

widespread disease recurrence in mesentery and peritoneum. At median follow up of 11 months, the disease free survival was 95%.

Conclusion: Experience of robotic surgery for rectal cancer at our centre suggests that high quality specimen is associated with safe short-term outcomes for local recurrence and acceptable outcomes for distant metastasis.

70. RECURRENCE +/- METASTASIS FOLLOWING IRON THERAPY VERSUS PRE-OPERATIVE BLOOD TRANSFUSION IN PROXIMAL COLORECTAL CANCERS

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Introduction: Colo-rectal Cancer (CRC) is the fourth most common cancer in the UK. Studies indicate 11-57% of the patients diagnosed with CRC develop Iron Deficiency Anaemia (IDA). A meta-analysis of 37 studies supports the association between Perioperative Blood Transfusion (PBT) and the recurrence of curable CRC.

Methods: Aim of this study is to compare recurrence in curable Proximal CRC patients between two cohorts; Pre-Operative Iron Therapy (IT) alone and Pre-Operative Blood Transfusion (BT). Data was collected from hospital database retrospectively from January 2016 to August 2018. Recurrence rates were calculated between the two cohorts. Chi-Square test was used to calculate p-values.

Results:

- 124 patients had curative intent Proximal CRC resections.
- 75 patients had anaemia of those 52 had IDA (41.9%).
- 44/124 patients received Pre-Operative IT.
- 28 patients had PBT out of those, 14 patients had Pre-Operative BT.
- Recurrence rate for IT cohort was 11.6% whereas, for Pre-operative BT; 14.2% (p-value 0.88).
- Average length of stay (LoS) for PBT was 19 days compared to 10 days in IT cohort.

Conclusion: Although the values are too small to suggest an impactful result, a prospective study could provide definitive data. Since medical optimisation with iron, therapy carries lower recurrence rates it is prudent to establish Pre-Operative anaemia clinics minimising the number of PBT and reducing average LoS.

82. SYSTEMIC ADJUVANT CHEMOTHERAPY FOR CHOLANGIOCARCINOMA SURGERY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: The role of adjuvant therapy for biliary tract cancer is not clearly defined with conflicting results demonstrated across non-randomized and randomized studies. We report a systematic review and meta-analysis to delineate the effect of AT on overall survival.

Methods: Eligible studies were identified from MEDLINE, EMBASE, Cochrane and PubMed. Studies comparing adjuvant chemotherapy or chemoradiotherapy after curative-intent surgery with curative surgery only for biliary tract cancer were included. Data pertaining to tumours of the gallbladder and bile ducts were included. The primary outcome assessed was overall survival.

Random-effects meta-analysis was performed, as well as pooling of unadjusted Kaplan-Meier Curve data.

Results: 35 studies involving 42,917 patients were analysed. There was a significant improvement in overall survival with any adjuvant therapy after surgery compared with surgery only (HR 0.74; 95% CI, 0.67 to 0.83; $P < 0.001$). There was a significant benefit for adjuvant therapy in those with margin positive surgery (RR, 0.83; 95% CI, 0.77 to 0.91; $P < 0.001$) and

node-positive disease (RR 0.82; 95% CI 0.76 to 0.89; $P < 0.001$)

Conclusion: Our review advocates the use of adjuvant therapy in bile duct cancer after curative intent resection. Further prospective studies are needed to determine the optimal regime and timing of an adjuvant approach.

118. PREDICTORS OF SURVIVAL LOCAL RECURRENCE AND METASTASES OF LEIOMYOSARCOMAS OF TRUNK WALL AND EXTREMITIES: A RETROSPECTIVE STUDY

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Introduction: The Leiomyosarcomas are aggressive neoplasms with poorly understood pathogenesis. More importantly, accurate prediction of their behaviour have proven to be difficult, and, there are no universally accepted prognostic factors.

Our aim was to identify the risk factors for early recurrence, metastases and poor survival with an aim to reduce relapse or enable early detection.

Methods: We included 97 patients who had Leiomyosarcomas involving trunk wall and extremities. We collected demographic, clinical, histopathologic data, and, recorded local recurrence, metastases and survival. We have used Kaplan Mier plot, Uni and multivariate analysis for prognostication.

Results: The mean survival was 60.8 months (SD 49.3). 14% patients had local recurrence. 56% of patients developed metastases. Age > 60 years (p value 0.02) was an independent predictor of poor survival. Whereas, induction treatment (P value 0.04) independently predicted better survival. The univariate analysis suggested that size > 5 cms (p value 0.029) and higher grade (p value 0.02) as possible prognostic factors predicting metastases. Similarly, induction treatment was associated with lower risk of metastases (p value 0.003). However, the multivariate analysis showed none of these factors were prognostic. Similarly, the multivariate analysis did not identify any risk factors which could independently prognosticate local recurrence.

Conclusion: Age > 60 years is an independent factor predicting death. Whereas Induction treatment is a factor associated with better survival and probably lower metastasis. Besides, >5 cm and high-grade tumours could potentially predict of higher risk of metastases.

121. PREDICTING SURVIVAL, LOCAL RECURRENCE AND METASTASIS IN LEIOMYOSARCOMA OF THE EXTREMITIES AND TRUNK WALL: A SYSTEMATIC REVIEW

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Background: Leiomyosarcomas are aggressive, their pathogenesis is poorly understood

Objectives: To quantify prognostic impact of various clinical and pathological markers on survival and recurrence of leiomyosarcomas.

Methods: We conducted a systematic review as per PRISMA protocol. Overall survival, local recurrence and metastasis were outcome measures. Odds ratios extracted from the studies, the odds ratio along with 95% CI were computed. The pooled odds ratio was calculated and weighted.

Results: Our search brought forth fifteen studies comprising 2799 patients, which we included in our analysis, 7 of these 15 publications were later than 2012. Our analysis showed that, age > 60 years was associated with poor overall survival with an odds ratio (O.R.) of 1.77(95% CI 1.33- 2.35, p 0.0001). Further, Size > 5 cms adversely affected the outcome with an O.R 2.79 (2.19- 3.56, p < 0.0001). Other factors which reduced the overall survival were, positive margins of excision O.R 2.32(1.67- 3.22, p < 0.0001), Grade >2 O.R 3.66(p < 0.0001) and deep location O.R 4.16 (2.34- 7.39, p < 0.0001). The risk of metastasis was strongly associated with increasing size

O.R 2.34 (1.35– 4.07, $p=0.002$) and deeper location OR 5.13 (2.8– 9.3, $p < 0.0001$). Only a few studies analysed the impact of factors on local recurrence.

Conclusions: A higher age (>60 years), size (> 5 cms), grade (>2), depth (deep to deep fascia) and positive margins of excision are associated with poor overall survival. Similarly, size (> 5cms) and deeper location are associated with higher metastasis.

Abstracts for BASO Audit & QIP Prize presentation at the BASO Skills Day on Saturday, 16th November 2019

20.

INTRADURAL SPINAL TUMOUR RESECTIONS AT THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST: SERVICE EVALUATION

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Background: Intradural spinal tumour resections at the Royal Orthopaedic Hospital NHS Foundation Trust (ROH) are undertaken by a team of three consultant spinal neurosurgeons. This service evaluation aims to assess current practice of intradural tumour resection at this tertiary centre and compare pre-operative, intra-operative and post-operative outcomes to principles of care published in 2006 by the National Institute of Health and Care Excellence (NICE) in 'Improving Outcomes for People with Brain and Other CNS Tumours'.

Method: Intradural tumour resections undertaken from January 2017 to December 2018 at the ROH were identified and the relevant patients' names and identifiers obtained. Required outcomes were extracted from patients' files, clinical portal and theatre logbooks.

Results: 15/17 patients were reviewed in a multidisciplinary team meeting (MDT) pre-operatively. 14/17 patients experienced improvement, 11 of which experienced complete resolution of symptoms. No change from presentation was seen in three patients. Post-operative MRI was ordered in 13/17 patients. No patients experienced a recurrence, with a minimum follow-up of five months. EuroQoL - Five Dimension (EQ-5D) and Oswestry Disability Index (ODI) scores were not calculated pre-operatively or post-operatively for any patients. Outcomes were not uploaded to the British Spine Registry (BSR) in any cases.

Conclusion: It was found that although the service satisfies NICE standards overall, there is a need to calculate and record pre-operative and post-operative quality of life scores such as EQ-5D and ODI, ensure all patients are reviewed at MDT pre-operatively, and to upload outcomes to the BSR.

89.

TRANSANAL ENDOSCOPIC MICROSURGERY- FOR LOW RECTAL CANCER

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Background: Transanal Endoscopic Microsurgery was first described by Prof. G Buess 1983 and it was first employed for low rectal tumours, near the anorectal junction. It is a recognized treatment modality for large and sessile benign rectal polyps, small carcinoid tumours, early rectal cancers, palliating advanced rectal cancers.

The rectal cancer (or suspicious neoplasm) should be less than 3cm in size for consideration of TEMS. The lesion must be T1/T2 N0 M0 on MRI and preferably on endo-rectal ultrasound. The patient has been seen by a colorectal surgeon and has been fully discussed at the referring MDT. The patient's views on local excision have been sought after discussion of risks/benefits of more radical procedures.

Method: All patients who underwent TEMs at SGH between 2010 and 2017 were identified. Retrospective data collected from clinic letters, discharge summaries, histology, and radiology and endoscopy reports.

Results: Total of 77 patients underwent the procedure. Average patient age was 70.9 years (Max – 92 and Min – 43). Average Follow-up – 2.5 Years all patients were offered the procedure after MDT discussion. (for malignant) 90% of patients had follow-up endoscopy.

Conclusion: R0 (complete resection) of T1/2 rectal tumours. Very low 30 and 90 day mortality. Very low intra peritoneal perforation rate.

Acceptable recurrence rates. Patients with suspected or proven rectal cancers suitable for transanal procedures must need to be discussed at the MDT.

90.

INAPPROPRIATE REFERRAL WITH IRON DEFICIENCY ANAEMIA UNDER THE TWO-WEEK WAIT RULE - INCREASE THE WORKLOAD AND FINANCIAL IMPLICATIONS

Mohammad Miah. Scunthorpe General Hospital, East Yorkshire, UK

Background: Iron deficiency anaemia (IDA) occurs in 2-5% of adult men and postmenopausal women in the developed world and is a common cause of referral to surgeons and gastroenterologists (4-13% of referrals). Asymptomatic colonic and gastric carcinoma may present with IDA, and seeking these conditions is a priority in patients with IDA. One of the criteria under the Two Week Referral (TWR) rule for suspected GI malignancy is iron deficiency anaemia (IDA).

The aim of the present study is to determine the percentage of patients referred inappropriately under the TWR as IDA and the cost accrued by unnecessary referral.

Method: Retrospective data were collected for consecutive 250 patients who were referred over 10 months from January 2016 till October 2016 as IDA and were identified using the hospitals cancer database.

Result: Total 250 patients data were collected among which 6 patients were excluded due to incomplete data. Staggering number of 169 patients were referred without true Iron deficiency anaemia.

Males and females were equally distributed. However, referral without having true IDA was more in male patients. Only 40% patients were referred following NICE guidelines.

Conclusion: Although iron deficiency is a good marker for gastrointestinal cancer, it is evident that 2WW referral guidelines are not being followed. Vast majority of referrals are inappropriate according to guidelines. This not only has considerable workload and financial implications but could be potentially detrimental to patient health.

93.

SMOKING CESSATION INTERVENTION FOR HEAD AND NECK PATIENTS: A COMPARISON IN PRACTICE BETWEEN ENT CONSULTANTS AND TRAINEES

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Introduction: Smoking at the time of a cancer diagnosis increases cancer related morbidity and mortality, while smoking cessation can reverse small T1 laryngeal tumours and improve outcomes in those who cease smoking within 3 months of diagnosis. 20% of patients in the Head & Neck 2-week-wait clinic are smokers.

We investigated differences in behaviour, attitudes and practice of ENT consultants and trainees in delivering smoking cessation advice, potential barriers to it, and areas for improvement of current practice.

Methods: Ethical approval was granted by the Imperial College Education Ethics Review Process. 20 ENT consultants and 22 trainees were recruited voluntarily and underwent qualitative interviews.

Results: Trainees are less likely to discuss smoking habits; 18% advised all smokers to stop and formally referred under 20% of smokers. Consultants had better results. Time limitations and poor understanding of referral processes were perceived barriers, with two trainees reporting the referral was less of a priority. 60% of trainees estimated smoking cessation takes under 1 minute to discuss, with consultants spending 1-2 minutes. 10% of trainees felt it wasn't their role to advise smoking cessation.

Conclusion: Surgeons should be able to advise and encourage smoking cessation to all smokers. Consultants discuss smoking cessation more often and take longer to do so than trainees in our study.

Structured local inductions and formal pathways for referrals will help overcome barriers referrals to smoking cessation. We demonstrate trainees require more support to maximize the opportunity of delivering the smoking cessation message in clinic.