Methods: We retrospectively reviewed all the patients admitted to the RBH with a diagnosis of gallstone pancreatitis between June and December 2013.
Results: Thirty patients met with the inclusion criteria but five were excluded - two were unfit for any definitive intervention, one declined it, one died prior to discharge and one was referred to a specialist paediatric unit. 0/25(0%) patients underwent laparoscopic cholecystectomy with operative cholangiography and imaging of the bile ducts within the stated time-frame. 7/25(28%) underwent laparoscopic cholecystectomy within the stated time-frame, but without undergoing operative cholangiography. 2/25(8%) patients were considered unfit for surgery, but underwent ERCP plus sphincterotomy within the two-week time frame. In-hospital mortality rate was 1/30(6.6%) and the death resulted from complications secondary to pancreatitis. No patients died following surgical intervention.
Conclusion: 70% of patients with gallstone pancreatitis did not undergo definitive treatment within the recommended timeframe. Imaging of the bile ducts, with either intra-operative cholangiography, ERCP or MRCP was not routinely performed.

0232: UNRESECTABLE PANCREATIC CANCER: WHAT IS OUR BYPASS RATE AND HOW COULD THIS BE IMPROVED?

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Aim: Five-year pancreatic cancer survival remains at around 5% and the only significant chance of prolonging survival is complete surgical resection (R0). Only 20% of cases are deemed operable at presentation and many found to be unresectable at subsequent laparotomy. We undertook this study to clarify our rate of palliative bypass surgery (Roux-en-Y hepatico-jejunostomy/gastro-jejunostomy) for patients with 'resectable' pancreatic cancer, and the reasons for non-resection.
Methods: We reviewed our cases of pancreatic and peri-ampullary cancer operated on with curative intent from April 2009-14 and identified all who were unresectable at laparotomy.
Results: Of 245 patients undergoing laparotomy with the intent of pancreatic resection 44 patients (18%) had unresectable disease, and 41 (16.7%) underwent palliative bypass. The reasons for non-resection were vessel involvement (40.5%), liver metastases (35.7%), distant lymph node involvement (26.2%), intra-peritoneal deposits (16.6%) or local organ involvement (14.3%). Pre-operative laparoscopy was performed selectively (high serum Ca 19-9) in 19% of patients bypassed. The median time from staging CT to operation was 56 days (1-131).
Conclusion: Surgeons wish to avoid non-resectability at planned resection. Our rates are comparable to those in the literature but we wish to explore changes in practice that would decrease these rates in the future.

0234: SIZE OF COMMON BILE DUCT STONES ON MRCP PREDICTS LIKELIHOOD OF POSITIVE FINDINGS AT ERCP

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Aim: To determine if the size of common bile duct stones (CBD) measured on magnetic resonance cholangio-pancreatography (MRCP) can be used to predict the likelihood of a positive endoscopic retrograde cholangio-pancreatography (ERCP) result.
Methods: We analyzed the records of 1812 patients undergoing MRCP between November 2009 and November 2014 at the Victoria Infirmary. A CBD stone was present in 383 patients. 293 successfully underwent ERCP.
Results: 221 patients (75%) had stones on ERCP. A receiver operating curve (ROC) was plotted correlating size with the likelihood of a positive ERCP result. A cut off of >4mm as an indication for ERCP gives the mathematical best-fit with sensitivity of 82.8% (95% CI 77.3 - 87.6) and specificity of 65.71% (95% CI 53.4 – 76.7).
Conclusion: Currently, all patients with stones on MRCP are considered for ERCP. Our results support the hypothesis that as size decreases the likelihood of stone passage increases. Although the threshold of mathematical best compromise is >4mm, we would suggest a lower threshold of 2mm above which ERCP is performed to minimise missed stones (sensitivity 98.65, 95% CI 96.1-99.7, sensitivity 25.71%, CI 16.0-37.6). For patients with stones measuring 2mm or less, early operative intervention with intra-operative cholangiography to confirm duct clearance could be an alternative.

0309: IMPROVING PATIENT CARE IN OUR CURRENT PRACTICE; MANAGING ACUTE PANCREATITIS WITH BRITISH SOCIETY OF GASTROENTEROLOGY (BSG) GUIDELINES

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Aim: BSG guidelines state that severity stratification should be made in all patients within 48-hours of diagnosis of acute pancreatitis (A.P) and severe cases should be managed in ITU/HDU. Aim of this audit is to compare management of A.P in our hospital with the BSG guidelines.
Methods: A retrospective analysis included patients diagnosed with A.P admitted from January 2012 till April 2014. Assessing the Glasgow score on admission and within 48-hours, length of hospital stay and whether ITU/HDU involvement was provided for high-risk patients. Patients with chronic pancreatitis or without a recorded amylase level were excluded.
Results: 79 patients were included. The primary cause was cholelithiasis (50%) while 8% were diagnosed as idiopathic in nature. 57% patients had incomplete documentation of Glasgow scoring in notes within 48-hours. Only 40% of patients with severe score received ITU input. Positive correlation was found between severity score and length of hospital stay (r=0.52925).
Conclusion: Recommendations were designing a scoring proforma with clear parameters; educating that better scoring would improve patient care. In a prospective study of 50 patients, 95% had a proforma in medical notes that led to a 69% increase in ITU/HDU involvement.

0312: MANAGEMENT OF GALLBLADDER STONES – ARE WE DELAYING THE INEVITABLE?

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Aim: Audit on management of symptomatic gallbladder stones, as compared to national guidelines, at Dumfries and Galloway Royal Infirmary. This showed that delaying laparoscopic cholecystectomy resulted in an increased readmission rate whilst increasing risk of postoperative complications.
Methods: Medical records of patients who underwent laparoscopic cholecystectomy between October 2013 and September 2014 were audited. PACS imaging software was used to identify patients with US-confirmed gallbladder stones. The period of time between diagnosis and operation was calculated and the readmission rate in the intervening period was measured. The rate of postoperative complications was then recorded as a function of time elapsed between diagnosis and operation.
Results: 55 patients with US-confirmed symptomatic gallbladder stones were included in the study (n=55). 48 patients had laparoscopic cholecystectomy as a day case procedure. The mean waiting time between diagnosis and operation was 124 days. 10 patients (18%) had to be readmitted with gallstone complications in this intervening period. 8 patients (15%) suffered postoperative complications, namely, conversion to open procedure and sepsis.
Conclusion: The waiting time between US confirmation and operation is prolonged resulting in a significant readmission rate. This increased waiting time is also statistically significant in terms of increased risk for postoperative complications.

0350: EMERGENCY LAPAROSCOPIC CHOLECYSTECTOMIES CAN BE DONE ON ELECTIVE LISTS TO IMPROVE PATIENT OUTCOMES AND COST EFFECTIVENESS IN THE NHS – A FEASIBILITY STUDY FOR WIDER IMPLEMENTATION

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