

Posters for BASO Trainees and BASO Poster Presentations (Part – 3)

at the 2020 BASO Annual (virtual) Scientific Meeting 21st – 23rd November 2020

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Poster 94: The role of expedited adjuvant intraperitoneal chemotherapy in locally advanced colorectal cancer

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Background

- Locally advanced colorectal cancer (LACRC) is defined as T4, NO-2 and MO tumours
- These frequently metastasize intraperitoneally and augur significant morbidity and mortality
- Expedited adjuvant intraperitoneal chemotherapy is delivered within one month after cytoreductive surgery
- This targets micro-metastatic deposits from the primary tumour which progress to peritoneal carcinomatosis
- We systematically reviewed the effect of expedited intraperitoneal chemotherapy delivered within a month of cytoreductive surgery on outcomes in LACRC

Objectives

This study aims to systematically review the effects of expedited adjuvant intraperitoneal chemotherapy in LACRC:

- 1. Survival benefit overall survival and progression-free survival
- 2. Adverse effects

Methods

- A literature search of all studies indexed on the MEDLINE from inception to September 2020 was performed
- Only randomised controlled trials pertaining to participants with LACRC, and who received intraperitoneal chemotherapy within a month of cytoreductive surgery were included (*Figure 1*)

Barking, Havering and Redbridge University Hospitals **NHS Trust**

Contact

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	🗾 Klaver, 2019 💌	Nordlinger, 2005 💌	Scheithauer, 1998 💌	Vaillant, 2000 💌
Number of Particpants	202	1857	241	267
Number of LACRC	175	735	116	88
Number receiving IPC	8	415	78	121

Table 1. The total number of patients, those with LACRC and those who received intraperitoneal chemotherapy for each study

References

- 2019. doi: 10.1016/S2468-1253(19)30239-0.
- 10.1038/bjc.1998.225
- 5. Vaillant JC, et al. Adjuvant intraperitoneal 5-fluorouracil in high-risk colon cancer: A multicenter phase III trial. doi: 10.1097/00000658-200004000-00001.

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Discussion

• This is the first review of adjuvant intraperitoneal chemotherapy in colorectal which considers the timing of its delivery and its use in T4 tumours

Although the COLOPEC study (Klaver, 2019) does not support the use of adjuvant intraperitoneal chemotherapy, its internal validity has been called into question

Evidence on expedited adjuvant intraperitoneal chemotherapy in LACRC obtained from this review is dated and limited, but points towards improved outcome

Conclusions

The study systemically reviewed four randomized controlled trials encompassing 622 patients receiving expedited intraperitoneal chemotherapy within a month of cytoreductive surgery. The results were suggestive or survival benefit and improved overall outcome, thereby highlighting the need for further randomised trials in expedited intraperitoneal chemotherapy.

et al. Locally Advanced Colorectal Cancer: True Peritoneal Tumor Penetration is Associated with Peritoneal Metastases. Ann Surg Oncol. 2018. doi: 10.1245/s10434-017-6037-6

et al. and the COLOPEC collaborators group. Adjuvant hyperthermic intraperitoneal chemotherapy in patients with locally advanced colon cancer (COLOPEC): a multicentre, open-label, randomised trial. Lancet

ger B et al. Adjuvant regional chemotherapy and systemic chemotherapy versus systemic chemotherapy alone in patients with stage II-III colorectal cancer: a multicentre randomised controlled phase III trial. Lancet Oncol.

^{4.} Scheithauer W et al. Combined intravenous and intraperitoneal chemotherapy with fluorouracil + leucovorin vs fluorouracil + levamisole for adjuvant therapy of resected colon carcinoma. Br J Cancer. 1998. doi:





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LAY SUMMARY

Outcomes in metastatic bone disease (MBD) are better if surgery is undertaken before a bone lesion causes a fracture.

Current scoring systems to predict which metastases will fracture do not take into account patient variables and so are often inaccurate and lead to unnecessary surgery.

This pilot study determines the sample size required for a large multivariate analysis to determine which patient factors predict risk of pathological fracture in patients with MBD.

Background



Outcomes after surgery for bone metastases are better for prophylactic surgery than after patients sustain a pathological fracture^{1,2}.

Will this lesion fracture, Doctor?

There is a poor evidence-base for predicting risk of pathological fracture in patients with bone metastases.

		a	Clinical Orthopaedics nd Related Research
	TABLE 1.	Scoring Sy	stem
		Score	
Variable	1	2	3
Site	Upper limb	Lower limb	Peritrochanter
Pain	Mild	Moderate	Functional
Lesion	Blastic	Mixed	Lytic
Size	<1/3	1/3-2/3	>2/3

Radiological scoring systems like Mirels fail to incorporate patient-specific variables like primary cancer type and patient age^{3,4}.

Objectives

The aim was to identify predictors of fracture at 12 months in patients with long bone metastases.

CONTACT

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THANKS TO:

Study funders (AO UK, RCSEd & Robertson Trust) PhD supervisors

Poster 98. Retrospective analysis of risk factors for progression to fracture in patients with metastatic bone disease (MBD)



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Results 2

In this cohort, **factors associated with** \uparrow **fracture rate** included:

lirels score (p=0.015)			X-ray appearance (p=0.0017)			
27% v	/S	8%	28%	VS	2%	
Mirels ≥9	5/65	Mirels <9	11/40 Lytic		1/42 Mixed	

With a fracture rate of 13.9%, a **sample size of 1055 lesions** will identify which of the 15 variables of interest are associated with \uparrow risk of fracture (95% confidence level, error margins 4-4.5).

ure risk	Conclusions
	Predicting risk of pathological fracture is vital
	in managing patients with bone metastases to
	avoid unnecessary surgery.
	This pilot study has generated a recommended
	sample size to validate the 15 variables of
	interest, and provided early evidence for their
/)	utility in predicting pathological fractures.
one	
	TAKE HOME MESSAGES

• Current methods to predict risk of pathological fracture in bone metastases (e.g. Mirels) do not account for the high heterogeneity in patients with systemic cancer

• We have identified 15 patient variables that could influence risk of pathological fracture

pilot study demonstrates a 13.9% fracture rate, recommending a sample size of 1055 to investigate the 15 variables of interest

³Mirels H. The classic: metastatic disease in long bones: a proposed scoring system for diagnosing impending pathologic fractures. Clin Orthop

⁴Van der Linden YM et al. Comparative analysis of risk factors for pathological fracture with femoral metastases. J Bone Joint Surg Br. 2004

¹Jonas SC *et al.* Current orthopaedic management of bony metastases in the proximal third of the femur. Hip International. 2017 Jan;27(1):1-7. ²Khodabukus A et al. Surgery for metastatic lesions of the femur: good outcome after 245 operations in 216 patients. Injury. 2008 Apr;39(4):404-



Poster 99: Characterising non-melanoma skin cancer undergoing surgical management during the COVID-19 pandemic

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Introduction & Objectives

During the COVID-19 pandemic, plastic surgery departments have strived to keep oncological services running despite significant operational pressures. Access to healthcare generally declined in all but the most urgent circumstances, and departments have already identified a reduction in referrals and diagnoses of skin malignancies.

Keratinocyte cancers (BCC and SCC) are the commonest malignancy worldwide. We aimed to characterise differences in patients undergoing surgical management of non-melanoma skin cancer (NMSC) during 'lockdown' in our centre.

Methods

A retrospective, single-centre case control study comparing 102 patients undergoing operative treatment for NMSC during the COVID-19 pandemic in 2020 to results from 127 patients undergoing treatment for NMSC in the same period in 2019.

Data was collected from electronic operating lists and the electronic patient record. Dichotomous data was compared using Chi-squared tests and contiguous data using unpaired ttests. A *p*-value of <0.05 was taken to be statistically significant.

Results

Cases and controls were well matched in terms of patient demographics, lesion location, and operator training grade (Table 1).

In 2020 there was a significant increase in the number of squamous cell carcinomas (SCC) excised relative to 2019, and a significant decrease in the number of basal cell carcinomas (BCC), as well as an **overall increase in the size of lesions**.

The overall incidence of incomplete excision rates was higher in 2020 than in 2019, although this did not reach statistical significance (Fig. 1).

This increase in size led to a relative **decrease in defects** amenable to primary closure (Fig. 2).

We found no significant difference in the time from initial referral to definitive treatment between groups.

Age (Mea

Sex (n)

Pre-op dia

Senior ope

Mean time

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Fig 1. Differences in tumour characteristics and incomplete excision rates between 2019 and 2020 during the COVID 19 pandemic. *indicates statistical significance



Fig 2. Distribution of NMSC excisions that could be directly closed and those requiring reconstruction in 2019 vs 2020 during the pandemic (%)

Contact

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		2019 (n (lesions) =	2020 (n (lesions) =	p =
		127)	102)	
n (SD))		75.67 (11.35)	74.6 (12.17)	0.17
	Males	56	54	_
	Females	36	36	
	BCC	86	51	
agnosis (n)	SCC	37	48	0.03*
	Other	2	3	
	Consultant	47.1	43.2	
erator grade (%)	Registrar	47.9	53.9	0.57
	SHO/Core trainee	5.0	2.9	
e to procedure – All	lesions (days)	109	115	0.77

Table 1. Table comparing demographics of patients, types of lesion, operator grade and mean time to procedure from referral in 2019 vs 2020. indicates statistical significance. Patient demographics are comparable and there is no difference in operator grade.



References

unter HJA, McMullen E, Griffiths CEM, Warren RB. Reduction in skin cancer diagnosis, and overall cancer referrals, during the COVID-19 pandemic. British Journal of Dermatology, 202 senbaum L. The Untold toll – the pandemic's effects on patients without COVID-19, NEJM, 2020;382;2368-237 Nolan GS, Kiely AL, Totty JP, Wormald JCR, Wade RG, Arbyn A, Jain A. Global incidence of incomplete surgical excision of keratinocyte skin cancers: a systematic review and meta-analysis. British Journal of Dermatology. October 2020. Online ahead of print.

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Discussion

Despite prioritisation of oncological services throughout the pandemic, our findings show substantial differences in the patients accessing skin oncology services in our centre.

Reasons for the significant differences in lesion characteristics during COVID-19 are likely to be multi-factorial. Patients have had delayed presentation to healthcare services throughout the pandemic.^{1,2} Reduction in face-to-face appointments in primary care and potential hesitancy in the use of usual onward referral pathways to secondary care may also play a part.

The increase in incomplete excision rate seen in 2020 is clinically significant, and higher than an estimated 10% global rate.³ Larger, more invasive lesions may be likely to result in an increase in incomplete excision margins. Timely diagnosis of these NMSC lesions and treatment with clear margins is important, as 31-41% of lesions without clear margins will recur,⁴ often requiring further surgical treatment.

In our study, since patients were well matched demographically and in terms of seniority of surgeon, this increase was likely to be related to lesion factors rather than surgical factors, or an as yet unexplored confounding factor.

Conclusions

It appears that current delays to definitive surgical treatment of smaller, less aggressive BCCs may mean patients are missing the opportunity to benefit from early excision. There is a risk that should this trend continue, a large cohort of patients with these ostensibly less aggressive tumours may experience a delay in their treatment, requiring yet more complex reconstructive surgery as seen in this study.

Further work is needed to streamline referral pathways and maintain access to services for patients, in the increasingly likely event of restrictions on elective services due to a second wave.

> NHS Hull University **Teaching Hospitals NHS Trust**



Aims:

Postoperative atrial fibrillation (AF) after oesophagectomy is associated with pulmonary and anastomotic complications. Landiolol hydrochloride is an ultrashort-acting B1-selective blocker that may prevent AF via its antiinflammatory and B1-adrenergic blockade effects. We aimed to perform a pilot systematic review, meta-analysis and trial sequential analysis of randomised trials to assess the level of current evidence for hypothesis synthesis.

Methods:

We conducted a search of electronic information sources, including MEDLINE; EMBASE; CINAHL; the Cochrane Central Register of Controlled Trials (CENTRAL); the World Health Organization International Clinical Trials Registry; ClinicalTrials.gov; and ISRCTN Register, and bibliographic reference lists to identify all randomised controlled trials (RCTs) comparing landiolol with placebo in patients aged >18 with pathologically confirmed oesophageal carcinoma undergoing planned transthoracic oesophagectomy. Fixed-effect model was applied to calculate pooled outcome data. Trial sequential analysis was performed to assess the possibility of type I or II error and compute the information size required for conclusive meta-analysis.

Results:

We identified two placebo-controlled randomised trials, enrolling a total of 139 patients. The included population were comparable in terms of age [67 vs 66, mean difference (MD): 1.32, 95% confidence interval (CI): -1.89, 4.53, P= 0.42], gender [male: 73% vs 84%, odds ratio (OR): 0.53, 95% CI, 0.23, 1.23, P= 0.14], hypertension (40%) vs 45%, OR: 0.81, 95% CI: 0.41, 1.58. P=0.53), diabetes mellitus (40% vs 45%, OR: 1.28, 95% CI: 0.49, 3.33. P=0.61), intraoperative blood loss (364 ml vs 391 ml, MD: 42.21 95% CI: -9.56, 93.97, P=0.11), and operative time (498min vs 504min, MD: -12.46, 95% CI: -36.57, 11.65, P=0.31). The risk of postoperative AF was lower in landiolol group compared to placebo (9% vs 31%, OR: 0.21, 95% CI: 0.08, 0.55. P=0.002). The landiolol reduced postoperative heart rate significantly compared with placebo (MD: -11.00, 95% CI: -17.39, -4.61, P=0.0007) without any adverse effect on systolic (MD: -1.68, 95% CI: -8.17, 4.81, P=0.61) and diastolic blood pressure (MD: -1.87, 95% CI -4.74, 1.00, P=0.20). A low level of heterogeneity among the studies existed (I2=0%, P=0.46). The information size was calculated at 156 patients and trial sequential analysis showed that the risk of type 1 error was minimal.

First author	Journal	Country	Design	Population	Exclusion criteria	Landiolol regimen	Control treatment	D a
Horikoshi 2017	Journal of Clinical Anesthesia	Japan	RCT	Patients undergoing oesophagectomy for oesophageal cancer	 History of cardiac (e.g., arrhythmias including AF, conduction abnormalities) Antiarrhythmic medications including- blockers Recent angina pectoris or myocardial infarction) Pulmonary, or renal disease Thyroid dysfunction 	5 µg/kg/min for 24 hours	0.9% saline solution as placebo	E) ar IC
Ojima 2017	British Journal of Surgery	Japan	RCT	Patients undergoing oesophagectomy for oesophageal cancer	 Need for dopamine Systolic blood pressure < 80 mmHg or >160mmHg Heart rate <50 beats per min Arrhythmias Need for ventilator assistance 	3 µg/kg/min for 72 hours	5% glucose solution as placebo	E) ar IC

Table 1. Baseline characteristics of the included studies

Presented by: Jigar shah Authors: Jigar Shah, Paul Peters, Shahab Hajibandeh. North Manchester General Hospital

Poster 100: Landiolol hydrochloride for the prevention of postoperative atrial fibrillation in patients undergoing oesophagectomy: a pilot trial sequential analysis of randomised trials for hypothesis synthesis.

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Table 2. Baseline characteristics of the included population

Baseline variable ⁸	Landiolol	Placebo	Summary measure*	P value ⁴
Age	67 (10)	66(8)	1.32 [-1.89, 4.53]	0.42
Male	51/69	59/70	0.53 [0.23, 1.23]	0.14
Female	18/69	11/70	1.89 [0.82, 4.39]	0.14
Hypertension	28/69	32/70	0.81 [0.41, 1.58]	0.53
Diabetes mellitus	11/69	9/70	1.28 [0.49, 3.33]	0.61
Operative time, min	498 (75)	504 (81)	-12.46 [-36.57, 11.65]	0.31
Blood loss, ml	364 (319)	391 (395)	42.21 [-9.56, 93.97]	0.11

* Odds ratio (OR) for dichotomous variables and mean difference for continuous variables. ^{\$}95% confidence level

§ Mean (SD) for continuous variables and proportions for dichotomous variables

Α	Landic	iei	Place	bo		Odds Ratio	
Study or Subgroup	Events	Total	Events	Total	Wright	M-H, Fixed, 95% CI	MH
Herikoshi 2017	1	19	7	- 20	32.4%	0.10 [0.01, 0.94]	
Ojima 2017	5	50	16	50	87.8%	0.28 (0.09, 0.76)	_
Total (95% CI)		69		70	100.0%	0.21 [0.08, 0.55]	
Total events	8		22				
Heterogeneity: Chiff =	0.54, df=	$1 \ (\mathbb{P} =$	$0.46(; l^2)$	0.05			0.01 0.1
Test for overall effect.	Z = 3.14 ((P = 0.1)	102)				Eavours Lane

Risk of bias legend

(A) Random sequence generation (selection bias).

(B) Allocation concealment (selection bias) (C) Blinding of participants and personnel (performance bias).

(D) Blinding of outcome assessment (detection bias).

(E) incomplete outcome data (attrition bias)

(F) Selective reporting (reporting bias).

(G) Other Mas.

A) Forest plot of the comparison of atrial fibrillation. The solid squares denote the odds ratio (OR); the horizontal lines represent the 95% confidence intervals (CIs), and the diamond denotes the pooled OR.B) Results of trial sequential analysis for atrial fibrilation. B1) To the left, the red inward-sloping dashed lines make up the trial sequential monitoring boundaries. To the right, the outward sloping red dashed lines make up the futility region. The solid blue line is the cumulative Z curve. B2) The solid green line presents penalised Z value.

Conclusions:

The best available evidence suggests that landiolol hydrochloride is promising in prevention of postoperative AF in patients undergoing oesophagectomy. The available evidence is restricted to a very limited number of RCTs. There is currently no ongoing trial investigating effect of landiolol in postoperative AF following oesophagectomy. This review warrants a need for designing more RCTs and our results can be used as a robust pilot for generation of hypothesis in future trials.

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Poster 101: Squamous cell carcinoma arising within the lining of a mandibular odontogenic keratocyst- a rare occurrence

Introduction

SCC (Squamous Cell Carcinoma) arising within OKC (Odontogentic Keratocyst) is a rare occurrence; OKCs are usually described as a cyst with locally aggressive behaviour and high recurrence rate¹. Peak incidence is usually between the second and third decade, with incidence gradually declining as age increases. We present a rare case of a 78-year-old male who presented to our department with an area of invasive SCC within an OKC in the left mandible.

Patient History

Medical history

Patient referred as routine to the department by his GDP with a suspected dentigerous cyst left mandible

T2DM, Hypertension, regular medication to manage his comorbidities

Patient is a non-smoker and drinks very little alcohol on a social basis. Pt is a retired British Army Veteran.

Social history



Figure 1. Pre-operative OPG examination showing a cystic lesion associated with the unerupted Lower Left 8

Clinical Findings

Clinical exam	CT mandible
3cm suspected dentigerous cyst in the	Well defined expansile cyst extending
left mandible associated with the	into the left mandibular ramus.
unerupted LL8 visible in (Figure 1). No	Appearances are in keeping with a
apparent bucco-lingual expansion.	Dentigerous cyst. (Figure 2)

Contact

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Figure 2. Coronal image from CT mandible showing a cystic lesion in the left ramus in the left mandible.

Operative plan

Differential diagnosis: Dentigerous cyst associated with un-erupted Lower Left 8

Operative plan: Surgical enucleation of cyst +/- removal of/coronectomy of LL8 in a day case setting.

Operative intervention: (as above) standard surgical approach used to surgical remove the LL8. Left cystic lesion enucleated with clinical appearance of cyst in keeping with a dentigerous cyst, samples sent for histo-pathological analysis. Note: lingual nerve protection used.

Histology: sections show odontogenic cyst with a lining epithelium that ranges from reactive to frankly dysplastic. There is a invasive component that extends to a depth of 3mm. No evidence of lympho-vascular invasion is seen

Definitive diagnosis: Invasive Squamous Cell Carcinoma arising from the lining of a Odontogenic Keratocyst lower left mandible



Figure 3. Post-operative coronal view showing bony infiltration at the site of surgery



Figure 4. Post-operative axial view showing bony infiltration at the site of surgery

References

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- 4. Colevas AD, Yom SS, Pfister DG, Spencer S, Adelstein D, Adkins D, et al. NCCN Guidelines Insights: Head and Neck Cancers, Journal of the National Comprehensive Cancer Network: 2018;16: 479-90.
- 5. Payne TF. An analysis of the clinical and histopathologic parameters of the odontogenic keratocyst. Oral Surg Oral Med Oral Pathol.1972;33:538-46.





Odontogenic keratocysts (OKCs) are a common dental cyst thought to arise from embryonal dental tissue² often occurring in the posterior mandibular area³. Squamous Cell Carcinoma (SCC) has the potential to develop in the lining of OKCs however they remain a rare occurrence; these entities remain poorly understood as studies describing their clinicopathological features remain few and far between⁴. The pathogenesis and malignant transformation rates of OKC are unknown with a commonly accepted hypothesis suggesting that long standing inflammatory microenvironment acts as a key factor for malignant degeneration of the epithelium of OKC⁵. Where there are cases of SCC arising from a OKC, 65.5% appear in the mandible, with the symptoms that patients experience as similar to our patient⁶ Although a local recurrence rate of OKCs can be as high as 62%, our patient has showed no current clinical nor radiographic signs of this, as well as displaying no long term paraesthesia or other co-morbidities as a result of his surgery. Although surgery is a common treatment modality for OKCs, there are few studies that have described the predictive and prognostic factors for the survival of patients with SCC arising in a OKC due to the fairly low incidence^{6.}

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Figure 5. post-operative OPG examination which shows bony infiltration within the body and ramus of the Left Mandible

Figure 6. Post-operative 3D reconstruction of the CT mandible. CT Mandible Post-Op (taken after 10 months) norma post operative appearances within this region with no bony destruction and no local soft tissue mass. There are no enlarged lymph nodes in the upper neck

Discussion

Smith IM, Harvey N, Logan RM, David DJ, Anderson PJ. Odontogenic keratocyst in a 5-year-old child: a rare cause of maxillary swelling in children. Journal of Plastic, Reconstructive & Aesthetic Surgery 2008;61(2):189-191. Pitak-Arnnop P, Chaine A, Oprean N, Dhanuthai K, Bertrand J, Bertolus C. Management of odontogenic keratocysts of the jaws: a ten-year experience with 120 consecutive lesions. Journal of Cranio-Maxillofacial Surgery 2010;38(5):358-364. 6. Ye P, Wei T, Gao Y, Zhang W, Peng X. Primary intraosseous squamous cell carcinoma arising from an odontogenic keratocyst: case series and literature review. Med. oral patol. oral cir. bucal (Ed. impr.). 2020 Oct 9



Poster 102: Outcomes Following Oesophagogastric Resection During COVID-19: A Comparative Analysis

Introduction / Background

- Oesophagogastric (OG) cancer is the fifth most common cancer in the UK
- Treatment strategies involve a multidisciplinary approach, neoadjuvant therapy and surgery.
- The COVID-19 pandemic has had a major impact on healthcare delivery globally.
- A 30% reduction in cancer surgery has been estimated across Europe during the peak period for COVID-19(1).
- Limited studies on the effect of COVID-19 pandemic on OG resections for cancer in published literature
- We present outcomes for oesophagogastric resections at our unit during the UK COVID-19 lockdown period and compare this to the same period in 2019.

Objectives

To compare outcomes of oesophagogastric cancer resections during the COVID lockdown period (16th March 2020 – 31st June 2020) with those of the same period in 2019 in a single tertiary referral centre.



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Methods and Materials

- A retrospective analysis of prospectively collected data
- Patients that underwent an oesophagectomy or a gastrectomy for cancer
- UK lockdown period for COVID-19 from 16 March 2020 to 31 June 2020
- Royal Stoke University Hospital, Stone-on-Trent
- Comparison made with data from same period in 2019
- IBM SPSS version 27 used for data analysis.
- Sociodemographic and perioperative data including morbidity and mortality data were analysed.

Results

- 24 oesophagogastric cancer resections were performed during the lockdown period (LD) compared to 18 during the same period in 2019.
- Median age in the LD group was 65.5 years (IQR 60 71 years) and in the non-lockdown (NLD) group 62.5 years (IQR 58-72years)(p=0.94)
- Male to Female ratio was 11:1 in the LD group and 2:1 in the NLD group which was statistically significant (p=0.04)
- 95.8% had neoadjuvant therapy in LD group; 88.2% in NLD group (p=0.17)
- Median LOS was 9.5 days in LD group and 10.5 days in NLD group (p=0.20).
- Postoperative complications of Cavien-Dindo 3 or more were 5(21%) in the LD group and 5 (28%) in the NLD group which was not statistically significant (p=0.60)
- No 90-day mortality in both groups and no COVID infections in the LD group.

Table 1. Sociodemographic and Perioperative Data

	COVID Lockdown	2019	р
Oesophagectomy	17 (70.8%)	12 (66.7%)	0.78
Gastrectomy	7 (29.2%)	6 (33.3%)	0.78
Median Age (years)	65.5	62.5	0.94
Neoadjuvant Therapy	23 (95.8%)	15 (88.2%)	0.17
$ASA \ge 3$	11 (45.8%)	4 (22.2%)	0.15
Median LOS (days)	9.5	10.5	0.2
Postop complications (Clavien-Dindo ≥ 3)	5 (21%)	5 (28%)	0.6
COVID-19 Positive	0	N/A	-
90-Day Mortality	0	0	-

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- year.



University Hospitals of North Midlands

NHS Trust



Chart 2. Oesophagogastric Resections

Discussion

The COVID-19 pandemic has resulted in global disruption of health services including delivery of surgical care.

While many centres across Europe experienced a reduction in cancer operations, we report a 33% increase in OG cancer resections.

Apart from a slight preponderance of male patients in the lockdown group, there was no statistically significant difference in sociodemographics in both cohorts

Perioperative outcomes including neoadjuvant chemotherapy, ASA and median LOS were similar in both groups.

Significant post-op complications were classified as Clavien-Dindo 3 or more. Although there was no statistically significant difference between both groups, the lockdown cohort had a reduced proportion of significant complications.

No COVID-related complications in the lockdown cohort.

Conclusions

More oesophagogastric cancer resections were performed at a single tertiary referral centre during the government implemented COVID-19 lockdown in 2020 when compared to a similar time-frame in the previous

Oesophagogastric resections during the COVID-19 lockdown were performed safely, with no difference in short-term outcomes when compared to a historical cohort in 2019

References

1. COVIDSurg Collaborative C, Nepogodiev D, Bhangu A. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans. Br J Surg. 2020 May 12



Liverpool Heart and Chest Hospital NHS NHS Foundation Trust

Poster 109: Early diagnosis and correction of lobar torsion following VATS left upper lobectomy

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Introduction

- Lobar torsion is a rare complication following lung resection. It is thought to occur in 0.089–0.300% of lobectomies¹.
- Clinical features are often non-specific and may include tachycardia, tachypnoea and fever. The median time of diagnosis is usually the 4th post-operative day².
- In their algorithm, Dai *et a*l. suggests a high degree of clinical suspicion and the progression of consolidation/atelectasis or a shift in the position of a lesion on chest x-ray are indications for further investigation by bronchoscopy or CT scan².
- Treatment is to reposition the lung back to the correct anatomical position or to resect the lung if it is not viable.
- We present a case of lobar torsion following left upper lobectomy that was diagnosed in the immediate postoperative period.

A 69-year-old lady underwent a three port, left VATS upper lobectomy and systematic lymph node sampling for a T2aN0 adenocarcinoma. At completion of the operation the lung appeared to expand well, with no air leak present on test inflation.

Observations were stable in theatre recovery however, the post-operative chest x-ray (see figure 1) showed the left lower lobe occupying an unusual position, suggesting possible torsion. The patient was taken back to theatre and the utility port was re-opened. This revealed that the left lower lobe had undergone a counter-clockwise twist. The lobe was untwisted by VATS and placed back in the correct anatomical position.

Chest x-ray after the repositioning showed the normal anatomical position of the left lower lobe following an upper lobectomy (see figure 2). Following this the patient made an uneventful recovery and was discharged home on day 4.

Discussion

- Our patient was asymptomatic as diagnosis was made in the early post-operative period.
- The left lower lobe occupied an abnormal position on the chest x-ray but there was no consolidation or collapse. The diagnosis of lobar torsion is usually made on a contrast enhanced CT scan, but we did not feel that a CT scan was warranted here, due to the obvious diagnosis on chest x-ray.
- Early diagnosis, whilst the lung is still viable, is important to preserve pulmonary function in the long term.
- We believe that the abnormal position of the remaining lobe on chest x-ray should be added to the algorithm by Dai et al.² for further investigation or intervention.

Contact

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Case Report

- operative chest x-ray.





Figure 1. Chest X-ray taken in the recovery room following left upper lobectomy shows the remaining lower lobe to be in an abnormal position.

References

- Journal of Thoracic and Cardiovascular Surgery. 2001;122(6):1091-3.
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Conclusions

This case report shows the value of early recognition and correction of lobar torsion. Early diagnosis, whilst the lung is still viable, is important to preserve pulmonary function in the long term.

We would suggest a high degree of clinical suspicion if the remaining lung following lobectomy is in an abnormal position on the initial post-

Figure 3. Diagnostic algorithm of lung torsion

Source: Dai J, Xie D, Wang H, He W, Zhou Y, Hernández-Arenas LA, et al. Predictors of survival in lung torsion: A systematic review and pooled analysis. The Journal of Thoracic and Cardiovascular Surgery 2016;152(3):737-45



Figure 2. CXR after repositioning of the lobe shows the left lower lobe to be in the correct anatomical position following upper lobectomy.

1. Cable DG, Deschamps C, Allen MS, Miller DL, Nichols FC, Trastek VF, et al. Lobar torsion after pulmonary resection: Presentation and outcome. The 2. Dai J, Xie D, Wang H, He W, Zhou Y, Hernández-Arenas LA, et al. Predictors of survival in lung torsion: A systematic review and pooled analysis. The



Poster 113. Outcomes Following Addition Of Pain Team Member To Thoracic **Multi-Disciplinary Team Morning Ward Round** M Smith¹, S Mason², D Duvva¹, R Devonshire¹, H McCormack¹, A Bhawnani¹, D Mayhew¹, M Shackcloth¹

Background

- Post-operative analgesia post thoracic surgery is challenging despite the widespread adoption of minimally-invasive surgery¹
- The WHO pain ladder, whilst designed for treatment of cancer pain, provides a useful framework for the incremental addition of analgesics in order to achieve comfort²
- A system of multimodality and side-effect minimisation is desirable in acute post-operative pain
- Step 3 • Oxycodone Step 2 • Dihydrocodeine Step 1 • Paracetamol
- Our local acute pain protocol is provided in Figure 1. •

Figure 1. Liverpool Heart and Chest Hospital Acute Pain Protocol.

Objectives

- We anecdotally suspected we could improved our adherance to our analgesia protocol and there had been an increase in patients being discharged on strong oral opiates
- In April 2018 we introduced a routine pain team presence on our morning multi disciplinary team thoracic ward round
- We reviewed this change in practice with an emphasis on patients strong opiate usage (step 3 of our protocol)



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References

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July August

Septem

Mean

Results

- We observed a reduction in patients taking both normal and modifiedrelease oxycodone from 21 to 8 in March 2018 and 2019 respectively.
- This was despite similar patient characteristics, case mix and pre-operative analgesia use.
- Over a 6 month period in 2018 compared to 2019 we observed significant reduction in the percentage of patients being discharge on strong opiates (Table 1).
 - 1. Timothy J P Batchelor, Neil J Rasburn, Etienne Abdelnour-Berchtold, Alessandro Brunelli, Robert J Cerfolio, Michel Gonzalez, Olle Ljungqvist, René H Petersen, Wanda M Popescu, Peter D Slinger, Babu Naidu, Guidelines for enhanced recovery after lung surgery: recommendations of the Enhanced Recovery After Surgery (ERAS[®]) Society and the European Society of Thoracic Surgeons (ESTS), European Journal of Cardio-Thoracic Surgery, Volume 55, Issue 1, January 2019, Pages 91–115
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	2018	2019	
	15	10	
	19	2	
	9	6	
	6	3	
	9	4	
nber	4	6	
SD)	10.33 (5.64)	5.17 (2.89)	p=0.037

Table 1. Number of patients discharged on both quick and modified release oxycodone.

Discussion

• The advent of our new more integrated approach of having a member of the pain team on our morning rounds coincided with a reduction in strong opiate prescriptions as an inpatient and on discharge

• The process led to more rationalized decision making and discharge planning of analgesia at the start of the working day

• Whilst clearly multi-factorial, these changes contributed to positive outcomes and other units may wish to consider performing routine ward rounds with a pain specialist

Conclusions

Pain team presence on our thoracic MDT ward round was well received with positive staff and patient feedback.
Whilst multi-factorial, we observed a statistical significant decrease in strong opiate usage on discharge and a more coordinated strategy to post-operative analgesia.
This has prompted further study into these outcomes and we are currently collecting patient reported pain scores

Poster 114: Comparison of extended right hemicolectomy, left hemicolectomy, and segmental colectomy for splenic flexure colon cancer: A systematic review and meta-analysis.

Aims:

To compare the outcomes of extended right hemicolectomy (ERH), left hemicolectomy (LH), and segmental colectomy (SC) for the surgical management of splenic flexure tumours.

Methods:

In compliance with PRISMA statement standards, a systematic review was performed to identify all studies comparing outcomes of ERH, LH, and SC for the surgical management of splenic flexure tumours. Primary outcomes included anastomotic leak and all postoperative complications. The secondary outcomes included operative time, R0 resection, number of harvested lymph nodes, >12 harvested lymph nodes, severe complications, postoperative mortality, paralytic ileus, wound infection, pancreatic fistula, intra-abdominal abscess, need for reoperation, length of hospital stay, 5-year overall survival and 5-year disease-free survival. ROBINS-I tool and GRADE system were used to assess the risk of bias and certainty of evidence, respectively.

Results:

Analysis of 956 patients from seven observational studies showed that ERHwas associated with more paralytic ileus compared with LH(OR: 2.74, P=0.002) and SC(OR: 6.67, P<0.0001) and the operative time was shorter in SC compared to ERH(MD: 25.48,P<0.0001) and LH (MD:-17.94,P=0.0002). There was no difference between ERH, LH, and SC in terms of anastomotic leak, postoperative complications, R0 resection, severe complications, postoperative mortality, wound infection, pancreatic fistula, intra-abdominal abscess, need for reoperation, length of hospital stay, >12 harvested lymph nodes, 5-year overall survival, and 5-year disease-free survival.

Types of studies	Randomized controlled trials, prospective cohort studies and retrospective
Participants of interest	Participants of any age and gender undergoing emergency or elective operation for splenic flexure tumours. A splenic flexure tumour was define splenic flexure or 10 cm proximal towards the transverse colon or 1
Intervention of interest	Extended right hemicolectomy, which is defined as the ligation of ileoco of the left colic vessels, the resection of the right and transverse colon an ileocolic anastomosis
Comparisons of interest	Left hemicolectomy, which is defined as the ligation of left colic and left the colon from the middle of the transverse colon to the recto-sigmoid distal sigmoid anastomosis. Segmental colectomy which is defined as ligation of left colic artery and formation of colo-colonic anastomosis after resection of the distal part the proximal descending colon
Primary outcome measures	Anastomotic leakage and all postoperative complications
Secondary outcome measures	Operative time, R0 resection, number of harvested lymph nodes, > 12 nodes, severe complications, postoperative mortality, paralytic ileus, w abscess, need for reoperation, length of hospital stay, 5-year overall st
Time frame for follow-up	Time frame for follow-up for postoperative outcomes: 30 days after op follow-up for survival outcomes: 5 years after operation

Table 1. Eligibility criteria for considering studies for this review.

ctive cohort studies

open or laparoscopic curative fined as any tumour located at 10 cm distal towards the descending colon

olic, right colic, middle colic and ascending branch and a part of descending colon, and formation of

t branch of the middle colic vessels, resection of junction and formation of a colorectal or colod left branches of the middle colic artery with of the transverse colon, the splenic flexure and

harvested lymph nodes, < 12 harvested lymph vound infection, pancreatic fistula, intra-abdominal urvival and 5-year disease-free survival

peration Time frame for



Figure 1 Study PRISMA flow diagram.





cancer: A systematic review and meta-analysis.

Study	Year	Countr	y Journal	Design	Duration of follow-up	Included population	Comparison(s)	Setting	Total	ERH group	LH group	SC group	Source of funding		ERH vs LH				ERH vs SC	2			SC vs LH			
de'Angelis et al. [15]	2020 F	-rance	Surg. Endosc.	Retrospective observational	42 months	Patients undergoing curativesurgery forsplenic flexuretumour	ERH vs LH vs SC	Elective	399	143	131	125	No funding was received		ERH (N = 353)	LH (N = 306	Summary measure) (95% Cl)	P-value	ERH (N = 224)	SC (N = 214)	Summary measure) (95% Cl)	P-value	SC (N = 242)	LH (N = 270	Summary measure)) (95%CI)	P-valu
Rega et al. [16]	2019 li	taly	Sci. Rep	Retrospective observational	42 months	Patients undergoing curativesurgery forsplenic flexuretumour	ERH vs LH vs SC	Elective	103	22	24	57	No funding was received	Age, mean (years) Male gender	69.1 60%	68.2 59%	MD 0.62 (1.47, 2.42) OR 1.06	0.50 0.73	67.6 59%	68.4 57%	MD 0. 7 5 - (3.14, 1.63 OR 1.11 (0.75, 1.65)	0.54 3) 0.59	68.3 57%	66.6 60%	MD 1.45 <u>(0.84, 3.74</u> OR 0.86 (0.60, 1.24)	4) 0.22 0.43
Bademci et al.	2019 5	Spain	Laparoendoso	Retrospective observational	84 months	Patients	LH vs SC	Elective	83	0	55	28	No funding was received	Female gender ASA I	40%	41%	(0.77, 1.43) OR 0.95 (0.69, 1.30)	0.73	41%	43%	(0.75, 1.65) OR 0.90 (0.61, 1.33)	0.59	43%	40%	(0.80, 1.24) OR 1.16 (0.80, 1.66)	0.43
[17]	204.9		Tech. A	Detrespective	01 months	flexuretumour			454	50	60	22	Not reported	Ⅱ Ⅲ Ⅳ TNM stage	8% 57%	10% 60%	OR 0.69 (0.39, 1.24) OR 0.83	0.22 0.27	3% 57%	0.5% 60%	OR 4.35 (0.70, 27.02 OR 0.78	0.11 2) 0.24	1% 58%	3% 63%	OR 1.16 (0.80, 1.66) OR 0.83	0.15 0.35
Arevalo etal.†	2018 5	spain	Int. J. Colorectal Dis.	observational	81 months	Patients undergoing curativesurgery forsplenic flexuretumour	SC	Elective and Emergency	151	59	60	32	Not reported	II III Emergency	34%	29%	(0.61, 1.15) OR 1.37 (0.98, 1.93)	0.07	39%	37%	(0.52, 1.18) OR 1.31 (0.87, 1.98)	0.19	39%	33%	(0.57, 1.22) OR 1.17 (0.80, 1.71)	0.42
de'Angelis et al.	2016 F	France	Int. J. Colorectal	Retrospective	71 months	Patients	ERH vs LH	Elective	54	27	27	0	Not	surgery Approach Open	0%	1%	OR 1.28 (0.30, 5.48)	0.74	6%	2.5%	(0.03, 1.25)	0.08	2%	11%	OR 5.17 (0.83, 32.19 OR 1.29	0.08
[12]			Dis.			flexuretumour							reported	Laparoscopic	46%	51%	(0.44, 1.37) OR 0.82 (0.60, 1.13)	0.23	52%	51%	(0.33, 1.58) OR 0.83	0.42	50%	54%	(0.69, 2.39) OR 0.91	0.42
Gravante et al. [13]	2016 U	JK	Surg. Engl.	Retrospective	60 months	Patients undergoing curativesurgery forsplenic flexuretumour	ERH vs LH	Elective and Emergency	98	64	34	0	No funding was		45%	39% 11%	OR 1.31 (0.96, 1.80) OR 2 16	0.09	42%	35%	OR 1.31 (0.88, 1.96) OR 1 33	0.18	35%	35% 6%	OR1.03 (0.71, 1.49) OR 0.71	0.89
Odermatt	2014 L	JK	Surg. Today	Retrospective	74 months	Patients	ERH vs LH	Elective	68	38	30	0	Teceived		56%	48%	(1.31, 3.58)	0.000	46%	54%	(0.48, 3.67)	0.17	48%	44%	(0.26, 1.94)	0.68
et al. [14]				observational		undergoing curativesurgery forsplenic flexuretumour		Emergency							44%	52%	(0.96, 2.16) OR 0.70 (0.46, 1.05)	0.08	54%	46%	(0.46, 1.15) OR 1.38	0.17	52%	56%	(0.72, 1.67) 0.91 (0.60, 1.39)	0.68
																	(0.40, 1.00)				(0.07, 2.13)				(0.00, 1.00)	

Table 2. Baseline characteristics of the included studies.



Table 3 Baseline characteristics of the included population.



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Conclusions:

The available evidence, limited to observational studies, suggests that there is no difference between ERH, LH and SC in terms of postoperative morbidity and mortality, lymph node yield and cancer survival. Randomized controlled trials are required for definite conclusions.



Poster 115: Semi-structured healthcare professional interviews to explore their preferences for the assessment and optimization of older adults facing major gastrointestinal surgery

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Introduction

The health status of older adults varies considerably, meaning that determining best practice in this group is complicated and treatment requires tailoring to individual patients, not their chronological age(1). Lack of clear evidence-based guidelines for the assessment of suitability ("fitness") for major GI surgery contributes to practice variation(2).

Adequate assessment of fitness and frailty and subsequent targeted peri-operative interventions to enhance resilience is often lacking(3). There is little published data on how healthcare professionals determine suitability for major gastrointestinal surgery and how they optimize them to improve outcomes(4). Understanding how clinicians make decisions and the value they place and availability of different optimisation strategies may help to understand variation in practice.

Clinician opinion factors heavily on patient decision-making and may form a substantial aspect of practice variance(5). The causes of this varying opinion are not known but may include personal experience, interpretation of the literature or unit protocols.

Objectives

This study aimed to explore the practices and attitudes of a wide range of healthcare professionals involved in the referral, assessment, optimization and rehabilitation of older patients undergoing major GI surgery to delineate barriers and facilitators to improving care.

Methods

Semi-structured qualitative interviews were undertaken with a range of healthcare professionals involved in the treatment, assessment and optimisation of gastrointestinal surgery patients across the South Yorkshire region. Ethical approval was granted by the Health Research Authority (ref: 19/HRA/5964) and local Research and Development approvals were obtained at individual NHS Trusts. Written informed consent was obtained prior to commencement of the interviews. Interviews were digitally recorded, transcribed verbatim and analysed for themes according to the Framework approach.

Healthcare professionals were selected across the spectrum of pre-, peri- and post-operative care, including Primary Care. Participants were selected to include at least one surgeon and one other healthcare professional from each unit. Participants had to be regularly involved in the care of patients undergoing major gastrointestinal surgery.

Interviews were conducted with reference to a pre-prepared interview schedule.

Results

Thirty-seven healthcare professionals (9 surgeons, 8 specialist nurses, 7 anaesthetists, 5 allied health professionals, 3 oncologists, 3 General Practitioners and 1 geriatrician) were interviewed across 5 hospitals in the South Yorkshire region.

Interviews lasted between 13 and 63 minutes, mean 30 minutes. 16/37 (43%) of participants were male. Three themes were developed with several sub-themes developed during interview analysis (Table 1).

Contact

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Thematic analysis

Experience of assessment of suitability for major surgery

There was variation between clinicians, subspecialties and units in how patients are currently assessed, with variable provision of cardiopulmonary exercise testing, frailty and nutritional assessment. Opinion varied on whose responsibility it is to assess fitness for surgery and how decisions regarding fitness are made in the cancer MDTs.

'The vast majority of patients who we think there's a realistic possibility of surgery have cardiopulmonary exercise testing That is then fed back into our weekly MDT meeting" Colorectal Surgeon

"PS is used for all patients. Whilst it is quite subjective we know that people with a poor PS will have a shorter life expectancy with chemotherapy than without" HPB Oncologist

"The MDT cannot generally make a decision about patient fitness because you do not have all the information needed in the first place" Colorectal surgeon

Commonly discussed barriers to adequate assessment included availability of relevant HCPs and time in their job plans, lack of interventions when deficits are identified and lack of routine screening.

"NICE guidance suggests that all outpatients are screened [for malnutrition] but that doesn't happen in this hospital just for capacity issues I suppose really." Dietician

"The reason we haven't done it up until now is because there's no point doing a frailty assessment if

Experience in optimizing older patients for major surgery Many clinicians spoke of their efforts to improve patient pathways and the value they place in prehabilitation and optimization strategies.

"Sometimes prehabilitation is a measure of their commitment to get themselves better" Colorectal surgeon

"[Surgery School aims] to educate them on the things that they can actually change for themselves" Anaesthetist

Common barriers to optimisation included time within the existing cancer pathways, restrictive job plans of ACPs and having to make business cases for service improvements. Lack of evidence-based guidelines and evidence of clear benefit were cited as barriers to securing funding for prehabilitation programmes. Optimisation of patients presenting as emergencies is seen as particularly challenging and requires co-ordination of care.

"We currently have really poor access to dieticians, not because of dieticians, just because they're too busy" HPB Oncologist

Decision-making in older patients

HCPs emphasized the importance of involving the patient and their family in discussions regarding treatment, particularly where there are concerns regarding poor outcomes after surgery. Many spoke about the effect of major surgery on functional abilities and that this will influence patient decision-making. Many spoke of the importance of symptom burden in older patients and that often they will accept higher risk if their symptom burden is high.

Theme 1: Subthem Usı Faci Atti

Theme 2 ubthem

Theme 3 Pot Fact Cha

Table 1. Themes and subthemes developed during analysis.

This study demonstrates wide variation across a region in how patients are currently assessed and optimized for major GI surgery. Hospitals with Cardiopulmonary Exercise Testing services were more likely to be developing prehabilitation services and making efforts to re-design pathways to enable time for optimization. Many HCPs spoke of the need for geriatrician input into the management of high-risk or frail older individuals, particularly those presenting as emergencies, however lack of geriatricians in their hospitals prevented this. Geriatrician-led multidisciplinary input was viewed as important in co-ordinating post-operative allied health professional input, managing medical co-morbidities and facilitating discharge preparations.

Patients with benign disease and those presenting as emergencies often have higher levels of co-morbidity, dependency and frailty, but historically the care of these patients has not received adequate funding or attention in National audits.



The University Of Sheffield.

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Experience of assessment of suitability for majo	r GI surgery in older adults								
s:	Examples								
I practice in the elective setting	Use of CPET, self-completion questionnaires								
I practice in the emergency setting	Frailty assessment, NELA scoring, functional ability								
ers to assessment	Time within the cancer pathway, job plans								
itators to assessment	Redesigning pathways to put fitness assessment first								
udes towards high risk patients	Symptom burden, trade-offs, alternatives								
Experience in optimising older patients for majo	r GI surgery								
s:									
I practice									
Physical activity	Advice given but limited access to prehabilitation programmes								
Nutritional	Limited access to dietician support, value of advice								
Psychological	Role of CNSs, access to psychologists								
Co-existing medical conditions	Role of protocols and guidelines								
• Lifestyle	Own practice regarding smoking cessation								
Geriatric	Access to geriatricians, role in emergency patients								
Peri-operative	ERAS, laparoscopic procedures								
Rehabilitation	Role of allied health professionals, time in job plans								
ers to optimisation	Constraints of the cancer timelines, emergency care								
	disorganised and difficult to optimise								
	Allied health professional input into cancer MDTs.								
itators to optimisation	co-ordinated post-operative care for emergency								
	patients								
Decision-making in older patients									
:									
Inct of age on treatment decisions	Fitness, function & frailty more important than age								
ntial treatment trade-offs for high-risk patients	Symptom burden important determinant								
ors influencing decision-making	Role of allied health professional input, engagement								
lenges in emergency GI surgery	Time, physiology								
orting patients to make decisions	Taking time for decisions, repeated discussions								

Discussion

Conclusions

Lack of evidence-based guidelines prevents the development of services and pathways. Difference in opinion between healthcare professionals regarding assessment and optimisation may account for some of the variation in gastrointestinal surgery outcomes observed in the UK.



Poster 120: A study demonstrating the accuracy of a new triage system for breast cancer referrals during the Covid-19 pandemic in a tertiary hospital.

Introduction / Background

The Covid-19 pandemic has led to a need for alternative methods of doctor-patient communication. Traditionally urgent or "2 week wait" referrals were booked directly into a manned clinic. During the pandemic however, most healthcare providers have utilised telecommunication to minimise face-to-face contact whilst continuing to provide essential services. At our institution, patients are being triaged by consultant breast surgeons to clinic or phone/video consultation on the basis of the referral letter. This triage system has gradually changed as the pandemic situation stabilised, with more emphasis placed on patient risk factors.

Objectives

This study aimed to assess the accuracy of this new triage process as it evolved at our hospital.

Methods and Materials

Data was collected prospectively from March 17th to June 30th 2020. This period of just over 3 months allowed an evaluation of the system to ensure it was valid and worth continuing. All breast patient referrals, having been triaged to either one-stop clinic, phone consultation or video consultation at Derriford Hospital, United Kingdom, were analysed. Electronic records were examined for clinic outcomes and histopathology results.



Contact

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Results

871 referrals were received and analysed. 588 (67.5%) of referrals were triaged to phone consultation; 270 (31%) were triaged to one-stop clinic; 12 (1.4%) were triaged to video consultation; and 1 (0.1%) was reviewed as an inpatient. 64 (7.3%) cancers were confirmed on histopathology.

In March, 6 out of 8 cancers were triaged to clinic initially (75% sensitivity) with 44 out of 80 benign cases being triaged to phone consultation (55% specificity). 6 out of 42 patients with clinic appointments were diagnosed with cancer (14.3% positive predictive value [PPV]) and 44 out of 46 of phone consultations were benign (95.7% negative predictive value [NPV]).

In April, 16 out of 21 cancers were triaged to clinic (76.2% sensitivity) and 148 out of 178 benign cases were triaged to phone consultation (83.1% specificity). PPV was 34.8% and NPV 96.7%.

In May, 10 out of 13 cancers were triaged to clinic (76.9% sensitivity) and 163 out of 239 benign cases were triaged to phone consultation (68.2% specificity). PPV was 11.6% and NPV 98.2%.

In June, 17 out of 22 cancers were triaged to clinic (77.3% sensitivity) and 230 out of 309 benign cases were triaged to phone or video consultation (74.4% specificity). PPV was 17.7% and NPV 97.9%.

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Discussion

Whilst there is some variability in cancer numbers from month-tomonth resulting in PPV fluctuation, sensitivity and NPV remain stable and improving, likely due to increased experience with triaging referrals with regards to the available resources and actual impact of Covid-19 locally. The initial expectation of a severe impact to services led to caution inviting more elderly or co-morbid patients to clinic, which has subsequently been less necessary as the situation stabilised.

Conclusions

This study demonstrates an improvement in the accuracy of the triage system as the process evolved. Despite switching to alternative forms of communication, there is ongoing and timely diagnosis of breast cancer from referrals. As such, given the long term and continuing implications of Covid-19 and the subsequent desire to keep hospital foot-fall as low as feasible, telephone and video consultation will continue to be utilised. Further analysis of the cost-effectiveness of this process will need to be performed however to ensure resources are allocated appropriately.

Progressive accuracy of triage

-Sensitivity

-Specificity

- Positive Predictive Value (PPV)
- -Negative Predictive Value (NPV)

June



Poster 121: Emergency Robotic Colorectal surgery – the new frontier; a case series study



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Introduction:

Robotic colorectal surgery is rapidly evolving as it addresses many of the technical and ergonomic limitations of laparoscopic surgery. The precision of robotic surgery results in smaller incisions, shortened hospital stay, less postoperative pain, and a much quicker return to normal, thus significantly improving patient experience. However the application of robotic surgery in the emergency setting remains very limited due to the logistical and organisational challenges and reluctance in adoption by the clinical teams. The aim of this study was to report the outcomes and early experience of emergency robotic colorectal surgery.

Method:

All consecutive patients having emergency robotic colorectal surgery at our institution over a 12 month period (October 2019 to September 2020) were recruited in this study. Data were collected from the electronic patient records.

Fig. 1: intraoperative views of vascular structures 1 Emergency robotic CME procedure



Fig.2: Quality assessment of the CME surgical specimen (labelling and description)



Results:

Five patients were included in the case series.

Demographics:

- Median age: 68.8 years (36-83).
- 3 female and 2 male patients.
- Median BMI was 27.1 (range 19-41).
- All were admitted with acute abdomen.

Operations:

- 3 emergency robotic right hemicolectomy, with complete mesocolic excision for obstructing right sided colon cancer.
- 1 robotic anterior resection of colo-vesical fistula secondary to diverticular disease with a pelvic abscess.
- 1 robotic subtotal colectomy for acute toxic colitis with failure of medical
- therapy/

Outcomes:

- All cancer patients had R0 resection.
- Median lymph node count was 48
- Median operating time was 212 min (range 120-350 min)

Conclusion:

Our case series highlighted that robotic colorectal surgery could achieve favourable outcome in emergency patients with acceptable operating times. Well led clinical teams with appropriate training can offer the benefits of robotic surgery to this challenging group of patients.



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There were no grade III/IV complications and no 90-day mortality. 1 patient developed surgical site infection treated with antibiotics.

