TOO MUCH OR TOO FRAIL: A REVIEW OF DECISION MAKING IN COLORECTAL CANCER

NWRC: North West Research Collaborative

Presenting author: Nick Heywood

Aim: Of approximately 30,000 patients diagnosed with colorectal cancer between April 2014 and March 2015, 37% did not undergo major resection. In 11.8%, there was too much cancer and in 4.7% the patients were too frail with a large variation across trusts (0 32%). 2 year survival in those not undergoing major resection is only 30%. This study is designed to review the decision making process for those patients who are deemed to be too frail. How are patients being assessed for surgery? Is the decision process robust?

Patients: All patients diagnosed with colorectal cancer through their first discussed at the MDT would be identified and included. Intervention: As a prospective multicentre observational study, there would be no intervention, however, patients will be divided into groups; those undergoing major resection (R) and those not undergoing major resection (NR), the second group being subdivided by reason; too much (TM) cancer, or too frail (TF).

Primary Outcomes: 1 & 2 year survival

Secondary outcomes: Mode of presentation (Emergency vs elective), Rockwood Frailty Score, anaesthetic assessment (performed or not, and type (i.e.CPEX)), review by geriatrician, patient decision, comorbidities, length of stay, Quality of life score , chemotherapy, colonic stenting, repeated blood transfusions, readmission with cancer complications.

All eligible patients identified at MDT will be included and have prospective data collected. Frailty scores, if not routinely used for MDT decision, will be collected posthoc and remain blind to the original MDT decision.

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RISCS 2 RISKS IN SPINAL CONSENTING FOR SURGERY 2: CONSENT WITHDRAWAL RATES FOR MAJOR SPINAL OPERATIONS BASED ON THE AWARENESS OF RISKS

SARCO:Severn Audit & Research Collaborative in Orthopaedics

Presenting author: James Fletcher

Patient centred consent is enshrined in GMC Guidance and the Montgomery ruling. However, a recent trial involving spinal injections has shown that current assumptions regarding patient decisions are incorrect. Patient decisions are uninfluenced by the severity of risks for minor procedures whilst encyclopaedic risk explanation may be harmful as it generates increased anxiety. Further work is warranted with more invasive procedures to confirm these findings to best inform clinical practice.

We propose a multicentre, noninferiority, controlled trial randomising 500 patients receiving spinal surgery (requiring a general anaesthetic) to either a medical centred consent process (control) involving material and frequently occurring risks for that procedure, or a legally centred consent process (intervention), involving all associated risks found in the literature.

The primary end point is consent withdrawal. Secondary endpoints include questionnaires assessing if anxiety levels change due to either process. This is scheduled to take twelve months.

This trial will challenge the stance generated by Chester vs Asfhar and help refine where consenting processes should be to account for patient expectations and their benefit. It will ensure that consenting processes are fit for purpose whilst maximising patient benefit and minimising unnecessary anxiety.

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SWARM: SOUTH WEST ANAESTHESIA RESEARCH MATRIX ACCELEROMETERS FOR ANAESTHESIA RESEARCH (AFAR); WEARABLE MOVEMENT SENSORS TO MEASURE RECOVERY FROM DAY CASE SURGERY: A FEASIBILITY STUDY FROM SOUTHWEST ANAESTHESIA RESEARCH MATRIX IN COLLABORATION WITH OPEN LAB AT NEWCASTLE UNIVERSITY

Presenting author: Anna Ratcliffe

Aim: Wearable movement sensors (accelerometers) are a novel technology that may have utility to measure patientcentred endpoints such as activity levels. We propose to investigate their feasibility to track recovery after day case surgery. We aim to gain experience with this technology and test a methodology that could be deployed at scale across a trainee research network.

Patients: The SWARM trainee network will recruit 50 consecutive functionally able adult patients from two NHS trusts, booked for urology, gynaecology or general day case surgery that requires general or neuraxial anaesthesia but does not in itself restrict mobility.

Comparator: We will compare a postoperative recovery profile of each patient to his or her own baseline preoperative activity profile. We will also investigate validity of this measure by comparing patients recovery profile against their sequential daily scores on a validated quality of recovery questionnaire (Q0R15), administered by phone call.

Outcomes: Participants will be asked to wear wrist devices for a week before and after surgery so that 7day baseline activity and postoperative recovery profiles can be characterized. Computer scientist collaborators from Open Lab at Newcastle University use raw movement data from the Axivity AX3 device to generate multiaxial parameters, quantifying movement in more than one dimension.

Our candidate measures are:

- step count
- intensity of activity
- aggregate sleep duration & quality
- energy expenditure
- character of activity.

We will compare the correlation between these and daily QoR15 score. Acceptability will be explored with a PPI group. Feasibility for future study will be checked by recording data about recruitment rate, wear time (compliance), device return rate, proportion of lost/unusable data.

Study design: Prospective, observational study.

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BNTRC: BRITISH NEUROSURGICAL TRAINEE RESEARCH COLLABORATIVE UNDERSTANDING CAUDA EQUINA SYNDROME

Presenting author: Julie Woodfield

Introduction: Cauda equina syndrome (CES) is a rare but potentially devastating condition caused by compression of the cauda

equina nerve roots. The clinical syndrome can include bilateral sciatica, saddle anaesthesia, bladder, bowel, and sexual dysfunction. The disabling nature of these symptoms has significant medical, social, and legal implications. Guidelines for the investigation and management of CES are based on evidence from small retrospective case series that include a range of presentations. Outcomes for those presenting with established loss of function may not be comparable to those with incipient symptoms. Arrangements for emergency imaging, patient transfer to specialist spinal units, and techniques for decompression also vary and could lead to differences in outcomes.

Aims*:* This study aims to provide evidence for appropriate investigation and management of CES through:

- ascertaining the incidence of CES
- describing the clinical and radiological features of patients who are treated for CES
- establishing current practice in timing of investigations and choice of management of CES
- determining patient outcome and service usage following CES diagnosis Patients

All patients over 18 years old treated for CES in a UK or Irish neurosurgical or orthopaedic spinal unit will be included. Patients will be identified via emergency admissions, and case ascertainment will be checked using coding records.

Comparator*:* Outcomes and management will be stratified by presenting features and timing and type of surgical intervention.

Outcome*:* Patient outcome will be assessed using validated patient reported outcome measures for back pain, leg pain, bladder, bowel, and sexual function. Health care services used over the following year will be recorded.

Study design*:* This is a prospective cohort study with patients identified on admission to a spinal unit. Patients will be asked to consent for use of their data, contact for follow up assessments, and data linkage with existing NHS and surgical registries.

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NATIONAL MULTICENTRE RANDOMISED TRIAL OF SUPERFICIAL WOUND DRAIN ON SURGICAL SITE INFECTION IN HIGH BODY MASS INDEX (BMI) KIDNEY TRANSPLANTS RECIPIENTS

Carrel Club Transplant Research Collaborative

Presenting author: James Hunter

Aim*:* To assess the role of a subcutaneous wound drain on Surgical Site Infection (SSI) rates in kidney transplant recipients with a body mass index (BMI) greater than 30.

Patients*:* Any adult patient undergoing a live or deceased donor kidney transplant with a BMI >30 being implanted in a virgin surgical site.

Exclusions*:* Inclusion in other antimicrobial or immunosuppression trial Routine placement of subcutaneous drain

Intervention*:*

Study Group

- Vacuum drain, minimum 10 French gauge within the subcutaneous layer of the wound and removed at the discretion of the surgical team.
- Wound closure technique according to surgeon preference and/or local protocols.

Control Group

- Routine wound closure determined by surgeon preference and/or local protocols. No subcutaneous drain inserted.

Outcome*:*

Primary Outcome:

- The incidence of surgical site infection in the first 30 days after transplant. SSI defined as either superficialincisional, deep incisional or organspace using criteria established by the National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention

Secondary Outcomes:

- The SSIrelated readmission rate in the first 30 days after transplant
- The SSIrelated return to theatre in the first 30 days after transplant
- Rates of Delayed Graft Function and primary nonfunction

Study Design*:* A multicentre, randomised, openlabel study to investigate the role of a subcutaneous suction wound drain on the rate of surgical site infection in obese (BMI >30) kidney transplant recipients. Study visits will be at baseline and 30 days. Following provision of informed consent, patients will be randomised 1:1 to superficial wound drain or usual care via a computerised online randomisation system. Data collection will be performed by local Investigators and entered online using REDCap (Research Electronic Data Capture) and stored on a secure server.

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