

operative notes at UHL, legibility continued to be a problem. Therefore, we introduced an e-template to compare against RCS guidelines. Our aim was to maintain accurate and legible records of surgical procedures.

Methodology: A total 100 of operative notes were audited prospectively. Audit population of general surgery patients who had procedures between 5th of April and 5th of July 2019 mainly at LRI and less at GH and LGH. Each document was assessed against RCS guidelines.

Results: 100% compliance in recording nature of operation, name of surgeon and assistant, name of procedure, operative findings, details of closure, blood loss and ability of FY1 and nurse to read.

99% had incision details written up, 98% had post-op instructions listed, 94% had recorded VTE prophylaxis and 90% with antibiotics prophylaxis. The least compliance was **prosthesis**, 83% Date and time were missed in 6 notes, **Name of anaesthetist** not documented in 3, **Operative diagnosis** not clearly written in 2, **Complications** not filled in 10, **Extra procedure** left blank in 11, Details of tissue removed/added not clarified in 9 and Signature missed in 10.

Conclusion: Remarkable improvement in legibility of operative notes noticed after introducing the e-forms as they are not subjected to hand-writing. A better outcome in all standards was also accomplished. We emphasized and discussed about the importance of surgeon signature for authentication.

119. ARE WE MONITORING URINE OUTPUT IN SURGICAL WARD SETTINGS WHILE INDICATED OR PLANNED?

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Background: Occurrence of AKI is associated with substantial in-hospital mortality, exceeding 50% when AKI is part of a multiple organ failure syndrome. According to the guidelines, physiological 'track and trigger' systems should be used to monitor acute patients. Monitoring urine output at admission, initial assessment and as a routine can help in recognising and responding to oliguria. Protocols are in place to monitor the urine output of people who are at risk of acute kidney injury alongside a track and trigger system, and to respond to any changes. Our audit objective was to find out the number of patients undergoing major surgery or advised by the physician do they have urine output monitoring in place?

Methods: Prospective data collected of all general surgical patients who were admitted in 2 weeks between 28th May to 10 June 2019 at District Hospital. The data was reviewed through record and on bedside who had planned or indicated urine output monitoring.

Results: 77 patients were included in which 39 had a plan in place for urine output monitoring while 27 patients had Urine output accurately monitored and in-addition 7 patients had no plan of monitoring but was monitored and all of them was catheterized. Total number of catheterized patients were 26 and unfortunately, 3 of them did not have their urine output monitored.

Conclusion: Decrease urine output is common among critically ill patients and prompt fluid resuscitation is needed to prevent.

122. SURGICAL PATIENTS SHOULD BE ASSESSED FOR VTE RISKS AND RECEIVE APPROPRIATE VTE PROPHYLAXIS – WARD PERSPECTIVE

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Background: The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. According to the guidelines risk assessment and VTE prophylaxis on admission for people undergoing abdominal surgery should have anti-embolism stockings or Intermittent pneumatic compression or pharmacological prophylaxis outweighs their risk of bleeding. Continue until the person no longer has significantly reduced mobility relative to their normal or anticipated mobility. Our audit objective is to find out whether all the patients assessed for VTE and bleeding risks, any patient was not on AES, was the pharmacological prophylaxis considered.

Methods: Prospective data were collected over 2 weeks by patients record review and bedside examination. All the patients who were admitted under General surgery were included.

Results: Out of 77 patients 37 underwent Surgery or Invasive procedure and 40 patients were treated conservatively. 99% had VTE risk assessment and 89% received pharmacological prophylaxis while 88% was indicated. 51% did not receive mechanical VTE prophylaxis compared to 71% in Published national report.

Conclusion: Pharmacological VTE prophylaxis is reaching the high-quality standards with almost 100% VTE risk assessment but need more improvement in mechanical VTE prophylaxis in a surgical patient.

123. HOW ADEQUATE IS THE INFORMATION ON THE HISTOPATHOLOGY FORM FOR COLORECTAL RESECTION: RETROSPECTIVE RE-AUDIT

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Background: Histopathology report is the most important and integral part in the management of colorectal resection. According to Royal college of pathologist, colorectal resection forms should contain confirmation of the specimen along with the diagram of the procedure, type of surgery, dissection plane, tumour detected as part of screening programme, previous biopsy details, previous chemoradiotherapy and its date mentioned on the report, history of familial cancer or IBD and preoperative staging. The aim of this re-audit was to review if we are compatible to the guidelines provided by the Royal college of pathologists.

Material and Methods: Data was collected retrospectively from 1/January 2016 to 30/July 2019 in Scunthorpe General hospital. All patient who underwent colorectal resection for bowel cancers were included in this study.

Results: 131 patients underwent colorectal resection the request form analysis revealed that 83 form mentioned it was open technique, 20 laparoscopic and 28 forms were unclear. The diagram was present in 44% and dissection plane was mentioned in 43%. Mention of previous biopsy on the report, preoperative staging and preoperative therapy was 11.4%, 5.4% and 4.5% respectively. Clinical information of familial cancer/IBD was mentioned in 0.76% request forms and 0% information of screening. In contrast to previous audit, presence of diagram and dissection planes was only 0.4%.

Conclusion: Compared to previous audit there is gradual improvement in clinical details on the request form according to the guidelines but still have not reached the standards. This audit identified that histopathology request form needs to be improved.

126. INTRODUCTION OF ERAS PROTOCOL TO A LIMITED RESOURCE SETTING – A SURGICAL AUDIT

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The principal aim of the ERAS protocol is to attenuate the stress response to surgery by optimizing the patient's normal physiology.

Elective colorectal cancer resections performed by a single surgeon at the University surgical unit of the Colombo-South-Teaching-Hospital, Sri Lanka from 2011 to 2019 were audited. The modified ERAS protocol was initiated with the aim of assessing the outcome of patients.

One hundred and twelve colorectal resections were performed (71.4% laparoscopic or laparoscopic-assisted). Median age was 60 years. Male: Female was 1.08: 1. Mobilization was started on post-operative day 01. Oral clear fluids were started on postoperative day 01 and normal diet was established by day 03. 70% of the patients had bowel opening on post-operative day 03. Naso-gastric intubation was done in 40% of the cases and median day of removal was day 02. Median day of catheter removal was post-operative day 02. Three, who underwent laparoscopic-assisted low anterior resections had anastomosis leaks. Two, needed re-opening and other was managed conservatively. Median days of hospital stay were 5 days (range 3–21 days). No difference observed between open and laparoscopic groups. Thirty day mortality rate was zero.

Although ERAS has proven promising results in western countries, the data from developing countries are scarce. In this background, this audit shows

ERAS items tailored to suit the practice have been followed up to a reasonable success with comparable results. Thus, ERAS protocol can be performed in our setting with worthy outcomes with few modifications to basal guidelines to overcome local limitations.

127.

DO WE PROVIDE ENOUGH INFORMATION TO PATHOLOGIST TO OBTAIN A QUALITY REPORT BACK? AN AUDIT TO ENHANCE THE QUALITY OF HISTOPATHOLOGY REPORTS IN A LIMITED RESOURCE SETTING IN SOUTH ASIA

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Adequate clinical details should be provided to histopathologist to obtain a quality report. We experienced shortcomings in histopathology reporting due to deficiencies in patient detail provision.

An audit was done by analysing 100 histopathology specimen forms sent from surgical unit of Base Hospital Panadura – Sri Lanka. After identifying deficiencies new form including patient demographic details, contact number, clinical details, relevant blood and biochemical investigation results, clinical diagnosis, space for a line diagram of specimen with orientating stitches if possible and contact details of the person filled the form, was developed (based on RCPATH guidelines). 100 new format forms were prospectively audited to identify a change.

Conventional forms designed for biochemical studies (Health 350) had been using as histopathology specimen forms as well. Percentages of properly written details were as follows; Patient demographic data -87%, clinical history -42%, relevant biochemical results -8%, radiological findings -2%, clinical diagnosis -1%. Orientation or a line diagram of the specimen was not mentioned in any forms. For further clarifications, histopathology department had to contact or get down the medical officer who filled the form in 68%, delaying final report. After introduction of new format details received were as follows; Patient demographic data -100%, clinical history -100%, relevant biochemical results -88%, radiological findings -90%, clinical diagnosis -96%. Line diagram with orientation stitches was included in all relevant specimens.

Considerable deficiency in clinical details provision with conventional forms was noted. Simple intervention of introduction of a well formatted specimen form with adequate space for diagrams helped to overcome that deficit. This could be implemented in other hospitals in the region.

128.

RADIOLOGICAL LEAKS - DO WE NEED TO INTERVENE?

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Background: Restoration of continuity of the bowel following low anterior resection is generally by a colo-rectal or colo-anal anastomosis. A classification system currently grades leaks into A, B and C, based on management. Grade B and C manifest in a clinical deterioration of a patient often requiring intervention whereas grade A leaks do not, meaning they are rarely discovered immediately post-operatively.

Methods: Cancer Registry Data of patients from 2012–2017 who underwent Low and Ultra-Low Anterior Resection at the Norfolk and Norwich Hospital (NNUH) were identified (n=186). Nine were excluded as non-NHS or non NNUH patients. Retrospective analysis was carried out with height of tumour, neo-adjuvant chemo/radiotherapy, length of hospital stay, unplanned readmissions, proctogram results and overall outcomes recorded.

Results: Of the 177 individuals (62 F vs 115 M), 162 had follow up imaging with 19 having a radiologically identified leak. Eighteen of the 154 patients had a Grade A leak on first proctogram with 17 left without active intervention. Management of Grade A leaks was serial follow up scans or no further imaging. Thirteen went on to have a successful reversal procedure.

Conclusion: Grade A leaks are usually discovered incidentally on routine imaging prior to ileostomy reversal. Their presence does not produce any clinical detriment or alter the course of recovery or subsequent reversal procedure. No current guidance is available as to the definitive management of grade A leaks despite this post-operative imaging being performed routinely in this group of patients.

136.

HUMAN IMMUNODEFICIENCY VIRUS AND HEAD AND NECK CANCER. ARE WE TESTING PATIENTS?

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Background: In 2008 the British Human Immunodeficiency Virus Association (BHIVA) guidance said opt-out Human Immunodeficiency Virus (HIV) testing is required when head and neck cancer is diagnosed.

HIV-seropositive patients may have greater risk of head and neck squamous cell carcinoma (HNSCC). This is due to increased incidence of Human Papilloma Virus in this population and individuals with HIV living longer with potential risk factors.

A study found radiotherapy +/- chemotherapy for HIV-seropositive HNSCC patients is less effective in regional control and overall survival, compared to rates without HIV.

This audit assessed if newly diagnosed head and neck cancer patients are tested for HIV.

Standard: All patients newly diagnosed with head and neck cancer should be tested for HIV, based on the BHIVA guidance.

Method: Somerset Cancer database accessed for patients of the Royal Liverpool Hospital.

Cycle 1: Retrospective analysis of whether HIV test carried out, using notes of patients diagnosed with HNSCC in 2018.

Intervention: Awareness of BHIVA at local meeting, clinic posters, introduced opt-out HIV testing for patients. Pre-op nurses agreed to test.

Cycle 2: Retrospective analysis 6 months after intervention.

Results:

1st Cycle: n= 102 patients, 10 tested, 9.8%.

2nd Cycle: n= 68 patients, 2 tested, 2.9%.

Discussion: HIV testing fell short of the standard, despite education and audit. Further education of clinical team needed, highlighting indication and importance of testing. A previous study revealed low prevalence of HIV in HNSCC, however is this representative or also the result of minimal testing?

Conclusions: Further research and education into clinical implications of HIV and HNSCC required.

137.

PRESENTATION AND SURVIVAL AFTER COLORECTAL CANCER IN YOUNG INDIVIDUALS UNDER 40 YEARS OF AGE

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Background: Incidence of colorectal cancer is increasing among young individuals and is associated with poor prognosis. The pattern of presentation in young individuals is also quite variable. We aim to access the presentation and survival of patients with colorectal cancer under 40 years of age.

Method: A retrospective review of prospectively maintained database of all the patients diagnosed with colorectal cancer under the age of 40 at a single institution between 2010 and 2016 was done.

Results: 28pts were included. 18 (64.28%) were males. Mean age was 33.3 years (range 21 – 38, SD +4.12). Primary symptom was abdominal pain in 16 (57.14%) and PR bleed in 13 pts (46.42%). Mean duration of symptoms was 4.8 months (range 1 – 18 months, SD +4.7). Primary site of the tumour was sigmoid in 10 (35.71%) and rectum in 8 pts (28.57%). 17pts (60.71%) underwent curative treatment with no mortality and recurrence over mean 3.8 years of follow up (range 3 – 8 years, SD +0.95). 11 pts were palliated (100% mortality) of which 54.5% died within 1 year of diagnosis.

Conclusion: Young patients present with advanced colorectal cancer. Early evaluation of symptoms is the key to prevent advanced presentation of colorectal cancer in young.