**O61 HEALTH IMPLICATIONS OF LATE CHOLECYSTECTOMY IN ACUTE GALLSTONE DISEASE**

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**Introduction:** Laparoscopic cholecystectomy is the definitive treatment for gallstone-related disease. Recommendations for timing of cholecystectomy for acute gallstones range from expert opinion to Cochrane Reviews. This report evaluated the management of gallstones at our hospital, and the impact upon patients' health.

**Method:** All cholecystectomies performed at the hospital between 2011-2012 and 2013-2014 were reviewed. Non-acute presentations were excluded. Parameters measured included symptomatic presentation (Biliary Colic, Acute Cholecystitis, Gallstone Pancreatitis and Obstructive Jaundice), cholecystectomy timing, gallstone-related complications, and duration of hospital stay.

**Result:** In total 105 cholecystectomies were performed. 7% were within the timeframe of a recommended early cholecystectomy (EC). More than a third of patients (39%) undergoing a late cholecystectomy (LC) experienced complications during the interim period. Readmission to A&E for gallstone-related symptoms accounted for 66% (25 patients) of these complications, of which 7 patients had ≥2 readmissions. 44% of patients reported reoccurrence of symptoms at outpatient clinic, and overall 10% of patients experienced complications both through readmission and at clinic. In total, the mean hospital stay for EC versus LC patients was 6 vs 10 days. The mean additional inpatient stay for LC readmission was 8.6 days. Post-operative stay was 2.1 vs 2.5 days (EC vs LC). CONCLUSION: Delayed cholecystectomy is associated with high reoccurrences of gallstone-related complications. Readmission to hospital incurs subsequent inpatient stay and investigations. Interestingly, LC patients post-operative stay is comparable to that of EC patients. Overall, this has a substantial negative impact on patients' health and places additional financial burden upon the hospital from initial diagnosis to definitive treatment.

**Take-home message:**
Delayed cholecystectomy is associated with high reoccurrences of gallstone-related complications. Overall, this has a substantial negative impact on patients' health and places additional financial burden upon the hospital from initial diagnosis to definitive treatment.

**O62 LAPAROSCOPIC CHOLECYSTECTOMY IN OBESE PATIENTS**

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**Introduction:** Laparoscopic cholecystectomy is the treatment of choice for gallstones. Obesity was initially considered a contraindication to this approach. Our aim was to review laparoscopic cholecystectomy in obese patients, to evaluate the role of BMI in the outcome.

**Method:** We carried out a prospective analysis of 383 patients who had a laparoscopic cholecystectomy in 2013-2014 in a district general hospital. A pro-forma was completed using Microsoft Excel for each patient documenting their demographics, pre-morbid condition, BMI, ASA grade, length of surgery, intra-operative and post operative complications and length of stay in hospital.

**Result:** 383 patients were analysed: 54% (205) were female and 46% (178) were male with a mean age of 41 years. Of the 383 patients who underwent laparoscopic cholecystectomy, 44% (169), 26% (99), 18% (70) and 12% (45) had BMI values of < or =25.0-29.9, 30.0-34.9, 35.0-39.9 and > or =40 kg/m2, respectively. Conversion to open cholecystectomy rate was 0%. Mean operating time was 46.8 minutes. 91% (348) of cases were carried out on a day case basis. Readmission rate was 2.4% (9) and all were secondary to post-op pain.

**Conclusion:** Laparoscopic cholecystectomy is safe and effective in obese and morbidly obese patients.

**Take-home message:**
Laparoscopic cholecystectomy is safe and effective in obese and morbidly obese patients.

**O63 THE IMPACT OF OPEN COLECTOMY ON RESECTION OF COLORECTAL LIVER METASTASES**

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**Introduction:** Laparoscopic liver resection (LLR) is increasingly utilized in the management of patients with metastatic colorectal cancer. The aim of this study was to determine the impact of open vs. colonic resection of the primary tumour on outcomes following LLR.

**Method:** A prospectively maintained database was searched to identify all patients undergoing laparoscopic resection for colorectal liver metastases (CRLM) between 1/1/2007 and 31/12/2013. Demographic, histological, surgical outcome and survival data were collated retrospectively. Statistical analysis was performed using GraphPad Prism.

**Result:** A total of 71 patients (median age 66yr; 64% male) underwent resection in this study of whom 35 had a laparoscopic colectomy (LC). The presence of a previous open colectomy (OC) surgical morbidity (17% vs. 11%; p=0.53); conversion to open surgery (22% both groups; p=0.95); duration of surgery (240min vs. 285min; p=0.28); or length of hospital stay (5 vs. 6 days; p=0.98). Overall survival in this series was 47months with no difference between groups (p=0.58). Patients who underwent OC appeared to have a poorer recurrence free survival (8 vs. 21 months; p=0.03) although on multivariate analysis the only factor predictive of early recurrence was a node positive primary (OR 3.8; p=0.05).

**Conclusion:** In patients being considered for LLR for metastatic colorectal cancer the surgical approach to colectomy has no bearing on either short term surgical outcomes or longer term disease specific survival.

**Take-home message:**
The surgical approach to colectomy has no impact on outcomes following laparoscopic liver resection.
94.5% of patients had locally advanced tumours, the remainder had metastatic disease. Treated tumour size ranged from 1-7cm. IRE approach included open (70.3%), laparoscopic (2.7%) and percutaneous (27%; ultrasound-guided 30%, CT-guided 70%) Morbidity ranged from 0-33%; due to the high number of simultaneous procedures performed (resection/bypass) it was difficult to ascertain IRE-related complications. However no significant bleeding occurred when IRE-alone was performed. Survival statistics suggest a prognostic benefit. Reported survival included: 6 month survival of 40% (n=5) and 70% (n=14); PFS and OS 14 and 20 months respectively (n=54).

**Result:** Of most interest showed a significant survival benefit in matched IRE vs non-IRE groups (PFS 14 vs 6 mths; p=0.01, OS 20 vs 11 mths; p=0.03).

**Conclusion:** IRE for pancreatic cancer is still very much in its infancy; nonetheless initial evidence suggests prognostic benefit and minimal morbidity. More high quality research is required to determine the role IRE may play in the multimodal management of pancreatic cancers.

**Take-home message:** Irreversible electroporation is an emerging treatment modality for pancreatic cancer which incurs no thermal effect and hence reduces the risk of vascular or ductal injury. Initial evidence suggests a prognostic benefit with minimal morbidity.

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**O66 FINANCIAL IMPLICATIONS OF EARLY CHOCEYSTECTOMY FOR ACUTE GALLSTONE DISEASE**

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**Introduction:** Laparoscopic cholecystectomy is the definitive treatment for gallstone-related disease. Recommendations for timing of cholecystectomy for acute gallstones range from expert opinion to Cochrane Reviews. An audit at a University Hospital reviewed how the timing of cholecystectomy can impact on trust finances.

**Method:** All cholecystectomies performed at the University Hospital between 2011-2012 were reviewed. Non-acute presentations were excluded. Parameters measured included symptomatic presentation (Biliary Colic, Acute Cholecystitis, Gallstone Pancreatitis and Obstructive Jaundice), cholecystectomy timing, and repeat gallstone-related admissions. A reaudit was conducted 3 months after departmental changes. This included 2 additional upper GI consultants and weekly departmental meetings adding acute patients onto elective lists.

**Result:** 59 and 46 cholecystectomies occurred [preliminary results vs reaudit]. Initial rates of early cholecystectomy were low (5%), but increased to 9% (p=0.70) after with a significant reduction in the mean time between diagnosis and cholecystectomy [138±20.8 vs 78±9.7 days, p=0.0125]. More than a third of patients undergoing late cholecystectomy experienced complications during the interim [36% vs 43%]. Additional resources for these patients included hospital readmission [16 vs 17], inpatient bed days [82 vs 97], outpatient clinics [41 vs 21] and repeat imaging [25 v 22]. The cost of additional resources was £574 vs £831 per patient, correlating to additional cost of late cholecystectomy as 15% and 18.5% respectively.

**Conclusion:** Through departmental changes the hospital demonstrated a small improvement in the rates of early cholecystectomy. Delayed cholecystectomy is associated with the use of additional resources, and a substantial increase in trust costs.

**Take-home message:** Well planned early management of acute gallstones can be financially beneficial.

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**O67 THE ROLE OF ANTI-STROMAL POLYPHARMACY IN INCREASING SURVIVAL AFTER PANCREATICODUODENECTOMY FOR PANCREATIC DUCTAL ADENOCARCINOMA**

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**Introduction:** Stromal interactions play a large part in the dismal prognosis associated with pancreatic cancer. Recent studies have examined the potential use of common pharmaceuticals in targeting stromal interactions and improving prognosis.

**Method:** Data was collected retrospectively for 164 patients who underwent a pancreaticoduodenectomy for ductal adenocarcinoma. Survival analysis was performed on patients receiving the following medications in a variety of combinations; Aspirin, Calcium Channel Blockers (CCB), Angiotensin-Converting-Enzyme Inhibitors (ACEI)/Angiotensin II Receptor Blockers (ARB) and statins.

**Result:** No significant survival benefit was observed with respect to ACEI/ARB (n=41) or statins (n=39). However median survival was significantly higher in the CCB+Aspirin group (n=15) compared with the group taking neither drug (n=98); 1414 vs 601 days (P=0.029, log-rank test).
Univariate cox regression revealed those receiving CCB and Aspirin had a 51.5% lower risk of death as compared to the control group; HR 0.485 (CI=0.250-0.942, P=0.033). No significant survival benefit was observed in the CCB alone group (n=11); HR 1.215 (CI=0.627-2.353, P=0.564), whilst the Aspirin alone group (n=40) had an increased chance of death; HR 1.540 (CI=1.035-2.293, P=0.033). Multivariate cox regression analysis revealed neither Aspirin nor CCB had a statistically significant impact on survival when given alone, however in combination the survival benefit was significant; HR 0.332 (CI=0.126-0.870, P=0.025).

**Conclusion:** Aspirin and CCB given in combination significantly increases survival in patients with pancreatic cancer after pancreaticoduodenectomy. This highlights the potential clinical use of combination therapy to target stromal interactions in pancreatic cancer.

**Take-home message:**
The benefits of combination therapy, using common pharmaceuticals, in improving survival after a pancreaticoduodenectomy for ductal adenocarcinoma.

O68 WITHDRAWN