

Introduction: NICE clinical guideline development includes a review of available data on UK clinical practice with regard to the management of the disease under consideration. The purpose is to identify concerning variability or areas of controversy, and set the scene for focused guideline recommendations.

Aims: To assess the availability and quality of current clinical practice data on aspects of colorectal cancer management for the purpose of the recently developed NICE colorectal cancer clinical guideline.

Methods: Methods include online data mining, national database queries, and the observation of the NICE guideline development process through both membership of the guideline development group established to produce the recommendations, and the technical development team supporting its production.

Results: Results show that data regarding current clinical practice on colorectal cancer collected by national databases has methodological challenges and is not easily accessible. Despite encouraging initial assessment of feasibility, the lack of a timely result from the national databases as accessed through the lead cancer registry for colorectal cancer is disappointing, and it is an important finding in itself.

Conclusion: In conclusion, there is a responsibility to patients to ensure their data, which is routinely collected and stored, is appropriately accessible for research and aids the provision of answers to important clinical questions that could help improve their overall management. At present there is a huge expansion in national database systems. Funding, human resources and technical support are being diverted to this chronically neglected field of health management and this is a welcome improvement.

<http://dx.doi.org/10.1016/j.ejso.2015.08.126>

P22. The Bladder Cancer Pathway: An analysis of the time taken to treat in a local centre

Richard Simpson¹, Tony Elliott², Satish Maddineni¹

¹Salford Royal Foundation Trust, Salford, UK

²The Christie Hospital, Manchester, UK

Rationale: Several recent studies have shown that a delay in radical therapy by over 12 weeks from the diagnosis of a muscle invasive bladder cancer can worsen prognosis.

Aim: To identify at which points in the patient pathway delays occur from the time of diagnosis to radical therapy.

Methods: This study retrospectively audited two groups of patients; 25 consecutive patients undergoing either radical cystectomy or cystoprostatectomy over a 12-month period; and 25 consecutive patients receiving radical radiotherapy over a 48-month period. From these two groups a third group was made for patients who received neo-adjuvant chemotherapy. The time at which these patients received their first course of chemotherapy was taken as the date of radical therapy. Two patients were excluded due to incomplete data available. Data was collected from clinic letters and clinical notes.

Results: Of the 48 patients studied the median time from TURBT to receiving histological diagnosis of bladder cancer was 6 (4–9.25) days (median (IQR)). The time from TURBT to being reviewed in MDT was a median of 15 (9–18) days. Of the patient population 33% were seen in clinic post MDT solely by a surgeon, 23% solely by an oncologist, 13% in a joint uro-oncology clinic and 31% by both a surgeon and oncologist but in separate clinics. The time taken from MDT to radical therapy was a median of 51 (46–69) days for the surgical group; 32 (28–40) days XRT group; and 34.5 (30–45) days for the neo-adjuvant chemotherapy group. Subsequently the total time taken to treat with radical therapy from TURBT was 66 days for the surgical group, 47 days XRT group, and 49.5 days for neo-adjuvant chemotherapy.

Conclusions: The time taken to treat in this centre was within the standards suggested in the literature. However it was felt that this could be improved following identifying delays in the referral process to MDT and waiting times once listed for surgery.

<http://dx.doi.org/10.1016/j.ejso.2015.08.127>

P23. A quick ileostomy: Is it that quick?

Yahya Al-Abed, Darren Zurawel, Jessica Garner

Southend University Hospital, Southend, UK

Introduction: Defunctioning loop ileostomy has been used to divert faecal stream to protect low rectal anastomosis and to reduce the consequences of anastomotic leak following open as well as laparoscopic low anterior resection surgery. The majority of colorectal surgeons consider this easy to perform and associated with low morbidity. However, the formation and the reversal of loop ileostomies are underrated operations and are associated with considerable morbidity and mortality.

Methods: We have evaluated our practice in formation of defunctioning loop ileostomy in colorectal surgery by measuring the number of complications associated with defunctioning loop ileostomy. A retrospective analysis of prospectively collected data on all patients who had diversion loop ileostomy either as a 'primary' procedure or as a 'secondary' procedure as part of major low rectal anastomosis surgery was performed at our institution over a 5 year period; a total of 255 patients. Patient's data related to age, diagnosis, type of surgery, length of stay, stoma reversal, pre and post-surgery urea and electrolytes' measurements and stoma complications were collected and data were analysed.

Results: There was a complication rate of 27.6%, with obstruction, parastomal hernias, high stomal output, and procedure related complications being the most common occurring complications.

Conclusion: This study has demonstrated that formation and reversal of loop ileostomy is associated with considerable morbidity following surgery and a decision to perform a loop ileostomy needs to be balanced against the risks of anastomotic leakage. While defunctioning loop colostomy is considered more difficult to manage, the authors believe that it might be associated with less morbidity. A call for a randomised controlled trial is suggested to help answering this question.

<http://dx.doi.org/10.1016/j.ejso.2015.08.128>

P24. An analysis of non-sentinel node positivity in mastectomy and wide local excision after sentinel node biopsy: when could the axilla be spared?

Fahad Iqbal¹, Harriet Bell¹, Ibrahim Natalwala³, Megha Tandon², Lisette Hammond², Sankaran Narayanan², Soni Soumian², Robert Kirby²

¹University of Keele, Newcastle under Lyme, UK

²Royal Stoke University Hospital, Stoke on Trent, UK

³University Hospital Birmingham, Birmingham, UK

Introduction: Axillary nodal clearance (ANC) remains standard therapy in sentinel lymph node (SLN) positive patients. A high rate of negative non-SLN (nSLN) and low axillary recurrence rates have prompted a more conservative approach. We have assessed patients having ANC to see where this might have been safely avoided in SLN positive axillae.

Methods: Patients having ANC after positive SLNB between Feb 2013-Jun 2015 were analysed retrospectively.

Results: 89 patients had ANC & 1 was excluded, N = 88 (WLE n = 45, mastectomy n = 43).

Number of positive sentinel nodes	Mastectomy group (n = 43)	Patients with further nSLN (%)	WLE group (n = 45)	Patients with further nSLN (%)
Micrometastasis	6	3 (50)	7	1 (14.2)
1	21	12 (57.1)	29	5 (17.2)
2	12	10 (83.3)	8	4 (50)
3	3	3 (100)	1	0 (0)
4	1	1 (100)		

In the mastectomy group, 39/43 (90.6%) had ≤ 2 SLN involved. Of these 39, 25 (64.1%) had further positive axillary lymph nodes on ANC. In contrast, the WLE group had only 10 patients (22.7%) with further positive axillary lymph nodes on ANC. In the mastectomy group, 14/44 patients had more than 3 nodes involved in ANC. This information would have been missed if ANC had not been carried out.

Discussion: For patients having mastectomy, the axilla should be treated in SLN positive patients because of the high burden of positive nSLN. However, ANC could be foregone in WLE patients with 1 or 2 positive SLNs.

Conclusion: Some patients can avoid ANC after positive SLN.

<http://dx.doi.org/10.1016/j.ejso.2015.08.129>

P25. Margin re-excision is unnecessary when no ink on margins identified following breast conserving surgery

Rachael Johnson, H. Sawford, I. Laidlaw, R. Daoud, I. Karat, D. Egbeare
Frimley Park Hospital, Surrey, UK

Introduction: Acceptable microscopic margin width following breast conserving surgery varies between breast units. Recently in the US, consensus guidelines have stated that there is no evidence to support a significant difference in recurrence rates between margins with no ink or margins ≤ 1 mm. We sought to determine whether re-excisions following wide local excision have residual disease.

Methods: Wire-guided WLE for DCIS or invasive disease between July 2013 and December 2014 were identified. The presence of residual disease was determined in the re-excision specimens. Our unit re-excises with involved or close margins (DCIS ≤ 2 mm and invasive disease ≤ 1 mm).

Results: 198 WLE were performed. Of these, 50 underwent re-excisions with 30% containing residual disease. With DCIS, 23 underwent re-excision with residual disease found in 7 specimens, 6 of which had involved margins at the original surgery. Similarly, in invasive disease, of 27 re-excisions, residual disease was present in 8 specimens, of which 5 had had involved and 3 close margins.

Conclusion: With further disease found in the re-excision specimen 73% had an involved margin at original surgery. We suggest that it is less likely for there to be residual disease with clear margins and radiotherapy may be sufficient, avoiding the morbidity of re-excision.

<http://dx.doi.org/10.1016/j.ejso.2015.08.130>

P26. A systematic review of the oncological safety of breast lipo-filing

Umar Wazir^{1,2}, Abdul Kasem¹, Hannah Headon¹, Kefah Mokbel¹

¹London Breast Institute, London, UK

²Princess of Wales Hospital, Bridgend, UK

Background: Lipofilling is a reconstructive and aesthetic technique that has recently grown in popularity and is increasingly being used in

breast surgery. Concerns have been raised regarding its safety when used for remodelling and reconstruction of the breast.

Methods: We reviewed the current literature by systematically searching PubMed and Google Scholar databases regarding the current evidence regarding the oncological safety of the procedure in patients seeking aesthetic breast enhancement and in patients requiring oncoplastic reconstruction.

Results: Among the 864 patients included in the currently available studies on breast cancer patients who underwent lipofilling, only 14 (1.6%) recurrences were identified. However, evidence has emerged regarding the use of lipofilling in the background of ductal carcinoma in situ (DCIS).

Conclusions: Over the subsequent two decades, little evidence has been found to support these early theoretical concerns, and growing numbers of proponents of the procedure are confident in its safety. Further study is required to better delineate the effect of lipofilling on DCIS.

<http://dx.doi.org/10.1016/j.ejso.2015.08.131>

P27. Multidisciplinary meeting and mastectomy making decisions

Meera Joshi, Anne-Marie Acheson, Ibrahim Ahmed, Abdul Kasem
Medway Maritime Hospital, Gillingham, UK

Introduction: 1/3 of women with early breast cancer are treated with mastectomy. There are concerns about over treatment and marked regional variations in procedures. Our breast unit protocol is to perform a mastectomy in patients with breast cancer if the disease is; multicentric Ductal Carcinoma in Situ (DCIS), extensive DCIS >4 cm unless breast size will permit an attempted breast conserving surgery (BCS), multicentric Invasive carcinoma, margins <2 mm when re-excision is not possible, recurrence and patient choice.

Aim: To investigate the mastectomy-making decision process and review adherence to local guidelines.

Methods: A retrospective study at Medway Hospital between 01/01/2014-30/12/2014 of breast cancer patients undergoing mastectomy. Data collection included clinic letters, radiology, MDM discussions and pathology.

Results: 277 patients with breast cancer required surgical treatment. 84 patients had mastectomy (31%). The mean age was 67 years (43–94). 80 patients had a mastectomy as a primary procedure after initial diagnosis of breast cancer. The most common indications for primary mastectomy were; Large Tumour >4 cm (21%), multicentric tumour (17%) and recurrence (12%). Other indications were; patient choice (11%), skin involvement, location, local control (10%), tumour distorting the areola-nipple complex (7%), extensive microcalcification (5%), patient mobility problems (5%), large central tumour (4%), tumour in small breasts (3%) and large multifocal tumour (1%). Four patients had a mastectomy as a completion procedure after having BCS.

Conclusion: Tumour size, multicentric and recurrence of tumour were the main criteria for mastectomy making decisions. BCS margin resection involvement is the main indication for completion mastectomy. The criteria for mastectomy have not changed. The rate of mastectomy has remained similar despite early diagnosis of breast cancer in the recent years.

<http://dx.doi.org/10.1016/j.ejso.2015.08.132>

P28. Audit: Assessment of the nodal burden and outcomes for malignant melanoma patients with loco-regional recurrence in a local DGH

Christopher Moseley, Veronika Pronisceva, Elizabeth Sharp
QEQM Hospital, EKHUFT, Margate, UK

Introduction: Incidence of malignant melanoma is predicted to rise by 15% in 15 years. There are survival variations between cancer networks.