Patients in the re-excision group were older than the group who underwent no re-excision. Smaller breast size, lobular histology, multifocality, presence of ductal carcinoma in situ (DCIS) component, concomitant cavity shave, and presence of ≥2 co-morbidities were factors significantly associated with re-excision. In Multivariate analysis, lobular histology, multifocality, and presence of DCIS component were independently associated with high re-excision rates.
In our experience, re-excision rates were not significantly related to tumour size or location. Our mastectomy rate of 12.8% following initial BCS was higher than the national rate of 7.7%. This was significantly associated with multiple positive margins and multifocality.
Conclusion: We have identified factors that potentially influence re-excision rates following BCS for breast malignancy. These may help to identify breast cancer patients that may benefit from larger initial re-sections. Furthermore, these factors should be carefully considered when counselling breast cancer patients, and when formulating their management plans, to minimise frequency of re-excision procedures.

49.
METASTATIC INVOLVEMENT OF THE OMENTUM IN PATIENTS UNDERGOING OESOPHAGECTOMY: A MULTI-CENTRE STUDY

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Background: There is currently little evidence to implicate the omentum in metastatic spread of oesophageal carcinoma. Routine excision of the omentum may not be justified in the absence of evidence of oncological benefit. This study aimed to characterise tumour involvement of the omentum in oesophageal carcinoma patients undergoing oesophagectomy with curative intent.
Methods: Histology reports were reviewed for 113 patients who underwent oesophagectomy with curative intent at two centres (Watford General Hospital, Hertfordshire, UK; St George Hospital, Sydney, Australia) between 2007 and 2017. Tumour type, stage and lymph node status for each patient was recorded. Each excised omentum was assessed by an experienced pathologist for tumour involvement.
Results: TNM classification was available for 110 cases. Tumour stage was T0 in 12 (10.6%), T1 in 22 (19.7%), T2 in 24 (21.2%), T3 in 43 (38%) and T4 in 9 (7.96%) patients. 68 patients (61.8%) had lymph node metastasis. Omentectomy was performed in 87 patients (77%). Of these, 84 resected omenta (97%) were tumour free and only three (3%) showed evidence of tumour involvement. Tumour staging in these cases was T3N3 (2 patients) and T4N3.
Conclusion: The omentum is rarely a site of metastasis in those undergoing oesophagectomy. Routine excision of the omentum during oesophagectomy is therefore unlikely to improve oncological clearance. Further studies are needed to determine if omentectomy confers any benefit to patient outcomes, and which patient or tumour factors might predispose to development of omental metastasis.

51.
COLORECTAL CANCER DIAGNOSIS PATHWAY AT KETTERING GENERAL HOSPITAL: A CLINICAL AUDIT

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Background: More than 300,000 new cancers are diagnosed yearly in the UK. Early diagnosis and treatment are very crucial. The aim of this audit is to check the compliance of Kettering General Hospital with the rapid CRC diagnostic pathway, recommended by NHS England.
Methods: The timescale of diagnostic process for confirmed CRC cases was extracted from Somerset database. The compliance percentages were calculated for the time of first seen, different tests, diagnosis and treatment started. A subgroup analysis was done to compare patients referred straight to test with those referred to clinic.
Results: 64 out of 2125 patients referred through 2 weeks wait pathway in 2018 were confirmed to have CRC. 97% were first assessed within 14 days. 42% had endoscopy within 2 weeks. A 36% compliance for CT abdomen & pelvis was double that of MRI pelvis (18%). Only 23 (35%) cases were diagnosed within 21 days. This has reflected on the average waiting time for treatment which was 73 days. The straight-to-test approach achieved faster diagnosis compared to clinic referrals (p=0.017).
Conclusion: Although the majority of patients were seen within 14 days, there was a significant delay in investigations, diagnosis and treatment. There was better compliance when patients were referred straight-to-test. A one-stop clinic is another suggestion to tackle the delay.

53.
STOP TABLET OVER PRESCRIBING IN DAY CASE BREAST CANCER SURGERY - STOP

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Background: Breast cancer surgery is mostly day case surgery as it is superficial and post-operative pain, classed as mild to moderate, can be controlled with over the counter analgesia (OTC). Many units have protocols to prescribe a standard multi-modal analgesia (Paracetamol, Non-Steroidal anti-inflammatories (NSAID), Opioid) on discharge. Prescribing OTC medication is costly and in many cases wasteful as patients have their own analgesia at home. Our aim is to assess practice, cost of prescribing OTC analgesia, and to propose a pathway that encourages patient self-supply of analgesia and education on how to best achieve symptomatic relief.
Method: Data from 100 consecutive breast surgery cases were analysed for age, sex, day case surgery, analgesia, and cost of prescription. Discharge summaries were reviewed to assess analgesia prescription. The pharmacy department calculated cost of processing and supplying one prescription of paracetamol, NSAID, and opioid.
Results: Eighty-two (82/100) cases were booked as day case surgery, one remained as an unplanned inpatient for observation and excluded. 80 Females v 1 male with a mean age of 56 years [IQR 47 – 66]. 72.8% (59/81) of day case patients were prescribed OTC analgesia. The cost per prescription per patient was calculated to be £24.15 with a total cost of £1425 for all cases.
Conclusion: Prescribing simple analgesia is costly and wasteful. A pathway encouraging and educating patients to self-supply OTC analgesia will incur savings to the NHS and a better patient experience.

59.
LONG TERM OUTCOMES FROM LATISSIMUS DORSI (LD) FLAP BASED BREAST RECONSTRUCTIONS

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The LD flap reconstruction has been the workhorse of breast reconstruction in delayed setting and until the advent of ADMs, was an important technique in immediate reconstructions. The study presents 12 years follow up of a large single Trust series of over 200 cases.
A consecutive series of LD flap reconstructions was derived from theatre logs between 2002 and 2016. Case notes were reviewed for type of surgery, acute and chronic complications. Risk factors for complications were recorded using Charlson co-morbidity index, smoking status, BMI and use of radiotherapy. Statistical analysis using SPSS was performed.
There were 212 LD flap reconstructions; 88 delayed and 120 immediate. Fully autologous surgery was performed in 68 and supplemented with implant in 136. Median follow up is 7 years. Early adverse events included 7 patients readmitted within 30 days of surgery, usually for infection, partial (2) or complete (1) flap necrosis. There were no deaths. Seromas required aspiration at least once in 150 patients (median of 2, range 1-11). There were 24 minor infections and 1 major infection causing implant loss. Further surgeries were required in 119 women, usually symmetrization (80). Median number of further procedures was 2 (range 1-10). Long-term chronic complications were reported in 30 women (such as back or wound pain, chronic seroma, shoulder stiffness).