Charlson Co-morbidity index (2.5±0.7 vs 2.3±0.6) were significantly increased in the delirium group. There were no significant differences between the groups in the use of neoadjuvant therapy. Analysis demonstrated that delirium was associated with a significantly longer hospital (14±7.5 vs 10.9±5.7 days) and ICU stay (3.6±3.8 vs 2.7±16.9 days). Furthermore post-operative delirium was associated with a significantly increased incidence of post-operative pneumonia (21.7% vs 7.9%), pneumothorax (10.9% vs 2.6%), re-intubation (10.9% vs 1.8%) and increased overall treatment costs ($28,223±13,018 vs $22,702±969; p<0.05). Age was the only pre-operative predictor of post-operative delirium in multivariate modelling (OR 1.08; 95% CI 1.04 to 1.12, p<0.05). This study demonstrates that delirium is a risk factor for complicated post-operative recovery and increased treatment costs following oesophagectomy, and furthermore that age is independently predictive of its development. Focused screening will allow early identification of at-risk patients, thus enabling more timely intervention which may prevent the detrimental consequences of delirium. Our data offers useful survival and 30-day mortality figures to help inform patients and make clinical management decisions.

Competing interests None declared.

REFERENCES

WHAT IS THE SURVIVAL OF PATIENTS WITH OESOPHAGEAL CANCER FOLLOWING PALLIATIVE STENTING?

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PWE-035 CENTRALISATION OF UPPER GI CANCER SERVICES—IS THE HUB REALLY BETTER THAN THE SPOKE?

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S Monkhouse,* J Torres-Grau, D Bawden, C Ross, R Krzyztopik. Upper GI Surgery, Royal United Hospital, Bath, UK

Introduction The aim of this study was to assess whether patients diagnosed with oesophageal or gastric cancer at a local district general hospital (the “spoke”) have a similar temporal pathway through the decision making and treatment process compared to those patients presenting at the centralised, tertiary hospital (the “hub”).

Methods Between April 2010 and April 2011, patients with a new diagnosis of oesophago-gastric cancer from both the hub and spoke hospitals were analysed. Data regarding diagnosis, time from diagnosis to multidisciplinary meeting (MDM) discussion and time from MDM decision to first treatment were all recorded. Statistical analysis was performed using parametric two-tailed t-test to assess significance.

Results There was a statistically significant increase in the time from diagnosis to MDM discussion at the spoke hospital compared to the hub (15.8 days vs +25.67 days; p=0.001). However, time to first treatment (surgery, palliative therapy, neo-adjuvant therapy or best supportive care) was significantly increased in the hub hospital compared to the spoke (43.4 days vs 25.5 days; p=0.025).

Conclusion This study is the first of its kind to show that there is a disparity in the management pathways of patients who first present to a regional hospital rather than the tertiary centre. Patients at the spoke hospital have a longer lead time into the MDM but non-operative treatment appears to be delivered more quickly locally.

Competing interests None declared.