20mL sprayed intraperitoneally, and 40mL into all wounds at closure) was associated with less than half the pain of standard practice at 1 and 4 hours. It adds under five minutes to the operation and uses nothing a day-surgery theatre does not already have.

Free Paper 05 (12:35 – 12:45)

INTRA AND POST-OPERATIVE OPIOID BURDEN IN BARIATRIC SURGERY: A COMPREHENSIVE COMPARISON OF ROBOTIC AND LAPAROSCOPIC APPROACHES ACROSS SEVEN OUTCOME DOMAINS

Presenter: Mr S Ramar

Author(s): Mr S Ramar, Mr K Bananis, Dr E Obale, Dr S Wijayaratne

Institution: King's College Hospital, London, United Kingdom

Aims: Intra and Post-operative opioid management in bariatric surgery remains a clinical challenge. Patients with severe obesity carry heightened risk of opioid-related respiratory complications, yet the influence of surgical approach on the full perioperative opioid trajectory — from theatre induction to 72-hour post-operative consumption — has not been comprehensively characterised under controlled anaesthetic conditions. Most published studies capture a single time point and fail to account for inter-provider analgesic variation, limiting the interpretability of between-group comparisons.

Methods: Single-centre retrospective cohort of 151 consecutive bariatric procedures performed at King's College Hospital (2024–2026) by five consultant surgeons under a standardised ERAS anaesthetic protocol delivered by a single anaesthetist, minimising inter-provider variability. Opioid administration was extracted from electronic records, converted to oral morphine equivalents, and separated into intraoperative and recovery phases using timestamped anaesthetic charts. Outcomes included intraoperative opioid use, post-operative OME (0–24, 24–48, 48–72 hours), theatre efficiency, length of stay, rescue analgesia timing, discharge prescribing, and perioperative correlations. Predictors included BMI, operative duration, procedure type, and pre-operative opioid use. Statistical significance was set at $p<0.05$.

Results: Robotic bariatric surgery (n=86) significantly reduced 72-hour post-operative opioid requirements versus laparoscopy (n=64) (median 15.5 vs 36.0 mg OME; p=0.0003), with benefits evident during the first 48 hours. Robotic cases also required less intraoperative fentanyl and had shorter induct-to-knife times. Multivariable analysis identified robotic surgery as the strongest independent predictor of lower opioid consumption (−56.9%) and shorter hospital stay (both p=0.0006). Male sex independently predicted lower OME, whereas BMI and operative duration did not influence opioid requirements. The opioid-sparing effect remained significant in opioid-naive patients but was attenuated in pre-operative opioid users.

Conclusion: In 151 consecutive bariatric procedures under standardised anaesthetic conditions, robotic surgery was independently associated with substantially lower post-operative opioid consumption and shorter hospital stay. The robotic analgesic advantage was most pronounced in

opioid-naive patients and was attenuated in those with pre-operative opioid use, suggesting opioid tolerance as a moderating mechanism. These findings support a pharmacological model of post-operative pain generation in bariatric surgery and provide a rationale for approach-stratified analgesic protocols.

Key statement: In 151 consecutive bariatric procedures performed under a standardised single-anaesthetist protocol, robotic surgery was associated with 2.3-fold lower post-operative opioid consumption and significantly shorter hospital stay compared with laparoscopic surgery, with the analgesic advantage most pronounced in opioid-naive patients and independent of BMI, procedure type, and operative duration.

Free Paper 06 (15:05 – 15:15)

LONDON RESIDENT ROBOTIC TRAINING PROGRAMME: A TWO-PHASE PILOT (2025-26)

Presenter: Mr G Ryan

Author(s): Ms F Cheung[1], Mr G Ryan[2], Dr L Merkabaoui[2], Professor N Francis[2]

Institution: [1]Barking Havering and Redbridge, London, United Kingdom. [2]The Griffin Institute, London, United Kingdom

Aims: Robotic surgery adoption has accelerated across general surgical subspecialties, yet structured training pathways for senior surgical trainees remain absent in the UK. This pilot evaluated a coordinated, deanery-wide, two-phase robotic surgery training programme for ST7-8 residents, measuring key learning outcomes: self-reported confidence, technical proficiency via trainer/trainee assessment, AI-assisted analysis, and participant satisfaction. The study identified barriers and enablers to progression toward operative autonomy and informing recommendations for sustainable robotic training delivery across London trusts**.**

Methods: Thirty-four ST7-8 residents from 18 London hospitals participated across two phases (Jan-Mar 2026). Phase 1 (one full day, Griffin Institute) delivered foundational competencies: robotic docking, port placement, ergonomics, VR simulation and dry-lab practice on dual-console Xi systems. Phase 2 (one full day, 6 weeks post-Phase 1) introduced procedural skills using high-fidelity synthetic tissue models: robotic hernia repair, cholecystectomy, and colorectal resections. Primary outcomes: participant satisfaction (5-point Likert), confidence trajectories (pre/post, 1-10 numeric scale), technical performance (Global Assessment Scale 1-6, trainer and trainee ratings), AI-assisted metrics (GEARS 1-5 domain analysis), and learning curves via CUSUM analysis.

Results: Phase 1 and Phase 2 achieved 5/5 satisfaction; 100% would recommend. Baseline confidence: 78% reported low confidence (1-3/10); post-Phase 1, 70% remained low (7.7% absolute decrease) but high confidence (8-10) increased from 3% to 11% (+76% relative gain). Technical performance: trainer GAS mean 3.64/6; trainee self-assessment 4.03/6. Performance clustered mid-upper range (3-4), indicating developing proficiency without consistent competence. CUSUM analysis of 333 assessments demonstrated progressive skill acquisition; early procedural domains (docking, theatre setup) showed steep learning gradients vs. safety-critical dissection tasks (hepatic/splenic flexure mobilisation, vascular dissection), highlighting teachability variability across skill components.

Conclusion: Structured two-phase robotic training demonstrates measurable early learning gains and sustained high satisfaction across both cohorts. However, confidence improvements plateau at low-moderate levels post-Phase 1; technical proficiency remains in the developing range (median GAS 3-4). Console access frequency and local simulator availability, not structured course delivery alone, emerge as the primary drivers of continued progression. Participant feedback reveals marked access inequality across London trusts, directly limiting continuation of practice and progression toward operative independence post-programme.

Key statement: Deanery-wide structured robotic training is necessary but insufficient without sustained post-course practice access. Recommendations: establish protected console/simulator time allocations at home trusts, create equitable access pathways across London deanery reducing trust-dependent variation, formalise bedside-assistant roles in clinical workflows, and implement longitudinal competency tracking beyond Phase 2 to quantify genuine progression to independence.

Free Paper 07 (15:15 – 15:25)

RECURRENCE AND FUNCTIONAL OUTCOMES FOLLOWING LAPAROSCOPIC HIATUS HERNIA REPAIR: A SINGLE-CENTRE STUDY

Presenter: Mr A Aosmali

Author(s): Mr Ahmed Aosmali[1], Mr Momen Abdelgil[2], Mr Mohamed Aboshiesha[3]

Institution: [1]Royal Derby Hospital, United Kingdom. [2]Paediatric Surgery, Mansoura University Children's Hospital, Mansoura, Egypt. [3]General Surgery Department, Wirral University Teaching Hospital NHS Trust, United Kingdom

Aims: To evaluate hernia recurrence, functional outcomes and factors associated with recurrence after laparoscopic hiatus hernia repair in a single-centre cohort, including both primary and revisional procedures.

Methods: This retrospective cohort study included consecutive adult patients who underwent primary or revisional hiatus hernia repair at a UK centre between January 2014 and January 2024. The primary outcome was postoperative hernia recurrence documented on imaging or endoscopy. Secondary outcomes included complications, length of stay, ICU admission, 30-day readmission, mortality, dysphagia, PPI use and reflux symptoms at 6 months. Kaplan–Meier analysis assessed time to recurrence, and multivariable logistic regression identified recurrence predictors.

Results: A total of 216 patients underwent hiatus hernia repair, including 201 primary and 15 revisional procedures. Fundoplication was performed in 93%, and mesh was used in 6%. Postoperative complications occurred in 35%, mostly minor. At 6 months, dysphagia was reported in 14%, while PPI use decreased from 94% preoperatively to 40% postoperatively. Hernia recurrence occurred in 19%, with median time to recurrence of 10 months. Revisional surgery was independently associated with recurrence, while age, sex, BMI, mesh use and fundoplication type were not.

Conclusion: Laparoscopic hiatus hernia repair was associated with meaningful functional improvement, particularly reduced postoperative PPI use and generally favourable symptom control. However, recurrence remained an important long-term issue, affecting approximately one in five patients and occurring mainly within the first two years. Revisional surgery was the strongest independent predictor of recurrence.

Key statement: Laparoscopic hiatus hernia repair provides meaningful symptom improvement and significantly reduces PPI use, but recurrence remains a clinically important long-term challenge. In this single-centre cohort, recurrence occurred in 19% of patients, most commonly within two years, and revisional surgery was the strongest independent predictor of recurrence.

Free Paper 08 (15:25 – 15:35)

OBJECTIVE SKILLS ASSESSMENT IN A DEANERY ROBOTIC TRAINING PILOT: VR AND BENCH PERFORMANCE IN SENIOR SURGICAL TRAINEES

Presenter: Dr L Merkabaoui,

Authors(s): Dr L Merkabaoui, Ms F Cheung, Mr G Ryan, Professor N Francis

Institution: The Griffin Institute, London, United Kingdom

Aims: Robotic training programmes frequently report satisfaction and self-rated confidence rather than objective performance. This analysis aimed to characterise objective technical performance in senior surgical trainees completing the foundational phase of a deanery-wide robotic training pilot, using a structured docking checklist, a virtual reality (VR) skills battery, and rubric-scored bench exercises. Secondary aims were to identify which domains and tasks discriminate between trainees, and to establish baseline performance benchmarks for future cohorts.

Methods: Thirty senior trainees were assessed across three modalities. A 21-item observational docking and undocking checklist with a three-question knowledge component was completed per candidate. A VR battery of eight modules (camera navigation, wrist articulation, fine motion control, pick and place, bimanual transfer, sea spikes, ring rollercoaster) was scored 0 to 100. Four bench exercises (suturing, glove cutting, sea spikes, ring rollercoaster) were scored across seven GEARS-style domains on a 0 to 5 rubric. Non-completions were recorded prospectively and distinguished from missing data. Three data anomalies were identified and corrected before analysis.

Results: All candidates passed docking and undocking (30/30; knowledge 3/3). Checklist "no" responses ranged 0 to 7, clustering on patient cart positioning and port depth re-check. VR module means ranged 72.1 to 91.5; camera navigation scored highest (91.5, SD 9.5) and ring rollercoaster lowest (72.1, SD 22.9). Bench domain means clustered 2.96 to 4.07. Autonomy was consistently the strongest domain (peak 4.07, sea spikes); overall performance (2.96 to 3.34) and force sensitivity/tissue handling (3.07 to 3.31) were consistently weakest. Ring rollercoaster was weakest in both modalities and carried the highest non-completion rate (4/30).

Conclusion: Trainees achieved uniform competence in docking and undocking and performed strongly on VR navigation tasks, but rubric-scored bench performance clustered in the mid-range, with force modulation and tissue handling the limiting domains. The pattern of high autonomy alongside lower overall performance indicates trainees operating independently before achieving refined technical control. Ring rollercoaster's combination of low completer scores and high dropout introduces a survivorship effect; reported means likely understate true task difficulty, and completion rates should be reported alongside means.

Key statement: Objective assessment discriminates where satisfaction data cannot. Foundational robotic training reliably delivers safe setup competence and VR navigation skill, but tissue handling and force modulation remain underdeveloped and should be the explicit target of subsequent training phases. Task-level completion rates must be reported alongside mean scores to avoid survivorship bias in programme evaluation.

Free Paper 09 (15:35 – 15:45)

AUTOMATED AI ASSESSMENT OF A BASIC ROBOTIC SKILL

Presenter: Mr S Wongsaroj

Author(s): Mr S Wongsaroj[1], Mr G Ryan[2], Mr T Shakir[1], Professor N Francis[2]

Institution: [1]University College London, United Kingdom. [2]The Griffin Institute, London, United Kingdom

Aims: Assessment of robotic surgical skill depends on manual rating, a process that is labour and time intensive, and is susceptible to inter-rater heterogeneity. Artificial intelligence applied to surgical video promises objective, reproducible scoring, but depends on standardised tasks that generate consistent footage and on reliable human-scored ground truth. We evaluate a novel method of automated AI scoring, using a vision-learning platform, applied to a dry-lab camera control task.

Methods: 40 camera target videos, anonymously recorded during a basic robotic skills course, were scored frame-by-frame using the Modified Global Evaluative Assessment of Robotic Skill (M-GEARS) by trained raters. A subset were independently blindly double-scored to establish inter-rater reliability (ICC). BlackFrame, a vision language model was utilised, which allows videos to be uploaded and returns structured outputs from a user-defined script. A bespoke script encoding each M-GEARS domain and its scoring factors was written. Automated and human scores were compared using Pearson and Spearman correlation, with human ratings assessed for agreement with ICC.

Results: Over 300,000 frames of operative video, across 40 camera target videos, were processed by the automated system, which showed moderate, statistically significant agreement with human M-GEARS scoring (Pearson $r=0.61$, $p<0.001$; Spearman $\rho=0.47$, $p=0.002$) and no significant systematic bias (mean difference 0.43 points, $p=0.44$; 95% limits of agreement −6.32 to +7.17). Per-domain agreement for M-GEARS components was strongest for Efficiency ($\rho=0.62$) and Depth Perception ($\rho=0.54$), and weakest for Bimanual Dexterity ($\rho=0.35$) and Robotic Control ($\rho=0.33$). Human inter-rater reliability was good (ICC=0.878).

Conclusion: A vision learning model scoring a video of a basic robotic skills task achieved moderate agreement with expert human M-GEARS scoring. Agreement was strongest in the efficiency and depth perception domains. This represents a proof-of-concept for automated, objective assessment. Larger, multi-centre evaluation is required before widespread use.

Key statement: Automated AI assessment of robotic skill, through a vision-learning platform, scores robotic camera control from video in moderate agreement with expert human raters. This has the potential to change the shape of robotic skills training.

Free Paper 10 (15:45 – 15: 55)

INTRACORPOREAL VERSUS EXTRACORPOREAL ANASTOMOSIS FOLLOWING MINIMALLY INVASIVE COLONIC RESECTIONS

Presenter: Dr SSS Debbati

Author(s): Dr SSS Debbati, Dr VSRP Bhayamkaram, Dr MK Ramkumar, Dr R Upadyaya, Mr TK Rajesh

Institution: University Hospitals Plymouth NHS Trust, United Kingdom

Aims: To compare perioperative, postoperative and oncological outcomes following minimally invasive colonic resections using extracorporeal (EC) versus intracorporeal (IC) anastomosis. Primary outcomes included operative time, anastsomotic breakdown incisional hernia, lymph node harvest, and length of hospital stay. We hypothesised that IC anastomosis would reduce wound-related and anastomotic morbidity without compromising short-term safety or oncological adequacy.

Methods: A Prospectively collected retrospective analysis study was undertaken of 150 patients undergoing minimally invasive colectomy (right, segmental and left) (EC n=75; IC n=75). Categorical variables were analyzed using Fisher's exact test and continuous variables using an independent-sampled t-test. Statistical significance was defined as $p<0.05$.

Results: EC and IC anastomosis required an equal amount of operating time, whereas IC required approximately 20 additional minutes for ICG and anastomosis, which was compensated by large laparotomy for EC anastomosis surgeries. Anastomotic complication rates were similar (EC 4/75 [5.3%] vs IC 3/75 [4.0%, including one twisted anastomosis]; p=1.000). Incisional hernia remained significantly less frequent after IC anastomosis (EC 8/75 [10.7%] vs IC 1/75 [1.3%]; p=0.034). Mean lymph node harvest was comparable between EC and IC (22.80 vs 23.11; p=0.877). The mean hospital stay for EC was 8.09 versus IC was 7.35 days (p=0.523).

Conclusion: Although intracorporeal anastomosis increased operative time by approximately 20 minutes, it significantly reduced incisional hernia and hospital stay while maintaining equivalent anastomotic safety and lymph node harvest. Intracorporeal anastomosis is therefore a safe and effective alternative to extracorporeal anastomosis.

Key statement: Intracorporeal anastomosis provides comparable short-term and oncological outcomes to extracorporeal anastomosis while significantly reducing incisional hernia and hospital stay h, at the expense of a modest increase in operative time.The key steps of video will be presented.

Poster of Distinction 01

PREVALENCE AND CLINICAL IMPACT OF SMALL INTESTINAL BACTERIAL OVERGROWTH (SIBO) FOLLOWING ONE ANASTOMOSIS GASTRIC BYPASS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: Mr A Aosmali

Author(s): Mr A Aosmali[1], Mr M Aboshiesha[2], Mr M Abdelglil[3]

Institution: [1]Royal Derby Hospital, United Kingdom. [2]General Surgery Department, Wirral University Teaching Hospital NHS Trust, United Kingdom. [3]Paediatric Surgery, Mansoura University Children's Hospital, Egypt

Aims: To assess the pooled prevalence, clinical impact and risk factors of small intestinal bacterial overgrowth following one-anastomosis gastric bypass.

Methods: A systematic literature search was performed in PubMed/MEDLINE, Web of Science, Scopus and Google Scholar from inception to January 2026, following PRISMA 2020 guidance. Studies of adult patients undergoing primary OAGB and later assessed for SIBO using validated diagnostic methods were included. Diagnostic methods included glucose breath testing, lactulose breath testing and jejunal aspirate culture. Random-effects meta-analysis was used to calculate pooled prevalence, with subgroup analysis by diagnostic method.

Results: A total of 503 OAGB cases were included. The pooled prevalence of SIBO after OAGB was 44.88%, although heterogeneity was substantial. In studies using specified validated diagnostic methods, pooled prevalence increased to 74.88%. Chronic diarrhoea was the most common symptom, followed by abdominal pain, flatulence and bloating. However, some patients were asymptomatic. SIBO was associated with nutritional deficiencies, including reduced folate and vitamin A deficiency. Risk factors included higher preoperative weight, female sex and older age.

Conclusion: SIBO is a common postoperative issue after OAGB and may affect nearly half of patients. It can contribute to gastrointestinal symptoms and worsen micronutrient deficiencies, although some patients remain asymptomatic. Variation in reported prevalence highlights the need for standardised diagnostic criteria, improved monitoring and appropriate nutritional follow-up after OAGB.

Key statement: Small intestinal bacterial overgrowth is common after one-anastomosis gastric bypass, with a pooled prevalence of 44.88%. It may cause diarrhoea, bloating, abdominal pain and micronutrient deficiencies, but can also be asymptomatic. Standardised diagnostic pathways are needed to improve detection, follow-up and nutritional management.

Poster of Distinction 02

INCIDENCE OF BILE REFLUX AFTER ONE-ANASTOMOSIS GASTRIC BYPASS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: Mr A Aosmali

Author(s): Mr A Aosmali[1], Mr M Aboshiesha[2], Mr M Abdelglil[3]

Institution: [1]Royal Derby Hospital, United Kingdom. [2]General Surgery Department, Wirral University Teaching Hospital NHS Trust, United Kingdom. [3]Paediatric Surgery, Mansoura, University Children's Hospital, Mansoura, Egypt

Aims: To estimate the pooled incidence of bile reflux after one-anastomosis gastric bypass and assess the frequency of severe reflux requiring revisional surgery and marginal ulceration.

Methods: A systematic review and meta-analysis was performed following PRISMA 2020 guidance. MEDLINE, Web of Science and Scopus were searched for original clinical studies reporting bile reflux after OAGB/MGB. Random-effects meta-analysis of proportions was used to estimate pooled incidences of bile reflux, severe reflux requiring revision and marginal ulceration.

Results: Eight observational studies including 6,301 patients were analysed, with follow-up ranging from approximately 5 to 20 years. A total of 112 bile reflux cases were reported, with study-level incidence ranging from 0.4% to 9.8%. The pooled incidence of bile reflux was 1.79%, while severe reflux requiring revisional surgery occurred in 0.87%. Marginal ulcers were reported in 48 patients, giving a pooled incidence of 1.10%. No significant difference was found by follow-up duration.

Conclusion: Clinically reported bile reflux after OAGB appears uncommon but remains clinically relevant. Severe reflux requiring revisional surgery is rare, and marginal ulceration is infrequent but important. Interpretation is limited by substantial heterogeneity, retrospective study designs and inconsistent definitions of bile reflux across studies.

Key statement: Bile reflux after one-anastomosis gastric bypass appears uncommon, with a pooled incidence of 1.79%, while severe reflux requiring revision is rare at 0.87%. However, bile reflux and marginal ulceration remain clinically relevant complications, highlighting the need for standardised definitions, consistent reporting and long-term follow-up after OAGB.

Poster of Distinction 03

ACUTE APPENDICITIS IN PREGNANCY: A SYSTEMATIC REVIEW OF CLINICAL PRACTICE GUIDELINES

Presenter: Ms N Husnoo

Author(s): Miss L Papadakis-Taylor[1], Miss R Dickson[1], Miss E Craig[1], Miss M Smith[1], Ms N Husnoo[2]

Institution: [1]University of Sheffield, Sheffield, United Kingdom. [2]Sheffield Teaching Hospitals NHS Foundation Trust, United Kingdom

Aims: Acute appendicitis is the most common general surgical emergency in pregnancy, affecting around 1 in 1000 pregnancies. Prompt diagnosis and appropriate management are essential for this population but can be challenging. As the evidence-base is weak and individual experience is hard to build, surgeons are likely to rely on clinical practice guidelines (CPGs) to aid decision-making. Robust guidance is therefore essential. We aimed to systematically assess the quality, consistency, and comprehensiveness of existing guidelines, and identify areas for improvement in future guidelines. We also aimed to generate a summary of high-quality CPG recommendations to aid surgeons in practice.

Methods: Medline, Scopus, and PubMed databases, the websites of professional associations, and the grey literature were searched from January 2005 to October 2025. Results prior to 2005 were excluded due to laparoscopic appendectomy not becoming firmly established in practice until the mid-2000s. Guidelines making recommendations relevant to the diagnosis and/or management of acute appendicitis in pregnancy were included. CPG quality was assessed independently by 3 reviewers using the AGREE-II instrument. Data was extracted by 2 reviewers. Recommendations of interest included scoring systems, diagnostic imaging, management approach (operative versus non-operative), surgical approach (laparoscopic versus open), specialist input, antibiotics, and VTE prophylaxis.

Results: Twenty CPGs were included. Only 6 exclusively targeted pregnant women, only 1 covered all recommendations of interest, and only 1 involved patients in development. Five CPGs were high-quality (AGREE-II score >= 75%), 11 moderate (>60% to <75%), and 4 poor (<60%). The lowest scoring AGREE-II domain across guidelines was ‘applicability’ (40.6%, SD 13.6). When discussed, first-line ultrasound followed by MRI if inconclusive was recommend by 64% guidelines. Guidelines unanimously (n=7/7) recommended operative management for all trimesters, with laparoscopic appendectomy generally considered the optimal surgical approach. However, few guidelines discussed trimester-specific surgical considerations, and recommendations on VTE prophylaxis were limited.

Conclusion: High-quality and comprehensive guidelines for appendicitis in pregnancy are lacking. Few guidelines contained enough detail to independently support practice. This may contribute to variation and uncertainty in practice. Moreover, most guidelines scored lowly on applicability and lacked patient input. This may have implications for guideline awareness and implementation. Dedicated guidelines that fully address surgeons’ informational needs are essential to standardise care in this population. Patient input in guideline development should be standard and future research should seek to understand patient perspectives and explore current UK practice and guideline awareness for this condition.

Key statement: Appendicitis in pregnancy is the most common general surgical emergency but individual experience is hard to build and the evidence-base is weak. High-quality and comprehensive guidance is essential, but this systematic review has shown that most existing CPGs for this condition contain considerable deficiencies.

Poster of Distinction 04

TRANSANAL VERSUS LAPAROSCOPIC TOTAL MESORECTAL EXCISION FOR RECTAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: Miss N Widanage

Institution: George Eliot Hospital NHS Trust, Nuneaton, United Kingdom

Aims: Transanal total mesorectal excision (TaTME) was developed to address the technical challenges of laparoscopic total mesorectal excision (LapTME), particularly in patients with low rectal cancer and a narrow pelvis. Although TaTME may improve pelvic access and specimen quality, concerns regarding its safety and oncological effectiveness remain. This systematic review and meta-analysis aimed to compare the pathological quality of resection and early postoperative outcomes following TaTME and conventional LapTME in patients undergoing curative rectal cancer surgery.

Methods: A systematic review was conducted according to PRISMA recommendations. MEDLINE, Embase and CENTRAL were searched from database inception to July 2026. Randomised controlled trials and comparative observational studies evaluating TaTME versus LapTME for rectal cancer were included. The primary outcome was circumferential resection margin (CRM) positivity. Secondary outcomes included complete mesorectal excision, anastomotic leak and major postoperative complications (Clavien–Dindo grade III or above). Risk of bias was assessed using RoB 2 and ROBINS-I. Random-effects meta-analysis generated pooled risk ratios (RR) with 95% confidence intervals (CI), and heterogeneity was assessed using the I^2 statistic.

Results: Fifteen comparative studies (2 RCTs and observational Cohort studies) involving 2,430 patients were included. CRM positivity was similar between TaTME and LapTME (5.8% vs 7.1%; RR 0.89, 95% CI 0.68–1.18; p=0.43; I^2=38%). Complete mesorectal excision was achieved in 86% of TaTME cases and 79% of LapTME cases (RR 1.09, 95% CI 0.98–1.22; p=0.11; I^2=45%). Anastomotic leak (10.4% vs 9.9%; RR 1.05, 95% CI 0.80–1.36; p=0.74) and major complications (7.3% vs 8.1%; RR 0.93, 95% CI 0.68–1.28; p=0.66) were comparable. Subgroup analysis of low rectal cancers suggested improved pathological outcomes with TaTME.

Conclusion: TaTME provides pathological and short-term clinical outcomes comparable with conventional laparoscopic TME and may offer advantages in selected patients with low rectal cancer. Overall perioperative safety appears similar between techniques when performed in experienced centres. Further adequately powered randomised trials with long-term oncological follow-up are required to clarify the role of TaTME and identify the patients most likely to benefit from this approach.

Key statement: This meta-analysis found that TaTME achieves comparable pathological quality and postoperative safety to laparoscopic TME, with potential advantages in low rectal cancer. These findings support the selective use of TaTME within experienced multidisciplinary units while awaiting further high-quality evidence on long-term oncological outcomes.

Poster of Distinction 05

ANTIBIOTICS AFTER APPENDICECTOMY: TRADITION OR EVIDENCE? A CLOSED-LOOP AUDIT OF GUIDELINE ADHERENCE AND EARLY CLINICAL OUTCOMES

Presenter: Miss A Mahmood

Author(s): Miss A Mahmood, Dr Z Oledrzynska, Mr A Venkatisan, Miss N Tanner

Institution: Northampton General Hospital NHS Trust, United Kingdom

Aims: World Society of Emergency Surgery (WSES) guidelines recommend against postoperative antibiotics for uncomplicated appendicitis and short-course therapy for complicated appendicitis. We conducted a closed-loop audit to evaluate postoperative antibiotic decision-making, adherence to guideline and operative note recommendations, and associated early clinical outcomes, with the aim of improving antimicrobial stewardship and reducing unnecessary antibiotic use.

Methods: A two-cycle audit was conducted at Northampton General Hospital. Cycle 1 retrospectively included appendicectomies performed between July and September 2025 . Following this, a multifaceted intervention comprising departmental education, governance presentation, dissemination of prescribing guidance, and point-of-care reminder posters was implemented. Cycle 2 prospectively included appendicectomies performed between February and May 2026. Data were collected from theatre electronic records, electronic patient notes and drug charts. Patients were classified as uncomplicated, complicated or normal according to intraoperative findings. Outcomes included postoperative antibiotic decision-making, adherence to operative note and WSES guidelines, antibiotic choice and duration, and 30-day postoperative complications.

Results: A total of 100 patients were included in each cycle. Following the intervention, operative note recommendations to withhold postoperative antibiotics in uncomplicated appendicitis increased from 40% (24/60) to 56% (37/66), accompanied by a reduction in postoperative antibiotic use from 45% (27/60) to 35% (23/66). Compliance with local guideline-recommended antibiotic choice improved from 40% (25/63) to 61% (33/54). Postoperative complications in uncomplicated appendicitis fell from 8.3% (5/60) to 0%, while rates in complicated appendicitis remained unchanged (13.9%, 5/36 vs 13.8%, 4/29). Mean antibiotic duration decreased from 5.5 days (n=64) to 5.1 days (n=54).

Conclusion: This closed-loop quality audit demonstrated modest improvements in adherence to evidence-based postoperative antibiotic practice following appendicectomy. Reduced postoperative antibiotic use in uncomplicated appendicitis was not associated with an increase in early postoperative complications. Opportunities remain to improve adherence to WSES guidelines, operative note recommendations and local antimicrobial guidelines through continued education and standardised prescribing pathways.

Key statement: Adherence to evidence-based postoperative antibiotic practice after appendicectomy can be improved through targeted education, operative note documentation, and point-of-care reminders.

Poster of Distinction 06

EFFECT OF GASTRIC POUCH SIZE ON WEIGHT LOSS, METABOLIC, AND OUTCOMES AFTER ROUX-EN-Y GASTRIC BYPASS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Presenter: Mr K Bananis

Author(s): Mr K Bananis, Mr S Ramar, Dr S Khan, Dr R Mor, Dr E Obale

Institution: King's College Hospital, London, United Kingdom

Aims: Gastric pouch size during Roux-en-Y gastric bypass (RYGB) varies widely between surgeons and centres, with published pouch volumes ranging from 15 mL to over 100 mL. Whether this variation influences patient outcomes has remained contested. The most recent qualitative systematic review (Mahawar et al., 2020) included 14 studies, concluded quantitative synthesis was not feasible, and called for definitive evidence to guide standardisation. Six years of additional trials, registry analyses, and three-dimensional CT volumetric studies now permit the first quantitative meta-analysis of pouch-size effects. We synthesise the available evidence to inform surgical standardisation of RYGB pouch construction.

Methods: We searched PubMed/MEDLINE and the Cochrane Library through April 2026 for adult RYGB studies comparing smaller versus larger gastric pouches. Two reviewers independently screened, extracted, and assessed risk of bias, with disagreements resolved by consensus. Random-effects meta-analyses (DerSimonian-Laird) were performed for percent excess weight loss (%EWL), percent total weight loss (%TWL), and marginal ulcer. Pre-specified sensitivity analyses included leave-one-out and a Boerboom 2019 reinterpretation under a length-based (Laplace/Poiseuille) geometric model. Certainty of evidence was rated by GRADE. Continuous-exposure studies contributed to narrative synthesis.

Results: Eighteen unique trials plus one long-term follow-up were included (N≈16,500). A smaller pouch produced 10.55 percentage points greater %EWL (95% CI +6.46 to +14.64; $p<0.0001$; $I^2=0\%$; k=4) and a 66% relative reduction in marginal ulcer risk (RR 0.34, 95% CI 0.11 to 1.04; p=0.058; $I^2=0\%$; k=2). Findings were consistent across randomised, observational, and registry designs, and robust to leave-one-out sensitivity. Inclusion of Boerboom 2019 under its length-based interpretation strengthened the %EWL estimate (MD +10.63, $p<0.0001$). Results converged with a 14,168-patient national registry analysis showing 14% increased marginal ulcer risk per centimetre of stapler length.

Conclusion: A smaller gastric pouch during RYGB produces clinically meaningful improvements in weight loss and substantially reduces marginal ulcer risk. The convergence of evidence across randomised trials, matched cohorts, national registries, and three-dimensional volumetric studies supports adoption of small-pouch construction (approximately 15–30 mL) as the surgical standard. These findings provide the quantitative basis for surgical society guidelines to formally recommend smaller pouch construction as the default approach during primary RYGB, with potential to reduce both revisional bariatric surgery for insufficient weight loss and marginal ulcer-related morbidity.

Key statement: Roux-en-Y gastric bypass; gastric pouch; bariatric surgery; weight loss; marginal ulcer; meta-analysis.

Poster of Distinction 07

DEVELOPMENT AND VALIDATION OF A NOVEL CAMERA-BASED DRY LAB SKILLS TASK AS A CORE COMPONENT OF ROBOTIC SKILLS TRAINING

Presenter: Mr S Wongsaroj

Author(s): Mr S Wongsaroj[1], Mr T Shakir[1], Mr A Sleeman[2], Ms E Ersan[3], Professor Nader Francis[4]

Institution: [1]University College London, United Kingdom. [2]Royal Free NHS Trust, London, United Kingdom. [3]University of Surrey, Guildford, United Kingdom. [4]The Griffin Institute, London, United Kingdom

Aims: Camera control represents a quintessential skill in robotic surgery. However, no validated dry-lab task currently assesses camera control as an individual skill. Preliminary validation of a purpose-built "camera target" dry-lab task is presented here and evaluated against the previously validated sea spikes task using Messick's framework**.**

Methods: A bespoke camera targeting task was designed requiring sequential navigation of a numbered board under paradoxical movement. Anonymous data was collected from participants attending a four-day societal basic robotic skills course, where they completed the novel camera target task and previously validated sea spikes task at Day 1 (attempt 1) and Day 4 (attempt 2). Videos were scored frame-by-frame using the Objective Clinical Human Reliability Analysis (OCHRA) for errors, with duration and consequence, and modified global evaluative assessment of robotic skills (M-GEARS) for skill. Inter-rater reliability (IRR) was assessed by independent, blinded scoring (ICC).

Results: 183,280 error frames were analysed with 1,442 errors across 92 videos from 23 participants. Participants ranged from having 0–15 years surgical experience. Camera target M-GEARS scores improved significantly from attempt 1 (15.6/30) to attempt 2 (20.3/30; $p<0.001$), mirroring sea spikes (16.1-20.4; $p<0.001$). Mean error duration fell from 262 to 153 frames ($p=0.043$), and errors without adverse consequence rose from 66.6% to 87.0%. "Instrument out of view" was the dominant error type (49.8%). M-GEARS correlated strongly and inversely with OCHRA error counts for camera target ($\rho=-0.785$) and sea spikes ($\rho=-0.800$; both $p<0.001$). IRR was good (ICC=0.878).

Conclusion: The camera target task demonstrates preliminary validity evidence and is sensitive to training-induced skill improvement. Convergence with an independent error-based assessment method and good inter-rater reliability support the internal structure and response process domains. Correlation with sea spikes indicates concurrent validity. Further multi-centre studies with expert comparison groups are required prior to curricular adoption.

Key statement: A novel, low-cost dry-lab task for robotic camera control is presented, with preliminary validity evidence supporting its inclusion in core robotic skills curricula.

Poster of Distinction 08

EARLY MINIMALLY INVASIVE RESECTION WITH PRIMARY ANASTOMOSIS IN ACUTE PERFORATED PURULENT DIVERTICULITIS: IS IT TIME TO CHANGE THE PARADIGM?

Presenter: Dr C Anand

Author(s): Mr A Botros, Dr C Anand, Mr J Richardson, Mr S Mercer

Institution: Queen Alexandra Hospital, Portsmouth, United Kingdom

Aims: Acute perforated purulent diverticulitis (Hinchey III) is commonly managed with prolonged antibiotics with or without image-guided drainage, yet many patients ultimately require surgery during the index or a subsequent admission. Although delayed elective resection is often perceived to be technically easier, interval inflammation, fibrosis and nutritional decline may increase operative complexity, conversion rates and stoma formation. The aim of this study was to review our institutional experience and determine whether early identification of patients unlikely to benefit from continued conservative management, followed by urgent minimally invasive resection with primary anastomosis, represents a safe and feasible alternative to delayed surgery.

Methods: We retrospectively reviewed six years of practice at Portsmouth University Hospitals NHS Trust. Patients who failed an initial period of conservative management but remained physiologically suitable for surgery underwent early laparoscopic or robotic anterior resection with primary anastomosis without routine ileostomy or end colostomy. Careful patient selection, optimisation of nutritional status where feasible, and timely escalation to surgery underpinned our approach.

Results: Over 40 patients underwent early minimally invasive resection with primary anastomosis. Two anastomotic leaks occurred. Most patients avoided permanent stoma formation and recurrent diverticulitis-related admissions. Where leakage occurred, salvage with re-operation and defunctioning ileostomy remained feasible, avoiding many of the long-term consequences of Hartmann's procedure.

Conclusion: Our experience suggests that early minimally-invasive-resection should not be reserved for failed conservative management, but as a proactive strategy for carefully selected patients. The objective is not to operate on more patients, but to operate on the right patients at the right time. Delaying surgery in anticipation of an easier elective operation may represent false reassurance for some patients. Rather than asking, "Can this patient avoid surgery?", perhaps we should ask, "Is this patient likely to benefit from early minimally-invasive definitive surgery before the opportunity is lost?" Prospective studies are needed to validate patient selection and this evolving treatment philosophy.

Key statement: A substantial proportion of patients managed non-operatively for Hinchey III diverticulitis ultimately require surgery, during the index admission or subsequently — the real choice often concerns timing rather than whether to operate. Delay does not reliably yield an easier operation: interval inflammation, fibrosis and nutritional decline may increase operative complexity, conversion rates and stoma formation. In this series, urgent minimally-invasive-resection with primary anastomosis without routine diversion proved feasible and safe in selected, physiologically fit patients. The useful question is therefore one of timing and selection: identifying early which patients are unlikely to benefit from continued non-operative management, before deterioration precludes anastomosis.

Poster of Distinction 09

IMPACT OF DIVERTING STOMA ON ANASTOMOTIC LEAKAGE AND LEAK-RELATED REOPERATION FOLLOWING LOW ANTERIOR RESECTION FOR RECTAL CANCER: AN UPDATED META-ANALYSIS

Presenter: Mr A Ibrahim

Author(s): Mr A Ibrahim[1], Mr A Said[2], Mr D AbdElnour[3]

Institution: [1]Epsom and St Helier University Hospitals NHS Trust, London, United Kingdom. [2]The Royal Hospital, Muscat, Oman. [3]Kettering General Hospital NHS Foundation Trust, United Kingdom

Aims: To evaluate the impact of diverting stoma formation on anastomotic leakage, leak-related reoperation, and postoperative mortality following low anterior resection for rectal cancer through an updated systematic review and meta-analysis of randomized and observational comparative studies.

Methods: A systematic search of PubMed was conducted from inception to 2 July 2026 and subsequently expanded to Embase and the Cochrane Central Register of Controlled Trials (CENTRAL) on 20 August 2026. Comparative studies evaluating diverting stoma versus no stoma during low anterior resection for rectal cancer were included. RCTs and observational studies were analysed separately using random-effects models. Risk ratios (RRs) with 95% confidence intervals (CIs) were calculated.

Results: Twenty-three studies involving 16,635 patients were included: 4 RCTs and 19 observational studies. In RCTs, diverting stoma reduced anastomotic leakage (RR 0.33, 95% CI 0.20–0.52; P<0.001), whereas observational studies showed no significant reduction (RR 0.79, 95% CI 0.62–1.01; P=0.059). Leak-related reoperation was reduced in both RCTs (RR 0.20, 95% CI 0.08–0.55; P=0.002) and observational studies (RR 0.36, 95% CI 0.27–0.47; P<0.001). Mortality was not significantly different in RCTs (RR 0.70, 95% CI 0.04–11.42; P=0.803), but was lower in observational studies (RR 0.45, 95% CI 0.31–0.67; P<0.001).

Conclusion: Randomized evidence indicates that diversion probably reduces anastomotic leakage, while both evidence types demonstrate reductions in leak-related reoperation. Evidence for leakage reduction is supported primarily by randomized data, whereas observational findings remain uncertain because of confounding and heterogeneity. Mortality benefit remains uncertain, supporting individualized rather than universal diversion.

Key statement: This updated systematic review and meta-analysis demonstrates that diverting stoma reduces anastomotic leakage and leak-related reoperation following low anterior resection for rectal cancer. The findings support selective, individualized use of diversion while highlighting the need for further prospective studies to refine patient selection and optimize outcomes.

Poster of Distinction 10

COMPARING TECHNICAL ERRORS DURING ROBOTIC VS LAPAROSCOPIC CHOLECYSTECTOMY USING OBJECTIVE CLINICAL HUMAN RELIABILITY ASSESSMENT (OCHRA)

Presenter: Dr GM Elliott

Author(s): Dr Greta May Elliott, Mr D Ricardo, Professor N Francis

Institution: Yeovil District Hospital, United Kingdom

Aims: Cholecystectomy is a common surgical procedure, traditionally performed laparoscopically, with robotic approach increasingly adopted in recent years. This study aims to apply Objective Clinical Human Reliability Assessment (OCHRA) to assess its validity on robotic cholecystectomy and to compare surgical technique with laparoscopic approach. Through detailed video analysis, errors observed can be compared to provide insight into how each operative method influences performance. Patterns of errors can guide further assessment and development of surgical technique, supporting targeted training and can contribute to the use of safer surgical practice.

Methods: OCHRA was used to review twenty operative videos, comparing ten laparoscopic with ten robotic cholecystectomies. All procedures were performed at Yeovil District Hospital. Seven stages were standardised across all cholecystectomies to divide the operation into tasks. Identified errors were recorded according to the task, sub-task, technical error observed, mechanism of error, instrument involved and recovery method. Errors were further classified according to the European Association for Endoscopic surgery (EAES), attributing each error a grade from one (inconsequential) to five (death) based on severity of the error.

Results: There were 595 (228 robotic, 367 laparoscopic) errors identified from analysis of 20 cases. Of these, 538 (90.4%) were inconsequential (EAES Grade 1) while 57 (9.6%) needed minor corrective actions (EAES Grade 2). Average total error was 29.8 ± 10.5 with robotic cases recording fewer errors (22.8 ± 5.0) when compared to laparoscopic cases (36.7 ± 9.5). Laparoscopic analysis found that 21.2% (n=126) of all errors involved the camera. Calot's dissection was notably the most error prone with 155 (26.1%) errors recorded, averaging 7.8 ± 4.9 errors per case. 57 errors needed corrective actions with bleeding (47, 82.5%) accounting for the majority.

Conclusion: Laparoscopic cholecystectomy was associated with a greater number of errors when compared to robotic cholecystectomy, largely attributable to poor camera control. Minor inconsequential errors were seen throughout both methods of cholecystectomy, both identifying dissection of Calot's triangle as the most technically challenging phase of the operation. OCHRA can therefore be applied as a valid tool to assess robotic cholecystectomy and provides a structure to compare robotic and laparoscopic approach that can target specific technical training.

Key statement: Robotic cholecystectomy identified fewer technical errors than laparoscopic cholecystectomy, supporting the application of OCHRA as a valid assessment tool to address training requirements.

Poster 11

UK SURGICAL TRAINING AT A CROSSROADS: CHALLENGES AND POTENTIAL SOLUTIONS

Author(s): Dr H Khalid[1], Ms M Yiasemidou[2]

Institution: [1]Leeds Teaching Hospitals, Leeds, United Kingdom. [2]Barts Health NHS Trust, London, United Kingdom

Aims: Surgical training in the United Kingdom (UK) has undergone a major transformation in reaction to evolving health service demands, policy reforms, and developments in medical education. Traditionally based on an apprenticeship model of supervised clinical learning, contemporary surgical training now faces multiple pressures that may threaten its sustainability. This review investigates the key challenges affecting UK surgical training and identifies feasible strategies to support the development of a sustainable surgical workforce.

Methods: We conducted a narrative review of the literature using PubMed to find relevant studies, reviews, and policy reports on challenges in UK surgical training. We included articles on structural, educational, and workforce issues affecting training. Key themes identified were training capacity, operative exposure, workforce pressures, and diversity. These were synthesised for the review.

Results: Several major challenges affect UK surgical training. Reduced working hours after the European Working Time Directive (EWTD) have limited trainees' operative exposure and experience. Growing sub-specialisation in surgery has extended both requirements and complexity. Pressures inside the NHS often favour service delivery over education, reducing time for training. More competition for surgical posts creates bottlenecks and increases stress and burnout. Monetary barriers to examinations, courses, and training may disadvantage some trainees. Concerns persist about limited diversity and inclusivity within the surgical workforce.

Conclusion: UK surgical training faces multiple structural and workforce-related challenges that may affect the profession's future sustainability. Likely strategies to handle these issues include expanding training capacity, improving workforce planning, strengthening mentorship and trainee support systems, and incorporating simulation-based and technological innovations to strengthen surgical education. Dealing with these challenges will be vital to secure the continued development of a competent and resilient surgical workforce able to meet future healthcare needs.

Key statement:

- Surgical training in the United Kingdom is undergoing a major transformation due to developing health service demands and reforms in medical education.
- Reduced operative exposure resulting from working-time restrictions and service pressures has challenged the traditional apprenticeship model of surgical training.
- Additional challenges in the surgical training pathway include intensified competition for training positions, financial obstacles, and insufficient diversity.
- Proposed solutions entail expanding training capacity, optimising workforce planning, enhancing mentorship and support systems, and integrating simulation and technological innovations to improve surgical education.

Poster 12

BENCHMARKING COLONOSCOPY QUALITY METRICS AGAINST NATIONAL JAG STANDARDS IN A DISTRICT GENERAL HOSPITAL

Author(s): Dr B Arifaj, Dr P Brown, Dr T Nguyen, Dr R Heldt, Mr M Saleem

Institution: Princess Alexandra Hospital, Harlow, United Kingdom

Aims: To evaluate the quality of adult colonoscopy practice at Princess Alexandra Hospital (PAH) against Joint Advisory Group (JAG)-defined failure criteria and determine whether local performance met national quality standards.

Methods: A retrospective audit of 300 consecutive adult colonoscopies performed at PAH between 1 July and 31 August 2024 was undertaken. Clinical records and endoscopy reports were reviewed using JAG key performance indicators. Procedures were categorised into predefined failure domains including incomplete caecal/terminal ileal intubation, inadequate bowel preparation, aborted procedures due to intolerance or complications, incomplete examination of the target segment, technical failure, and missed pathology identified on follow-up.

Results: Of 300 colonoscopies, 28 (9.3%) met JAG failure criteria. Failures included incomplete caecal/terminal ileal intubation in eight cases, inadequate bowel preparation in 18 cases, one procedure aborted due to intolerance/complications, and one incomplete assessment of the intended segment. No cases met criteria for technical failure or missed pathology on follow-up. All failed procedures had clear documentation of indication and reason for failure.

Conclusion: PAH achieved a colonoscopy failure rate within the JAG benchmark of less than 10%; however, the rate was close to the threshold requiring review under the Managing Underperformance Framework. Inadequate bowel preparation was the predominant contributor to failure and represents an important target for future quality improvement initiatives aimed at enhancing colonoscopy performance and diagnostic accuracy.

Key statement: Princess Alexandra Hospital achieved compliance with national JAG standards for colonoscopy quality, with an overall failure rate of 9.3%. Inadequate bowel preparation accounted for most failed procedures, highlighting a modifiable factor for service improvement. Continued monitoring and targeted interventions to optimise bowel preparation may further improve colonoscopy quality and reduce avoidable incomplete examinations.

Poster 13

OPTIMISING ACUTE DIVERTICULITIS MANAGEMENT THROUGH AN EVIDENCE-BASED PATHWAY: A CLOSED-LOOP AUDIT

Author(s): Mr F Shafeik

Institution: Royal Berkshire Hospital, Reading, United Kingdom

Aims: To assess adherence to evidence-based recommendations in the management of acute diverticulitis and evaluate the impact of introducing a structured clinical pathway on ambulatory management and endoluminal follow-up practice.

Methods: A closed-loop audit was conducted assessing the management of patients presenting with acute diverticulitis in a district general hospital. The first audit cycle included 50 patients identified between October and December 2024. Following the initial cycle, an evidence-based diverticulitis management pathway derived from NICE and ACPGBI guidance was introduced alongside targeted departmental education. A second audit cycle including 46 patients presenting between August and October 2025 was subsequently performed. Data were reviewed using electronic patient records and compared across predefined domains including ambulatory management and appropriateness of endoluminal follow-up.

Results: During the first audit cycle, only 29% of patients suitable for ambulatory management were treated through an outpatient pathway. Following pathway implementation, this improved to 50% in the second cycle. Routine endoluminal investigations in patients with radiologically uncomplicated diverticulitis decreased from 61% to 57.5%. Compliance with recommended follow-up in complicated diverticulitis improved from 79% to 100% after exclusion of clinically justified exceptions. Pain control was identified as the main factor contributing to inpatient admission among otherwise suitable ambulatory patients.

Conclusion: Introduction of a structured diverticulitis management pathway was associated with improved adherence to evidence-based practice, particularly regarding ambulatory management and follow-up of complicated diverticulitis. Ongoing variation in the management of uncomplicated disease highlights the need for continued education, improved documentation, and standardised decision-making pathways to reduce unnecessary admissions and investigations.

Key statement: Implementation of an evidence-based diverticulitis pathway improved ambulatory management and follow-up compliance while identifying pain control as a key barrier to reducing avoidable admissions.

Poster 14

DOES DRAIN INSERTION AFTER LAPAROSCOPIC CHOLECYSTECTOMY AFFECT POST OPERATIVE PATIENT OUTCOMES, WHEN COMPARED TO NO DRAINAGE? A META-ANALYSIS OF RCTS

Author(s): Mr A Kafagi[1], Mr M Chowdhury[1], Mr AR Kafagi[2]

Institution: [1]Manchester Foundation Trust, United Kingdom. [2]University of Manchester, United Kingdom

Aims: To evaluate the outcomes of post-operative abdominal drain following laparoscopic cholecystectomy (LC) by comparing its use to no drain. This study aims to assess the impact of drain insertion on postoperative complications, pain and recovery metrics.

Methods: A systematic review and meta-analysis were performed, including studies up to December 2024. Studies were identified from major databases, including MEDLINE, Cochrane, and EMBASE. Randomised control trials evaluating the use of abdominal drains versus no drains after LC were included.

Primary outcomes included surgical site infections (SSI), post-operative nausea and vomiting (PONV), visual analogue scores (VAS) at 24 hours post-operation, abdominal collections, haemorrhage, bile leaks, re-operation, prolonged shoulder pain and respiratory complications. Secondary outcomes included operation times and length of stay.

Results: Forty-four studies with 5,692 patients were included in the meta-analysis. The use of drains was significantly associated with higher rates of SSIs ($P = 0.00001$), PONV ($P = 0.04$), longer operation times ($P = 0.0002$), longer hospital stays ($P = 0.0007$), and higher post-operative pain scores at 24 hours ($P = 0.00001$).

However, no significant difference was observed between the drain and no-drain groups for abdominal collections ($P = 0.60$), haemorrhage ($P = 0.40$), bile leaks ($P = 0.18$), re-operation ($P = 0.35$), prolonged shoulder pain ($P = 0.24$), or respiratory complications ($P = 0.30$).

Conclusion: Routine use of prophylactic abdominal drains following laparoscopic cholecystectomy is associated with increased postoperative complications. However, it does not aid in preventing abdominal collections, bile leaks or other complications. A selective approach is more appropriate, reserving drain use for high-risk scenarios such as challenging dissections, bile spillage, uncertain haemostasis or unclear anatomy.

Key statement: Routine drain placement following laparoscopic cholecystectomy was associated with significantly worse peri-operative outcomes including higher SSI rates, increased pain, PONV, longer operative duration, and prolonged hospital stay without reducing major post-operative complications such as bile leak, haemorrhage, abdominal collections, or re-operation.

Poster 15

GASTROINTESTINAL SYMPTOMS AND COLORECTAL REFERRAL IN WOMEN WITH ENDOMETRIOSIS: IDENTIFYING PATIENTS MOST LIKELY TO BENEFIT FROM MULTIDISCIPLINARY CARE

Author(s): Dr M Glover, Dr O Abiodun

Institution: Mid Yorkshire NHS Trust, Wakefield, United Kingdom

Aims: Gastrointestinal (GI) symptoms are common in women with endometriosis, but the relationship between symptom burden and disease phenotype remains incompletely understood. This study aimed to determine the prevalence of pre-operative GI symptoms in women attending a specialist endometriosis clinic and identify clinical, radiological and pathological factors associated with GI symptoms, including patterns of referral to colorectal services.

Methods: A retrospective service evaluation was conducted of women attending a single-centre endometriosis clinic at a district general teaching hospital within Mid Yorkshire Teaching NHS Trust between January and June 2026. Endometriosis was confirmed radiologically, surgically or histologically. Pre-operative GI symptoms were identified from clinic documentation. Associations between patient characteristics, disease phenotype and GI symptoms were assessed using chi-square and independent t-tests, with multivariable logistic regression performed to identify independent predictors of GI symptoms.

Results: Among 284 women, 220 (77.5%) reported at least one GI symptom. Dyschezia (45.8%) and bloating (42.3%) were the most prevalent symptoms. Women with deep infiltrating endometriosis (DIE) were more likely to report GI symptoms than those without DIE (81.7% vs 73.9%), with diarrhoea significantly more common (39.7% vs 26.8%, p=0.029). Following adjustment, DIE remained the only independent predictor of GI symptoms (adjusted OR 3.06, p=0.013). Rectovaginal disease and ovarian endometriomas were not independently associated with GI symptoms. Only 92/220 (41.8%) symptomatic women were referred to colorectal services.

Conclusion: GI symptoms affect over three-quarters of women attending a specialist endometriosis clinic. DIE is the strongest independent predictor of GI symptom burden, whereas rectovaginal disease and ovarian endometriomas are not. Despite the high prevalence of symptoms, fewer than half of symptomatic patients were referred for colorectal assessment, highlighting an opportunity to optimise multidisciplinary pathways for women with suspected bowel involvement.

Key statement: Deep infiltrating endometriosis is the strongest independent predictor of gastrointestinal symptoms in women with endometriosis, whereas rectovaginal disease and ovarian endometriomas are not. Despite the high prevalence of gastrointestinal symptoms, fewer than half of symptomatic women were referred to colorectal services, highlighting an opportunity to optimise multidisciplinary care.

Poster 16

FORAMEN OF WINSLOW HERNIA: FROM DIAGNOSTIC DILEMMA TO MINIMALLY INVASIVE MANAGEMENT—A SYSTEMATIC REVIEW

Author(s): Mr S Farahat

Institution: Hywel Dda University Health Board, Carmarthen, United Kingdom. Kafr Elsheikh University, Kafr Elsheikh, Egypt

Aims: Foramen of Winslow hernia (FWH) is a rare internal hernia associated with delayed diagnosis and significant morbidity. Owing to its rarity, evidence regarding optimal diagnostic and operative strategies remains limited. This systematic review aimed to evaluate the contemporary presentation, diagnostic modalities, operative management and clinical outcomes of patients with FWH, with particular emphasis on the evolving role of minimally invasive surgery and factors influencing bowel resection and postoperative outcomes.

Methods: A systematic review was performed according to PRISMA guidelines. PubMed, Scopus and Cochrane Library databases were searched from inception until 2026. Studies reporting patients with herniation through the foramen of Winslow were included. Data extracted included demographics, presenting symptoms, imaging findings, operative approach, need for bowel resection, complications and recurrence. Descriptive analyses were performed to evaluate temporal trends in diagnosis and management.

Results: Seventy-nine studies involving eighty-five patients were included. Most patients presented with acute abdominal pain and bowel obstruction. Computed tomography was the predominant diagnostic modality and substantially improved preoperative diagnosis. Historically, most patients underwent laparotomy; however, increasing utilisation of laparoscopy has been observed in recent years. Bowel resection was required predominantly in patients presenting with delayed diagnosis and intestinal ischaemia. Overall postoperative outcomes were favourable, with low mortality and very low recurrence rates. Laparoscopic management was shown to be feasible and safe in selected patients.

Conclusion: Foramen of Winslow hernia remains a rare but important cause of acute abdomen. Early cross-sectional imaging has significantly improved diagnostic accuracy and facilitated timely intervention. Minimally invasive surgery is increasingly being adopted and appears safe and effective in appropriately selected cases. Delayed diagnosis remains the principal factor associated with bowel ischaemia and resection. A laparoscopic-first strategy should be considered whenever technically feasible.

Key statement: This represents one of the largest contemporary systematic reviews of Foramen of Winslow hernia and demonstrates a clear shift towards earlier diagnosis with CT imaging and increasing adoption of laparoscopic management, resulting in improved patient outcomes and reduced need for bowel resection.

Poster 17

CAN WE ABANDON STAPLERS? A PROSPECTIVE EVALUATION OF HEM-O-LOK CLIPS IN PEDIATRIC SPLENECTOMY

Author(s): Mr S Farahat

Institution: Hywel Dda University Health Board, Carmarthen, United Kingdom. Kafr Elsheikh University, Kafr Elsheikh, Egypt

Aims: Laparoscopic splenectomy is considered the standard approach for benign haematological disorders in children. However, hilar control remains technically demanding and vascular staplers substantially increase procedural costs. This study aimed to evaluate the feasibility, safety and effectiveness of selective splenic hilar control using Hem-o-Lok polymer clips during paediatric laparoscopic splenectomy and to determine whether this technique could represent a reliable alternative to stapling devices.

Methods: A prospective study was conducted between May 2019 and December 2021 including children undergoing laparoscopic splenectomy for benign haematological disorders. The splenic artery and vein were individually skeletonised and controlled using Hem-o-Lok clips. Patient demographics, operative characteristics, intraoperative complications, conversion rates and postoperative outcomes were analysed. Patients were followed for three months after surgery.

Results: Twenty-three children underwent laparoscopic splenectomy with a mean age of 8.7 years. Indications included thalassaemia major (69.6%), hereditary spherocytosis (26.1%) and immune thrombocytopenic purpura (4.3%). Mean operative time was 93.4 minutes. Three cases (13.1%) experienced intraoperative bleeding; all were successfully managed laparoscopically and none were related to clip failure. No conversion to open surgery, postoperative bleeding or mortality occurred. Mean hospital stay was 1.2 days. Splenic extraction was achieved using a handmade retrieval bag in 73.9% of patients.

Conclusion: Selective control of the splenic hilum using Hem-o-Lok clips is feasible, safe and cost-effective in paediatric laparoscopic splenectomy. The technique achieved excellent vascular control with zero conversions and no clip-related complications. Given the increasing financial pressures on healthcare systems, Hem-o-Lok clips may represent an attractive alternative to expensive stapling devices, particularly in low-resource settings. Larger multicentre studies are warranted to validate these findings**.**

Key statement: Hem-o-Lok clips provided reliable hilar control during paediatric laparoscopic splenectomy with no clip-related morbidity or conversion to open surgery. This study suggests that stapling devices may not be routinely necessary, offering a simpler and substantially more cost-effective approach to minimally invasive splenectomy in children.

Poster 18

APPENDICECTOMY AS AN ADJUNCTIVE STRATEGY IN ULCERATIVE COLITIS: WHERE DOES THE EVIDENCE STAND?

Author(s): Ms MJNR Vanojan[1], Dr D Kumaresan[2], Dr OO Agbabiaka[3], Mr S Yahia[4]

Institution: [1]Queen Alexandra Hospital: Portsmouth Hospitals NHS Trust, United Kingdom. [2]University Hospital Coventry, United Kingdom. [3]Doncaster Royal Infirmary, United Kingdom. [4]George Eliot Hospital, Nuneaton, United Kingdom

Aims: Growing epidemiological, immunological, and clinical evidence suggests appendicectomy may play a role in the disease pathogenesis of ulcerative colitis (UC). This review aims to evaluate the role of the appendix in UC and assess the clinical impact of appendicectomy on disease onset, severity, relapse, and long-term outcomes. It explores the therapeutic potential of appendicectomy as an adjunctive treatment and discusses the associated long-term risks of colectomy and colorectal cancer. The review also identifies important directions for future research.

Methods: A narrative review was conducted using a structured PubMed search for studies published after 2000. Eligible publications included systematic reviews, meta-analyses, randomised controlled trials, prospective and retrospective cohort studies, and case-controlled studies. Evidence was appraised based on disease onset, surgical timing (pre- vs. post-UC diagnosis), colectomy risk, refractory disease state, and long-term risk of colorectal cancer. Single case reports, non-English publications, and studies without defined endpoints were excluded. Given the marked heterogeneity of published study designs, a qualitative synthesis was performed.

Results: Current evidence suggests that the appendix functions as an immune-priming site and microbial reservoir in UC pathogenesis. Appendicectomy before UC diagnosis, particularly for appendicitis, correlates with lower hospitalisation and colectomy rates. But appendicectomy after UC diagnosis shows variable outcomes depending on the presence of inflammation at the time of surgery and other patient factors. The two major clinical trials ACCURE and PASSION, demonstrate reduced relapse rates in patients with refractory disease. However, some studies show conflicting evidence related to colectomy rates and the risk of developing colorectal cancer in the long term.

Conclusion: Appendicectomy may act as a selected, organ-preserving adjunct to medical therapy in carefully chosen patients with UC. Current evidence, however, remains heterogeneous, largely retrospective, and limited by small sample sizes and short follow-up. Robust, biomarker-driven, multicentre randomised controlled trials are required to establish clear patient selection criteria, definitive long-term safety profiles, and therapeutic efficacy before this approach can be safely adopted in routine surgical practice.

Key statement: The appendix plays a vital immunological and microbial role in the disease pathogenesis of UC. Emerging studies suggest appendicectomy might be beneficial in selected patients with UC. But it also carries risks of colectomy and colorectal cancer. The current evidence is heterogeneous and limited to smaller sample sizes and short-term follow up restricting drawing definitive conclusions. Large multicentre studies are required to recognise the correct biomarkers of patient selection and to understand the place of appendicectomy in the algorithm of UC management. Until we have robust evidence, appendicectomy should only be considered in research settings in highly selected patients.

Poster 19

OUTCOMES OF COLLAGEN AND CONVENTIONAL DRESSINGS IN DIABETIC FOOT ULCERS: A COMPARATIVE STUDY IN BANGLADESH

Author(s): Mr MA Rahman

Institution: Kettering General Hospital and NHS Trust, United Kingdom

Aims: With a lifetime risk of 19% to 34%, diabetic foot ulcers (DFU) are a major consequence of diabetes and a major cause of lower-extremity amputation. Effective management techniques are essential given this high burden, especially in Bangladesh where DFU is becoming a more serious health issue. The purpose of this study was to compare the effectiveness of collagen and traditional dressings in the treatment of DFU patients.

Methods: An observational comparative cross-sectional study was conducted in the Department of Surgery, Dhaka Medical College Hospital, over six months. A total of 100 patients with DFU were enrolled and equally divided into two groups: one treated with collagen dressing and the other with conventional dressing. Patients were recruited following inclusion and exclusion criteria, and informed consent was obtained. Data on socio-demographic characteristics, glycemic control, and treatment outcomes were collected. Outcome assessment focused on time to granulation and complete healing. Data were analyzed using STATA(version 13).

Results: The mean age of participants was 60.07±10.39 years (range: 34–78 years); 77% were male. Mean HbA1c was comparable between groups (collagen: 8.12±1.14% vs. conventional: 8.05±0.74%). Granulation occurred significantly earlier in the collagen group (2.26±1.58weeks) than in the conventional group (3.76±1.57 weeks; $p<0.001$). Similarly, mean healing time was shorter with collagen (4.90±2.54 weeks) compared to conventional dressing (6.24±3.76 weeks; $p<0.05$). Hazard ratio analysis showed granulation tissue appeared 1.96 times more likely with collagen dressing than conventional (HR: 1.96; 95% CI: 1.31–2.96; $p<0.05$).

Conclusion: Diabetic foot ulcers, which involve prolonged healing and high risk of infection, are a major cause of morbidity, mortality, and hospitalization in diabetic patients. This study found that collagen dressing outperforms conventional dressings, promoting faster healing and earlier granulation, with granulation tissue nearly twice as likely to appear early.

Key statement: Collagen dressing is more effective than conventional dressing for diabetic foot ulcers, resulting in significantly earlier granulation tissue formation and faster wound healing.

Poster 20

GRAHAM'S PATCH VERSUS MODIFIED GRAHAM'S PATCH IN THE MANAGEMENT OF PERFORATED DUODENAL ULCER

Author(s): Mr MA Rahman

Institution: Kettering General Hospital and NHS Trust, United Kingdom

Aims: Perforated duodenal ulcer is a severe complication of peptic ulcer disease, necessitating prompt resuscitation and surgical intervention to reduce morbidity and mortality. This study compared outcomes and complications of Graham's patch versus Modified Graham's patch repair in patients with perforated duodenal ulcers at a tertiary care hospital in Bangladesh.

Methods: A comparative observational study was conducted in the Department of Surgery, Dhaka Medical College Hospital, over six months in 2018. Sixty patients meeting inclusion criteria were enrolled (30 per group) using systematic sampling. Postoperative outcomes, including wound infection, leakage, intra-abdominal abscess, pyrexia, and hospital stay, were recorded using a pre-designed data sheet and analyzed with SPSS version 24.

Results: The mean age of participants was 34.22 ± 8.59 years, with a male-to-female ratio of 2:1. Pus in the intraperitoneal cavity was noted in 90% of the Graham's patch group and 67% of the Modified Graham's patch group. Wound infection and postoperative fever were the most common complications in both groups, with no statistically significant differences ($p=0.59$ and $p=0.78$, respectively). Mean hospital stay was 6 days for Graham's patch and 7.8 days for Modified Graham's patch ($p=0.145$).

Conclusion: Both Graham's patch and Modified Graham's patch repairs were safe and effective, showing comparable short-term outcomes and postoperative complications. Surgical choice can be guided by surgeon experience and intraoperative considerations. Larger multi-center studies with extended follow-up are recommended to assess long-term outcomes.

Key statement: Graham's patch and Modified Graham's patch are equally safe and effective for the surgical repair of perforated duodenal ulcers, with no significant differences in short-term outcomes.

POSTER 21

EVALUATION OF AWARENESS AND COMPLIANCE WITH THE GASTROGRAFIN SOP FOR ADHESIVE SMALLBOWEL OBSTRUCTION AT KETTERING GENERAL HOSPITAL

Author(s): Mr MA Rahman

Institution: Kettering General Hospital and NHS Trust, United Kingdom

Aims: Adhesive small bowel obstruction (ASBO) accounts for a significant proportion of emergency surgical admissions. Gastrografin, a hyperosmolar water-soluble contrast agent, is both diagnostic and therapeutic in non-surgical ASBO management. A new Gastrografin standard operating procedure (SOP) was implemented at Kettering General Hospital in March 2024 to improve standardized care.

Methods: An initial survey assessed staff awareness, confidence, and involvement with the new SOP. Recommendations, including email dissemination, posters, and targeted education sessions were implemented. A re-audit using the same questionnaire measured improvements in awareness and confidence across staff groups.

Results: Initial results showed 61.9% SOP awareness and 59.5% confidence, though 81% had participated in Gastrografin use. Respondents ranged from nurses to consultants, with confidence gaps greatest among junior staff. After implementing recommendations, awareness rose to 83.9%, confidence to 78.1%, and 81% reported active SOP involvement.

The re-audit demonstrated substantial improvement in communication, engagement, and protocol adoption among clinical teams.

Conclusion: Targeted quality improvement interventions markedly increased staff awareness, confidence, and engagement with the Gastrografin SOP, highlighting the value of continuous education and re-audit in improving clinical practice.

Key statement: Structured education sessions and effective, strategic dissemination of the SOP significantly improved staff engagement with the Gastrografin SOP. Continuous training, visibility of protocols, and periodic re-auditing are essential to sustain awareness, ensure adherence, and enhance patient management in adhesive small bowel obstruction.

Poster 22

REDUCING THE ENVIRONMENTAL IMPACT OF COLORECTAL MDT MEETINGS THROUGH EXISTING DIGITAL WORKFLOWS: A TWO-CYCLE AUDIT

Author(s): Miss A Mahmood, Mr J Finch

Institution: University Hospitals of Northampton NHS Trust, United Kingdom

Aims: To evaluate the environmental and financial impact of colorectal MDT printing and assess whether promoting the use of existing digital workflows could reduce unnecessary printing, associated costs and carbon emissions.

Methods: Five colorectal MDT meetings were evaluated before and after an intervention encouraging MDT members to use electronically distributed agendas on Trust laptops following presentation of baseline environmental impact data. Data collected included agenda size, pages printed, paper type, printing format and unused agendas. Printing costs were derived from Trust procurement data. Carbon emissions from paper, printing and disposal were estimated using UK Government Department od environment food and rural affairs (DEFRA) greenhouse gas conversion factors, while toner emissions were estimated using published life-cycle assessment data. Outcomes were compared using identical methodology between audit cycles.

Results: Across five MDT meetings in each audit cycle, the combined number of pages in provisional and final agendas increased by 40% (1,045 to 1,416), yet printed pages decreased by 16.5% (8,078 to 6,743). Routine printing of provisional agendas and use of virgin paper were eliminated. Mean carbon emissions fell from 5.8 to 4.84 $kgCO_2e$ per MDT (17.2% reduction), while printing costs decreased from £9.04 to £7.48 per MDT. Estimated emissions and electricity costs associated with using existing laptops were substantially lower (0.45 $kgCO_2e$ and £0.74 per MDT), highlighting the environmental and financial benefits of utilising existing digital infrastructure.

Conclusion: Promoting the use of existing electronic MDT documentation reduced unnecessary printing, associated costs and carbon emissions. However, the increasing volume of MDT documentation suggests that further sustainability gains will require optimisation of agenda content alongside wider adoption of digital working.

Key statement: Existing digital systems are underused in many MDTs. Small changes to how these systems are used may reduce unnecessary printing and support NHS sustainability without requiring major technological investment.

Poster 23

AN UNUSUAL CAUSE OF ANORECTAL SEPSIS: ISCHIORECTAL ABSCESS SECONDARY TO AN INGESTED FISHBONE

Author(s): Mr S Olusola

Institution: Royal Free London Hospital Foundation Trust, United Kingdom

Aims: Anorectal abscesses are a common surgical emergency, most frequently resulting from cryptoglandular infection following obstruction of the anal glands. Foreign body-associated anorectal abscesses are exceptionally rare.

Methods: We report the case of a 26-year-old man presenting with a one-week history of dyschezia, fever, and progressively worsening perianal pain. Examination demonstrated extensive induration of the left ischiorectal fossa extending posteriorly towards the natal cleft. Laboratory investigations revealed a white cell count of 19.44×10^9/L and a C-reactive protein level of 129.5 mg/L. Owing to significant pain and clinical suspicion of a deep anorectal abscess, urgent examination under anaesthesia and incision and drainage were performed.

Results: Operative findings demonstrated a large left ischiorectal abscess extending into the posterolateral intersphincteric space. Drainage of the collection revealed a sharp, splinter-like foreign body measuring approximately 3 cm, embedded within the sphincter complex. The object was removed and was considered most consistent with a fishbone. A small area of dimpling and surrounding inflammatory change was identified in the posterolateral anal canal, likely representing the site of mucosal perforation and entry of the foreign body. The patient made an uncomplicated recovery, completed a course of antibiotics, and was discharged on postoperative day three.

Conclusion: Foreign body-induced anorectal abscesses are extremely uncommon, with only 15 cases identified in the published literature. We hypothesise that the fishbone perforated the anal canal, creating a fistulous tract into the surrounding soft tissues and resulted in abscess formation. Prompt surgical drainage and complete foreign body removal are essential to achieve source control and prevent ongoing sepsis.

Key statement: Surgeons should be aware that foreign bodies can rarely result in acute anorectal abscess formation. Prompt surgical drainage and complete foreign body removal are essential to achieve source control and prevent ongoing sepsis.

Poster 24

MIGRATED BILIARY STENT RESULTING IN CAECAL PERFORATION INTO THE APPENDIX: A RARE DELAYED COMPLICATION OF ERCP

Author(s): Mr S Olusola, Mr A Alkhlaifat, Mr J Gosling

Institution: Royal Free London NHS Foundation Trust, United Kingdom

Aims: Biliary tract obstruction is multifactorial and is managed surgically and non-surgically. Endoscopic Retrograde Cholangiopancreatography (ERCP) with biliary stent insertion for biliary obstruction offers less invasive management. Stent migration occurs in 5–10% of cases and usually resolves spontaneously; however, approximately 1% result in intestinal perforation.

Methods: We present the case of a 62-year-old female who underwent elective laparoscopic cholecystectomy in December 2023. One week later, she required laparoscopic biliary washout and ERCP with plastic biliary stent insertion for bile leak and intra-abdominal collection. In September 2024, ERCP was attempted for stent removal; however, the stent was not visualised and presumed to have passed spontaneously. One month later, the patient presented with intermittent right-sided abdominal pain. CT imaging demonstrated migration of the biliary stent into the caecum.

Results: She remained haemodynamically stable with no evidence of bowel obstruction, hence elective colonoscopy was arranged, where the stent was visualised in the ascending colon but could not be retrieved endoscopically.
We subsequently performed a laparoscopic right colonic mobilisation, appendicectomy, and stent removal. Intra-operatively, the appendiceal tip was adherent to the caecum, with the stent having migrated through the colonic wall into the appendiceal tip lumen. The small caecal defect was repaired primarily with PDS sutures. Recovery was uncomplicated, and the patient was discharged on postoperative day two.

Conclusion: Biliary stent migration causing caecal and appendiceal perforation is rare. Surgeons should maintain a high index of suspicion for stent-related complications in symptomatic patients following ERCP and ensure close follow-up of biliary stents, to avoid delayed intestinal perforation.

Key statement: Migrated biliary stents can cause delayed intestinal perforation. This rare case highlights the importance of maintaining a high index of suspicion for stent-related complications in symptomatic patients following ERCP and ensuring close follow-up of biliary stents.

Poster 25

REDUCING POST BREAST RECONSTRUCTION INFECTION RATES: OUR JOURNEY TO ACHIEVING LOW POSTOPERATIVE INFECTION OUTCOMES

Author(s): Mr B Meglaa[1], Mr M Tawfeek[1], Mr A Abdel-ghani[1], Dr M Elsaify[2], Mr M Shaaban[1]

Institution: [1]Department of Breast Surgery, South Tees Hospitals NHS Foundation Trust, James Cook University Hospital., Middlesbrough, United Kingdom. [2]The Medical School, Newcastle University, United Kingdom

Aims: This retrospective study aimed to evaluate surgical site infection (SSI) rates following implant-based breast reconstruction at James Cook University Hospital and Friarage Hospital between December 2022 and June 2024, and to compare infection rates before and after implementation of the Protocol of Breast Reconstruction Surgery (PBRS).

Methods: The PBRS covered every stage of care.

Preoperative: MRSA screening and treatment if positive, chlorhexidine showering, medical photography, and maintenance of normal body temperature.

Perioperative: Intravenous teicoplanin at induction and for 48 hours, laminar airflow, restricted theatre traffic, masks, hooded covers, and double-gloving, chlorhexidine skin preparation, nipple shields, atraumatic dissection and meticulous haemostasis. Before implant insertion, the field was re-prepared and re-draped, gloves changed, and a separate sterile tray opened. Implant exposure was minimised, and antibiotic irrigation was used for the pocket, implant, and mesh.

Postoperative: PICO dressing for seven days, wound monitoring, and standardised drain removal and closure.

Results: Thirty-one women underwent 48 breast reconstruction procedures. Two infection related complications occurred (2/48; 4.17%). The first was a delayed implant-site infection at 47 days (1/48; 2.08%), which required implant removal, compared with our previously documented local infection rate of 23% and the 25% rate reported in the National Mastectomy and Breast Reconstruction Audit. The second was a superficial drain-exit-site infection (1/48; 2.08%), which did not involve the reconstruction and resolved with an appropriate course of culture directed oral antibiotics. Overall, six procedures (6/48; 12.5%) developed complications, including skin necrosis (n=2), wound dehiscence (n=1), and seroma (n=1).

Conclusion: Strict adherence to a standardised, multimodal breast reconstruction infection-control protocol was associated with a low implant-site infection rate . The protocol may improve outcomes by combining patient preparation, theatre controls, antimicrobial measures, careful implant handling, wound management, and drain care.

Key statement: A coordinated infection control bundle reduced implant-site infection . Consistent multidisciplinary adherence to every stage of the pathway appears central to achieving safer implant based reconstruction.

Poster 26

PATTERNS OF MICROSCOPIC MARGIN INVOLVEMENT FOLLOWING PANCREATICODUODENECTOMY FOR PANCREATIC AND PERIAMPULLARY CANCER

Author(s): Dr S Quraishi, Ms A Hussein, Mr E Mohamed, Dr S Pathiraja, Dr A Zaitoun

Institution: Nottingham University Hospitals, United Kingdom

Aims: Surgical resection with tumour-free margins remains the cornerstone in offering the best chance of cure and prolonged survival for patients presenting with pancreatic cancers. The aim of this study was to evaluate the frequency of R1 resections and the pattern of histopathological margin involvement at our institution.

Methods: We retrospectively analysed patients who underwent pancreaticoduodenectomy for biopsy confirmed pancreatic or periampullary cancer at our centre in the period between 1st January 2020 to 31st May 2026. Patient's demographics in addition to pertinent clinicopathological data were extracted and logged.

Results: 141 pancreaticoduodenectomies were performed at our institution during the study period of which 100 cases were within the inclusion criteria. These were for pancreatic cancer (n=40), distal cholangiocarcinoma (n=18), ampullary (n=34) and duodenal (n=8). Neoadjuvant chemotherapy was administered in 7% of the cases (n= 7).

The overall rate of R1 resection was 37% (n=37) with incidence of margin involvement in order of frequency as follows: SMV groove 18% (n=18), posterior margin 17 % (n=17), neck margin 10% (n=10), anterior margin 7% (n=7) with no margin involvement of bile duct, gastric/duodenal, jejunal margins in any of the resected cases

Conclusion: This study highlights the high prevalence of R1 resections following pancreaticoduodenectomy in contemporary series, appropriate preoperative staging is crucial and in particular tumour contact with mesenteric vessels to guide decisions for receiving neoadjuvant chemotherapy. Routine frozen section from pancreatic neck margin should be routine as well as skillset to perform venous resection in expert HPB centres.

Key statement: This study highlights the high prevalence of R1 resections following pancreaticoduodenectomy in contemporary series, appropriate preoperative staging is crucial and in particular tumour contact with mesenteric vessels to guide decisions for receiving neoadjuvant chemotherapy. Routine frozen section from pancreatic neck margin should be routine as well as skillset to perform venous resection in expert HPB centres.

Poster 27

AVOIDING A SECOND SURGERY: USE OF AN ALEXIS (APPLIED MEDICAL) FOR LAPAROSCOPIC CHOLECYSTECTOMY DURING STOMA REVERSAL

Author(s): Miss A Carrie, Mr R Mitchell, Miss HA Owen, Mr D Tsironis

Institution: St George's University Hospitals NHS Foundation Trust, London, United Kingdom

Aims: This case describes a novel approach of laparoscopic cholecystectomy using a medium Alexis (Applied Medical) during open closure of stoma, to avoid multiple operations for a comorbid patient. Comorbidities included Rheumatoid Arthritis on long-term steroids, Crohn's Disease, high output ileostomy and chronic kidney disease. This interesting technique allowed minimally invasive access to the gallbladder and avoided the morbidity associated with further surgery or a large wound extension to perform an open cholecystectomy. This technique can be considered in high-risk patients where two pathologies can be safely managed simultaneously.

Methods: This 60-year-old lady had a background of emergency ileocolic resection for Crohn's disease with ileocolostomy and a large parastomal hernia causing abdominal pain and bag leaks. Her CT scan showed chronic cholecystitis. She was reviewed in joint clinic in a tertiary centre by a Colorectal and an Upper GI consultant and was planned for surgery to treat both pathologies following high risk anaesthetic assessment. She received preoperative ultrasound guided abdominal wall Botox and underwent an open closure of ileocolostomy, laparoscopic cholecystectomy and retro-rectus incisional hernia repair at the former stoma site.

Results: The ileocolostomy was mobilised and the anastomosis was hand sewn. It was introduced to the abdomen and a medium capped Alexis with 12mm port was placed over the stoma site. This is a common technique in laparoscopic colorectal surgery. Ports were inserted in the right upper quadrant and flank. A laparoscopic cholecystectomy was performed. The gallbladder was retrieved through the Alexis. The hernia sac was excised, and the abdominal wall was reconstructed with a biologic mesh placed in the retrorectus plane. The stoma site was closed. She was discharged postoperative day fourteen following a chest infection with no abdominal complications.

Conclusion: A laparoscopic cholecystectomy was successfully performed through a medium Alexis through a stoma site closure. This technique allows the operations to be performed together and avoids a further general anaesthetic in a high-risk patient. Use of the Alexis avoided extending the stoma site to perform an open cholecystectomy and prevents the associated morbidity and mortality. She developed a pneumonia but no abdominal complications. This technique could be considered in further appropriate patients who are candidates for stoma closure and require a cholecystectomy.

Key statement: The application of minimal access techniques after formation of the anastomosis in stoma closure can facilitate laparoscopic surgery to treat a separate pathology. This can be considered in carefully selected patients during preoperative planning to avoid multiple operations. This has positive implications for patient care, as the surgery is minimally invasive which has reduced morbidity and the patient only requires a single operation which further prevents morbidity, provides efficient care and carries financial benefits.

Poster 28

OCKHAM'S RAZOR OR HICKAM'S DICTUM? A REVIEW OF ABDOMINAL CT TO ESTIMATE THE PREVALENCE OF SAINT'S TRIAD IN ACUTE ABDOMEN

Author(s): Dr P Wanichnopparat, Mr SBB Pillai, Dr H Bagul

Institution: Lincoln County Hospital, United Kingdom

Aims: Saint's triad postulates the co-existence of hiatus hernia, diverticulosis, and gallstones. It suggests active search for the other two components if one entity is encountered.Prevalence rates as high as 25% have been reported in some historical series even though contemporary evidence is sparse and variable . This study aims to revisit the triad and estimate it's prevalence in a large series of contrast enhanced CT images done in acute abdominal conditions.

Methods: This retrospective observational study was conducted in the emergency department of a District General/Teaching Hospital in East Midlands, UK. Patients presenting to the emergency department with a clinical diagnosis with acute abdomen and undergoing CECT scans were included in the study. Data was entered in Excel worksheet and processed using Numiqo Datatab statistical calculator. Results were expressed in numbers and percentages, and 2x2 contingency tables and Venn diagrams were created to organise and visualise the outcomes.

Results: We analysed 486 CT scans. Sixty patients (12.35%) had hiatus hernia, 117 had gallstones, and 127 patients had diverticulosis. Fifteen patients (3.09%) had a combination of hiatus hernia and gallstones, while 27 patients (5.56%) had both hiatus hernia and diverticulosis. Gallstones with diverticulosis was found in 45 patients (9.26%). Only 5 out of 486 patients (1.02%) had all three components of Saint's triad.

Conclusion: We conclude that the co-existence of these three entities are likely due to chance than any underlying common pathogenic pathway, given the high prevalence of individual components in the population.

Key statement: This study was an attempt to estimate the prevalence of Saint's triad in a large series of acute abdominal imaging. The very low prevalence of 1.02% suggests that the triad is more likely due to chance (supporting Hickam's dictum) rather than a common underlying thread of causation (favoring Ockham's razor).

Poster 29

QUALITY OF LIFE FOLLOWING SURGICAL MANAGEMENT OF INFLAMMATORY BOWEL DISEASE: A SYSTEMATIC REVIEW OF OPEN, LAPAROSCOPIC, AND ROBOTIC APPROACHES

Author(s): Dr B Alrayes[1], Dr A Farrugia[2]

Institution: [1]University Hospital of Coventry and Warwickshire, Coventry, United Kingdom. [2]UHNM, Stoke on Trent, United Kingdom

Aims: To systematically evaluate postoperative quality-of-life outcomes following surgical management of IBD and compare QoL outcomes across open, laparoscopic, and robotic surgical approaches.

Methods: A systematic review was conducted in accordance with PRISMA 2020 guidelines and prospectively registered in PROSPERO. MEDLINE, Embase, Web of Science, and the Cochrane Central Register of Controlled Trials were searched from database inception to March 2026. Studies involving adult patients with IBD undergoing surgical treatment and reporting postoperative QoL using validated instruments were eligible. Two reviewers independently screened studies, extracted data, and assessed methodological quality, with disagreements resolved by a third reviewer. Risk of bias was evaluated using the Newcastle–Ottawa Scale as appropriate. Owing to substantial clinical and methodological heterogeneity, findings were synthesized narratively.

Results: Forty-eight studies involving over 13,000 patients were included. Surgical treatment was generally associated with favourable long-term QoL outcomes in both Crohn's disease and ulcerative colitis. Comparative studies suggested improved short-term recovery and QoL following laparoscopic surgery compared with open surgery, although long-term outcomes were largely similar. Limited evidence indicated comparable QoL outcomes between robotic and laparoscopic surgery. Disease recurrence, chronic pouchitis, pelvic sepsis, pouch dysfunction, faecal incontinence, increased stool frequency, and permanent stoma formation were consistently associated with poorer QoL.

Conclusion: Surgery is associated with favourable long-term QoL in IBD. Long-term outcomes appear to depend more on disease control and functional outcomes than on surgical access alone.

Key statement: Inflammatory bowel disease; Crohn's disease; ulcerative colitis; quality of life; laparoscopy; robotic surgery; systematic review.

Poster 30

EARLY OUTCOMES OF A NEW-DESIGN ACELLULAR DERMAL MATRIX IN IMMEDIATE BREAST RECONSTRUCTION: A RETROSPECTIVE COHORT STUDY

Author(s): Mr B Meglaa, Mr M Tawfeek, Mr A Abdelghani, Mr M Shaaban

Institution: Department of Breast Surgery, South Tees Hospitals NHS Foundation Trust, James Cook University Hospital., Middlesbrough, United Kingdom

Aims: Acellular dermal matrix (ADM) facilitates implant-based breast reconstruction, particularly prepectoral reconstruction, but evidence regarding newer ADM designs remains limited. This study evaluated the early clinical outcomes of a new-design ADM used in immediate breast reconstruction. Secondary objectives were to assess reconstructive approach, postoperative complications, aesthetic outcomes, and patient satisfaction.

Methods: A retrospective observational cohort study included all patients undergoing ADM-assisted breast reconstruction between January 2021 and June 2024. Demographic, operative, treatment, complication, and follow-up data were obtained from clinical records, operation notes, multidisciplinary team documentation, and clinic correspondence. Patient-reported recovery and aesthetic outcomes were assessed using a questionnaire.

Results: Twenty-five women underwent 33 reconstructions; 32% had bilateral procedures. Prepectoral placement was used in 31 breasts (94%), with 13 direct-to-implant (39%) and 20 two-stage reconstructions (61%). Complications affected nine breasts (27%): infection 2 (6%), capsular contracture 3 (9%), and skin necrosis, seroma requiring intervention, implant rupture, and a minor wound defect in one breast each (3%). One infection required implant removal; the other was managed with washout and expander exchange. Nineteen patients (76%) reported satisfaction with recovery and aesthetic outcomes.

Conclusion: Early experience with this new-design ADM demonstrates that it can support immediate implant-based breast reconstruction, predominantly using a prepectoral approach, with favourable patient-reported outcomes. Complications occurred in 27% of reconstructed breasts, although implant loss following infection was uncommon.

Key statement: In this early cohort of 25 patients and 33 ADM-assisted breast reconstructions, 94% were prepectoral and 76% of patients were satisfied with recovery and aesthetic outcomes. The overall complication rate was 27% per reconstructed breast, while infection occurred in 6%. New-design ADM appears to be a feasible option for immediate implant-based reconstruction, but larger prospective comparative studies are needed before definitive conclusions can be drawn.

Poster 31

MANAGEMENT OF INFECTED MESH POST LAPAROSCOPIC TRANS-ABDOMINAL PRE-PERITONEAL INGUINAL HERNIA REPAIR: A RARE CASE REPORT

Author(s): Dr S Bhusal

Institution: NPI - Narayani Samudayik Hospital, Bharatpur, Nepal

Aims: The laparoscopic approach to an inguinal hernia is a popular technique for many reasons, one being the low risk of mesh infection. This case report highlights the management of infected mesh following Trans-abdominal Pre peritoneal (TAPP) repair of inguinal hernia surgery.

Methods: 43-year-old man presented to the surgical outpatient department with a five-week history of pain and swelling in the right groin with fever. He had a history of a laparoscopic trans-abdominal pre-peritoneal right inguinal hernia repair seven weeks prior in other center. Initial treatment was done with oral antibiotics and watchful waiting. Unfortunately, his symptoms and the swelling persisted. Mesh Infection confirmed and surgery planned with laparoscopic approach. During laparoscopy the collection was approached via peritoneal opening slightly different to previous incision. Drainage of the collection along with removal of the mesh was done.

Results: Following the surgery the patient recovered gradually and was discharged five days after the operation. He did require brief period of intravenous antibiotics before being discharged.

Conclusion: This case illustrates management approach of very rare case. Classical management of mesh infection is local debridement, irrigation, mesh removal and systemic antibiotics. It is the method of mesh removal that differentiates this case from other cases described in the literature. That technique, though useful in encouraging any ongoing infection to drain out via the skin, disrupts the planes of tissue of the inguinal canal, thus making an open repair more difficult in the future. Thus this case demonstrates successful treatment of infected mesh with laparoscopic approach.

Key statement: Infected mesh, mesh explantation, laparoscopy, inguinal hernia, TAPP.

Poster 32

PAIN DURING INTERMITTENT SELF-CATHETERISATION PRECEDING BLADDER PERFORATION IN A PATIENT WITH MULTIPLE SCLEROSIS

Author(s): Dr M Glover

Institution: Pinderfields Hospital, Wakefield, United Kingdom

Aims: Intermittent self-catheterisation (ISC) is the gold standard for managing neurogenic bladder dysfunction and is generally considered safe. Bladder perforation is an exceptionally rare but potentially life-threatening complication, with delayed diagnosis associated with significant morbidity. We report a case of intraperitoneal bladder perforation in a patient with multiple sclerosis, highlighting sudden deep pelvic pain during catheter insertion as a potentially novel early warning sign.

Methods: A woman in her 30s with multiple sclerosis and neurogenic bladder managed with ISC for 13 years presented with severe abdominal pain, nausea and urinary retention after experiencing sudden deep pelvic pain during routine catheterisation. Initial assessment suggested urinary tract infection; however, clinical deterioration prompted further investigation with laboratory tests, point-of-care ultrasound and computed tomography. Following haemodynamic instability and persistent diagnostic uncertainty, exploratory laparoscopy with conversion to laparotomy was performed.

Results: The patient developed acute kidney injury, abdominal free fluid and haemodynamic instability. CT demonstrated ascites but no definite bladder perforation. Exploratory laparoscopy with conversion to laparotomy with intraoperative methylene blue testing and cystoscopy identified a small intraperitoneal perforation at the bladder dome, which was repaired primarily. Postoperative cystography demonstrated successful healing without contrast extravasation, and the patient resumed ISC following catheter removal. A review of the published literature identified five previous reports of native bladder perforation associated with ISC; none described acute pain during catheter insertion preceding diagnosis.

Conclusion: Bladder perforation should be considered in patients presenting with abdominal pain or clinical deterioration following ISC, even when initial imaging is inconclusive. Sudden deep pelvic pain during catheter insertion may represent an early clinical indicator of bladder injury and should prompt immediate cessation of catheterisation and urgent assessment. Recognition of this symptom may facilitate earlier diagnosis and reduce morbidity associated with delayed treatment.

Key statement: Bladder perforation is a rare but potentially life-threatening complication of intermittent self-catheterisation that should be considered in patients presenting with abdominal pain, urinary retention, acute kidney injury or abdominal free fluid, even when initial CT imaging is inconclusive. This case identifies sudden deep pelvic pain during catheter insertion as a potentially novel early warning sign of bladder perforation. A review of the literature identified five previous cases of native bladder perforation associated with intermittent self-catheterisation, none of which reported pain during catheter insertion preceding diagnosis. Early recognition and prompt surgical management are essential to reduce morbidity.

Poster 33

EVALUATING THE EFFECTIVENESS OF URGENT ULTRASOUND SCAN REQUESTS FROM THE SURGICAL SAME DAY EMERGENCY CARE

Author(s): Dr S Rehman, Dr D Muraleetharan, Mr B Abdeen, Mr G Finch

Institution: Northampton General Hospital, United Kingdom

Aims: To evaluate the appropriateness, quality, and timeliness of urgent ultrasound requests from the surgical SDEC department. To quantify the request volume and clinical indications, assess their clinical appropriateness against national guidelines, evaluate the quality of request documentation, and determine the proportion of urgent requests that could have been managed safely through routine outpatient pathways. To develop local ultrasound requesting guidelines.

Methods: A retrospective clinical audit in which 94 urgent ultrasound requests from surgical SDEC were analysed between the 20th of January and the 26th of February 2026. Scan requests were assessed against national guidelines to determine their appropriateness for SDEC USS hot clinic. The quality of requests including clarity of clinical details and documentation was also assessed as well as the interval time from scan request to completion. The proportion of patients who do not attend (DNA's) was also calculated to assess whether appointment delay is associated with non-attendance.

Results: Out of 94 patients (66F, 27M) only 45% of the USS requests were deemed appropriate for SDEC with 42/94 having a clear clinical question documented. 85% of the requests were from general surgery with biliary pathology being the most frequent reason for scan request. Out of those, 56 requests were for investigating gallstones and 7 queering acute cholecystitis. 13 requests were for gynaecological abdominal pain, 9 investigating testicular abnormalities, 2 looking for renal stones, and 3 assessing a collection. The average wait time for USS was 11 days and there was 34 DNAs in the that period (25%).

Conclusion: The audit identified the overutilisation of urgent USS capacity for non-time critical indications alongside inconsistent documentation quality. This has resulted in long waits and delays for urgent scans. As a result, we have developed local guidelines defining urgent versus outpatient scan indications to ensure appropriate requesting, improved prioritisation of urgent cases and more efficient use of radiology capacity We have carried out departmental teaching to resident doctors to further reinforce this.

Key statement: Audit cycle completion is planned in 3 months, and we hope to see improved patient flow and safety as a result of our intervention along with increased appropriateness of scan requests which will also relieve radiological burden.

Poster 34

IS THE INVESTMENT WORTH IT? EARLY CLINICAL AND PROCEDURAL COST-EVALUATION OF ROBOTIC-ASSISTED SURGERY (RAS), FOR BENIGN DISEASE, IN A DGH

Author(s): Ms B Davies, Mr R Parameswaran, Mr C Brunning

Institution: Arrowe Park Hospital, Birkenhead, United Kingdom

Aims: RAS is becoming rapidly adopted in the surgical management of benign disease. Whilst RAS has been mainly confined to tertiary centres and specific procedures, the utilisation in District General Hospitals (DGHs) has limited published data.

We aimed to evaluate the early introduction of RAS in a DGH, by assessing the learning curve, peri-operative outcomes, complications and direct procedural costs of robotic cholecystectomies (RC) and robotic inguinal hernia repairs (RIH).

Methods: Retrospective analysis of a prospective database of RC (n=21) and RIH (n=16) in the first two years of implementation (2024-2026). Patient demographics, operative details, peri-operative outcomes and post-operative status were all explored and analysed. Direct procedural costs, including consumables and theatre utilisation was then compared with laparoscopic procedures.

Results: RC patients had a mean age of 49.8 years and BMI of 29.9kg/m^2. 43% had pathology beyond uncomplicated biliary colic. There were no conversions, 84.7% required three ports, and 90.5% were day cases. Consumable cost for RC averaged £815.53 versus £573.71 (standard) and £1,117.31 (complex cases).

RIH patients had a mean age of 56.2 years and BMI of 26.0kg/m^2. There were no conversions, 87.5% were day cases and consumable costs comparable with laparoscopy (£1,050.52 vs £1,046.28). Bilateral and recurrent repairs each accounted for 12.5%.

A positive learning curve was demonstrated, with mean operative times of 83.2 and 112.4 minutes, respectively.

Conclusion: Early implementation of RAS for benign general surgery in a DGH was safe and feasible, with high day-case rates and no conversions. Despite a higher cost in consumables for RC, appropriate case selection (overweight or obese patients (81%) and complex pathology (43%)) make this appropriate utilisation of the robotic platform. Additionally, the positive learning curve further supports a successful introduction in a DGH and continued expansion.

Key statement: Our early experience in a DGH suggests that RAS can be safely introduced for selected benign general surgical procedures. The findings demonstrate favourable peri-operative outcomes and acceptable consumable costs in selected cases for both RC and RIH.

Poster 35

ROBOTIC HIATUS HERNIA SURGERY BEYOND THE TERTIARY CENTRE: EARLY OUTCOMES FOLLOWING IMPLEMENTATION IN A DISTRICT GENERAL HOSPITAL (DGH)

Author(s): Ms B Davies, Mr C Brunning, Ms C Parappally, Mr R Parameswaran, Mr J Muhammad

Institution: Wirral University Teaching Hospital NHS Foundation Trust (WUTH), Birkenhead, England, United Kingdom

Aims: Robotic-Assisted Surgery (RAS) data for benign upper gastrointestinal pathology is still relatively limited, and the burden of HH disease is high with 60% of people over the age of 50 years suffering from HH symptoms.

We aimed to evaluate the early implementation of our DGH Robotic HH programme by comparing peri-operative outcomes with national data and benchmarks currently published.

Methods: A retrospective analysis of a prospective database was undertaken of patients undergoing a robotic hiatus hernia repair. Data were collected between February 2024-April 2026, excluding patients with incomplete data or a history of previous robotic procedures. Patient demographics, pre-operative investigations, operative characteristics, length of stay (LOS) and post-operative complications were then collected and compared to published standards, benchmarks and data in the existing literature.

Results: Forty-one patients underwent a Robotic HH repair (mean age of 57.2 years, 57.5% female, mean BMI of 29kg/m^2). Reflux-type symptoms predominated (65%), followed by obstructive-type symptoms (26%). Pre-operative assessment was comprehensive, with 97.5% having more than two investigations and 70% having three or more investigations. Investigations included OGDs (95%), barium swallows (57.5%) and ph/manometry testing (57.5%).

Anterior fundoplication was performed in 87.5%. Mean operative time was 161.5 minutes, with no conversions and a mean length of stay (LOS) of 2.4 days. Pneumothorax (10%), transient dysphagia (20%), wrap-migration (0%), gas-bloat syndrome (7.5%) and radiological recurrence (7.5%) occurred.

Conclusion: Robotic hiatus hernia repair was safely implemented in a DGH, achieving favourable peri-operative outcomes, operative times consistent with published literature and a length of stay in keeping with national standards.

Comprehensive pre-operative assessments supported an individualised operative approach and service planning. Comparable outcomes were achieved despite a complex case mix that included a high proportion of giant hiatus hernias, elevated Demeester scores and oesophageal motility disorders.

Overall complication rates were in line with national published robotic series. All pneumothoraces were managed conservatively and gas-bloat rates were below those reported in the literature.

Key statement: A district general hospital can successfully deliver Robotic hiatus hernia surgery with peri-operative outcomes comparable to published standards, literature and benchmarks, despite managing complex disease. These findings add to the growing evidence supporting robotic hiatus hernia surgery beyond tertiary centres.

Poster 36

ARTIFICIAL INTELLIGENCE IN SURGICAL EDUCATION: A SYSTEMATIC REVIEW

Author(s): Dr J Scholes, Dr A Herbert, Dr N Pattani, Dr JS Sanghera, Dr J Burke

Institution: Walsall Manor Hospital, Birmingham, United Kingdom

Aims: Artificial intelligence (AI) is rapidly reshaping healthcare and surgical practice. Preparing the surgical workforce to critically evaluate, safely implement and effectively utilise Al will be essential if these technologies are to realise their clinical potential. This systematic review evaluated the applications of Al in surgical education, its educational utility, and its impact on learner outcomes.

Methods: PubMed, Scopus and Embase were systematically searched for primary studies published between January 2021 and March 2026 evaluating Al as an educational tool for medical students or doctors within surgical specialties. Data on study design, participants, AI modality, comparator and educational outcomes were extracted and synthesised using a narrative approach.

Results: The search identified 2,210 records, with 43 studies meeting the inclusion criteria. The most frequently evaluated applications were intraoperative feedback (14 studies), post-procedural performance assessment (10), examination content generation (7), anatomy training (6) and clinical educational support (6), with fewer studies evaluating curriculum development (4), revision resources (4), communication training 3) and ergonomics (2). AI frequently demonstrated moderate-to-high technical accuracy in recognising procedural stages, classifying expertise and approximating expert assessment. However, technical accuracy did not consistently translate into improved learning or skill acquisition. The strongest educational outcomes were reported for task-specific Al systems integrated with expert supervision.

Conclusion: Overall, Al appeared more mature as an assessment and feedback tool than as a standalone educational intervention. Although AI has considerable potential to provide scalable, objective and personalised support within surgical education, the evidence remains heterogeneous and is dominated by small, short-term, simulation-based studies with limited educational outcome reporting. Future research should compare Al-supported education with conventional teaching, evaluate long-term knowledge retention and clinical transter, and establish evidence-based frameworks for the responsible adoption of Al within surgical education.

Key statement: The educational value of artificial intelligence appears greatest when it is task-specific, clinically contextualised and integrated with expert instruction; technical accuracy alone should not be assumed to produce meaningful learning.

Poster 37

GROUP AND SAVE SCREENING IS NOT NECESSARY PRIOR TO LOW RISK EMERGENCY APPENDICECTOMIES - AN AUDIT

Author(s): Dr J Kang, Dr E Sugita, Mr M Radhakrishnan, Professor C Parmar

Institution: Whittington Hospital, London, United Kingdom

Aims: Group and Save (G&S) samples are routinely sent before all emergency appendicectomies in the trust in case emergency transfusions are needed. Recent studies and local audits showed that such procedures are associated with minimal rates of transfusion (0%- 0.3%), thus their necessity is in question. Awaiting G&S results delay surgery, leading to complications like perforation of appendix, and unnecessary tests adds costs and environmental burden. The audit aims to explore transfusion rates and associated risk factors in this population. The findings will evaluate necessity of routine G&S before emergency appendicectomies with the view of contributing to local guidelines.

Methods: Retrospective analysis of 71 cases of emergency appendicectomies from October 2025-March 2026 was conducted. Extracted data included demographic data, surgical approach, number of G+S samples sent and number of transfusions required. Subsequent to this, upon careful discussion with the surgical and anaesthetic teams, a period (duration TBC) of selective G&S testing based on the list of risk factors suggested by a regional SOP, due to absence of national guidelines, was implemented. New local guidelines were disseminated to the ED, anaesthetic and surgical teams. Findings were analysed post intervention of the number of G&S testing and transfusion rates.

Results: Pre-intervention data of 65 patients showed that 46.2% (n=30) had risk factors as per the criteria identified by the regional SOP, eg: complicated appendicitis, obesity, etc. 80% (n=52) had G&S samples sent. Post-intervention data of 33 patients showed 27.3% (n=9) had risk factors. 51.5% (n=17) of patients had G&S samples sent. Between the pre-intervention and post intervention period, there was a 30% (63% pre, 33% post) reduction in the number of unnecessary G&S samples sent (ie: excluding those who had risk factors). 0% of patients pre and post intervention (n=98) required a transfusion. Lastly, there were 5 patients pre-intervention who had risk factors who did not have a G&S sample sent, but all patients post intervention with relevant risk factors had G&S samples sent.

Conclusion: In line with previous literature, this audit identified that emergency appendicectomies were associated with 0% transfusion, thus routine G&S are not required where there are no identified risk factors. It demonstrates successful implementation of an intervention to decrease unnecessary G&S, improving patient outcome, cost effectiveness, and sustainability. Post intervention data shows a tangible decrease in unnecessary G&S sent. The audit further identifies the need for national guidelines for G&S screening prior to emergency appendicectomies with consideration of safety measures including risk identification and robust major haemorrhage protocol.

Key statement: There were zero transfusions needed in patients who underwent emergency appendicectomies. We implemented an intervention for selective, as opposed to routine, G&S screening prior to emergency appendicectomies, guided by existing risk factors. These findings could contribute to national guidelines to decrease unnecessary G&S screening.

Poster 38

SPLENIC LITTORAL CELL ANGIOMA DISCOVERED INCIDENTALLY AFTER A MAJOR TRAUMA: A RARE CASE REPORT

Author(s): Mr S Olusola

Institution: Whittington Hospital, London, United Kingdom

Aims: Littoral cell angioma (LCA) is a rare, benign primary vascular neoplasm of the spleen arising from specialised littoral cells lining the red pulp sinuses. First described in 1991, approximately 150 cases have been described since. We present a rare case of splenic LCA incidentally discovered after a major trauma.

Methods: A 73-year-old woman with a background of type 2 diabetes presented to the emergency department following a mechanical fall down her stairs. Observations were stable and biochemistry results were within normal limits. A Trauma CT scan revealed minimally displaced fractures of the left posterior 12th rib and left L1-L4 transverse processes. It also revealed an enlarged spleen of 16 cm with contour irregularity and multifocal nodules, the largest of which were part cystic. Differentials reported by the radiology consultant were wide and included infective and inflammatory processes, including granulomatous disease, as well as neoplastic.

Results: The patient was referred to spinal surgery and her fractures were managed conservatively. A 2-week-wait MRI liver with contrast and haematology referral was arranged. This revealed 14.5cm splenomegaly with multiple solid lesions demonstrating progressive centripetal enhancement without restricted diffusion, most consistent with littoral cell angioma. Haemolysis, myeloproliferative, and myeloma screens were all negative, and haematology review deemed a haematology cause unlikely. The findings were then discussed at the benign upper GI MDT and plans were made for a splenectomy.

Conclusion: The patient underwent uncomplicated laparoscopic splenectomy. Due to altered splenic contour and significant intra-abdominal fat the procedure was above average difficulty, but the spleen was removed with its capsule intact. Post operatively the patient was admitted to HDU for observation, then stepped down to the ward and discharged. Histology showed anastomosing vascular channels lined by cells with foamy cytoplasm, without atypia or necrosis. Immunohistochemistry confirmed a hybrid endothelial–histiocytic phenotype (CD31, CD163,, CD4, S100, CD21, Langerin positive). Low Ki-67 supported a benign lesion. Overall, the morphological and immunohistochemical features were in keeping with a splenic littoral cell angioma.

Key statement: Given its rarity Littoral cell angioma remains a diagnostic challenge in clinical practice. Splenic LCA should be considered in the differential diagnosis of incidentally discovered splenic lesions. Its clinical manifestation is usually asymptomatic and is mostly diagnosed as an incidental finding through abdominal imaging. Diagnosis relies on histopathology and immunohistochemistry following splenectomy, and this can be done laparoscopically.

Poster 39

AN UNUSUAL CAUSE OF ANORECTAL SEPSIS: ISCHIORECTAL ABSCESS SECONDARY TO AN INGESTED FISHBONE

Author(s): Mr S Olusola, Mr A Samant

Institution: Royal Free Hospital, London, United Kingdom

Aims: Anorectal abscesses are a common surgical emergency, most frequently resulting from cryptoglandular infection following obstruction of the anal glands. Foreign body-associated anorectal abscesses are exceptionally rare.

Methods: We report the case of a 26-year-old man presenting with a one-week history of dyschezia, fever, and progressively worsening perianal pain. Examination demonstrated extensive induration of the left ischiorectal fossa extending posteriorly towards the natal cleft. Laboratory investigations revealed a white cell count of 19.44×10^9/L and a C-reactive protein level of 129.5 mg/L. Owing to significant pain and clinical suspicion of a deep anorectal abscess, urgent examination under anaesthesia and incision and drainage were performed.

Results: Operative findings demonstrated a large left ischiorectal abscess extending into the posterolateral intersphincteric space. Drainage of the collection revealed a sharp, splinter-like foreign body measuring approximately 3 cm, embedded within the sphincter complex. The object was removed and was considered most consistent with a fishbone. A small area of dimpling and surrounding inflammatory change was identified in the posterolateral anal canal, likely representing the site of mucosal perforation and entry of the foreign body. The patient made an uncomplicated recovery, completed a course of antibiotics, and was discharged on postoperative day three.

Conclusion: Foreign body-induced anorectal abscesses are extremely uncommon, with only 15 cases identified in the published literature. We hypothesise that the fishbone perforated the anal canal, creating a fistulous tract into the surrounding soft tissues and resulted in abscess formation. Prompt surgical drainage and complete foreign body removal are essential to achieve source control and prevent ongoing sepsis.

Key statement: Surgeons should be aware that foreign bodies can rarely result in acute anorectal abscess formation. Prompt surgical drainage and complete foreign body removal are essential to achieve source control and prevent ongoing sepsis.

Poster 40

MINIMALLY INVASIVE INTRACORPOREAL ANASTOMOSIS FOR COLONIC FLEXURE TUMOURS: A PROSPECTIVE SURGEON COHORT STUDY

Author(s): Mr T Olanrewaju, Dr MK Ramkumar, Dr SSS Debbati, Miss B Jamila, Mr RK Thengungal

Institution: University Hospitals Plymouth NHS Trust, United Kingdom

Aims: Colonic flexure tumours present technical challenges owing to their anatomical location and variable vascular supply. This prospective study evaluated the safety, feasibility and oncological adequacy of minimally invasive intracorporeal anastomosis (ICA) for elective hepatic and splenic flexure tumour resections, comparing robotic and laparoscopic approaches.

Methods: A prospective single-surgeon cohort included 25 elective patients (14 robotic, 11 laparoscopic). Emergency surgery, stoma formation and extracorporeal anastomosis were excluded. Demographic, perioperative, pathological and oncological outcomes, including lymph-node harvest, lymph-node ratio, recurrence and survival, were analysed using appropriate comparative statistics.

Results: Twenty-five patients (mean age 70.8 years) underwent successful minimally invasive resection. Mean length of stay was 6.36 days with no significant difference between approaches. Mean lymph-node harvest was 17.8. All patients achieved R0 resection. No transfusions, clinically confirmed anastomotic leaks, reoperations, recurrence or 30-day mortality occurred. Crude overall survival was 96.0%.

Conclusion: Minimally invasive ICA for hepatic and splenic flexure tumours is safe and feasible, providing excellent short-term recovery, consistent R0 oncological resection and satisfactory nodal assessment. Robotic and laparoscopic approaches demonstrated comparable early outcomes. Larger multicentre studies with longer follow-up are required.

Key statement: Minimally invasive intracorporeal anastomosis achieved consistent R0 resection with favourable perioperative recovery and encouraging early oncological outcomes. Robotic and laparoscopic approaches showed similar short-term results, supporting both techniques for appropriately selected flexure tumours. Videos of Procedure will be demonstrated .

Poster 41

BEYOND ROUTINE HERNIA REPAIR: ROBOTIC RECONSTRUCTION OF A CHALLENGING RIGHT LOWER QUADRANT INCISIONAL HERNIA WITH COMPLETE SAC EXCISION

Author(s): Mr M Olawale, Mr K Siddique, Mr U Qureshi

Institution: Northern Care Alliance NHS Foundation Trust, Manchester, United Kingdom

Aims: Right lower quadrant incisional hernias following open appendicectomy are uncommon and technically challenging due to adhesions, distorted anatomy and scarred fascial planes. Robotic repair is particularly demanding when complete hernial sac excision and anatomical reconstruction are attempted rather than simple defect bridging. This video demonstrates an advanced robotic approach to a symptomatic incisional hernia following previous open appendicectomy, highlighting the technical challenges of adhesiolysis, circumferential sac dissection, identification of healthy fascial margins, primary fascial reconstruction and mesh reinforcement.

Methods: Following robotic access, meticulous adhesiolysis was performed to define the defect within a previously operated and scarred right lower quadrant. The hernial sac was circumferentially dissected from distorted tissue planes and completely excised using controlled robotic traction and counter-traction while preserving viable fascia. This technically demanding step enabled accurate identification of the true defect and healthy fascial margins. Anatomical reconstruction was achieved with continuous barbed non-absorbable primary fascial closure, followed by robotic placement and fixation of prosthetic mesh with adequate overlap. The video demonstrates operative strategy, port placement and key technical manoeuvres.

Results: The procedure was completed entirely robotically without conversion or intraoperative complications. Despite adhesions, altered anatomy and challenging scarred tissue planes, complete hernial sac excision was achieved, allowing clear definition of the fascial defect and facilitating anatomical reconstruction. Primary fascial closure was completed without undue tension, followed by satisfactory mesh reinforcement. Postoperative recovery was uncomplicated, with minimal pain, early mobilisation and discharge through an enhanced recovery pathway. At early follow-up, there were no wound complications, clinically significant seroma or clinical evidence of recurrence.

Conclusion: Robotic repair of a right lower quadrant incisional hernia following open appendicectomy is an advanced and technically demanding procedure. Previous surgery creates adhesions, distorted anatomy and poorly defined fascial planes, making complete sac excision and anatomical reconstruction particularly challenging. Although robotic technology provides enhanced visualisation, articulated dissection and intracorporeal suturing, successful repair requires advanced robotic expertise and meticulous surgical technique. Complete sac excision facilitates accurate identification of healthy fascial margins, enabling primary anatomical closure and optimal mesh reinforcement. This video demonstrates a reproducible robotic strategy for managing this challenging abdominal wall defect.

Key statement: Robotic repair of a right lower quadrant incisional hernia following open appendicectomy is technically demanding due to adhesions, distorted anatomy, scarred fascial planes and the difficulty of defining the true defect. Complete circumferential hernial sac dissection and excision requires advanced robotic skills, meticulous traction and counter-traction, and careful preservation of healthy fascia. Complete sac excision facilitates accurate anatomical definition, enabling primary fascial reconstruction and optimal mesh reinforcement. This video demonstrates a systematic and reproducible robotic approach to a challenging abdominal wall reconstruction while highlighting key technical steps, operative decision-making and strategies for safe repair.

Poster 42

ROBOTIC HARTMANN'S REVERSAL AND ROBOTICALLY ASSISTED END-TO-END COLORECTAL ANASTOMOSIS: A STEPWISE APPROACH TO COMPLEX RECONSTRUCTION

Author(s): Mr A Mohammed, Mr K Siddique, Mr U Quershi

Institution: Royal Oldham Hospital, Northern Care Alliance NHS Foundation Trust, United Kingdom

Aims: Hartmann's reversal can be technically challenging due to adhesions, difficulty identifying and mobilising the rectal stump, and the requirement for a well-perfused, tension-free colorectal anastomosis. This video demonstrates a structured robotic approach to complex Hartmann's reversal, highlighting meticulous adhesiolysis, safe rectal stump mobilisation, splenic flexure mobilisation and, importantly, robotically assisted end-to-end colorectal anastomosis using a 29-mm powered circular stapler.

Methods: A 76-year-old woman initially underwent emergency laparoscopic Hartmann's procedure for large bowel obstruction secondary to a sigmoid diverticular stricture. Following regular postoperative follow-up, robotic reversal was undertaken two years later. Extensive intra-abdominal adhesions were encountered, including dense small bowel adhesions to the rectal stump. A systematic robotic adhesiolysis was performed, followed by careful identification and mobilisation of the rectal stump and splenic flexure mobilisation to obtain adequate colonic length for a tension-free reconstruction.

Results: Following complete mobilisation, the colon reached the rectal stump without tension. A robotically assisted end-to-end colorectal anastomosis was constructed using a powered 29-mm CDH circular stapler. Robotic visualisation and instrument control facilitated precise exposure and alignment of the rectal stump and proximal colon during stapler positioning and anastomotic construction. Anastomotic integrity was confirmed intraoperatively. The patient had an uncomplicated postoperative recovery and was discharged home within 72 hours.

Conclusion: A robotic approach can facilitate complex Hartmann's reversal by providing stable three-dimensional visualisation, wristed instrumentation and precise dissection within an adhesive abdomen and pelvis. Successful reconstruction depends on a systematic strategy: safe adhesiolysis, clear identification and adequate preparation of the rectal stump, sufficient proximal colonic and splenic flexure mobilisation, and construction of a well-perfused, tension-free anastomosis. Robotically assisted circular stapled anastomosis allows controlled exposure and alignment during the critical reconstructive phase.

Key statement: Robotic Hartmann's reversal should be approached as a structured reconstructive procedure rather than adhesiolysis alone. Meticulous robotic adhesiolysis, deliberate rectal stump preparation, adequate splenic flexure mobilisation and precise robotic assistance during circular stapled end-to-end colorectal anastomosis can convert a technically hostile abdomen and pelvis into a controlled reconstruction, facilitating safe restoration of intestinal continuity and early postoperative recovery.

Video 01 (16:10 – 16:18)

A STANDARDIZED TEN-STEP ROBOTIC APPROACH TO COMPLETION PROCTECTOMY AND ILEOANAL POUCH ANASTOMOSIS

Presenter: Ms O Mangana

Author(s): Ms O Mangana[1], Mr M Frountzas[2], Ms F Liccardo[1], Mr V Celentano[1]

Institution: [1]Inflammatory Bowel Disease and Ileoanal Pouch Surgery Centre, Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom. [2]First Propaedeutic Department of Surgery, Hippocration General Hospital, National and Kapodistrian University of Athens, School of Medicine, Athens, Greece

Aims: To present a standardized ten-step robotic approach for completion proctectomy and ileoanal pouch anastomosis, designed to improve reproducibility and facilitate training.

Methods: This video demonstrates our standardized robotic technique. The procedure is divided into ten sequential steps: (1) ileostomy mobilization and establishment of pneumoperitoneum; (2) standardized robotic port placement; (3) sub-ileal approach with small bowel mesenteric mobilization; (4) trial descent of the pouch; (5) completion proctectomy in the total mesorectal excision plane; (6) rectal transection at the level of the levator ani; (7) extracorporeal J-pouch formation with routine mesenteric lengthening manoeuvres; (8) stapled pouch–anal anastomosis; (9) intraoperative pouchoscopy to assess orientation, haemostasis, and anastomotic integrity; and (10) maturation of a diverting loop ileostomy.

Results: The standardized stepwise approach enabled safe and reproducible robotic completion proctectomy and ileoanal pouch anastomosis with excellent visualisation of both abdominal and pelvic compartments. Routine trial descent and mesenteric lengthening manoeuvres facilitated a tension-free pouch reach. Intraoperative pouchoscopy confirmed anastomotic integrity. The technique proved feasible and reproducible, providing a structured framework for surgical training and standardization of robotic proctectomy and restorative ileoanal pouch surgery.

Conclusion: This standardized ten-step robotic technique provides a safe, reproducible, and educationally valuable approach to completion proctectomy and ileoanal pouch anastomosis. Its structured format may facilitate training, improve procedural consistency, and contribute to optimisation of surgical outcomes in restorative proctocolectomy.

Key statement:

- Standardized ten-step robotic technique for completion proctectomy and IPAA
- Reproducible and training-oriented stepwise approach
- Optimized pouch reach with tension-free anastomosis
- Potential to improve consistency and surgical outcomes

Video 02 (16:18 – 16:26)

ROBOTIC THORACOSCOPIC RESECTION OF A LARGE MID-OESOPHAGEAL DIVERTICULUM: STEPWISE VIDEO DEMONSTRATION OF A NOVEL TECHNIQUE USING DAVINCI XI ROBOTIC SYSTEM

Presenter: Mr JKA Jameel

Institution: Department of Surgical Gastroenterology, Apollo Hospitals, Greams Road, Chennai, India

Aims: Mid-oesophageal diverticula are rare oesophageal lesions that account for approximately 15% of all oesophageal diverticula. Although many remain asymptomatic, larger diverticula may present with dysphagia, regurgitation, aspiration, and impaired quality of life. Surgical intervention is reserved for symptomatic patients and can be technically demanding because of the close relationship of the diverticulum to vital mediastinal structures. Robotic surgery offers enhanced three-dimensional visualisation and superior instrument dexterity, facilitating precise dissection in confined anatomical spaces. This video demonstrates the robotic thoracoscopic excision of a large symptomatic mid-oesophageal diverticulum using the da Vinci Xi surgical system.

Methods: The procedure was completed entirely robotically without any intraoperative complications. Blood loss was minimal. A Gastrografin swallow study performed on postoperative day three demonstrated no leak or obstruction. Oral intake was resumed and advanced without difficulty. The intercostal drain was removed on postoperative day four, and the patient was discharged on postoperative day five. Follow-up demonstrated complete resolution of dysphagia and return to normal daily activities.

Results: Robotic thoracoscopic diverticulectomy is a safe and feasible minimally invasive approach for selected patients with large symptomatic mid-oesophageal diverticula. The da Vinci Xi platform provides excellent visualisation, precise mediastinal dissection, secure stapled resection, and preservation of critical structures such as the vagus nerve.

Conclusion: This video presents a reproducible stepwise operative technique and highlights the potential advantages of robotic technology in the management of this rare oesophageal pathology.

Key statement: Mid-Oesophageal Diverticulum is a rare pathology. Its proximity to major intra-thoracic structures such as Heart, Trachea, Azygos vein, Vagus Nerve makes operating in this area quite challengng. This video demonstrates a novel robotic technique for the management of a rare large mid-oesophageal diverticulum, highlighting the advantages of the da Vinci Xi system in facilitating safe dissection and secure resection within the confined mediastinal space.

Video 03 (16:26 – 16:24)

IMAGE INVERSION-ASSISTED ROBOTIC BILATERAL TAR FOR COMPLEX WIDE-NECKED INCISIONAL HERNIA IN A HOSTILE ABDOMEN

Presenter: Mr A Tibude

Author(s): Mr A Tibude, Mr A Awan, Mr I Bhatti

Institution: Royal Derby Hospital, United Kingdom

Aims: To demonstrate a totally robotic bilateral transversus abdominis release for a complex wide-necked incisional hernia in a previously operated patient with multiple prior surgeries and mesh repair with dense intra-abdominal adhesions. The video aims to show safe adhesiolysis in a hostile abdomen, stepwise development of the retrorectus and lateral abdominal wall planes, recognition of key TAR anatomical landmarks, and the use of image inversion on the da Vinci platform to optimise visualisation and facilitate accurate anterior rectus sheath reinforcement.

Methods: A bilateral robotic TAR was performed using a six-port strategy, with three ports placed on each side. Extensive adhesiolysis was undertaken carefully to define the abdominal wall and hernia defect. The retrorectus space was developed, followed by incision of the posterior rectus sheath medial to the linea semilunaris, preserving the neurovascular bundles. The transversus abdominis fibres were identified and divided to enter the lateral preperitoneal plane. The video demonstrates the rectus muscle, posterior sheath, linea semilunaris, transversus fibres, transversalis fascia and lateral dissection plane.

Result: The bilateral release enabled wide medialisation of the abdominal wall and tension-reduced closure of the complex wide-necked defect. The posterior layer was reconstructed and a large 30 × 30 cm mesh was placed in the retromuscular plane with broad overlap. A key technical step was inversion of the robotic image during anterior rectus sheath closure. This improved orientation, clearly delineated the abdominal wall muscle layers and facilitated accurate strengthening of the anterior sheath using a running V-Loc suture**.**

Conclusion: Totally robotic bilateral TAR is feasible in a hostile, multiply operated abdomen when performed with meticulous adhesiolysis, structured anatomical orientation and controlled plane development. Clear identification of the posterior rectus sheath, linea semilunaris, neurovascular bundles, transversus abdominis fibres and lateral preperitoneal plane is essential for safe progression. Image inversion is a useful adjunct during anterior sheath closure, improving visualisation, ergonomics and layer definition while allowing precise reinforcement of the abdominal wall before mesh placement.

Key statement: This video demonstrates a structured, totally robotic bilateral TAR for a complex wide-necked recurrent incisional hernia in a hostile abdomen. Image inversion on the da Vinci platform is highlighted as a practical technical adjunct that improves visualisation of abdominal wall layers and facilitates accurate anterior rectus sheath reinforcement with running V-Loc closure.

Video 04 (16:24 – 16:32)

EMERGENCY LAPAROSCOPIC SURGERY FOR GASTRIC VOLVULUS IN RECURRENT HIATUS HERNIA AFTER PREVIOUS FUNDOPLICATION

Presenter: Mr A Ghoneima

Author(s): Mr A Ghoneima, Mr A Elshaer

Institution: Bradford Teaching Hospitals NHS Foundation Trust, United Kingdom

Aims: Intra-thoracic Gastric Volvulus after fundoplication surgery is a life-threatening emergency that occurs when the stomach wrapped around the oesophagus migrates to the chest and rotates along its axis. It can cause gastric outlet obstruction and potentially strangulation which might lead to necrosis and perforation. It is a rare condition with only five cases documented according to a literature review from 2025 by Albandar et al. In this video presentation we aim to demonstrate the operative management of one such case laparoscopically with good results.

Methods: This video presentation shows an Emergency laparoscopic reduction of gastric volvulus, repair of hiatus hernia, cruroplasty and gastropexy of stomach to abdominal wall and diaphragm in a 36-year-old gentleman who presented with 1 week of abdominal pain associated with reflux and vomiting on the background of having surgery as a child for recurrent vomiting. A CT had showed mesentero-axial gastric volvulus in a stomach herniating through a defect in the diaphragm with preserved enhancement but thinning in the stomach wall.

Results: After extensive adhesiolysis, the procedure was completed successfully through a minimally invasive approach and an OGD confirmed the correct position of the stomach.

Post-operatively, the patient made a good recovery on ITU. On day 2, the NG tube and drain were removed and he started oral intake. He was discharged on day 4.

On day 38 after the operation, he was found to have acute portal vein thrombosis was started on a DOAC and he is currently followed up by the anticoagulation clinic and Upper GI Surgery.

Conclusion: This is an interesting case that highlights the challenges caused by previous Upper GI Surgery, the technical skills required to overcome them including accurate and systematic dissection and the role of laparoscopic surgery in facilitating the procedure without the morbidity of open surgery.

Key statement: Specialist Upper GI Surgery has an important place in emergency general surgery allowing timely treatment of patients with potentially life-threatening conditions. Laparoscopic Surgery is feasible in this context and leads to shorter hospital stays and good outcomes.

Video 05 (16:32 – 16:40)

ROBOT-ASSISTED TOTAL PELVIC EXENTERATION FOR LOCALLY RECURRENT RECTAL CANCER

Presenter: Dr JJ Sharon

Author(s): Dr JJ Sharon**,** Professor CR Selvasekar, Mr J Oates, Mr J Wild

Institution: Christie NHS Foundation Trust, Manchester, United Kingdom

Aims: This video demonstrates the operative technique and key anatomical landmarks of robot-assisted total pelvic exenteration (TPE) for locally recurrent rectal cancer. A 62-year-old male with prior R1 endoscopic resection of a rectal polyp and adjuvant radiotherapy developed luminal recurrence with interval disease progression. Restaging MRI showed posterolateral extension to the prostate and seminal vesicle (T4b), and the MDT recommended robotic TPE. The video highlights a structured, stepwise approach combining the colorectal and urological phases within a single minimally invasive procedure.

Methods:

1. Medial-to-lateral mobilisation with division of the superior rectal vessels and ureteric preservation
2. Proximal colonic transection and TME-plane dissection to the pelvic floor, tailored laterally to MRI findings
3. Bilateral circumferential ureteric mobilisation, slinging, division, and stenting
4. Anterior dissection through the space of Retzius with division of the vasa deferentia and vesical and prostatic pedicles
5. Endopelvic fascia opening, dorsal venous complex ligation, and urethral transection
6. Perineal en bloc delivery and reconstruction with Wallace type 1 uretero-ileal anastomosis, ileal conduit, and end colostomy

Results:

The video successfully demonstrates:

- Precise dissection planes tailored to tumour extent, staying wide of the mesorectal fascia on the involved side
- Preservation of periureteric tissue and ureteric vascularity for the conduit
- Secure haemostatic control of the dorsal venous complex before apical dissection
- En bloc resection of the rectum, bladder, prostate, and urethra with intact margins
- Dual-specialty reconstruction with urostomy and end colostomy

The patient recovered without complication; both stomas functioning, stents removed as planned. Final histology awaited.

Conclusion:

Robot-assisted TPE is feasible and safe in carefully selected patients with locally recurrent rectal cancer. The robotic platform provides magnified visualisation of deep pelvic planes, precise dissection around critical neurovascular and urological structures, and seamless collaboration

between colorectal and urological teams. A standardised, stepwise approach enhances anatomical reproducibility, reduces intraoperative complications, and optimises the prospect of clear resection margins in the multivisceral setting.

Key statement: This video provides a stepwise guide to robot-assisted total pelvic exenteration, demonstrating a reproducible dual-specialty robotic technique for locally recurrent rectal cancer.