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BASO~The Association for Cancer Surgery Annual Scientific Meeting 16th-18th November 2019

Abstracts for presentation at the BASO Skills Day on Saturday 16th November 2019

BASO Trainees Proffered Prize Papers

Saturday, 16th November 2019, 09.00 to 09.25

63.

DOES PRE-OPERATIVE ANTI-COAGULATION THERAPY IMPACT MORBIDITY FOLLOWING REGIONAL LYMPH NODE DISSECTION?

Jennifer Allan, Richard Thompson. *Glasgow Royal Infirmary, Glasgow, UK*

Background: Lymph node dissection is the gold standard treatment for those with metastatic deposits in regional lymph nodes despite conferring significant morbidity, with complication rates between 30-40% in the literature. Anecdotally in our unit, therapeutic anti-coagulation pre-operatively appeared to increase complications. The aim was to establish the complication rate within our regional plastic surgery unit following lymph node dissection and whether this increased in patients anti-coagulated pre-operatively.
Method: Retrospective patient list was generated from patients undergoing regional lymph node dissection between January-December 2018. Database was compiled with patient demographics, procedures, complications and re-intervention. Unpaired t-test was performed to determine significance.
Results: 47 patients underwent regional lymph node dissection. 6 were anti-coagulated with either LMWH or NOAC. Primary malignancies included melanoma (n=31), breast carcinoma (n=10), SCC (n=4) and Merkels cell carcinoma (n=1).
The complication rate was 40.4% with a re-intervention rate of 78.94%. Patients with primary melanoma had the highest complication rate at 45.16%. Those undergoing inguinal dissection had the highest morbidity based on anatomical location at 50%. Patients on anticoagulation experienced a complication rate of 66.66% (p 0.1678).
Conclusions: Overall, complication rates were comparable with those in the literature. Complications were more frequent in those with a primary melanoma, which is likely due to a higher median age and associated comorbidities. Those anti-coagulated pre-operatively were shown to have a higher complication rate. However, due to small sample size, this was not statistically significant. It is hypothesised this may explained by a higher rate of comorbidities associated with anti-coagulation requirement.

73.

THE ROLE OF ETHNICITY IN COLORECTAL CANCER SCREENING UPTAKE: A SYSTEMATIC REVIEW

Harpreet Kaur Sekhon[1], Inderjit Singh[1], Nikhil Lal[2], Nikhil Pawa[1]. [1] *West Middlesex University Hospital, Isleworth, UK;* [2] *Sheffield Teaching Hospital NHS Foundation Trust, Sheffield, UK*

Background: Bowel Cancer Screening aims to reduce mortality from colorectal cancer (CRC), however, uptake remains low and disproportionate. Ethnicity is thought to contribute to this and can depend on modality of screening. We performed a systematic review to summarise and clarify the impact of ethnicity on CRC screening uptake Worldwide.
Methods: EMBASE and MEDLINE databases were searched until May 2019 to identify studies reporting on the odds ratio of uptake (OU) for ethnic minority groups in CRC screening compared to their majority ethnic counterpart.
Results: Twenty-nine studies were included with a total of 3,994,081 (Range: 163-1,756,714) participants. The majority of studies were carried out in the USA (24/29) and compared Black (19/29), Hispanic (14/29) and Asian (15/29) minorities to the reference White population. Irrespective of screening modality, Hispanics (57.14%) and Asians (53.33%) had a significantly lower OU. Hispanics had an especially low OU with FIT/FOBT (66.67%) while this was true for Asians with endoscopic screening (57.14%). 63.16% of studies suggest that there is no association between black ethnicity and screening uptake.
Conclusion: This is the only review focusing on the impact of ethnicity on CRC screening uptake. It demonstrates that uptake varies with Ethnicity and modality of screening. Substantial variation in the size of studies and categorisation of ethnicities was observed. A move to international standardisation of ethnicity classification and routine collection of demographics including ethnicity in bowel cancer screening programmes worldwide will better understand this impact and direct research to reduce health inequality in multi-ethnic populations.

81.

ROBOTIC MULTI-VISCERAL RESECTION FOR LOCALLY-ADVANCED RECTAL CANCER INVADING OTHER VISCERA

Samuel Stefan, Najaf Siddiqi, Marieke Rutgers, Syed Naqvi, Jim Khan. *Queen Alexandra Hospital, NHS Portsmouth, Portsmouth, UK*

Background: Laparoscopy is seen as a relative contraindication for locally-advanced (T4) rectal cancers invading into other viscera. This is a prospective, descriptive case series with literature review, to determine feasibility of robotic multivisceral resection for locally advanced rectal cancers, including clinical and oncological outcomes.
Method: 21 patients underwent total robotic anterior resection with en-bloc resection of other viscera in a single UK robotic centre between 06/2013-07/2018. Patient demographics, comorbidities, endoscopy, preoperative imaging, operative data, perioperative findings, histopathology, duration of hospital stay, and postoperative complications were noted.
Results: 21 patients included (median age: 74; male:female 1.6:1); median body mass index: 28.5 kg/m^2; 77% tumours were in the mid/lower rectum; 7 patients received long-course chemoradiotherapy and 7 short-course preoperative radiotherapy. En-bloc resected viscera included ovaries, uterus, vagina, seminal vesicle, prostate, bladder, small bowel. 7 patients had permanent stoma. Median length of hospital stay: 6 days. 2 patients required postoperative intensive therapy unit admission. There were 3 readmissions in the postoperative period, primarily due to postoperative nausea & vomiting, high output stoma, poor pain management. R0 resection was achieved in 19/21 patients. Of the remaining, one with a positive margin developed local recurrence on follow-up, while the other remained disease-free at 21-month follow-up; no 90-day mortality.
Conclusion: The first reported series of robotic rectal cancer surgery for

T4b tumours. With experience, robotic en-bloc multi-visceral resection of locally advanced rectal cancers is feasible and oncologically safe. The robotic approach allows the benefits of the minimal access approach to be extended to this group of patients.

Abstracts for BASO Trainees Poster Presentation at the BASO Skills Day on Saturday, 16th November 2019

4.
INVASIVE BREAST CANCER OVER FOUR DECADES REVEALS PERSISTING POOR METASTATIC OUTCOMES IN TREATMENT RESISTANT SUBGROUP – THE "ATRESS" PHENOMENON

Patriek Jurrius[1,2], Thomas Green[1], Hans Garmo[1], Matthew Young[2], Massimilano Cariati[1,2], Cheryl Gillett[1], Anca Mera[1], Mark Harries[1,2], Anita Grigoriadis[1], Sarah Pinder[1,2], Lars Holmberg[1,3], Arnie Purushotham[1,2]. [1] *King's College London, London, UK;* [2] *Guy's and St Thomas NHS Foundation Trust, London, UK;* [3] *Uppsala University, Uppsala, Sweden*

Major advances in breast cancer care have led to a noteworthy reduction in mortality. However, there are still women who are not cured. Therefore, we hypothesised there is a sub-group of treatment-resistant women who succumb to their disease early.

Between January 1st, 1975 and December 31st, 2006 5,392 women underwent surgery for primary operable invasive breast cancer at Guy's Hospital, London, UK. Data on patient demographics, tumour characteristics, treatment regimens, recurrence, and mortality were prospectively recorded. We considered four time periods (1975-1982, 1983-1990, 1991-1998, 1999-2006). Time to event analysis was performed with Cox proportional hazards model and Kaplan-Meier estimation.

The unadjusted hazard ratio for developing metastasis and overall mortality relative to the 1975-1982 cohort decreased steadily to 0.21 and 0.77, respectively in 1999-2006. However, the metastasis-free interval shortened, with the proportion of women developing metastasis ≤5 years increasing from 73.9% to 83.0%. Furthermore, median survival following the detection of metastasis decreased from 1.49 years in 1975-1982 to 0.94 years in 1999-2006. A filter based on the St. Gallen criteria for high-risk patients and grade 3 tumours identified the presence of ±200 patients in each of the time periods who developed metastasis early and died within a much shorter time frame.

Advances in treatment have decreased the risk of metastasis and improved survival in women with invasive breast cancer over the last 40 years. Despite this, a subpopulation with shorter distant disease-free and overall survival remains. This subgroup may considerably overlap with women harbouring an underlying genome-based treatment resistance signature.

6.
CARDIOPULMONARY EXERCISE TESTING AND ANAEROBIC THRESHOLD: AN EFFECTIVE WAY TO JUDGE FITNESS FOR MAJOR HEPATOBILIARY SURGERY FOR UPPER GI MALIGNANCY?

Samuel Belete[1], Alex Poovathoor[2], Jonathan Afoke[1], Duncan Spalding[1], Prakash Punjabi[1]. [1] *Imperial College London, London, UK;* [2] *Cambridge University, Cambridge, UK*

Background: Cardiopulmonary exercise testing (CPET) is a pre-operative risk stratification tool utilising factors such as the anaerobic threshold (AT). Evidence suggests that patients undergoing major hepatobiliary surgery with an AT < 11 ml/kg/min are at increased risk of post-operative morbidity and mortality. This review aims to compare outcomes in patients with a pre-operative CPET with a AT > 11 ml/kg/min against those < 11 ml/kg/min.

Methods: Patients who underwent major hepatobiliary surgery for upper GI malignancy with a pre-operative CPET between January 2016 and December 2018 were reviewed. 18 patients were identified, six had an AT > 11 ml/kg/min (group A) and 12 had an AT < 11 ml/kg/min (group B). Primary outcomes were length of stay and 30-day mortality.

Results: There was no significant difference in age (74.3 years vs 71.5 years, p=0.42, all results expressed as group A vs B). There was a significant difference in AT (12.6 ml/kg/min vs 9.2 ml/kg/min, p=0.0001). There was no mortality at 30 days in either group and a non-significant longer length of stay (21 days vs 13.5 days p=0.20).

Conclusions: This review was unable to demonstrate that patients with a AT < 11 ml/kg/min were at increased risk of prolonged hospital stay or 30-day mortality. Further prospective studies with larger patient numbers are warranted.

7.
A DAILY DIAGNOSTIC MULTIDISCIPLINARY TEAM MEETING TO REDUCE TIME TO DEFINITIVE DIAGNOSIS IN THE CONTEXT OF BONE AND SOFT TISSUE SARCOMA

L.J. Hartley[1], S.E. Evans[2], M.A. Davies[2], S. Kelly[2], J. Gregory[2]. [1] *University Hospitals Birmingham, Birmingham, UK;* [2] *Royal Orthopaedic Hospital, Birmingham, UK*

Introduction: Cancer services are under increasing pressure to deliver waiting time targets. Our service has seen referral numbers increase to over 3000 per annum, with more than 80% coming from secondary care. In order to deliver a responsive service, the department has introduced a daily diagnostic multidisciplinary meeting (DMDT) with the aim being stratification of resources by directing rapid access to clinics and diagnostics to those felt to be at greatest risk of malignancy at the start of the pathway. It also aimed to improve communication with patients and referrers, consistency in decision making and deliver improved diagnostic turn-around times in a sustainable manner.

Aims: An evaluation was undertaken to assess whether the introduction of a daily DMDT has improved the pathway, the primary endpoint being a reduction in time to definitive diagnosis (TTDD). Secondary endpoints included measurements of efficiency and whether there has been a reduction in variation in practice.

Methods: Retrospective access to patient notes via Onkos and IMPAX over a 1-month period before (2015) and after (2018) the intervention.

Results: The introduction of the DMDT has led to an improvement in service efficiency and a reduction in both TTDD (9 days) and time to first management decision (8 days). The service also has an added benefit in reducing average total patient miles travelled over the course of diagnosis by 24.41 miles.

Conclusion: The introduction of a diagnostic MDT at the start of the pathway does lead to an improvement in service efficiency and a reduction in TTDD.

8.
CLINICAL, HISTOPATHOLOGICAL FEATURES AND SURGICAL OUTCOME FOR APPENDIX ADENOCARCINOMA

Ahmed Waqas, Yousaf Aawsaj, Seamus Kelly. *Northumbria NHS, Northumbria, UK*

Background: Aim of this series is to explore the clinical presentation, histological characteristics of appendix primary adenocarcinoma and surgical outcome.

Method: Retrospective data collection from patient's notes from January 2011 to Feb 2018 in a single trust.

Results: 13 (0.005 %) appendix primary adenocarcinoma from 2383 appendectomy performed during the period from 2011 to 2018 (Table 1). Completion treatment was right hemi-colectomy in 10, de-functioning ileostomy in 1 and no further intervention in 2. 7 out of 8 patients died of complications related to stage IV disease.

Conclusion: Natural history of appendix adenocarcinoma carries lot of morbidity and mortality even with best of follow-ps. With careful clinical & radiological assessment, still pre-operative diagnosis is very difficult. Peri-operative diagnosis of appendix cancer is still challenge and needs to be investigated further.

Table 1