

Abstract OC-126 Table 1 Results

Outcome	VMMC (1)	Prepathway (2)	Nonpathway (3)	Pathway (4)	p Value
Pts 1st day mobilisation (%)	93	8.3	42	100	>0.99 (1 vs 4) <0.05 (2 vs 4) 0.16 (2 vs 3)
Complications (%)	47.3	75	75	33.3	0.53 (1 vs 4) <0.05 (2 vs 4)
ICU stay (days)	1 (0–22)	4 (2–20)	3 (2–9)	3 (1–5)	<0.05 (1 vs 4, 2 vs 4) 0.13 (2 vs 3)
Hospital stay (days)	8 (6–54)	17 (12–30)	13 (8–22)	7 (6–37)	0.25 (1 vs 4) <0.05 (2 vs 4) 0.09 (2 vs 3)

Methods Four groups were included in this study:

1. 74 patients operated on at VMMC (2009–2011).
2. 12 RSC patients operated on before the introduction of SPCP.
3. 12 RSC patients operated on after the introduction of SPCP but not included.
4. 12 RSC patients managed according to the SPCP.

Groups were compared with respect to patient demographics, peri- and post-operative outcomes.

Results Presenting demographics were similar in all groups with respect to BMI, medical co-morbidities, ASA grade and clinical stage. Age was significantly reduced Group 4 compared to Group 2 ($p < 0.05$). Following initiating SPCP the use of feeding jejunostomies increased (67%–100%; $p < 0.05$) as did immediate extubation (67%–100%; $p < 0.05$). Further statistically significant improvements were noted in complications, length of ICU and hospital stay. Group 3 also showed a less significant improvement in length of ICU and hospital stay, and first day mobilisation.

Conclusion The results of this study demonstrate the potential for accelerated improvement in short-term outcomes following oesophagectomy through the translocation and integration of standardised postoperative pathways. SPCP can also change hospital processes to improve outcomes in other patients. A multidisciplinary approach with involvement of the entire health care team in the design, implementation, evaluation and revision of these pathways is essential and will help ensure all team members are committed to achieving specific targeted pathway goals.

Competing interests None declared.

OC-127 ONE THOUSAND LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASSES: PERIOPERATIVE AND LONG TERM OUTCOMES

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Introduction Laparoscopic Roux-en-y gastric bypass (LRYGB) has been established as an effective treatment for obesity and obesity related morbidity. However, safety of LRYGB remains under public scrutiny. Defining operative outcomes is vital to establish its safety and long term efficacy.

Methods One thousand consecutive patients underwent LRYGB as a primary procedure by two surgeons in a single centre from 2004 to 2011. Twenty-six patients had intra-gastric balloon insertion before LRYGB to reduce Body Mass Index (BMI). LRYGB was done using a retrocolic, antegastric linear staple technique with routine closure of internal hernia defects. Patient demographics and complications were collected prospectively in a local database, and after January 2009, in the National Bariatric Surgery Registry. The Obesity Surgery Mortality Risk Score (OS-MRS) was used for risk stratification. Analysis was performed on each 100 patients making up 10 groups sequentially with the first 100 in group 1.

Results Mean age±SD was 45.5±10.4 with mean BMI of 49.5±7.7 and 79.3% were female. There were 61 (6.1%) high-risk patients (OS-MRS class C). The follow-up rate up to 6 years was 87.9%. There were four conversions-to-open surgery in the first 400 patients with no conversions thereafter. Mean % excess weight loss (EWL) pre-operatively as compared to initial weight was 11.6%±12.5. % EWL subsequently was: 1 year 67.7%±18.9; 2 years: 71.6%±20.3; 5 years: 57.5%±21.8; 6 years: 61.1%±21.4. Overall, the 30-day complication rate was 5.5% with a 30-day reoperation rate of 2.9%. The 30-day complication rate fell over time; 13 patients had a complication in group 1 compared to 1 patient in group 10 ($p = 0.03$). Further, there was significant reduction in complications between groups 1 and 2 ($p < 0.001$) but no difference between each group thereafter. Major complications within 30 days postoperatively were gastrointestinal leak (0.6%), gastro-jejunal stenosis (0.3%), stenosis at the mesocolic defect (0.3%), jejuno-jejunosomy hernia (0.7%), mesocolic hernia (1%) and bleeding (2.1%). There was one death (0.1%) within the 30 postoperative days (in group 2). The cumulative complication rate at 6 years was 9.1% with 5.8% needing re-operation or endoscopic intervention. The mean operative time per group for the first 600 patients was, in minutes, 163±53.7, 129.2±109.8, 100.0±27.8, 104.3±28.9, 92.7±32.1 and 93.8±30.9, a significant decrease between groups 1 and 2 ($p = 0.003$), 2 and 3 ($p = 0.007$), and 4 and 5 ($p = 0.008$) respectively, but not between 3 and 4.

Conclusion LRYGB is a safe and efficacious procedure with sustained weight loss at 6 years. The learning curve is about 100 cases but operative time continues to improve up to the 500th case. A high volume centre is associated with low morbidity and mortality.

Competing interests None declared.

OC-128 THE EFFECT OF OBESITY ON THE RADICALITY OF SUBTOTAL OESOPHAGECTOMY FOR OESOPHAGEAL ADENOCARCINOMA

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Introduction Obesity is on the increase in the UK and is a known risk factor for adenocarcinoma of the oesophagus. It is recognised that oesophagectomy in obese patients is more difficult with concerns that radicality of resection is reduced. The aims of this study were to evaluate body mass index (BMI) in patients with oesophageal adenocarcinoma who underwent subtotal oesophagectomy with radical lymphadenectomy and to evaluate the effect of obesity on lymph node (LN) dissection and survival.

Methods All patients who underwent subtotal oesophagectomy for adenocarcinoma between January 2000 and December 2010 were identified from a prospectively maintained database. All other histological types were excluded. Patients were categorised according to BMI using the WHO criteria: underweight (2), normal