

ASSOCIATION OF  
LAPAROSCOPIC SURGEONS



INC. ROBOTIC & TECHNOLOGY  
ENHANCED SURGERY

**ALSGBI ANNUAL SCIENTIFIC MEETING**

# Abstract Book 2022

Monday 7–Tuesday 8 November 2022

# AESCULAP® EinsteinVision® 3.0 FI

## 3D Fluorescence Imaging in real-time

3D Fluorescence Imaging (FI) aims for the best patient outcome during diagnostics or surgery.<sup>1</sup>

To find out more, please scan QR code or contact:

**Sam Miller**  
sam.miller@bbraun.com

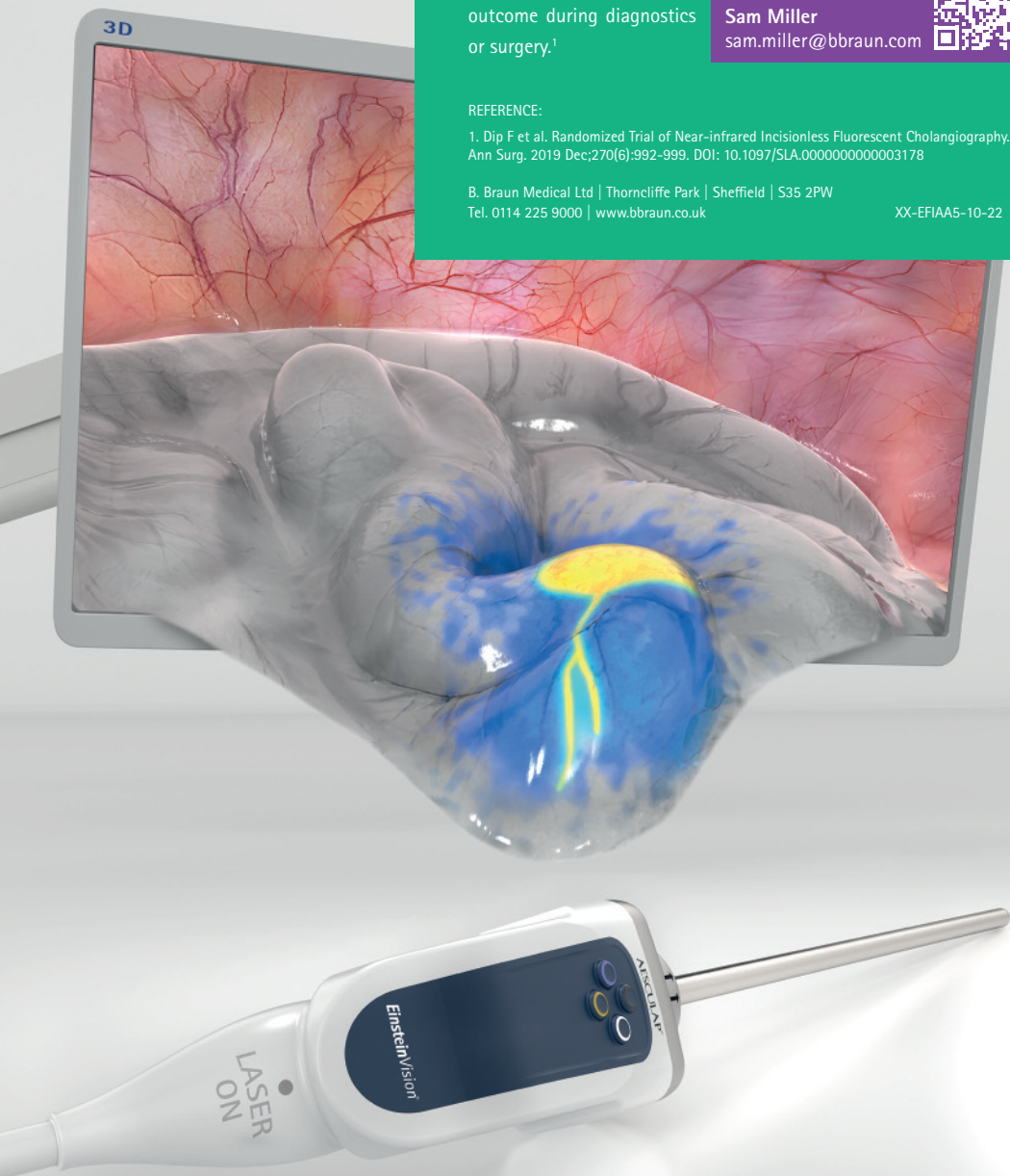


#### REFERENCE:

1. Dip F et al. Randomized Trial of Near-infrared Incisionless Fluorescent Cholangiography. Ann Surg. 2019 Dec;270(6):992-999. DOI: 10.1097/SLA.0000000000003178

B. Braun Medical Ltd | Thorncliffe Park | Sheffield | S35 2PW  
Tel. 0114 225 9000 | www.bbraun.co.uk

XX-EFIAA5-10-22





|  |       |
|--|-------|
| Free Paper Abstracts FP01-FP10                         | 5-9   |
| Video Of Distinction Session Abstracts Video01-Video05 | 10-12 |
| Parallel Video Session Abstracts Video01-Video05       | 13-15 |
| Posters Of Distinction Abstracts Poster01-Poster10     | 17-21 |
| Poster Monitor Abstracts P01-P44                       | 23-45 |
| Index  | 46-49 |

## CONFERENCE MANAGEMENT

Mrs Jennifer Treglohan, Executive Director  
 E: [jtreglohan@alsgbi.org](mailto:jtreglohan@alsgbi.org) Tel: Mob: +44 (0)7973 232038

Mrs Sarah Williams, Director of Fundraising  
 E: [swilliams@alsgbi.org](mailto:swilliams@alsgbi.org) Tel: Mob: +44 (0)7854 858714

Association of Laparoscopic Surgeons of Great Britain & Ireland @ The Royal College of Surgeons of England  
 38-43 Lincoln's Inn Fields, London WC2A 3PE

Please note that the Free Paper, Video and Poster Abstracts which follow have been reproduced directly from the authors' own scripts, and the Association of Laparoscopic Surgeons of Great Britain & Ireland can take no responsibility whatsoever for any literal errors these may contain.

**ENSEAL™**  
Tissue Sealers

# ENSEAL™ X1 Tissue Sealers Expect More<sup>1-3\*</sup>



**ENSEAL™**  
X1 Large Jaw  
Tissue Sealer

**ENSEAL™**  
X1 Straight Jaw  
Tissue Sealer

**ENSEAL™**  
X1 Curved Jaw  
Tissue Sealer

**ETHICON**

Johnson & Johnson SURGICAL TECHNOLOGIES

Reimagining how we heal™

1. Ethicon, Project Floyd: Claims Metrology Report, June 2018, PRC0795648 (145171-200630)

2. Ethicon, Floyd Relaunch Claims Metrology, June 2020, PRC095763A (145171-200630)

3. Ethicon, Floyd Relaunch Claims Ex-Vivo Sealing, June 2020, PRC094697A (145171-200630)

\* ENSEAL™ X1 Curved Jaw has a longer jaw, longer cut length and wider jaw aperture compared to LigaSure Maryland (LF1937) (p < 0.001). In benchtop testing on porcine arteries, vessels sealed with ENSEAL X1 Curved Jaw had a 22% higher average burst pressure than vessels sealed with LigaSure™ Maryland (LF1937), (1055mmHg vs. 862mmHg, p < 0.001)

**FP01** (09:05–09:15: 08.11.22)**LAPAROSCOPIC MANAGEMENT OF ACUTE SMALL BOWEL OBSTRUCTION IN NON-SELECTED PATIENTS: OUR 10-YEAR EXPERIENCE**

**Presenter:** Miss N Petrou  
**Author(s):** Miss N Petrou, Miss E Bonelli, Mr C Kontovounisios, Mr N Behar  
**Institution:** Chelsea and Westminster Hospital, London, United Kingdom

**Aims:** The laparoscopic approach in the management of small bowel obstruction (SBO) has been associated with reduced hospital length of stay, complications, and mortality. We report our 10-year experience and outcomes within a dedicated Emergency Surgery unit that has adopted a non-selective approach in the laparoscopic management of SBO.

**Methods:** All patients that underwent surgery for SBO by an experienced Emergency Surgeon, over a period of 10 years, were divided into two groups of Open Surgery (OS) and Laparoscopy-first (LF). Outcomes length of stay, complications, mortality, readmission rates and reasons for conversion. Data was reviewed to identify patterns of learning.

**Results:** 189 patients were included in the study. 81.5% were managed with a LF approach. Of these, 25.3% required conversion. LF patients had similar length of stay, lower 30-day readmission rates and wound complications. Reasons for conversion included need for bowel resection, perforation, and malignancy.

**Conclusion:** Our study had a high intention-to-treat LF population and identified major indications for conversion. As our laparoscopic experience increased, conversion rates substantially reduced. We propose that a LF approach is feasible and can benefit from training within dedicated Emergency Surgery teams.

**Key statement:** A laparoscopy-first approach in the management of SBO has so far been limited to highly selective cases. Instead, we propose that a laparoscopy-first approach is feasible and can benefit from training within dedicated Emergency Surgery teams.

**FP02** (09:15–09:25: 08.11.22)**COMPARISON OF OUTCOMES IN SURGICAL AND ENDOSCOPIC TRANSGASTRIC CYSTGASTROSTOMY FOR SEVERE ACUTE PANCREATITIS**

**Presenter:** Miss P Mountjoy  
**Author(s):** Miss P Mountjoy, Mr J Latif, Mr N Bandlamudi, Mr I Bhatti, Mr A Awan  
**Institution:** Derby Pancreaticobiliary, Advanced Laparoscopic and Robotic Unit, Derby, United Kingdom

**Aims:** The heterogeneous nature of severe acute pancreatitis (SAP) renders decisions related to complications challenging. A select group of patients may be suitable for surgical (S-CG), which can be performed open or laparoscopic, or endoscopic (E-CG) transgastric cystgastrostomy (TCG) of symptomatic or infected retrogastric pancreatic collections (walled-off pancreatic necrosis (WON)/pseudocyst).

**Methods:** Retrospective analysis of all patients that underwent S-CG or E-CG was performed from a single, high-volume benign pancreatic centre between 2012 – 2021 inclusive. Patient demographics, clinical characteristics, and outcomes of these 3 groups was compared. One-way analysis of variance tests was used to compare categorical data.

**Results:** 47 patients - 20 S-CG (12 open/8 laparoscopic), and 27 E-CG. S-CG patients had less burden of pre-existing comorbidities (APACHE-II/Charlson-Co-morbidity-Index (CCI)) ( $p < 0.05$ ). S-CG patients had shorter length of stay, readmission, and reintervention ( $p < 0.05$ ). E-CG had higher burden of intervention due to persistent/recurrent pancreatic collections - 33% mortality rate ( $p < 0.05$ ).

**Conclusion:** Complicated SAP is a challenging condition to manage. Both endoscopic and surgical intervention have important roles in its management. With the physiological burden this disease process places on patients, the aim of intervention should be to achieve the maximal clearance of a pancreatic collection with the least number of interventions.

**Key statement:** S-CG, in a select group of patients, provides a single-staged intervention for drainage of transgastric pancreatic collections, especially when they predominantly contain solid necrosis and patient is suitable for general anaesthetic. Outcomes are favourable for S-CG but multidisciplinary approach is critical to delineate the most appropriate approach for each individual.

**FP03** (09:25–09:35: 08.11.22)**ROBOTIC MULTI-VISCERAL RESECTION (RMVR) FOR LOCALLY ADVANCED COLORECTAL CARCINOMA – SINGLE ONCO-SURGICAL CENTRE EXPERIENCE****Presenter:** Dr C Lakmal**Author(s):** Dr C Lakmal, Professor CR Selvasekar**Institution:** The Christie NHS Foundation Trust, Manchester, United Kingdom

**Aims:** Robotic colorectal surgery for malignancy is evolving. But locally advanced pelvic disease is still a challenge due to multiple reasons like post neo-adjuvant radiotherapy changes in the pelvis. Previous abdominal surgery including defunctioning stoma makes dissection even difficult as the port positioning would be challenging.

**Methods:** This is a retrospective analysis of robotic colorectal surgery database. Patients who underwent multi-visceral robotic colorectal surgery from 2012 to 2022 were included in this study. Robotic colorectal surgeries without multi-visceral resections were excluded.

**Results:** Twenty-one underwent RMVR. Male: female 6:15. Surgeries were; posterior clearance - 14 females, APER with seminal vesicle excision -5, total pelvic exenteration-1. 20/21 had neo-adjuvant radiotherapy. Eleven (55%) had previous defunctioning stoma. Preoperative tumour staging was T3 or T4 in 90%. 80% had R0 resection. Median LN harvest was 15(Range 4-31).

**Conclusion:** Almost all patients had neo-adjuvant radiotherapy. Half of them had stoma, making the port positioning a challenge. Use of robot may have assisted in avoiding total pelvic clearance by limiting excision of seminal vesicles with APER. RMVR is a possible approach for locally advanced colorectal cancer, with acceptable surgical clearance.

**Key statement:** Robotic MVR is a possible approach for locally advanced colorectal cancer, with acceptable surgical clearance. Versatility in port positioning is essential as presence of stoma makes it a challenge.

**FP04** (09:35–09:45: 08.11.22)**ROBOTIC COLORECTAL SURGERY FOR COLORECTAL MALIGNANCY – EXPERIENCE OF FIRST 100 CASES IN A ONCO-SURGICAL CENTRE****Presenter:** Dr C Lakmal**Author(s):** Dr C Lakmal, Professor CR Selvasekar**Institution:** The Christie NHS Foundation Trust, Manchester, United Kingdom

**Aims:** Robotic colorectal surgery (RCS) is believed to eliminate many limitations of conventional laparoscopic surgery. Sometimes advanced disease may preclude the use of robotic surgery. Here we analyse the first 100 cases of robotic resections of colorectal malignancies done in single onco-surgical centre.

**Methods:** This is a retrospective analysis of robotic surgery database. Patients who underwent robotic colorectal surgery from 2012 to 2022 were included in this study. Patients who underwent non colorectal surgeries were excluded.

**Results:** 101 patients were included. Male: female 61:40. Median age was 65. Surgeries were; APR 52%, AR 29%, multi-visceral resection 16%, hemicolectomy/Colonic resection 3%. 70% had Neo-adjuvant therapy. Median hospital stay was 9 days. 9% had Clavien-Dindo =/ >3 complications. No leaks. No leaks. Zero 30 day mortality. One conversion reported.

**Conclusion:** Majority had preoperative pelvic radiotherapy in our cohort. One in six patients has undergone multi-visceral resection, a complex pelvic surgery. Only one case of conversion reported during first 100 cases. Rates of complications were comparable with literature and no major complications was reported in our series.

**Key statement:** RCS can be safely conducted for advanced colorectal malignancies within accepted complication rates.

**FP05** (09:45–09:55: 08.11.22)**TO ASSESS THE IMPACT OF AUGMENTED REALITY (AR) TRAINING ON IMPROVING LAPAROSCOPIC APPENDECTOMY USING OBJECTIVE PERFORMANCE METRICS****Presenter:** Dr D Rawaf**Author(s):** Dr D Rawaf<sup>1,2</sup>, Dr J Toms<sup>3</sup>, Dr G Beghal<sup>3</sup>, Miss A Joynson<sup>1,4</sup>, Miss N Kaur<sup>1,4</sup>**Institution:** <sup>1</sup>Inovus Medical, St Helens, United Kingdom, <sup>2</sup>Imperial College WHO CC, London, United Kingdom  
<sup>3</sup>ESTH, St Helier, United Kingdom, <sup>4</sup>Liverpool University, United Kingdom

**Aims:** We asked surgical trainees to perform several AR simulated appendectomies interspersed with LapPass tasks. Objective metrics measured include time to completion, distance travelled, smoothness, acceleration, handedness and time in view. A comparison was made with a benchmark score set by an experienced (MIS) surgeon. Subjective performance feedback was also provided.

**Methods:** During the course, benchmarks of both LapPass tasks and Appendectomies were set by each trainee in addition to an experienced MIS surgeon. Trainees were then asked to perform a series of tasks including further Appendectomies and LapPass tasks. Following this period of intervention, trainees were set one final benchmark.

**Results:** We found performance metrics improved when comparing benchmarks. In addition, the final metrics of the trainees were compared in a standardisation exercise to experienced benchmarks. Of note, time to completion and distance travelled were both markedly reduced following the intervention period. WBA based review demonstrated improvements in skill.

**Conclusion:** Augmented Reality task training using a high-fidelity Laparoscopic box trainer such as the LapAR improves objective and subjective performance in appendectomies. It can be inferred that this technique improves the surgical learning curve whilst safely taking it away from the live patient.

**Key statement:** Augmented Reality training offers direct, measurable improvements in objective metrics and subjective performance translatable to clinical care.

**FP06** (14:25–14:35: 08.11.22)**OUTCOMES OF EMERGENCY LAPAROSCOPIC CHOLECYSTECTOMY IN THE ELDERLY: A RETROSPECTIVE 9-YEAR SINGLE-CENTRE EXPERIENCE****Presenter:** Mr KW Ho**Author(s):** Mr KW Ho, Dr R Al-Zubaidy, Ms F Soggiu, Mr H Sheth**Institution:** Ealing Hospital, London North West Univesity Healthcare NHS Trust, London, United Kingdom

**Aims:** Emergency laparoscopic cholecystectomy (ELC) is the gold-standard treatment for acute cholecystitis (AC). WSES guidelines recommend consideration of non-surgical treatment only in high-risk patients >65 due to postoperative morbidity/mortality. This study aims to assess the outcomes of ELC performed at a DGH in patients' ≥75 presenting with acute gallstone complications.

**Methods:** Consecutive patients aged ≥75 who underwent ELC from January 2013–December 2021 were included from a prospectively collected dataset, with a minimum follow-up of 2–3 months. Demographics, clinical parameters and postoperative outcomes were assessed. The primary outcomes were 30-day morbidity and mortality (Clavien-Dindo classification) and readmission rate.

**Results:** 101 patients were included. 68/101(67.3%) presented with AC and 20/101(19.8%) with gallstone pancreatitis. 62/101(61.4%) were ASA III-IV. Postoperative complications were observed in 30/101(29.7%) with Clavien-Dindo 3A/3B in 11(10.9%)/2(2.0%) patients respectively. 30-day readmission rate was 8.9%. The mean postoperative length-of-stay was 6.0±1.0 days.

**Conclusion:** This study showed that ELC is safe and effective in the elderly with complication and readmission rates comparable to published data on the elderly and in other age cohorts. Frailty, more than age should be considered in management decision-making. Further research should explore the health-economics and long-term patient outcome benefits.

**Key statement:** Early laparoscopic cholecystectomy in the elderly is recommended for acute cholecystitis and other gallstone diseases. The paucity of significant evidence results in ELC reluctance in the elderly. This service however was provided efficiently and safely in our surgical centre and extended for other gallstone-related diseases in the elderly.

**FP07** (14:35–14:45: 08.11.22)**FEASIBILITY OF LAPAROSCOPIC MULTI-VISCERAL RESECTION FOR LOCALLY ADVANCED COLORECTAL CANCER****Presenter:** Mr AY Mohamedahmed**Author(s):** Mr AY Mohamedahmed<sup>1</sup>, Mr P Bhattacharya<sup>1</sup>, Mr S Zaman<sup>1</sup>, Mr A Ayeni<sup>1</sup>, Mr A Akingboye<sup>2</sup>**Institution:** <sup>1</sup>Sandwell and West Birmingham NHS Trust, Birmingham, United Kingdom<sup>2</sup>The Dudley Group NHS Trust, Dudley, United Kingdom

**Aims:** The role of laparoscopic surgery for multi-visceral resection (MVR) of locally advanced colorectal cancer (LACC) with invasion or adherence to neighbouring organs is considered controversial. This meta-analysis aims to compare the morbidity, mortality, and oncological safety after laparoscopic MVR (LMVR) of LACC compared with open surgery (OMVR).

**Methods:** A systematic search of electronic databases was conducted and all studies comparing LMVR and OMVR in patients with LACC were selected. Outcomes were operative time, intra-operative blood loss, post-operative complications, number of harvested lymph nodes, RO and R1 resection, recurrence, and disease-free survival. Revman 5.3 was used for data analysis.

**Results:** Ten studies reporting 936 patients undergoing LMVR (n=452) and OMVR (n=484) were identified. LMVR showed longer operative time (MD: 40.18, P=0.008), less intra-operative blood loss (MD: -753.95, P=0.00001), reduced SSI rate (OR: 0.51, P=0.05). There was no difference regarding Anastomotic leak, intra-abdominal abscess, number of harvested lymph nodes, RO and R1 resection and cancer recurrence.

**Conclusion:** Although inherent limitations exist with observational studies the available evidence demonstrates that LMVR in LACC provides comparable results to OMVR with reduced wound infection rate and other well-established benefits of laparoscopic surgery.

**Key statement:** Laparoscopic MVR in locally advanced colorectal cancer seems to be a feasible and oncologically safe surgical option in carefully selected cohorts. Reduced wound infection rate and other well-established benefits of laparoscopic surgery warrant this approach to be investigated further through well-designed randomised controlled trials.

**FP08** (14:45–14:55: 08.11.22)**FEASIBILITY OF LAPAROSCOPIC ADHESIOLYSIS FOR SMALL BOWEL OBSTRUCTION****Presenter:** Dr LE Spyropoulou**Author(s):** Dr LE Spyropoulou, Dr Y Hamza, Dr H Ubaide, Dr O Hadjicosta, Professor T Arulampalam**Institution:** East Suffolk & North Essex NHS Trust, Colchester, United Kingdom

**Aims:** Adhesional small bowel obstruction (aSBO) has traditionally been managed with open surgery (laparotomy), although advances in technology and technical skill have enabled the use of the minimally invasive laparoscopic approach. This study aimed to investigate the feasibility of laparoscopy for the management of aSBO.

**Methods:** Data on patient admissions with suspected SBO was collected retrospectively over three years (2019–2021), using electronic records. Non-adhesional SBO, large bowel pathology, non-laparoscopic and conservative management were excluded from analysis. Outcomes included the rate and reason for conversion to, incidence of laparoscopic enterotomies, length of hospital stay and patient mortality.

**Results:** 69 patients underwent laparoscopic adhesiolysis. 22(31.88%) were converted to laparotomy due to inability to proceed (54.55%), emergency (18.18%) or planned (27.27%) operation. Length of stay frequency was 4 days, with 11.59% re-admission. Rate of enterotomy was 36.23%, post-operative complication was 33.33% and mortality rate was 18.84%

**Conclusion:** Laparoscopy could be a suitable management option for the serious presentation of aSBO, enabling a short hospital stay and improved patient recovery. However, intraoperative bowel injury remains a concern that could be avoided by careful selection of suitable patients and appropriate training in laparoscopic techniques.

**Key statement:** Laparoscopy in the hands of the experienced surgeon and for a specific group of patients can be a potentially feasible approach in the management of aSBO in the emergency setting, showing promising results in terms of mortality, rate of complications and length of hospital stay.



**FP09** (14:55–15:05: 08.11.22)**LONG-TERM OUTCOMES OF ROBOTIC RECTAL CANCER SURGERY  
A PROPENSITY SCORE MATCHED ANALYSIS OF DATA FROM AN EXPERT UK COLORECTAL CENTRE****Presenter:** Dr R Duhoky**Author(s):** Dr R Duhoky<sup>1,2</sup>, Dr M Rutgers<sup>1</sup>, Mr S Stefan<sup>1</sup>, Mr F Sagias<sup>1</sup>, Professor J Khan<sup>1</sup>**Institution:** <sup>1</sup>Portsmouth Hospital University NHS Trust, United Kingdom<sup>2</sup>University of Portsmouth, United Kingdom**Aims:** We sought to analyse a large dataset of laparoscopic and robotic rectal cancer patients treated at an expert colorectal cancer centre in the UK between 2013 and 2021.**Methods:** We included patients undergoing laparoscopic and robotic rectal cancer surgery between 2013 and 2021 in our expert colorectal cancer centre. Outcomes were compared between the cohorts after propensity score matching. The primary outcome was 5-year Overall Survival (OS). Secondary outcomes were other long-term outcomes, surgical outcomes, and patient-related outcomes.**Results:** There was a significant difference in 5-year OS (79.8% in robotic vs 69.9% in laparoscopic,  $p=0.043$ ), but no difference in other oncological outcomes.

|                       |       | Laparoscopic (n=207) | Robotic (n=207) | p-value |
|-----------------------|-------|----------------------|-----------------|---------|
| Length-of-Stay (days) |       | 7.00                 | 6.00            | <0.001  |
| Operative time (mins) |       | 270                  | 240             | 0.058   |
| Complications         | None  | 33.8%                | 47.8%           | 0.006   |
|                       | Minor | 50.7%                | 39.6%           |         |
|                       | Major | 11.1%                | 12.6%           |         |

**Conclusion:** Robotic rectal cancer surgery in our centre shows improved survival and non-inferior oncological long-term outcomes to the laparoscopic approach. It also shows statistically significant better short-term outcomes in Length of Stay, blood loss, and postoperative complications, as well as a non-significant trend towards shorter operative time and less conversion.**Key statement:** Robotic rectal cancer surgery is a safe and favourable alternative to the traditional approaches.**FP10** (15:05–15:15: 08.11.22)**SINGLE-CENTRE, RETROSPECTIVE STUDY EVALUATING THE SHIFT FROM ROUTINE TO SELECTIVE  
DIVERSION OF LOW ANASTOMOSIS IN RECTAL CANCER SURGERY (KHANS TECHNIQUE)****Presenter:** Dr D Nunes**Author(s):** Dr R Duhoky, Dr M Rutgers, Dr D Nunes, Dr Y Adeluola, Professor J Khan**Institution:** Queen Alexandra Hospital, Portsmouth, United Kingdom**Aims:** There has been a recent change in practice for diverting stomas in rectal cancer surgery, shifting towards a more selective approach. Recent studies suggest that the benefits of temporary ileostomies do not outweigh postoperative risks. We aim to evaluate outcomes of a selective strategy compared with a routine approach.**Methods:** Data for all rectal cancer patients with robotic resections between 2013-2021 were included. In 2016, a selective approach in temporary diverting ileostomies was implemented. Our cohort was divided into a routine diversion group (A) and a selective diversion group (B). We analysed these groups for short-term outcomes and morbidities.**Results:** There was a significant difference in diverting stomas (90% vs 72.6%,  $p=0.004$ ), but no differences in anastomotic leakages (11.8% vs 17.8%,  $p=0.312$ ), other complications ( $p=0.117$ ), readmission (2.9% vs 5.2%,  $p=0.117$ ) or reoperation rates (2.9% vs 1.5%,  $p=0.607$ ) after stoma closure, or stoma-free survival after 1 year (71.6% vs 71.9%,  $p=1.000$ ).**Conclusion:** This study shows that a more selective approach in diverting stomas for robotic rectal cancer patients does not lead to more complications or leaks, and can be considered in the treatment of rectal cancer.**Key statement:** Selective diversion does not lead to a higher incidence of complications and is beneficial in robotic cancer surgery.

## VIDEO OF DISTINCTION SESSION – AUDITORIUM, HILLGATE SUITE

### Video01 (16:00–16:08: 08.11.22)

#### ROBOTIC LOW ANTERIOR RESECTION FOR LOCALLY ADVANCED RECTAL CANCER

**Presenter:** Dr O Guest

**Author(s):** Dr O Guest, Mr A Memon, Mr A Chukwuebuka, Mr M Zaheer, Mr N Sidiqi

**Institution:** University Hospital Dorset, Poole, United Kingdom

**Aims:** The aim of this technical video is to demonstrate the operative technique of robotic low anterior resection in a patient with locally advanced rectal cancer (pT1N1M0 (1/30 LN). This will facilitate training in colorectal surgery, demonstrating the advantages of robotic technique in this setting.

**Methods:** The operative steps demonstrated include inferior mesenteric artery and vein isolation and ligation, medial to lateral dissection to mobilise the descending colon and mobilisation of the splenic flexure. Pelvic dissection is demonstrated, wider dissection was performed on the right side staying close to seminal vesicle given threatened right anterolateral margins.

**Results:** Pathological staging was pT1N1M0 (1/30 LN). The patient was discharged on fourth postoperative day without any postoperative complication. This dissection demonstrates technique in seminal vesicle and pelvic nerve identification and preservation and curative resection of the tumour.

**Conclusion:** Robotic colorectal surgery has gained popularity since it was first used in 2001. It confers lower conversion rates compared to laparoscopic surgery, especially in obese male patients and narrow pelvic cavities due to three-dimensional magnified vision, stable camera platform and better dexterity. This video demonstrates these advantages.

**Key statement:** Demonstrating the key operative techniques for robotic low anterior resection for a locally advanced colorectal cancer, this video facilitates training in colorectal surgery. This surgical technique is advantageous in enhancing post-operative recovery and facilitates greater surgical precision in delicate anatomical planes.

### Video02 (16:08–16:16: 08.11.22)

#### LAPAROSCOPIC INTRACORPOREAL MESH REPAIR OF LATERAL AND ANTERIOR ABDOMINAL WALL INCISIONAL HERNIAS

**Presenter:** Dr L Yao

**Author(s):** Dr L Yao, Professor M Coleman

**Institution:** University Hospitals Plymouth, United Kingdom

**Aims:** Repairing lateral abdominal wall hernias are challenging with high recurrence rates. We present a video demonstrating a laparoscopic repair of a patient with multiple abdominal wall hernias – one large hernia in lateral abdominal wall and two anterior abdominal wall hernias.

**Methods:** The camera was inserted via two sites to allow full visualisation of all three hernia defects. The literature recommends a bridging mesh repair that reinforces the far beyond the immediate defect border. The hernias were repaired using large intracorporeal meshes which were secured with crown Tackers and sutures.

**Results:** The patient underwent an uneventful recovery, medically fit for discharge the on the following day.

**Conclusion:** Lateral abdominal wall hernia repairs are challenging due to myofascial laxity, lack of muscle mobility and aponeurotic fascia. Careful assessment, understanding of anatomy, physiological forces and reconstruction techniques are key in planning a successful repair.

**Key statement:** Minimally invasive repair of lateral wall abdominal hernias are challenging but good outcomes are achievable with careful planning.

## Video03 (16:16–16:24: 08.11.22)

### VIDEO DEMONSTRATION OF ABDOMINAL LYMPHADENECTOMY IN A ROBOTICALLY ASSISTED OESOPHAGECTOMY

**Presenter:** Mr J Chmelo  
**Author(s):** Mr J Chmelo, Mr J Brown, Miss P Prasad, Mr M Navidi, Mr A Immanuel  
**Institution:** Northern Oesophagogastric Unit, Newcastle upon Tyne, United Kingdom

**Aims:** Lymphadenectomy is essential for adequate oncological clearance and accurate staging during oesophagectomy for malignant disease. Adequate lymph node clearance has implications on patient outcomes and confers a survival benefit. Robotic assistance during abdominal lymphadenectomy permits improved 3-D visualisation and instrument articulation in a potentially constricted space.

**Methods:** This video demonstrates a technique for coeliac axis lymph node clearance during the abdominal phase of an oesophagectomy, as practiced at this institution. The intention for such a video is for ongoing appraisal and refinement of robotic techniques within the unit, as well as for teaching and training.

**Results:** Dissection of all relevant coeliac axis nodal stations is successfully demonstrated, with the lymph nodes resected en-bloc with the specimen.

**Conclusion:** Robotic assistance permits safe and adequate lymphadenectomy during minimally invasive oesophagectomy, as demonstrated in this video.

**Key statement:** This video demonstrates a technique for robotic abdominal lymphadenectomy during oesophagectomy.

## Video04 (16:24–16:32: 08.11.22)

### ROBOTIC ASSISTED CHOLECYSTECTOMY AND COMMON BILE DUCT EXPLORATION FOR SINGLE STAGE MANAGEMENT OF COMPLEX GALLSTONE DISEASE

**Presenter:** Miss P Mountjoy  
**Author(s):** Miss P Mountjoy, Mr J Latif, Mr N Bandlamudi, Mr I Bhatti, Mr A Awan  
**Institution:** Derby Pancreaticobiliary, Advanced Laparoscopic and Robotic Unit, Derby, United Kingdom

**Aims:** Common bile duct exploration (CBDE) is an alternative to endoscopic retrograde cholangiopancreatography (ERCP) for choledocholithiasis and has the advantage of providing single stage management of complex gallstone disease. Advantages of robotic assisted surgery (RAS) include use of articulated instruments, improved views (3D enhancement) and minimising physical stress to the surgeon.

**Methods:** We describe a case of a robotic assisted cholecystectomy and CBDE for a case of obstructing distal common bile duct stone (CBDS). This procedure was undertaken on the Da Vinci X robotic system with use of 5mm video choledochoscope for retrieval of distal CBDS.

**Results:** 31-year-old female with known gallstones who presented with right upper quadrant pain and concomitant jaundice. Pre-operative MRCP demonstrated a distal CBDS and cystic duct stone. Following robotic assisted cholecystectomy and CBDE, the patient was discharged on post-operative day (POD) 2 with removal of drain on POD1.

**Conclusion:** Robotic assisted cholecystectomy and CBDE is a feasible alternative to laparoscopic CBDE (LCBDE) and ERCP for treatment of choledocholithiasis. It is a safe and effective approach with equivocal outcomes to LCBDE however comparable studies are needed before definitive conclusions are drawn.

**Key statement:** This case demonstrates the effective use of robotic assisted cholecystectomy and CBDE for single stage management of complex gallstone disease. Some theoretical benefits of RAS include improved views, especially at site of choledochotomy, and improved ergonomics for suture closure of choledochotomy.

## Video05 (16:32–16:40: 08.11.22)

### MESH FIXATION TECHNIQUES IN TAPP REPAIR OF INGUINAL HERNIAS

**Presenter:** Mr R Salem

**Author(s):** Mr R Salem, Mr A Khanna, Mr A Qureshi

**Institution:** Milton Keynes University Hospital NHS Foundation Trust, United Kingdom

**Aims:** Inguinal hernia repair with mesh is regarded as the standard treatment for adult symptomatic inguinal hernia. In this video we demonstrate three methods of mesh fixation techniques for minimally invasive transabdominal preperitoneal repair (TAPP) of inguinal hernias in adults.

**Methods:** Over two months (July - Sept 2022), three elective TAPP inguinal hernia repairs were video recorded. These videos were combined to show different researched and validated techniques to safely secure a mesh in TAPP repairs. All operations were recorded in a district general hospital with the consent obtained from patients beforehand.

**Results:** A 4:46 minutes video was produced showing three different ways (sutures, glue, and tackers) used to secure a mesh in TAPP repairs. The dissection and the fixation using sutures and glue were done robotically, while, the tackers technique was done laparoscopically.

**Conclusion:** There is an ongoing debate on the various mesh fixation methods in inguinal hernia repair. This video has shown three validated mesh fixation techniques, as well as, a clear demonstration of the anatomy of the inguinal region.

**Key statement:** We have demonstrated three methods of mesh fixation techniques for TAPP repair of inguinal hernias in adults. Robotic technology allowed for more delicate dissection and better visualisation of key anatomical landmarks, which were displayed clearly in this video.

## PARALLEL VIDEO SESSION – EXHIBITION, GATESHEAD SUITE

### Video01 (16:00–16:08: 08.11.22)

#### VIDEO DEMONSTRATION OF A ROBOTICALLY ASSISTED INSERTION OF A FEEDING JEJUNOSTOMY

**Presenter:** Mr J Chmelo

**Author(s):** Mr J Brown, Mr J Chmelo, Miss P Prasad, Mr M Navidi, Mr A Immanuel

**Institution:** Northern Oesophagogastric Unit, Newcastle upon Tyne, United Kingdom

**Aims:** The insertion of a feeding jejunostomy (FJ) is a nutritional adjunct for patients undergoing a subtotal oesophagectomy. Various techniques and equipment can be utilised for robotic insertion of the FJ, which highlights the need for video documentation of such methods for the purpose of training.

**Methods:** A video recording of a robotic FJ was taken at our institution which has initiated a robotic program for resectional oesophago-gastric surgery.

**Results:** This video presentation highlights the key steps to robotic FJ insertion as followed at our institution.

**Conclusion:** Our video demonstrates how robotic FJ is inserted at our institution. We hope that such videos can be used to further training of surgeons in training or for those who are planning to establish robotic programs for oesophago-gastric surgery at their own units.

**Key statement:** This video presentation highlights the key steps to robotic feeding jejunostomy insertion.

### Video02 (16:08–16:16: 08.11.22)

#### EMERGENCY LAPAROSCOPIC PARASTOMAL HERNIA REPAIR

**Presenter:** Mr A Butt

**Author(s):** Mr A Butt, Mr J Natale, Mr TK Rajesh

**Institution:** University Hospitals Plymouth, United Kingdom

**Aims:** To demonstrate a safe and effective method for laparoscopic parastomal hernia repair for use in the emergency or elective setting.

**Methods:** Entry to the abdominal cavity was gained using VisiPort technique. The parastomal hernia defect was identified and small bowel adhesiolysis performed to free the bowel from the sac. Once the hernia is reduced the defect is repaired using V-lock suture and a DynaMesh secured with ProTack.

**Results:** Emergency laparoscopic parastomal hernia repair resulted in a satisfactory result and safe discharge in this patient with no further intervention required.

**Conclusion:** Laparoscopic parastomal hernia repair, as demonstrated in this video, presents a safe and effective alternative to open surgery. This gives surgeons and patient's a laparoscopic alternative option to open surgery and all the benefits this confers.

**Key statement:** This case and video demonstrate the safe use of laparoscopic surgery to perform a parastomal hernia repair in the emergency setting.

## Video03 (16:16–16:24: 08.11.22)

### ROBOTIC TRANSABDOMINAL RETROMUSCULAR UMBILICAL PROSTHETIC (RTARUP) REPAIR FOR RECURRENT VENTRAL HERNIA

**Presenter:** Mr J Latif

**Author(s):** Mr J Latif, Mr N Bandlamudi, Mr I Bhatti, Mr A Awan

**Institution:** Derby Pancreaticobiliary, Advanced Laparoscopic and Robotic Unit, Derby, United Kingdom

**Aims:** Robotic assisted surgery (RAS) has advantage of articulated instruments making procedures in the abdominal wall planes feasible, without adding physical stress to the surgeon. Midline ventral hernias (<5cm) can be repaired by dissection of the retromuscular plane and suturing of the defect with placement of the mesh (TARUP).

**Methods:** We describe a case of a RTARUP repair in a patient with recurrent ventral hernia (M3, W1), using the Da Vinci X robotic system.

**Results:** 55-year-old male (BMI-34) that underwent previous open suture repair of ventral hernia presented with symptomatic recurrence. Three 8mm robotic ports were placed in the left lateral compartment of the abdomen following Veress assisted insufflation. The patient had a same day nurse led discharge. 3-month follow-up confirmed no signs of recurrence.

**Conclusion:** RTARUP is an alternative approach for repair of ventral hernia with defects up to 5cm. The mesh is placed in the retromuscular plane and avoids contact with the intra-peritoneal viscera. Outcomes in this case have been satisfactory, however comparison to alternative techniques are warranted before definitive conclusions are drawn.

**Key statement:** This case demonstrates the effective use of RTARUP for repair of recurrent ventral hernia. Some theoretical benefits include improved mesh coverage, avoidance of mesh contact with intra-abdominal viscera and potential less pain by evasion of the use of tackers for mesh fixation used in the intraperitoneal on-lay mesh (IPOM) repair.

## Video04 (16:24–16:32: 08.11.22)

### DEMONSTRATING A MINIMALLY-INVASIVE APPROACH TO OESOPHAGEAL LEIOMYOMA VIDEO-ASSISTED THORACIC SURGERY (VATS) EXTRA-MUCOSAL EXCISION

**Presenter:** Mr A Ammar

**Author(s):** Mr A Ammar, Mr J Chean Khun Ng, Mr P Leeder

**Institution:** University Hospitals of Derby and Burton NHS Trust, Derby, United Kingdom

**Aims:** Oesophageal leiomyomas, although relatively rare, account for two-thirds of all oesophageal neoplasms. Symptomatic leiomyomas are usually excised, conventionally via open thoracotomy. VATS extra-mucosal excision has gained popularity over the last few years becoming the preferred method, due to its minimally invasive nature, shorter operative duration, post-operative stay & reduced blood loss.

**Methods:** We present a case of a 38 year old male with 8-10 years history of retrosternal burning pain and intermittent dysphagia to solid food. A combination of barium swallow, computed-tomography scan, gastroscopy and endoscopic ultrasound biopsy confirmed a mid-oesophageal leiomyoma at 25 cm.

**Results:** Following discussion at MDT meeting, an excision via right thoracoscopy was offered. Patient was put under surveillance while COVID-19 was at its peak. He subsequently underwent surgery 9 months later & discharged after 4 days, following removal of chest drain & contrast swallow confirming no leak. Excisional histology confirmed 50x20x15mm benign leiomyoma.

**Conclusion:** This video demonstrated a minimally-invasive approach to an operation that was conventionally performed open. VATS allowed better visualisation of plane for more delicate dissection and thorough haemostasis. Evidence has also suggested VATS associated with shorter operative time, post-operative stay and less blood loss, with no significant difference in post-operative complication.

**Key statement:** VATS is a safe and effective approach to perform excision of oesophageal leiomyoma with additional benefits.

## Video05 (16:32–16:40: 08.11.22)

### FLUORESCENCE IMAGE-GUIDED LAPAROSCOPIC CHOLECYSTECTOMY IN ALAGILLE SYNDROME

**Presenter:** Ms R Karmarkar

**Author(s):** Ms R Karmarkar, Mr S Aroori

**Institution:** University Hospitals Plymouth NHS Trust, United Kingdom

**Aims:** Alagille syndrome is an autosomal dominant genetic condition primarily affecting the liver and the heart. It is characterised by a lack of bile ducts in the liver, which results in the building up of bile inside the liver and, eventually, liver cirrhosis and failure.

**Methods:** We present a video demonstration of a difficult laparoscopic cholecystectomy in a patient with Alagille syndrome with background liver cirrhosis using indocyanine green (ICG) fluorescence-image-guidance.

Anticipating the complex anatomy, we decided to use ICG fluorescence-image-guidance. ICG was given intravenously in a dose of 0.03–0.05mg/kg 2–3 hrs before surgery.

**Results:** Laparoscopic cameras were switched to near-infra-red-mode intermittently to delineate the biliary anatomy and complete the procedure laparoscopically. The gall bladder, cystic duct and common bile duct was easily visualised before clipping and dividing the cystic duct. Given the distorted anatomy, this would not have been possible without fluorescence-image-guidance.

**Conclusion:** Fluorescence cholangiography using ICG is a simple, safe, and effective method to identify extrahepatic biliary anatomy. Its use along with white light can be considered superior to white light alone in difficult laparoscopic cholecystectomy.

**Key statement:** Fluorescence Cholangiography has great potential to reduce the risk of bile duct injuries and conversion rates in complicated cases like these. Large-scale studies are required to explore its clinical value further.

# Experience da Vinci technology for yourself

Learn more at [www.intuitive.com/en-gb](http://www.intuitive.com/en-gb)



## Product Information

The da Vinci X and da Vinci Xi Surgical Systems are class IIb medical devices. Refer to complete mandatory statements available on the booth.

The Vessel Sealer Extend is a class IIb medical devices. Refer to complete mandatory statements available on the booth.

© 2022 Intuitive Surgical Operations, Inc. All rights reserved. Product names are trademarks or registered trademarks of their respective holders.



## POSTERS OF DISTINCTION

### Poster01

#### SAFELY SWITCHING FROM LAPAROSCOPY TO ROBOTICS WHILE PROSTATE CANCER SPECTRUM EVOLVES

**Presenter:** Dr A Uthman

**Author(s):** Dr A Uthman<sup>1</sup>, Dr E Bass<sup>2</sup>, Dr J Jaipuria<sup>2</sup>, Dr Muhammad-Kabir Ali<sup>2</sup>, Mr M Winkler<sup>2</sup>

**Institution:** <sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom

<sup>2</sup>Imperial College NHS Trust, London, United Kingdom

**Aims:** A shift towards robotics is increasing. Simultaneously, active surveillance (AS) and focal therapy (FT) are becoming mainstream for lower grade disease. We hypothesize a change in the patient profile presenting to the radical surgeon. The audit sees if surgeons face more challenges with robotics and do robotics improve the service.

**Methods:** A laparoscopic surgeon affiliated to a university teaching hospital in UK performed 656 laparoscopic radical prostatectomies from 2007-2019 before making a switch to robotics, and then performed 148 cases. Meanwhile the institute started FT service. A prospectively database was analysed, audited and compared to National Prostate Cancer Audit (NPCA) 2021.

**Results:** We treated more D'Amico high risk and comorbid patients and larger tumours as well as offered more bilateral nerve sparing without affection of the positive surgical margin and biochemical recurrence.

- Robots are safer, including blood loss and early complications.
- Functional outcomes are not available due to limited follow up.

**Conclusion:** Our experience proves that radical surgeons are likely to face patients with higher comorbidity and advanced disease and yet, transition to robotics can be safely done with improved outcomes. We recommend to transition early, rather than late.

**Key statement:** After this session, participants will be able to:

- 1 Appreciate the changing profile of prostate cancer patients over the decade.
- 2 See how patient profile treated by a radical surgeon from a centre with a busy FT differs from the NPCA 2021 audit.
- 3 Ascertain safe implementation of the robotics.

### Poster02

#### PREOPERATIVE IMAGING TO AVOID UNNECESSARY SURGERY FOR SUSPECTED ACUTE APPENDICITIS

**Presenter:** Dr T Kenyon-Smith

**Author(s):** Dr T Kenyon-Smith, Associate Professor H Kroon, Dr G Nair, Dr J Virgin, Dr P Hollington

**Institution:** Flinders University, Adelaide, Australia

**Aims:** Preoperative imaging, is becoming increasingly used for suspected acute appendicitis (AA). Although preoperative imaging reduces negative appendectomy rates (NA), there is no consensus on which patients should receive imaging or what kind. This study evaluated the use of preoperative imaging in a high-volume centre, and compared different imaging modalities.

**Methods:** Flinders Medical Centre's appendectomy database was analysed for patients who underwent surgery. Baseline and treatment characteristics, histopathology and postoperative outcomes were collected. Patients were evaluated based on undergoing preoperative imaging and which kind. Primary outcome was NA. Secondary outcomes were postoperative complications, length of stay and readmissions.

**Results:** 2,011 patients underwent an appendectomy, 1,222 had imaging. CT was the most common modality (79.6%), followed by US (18.7%). Imaging reduced NA rates. Older, comorbid and female patients were more commonly imaged and was associated with higher complications and longer stays. NA rates were higher with US compared to CT.

**Conclusion:** In current clinical practice, NA rates without preoperative imaging remain high. Indicated perioperative imaging increases the accuracy of the preoperative diagnosis of AA, preventing unnecessary surgery and morbidity.

**Key statement:** Preoperative imaging for suspected AA increases the accuracy of diagnosis, preventing unnecessary operations and improving patient care.

## Poster03

### SHORT-COURSE INTRAVENOUS ANTIBIOTICS AFTER COMPLICATED APPENDICITIS IN SELECTED PATIENTS

**Presenter:** Dr T Kenyon-Smith  
**Author(s):** Dr T Kenyon-Smith, Associate Professor H Kroon, Dr K Hidde  
Dr G Nair, Dr J Virgin, Dr P Hollington  
**Institution:** Flinders University, Adelaide, Australia

**Aims:** After surgery for complicated appendicitis (CA), common practice is to treat all patients with a standardised long-course of intravenous antibiotics (IVAB) to reduce the risk of postoperative surgical infections (PSI). This study aimed to evaluate the safety and efficacy of a short-course IVAB after CA in selected patients.

**Methods:** Flinders Medical Centre's prospectively collected database identified CA patients treated between 2015 and 2019. Baseline and treatment characteristics and postoperative outcomes were analysed. The cut-off between short- and long-course IVAB was 2 days. Outcomes of interest were PSI and 30-day unplanned readmission.

**Results:** 226 patients had CA: 43.8% received short-course IVAB and 56.2% received long-course. Rates of PSI and unplanned readmissions were comparable between short and long patients. Multivariable analysis demonstrated intraoperative findings to be the strongest predictor for PSI. ASA score and surgical approach were prognostic predictors for 30-day unplanned readmission.

**Conclusion:** This study shows that when patients respond well, a short-course IVAB can safely be applied after CA without increasing risk of PSI or 30-day unplanned readmission.

**Key statement:** Short course IVAB is safe in selected patients with CA, and does not result in worst post-operative outcomes.

## Poster04

### ROUTINE GROUP AND SAVE TESTING IS UNNECESSARY FOR ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY: AN AUDIT OF BLOOD TRANSFUSION IN LAPAROSCOPIC CHOLECYSTECTOMY

**Presenter:** Mr I Blake  
**Author(s):** Mr I Blake<sup>1</sup>, Mr A Tandon<sup>2</sup>  
**Institution:** <sup>1</sup>Liverpool University Hospitals NHS Foundation Trust, United Kingdom  
<sup>2</sup>Warrington and Halton Hospitals NHS Foundation Trust, Warrington, United Kingdom

**Aims:** Vascular complications of elective laparoscopic cholecystectomy are rare but serious. Guidelines on group and save testing prior to laparoscopic cholecystectomy vary between hospitals. We aimed to determine the transfusion rate following elective laparoscopic cholecystectomy in our hospital to determine whether routine pre-operative group and save testing is required.

**Methods:** All patients who underwent elective laparoscopic cholecystectomy in a single general hospital over a three-year period (September 2017 to September 2020) were retrospectively identified. Transfusion and medical records were analysed to identify where blood products had been issued, the volume of transfusion and the cause.

**Results:** Only one patient out of 921 elective laparoscopic cholecystectomies required transfusion giving a rate of 0.11%. This patient received 2 units of packed red cells due to bleeding from the liver bed, this necessitated a critical care stay and return to theatre.

**Conclusion:** Transfusion following elective laparoscopic cholecystectomy is rare. Therefore, we argue routine group and save testing is unnecessary. Potential benefits include lower laboratory costs, time saved on phlebotomy and fewer theatre delays. Targeted testing can be performed as required with interim emergency cover provided by group O negative blood if needed.

**Key statement:** The need for transfusion following elective laparoscopic cholecystectomy is rare and routine group and save testing prior to the procedure is unnecessary. Patient safety can be maintained with targeted testing whilst delivering potential cost savings and time benefits.

## Poster05

### IDENTIFICATION OF GASTRIC CONDUIT PERFUSION DEFICITS WITH LAPAROSCOPIC LASER SPECKLE CONTRAST IMAGING

**Presenter:** Dr JT Hoffman

**Author(s):** Dr JT Hoffman<sup>1,2,3,4</sup>, Dr WT Heeman<sup>1,2,3</sup>, D. JP Pierie<sup>4</sup>, Dr EC Boerma<sup>4</sup>

**Institution:** <sup>1</sup>University of Groningen, Leeuwarden, Netherlands

<sup>2</sup>University Medical Center Groningen, Netherlands

<sup>3</sup>LIMIS Development, Leeuwarden, Netherlands, <sup>4</sup>Medical Centre Leeuwarden, Netherlands

**Aims:** Determining the feasibility of Laser Speckle Contrast Imaging (LSCI) for perfusion assessment of the gastric conduit using the PerfusionX-Imaging system, compared to the surgical eye and Indocyanine Green (ICG) Fluorescence Perfusion Imaging in the laparoscopic setting.

**Methods:** This prospective, observational study includes 30 patients undergoing esophagectomy. LSCI images are compared with standard-of-care for perfusion assessment (i.e., ICG-fluorescence and surgical eye). Post-operative analysis is performed on the location of the watershed area and change in location of the anastomosis by both involved and non-involved surgeons, based on LSCI-imaging.

**Results:** The PerfusionX-Imaging Laser Speckle Contrast images derived additional visual feedback showed imminent perfusion differences at the esophageal stump and the gastric conduit. The perfusion was visualized in real-time and the both involved and non-involved surgeons were able to identify the watershed area.

**Conclusion:** Laparoscopic Laser Speckle Contrast Imaging is a feasible method to generate perfusion maps of the gastric conduit and provides the surgeon with valuable data to analyze and locate possible perfusion deficits.

**Key statement:** Laparoscopic LSCI is a feasible method to generate tissue perfusion maps of the gastric conduit.

## Poster06

### PARASTOMAL HERNIA REPAIR – 5 YEAR EXPERIENCE FROM A SINGLE CENTRE

**Presenter:** Miss AA Thrikandiyur

**Author(s):** Miss AA Thrikandiyur<sup>1</sup>, Miss C Reali<sup>2</sup>, Mr G Wynn<sup>3</sup>

**Institution:** <sup>1</sup>James Cook University Hospital, Middlesbrough, United Kingdom

<sup>2</sup>Yeovil Hospital, United Kingdom, <sup>3</sup>Colchester General Hospital, United Kingdom

**Aims:** To assess the success of parastomal hernia repairs, carried out at a single Centre, measured in terms of post-operative complications and recurrence rates.

**Methods:** Retrospective data collection for patients undergoing parastomal hernia repairs in Colchester General Hospital, over a period of 5 years, between January 2015 – December 2019. Data was collected from patient notes, clinic letters, electronic results and operation notes.

**Results:** 43 patients had a total of 63 parastomal hernia repairs. 41 cases (65%) were open, 18 (29%) laparoscopically with 4 being converted to open. 54% of procedures were uncomplicated with 37% having minor complications, Clavien Dindo I/II. Total recurrence rate was 36% with no difference between both groups.

**Conclusion:** A laparoscopic approach for parastomal hernia repair is safe, reduces the length of stay, postoperative complication and allows an earlier stoma function. However, choice of operation should depend on available resources and other specific patient conditions.

**Key statement:** Laparoscopic parastomal hernia repairs are a safe method with good immediate post-operative recovery and facilitates earlier discharges from hospital.

## Poster07

### LAPAROSCOPIC VERSUS ROBOTIC APPROACH IN COLORECTAL CANCER. SINGLE CENTRE COMPARATIVE STUDY

**Presenter:** Dr V Butnari  
**Author(s):** Dr V Butnari, Ms S Momotaz, Mr R Boulton, Mr J Huang, Mr N Rajendran  
**Institution:** Barking, Havering and Redbridge University Hospitals NHS Trust, London, United Kingdom

**Aims:** To present and compare a single-center experience of the intra and short-term postoperative results of oncological resections performed robotically (ROR) to laparoscopically (LOR).

**Methods:** Between February 2020 and July 2022, 210 patients underwent minimally invasive colorectal resections. All procedures were performed by one of three experienced laparoscopic colorectal consultant surgeons within a high-volume unit performing over 220 resections annually. Parameters compared include Operative time (OT), length of stay (LOS), and 30- day complications.

**Results:** ROR had shorter LOS, 7 vs 8 days, and lower rate of conversion rate (4% vs 5.18 %). Median OT was shorter in LOL group 200 versus 257.5 for ROR. The rate of complication was 26,66 % for ROR and 29,62% for LOR, with an anastomotic leak rate of 4% vs 4,7%.

**Conclusion:** Our data suggest that the robotic approach to oncological colorectal resections is safe and may reduce inpatient stays, offsetting the cost of robotic surgery.

**Key statement:** Our study suggests a robotic approach for the treatment of colorectal cancer is more beneficial to patients because of shorter postoperative recovery and shorter hospital stays with adequate case selection. Future research should focus on the long-term effects.

## Poster08

### EFFICACY OF UTILISING AN AUGMENTED REALITY LAPAROSCOPIC SIMULATOR FOR IMPROVING PERFORMANCE METRICS IN GENERAL SURGICAL TRAINEES

**Presenter:** Mr M El-Bahnasawi  
**Author(s):** Mr M El-Bahnasawi<sup>1</sup>, Mr D Rawaf<sup>2</sup>, Mr E Street<sup>2</sup>, Mr J Van Flute<sup>3</sup>, Professor P Luthra<sup>4</sup>  
**Institution:** <sup>1</sup>Wythenshawe Hospital, MFT, Manchester, United Kingdom  
<sup>2</sup>Inovus Medical, Manchester, United Kingdom, <sup>3</sup>Inovuv Medical, Manchester, United Kingdom  
<sup>4</sup>Edge Hill University, Liverpool, United Kingdom

**Aims:** To assess the impact of simulated laparoscopic trainers on improving surgical trainees' technical ability in completing a laparoscopic appendicectomy by measuring effect on completion time and distance travelled with standard instruments.

**Methods:** Four CT1 (early-stage) trainees with little prior operative exposure were selected from the North-West of England Deanery to perform x10 appendicectomy simulated exercises with the Augmented Reality Laparoscopic Simulator (LapAR™), interspersed by x9 Lapass exercises. Metrics including 'Time of completion' and 'Distance travelled' were collected by the simulators and analysed.

**Results:** Repeated laparoscopic appendicectomies with the LapAR™ improved performance time for 100% of trainees, with an average of 55% (Regression coefficient -0.65) and improved distance travelled for 75% of the trainees with an average improvement of 39% (Coefficient -2.67). Improvement in instrument smoothness, acceleration and ambidexterity were also observed.

**Conclusion:** LapAR™ use has improved all performance metrics for most surgical trainees and proves to be an invaluable tool for surgical training.

**Key statement:** Simulation has a key role to play in surgical training amidst growing challenges in post-Covid era to train junior surgeons. Larger samples of trainees from across the country are needed to further evaluate the efficacy of LapAR™ as a training tool.

## Poster09

### LAPAROSCOPIC MAGNETIC SPHINCTER AUGMENTATION WITH THE LINX® DEVICE FOR MANAGEMENT OF GASTRO-OESOPHAGEAL REFLUX DISEASE: A 10-YEAR EXPERIENCE AND SAFETY PERSPECTIVE

**Presenter:** Miss S Bezzaa  
**Author(s):** Miss S Bezzaa, Miss C Clements, Mr D Nehra  
**Institution:** Epsom & St Helier University Hospitals, London, United Kingdom

**Aims:** To assess 10-years of safety and peri-operative experience of laparoscopic magnetic lower oesophageal sphincter augmentation with the LINX® device for gastro-oesophageal reflux disease in a single district general hospital looking at length of stay, readmission, explantation and complication rates.

**Methods:** 166 patients underwent laparoscopic LINX® insertion during the time-period. A retrospective analysis was carried out using theatre logbooks and electronic medical records of all patients undergoing insertion of the LINX® device between December 2012 and July 2022 at a single district general hospital.

**Results:** 69 females and 90 males were included (range 18-76 years). Median length of stay was 1 day, 54 patients were discharged on the same day and 2 patients were readmitted. Complications included 2 pneumothoraces, 1 post-operative bleed, 1 food bolus and 1 suspected vagal nerve injury. 3 devices were explanted.

**Conclusion:** This data demonstrates laparoscopic LINX® insertion has an acceptable long term safety profile. There is a low rate of early post-operative complications (3.1%) and explantation (1.9%). Migration or erosion of the device did not occur during this period.

**Key statement:** This centre has shown that surgical management of gastro-oesophageal reflux disease with Laparoscopic LINX® insertion is a safe and feasible day-case procedure in a district general hospital.

## Poster10

### USE OF EXTRACORPOREAL KNOT-TYING IN LAPAROSCOPIC SURGERY: A REFLECTION AND SURVEY OF CURRENT PRACTICE AND TRAINING

**Presenter:** Dr B Amini  
**Author(s):** Dr B Amini<sup>2</sup>, Dr NA Kader<sup>1,2</sup>, Ms TEM Morrison<sup>1,2</sup>, Ms J Bradley-Hendricks<sup>1</sup>, Ms JB Reed<sup>1</sup>  
**Institution:** <sup>1</sup>Colchester General Hospital, Essex, United Kingdom, <sup>2</sup>Association of Laparoscopic Surgeons of Great Britain and Ireland Academy, London, United Kingdom

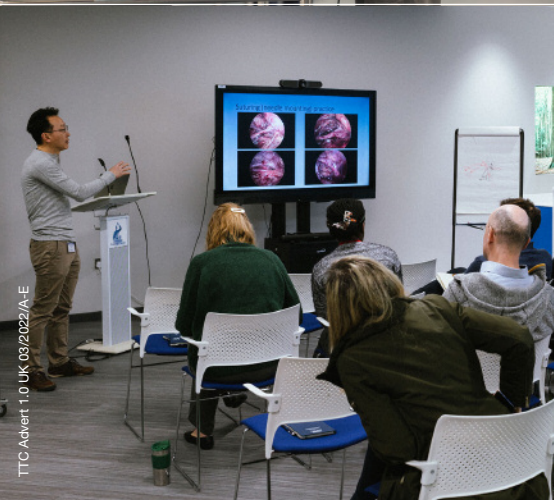
**Aims:** To evaluate the value of extracorporeal knot-tying as part of Laparoscopic Skills curricula, assess the indications and patterns of use of extracorporeal knot-tying, such as that of the Roeder knot in clinical practice and identify its perceived value in surgical training and practice.

**Methods:** An anonymous, electronic white space and multiple choice survey was distributed globally to participants via social media, local and surgical society networks. The responses were reviewed using data analytic software after a 4 month period. Part of the questionnaire was based on opinion, which is variable.

**Results:** 92 responses across 11 specialties were obtained. 67% used intracorporeal methods over extracorporeal (11%). 51% learnt extracorporeal knots on courses. Uses included for hiatus hernia, appendicectomy, ductal and pedicle ligation. 56% last performed an extracorporeal knot in simulation, 33% had never tied one. 54% considered extracorporeal knot-tying an essential skill.

**Conclusion:** The continued teaching of extracorporeal knot-tying to future surgeons was advocated to maintain transferable skills. However, these methods were reported as less reliable, less convenient and used infrequently in clinical practice compared to intracorporeal alternatives. This study recognises that a survey-based questionnaire may not capture the full range of experience.

**Key statement:** These results suggest that although uncommon in practice, the ability to perform extracorporeal knots provides an adjunctive skill for trainees and its use may be influenced by available resources. However, the ability to perform a safe intracorporeal laparoscopic knot is considered comparatively more practice, efficient and relevant to clinical practice.



For more information, or to make a booking, please scan the QR Code below:



# The Training & Technology Centre – Our Commitment to Your Future

- Clinic/outpatient setting, Anaesthetic Room and fully integrated OR1™ theatre
- Breakout rooms, refreshment areas and green screen studio
- For meetings and training sessions of between 5 and 60 people

**STORZ**  
KARL STORZ – ENDOSKOPE



## POSTER MONITORS

### P01

#### ULTRASOUND SCANNING OF PATIENTS WITH SUSPECTED ACUTE CHOLECYSTITIS: THE SOONER THE BETTER

**Author(s):** Dr I Moutsos<sup>1,2</sup>, Mr R Lunevicius<sup>3</sup>

**Institution:** <sup>1</sup>401 General Military Hospital of Athens, Greece, <sup>2</sup>University of Edinburgh, United Kingdom  
<sup>3</sup>Liverpool University Hospitals NHS Foundation Trust, United Kingdom

**Aims:** The aim of this study was to evaluate how patients presenting with right upper quadrant pain were managed at Aintree University Hospital, Liverpool. We focused on checking when patients with suspected acute cholecystitis underwent transabdominal ultrasound scan (US-scan) and compared our practice with the national guidelines.

**Methods:** It was a two-phase retrospective clinical audit. The electronic charts of 74 patients were reviewed: 50 during the first phase, from 01/01/2019 to 30/07/2019, and 24 during the re-audit phase, from 01/01/2020 to 28/02/2020. An Excel file was used for data recording. Conventional descriptive statistics were utilised.

**Results:** Interval between admission and US-scan was 56h (SD 41) in 2019 vs 60h (SD 34.1) in 2020. Acute cholecystitis was confirmed in 27 patients (54.0%) in 2019 vs 8 patients (33.3%) in 2020. Early cholecystectomy was performed in 14 patients (28.0%) in 2019 vs 5 patients (20.8%) in 2020.

**Conclusion:** The interval between admission and US-scan took longer in early 2020 vs 2019, and fewer patients underwent early cholecystectomy during the re-audit phase. Improving the timing of cholecystectomy to meet NICE guidelines and communication with the radiology team were proposed to enhance the service provided to the patients.

**Key statement:** Based on NICE, AUGIS, WSES and TOKYO guidelines, laparoscopic cholecystectomy within seven days from the onset of acute symptoms is the standard treatment for acute cholecystitis. Hence, US-scan should be conducted at the earliest opportunity. Early confirmation of diagnosis should lead to quicker consideration of laparoscopic cholecystectomy.

### P02

#### POST-OPERATIVE MANAGEMENT OF SMALL BOWEL OBSTRUCTION (SBO) AT ADDENBROOKE'S HOSPITAL, CAMBRIDGE

**Author(s):** Dr Y Hirayama<sup>1</sup>, Mr PG Nagappan<sup>2</sup>, Dr N Dai<sup>1</sup>

**Institution:** <sup>1</sup>Addenbrooke's Hospital, Cambridge, United Kingdom  
<sup>2</sup>Cambridge University Clinical School, United Kingdom

**Aims:** This study aims to establish

- 1 Whether there is difference in the time taken for a nutritional interventions (NI) for small bowel obstruction (SBO) due to adhesions versus cancer;
- 2 Total time of stay in relation to time spent in SBO; 3 Time to surgery; 4 Time to gastrograffin.

**Methods:** This was a retrospective audit for a 6 month period from July – December 2020. We identified all patients diagnosed with SBO and reviewed their medical records in line with our aims mentioned above.

**Results:** Study size: 165.

- 1 Median'sd time to NI for adhesions: 3.7'2.61 days; cancer: 2.5'4.76 days.
- 2 Median'mean time for hospital stay: 9'15 days, despite 3'4.9 days in SBO.
- 3 Mean time to surgery: 4.84 days. 4 Mean'median time to gastrograffin: 1.5'3.2 days for SBO due to adhesions.

**Conclusion:** 1 The data showed a trend towards treating SBO due to cancer earlier than in those due to adhesions. 2 There was a lengthy stay in hospital beyond resolution of SBO. 3 Time to surgery is at the boundary of 5 days. 4 There was a delay in giving gastrograffin.

**Key statement:** Addenbrooke's has good post-operative care for patients with SBO. Appropriate prioritisation in the treatment of patients based on cause is seen, with cautious observation periods post SBO resolution. The surgical option has been performed when necessary and no later. However, the delay in giving gastrograffin should be investigated.

## P03

### THE IMPACT OF TELEPHONE CONSULTATIONS ON CLINIC DID NOT ATTEND RATES, THE ENVIRONMENT AND HEALTHCARE SAVINGS

**Author(s):** Miss A Winarski, Miss E Ross, Miss A Ng, Miss G Lim, Mr A Gilliam  
**Institution:** Darlington Memorial, Darlington, United Kingdom

**Aims:** General surgery clinic DNAs have an impact on the efficiency of how healthcare is delivered. Travelling long distances to attend appointments has an effect on the environment. This study's aim was to assess if telephone clinics improved access to clinics, & estimate reduction in carbon footprint due to their introduction.

**Methods:** A retrospective cohort study of all general surgery clinics in our Trust was conducted over a 3-year period (2016–2018), and one year after introduction of telephone clinics (2020–2021) – the outcomes from these were compared. The primary outcome measure was consultation rates. Secondary outcome measures included healthcare cost and environmental impact.

**Results:** During 2020–2021 study period, 36678 consultations were scheduled (27370 face-to-face and 9308 telephone). DNA rates pre-pandemic were 6.92% and during the pandemic 6.87% (9.01% face-to-face and 0.35% telephone). An estimated 119142 miles of patient travel, and 40 tons of carbon dioxide emissions, were saved during the study period.

**Conclusion:** Telephone clinics improve access, and reduce cost and carbon footprint. Further improvements are likely as processes for contacting patients improve and digitalisation of healthcare improves.

**Key statement:** Telephone consultations should be maximally utilised where appropriate, as a means of increasing patient engagement with surgical services, while improving the sustainability and lessening the environmental impact of the surgical outpatient department.

## P04

### PERCUTANEOUS CHOLECYSTOSTOMY AS A BAIL-OUT OPTION IN CURRENT ERA: A RETROSPECTIVE REVIEW FROM A DGH

**Author(s):** Mr MI Hussain<sup>1</sup>, Mr A Sultan<sup>2</sup>, Mr S Banerjee<sup>3</sup>, Mr P Bhattacharya<sup>4</sup>, Mr C Sellaheva<sup>2</sup>  
**Institution:** <sup>1</sup>Portsmouth Hospital University NHS Trust, Portsmouth, United Kingdom  
<sup>2</sup>The Dudley Group NHS Foundation Trust, United Kingdom, <sup>3</sup>Manchester Royal Infirmary United Kingdom, <sup>4</sup>Sandwell and City Hospital, Birmingham, United Kingdom

**Aims:** Cholecystostomy remains a minimally invasive bail-out procedure to decompress an acutely inflamed gallbladder in critically ill surgical patients unfit for cholecystectomy. This study reviews the indications, outcomes, and further management plans following percutaneous transhepatic cholecystostomy performed by the interventional radiology (IR) department in a medium-sized district general hospital (DGH).

**Methods:** We performed a retrospective assessment of 31 adult patients who underwent percutaneous cholecystostomy between April 2020 and April 2022. The data was retrieved from hospital records and the Radiology datasets. Malignant aetiology was excluded. Assessment of mortality and morbidity at 1, 3 and 6 months was reviewed as well.

**Results:** The median age was 79 years. 4 patients had cholecystostomy for gallbladder perforation, 13 had severe acute cholecystitis. 10 patients were optimised for subsequent elective cholecystectomy. 21 patients had cholecystostomy as a definitive treatment. The median length of time for which the cholecystostomy was in place was 28 days.

**Conclusion:** Percutaneous cholecystectomy remains a safe option in patients with acute severe cholecystitis unfit for definitive surgery. Laparoscopic cholecystectomy following cholecystostomy is feasible in selected patients without significant risk of complications. The option of offering Cholecystostomy needs to be individualised based on Tokyo Guidelines and Performance Status.

**Key statement:** Cholecystostomy is an excellent temporising measure and often a life-saving procedure for patients unfit for cholecystectomy. Subsequent laparoscopic cholecystectomy following optimisation can be undertaken without any additional risk. Decision to perform Cholecystostomy should be tailored to the patient taking Tokyo Guidelines and individual Performance Status into consideration.



## P05

### LAPAROSCOPIC MANAGEMENT OF PERITONITIS WITH SMALL BOWEL PERFORATION CAUSED BY A FISH BONE

**Author(s):** Dr M Hasan, Professor SA Chowdhury  
**Institution:** Jalalabad Ragib-Rabeya Medical College, Sylhet, Bangladesh

**Aims:** To highlight use of laparoscopy that can be used for management of peritonitis due to small bowel perforation in developing country like Bangladesh.

**Methods:** An emergency surgical intervention: laparoscopy was performed after the diagnosis was made. A sealed perforation identified in jejunum which was adhered with parietal wall. After adhesiolysis a fish bone (3 cm in length and 9mm in breadth) was found penetrating jejunum which was removed and jejunum was repaired laparoscopically by intracorporeal suturing.

**Results:** The result shows that laparoscopy can be widely used for peritonitis due to perforation rather than going for laparotomy.

**Conclusion:** This case highlights the importance of considering intestinal perforation by ingested foreign body as differential for acute abdomen. Clinical suspicion along with careful detailed history combined with appropriate investigation will lead towards correct diagnosis. Laparoscopy may be tried first to manage perforation due to ingested foreign body rather than laparotomy.

**Key statement:** Laparoscopy can be and should be used as first line treatment rather than laparotomy in case of perforation. It will reduce post-operative pain and hospital stay of patient. If required laparotomy can be opted later on.

## P06

### THE USE OF AUGMENTED REALITY SIMULATORS IN LAPAROSCOPIC SURGICAL TRAINING

**Author(s):** Dr D Rawaf<sup>1,2</sup>, Miss C Ludick<sup>3</sup>, Dr E Street<sup>1</sup>, Dr A Omurtag<sup>3</sup>, Mr J Van Flute<sup>1</sup>  
**Institution:** <sup>1</sup>Inovus Medical, St Helens, United Kingdom  
<sup>2</sup>Imperial College WHO CC, London, United Kingdom, <sup>3</sup>NTU, Nottingham, United Kingdom

**Aims:** To determine the suitability of AR simulators for laparoscopic surgical training through a review of literature.

**Methods:** 26 full-text articles established through thorough MESH term search and put through stringent inclusion / exclusion criteria as per a systematic review.

**Results:** Wide variety of features between available simulators.  
Demonstrates construct, concurrent, face and construct validity.  
Faster skill acquisition when compared to verbal teaching methods.  
Improves the procedural success rate vs other modalities.  
Preferred over other modalities except cadaver models.  
Both single or multimodality training programs are sufficient.

**Conclusion:** Cadaver models remain the gold standard for laparoscopic surgical training with further investigation and technological improvement AR simulators have the potential to become the new gold standard.

**Key statement:** AR simulation is a novel technology providing good educational content and performance assessment.

## P07

### EVALUATION OF OUR "HOT GALLBLADDER" SERVICE: DESIGNING THE SAFE MANAGEMENT OF ACUTE CHOLECYSTITIS IN THE NHS

**Author(s):** Mr N Ali

**Institution:** Yeovil District Hospital NHS Trust, Yeovil, United Kingdom

**Aims:** Evaluation of surgical management of acute cholecystitis via the ambulatory pathway.

**Methods:** Retrospective observational analysis of management of acute cholecystitis via the ambulatory surgery pathway. Evaluating the timing of cholecystectomy after the onset of symptoms, the operative outcomes including operative time, conversion, perioperative complications and hospital stay.

**Results:** The findings reflect no extra perioperative complications related to this approach despite missing the ideal time for acute surgery. The operative time ranged from 60-240 min, no increase in conversion rates. Most of the procedures done as day case surgery.

**Conclusion:** Surgical management of acute cholecystitis is adversely affected by its competition with other emergency conditions demanding more urgent access to the operating theatres. The ambulatory service model results in safe management of mild to moderate episodes of acute cholecystitis by reducing the need for in hospital stay and ensuring a dedicated slot for the patient to avoid undue cancellations.

**Key statement:** Addressing the ever present issue of managing acute gall bladders with in limited NHS resources in the setting of a district hospital.

## P08

### JOINING FORCES: A COLORECTAL-GYNAECOLOGY ADVANCED LAPAROSCOPIC SKILLS COURSE

**Author(s):** Miss L Rimmer, Miss LI Lim, Mr F Akram, Mr K Siddique

**Institution:** Northern Care Alliance, Oldham, United Kingdom

**Aims:** Improve the knowledge and confidence in gynaecology and general surgery trainees and consultants in bowel and gynaecological issues using a range of lecture-based and wet lab activities.

**Methods:** A 1-day Laparoscopic skills course was carried out covering a range of topics related to bowel and ovarian surgical complications. A mixture of lecture-based workshops and wet lab activities using laparoscopic instruments were carried out. Evaluation forms were handed to participants rating their confidence levels before and after the course.

**Results:** Overall, the participants felt their knowledge of topics improved. The highest ratings of improved confidence were 83.3% in topics of advanced endometriosis and rectal shaving. 66.7% improved their management of bowel and tubo-ovarian adhesiolysis, 72.7% for ovarian cystectomy, 50% for bowel mobilisation and colostomy, and 75% in managing iatrogenic injuries.

**Conclusion:** A 7.5-year delay in diagnosis for endometriosis has been highlighted by NICE in 2017. Following our course, 83.3% of candidates, including general surgical registrars, felt more confident in recognition of endometriosis. This unique hybrid course covering cross-specialties allowed a joint learning experience to improve the patient experience and participant confidence.

**Key statement:** To our knowledge, this Advanced Laparoscopic Skills course combining colorectal and gynaecology topics is the first of its kind. On average, participants from both gynaecology and general surgical specialties reported improved confidence in managing complications involving bowel, ovary and endometriosis.

## P09

## AN UNWELCOME 'NOVEL BREAKTHROUGH' FOR GASTRIC BANDS

**Author(s):** Mr J Banks<sup>1,2</sup>, Ms H Younus<sup>1</sup>, Mr H Malik<sup>1</sup>, Mr A Goralczyk<sup>1</sup>

**Institution:** <sup>1</sup>Homerton University Hospital, London, United Kingdom  
<sup>2</sup>Royal London Hospital, United Kingdom

**Aims:** We share a rare case of 39 year old obese male with a percutaneous erosion of gastric band tubing following a protracted ITU admission. Until today, there is no comparable case in the literature. We present a poster with important learning points for surgeons in management of such a case.

**Methods:** We retrospectively studied the case history and identified factors leading to this complication. We prospectively approached the management in multidisciplinary fashion and had discussions about preventing this in future. We undertook a literature search to explore similar presentations and lessons that can be learnt accordingly.

**Results:** We identify factors in the patient's history contributing to the erosion: ITU admission with pyloric perforation necessitating laparotomy, relook, laparostomy and concurrent severe COVID-19 pneumonitis, prolonged catabolic state with muscle overlying implanted material atrophying and ensuing liposarcopaemia. We go on to discuss management and potential pitfalls.

**Conclusion:** There is growing evidence for late complications of gastric bands with up to 50% of patients requiring further surgery; <5% experience slippage, <1% experience luminal erosion, but to our knowledge there has not been another case of percutaneous erosion reported. This thus represents an important learning opportunity.

**Key statement:**

- Consider removing gastric bands when therapeutic aims achieved or no longer in use, before complications preclude retrieval.
- Catabolic states may complicate tunnelled implants, further research is required
- Bariatric complications should be managed in bariatric centres or by those with sufficient prior exposure to this speciality. This may require patient transfer.

## P10

## MORE THAN JUST A TAN, ACQUISITIONS FROM OVERSEAS OPERATIONS

**Author(s):** Mr J Banks<sup>1,2</sup>, Ms H Younus<sup>1</sup>, Ms A Siddika<sup>1</sup>

**Institution:** <sup>1</sup>Homerton University Hospital, London, United Kingdom  
<sup>2</sup>Royal London Hospital, United Kingdom

**Aims:** We present a case of a 42 year old female with a retained surgical item (RSI) presenting to the emergency take some 3 years after an initial laparotomy abroad for penetrating abdominal trauma. We explore the case presentation and present a number of learning points for surgeons.

**Methods:** We retrospectively studied the case history and identified factors leading to this diagnosis. We prospectively approached the management in multidisciplinary fashion and had discussions about identifying this in future. We undertook a literature search to explore similar presentations and lessons that can be learnt accordingly.

**Results:** Initial laparotomy (2018) in Turkey for penetrating abdominal trauma was followed by midline incisional hernia repaired with mesh (Turkey, 2019). Following a well interval, the patient presented in November 2021 with a 2 day history of sudden onset, non-radiating right sided abdominal pain with no associated systemic features.

**Conclusion:** CT demonstrated foreign body reaction without radio-opaque marker. Exploratory laparotomy revealed the following findings: an abdominal wall cavity containing 300mL pus and a large 20x25cm hand towel, surrounded by posterior peritoneal layer and loops of distal ileum intra-abdominally. On-lay mesh was intact and not the source of infection.

**Key statement:** Presentation of retained surgical items may be delayed; we demonstrate at least a 2-year interval from operation to presentation.

- Radio-opaque markers used routinely in the UK may not be used overseas. Some foreign bodies are not identifiable on plain x-ray films.
- Multidisciplinary approach for patients presenting with RSI is essential.

## P11

**A COMPARATIVE ANALYSIS TO ASSESS THE CONCORDANCE BETWEEN RADIOLOGICAL REPORTING AND FINAL HISTOPATHOLOGY FOR COLORECTAL CANCER IN AN NHS TRUST****Author(s):** Mr O Olatunbode, Dr K Mathew, Mr F Rahman-Casans**Institution:** County Durham and Darlington Foundation Trust, Darlington, United Kingdom

**Aims:** Neo-adjuvant therapy is used in advanced rectal cancer and there is a growing interest to use it for advanced non-metastatic colon cancer. This will be based on the pre-operative radiological staging. Is radiological staging accurate enough to guide delivery of appropriate treatment?

**Methods:** Radiological and histological T and N stages were obtained retrospectively for 99 colon cancers, 48 early rectal cancers and 75 rectal cancers (following neo-adjuvant treatment) performed in 2021. Assessment of discordance was done. Tx or Nx was considered indeterminate. Interval between histology and radiology was obtained for colon cancers.

**Results:**

| T-Stage (Total)         | Over-stage | Under-stage | Total | Indeterminate |
|-------------------------|------------|-------------|-------|---------------|
| Colon (99)              | 12         | 33          | 45    |               |
| Rectum (48)             | 14         | 3           | 17    |               |
| Neoadjuvant Rectum (75) | 19         | 11          | 30    | 15            |
| N-Stage                 |            |             |       |               |
| Colon (99)              | 33         | 6           | 39    |               |
| Rectum (48)             | 14         | 3           | 17    | 3             |
| Neoadjuvant Rectum (75) | 8          | 3           | 11    | 13            |

80% had surgery/histology within 8 weeks.

**Conclusion:** Overall, accuracy of reporting was approximately 60%. There was more under-staging with colon cancer T-staging. Otherwise, there was more over-staging. There is evidence that the accuracy of T-staging can improve with practice to about 80%. The MDT can be used to highlight any significant discrepancies and improve reporting.

**Key statement:** Over-staging may result in unnecessary treatment with high morbidity. Notably, our neo-adjuvant rate for rectal cancers is relatively high at 61%, compared to 41% regionally and 34% nationally as per NBOCA. Addressing this could improve patient care.

## P12

**A SINGLE CENTRE EXPERIENCE OF LAPAROSCOPIC PARTIAL FUNDOPLICATION FOR GORD****Author(s):** Dr R AL-Zubaidy, Dr M Sheikh, Mr D Raje, Mr H Sheth, Mr N Pore**Institution:** Ealing Hospital, London, United Kingdom

**Aims:** Laparoscopic fundoplication is the prominent surgical option for management of GORD. Nissen fundoplication involves a 360-degree wrap, which is a popular operative approach. There have been studies indicating partial wraps having better functional outcomes. The aim of this study is to evaluate our hospital's experience with partial laparoscopic fundoplication.

**Methods:** A retrospective review of 54 anti-reflux surgeries performed from June 2016 until January 2022 was done. 9 patients were excluded from the study. The data collected included: patient demographics, presenting symptoms, types of wraps performed, and post-operative complications. These patients were followed up for an average of 9 months post-operatively.

**Results:** The majority of patients were referred for symptoms of heartburn, epigastric pain and dyspepsia. 93% underwent a Watson repair and 7% had a Toupet. 45 patients had complete resolution of symptoms and 5 experienced post-operative morbidity, 3 of which were self-limiting. There was 1 patient mortality secondary to non-surgical causes.

**Conclusion:** Early success rates at our institution are encouraging, showing positive results from partial wraps. We would like to look at larger numbers going forward with longer follow up times to further support the outcomes of partial wraps for GORD.

**Key statement:** 83% of patients who underwent a laparoscopic partial fundoplication at our district general hospital had complete resolution of their symptoms. Our successful outcomes are also likely to be a result of appropriate patient selection.

## P13

### STANDARDIZED APPROACH IN LAPAROSCOPIC COLORECTAL SURGERY: SHORT TERM OUTCOMES OF OVER 100 CASES

**Author(s):** Mr MU Rehman, Mr FA Khan, Miss S Kim, Mr A Jamil, Mr T Nasir  
**Institution:** Northampton General Hospital, United Kingdom

**Aims:** The purpose of this study was to audit our short-term outcomes after using the standardized operative approach of laparoscopic colorectal surgery performed by single colorectal surgeon.

**Methods:** From 2019 to 2022, 161 patients underwent colorectal surgery. These cases included benign and malignant pathology performed in elective and emergency setting. 30 patients were planned for open surgery were excluded Data was maintained prospectively. Operative steps and instrumentation for the procedure were standardized and published previously.

**Results:** Procedures were, right hemicolectomy (n=41), LAR (n=26), LAR with loop-ileostomy (n=22), Hartmann's (n=30), subtotal colectomy (n=04), left hemicolectomy (n=02) and APR (n=06). The median stay was 6 days .Complication rate 16 %, anastomotic leak 2.9 %. 30-day readmission 6.8 % whereas 30-day mortality 2.2 % respectively. The median lymph nodes harvested was 17.

**Conclusion:** Standardized approach in colorectal surgery very useful and helps in better perioperative and the oncological outcomes.

**Key statement:** Standardized approach in colorectal surgery very useful and helps in better perioperative and the oncological outcomes.

## P14

### DIGITAL SURGICAL CONFERENCES DURING COVID-19 PANDEMIC: NEWER CHALLENGES & OPPORTUNITIES

**Author(s):** Dr S Easwaramoorthy, Dr A Easwaramoorthy, Dr J Yasmine, Dr C Sakthivel  
**Institution:** Lotus Hospital, Erode, India

**Aims:** COVID-19 pandemic has caused untold miseries to life and livelihood of people across world. Surgical teaching & training have been severely disrupted with surgeons treating COVID victims leaving little time for surgical education. Repeated lock downs, travel restrictions, impact on clinical practices prevented many surgeons from attending surgical workshops, & annual conferences

**Methods:** Indian Association of Gastrointestinal Endo Surgeons (IAGES) is an academically vibrant minimal access surgery association in India. IAGES has conducted both midterm (INDOUK SURGICON 2020) and annual conference (IAGES 2021 @ COIMBATORE) in digital format in the last academic year. The experience and feedback from these virtual conferences was documented

**Results:** General laparoscopy session was the most preferably viewed specialty followed by hernia, colorectal & endoscopy sessions. Most of the viewers preferred to watch live/virtual live operating session (85%) followed by expert talks & panel discussions. Two third of the viewer spent more than 4 h to 8 hours in academic session.

**Conclusion:** Digital or hybrid conferences are the 'new normal' for most of the surgical fraternity for foreseeable future.

**Key statement:** Digital conferences, Covid 19 pandemic, virtual meeting.

## P15

### STRANGULATED PENIS IN A PRISONER: COMPLETE PENILE DEGLOVING AND FULL THICKNESS SKIN GRAFT: A CASE REPORT

**Author(s):** Dr A Uthman<sup>1</sup>, Dr Ibrahim Eid<sup>2</sup>

**Institution:** <sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom

<sup>2</sup>Elmenshawy Hospital, Egypt

**Aims:** Penile strangulation is a rare urological emergency. The motives behind it are sexual gratification, desire to enhance erection or psychiatric disturbance. Gangrene is an uncommon outcome. However, we report a prisoner patient who presented with Fournier's gangrene after using penile constriction material. His Management will be reviewed.

**Methods:** A 45-year-old prisoner presented with penile shaft Fournier's gangrene after using penile constriction material. He reported a 5-day history of progressive penile pain, oedema and skin injury. He had no urinary symptoms. The patient had complete penile skin degloving, circumcision and suprapubic catheter. Histopathology results confirmed Fournier's gangrene.

**Results:** Post-operatively, penile tissue was healthy. There was no infection nor necrotic tissue. The wound was healing with good granulation tissue. Full thickness skin graft, from the groins, was undertaken on the eleventh day post-degloving. Hospital stays length was 20 days. He was clinically stable with clean wounds.

**Conclusion:** Our case had grade V injury in Bhat grades or high-grade injury in Silberstein grades. Penile strangulation complications vary and depend on many factors, including type of device used, degree of constriction and time elapsed until presentation. Early management is vital to prevent ischemic necrosis, gangrene and tissue loss.

**Key statement:** Penile strangulation must be treated as early as possible to prevent vascular and mechanical complications such as irreversible penile ischemia, gangrene or amputation of the penis. Psychological assessment is required for these patients.

## P16

### A REVIEW OF ACCESS TO SUTURING TEACHING IN UNDERGRADUATE MEDICAL EDUCATION

**Author(s):** Dr N Badat

**Institution:** Bradford Teaching Hospitals Foundation Trust, Bradford, United Kingdom

**Aims:** This audit aimed to measure the accessibility of formalised teaching for suturing against the current layout of skills teaching for final year medical students. The standard by which this audit was measured against was a 100% compliance with access to teaching available.

**Methods:** All fifth year medical students undertaking their clinical attachments between September–December 2021 within one Trust were contacted via e-mail and offered suturing teaching sessions. Anonymous questionnaires were completed prior to and after the teaching sessions to determine the demand and usefulness of such sessions.

**Results:** 34% of students contacted signed up for suturing teaching. Due to limited capacity, only 32% of these students were able to access teaching. 80% of students didn't feel confident in their suturing abilities and 60% stated they couldn't suture independently before teaching, both which increased to 100% after.

**Conclusion:** An audit was performed looking at accessibility of suturing teaching as part of the undergraduate medical education curriculum. This audit showed 32% of students had access to teaching for which an intervention was made. A re-audit showed access improved to >80%, improving on initial standards set out in this audit.

**Key statement:** Unfortunately, though there was a demand for suturing skills teaching, access was limited and there was no formalised teaching programme established, failing to meet the standards set out in this audit. Results were presented at a local meeting and suturing teaching was incorporated into the programme with multiple sessions available.

## P17

**A SINGLE CENTRES' EXPERIENCE ON MANAGEMENT AND OUTCOMES OF GALL BLADDER CANCER (GBC) OVER TWENTY YEARS****Author(s):** Dr J Xiang, Mr S Bodla, Mr T Athwal, Mr C Cheruvu**Institution:** Royal Stoke University Hospital, Stoke on Trent, United Kingdom

**Aims:** To establish patterns in presentation and subsequent stage dependent management and survival outcomes of gallbladder cancer (GBC) from a tertiary hepatobiliary centre. In particular, we compared outcomes of local (T1a, T1b) with regional (T2,T3) cancers in terms of resection offered and survival.

**Methods:** The patient cohort comprised of primary GBC cases between 2001 and 2021, this was identified from clinical coding, and relevant information through electronic records. Patients with incomplete data were excluded. Staging information obtained from histology and radiological reporting. All survival data are for 5 years following diagnosis (Unless stated otherwise).

**Results:**

|  | Percentage |
|--|------------|
| Male   | 40%        |
| Female   | 60%        |
| Average age                                    |            |
| Emergency presentation                         | 63%        |
| Elective presentation                          | 37%        |
| Overall 1-year survival                        | 37.8%      |
| Overall survival                               | 15.70%     |
| T1 survival                                    | 78%        |
| T2 survival                                    | 32.6%      |
| T3 survival                                    | 7%         |
| T4 survival                                    | 0%         |
| T2 without liver bed resection 1 year survival | 89%        |
| T2 with liver bed resection 1 year survival    | 56%        |

**Conclusion:** This study was able to stratify various presentations and radiological findings with survival. Data over a 20-year period provides demographic and clinical information relevant to improving outcomes of GBC which have historically been extremely poor. In the T2 disease patients, liver resection was significantly more beneficial for survival.

**Key statement:** This unique single centre study provides a detailed picture of GBC incidence, management, and prognosis in England. GBC is relatively rare although confers extremely poor outcomes for patients. This original research looks at the benefit of surgical interventions and significant clinical factors that impact disease survival.

## P18

### LEVEL OF HARM OF COVID-19-SARS PANDEMIC ON PHYSICIANS' LIVES AND CAREERS. A MULTINATIONAL CROSS-SECTIONAL COHORT STUDY

**Author(s):** Dr med M Galanis<sup>1</sup>, Mr C Parmar<sup>2</sup>, MD AH Bangash<sup>3</sup>, Professor YKS Viswanath<sup>4</sup>  
**Institution:** <sup>1</sup>Inselspital Bern, Bern, Switzerland, <sup>2</sup>Whittington Hospital, London, United Kingdom  
<sup>3</sup>STMU Shifa College of Medicine, Islamabad, Pakistan  
<sup>4</sup>The James Cook University Hospital, Middlesbrough, United Kingdom

**Aims:** We designed a survey with the aim to assess the level of harm to the personal lives and careers of physicians worldwide during the COVID-19-SARS pandemic.

**Methods:** An online survey was conducted from 9th March 2021 to 17th May 2021. Invitations were sent through social media to physicians and residents across the world.

**Results:** A proportion of the physicians responded that they had used or started using substances, including tranquilizers and/or recreational drugs, during the COVID pandemic, while others started feeling insecure, unsafe or pessimistic regarding their present and future. These responses were particularly evident among younger physicians.

**Conclusion:** The COVID-19-SARS pandemic not only affected the residency and fellowship programs, but also the personal, physical and psychological well-being of physicians. More studies with in-depth analysis of quality of life and mental health questionnaires are needed to assess all levels of harm among physicians during the COVID-19-SARS pandemic.

**Key statement:** The pandemic is here to stay. Although health systems got into a stressful situation because of the COVID-19 pandemic, physicians internationally understand their role in this situation and offer their services and getting mentally and psychologically harmed. Health systems shall takes actions in order to protect/support physicians' mental health.

## P19

### IMPACT OF COVID-19 AND LEVEL OF HARM IN PATIENTS WITH ESOPHAGEAL CANCER FOR THE PERIOD 04.2020 – 03.2021

**Author(s):** Dr med M Galanis<sup>1</sup>, Dr F Di Maggio<sup>2</sup>, Dr JH Herrera Kok<sup>3</sup>, Dr W Yang<sup>4</sup>, Professor YKS Viswanath<sup>5</sup>  
**Institution:** <sup>1</sup>Inselspital Bern, Bern, Switzerland, <sup>2</sup>Barking Havering and Redbridge University Hospital NHS Trust, Romford, United Kingdom, <sup>3</sup>Complejo Asistencial Universitario de León, Leon, Spain  
<sup>4</sup>The First Affiliated Hospital of Jinan University, Guangzhou, China  
<sup>5</sup>The James Cook University Hospital, Middlesbrough, United Kingdom

**Aims:** We designed a survey with the aim to assess the level of harm among patients with esophageal cancer during the COVID-19-SARS pandemic.

**Methods:** An online survey was conducted from 25th October 2021 to 12th March 2022. Invitations were sent through social media to surgical oncological centers across the world.

**Results:** 46 responses from 16 countries with 100% complete ratio. The data presented physical and psychological well-being of patients with esophageal cancer. Increased re-admission rate, increased ratio of delayed or postponed operations leading to worsening of symptoms and prognosis.

**Conclusion:** The COVID-19-SARS pandemic affected the physical and psychological well-being of patients with esophageal cancer. More studies are needed to assess all Levels of Harm among tumor patients during the COVID-19-SARS pandemic.

**Key statement:** Even in difficult and unexpected situations, tumor patients and their therapeutic plans should remain a priority for the health systems. Therefore, OR and IMC/ICU capacities should be guaranteed for the treatment of patients with esophageal cancer and other malignant diseases even in pandemic or similar critical situations.



## P20

**A NEW DIAGNOSTIC TOOL FOR COMPREHENSIVE CLASSIFICATION OF ACUTE APPENDICITIS: MULTIVARIATE ANALYSIS OF LABORATORY PROGNOSTIC FACTORS****Author(s):** Dr B Afzal, Dr G Tebala, Dr J Fung, Dr A Dawani**Institution:** Oxford University Hospital, United Kingdom**Aims:** To determine a new classification tool for acute appendicitis, considering various readily available laboratory parameters.**Methods:** This retrospective cohort study was conducted on the electronic clinical notes of 2506 patients who underwent appendectomy from 1st September 2016 to 31st August 2021. Laboratory findings were noted. Early mucosal inflammation, transmural inflammation and gangrenous or perforated appendicitis were all pathologically categorized. Each case was pathologically classified.**Results:** WBC, bilirubin, creatinine, CRP, haemoglobin, lymphocytes, neutrophils, platelet count and serum sodium level were significant parameters for the diagnosis of acute appendicitis. Through regression analysis, it was noted that albumin, CRP, lymphocytes count, neutrophils, platelets and WBC were significant factors that are associated to progression to complicated appendicitis.**Conclusion:** Our predictive model may be helpful for the diagnosis of complicated appendicitis and may help stratify patients according to their severity.**Key statement:** Severity of appendicitis can be estimated by considering several serological factors. Some are associated to progression to complicated appendicitis. A predictive model was developed to try to predict this progression, and this can be helpful for the diagnosis of complicated appendicitis and may help stratify patients according to their severity.

## P21

**ARE ANTIBIOTICS REQUIRED? AN AUDIT ON ANTIBIOTIC USAGE FOR PATIENTS UNDERGOING EMERGENCY APPENDICECTOMY****Author(s):** Ms R Khaw<sup>1</sup>, Mr J Russ<sup>2</sup>, Mr K Khan<sup>2</sup>, Mr C Emmett<sup>1</sup>**Institution:** <sup>1</sup>Northumbria Healthcare NHS Foundation Trust, Newcastle-Upon-Tyne, United Kingdom<sup>2</sup>County Durham and Darlington NHS Foundation Trust, Durham, United Kingdom**Aims:** Acute appendicitis is a common cause of acute abdominal pain, with differing practice in antibiotic treatment. This audit reviews peri- and post-operative use of antibiotics for patients undergoing emergency laparoscopic appendicectomy at two centres in North East England, comparing practice to the World Society of Emergency Surgery acute appendicitis recommendations.**Methods:** All adult patients undergoing emergency laparoscopic appendicectomy between 1st January 2022 - 31st January 2022 at two centres in the North East were identified. Data from the two centres were collected on demographics, severity of appendicitis, peri- and post-operative antibiotic use and any complications at post-operative day 30.**Results:** Thirty-six patients (18 female) were identified, median age 38 years (range 16-93) and mean ASA of 1.68. Peri-operatively, 97.2% patients received a single dose of antibiotics. Postoperatively, for simple appendicitis, 63.2% (n=12) patients did not receive further antibiotics. Of patients with complex appendicitis, none received 3-5 days of postoperative antibiotics.**Conclusion:** Preoperative antibiotic usage had high compliance with guidelines, however there was disparity in practice for post-operative antibiotics usage. Patients with simple appendicitis had high rates of antibiotic use, against guidance. Local practice varied between centres, particularly in length of postoperative antibiotic treatment for complex appendicitis.**Key statement:** The creation and use of standardised regional guidelines specific to antibiotics in appendicitis would aid in streamlining patient treatment pathways, and may have positive impacts on length of hospital stay and antibiotic stewardship. Further audit and data collection will investigate these factors and contribute to guideline design.

## P22

### STREAMLINING ACCESS TO URGENT ABDOMINAL ULTRASOUND ASSESSMENT REDUCES PATIENT WAIT TIMES IN A SURGICAL ASSESSMENT UNIT

**Author(s):** Dr M Gowell, Mr A Walsh

**Institution:** Gloucestershire Royal Hospital, Gloucester, United Kingdom

**Aims:** Acute referrals to secondary care continue to increase each year, with "high-volume, low-intensity" presentations such as biliary calculi occupying most of the time and investigation. We sought to determine whether an ambulatory pathway direct from GP or ED for biliary ultrasound decreased surgical assessment unit (SAU) wait times.

**Methods:** Patients attending within two seven-day periods, before and after pathway introduction, were captured. Patients with a history consistent with biliary calculi and a clinical assessment that investigation the following day was appropriate, were given a pre-booked USS slot. Times of presentation, clinical review, and discharge were compared across these periods.

**Results:** N=137 attended the first week, N=214 attended the second. Mean time (+/-95% CI) until clinical review was similar (2hours 32minutes +/-17minutes vs 2hours 31minutes +/-10minutes). Mean overall time (+/-95% CI) on SAU decreased (4hours 26minutes +/-35minutes vs 3hours 58minutes +/-25 minutes). No results were statistically significant.

**Conclusion:** Despite a 56% increase in attendance, introduction of this pathway reduced average time on SAU by 28 minutes. Although confounding factors were not examined, results are compelling when considering the potential accumulation of patient time saved. In this instance 99 hours 52 minutes in a single week.

**Key statement:** We introduced a pathway streamlining patients with biliary colic for urgent ambulatory abdominal ultrasound, if deemed well enough to return the following day for the investigation. This saved 28minutes of time spent in SAU on average per patient, suggesting potential means to improve departmental operating efficiency.

## P23

### CONSENTING FOR THE RISK OF COVID-19: OUR EXPERIENCE IN A DISTRICT GENERAL HOSPITAL

**Author(s):** Dr A Rahman, Dr M Badawi, Dr M Swamad, Dr M Koundu, Mr H Wilmott

**Institution:** East Sussex Healthcare NHS Trust, Saint Leonards-on-sea, United Kingdom

**Aims:** The UK is one of the most affected countries with almost 22.2 million COVID-19 cases diagnosed and over 165,000 reported deaths in England alone to date. The Royal College of Surgeons of England in their Recovery of Surgical Service Guideline emphasises on discussing COVID-19 risk when consenting to operative procedures.

**Methods:** A retrospective analysis of all surgical cases admitted to the East Sussex Healthcare NHS Trust between 24th to 30th January 2022 was undertaken. This was presented at the local governance meeting on 25th May 2022. A similar retrospective analysis was performed between 27th June to 3rd July 2022 following intervention.

**Results:** Compliance in documenting COVID-19 risk remained same in both the cycles (35.54% vs 34.19%). Improvement was noted when specifically looking into elective cases alone. Among staff groups, core trainees maintained a high compliance rate in both cycles whereas there remains scope of improvement among registrars and consultants.

**Conclusion:** There was a lack of compliance to discuss COVID-19 risk during our study period among all staff level despite concern with nosocomial infection and associated high mortality and morbidity. A holistic approach should be taken to create awareness regarding open discussion of such risk with every patient undergoing surgical procedure.

**Key statement:** Given the high risk of mortality and morbidity associated with nosocomial COVID-19 infection, it is important to discuss the risk while consenting patients undergoing surgical procedure. There was no significant improvement noted in our study period. Further steps must be undertaken to raise awareness among all level of surgical doctors.

## P24

### PERSISTENT GLANS ISCHEMIA AND TISSUE LOSS AFTER INFLATABLE PENILE PROSTHESIS EXPLANTATION: A CASE REPORT AND LITERATURE REVIEW

**Author(s):** Dr A Uthman, Mr A Shanahan, Professor G Brown

**Institution:** Cwm Taf Morgannwg University Health Board, Wales, United Kingdom

**Aims:** Glans ischemia post-PPI is a rare and underreported complication. Early recognition is vital. Our patient is the third reported case with persistent glans ischemia and tissue loss after prosthesis explantation and the first one without pre-existing ischemic risk factors. A literature review was undertaken examining peri-operative risk factors and management.

**Methods:** A 52-year-old male patient, with refractory erectile dysfunction and Peyronie's disease had a plaque incision, graft, insertion of a 3-piece inflatable penile prosthesis and circumcision in Turkey. Eight days postoperatively, he presented with a 6-day history of dusky, cold glans.

**Results:** The patient underwent prosthesis explantation at which time the right cylinder was found to have perforated the urethra. Post operatively, the glans slowly recovered with subsequent sloughing of superficial necrotic skin. Glans sensation is preserved but there has been a significant loss of penile length.

**Conclusion:** In the literature, 19 cases were managed conservatively of which 18 cases had tissue loss. While 10 cases had immediate prosthesis explantation of which 2 cases had tissue loss. Therefore, if glans ischemia is suspected, then early recognition and immediate explantation of the device is essential in preventing tissue loss.

**Key statement:** Glans ischemia complication has bad physical and psychological effects. It was mentioned in EAU guidelines but not in BAUS guidance. Patient counselling and informed consent about this possible complication is important. We recommend adding this complication to the BAUS guidance.

## P25

### URACHAL ADENOCARCINOMA MANAGED WITH TRANSURETHRAL RESECTION

**Author(s):** Dr A Uthman<sup>1</sup>, Dr C Khoo<sup>2</sup>, Dr N Taylor<sup>2</sup>, Dr E Bolton<sup>2</sup>

**Institution:** <sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom

<sup>2</sup>Imperial College Healthcare NHS Trust, London, United Kingdom

**Aims:** Urachal adenocarcinoma (UrCa) is rare. Although no consensus guidelines exist, management is usually via en bloc resection of the bladder (full/partial cystectomy), urachal remnant and umbilicus. We report a case of UrCa completely cleared by transurethral resection, suggesting that this may be an appropriate surgical option in selected cases.

**Methods:** Retrospective review of clinical, radiological and operative records of a 30-year-old non-smoking female referred with visible haematuria were examined. Relevant features were extracted and collated.

**Results:** CT Urogram suggested a 3cm bladder dome mass. During transurethral resection, a urachal tube was visible in the centre. Histopathology revealed pT1 mucinous UrCa. Histopathology of subsequent open partial cystectomy, umbilectomy, and pelvic lymph nodes dissection was benign, and 6-month follow-up was clear. Final stage was pT1N0M0/Sheldon III/Mayo I.

**Conclusion:** To the best of our knowledge, literature review returns only two previous cases of UrCa cleared with endoscopic resection alone. In conjunction with the currently reported case, this suggested that, in selected patients with small, non-muscle invasive tumours, endoscopic treatment alone can be considered.

**Key statement:** In patients with specific UrCa characteristics, endoscopic management may allow oncological clearance whilst avoiding the morbidity of cystectomy.

## P26

**URACHAL CANCER: EXPERIENCE OF A HIGH-VOLUME BLADDER CANCER CENTRE****Author(s):** Dr A Uthman<sup>1</sup>, Dr C Khoo<sup>2</sup>, Dr N Taylor<sup>2</sup>, Dr E Bolton<sup>2</sup>**Institution:** <sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom  
<sup>2</sup>Imperial College Healthcare NHS Trust, London, United Kingdom

**Aims:** Primary urachal cancer (UrCa) is rare. Although preferred treatment is surgical, there is no consensus on best approach. Our approach included radical cystoprostatectomy (1) and partial cystectomy (13) of which 3 and 1 patients had robotic and laparoscopic surgery, respectively. We present our experience managing 14 cases of primary UrCa.

**Methods:** Operative records of a high-volume UK bladder cancer centre were retrospectively interrogated (May-2013 to June-2022). 14 patients with primary UrCa were identified. (Male=9, female=6, age: 30-85 years). Pre- (demographics, mode of presentation, cystoscopy, imaging findings), peri- (surgical method, histopathology results, complications) and post-operative (recurrence, mortality) outcomes were extracted.

**Results:**

- Most frequently, diagnosis was made via flexible cystoscopy for haematuria, and tumour location was bladder dome.
- Four patients presented with metastases.
- Most common histological subtype was mucinous adenocarcinoma.
- Two patients experienced recurrence.
- Two patients have died a 9-year average after presentation.
- Umbilectomy and lymph-nodes dissection did not improve oncological outcomes.

**Conclusion:** UrCa can occur at any age and can be advanced at presentation. This series demonstrates that bladder sparing surgery is feasible; this approach spares the patient the morbidity of cystectomy. Routine umbilectomy and lymph nodes dissection do not ameliorate oncological outcomes.

**Key statement:** UrCa is rare and aggressive. Prompt recognition and diagnosis enables timely intervention. Bladder-sparing management is increasing, with chemotherapy reserved for local recurrence or metastasis.

## P27

### IMPROVING THE MANAGEMENT OF PATIENTS PRESENTING WITH SYMPTOMATIC GALLSTONE DISEASE THROUGH THE SURGICAL AMBULATORY UNIT IN AN NHS TRUST

**Author(s):** Mr O Olatunbode, Dr S Al-Ani, Dr R Gill, Mr A Mitchel

**Institution:** County Durham and Darlington NHS Trust, Darlington, United Kingdom

**Aims:** Symptomatic gallstone disease accounts for a significant number of patients seen during the surgical take. NICE recommends surgery at the index admission where possible. Many Trusts provide a 'Hot Gallbladder' service which quickly becomes overwhelmed with significant waiting times. Can a concurrent service via the surgical ambulatory unit improve this?

**Methods:** An audit of patients presenting through the ambulatory service over a 2-week period was done to identify how those with symptomatic gallstones were being managed. A protocol aimed at identifying suitable patients who could be offered surgery on the CEPOD list was put in place. The service was re-audited afterwards.

**Results:**

|          | Symptomatic gallstones | MRCP/ERCP required | Laparoscopic cholecystectomy performed |
|----------|------------------------|--------------------|--|
| Audit    | 14                     | 3                  | 0                                      |
| Re-audit | 23                     | 15                 | 11                                     |

Presentations included biliary colic, cholecystitis, CBD stones and mild pancreatitis. Notably, during the re-audit, some patients had MRCP/ERCP and then a laparoscopic cholecystectomy, all via the ambulatory service.

**Conclusion:** The skill mix on emergency surgical rotas vary and the CEPOD list often has more pressing emergencies to accommodate. Notwithstanding, symptomatic gallstone disease can be treated as we would an acute appendicitis. This will improve waiting list times and more importantly reduce the morbidity associated with representations with gallstone-related complications.

**Key statement:** For selected patients, it is possible to offer same-day or same-episode laparoscopic cholecystectomy. Concerted effort is required between the surgical, anaesthetic and theatre teams to identify and treat this as a surgical emergency thereby reducing subsequent morbidity and improving the overall service.

## P28

### EFFECTIVENESS OF STRAIGHT TO TEST (STT) PATHWAY FOR 2 WEEKS WAIT COLORECTAL REFERRALS DURING COVID AND ITS COMPARISON WITH PRE-COVID

**Author(s):** Miss S Kudchadkar<sup>1,2</sup>, Dr A Rai<sup>2</sup>, Dr A Mahmood<sup>2</sup>, Miss K Brown<sup>2</sup>

**Institution:** <sup>1</sup>St. Richard's Hospital, Chichester, United Kingdom

<sup>2</sup>Luton and Dunstable Hospital, Luton, United Kingdom

**Aims:**

- 1 To identify the impact of COVID-19 pandemic on the Straight to Test (STT) pathway for 2 weeks-wait colorectal referrals.
- 2 To study the modifications adopted in the pathway and compare to pre-covid time.
- 3 To analyse the effectiveness of the new pathway and its effect on clinical outcomes.

**Methods:** Clinical data of patients within age groups of 40-80 years, referred under 2 weeks wait colorectal referrals, during pre-covid (February 2020, Number = 85) and covid (February 2021, Number = 121) were reviewed. Outcomes analysed include patient demographics, clinical presentation, STT pathway and management plan.

**Results:** During Pre-covid, 61.2% underwent colonoscopy as an initial investigation and only 15.2% had FIT, with cancer detection in 3.5% cases. During Covid, FIT became an index test for 2WW colorectal referrals. 76.8% underwent FIT as a primary investigation, of which 2.1% had FIT > 200, correlating with carcinoma of colon.

**Conclusion:** FIT can appropriately triage patients off urgent pathways.

- Setting of f-Hb cut-off is critical to meet the demand for colonoscopy at the expense of not missing any CRC.
- Negative FIT result is reassuring to rule out CRC (High NPV - 99.8% at 2 µg/g & 99.6% at 10 µg/l).

**Key statement:** New modifications were introduced in the pre-existing STT pathway for 2 weeks wait colorectal referrals during Covid, while maintaining effectiveness and accuracy of CRC detection rate.

- Avoid overuse of endoscopy / imaging.
- Prioritize urgent investigations to detect CRC effectively.
- FIT < 10 can be safely discharged from 2WW pathway, unless clinically indicated.

## P29

### AUDIT ON TIMING OF LAPAROSCOPIC CHOLECYSTECTOMY FOLLOWING INDEX ADMISSION WITH GALLSTONE PANCREATITIS

**Author(s):** Dr K Das, Dr H Wright, Mr J Latif, Mr I Bhatti, Mr A Awan

**Institution:** University Hospitals of Derby & Burton NHS Foundation Trust, Derby, United Kingdom

**Aims:** The British Society of Gastroenterology (BSG) recommend that mild gallstone pancreatitis (GSP) cases should be definitively managed ideally within 2 weeks but no longer than 4 weeks after presentation. This audit assessed whether timings of laparoscopic cholecystectomy (LC) for GSP met these guidelines and if admitting specialty affects waiting times.

**Methods:** All patients undergoing LC for GSP between October 2020 - November 2021 at the Royal Derby Hospital were identified using the hospital's theatre management system. Data was collected on GSP severity, admitting specialty, time to definitive LC and rates of readmission between discharge and LC. Significance was set at  $p < 0.05$ .

**Results:** 35 patients analysed. 37% had LCs performed in <2 weeks. 23% had LCs within 2-4 weeks with all listed and consented during index admission. 37% had LCs >4 weeks after initial presentation. 37.1% of patients were re-admitted prior to definitive LC. No association found between admitting specialty and waiting times.

**Conclusion:** Adherence to BSG guidelines could be improved in our centre with delays in definitive treatment associated with re-admissions. Advanced planning for patients through listing and consenting for semi-elective LC during index admission is associated with higher rates of compliance to guidelines.

**Key statement:** Delays in definitive management of GSP is associated with morbidity. We believe simple measures such as advanced consenting and educational material for junior doctors could be implemented to increase compliance to BSG guidelines. More complex solutions such as hot gallbladder theatre lists could be introduced after further investigation.

## P30

### CAUSES OF BILE DUCT INJURIES DURING LAPAROSCOPIC CHOLECYSTECTOMIES

**Author(s):** Dr A Jindal, Ms. A Fernandez, Ms. F Soomro, Mr C Schneider, Mr P Srinivasan

**Institution:** King's College Hospital, London, United Kingdom

**Aims:** The aim of this paper is to review papers about bile duct injuries to identify the causes that lead to bile duct injuries during laparoscopic cholecystectomies.

**Methods:** The study is a traditional review of studies from the past 5 years, 2018 to 2022. It was carried out in a multistep method: deciding on research questions, identifying key words, formation of Mesh keywords, searching for studies that are relevant, reviewing and shortlisting relevant studies, forming a data sheet of relevant data and evaluating the data. The research question was formulated by collaborating a surgery 'Cholecystectomy' with a complication associated with that surgery 'bile duct injuries'. The keywords used were: 'Cholecystectomy' and 'Bile duct injuries'. The above mentioned keywords were used to search on the search engines: PubMed and Google scholar. The results obtained were from over the past 5 years (2018 - present), including all free flowing texts in English for the adult population, with no demographic limitations and not including grey literature.

**Results:** The main cause for Bile duct injuries during Laparoscopic Cholecystectomies is misidentification of anatomy. Other causes include experience of the surgeon, technique used, and unsafe use of energy devices, lack of time out or not using bail out methods. Human factors like mental state, anxiety and fatigue are some of the other causes of bile duct injuries. Several pre-operative patient factors like previous abdominal surgeries, history of gallbladder problems and delayed referrals also increase the risk of this complication.

**Conclusion:** Bile duct injuries can be reduced with experience, proper knowledge and understanding of anatomy, proper pre assessment of risk factors for complicated cholecystectomy, use of time out and bail out methods along with use of proper technique and instruments and timely referrals and presentations. Human factors of the surgeon also play a vital role.

**Key statement:** Laparoscopic cholecystectomies are among the commonest surgical procedures and bile duct injuries are the most dreaded complication of this procedure. These can cause mortality, impact the quality of life and also have several long term complication. It is essential to understand the causes of bile duct injuries to reduce and prevent them. Several causes and factors can be managed, therefore reducing the risk of bile duct injuries.

## P31

**TRANSANAL MINIMALLY INVASIVE SURGERY AT CUMBERLAND INFIRMARY, CARLISLE  
EARLY EXPERIENCE OF DISTRICT HOSPITAL****Author(s):** Dr B Mohamed<sup>1</sup>, Mr M Aung<sup>1</sup>, Mr A Mohammed<sup>1</sup>, Mr M Mohamed<sup>1</sup>, Mr M Edilbe<sup>2</sup>**Institution:** <sup>1</sup>Cumberland Infirmary, Carlisle, United Kingdom<sup>2</sup>Cumberland Infirmary, Hospital Accommodation, Carlisle, United Kingdom**Aims:** To assess the outcome of TAMIS at Cumberland infirmary hospital to measure the outcome of TAMIS as an early experience of district hospital and its role of management of the large colorectal polyps and early rectal cancer.**Methods:** Retrospective data of all patients under went to TAMIS at Cumberland infirmary from July 2017 to July 2022 for big benign rectal polyps or early rectal cancer. The data base reviewed for all patients who underwent for resection of rectal masses benign or early malignant masses via a transanal approach.**Results:** 42 patients. Median age 71 years. The mean operative time 45-240 minutes, no peritoneum breach. 6 patients had rectal defect closure. 30 Patients are day case. The median distance from anal verge 7.6cm. Mean polyp size 6cm. Specimen fragmentation 8 patients. Positive margins 2 patients. Histology, Tubulovillous adenoma 31(73.81%) patients. Recurrence rate 11 patients (26.19%). 30day re-operation 1 patient/bleeding. No mortality.**Conclusion:** Favourable outcomes from TAMIS when compared with published literature. Specimen fragmentation and polyp recurrence rate reflect the size of the polyps excised and early learning curve effect. TAMIS is viable alternative to radical excision of the rectum. We support its use for complex colorectal surgeries at our centre.**Key statement:** TAMIS rectal polyps early rectal cancer histopathology.

## P32

**MYCOTIC AORTIC INFECTION, CASE SERIES AT CUMBERLAND INFIRMARY  
LITERATURE REVIEW, PRESENTATION AND MANAGEMENT OPTIONS****Author(s):** Mr B Mohamed, Mr T Ojimba, Mr T Barakat, Miss M Cusso, Mr R Eiffell**Institution:** Cumberland infirmary, Hospital Accommodation, Carlisle, United Kingdom**Aims:** To assess the current clinical knowledge about the MAA, presentation and management options and challenges. To compare the literature experience with current practice of the analyzed patients at Cumberland Infirmary.**Methods:** Single-centre, retrospective study of patients presenting with PMAAs at Cumberland infirmary Hospital from April 2016 to July 2022. Also a systematic literature review assessing knowledge about MAA, presentation management options and challenges.**Results:** 6 patients (4 males) Age 57-88 years. Presentation: Back pain 2 patients abdominal pain 1 patient, FUO/ sepsis 2 patients, collapsed 2 patients, confused 1 patient and other. Immune suppression: DM 1 patient, IS medication 2 patients, bladder cancer 1 patient. Potential: retroperitoneal abscess infection 2 patients chest infection, pyelonephritis, Gastritis systemic sepsis 1 patient each. Management: EVAR 2 patients, axillo-bifemoral bypass 2 patients. Non-surgical management 3 patients.**Conclusion:** Mycotic aneurism is rare but carries high risk of morbidity and mortality. The diagnosis is challenging but CT abdomen remain valuable for diagnosis. surgery bypass/EVAR with antibiotics are cornerstones for management, however other alternatives should be considered.**Key statement:** Mycotic aortic aneurysm and infected aortic aneurysm carries high mortality and morbidity high index of suspicion is required and combination of medical and surgical management is required to achieve the best outcome as well as MDT involvement at the management plan.

## P33

### TUBOGRAM, USEFUL INVESTIGATION FOR ASSESSMENT CHOLECYSTOSTOMY DRAIN PATIENT, SINGLE CENTRE EXPERIENCE

**Author(s):** Mr B Mohamed, Mr A Mohammed, Mr M Mohamed, Professor R Canelo  
**Institution:** Cumberland Infirmary, Carlisle, United Kingdom

**Aims:** To investigate the clinical factors and the outcome of patients who had tubogram as part of cholecystostomy drain in management of acute cholecystitis at Cumberland infirmary and compare the outcome with the patients who did not had tubogram during their management course.

**Methods:** Retrospective study of patients had Cholangiogram/ Tubogram over last 3 years at Cumberland infirmary post cholecystostomy drain insertion for non-malignant cause from January 2019 to January 2022 and comparing their outcome post cholecystostomy drain with the patients who did not had tubogram. Data from information department (search code J 24.1).

**Results:** Cholecystostomy drain(CD) 58 patient, 21(36.21%) had tubogram, 44 patients(75.86%) had one drain;only 10patients(22.73%) had tubogram. 14 patients had tubogram 3-4 weeks from CD.Tubogram patients 17patients had CT abdomen and 14 patients has US abdomen. outcome: Laparoscopic Cholecystectomy(LC) 6 weeks after CD removal 10/21patients. ERCP &LC 06patients.

**Conclusion:** Tubogram is useful, cheap, non-invasive test linked with lower recurrence rate of the cholecystitis symptoms after removal of cholecystostomy drain, also associated with earlier cholecystostomy drain removal. We recommend all patient who had cholecystostomy drain should have tubogram as routine investigation after three to four weeks post cholecystostomy drain insertion.

**Key statement:** Tubogram is safe ,cheap investigation lined associated with improvement of outcome after cholecystostomy drain, low morbidity and mortality and decrease the load on the hospitals/NHS system by decrease number of the post drain investigation and Same day emergency clinic visits.

## P34

### ROLE OF ELECTRONIC CONSENT IN EMERGENCY SURGERY A QIP IN A HIGH VOLUME SURGICAL EMERGENCY UNIT AT A TERTIARY HOSPITAL

**Author(s):** Miss A Sharmin, Dr V Loyala, Miss O Shams, Mr G Bond-Smith  
**Institution:** Oxford University Hospitals NHS Foundation Trust, Oxford, United Kingdom

**Aims:** The RCS discusses the significance of maintaining a record of consent. Studies show 27-50% errors with handwritten consent. Missing/incomplete consent is also the most common reason for first case delay. This prompted the generation of a standard template for emergency surgery in our department to reduce errors and delays.

**Methods:** Procedure-specific Electronic Surgical Consent (eSConsent) templates for common emergency general surgery operations were added to the online database so they can be easily added to the patient record. The format was designed to allow even junior surgical trainees to adapt and perform the consent process early on in their placement.

**Results:** The first cycle (20/09/2021 -26/09/2021) showed compliance of only 18%. After discussing the audit findings with the members of the surgical team involved in the consenting process in the local meeting and implementing eSConsent, the compliance increased to 83.7%, 78%, and 73% in the next three audit cycles.

**Conclusion:** A consent form is a medicolegal document. The transition to eSConsent is justifiable and easily translated to practice particularly by using simple technology as used in our QIP. Weekly data capture has been adopted in our department as a surveillance protocol to ensure adherence and standardize our practice.

**Key statement:** Health care systems have taken advantage of technology to facilitate accuracy and robust monitoring. Emergency surgical consent process can benefit from this to avoid delays, errors and litigation. Challenges including trainee changeover and new recruitments will expectedly affect the compliance of eSConsent but a proper induction will help overcome this.



## P35

### USING MIXED FIDELITY SIMULATION TO MAXIMISE BASIC LAPAROSCOPIC SKILLS TRAINING AND STUDENT'S CONFIDENCE

**Author(s):** Mr M Harris<sup>1</sup>, Mr D Rawaf<sup>2</sup>, Mr E Street<sup>2</sup>, Mr J Van Flue<sup>2</sup>

**Institution:** <sup>1</sup>Leighton Hospital, Crewe, United Kingdom, <sup>2</sup>Inovus Medical, St Helens, United Kingdom

**Aims:** We aim to show that using tasks with increasing complexity with increasing fidelity of simulation, can maximise student's laparoscopic skills learning, confidence and satisfaction when applied in a single day course.

**Methods:** Holding a laparoscopic skills day, students went through skills simulation with increasing fidelity and complexity. We collected surveys prior to and after: including demographics, prior experience, and self-confidence scores for key laparoscopic tasks on a 1-10 scale, as well as operative skill data using Inovus Augmented Reality simulation software.

**Results:** Every area of student's self-confidence improved, with a mean improvement of 3.82 ( $p=0.03$ ). The more junior the student, the greater their increase in confidence (Mean Pre-FY = 5.23). Notably, using Inovus AR software we found the skills day to provide an improvement on distance travelled when compared to cohort averages.

**Conclusion:** Mixed fidelity simulation is an effective way of rapidly progressing student's skills over the course of a single day. Augmented-Reality is a way of bridging the gap between basic box-trainer tasks and more complex wet-lab simulation. Capturing operative skill data with software provides opportunity to focus training to maximise progression.

**Key statement:** Junior students have the most to gain. Early exposure to laparoscopic skills may benefit faster learning curve progression. Including multiple methods of skills training, with increasing fidelity and complexity into a single session, is an effective way to bridge the gap between low fidelity box training and real-life practice.

## P36

### EMERGENCY MANAGEMENT OF SPONTANEOUS HYPERINFLATION OF INTRAGASTRIC BALLOON

**Author(s):** Dr J Rayer, Mr A Currie, Mr M Mason, Mr H Noble, Mr D Mahon

**Institution:** Somerset NHS Foundation Trust, Taunton, United Kingdom

**Aims:** Intra-gastric balloon placement is an approved endoscopic therapy for the management of severe obesity. The Orbera (BiB) intra-gastric balloon is endoscopically inserted for a period of six or twelve months. Rare balloon-related complications include hyperinflation, gastric outlet obstruction, and pancreatitis. We report two cases of spontaneous hyperinflation necessitating emergency removal.

**Methods:** A 43-year-old male and a 52-year-old female presented with abdominal pain and vomiting, two months and one week post-insertion, respectively. In both cases, CT demonstrated intra-gastric balloon position but tense balloon enlargement with an air-fluid level causing gastric distension. Both were scheduled for urgent endoscopic balloon removal under general anaesthetic.

**Results:** Endoscopically in both patients, the balloon appeared maximally inflated and tense with an air-fluid level. Using specialist endoscopic equipment, the balloons were deflated and retrieved. Both patients recovered well and were discharged home within three days. Subsequent liaison with Apollo Endosurgery suggested improved aseptic insertion technique to minimise this complication.

**Conclusion:** Spontaneous hyperinflation of intra-gastric balloons is a possible complication of the procedure. Prompt imaging and endoscopic removal facilitated prompt recovery. Focussing on maintaining an aseptic technique may reduce the future risk of this complication.

**Key statement:** Spontaneous hyperinflation is a rare but urgent complication following intra-gastric balloon placement. Endoscopic treatment of this complication with balloon removal is feasible and should be promptly carried out following clinical and imaging diagnosis. Aseptic insertion technique may minimise the risk of this complication.

## P37

### LAPAROSCOPIC CONVERSION FROM GASTRIC BYPASS TO SLEEVE GASTRECTOMY. OVERCOMING THE CHALLENGE

**Author(s):** Dr E Dexter<sup>1</sup>, Dr J Walshaw<sup>1</sup>, Mr M Gouda<sup>2</sup>, Mr S Dexter<sup>2</sup>  
**Institution:** <sup>1</sup>Hull University Teaching Hospitals, Hull, United Kingdom  
<sup>2</sup>Leeds Teaching Hospitals, Leeds, United Kingdom

**Aims:** Evaluation of a method and outcomes of laparoscopic conversion from Roux en Y gastric bypass (RYGB) to sleeve gastrectomy (SG).

**Methods:** 4 patients were reviewed following conversion from RYGB to SG +/- duodenal switch (DS). 3 patients were converted to DS due to weight gain, 1 had RYGB to sleeve for severe hypoglycaemic dumping. Technical elements of the procedure will be described with particular reference to vascularity at the crossing staple lines.

**Results:** There were no post-operative complications, in particular no leaks. All patients were discharged by day 2. Weight loss was consistent with revisional duodenal switch outcomes and hypoglycaemic dumping improved initially.

**Conclusion:** The technique described appears to be a satisfactory approach to a technically challenging reconstruction.

**Key statement:** Laparoscopic conversion from bypass to sleeve gastrectomy using the technique as described appears to have good outcomes.

## P38

### THE NECESSITY OF ROUTINE PREOPERATIVE 'GROUP AND SAVE' SAMPLES IN EMERGENCY LAPAROSCOPIC APPENDICECTOMY

**Author(s):** Dr R Govindaraju, Dr YT Yap, Dr J Walshaw, Dr M Suntharamoorthy, Mr A Wilkins  
**Institution:** Hull University Teaching Hospital NHS Trust, United Kingdom

**Aims:** Obtaining two valid group and save (G&S) samples preoperatively for emergency surgery is widely practised. Bleeding requiring transfusion following appendicectomy is rare. We aim to determine the perioperative blood transfusion rates in patients undergoing laparoscopic or laparoscopic converted to open appendicectomy.

**Methods:** 100 emergency laparoscopic appendicectomy cases performed between July 2021 and August 2022 were identified retrospectively from theatre list records. Pre-operative, peri-operative and post-operative data was collected from electronic patient records, including pre-op valid G&S samples and transfusion rates.

**Results:** 94% of patients had two G&S samples pre-operatively. All patients' pre-operative haemoglobin levels were above the transfusion threshold. Intraoperative blood loss ranged from <5ml to 200ml, with an average of 17ml. 1 postoperative transfusion of 2 units was required in a patient whose procedure was converted to open.

**Conclusion:** Despite the majority of patients having two G&S samples, the results demonstrate small volumes of blood loss and low perioperative transfusion rates in this patient cohort. We acknowledge this is a single study centre with a small case number and more robust datasets are needed.

**Key statement:** Low transfusion rates in the perioperative period for laparoscopic appendicectomy indicate that routine preoperative G&S samples are potentially unnecessary and changing the practice widely could be time-saving and more cost-effective.

## P39

### THE NECESSITY OF ROUTINE PREOPERATIVE 'GROUP AND SAVE' SAMPLES IN EMERGENCY AND ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY

**Author(s):** Dr J Agbo, Dr YT Yap, Dr M Sunthara-Moorthy, Dr M Quaunine, Dr J Walshaw, Mr A Wilkins  
**Institution:** Hull University Teaching Hospital, NHS Trust, Hull, United Kingdom

**Aims:** Laparoscopic cholecystectomy may be performed in an elective or emergency setting and it is common practice for two preoperative group and save (G&S) samples, despite bleeding being rare. We aim to determine the necessity of routine preoperative G&S samples for laparoscopic cholecystectomy by identifying perioperative blood transfusion rates.

**Methods:** A selection of patients who had a laparoscopic cholecystectomy performed for any indication between January 2021 and August 2022 were recruited retrospectively. 99 patients were identified from theatre records, 69 elective and 30 emergency procedures. Data was collected electronic trust records, including number of G&S samples and transfusion rates.

**Results:** 98% of patients had at least one G&S sample pre-operatively, 68.7% had two samples. The mean estimated intraoperative blood loss was 25ml for elective procedures and 118ml for emergency. There were no post-operative transfusions required.

**Conclusion:** The mean blood loss was higher in emergency vs elective procedures. The majority of patients had preoperative G&S samples, however no patients required post-operative transfusions. Therefore routine preoperative G&S samples may place unnecessary strain on workload and resources.

**Key statement:** Laparoscopic cholecystectomy is associated with low transfusion rates in the perioperative period therefore routine preoperative G&S samples are potentially unnecessary.

## P40

### EMERGENCY LAPAROSCOPIC APPENDICECTOMY CONVERSION RATE AND POSTOPERATIVE OUTCOMES IN A SINGLE CENTRE TEACHING HOSPITAL

**Author(s):** Dr YT Yap, Dr R Govindaraju, Dr M Sunthara-Moorthy, Dr J Walshaw, Mr A Wilkins  
**Institution:** Hull University Teaching Hospitals NHS Trust, Hull, United Kingdom

**Aims:** Appendicectomy is the most frequently performed emergency general surgery procedure in the UK and laparoscopic appendicectomy is the current standard practice for acute appendicitis. The aim of this study was to identify the conversion rate for emergency laparoscopic appendicectomy and whether this is associated with increased rate of postoperative complications.

**Methods:** Emergency laparoscopic appendicectomy cases in adult patients performed between July 2021 and August 2022 were recruited retrospectively. 100 patients were identified using theatre list records, and intraoperative and postoperative data was collected using operation notes and electronic trust records respectively.

**Results:** The conversion rate was 4%, all using a midline incision. Complications included intra-abdominal collection (7%), pulmonary embolism (1%), transfusion rate (1%), readmissions (3%), and reoperations (1%). Mean hospital stay was 3 days (laparoscopic) vs 9 days (converted). The 30-day mortality rate was 0%.

**Conclusion:** Our conversion rate was comparable with pre-pandemic rates quoted in literature however acute appendicitis is becoming increasingly managed non-operatively, therefore patients requiring appendicectomy may be at higher risk. Patients who underwent an emergency laparoscopic appendicectomy that was converted to open had a longer mean hospital stay.

**Key statement:** Emergency laparoscopic appendicectomy conversion rates are low and comparable to pre-pandemic rates. Converting to open surgery is associated with a longer length of hospital stay.

## P41

### IS THERE A VALUE OF CARCINO EMBRYONIC ANTIGEN IN REGULAR SURVEILLANCE OF PATIENTS WITH RECTAL CANCER?

**Author(s):** Mr A Bavikatte, Dr V Vashist, Dr NS Keshavmurthy, Mrs J Olugbemi  
Mr J Alberts, Mr N Ward, Mr N Keeling

**Institution:** West Suffolk Hospital NHS Trust, Bury Saint Edmunds, United Kingdom

**Aims:** NICE recommends surveillance of colorectal cancer patients with carcinoembryonic antigen (CEA) and computerized tomography (CT) of the chest and abdomen. We wanted to explore the role of CEA in predicting both local and distant recurrence in comparison to CT scan as the gold standard with regards to rectal cancer specifically.

**Methods:** We retrospectively analyzed 200 rectal cancer patients treated at west Suffolk hospital NHS trust from 2014 to 2018. We have included all patients who underwent curative rectal cancer resection with no metastasis. We have excluded patients who had palliative management. Our aim is assess the sensitivity and specificity of CEA.

**Results:** Out of the 200, rectal cancer patients analyzed, 54 patients underwent palliative treatment and were excluded from the study. 40patients (27.7%) out of 146 developed recurrence in within the next 3 years. The overall sensitivity of CEA in comparison to CT scan was 13.89% and specificity was 96.36%.

**Conclusion:** Our study shows that the specificity of CEA is high, and the sensitivity is very poor. Routine surveillance of rectal cancer cases with CEA may not be ideal. However, if the CEA is high, the chance of recurrence on the CT scan is proportional.

**Key statement:** Routine surveillance of Rectal cancer patients with CEA in the prediction of recurrence is not ideal for all patients as it adds to anxiety to the patients as well as increases the workload of surveillance programs without much value.

## P42

### FILTER: A PROSPECTIVE COHORT STUDY OF FUNCTIONAL AND IMMUNOLOGICAL OUTCOMES AFTER LAPAROSCOPIC AND ROBOTIC TOTAL MESO-RECTAL EXCISION FOR RECTAL CANCER

**Author(s):** Dr R Duhoky, Ms Al Qureshi, Dr RJ Pires, Mrs E Hawes, Professor J Khan

**Institution:** Portsmouth Hospitals University NHS Trust, Portsmouth, United Kingdom

**Aims:** Objectives and research questions:

- 1 Qualitative functional assessment of sexual, urological, and bowel function using validated questionnaires.
- 2 Measurement of postoperative stress and immune response.

Does robotic rectal cancer surgery result in a more precise dissection with a reduced stress response and better functional outcomes as compared to laparoscopic surgery?

**Methods:** A prospective, single center, observational study of rectal cancer patients comparing robotic with laparoscopic surgery with 40 patients in each arm. Qualitative assessment of sexual, urological, bowel function, as well as assessment of stress response measured in blood samples taken at baseline and post-operatively on days 1, 3 and 5.

**Results:** As we are still early into our recruitment period, we do not yet have any relevant results to share with this protocol abstract. Recruitment is estimated to run for up to 24 months and is expected to finish within 36 months after starting.

**Conclusion:** Laparoscopic rectal cancer surgery is a comparable alternative to open surgery with proven short-term outcome benefits and similar long-term oncological outcomes. The robotic approach is becoming more attractive, due to better ergonomics. In this study we aim to help fill the current gap in knowledge.

**Key statement:** Rectal cancer surgery can be associated with a high risk of nerve damage, due to technical difficulties. To our knowledge this is the first trial comparing robotic and laparoscopic surgery to assess the degree of that stress response post-operatively and linking it to functional outcomes in these patients.

## P43

### A RETROSPECTIVE 7-YEAR SINGLE CENTRE STUDY OF LAPAROSCOPIC COMMON BILE DUCT EXPLORATION OUTCOMES

**Author(s):** Dr L Chang, Dr J Walshaw, Dr H Spence, Dr S Nazir, Mr A Wilkins  
**Institution:** Hull University Teaching Hospitals Trust (HUTH), Hull, United Kingdom

**Aims:** Common bile duct (CBD) stones affect approximately 10% of patients with gallstones with risks of cholangitis and pancreatitis. When ERCP fails or is unsuitable, laparoscopic or open common bile duct exploration (CBDE) can be performed. The aim of this study was to analyse the operative outcomes for laparoscopic CBDE (LCBDE).

**Methods:** All patients who underwent planned LCBDE for choledocholithiasis between May 2015 and August 2022 in a single centre were included. 65 patients were identified through theatre list records and data was collected retrospectively using electronic patient records.

**Results:** LCBDE approaches were transcholedochal (95.4%) and transcystic (4.6%). Intraoperative duct clearance rate of LCBDE was 94.7%. Conversion rate to open surgery was 9.2%. 30-day readmission rates were 15.3%, with 6 repeat ERCP and 3 re-laparoscopy for bile leaks. 90-day mortality was 0%.

**Conclusion:** LCBDE is effective with no mortality in this cohort. However, a significant number of complications occurred in the postoperative period. We acknowledge the limitations of a single-centre retrospective cohort and any patients who presented with complications outside the trust would be missed. The multicentre ALICE study results are awaited.

**Key statement:** LCBDE proves to be a technically challenging procedure and there is still limited data on the outcomes of this procedure. Despite this, LCBDE is an effective way to manage choledocholithiasis and can be performed at the same time as laparoscopic cholecystectomy allowing simultaneous management.

## P44

### ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY OUTCOMES IN A SINGLE-CENTRE COHORT FOLLOWING THE COVID-19 PANDEMIC

**Author(s):** Dr J Walshaw<sup>1</sup>, Dr E Dexter<sup>1</sup>, Mr A Wilkins<sup>1</sup>, Mr B Karki<sup>2</sup>, Mr P Sedman<sup>1</sup>  
**Institution:** <sup>1</sup>Hull University Teaching Hospital NHS Trust, Hull, United Kingdom  
<sup>2</sup>Leeds Teaching Hospital NHS Trust, Leeds, United Kingdom

**Aims:** Endoscopic retrograde cholangiopancreatography (ERCP) is a minimally invasive diagnostic and therapeutic procedure used in pancreaticobiliary diseases. It is generally considered safe however is associated with known risks, particularly in severe cases due to delayed presentation. This study aimed to assess ERCP outcomes in a single-centre cohort following the COVID-19 pandemic.

**Methods:** 100 adult patients who had ERCP performed for any indication between October 2021 and May 2022 were recruited retrospectively. Electronic records were used to identify procedure details and any subsequent complications or additional procedures required.

**Results:** The most frequent indication for ERCP was choledocholithiasis. Complications occurred in 11% of patients; bleeding (6%), perforation (4%), and pancreatitis (4%) rates were higher than anticipated. Additional procedures were required in 16% of cases, including external biliary drainage and surgical intervention. Repeat ERCP was indicated in 10% of cases.

**Conclusion:** Although generally considered a safe procedure, ERCP does not come without risks. This cohort included a large number of acute presentations and experienced higher complication rates compared to pre-pandemic results. Truly informed consent should reflect the outcomes of recent practice, including the potential impact of COVID-19 and associated treatment delays.

**Key statement:** Patients who are to undergo ERCP following the COVID-19 pandemic may be at an increased risk for ERCP-related complications compared to pre-pandemic outcomes and this should be used to guide informed consent.

## FREE PAPERS

**FP01**  
**LAPAROSCOPIC MANAGEMENT OF ACUTE SMALL BOWEL OBSTRUCTION IN NON-SELECTED PATIENTS: OUR 10-YEAR EXPERIENCE**  
 Miss N Petrou, Miss E Bonelli, Mr C Kontovounisios, Mr N Behar  
 Chelsea and Westminster Hospital, London, United Kingdom

**FP02**  
**COMPARISON OF OUTCOMES IN SURGICAL AND ENDOSCOPIC TRANSGASTRIC CYSTGASTROSTOMY FOR SEVERE ACUTE PANCREATITIS**  
 Miss P Mountjoy, Mr J Latif, Mr N Bandlamudi, Mr I Bhatti, Mr A Awan  
 Derby Pancreaticobiliary, Advanced Laparoscopic and Robotic Unit, Derby, United Kingdom

**FP03**  
**ROBOTIC MULTI-VISCERAL RESECTION (RMVR) FOR LOCALLY ADVANCED COLORECTAL CARCINOMA-SINGLE ONCO-SURGICAL CENTRE EXPERIENCE**  
 Dr C Lakmal, Professor CR Selvasakar  
 The Christie NHS Foundation Trust, Manchester, United Kingdom

**FP04**  
**ROBOTIC COLORECTAL SURGERY FOR COLORECTAL MALIGNANCY- EXPERIENCE OF FIRST 100 CASES IN A ONCO-SURGICAL CENTRE**  
 Dr C Lakmal, Professor CR Selvasakar  
 The Christie NHS Foundation Trust, Manchester, United Kingdom

**FP05**  
**TO ASSESS THE IMPACT OF AUGMENTED REALITY (AR) TRAINING ON IMPROVING LAPAROSCOPIC APPENDECTOMY USING OBJECTIVE PERFORMANCE METRICS**  
 Dr D Rawaf<sup>1,2</sup>, Dr J Toms<sup>3</sup>, Dr G Beghal<sup>3</sup>, Miss A Joynson<sup>1,4</sup>, Miss N Kaur<sup>1,4</sup>  
<sup>1</sup>Inovus Medical, St Helens, United Kingdom  
<sup>2</sup>Imperial College WHO CC, London, United Kingdom  
<sup>3</sup>ESTH, St Helier, United Kingdom, <sup>4</sup>Liverpool University, United Kingdom

**FP06**  
**OUTCOMES OF EMERGENCY LAPAROSCOPIC CHOLECYSTECTOMY IN THE ELDERLY: A RETROSPECTIVE 5-YEAR SINGLE-CENTRE EXPERIENCE**  
 Mr KW Ho, Dr R Al-Zubaidy, Ms F Soggiu, Mr H Sheth  
 Ealing Hospital, London North West University Healthcare NHS Trust, London, United Kingdom

**FP07**  
**FEASIBILITY OF LAPAROSCOPIC MULTI-VISCERAL RESECTION FOR LOCALLY ADVANCED COLORECTAL CANCER**  
 Mr AY Mohamedahmed<sup>1</sup>, Mr P Bhattacharya<sup>1</sup>, Mr S Zaman<sup>1</sup>  
 Mr A Ayeeni<sup>1</sup>, Mr A Akingboye<sup>2</sup>  
<sup>1</sup>Sandwell and West Birmingham NHS Trust, Birmingham, United Kingdom  
<sup>2</sup>The Dudley Group NHS Trust, Dudley, United Kingdom

**FP08**  
**FEASIBILITY OF LAPAROSCOPIC ADHESIOLYSIS FOR SMALL BOWEL OBSTRUCTION**  
 Dr LE Spyropoulou, Dr Y Hamza, Dr H Ubaide  
 Dr O Hadjicosta, Professor T Arulampalam  
 East Suffolk & North Essex NHS Trust, Colchester, United Kingdom

**FP09**  
**LONG-TERM OUTCOMES OF ROBOTIC RECTAL CANCER SURGERY A PROPENSITY SCORE MATCHED ANALYSIS OF DATA FROM AN EXPERT UK COLORECTAL CENTRE**  
 Dr R Duhoky<sup>1,2</sup>, Dr M Rutgers<sup>1</sup>, Mr S Stefan<sup>1</sup>  
 Mr F Sagias<sup>1</sup>, Professor J Khan<sup>1</sup>  
<sup>1</sup>Portsmouth Hospital University NHS Trust, United Kingdom  
<sup>2</sup>University of Portsmouth, United Kingdom

**FP10**  
**SINGLE-CENTRE, RETROSPECTIVE STUDY EVALUATING THE SHIFT FROM ROUTINE TO SELECTIVE DIVERSION OF LOW ANASTOMOSIS IN RECTAL CANCER SURGERY (KHANS TECHNIQUE)**  
 Dr R Duhoky, Dr M Rutgers, Dr D Nunes, Dr Y Adeluola, Professor J Khan  
 Queen Alexandra Hospital, Portsmouth, United Kingdom

## VIDEO OF DISTINCTION SESSION

**Video01**  
**ROBOTIC LOW ANTERIOR RESECTION FOR LOCALLY ADVANCED RECTAL CANCER**  
 Dr O Guest, Mr A Memon, Mr A Chukwuebuka, Mr M Zaheer, Mr N Sidiqi  
 University Hospital Dorset, Poole, United Kingdom

**Video02**  
**LAPAROSCOPIC INTRACORPOREAL MESH REPAIR OF LATERAL AND ANTERIOR ABDOMINAL WALL INCISIONAL HERNIAS**  
 Dr L Yao, Professor M Coleman  
 University Hospitals Plymouth, United Kingdom

**Video03**  
**VIDEO DEMONSTRATION OF ABDOMINAL LYMPHADENECTOMY IN A ROBOTICALLY ASSISTED OESOPHAGECTOMY**  
 Mr J Chmelo, Mr J Brown, Miss P Prasad, Mr M Navidi, Mr A Immanuel  
 Northern Oesophagogastric Unit, Newcastle upon Tyne, United Kingdom

**Video04**  
**ROBOTIC ASSISTED CHOLECYSTECTOMY AND COMMON BILE DUCT EXPLORATION FOR SINGLE STAGE MANAGEMENT OF COMPLEX GALLSTONE DISEASE**  
 Miss P Mountjoy, Mr J Latif, Mr N Bandlamudi, Mr I Bhatti, Mr A Awan  
 Derby Pancreaticobiliary, Advanced Laparoscopic and Robotic Unit, Derby, United Kingdom

**Video05**  
**MESH FIXATION TECHNIQUES IN TAPP REPAIR OF INGUINAL HERNIAS**  
 Mr R Salem, Mr A Khanna, Mr A Qureshi  
 Milton Keynes University Hospital NHS Foundation Trust, United Kingdom

## PARALLEL VIDEO SESSION

**Video01**  
**VIDEO DEMONSTRATION OF A ROBOTICALLY ASSISTED INSERTION OF A FEEDING JEJUNOSTOMY**  
 Mr J Brown, Mr J Chmelo, Miss P Prasad, Mr M Navidi, Mr A Immanuel  
 Northern Oesophagogastric Unit, Newcastle upon Tyne, United Kingdom

**Video02**  
**EMERGENCY LAPAROSCOPIC PARASTOMAL HERNIA REPAIR**  
 Mr A Butt, Mr J Natale, Mr TK Rajesh  
 University Hospitals Plymouth, United Kingdom

**Video03**  
**ROBOTIC TRANSABDOMINAL RETROMUSCULAR UMBILICAL PROSTHETIC (RTARUP) REPAIR FOR RECURRENT VENTRAL HERNIA**  
 Mr J Latif, Mr N Bandlamudi, Mr I Bhatti, Mr A Awan  
 Derby Pancreaticobiliary, Advanced Laparoscopic and Robotic Unit, Derby, United Kingdom

**Video04**  
**DEMONSTRATING A MINIMALLY-INVASIVE APPROACH TO OESOPHAGEAL LEIOMYOMA VIDEO-ASSISTED THORACIC SURGERY (VATS) EXTRA-MUCOSAL EXCISION**  
 Mr A Ammar, Mr J Chean Khun Ng, Mr P Leeder  
 University Hospitals of Derby and Burton NHS Trust Derby, United Kingdom

**Video05**  
**FLUORESCENCE IMAGE-GUIDED LAPAROSCOPIC CHOLECYSTECTOMY IN ALAGILLE SYNDROME**  
 Ms R Karmarkar, Mr S Aroori  
 University Hospitals Plymouth NHS Trust, United Kingdom

## POSTERS OF DISTINCTION

**Poster01 SAFELY SWITCHING FROM LAPAROSCOPIC WHILE PROSTATE CANCER SPECTRUM EVOLVES**  
Dr A Uthman<sup>1</sup>, Dr E Bass<sup>2</sup>, Dr J Jaipuria<sup>2</sup>  
Dr Muhammad-Kabir Ali<sup>2</sup>, Mr M Winkler<sup>2</sup>  
<sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom  
<sup>2</sup>Imperial College NHS Trust, London, United Kingdom

**Poster02 PREOPERATIVE IMAGING TO AVOID UNNECESSARY SURGERY FOR SUSPECTED ACUTE APPENDICITIS**  
Dr T Kenyon-Smith, Associate Professor H Kroon  
Dr G Nair, Dr J Virgin, Dr P Hollington  
Flinders University, Adelaide, Australia

**POSTER03 SHORT-COURSE INTRAVENOUS ANTIBIOTICS AFTER COMPLICATED APPENDICITIS IN SELECTED PATIENTS**  
Dr T Kenyon-Smith, Associate Professor H Kroon, Dr K Hidde  
Dr G Nair, Dr J Virgin, Dr P Hollington  
Flinders University, Adelaide, Australia

**Poster04 ROUTINE GROUP AND SAVE TESTING IS UNNECESSARY FOR ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY: AN AUDIT OF BLOOD TRANSFUSION IN LAPAROSCOPIC CHOLECYSTECTOMY**  
Mr I Blake<sup>1</sup>, Mr A Tandon<sup>2</sup>  
<sup>1</sup>Liverpool University Hospitals NHS Foundation Trust, United Kingdom  
<sup>2</sup>Warrington and Halton Hospitals NHS Foundation Trust, Warrington, United Kingdom

**Poster05 IDENTIFICATION OF GASTRIC CONDUIT PERFUSION DEFICITS WITH LAPAROSCOPIC LASER SPECKLE CONTRAST IMAGING**  
Dr JT Hoffman<sup>1,2,3,4</sup>, Dr WT Heeman<sup>1,2</sup>, D.J. Perle<sup>4</sup>, Dr EC Boerma<sup>4</sup>  
<sup>1</sup>University of Groningen, Leeuwarden, Netherlands  
<sup>2</sup>University Medical Centre Groningen, Netherlands  
<sup>3</sup>LIMIS Development, Leeuwarden, Netherlands  
<sup>4</sup>Medical Centre Leeuwarden, Netherlands

**Poster06 PARASTOMAL HERNIA REPAIR – 5 YEAR EXPERIENCE FROM A SINGLE CENTRE**  
Miss AA Thrikandiyur<sup>1</sup>, Miss C Reali<sup>2</sup>, Mr G Wynn<sup>3</sup>  
<sup>1</sup>James Cook University Hospital, Middlesbrough, United Kingdom  
<sup>2</sup>Yeovil Hospital, United Kingdom  
<sup>3</sup>Colchester General Hospital, United Kingdom

**Poster07 LAPAROSCOPIC VERSUS ROBOTIC APPROACH IN COLORECTAL CANCER. SINGLE CENTRE COMPARATIVE STUDY**  
Dr V Butnari, Ms S Momotaz, Mr B Boulton  
Mr J Huang, Mr N Rajendran  
Barking, Havering and Redbridge University Hospitals NHS Trust  
London, United Kingdom

**Poster08 EFFICACY OF UTILISING AN AUGMENTED REALITY LAPAROSCOPIC SIMULATOR FOR IMPROVING PERFORMANCE METRICS IN GENERAL SURGICAL TRAINEES**  
Mr M El-Bahnasawi<sup>1</sup>, Mr D Rawaf<sup>2</sup>, Mr E Street<sup>2</sup>  
Mr J Van Flute<sup>3</sup>, Professor P Luthra<sup>4</sup>  
<sup>1</sup>Wythenshawe Hospital, MFT, Manchester, United Kingdom  
<sup>2</sup>Inovus Medical, Manchester, United Kingdom  
<sup>3</sup>Inovus Medical, Manchester, United Kingdom  
<sup>4</sup>Edge Hill University, Liverpool, United Kingdom

**Poster09 LAPAROSCOPIC MAGNETIC SPHINCTER AUGMENTATION WITH THE LINX® DEVICE FOR MANAGEMENT OF GASTRO-OESOPHAGEAL REFLUX DISEASE: A 10-YEAR EXPERIENCE AND SAFETY PERSPECTIVE**  
Miss S Bezzaa, Miss C Clements, Mr D Nehra  
Epsom & St Helier University Hospitals, London, United Kingdom

**Poster10 USE OF EXTRACORPOREAL KNOT-TYING IN LAPAROSCOPIC SURGERY: A REFLECTION AND SURVEY OF CURRENT PRACTICE AND TRAINING**  
Dr B Amini<sup>2</sup>, Dr NA Kader<sup>1,2</sup>, Ms TEM Morrison<sup>1,2</sup>  
Ms J Bradley-Hendricks<sup>1</sup>, Ms JB Reed<sup>1</sup>  
<sup>1</sup>Colchester General Hospital, Essex, United Kingdom  
<sup>2</sup>Association of Laparoscopic Surgeons of Great Britain and Ireland Academy, London, United Kingdom

## POSTER MONITORS

**P01 ULTRASOUND SCANNING OF PATIENTS WITH SUSPECTED ACUTE CHOLECYSTITIS: THE SOONER THE BETTER**  
Dr I Moutsos<sup>1,2</sup>, Mr R Lunevicius<sup>3</sup>  
<sup>1</sup>401 General Military Hospital of Athens, Greece  
<sup>2</sup>University of Edinburgh, United Kingdom  
<sup>3</sup>Liverpool University Hospitals NHS Foundation Trust, United Kingdom

**P02 POST-OPERATIVE MANAGEMENT OF SMALL BOWEL OBSTRUCTION (SBO) AT ADDENBROOKE'S HOSPITAL, CAMBRIDGE**  
Dr Y Hirayama<sup>1</sup>, Mr PG Nagappan<sup>2</sup>, Dr N Dai<sup>1</sup>  
<sup>1</sup>Addenbrooke's Hospital, Cambridge, United Kingdom  
<sup>2</sup>Cambridge University Clinical School, United Kingdom

**P03 THE IMPACT OF TELEPHONE CONSULTATIONS ON CLINIC DID NOT ATTEND RATES, THE ENVIRONMENT AND HEALTHCARE SAVINGS**  
Miss A Winarski, Miss E Ross, Miss A Ng, Miss G Lim, Mr A Gilliam  
Darlington Memorial, Darlington, United Kingdom

**P04 PERCUTANEOUS CHOLECYSTOSTOMY AS A BAIL-OUT OPTION IN CURRENT ERA: A RETROSPECTIVE REVIEW FROM A DGH**  
Mr MI Hussain<sup>1</sup>, Mr A Sultan<sup>2</sup>, Mr S Banerjee<sup>3</sup>  
Mr P Bhattacharya<sup>4</sup>, Mr C Sellahewa<sup>2</sup>  
<sup>1</sup>Portsmouth Hospital University NHS Trust, Portsmouth, United Kingdom  
<sup>2</sup>The Dudley Group NHS Foundation Trust, United Kingdom  
<sup>3</sup>Manchester Royal Infirmary United Kingdom  
<sup>4</sup>Sandwell and City Hospital, Birmingham, United Kingdom

**P05 LAPAROSCOPIC MANAGEMENT OF PERITONITIS WITH SMALL BOWEL PERFORATION CAUSED BY A FISH BONE**  
Dr M Hasan, Professor SA Chowdhury  
Jalalabad Ragib-Rabeya Medical College, Sylhet, Bangladesh

**P06 THE USE OF AUGMENTED REALITY SIMULATORS IN LAPAROSCOPIC SURGICAL TRAINING**  
Dr D Rawaf<sup>1,2</sup>, Miss C Ludick<sup>3</sup>, Dr E Street<sup>1</sup>, Dr A Ormurtag<sup>3</sup>, Mr J Van Flute<sup>1</sup>  
<sup>1</sup>Inovus Medical, St Helens, United Kingdom  
<sup>2</sup>Imperial College WHO CC, London, United Kingdom  
<sup>3</sup>NTU, Nottingham, United Kingdom

**P07 EVALUATION OF OUR "HOT GALLBLADDER" SERVICE: DESIGNING THE SAFE MANAGEMENT OF ACUTE CHOLECYSTITIS IN THE NHS**  
Mr N Ali  
Yeovil District Hospital NHS Trust, Yeovil, United Kingdom

**P08 JOINING FORCES: A COLORECTAL-GYNAECOLOGY ADVANCED LAPAROSCOPIC SKILLS COURSE**  
Miss L Rimmer, Miss Li Lim, Mr F Akram, Mr K Siddique  
Northern Care Alliance, Oldham, United Kingdom

**P09 AN UNWELCOME 'NOVEL BREAKTHROUGH' FOR GASTRIC BANDS**  
Mr J Banks<sup>1,2</sup>, Ms H Younus<sup>1</sup>, Mr H Malik<sup>1</sup>, Mr A Goralczyk<sup>1</sup>  
<sup>1</sup>Homerton University Hospital, London, United Kingdom  
<sup>2</sup>Royal London Hospital, United Kingdom

**P10 MORE THAN JUST A TAN, ACQUISITIONS FROM OVERSEAS OPERATIONS**  
Mr J Banks<sup>1,2</sup>, Ms H Younus<sup>1</sup>, Ms A Siddika<sup>1</sup>  
<sup>1</sup>Homerton University Hospital, London, United Kingdom  
<sup>2</sup>Royal London Hospital, United Kingdom

**P11 A COMPARATIVE ANALYSIS TO ASSESS THE CONCORDANCE BETWEEN RADIOLOGICAL REPORTING AND FINAL HISTOPATHOLOGY FOR COLORECTAL CANCER IN AN NHS TRUST**  
Mr O Olatunbode, Dr K Mathew, Mr F Rahman-Casans  
County Durham and Darlington Foundation Trust  
Darlington, United Kingdom

**P12 A SINGLE CENTRE EXPERIENCE OF LAPAROSCOPIC PARTIAL FUNDOPPLICATION FOR GORD**  
Dr R AL-Zubaidy, Dr M Sheikh, Mr D Raje, Mr H Sheth, Mr N Pore  
Ealing Hospital, London, United Kingdom

**P13 STANDARDIZED APPROACH IN LAPAROSCOPIC COLORECTAL SURGERY: SHORT TERM OUTCOMES OF OVER 100 CASES**

Mr MU Rehman, Mr FA Khan, Miss S Kim, Mr A Jamil, Mr T Nasir  
Northampton General Hospital, United Kingdom

**P14 DIGITAL SURGICAL CONFERENCES DURING COVID-19 PANDEMIC: NEWER CHALLENGES & OPPORTUNITIES**

Dr S Easwaramoorthy, Dr A Easwaramoorthy, Dr J Yasmine, Dr C Sakthivel  
Lotus Hospital, Erode, India

**P15 STRANGULATED PENIS IN A PRISONER: COMPLETE PENILE DEGLOWING AND FULL THICKNESS SKIN GRAFT: A CASE REPORT**

Dr A Uthman<sup>1</sup>, Dr Ibrahim Eid<sup>2</sup>  
<sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom  
<sup>2</sup>Elmenshawey Hospital, Egypt

**P16 A REVIEW OF ACCESS TO SUTURING TEACHING IN UNDERGRADUATE MEDICAL EDUCATION**

Dr N Badat  
Bradford Teaching Hospitals Foundation Trust, Bradford, United Kingdom

**P17 A SINGLE CENTRES' EXPERIENCE ON MANAGEMENT AND OUTCOMES OF GALL BLADDER CANCER (GBC) OVER TWENTY YEARS**

Dr J Xiang, Mr S Bodla, Mr T Athwal, Mr C Cheruvu  
Royal Stoke University Hospital, Stoke on Trent, United Kingdom

**P18 LEVEL OF HARM OF COVID-19-SARS PANDEMIC ON PHYSICIANS' LIVES AND CAREERS. A MULTINATIONAL CROSS-SECTIONAL COHORT STUDY**

Dr med M Galanis<sup>1</sup>, Mr C Parmar<sup>2</sup>, MD AH Bangash<sup>3</sup>  
Professor YKS Viswanath<sup>4</sup>  
<sup>1</sup>Inselspital Bern, Bern, Switzerland  
<sup>2</sup>Whittington Hospital, London, United Kingdom  
<sup>3</sup>STMU Shifa College of Medicine, Islamabad, Pakistan  
<sup>4</sup>The James Cook University Hospital, Middlesbrough, United Kingdom

**P19 IMPACT OF COVID-19 AND LEVEL OF HARM IN PATIENTS WITH ESOPHAGEAL CANCER FOR THE PERIOD 04.2020-03.2021**

Dr med M Galanis<sup>1</sup>, Dr F Di Maggio<sup>2</sup>, Dr JH Herrera Kok<sup>3</sup>, Dr W Yang<sup>4</sup>,  
Professor YKS Viswanath<sup>5</sup>  
<sup>1</sup>Inselspital Bern, Bern, Switzerland, <sup>2</sup>Barking Havering and Redbridge  
University Hospital NHS Trust, Romford, United Kingdom  
<sup>3</sup>Complejo Asistencial Universitario de León, Leon, Spain  
<sup>4</sup>The First Affiliated Hospital of Jinan University, Guangzhou, China  
<sup>5</sup>The James Cook University Hospital, Middlesbrough, United Kingdom

**P20 A NEW DIAGNOSTIC TOOL FOR COMPREHENSIVE CLASSIFICATION OF ACUTE APPENDICITIS: MULTIVARIATE ANALYSIS OF LABORATORY PROGNOSTIC FACTORS**

Dr B Afzal, Dr G Ghahani, Dr J Fung, Dr A Dawani  
Oxford University Hospital, United Kingdom

**P21 ARE ANTIBIOTICS REQUIRED? AN AUDIT ON ANTIBIOTIC USAGE FOR PATIENTS UNDERGOING EMERGENCY APPENDICECTOMY**

Ms R Khaw<sup>1</sup>, Mr J Russ<sup>2</sup>, Mr K Khan<sup>2</sup>, Mr C Emmett<sup>1</sup>  
<sup>1</sup>Northumbria Healthcare NHS Foundation Trust  
Newcastle-Upon-Tyne, United Kingdom  
<sup>2</sup>County Durham and Darlington NHS Foundation Trust  
Durham, United Kingdom

**P22 STREAMLINING ACCESS TO URGENT ABDOMINAL ULTRASOUND ASSESSMENT REDUCES PATIENT WAIT TIMES IN A SURGICAL ASSESSMENT UNIT**

Dr M Gowell, Mr A Walsh  
Gloucestershire Royal Hospital, Gloucester, United Kingdom

**P23 CONSENTING FOR THE RISK OF COVID-19: OUR EXPERIENCE IN A DISTRICT GENERAL HOSPITAL**

Dr A Rahman, Dr M Badawi, Dr M Swamad, Dr M Koundu, Mr H Wilmott  
East Sussex Healthcare NHS Trust, Saint Leonards-on-sea, United Kingdom

**P24 PERSISTENT GLANS ISCHEMIA AND TISSUE LOSS AFTER INFLATABLE PENILE PROSTHESIS EXPLANTATION: A CASE REPORT AND LITERATURE REVIEW**

Dr A Uthman, Mr A Shanahan, Professor G Brown  
Cwm Taf Morgannwg University Health Board, Wales, United Kingdom

**P25 URACHAL ADENOCARCINOMA MANAGED WITH TRANSURETHRAL RESECTION**

Dr A Uthman<sup>1</sup>, Dr C Khoo<sup>2</sup>, Dr N Taylor<sup>2</sup>, Dr E Bolton<sup>2</sup>  
<sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom  
<sup>2</sup>Imperial College Healthcare NHS Trust, London, United Kingdom

**P26 URACHAL CANCER: EXPERIENCE OF A HIGH-VOLUME BLADDER CANCER CENTRE**

Dr A Uthman<sup>1</sup>, Dr C Khoo<sup>2</sup>, Dr N Taylor<sup>2</sup>, Dr E Bolton<sup>2</sup>  
<sup>1</sup>Cwm Taf Morgannwg University Health Board, Wales, United Kingdom  
<sup>2</sup>Imperial College Healthcare NHS Trust, London, United Kingdom

**P27 IMPROVING THE MANAGEMENT OF PATIENTS PRESENTING WITH SYMPTOMATIC GALLSTONE DISEASE THROUGH THE SURGICAL AMBULATORY UNIT IN AN NHS TRUST**

Mr O Olatunbode, Dr S Al-Ani, Dr R Gill, Mr A Mitchell  
County Durham and Darlington NHS Trust, Darlington, United Kingdom

**P28 EFFECTIVENESS OF STRAIGHT TO TEST (STT) PATHWAY FOR 2 WEEKS WAIT COLORECTAL REFERRALS DURING COVID AND ITS COMPARISON WITH PRE-COVID**

Miss S Kudachadkar<sup>1,2</sup>, Dr A Rai<sup>2</sup>, Dr A Mahmood<sup>2</sup>, Miss K Brown<sup>2</sup>  
<sup>1</sup>St. Richard's Hospital, Chichester, United Kingdom  
<sup>2</sup>Luton and Dunstable Hospital, Luton, United Kingdom

**P29 AUDIT ON TIMING OF LAPAROSCOPIC CHOLECYSTECTOMY FOLLOWING INDEX ADMISSION WITH GALLSTONE PANCREATITIS**

Dr K Das, Dr H Wright, Mr J Latif, Mr I Bhatti, Mr A Awan  
University Hospitals of Derby & Burton NHS Foundation Trust  
Derby, United Kingdom

**P30 CAUSES OF BILE DUCT INJURIES DURING LAPAROSCOPIC CHOLECYSTECTOMIES**

Dr A Jindal, Ms. A Fernandez, Ms. F Soomro  
Mr C Schneider, Mr P Srinivasan  
King's College Hospital, London, United Kingdom

**P31 TRANSANAL MINIMALLY INVASIVE SURGERY AT CUMBERLAND INFIRMARY, CARLISLE EARLY EXPERIENCE OF DISTRICT HOSPITAL**

Dr B Mohamed<sup>1</sup>, Mr M Aung<sup>1</sup>, Mr A Mohammed<sup>1</sup>  
Mr M Mohamed<sup>1</sup>, Mr M Edilbe<sup>2</sup>  
<sup>1</sup>Cumberland Infirmary, Carlisle, United Kingdom  
<sup>2</sup>Cumberland Infirmary, Hospital Accommodation  
Carlisle, United Kingdom

**P32 MYCOTIC AORTIC INFECTION, CASE SERIES AT CUMBERLAND INFIRMARY LIVERMORE REVIEW PRESENTATION AND MANAGEMENT OPTIONS**

Mr B Mohamed, Mr P Djinba, Mr T Barakat, Miss M Cusso, Mr R Eifell  
Cumberland Infirmary, Hospital Accommodation  
Carlisle, United Kingdom

**P33 TUBOGRAM, USEFUL INVESTIGATION FOR ASSESSMENT CHOLECYSTOSTOMY DRAIN PATIENT, SINGLE CENTRE EXPERIENCE**

Mr B Mohamed, Mr A Mohammed, Mr M Mohamed, Professor R Canelo  
Cumberland Infirmary, Carlisle, United Kingdom

**P34 ROLE OF ELECTRONIC CONSENT IN EMERGENCY SURGERY A QIP IN A HIGH VOLUME SURGICAL EMERGENCY UNIT AT A TERTIARY HOSPITAL**

Miss A Sharmin, Dr V Loyala, Miss O Shams, Mr G Bond-Smith  
Oxford University Hospitals NHS Foundation Trust  
Oxford, United Kingdom

**P35 USING MIXED FIDELITY SIMULATION TO MAXIMISE BASIC LAPAROSCOPIC SKILLS TRAINING AND STUDENT'S CONFIDENCE**

Mr M Harris<sup>1</sup>, Mr D Rawaf<sup>2</sup>, Mr E Street<sup>2</sup>, Mr J Van Flue<sup>2</sup>  
<sup>1</sup>Leighton Hospital, Crewe, United Kingdom  
<sup>2</sup>Innovus Medical, St Helens, United Kingdom

**P36 EMERGENCY MANAGEMENT OF SPONTANEOUS HYPERINFLATION OF INTRAGASTRIC BALLOON**

Dr J Rayer, Mr A Currie, Mr M Mason, Mr H Noble, Mr D Mahon  
Somerset NHS Foundation Trust, Taunton, United Kingdom



**P37 LAPAROSCOPIC CONVERSION FROM GASTRIC BYPASS TO SLEEVE GASTRECTOMY. OVERCOMING THE CHALLENGE**Dr E Dexter<sup>1</sup>, Dr J Walshaw<sup>1</sup>, Mr M Gouda<sup>2</sup>, Mr S Dexter<sup>2</sup><sup>1</sup>Hull University Teaching Hospitals, Hull, United Kingdom<sup>2</sup>Leeds Teaching Hospitals, Leeds, United Kingdom**P38 THE NECESSITY OF ROUTINE PREOPERATIVE 'GROUP AND SAVE' SAMPLES IN EMERGENCY LAPAROSCOPIC APPENDICECTOMY**

Dr R Govindaraju, Dr YT Yap, Dr J Walshaw

Dr M Suntharamoorthy, Mr A Wilkins

Hull University Teaching Hospital NHS Trust, United Kingdom

**P39 THE NECESSITY OF ROUTINE PREOPERATIVE 'GROUP AND SAVE' SAMPLES IN EMERGENCY AND ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY**

Dr J Agbo, Dr YT Yap, Dr M Sunthara-Moorthy

Dr M Quaanine, Dr J Walshaw, Mr A Wilkins

Hull University Teaching Hospital, NHS Trust, Hull, United Kingdom

**P40 EMERGENCY LAPAROSCOPIC APPENDICECTOMY CONVERSION RATE AND POSTOPERATIVE OUTCOMES IN A SINGLE CENTRE TEACHING HOSPITAL**

Dr YT Yap, Dr R Govindaraju, Dr M Sunthara-Moorthy

Dr J Walshaw, Mr A Wilkins

Hull University Teaching Hospitals NHS Trust, Hull, United Kingdom

**P41 IS THERE A VALUE OF CARCINO EMBRYONIC ANTIGEN IN REGULAR SURVEILLANCE OF PATIENTS WITH RECTAL CANCER?**

Mr A Bavikatte, Dr V Vashist, Dr NS Keshavmurthy

Mrs J Olugbemi, Mr J Alberts, Mr N Ward, Mr N Keeling

West Suffolk Hospital NHS Trust, Bury Saint Edmunds, United Kingdom

**P42 FILTER: A PROSPECTIVE COHORT STUDY OF FUNCTIONAL AND IMMUNOLOGICAL OUTCOMES AFTER LAPAROSCOPIC AND ROBOTIC TOTAL MESO-RECTAL EXCISION FOR RECTAL CANCER**

Dr R Duhoky, Ms Al Qureshi, Dr RJ Pires, Mrs E Hawes, Professor J Khan

Portsmouth Hospitals University NHS Trust, Portsmouth, United Kingdom

**P43 A RETROSPECTIVE 7-YEAR SINGLE CENTRE STUDY OF LAPAROSCOPIC COMMON BILE DUCT EXPLORATION OUTCOMES**

Dr L Chang, Dr J Walshaw, Dr H Spence, Dr S Nazir, Mr A Wilkins

Hull University Teaching Hospitals Trust (HUTH), Hull, United Kingdom

**P44 ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY OUTCOMES IN A SINGLE-CENTRE COHORT FOLLOWING THE COVID-19 PANDEMIC**Dr J Walshaw<sup>1</sup>, Dr E Dexter<sup>1</sup>, Mr A Wilkins<sup>1</sup>, Mr B Karki<sup>2</sup>, Mr P Sedman<sup>1</sup><sup>1</sup>Hull University Teaching Hospital NHS Trust, Hull, United Kingdom<sup>2</sup>Leeds Teaching Hospital NHS Trust, Leeds, United Kingdom



PARTNERS 2022/2023

PLATINUM



GOLD



SILVER

