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?

William Thompson, Ella Ward-Baker, Thomas Hampton. *Royal Liverpool Hospital, Liverpool, UK*

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.