

1 patients). The data was analysed and the difference stricture rates in current smokers and ex-smokers was found to be statistically significant (p-value 0.0002).

Conclusion Active smoking within six weeks of surgery is an independent extremely significant risk factor for anastomotic strictures following stomach to neck oesophagectomy.

THE EFFECT OF SMOKING ON ANASTOMOTIC STRICTURE RATES FOLLOWING OESOPHAGECTOMY

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Introduction Anastomotic stricture following oesophagectomy causes a significant morbidity and often necessitates repeated dilation or even revision surgery. Smoking has been identified as a cause of microvascular disease associated with ischaemia.

Aims/Background Previously identified as an independent cause of anastomotic stricture following colorectal surgery, this study assessed the effects of smoking on stricture rates following all stomach-to-neck type oesophagectomies in oesophageal cancer patients.

Method 66 sequential patients had oesophagectomy for oesophageal cancers by a single surgeon. Multiple cancer types were included in the analysis. All medical records were reviewed and a multivariate analysis was carried out to identify risk factors. Patients were divided into current smokers, smoking within six weeks of the surgery, ex-smokers, those with a significant smoking history, and non-smokers.

Results The rate of anastomotic strictures in current smokers was 52% (11 of 21 patients), in ex-smokers was 9% (4 of 44 patients), and in patients who had never smoked was 0% (0 of