18.5–24.99 kg/m²), overweight (25–29.99 kg/m²) and obese (≥30 kg/m²). Demographics, presence of Barrett’s oesophagus or reflux disease, operative time, R0 resections, complications, LN resection and positivity were analysed. Long-term and disease free survival were calculated using the Kaplan–Meier method.

**Results** 413 patients were identified. 25 had no BMI recorded and were excluded leaving 390 patients: eight underweight; 117 normal BMI; 172 overweight; 93 obese. BMI significantly increased over time (mean BMI 26.0 in 2000–2001, 27.3 in 2010, p=0.041). Obese patients were younger compared to normal BMI patients (mean age 60.1 and 64.4 respectively, p=0.003). The incidence of Barrett’s oesophagus and reflux disease were not significantly different between groups. Operating time was significantly longer for obese patients (p=0.018). R0 resections were similar between groups (normal patients 96.4% and obese 95.5%). The mean number of LNs resected (55 for both normal BMI and obese groups) and the LN ratio did not differ significantly between groups. Obese patients had significantly lower disease stages (52.3% stage 1 obese patients vs 16.2% stage 1 normal BMI patients, p=0.006). Overall survival was longer for obese patients compared with those of normal BMI (31 months vs 35 months, p=0.004). When matched for stage, this difference did not reach significance (p=0.236). Disease free survival did not differ between groups. The overall complication rate was similar between groups (70.1% for normal BMI; 66.8% for obese).

**Conclusion** This is the first study to evaluate BMI in a homogenous group of patients with adenocarcinoma undergoing subtotal oesophagectomy with a standardised radical lymphadenectomy. BMI and obesity among these patients increased with time. The radicality of surgery, in terms of LN yields and R0 resections, did not reduce in the obesity group and this is further supported by equivalent stage-matched long-term survival.

**Competing interests** None declared.

### REFERENCES


**OC-130**

**EMERGENCY CHOLECYSTECTOMY: AN ECONOMIC EVALUATION OF PRACTICE AT A REGIONAL HEPATOBILIARY CENTRE**

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N Misra,* V Kalyaperumal, N Grimes, R E McChesney, D Dunne, G Poston, S Fenwick, H Malik. 1North Western Hepatobiliary Centre, University Hospital Aintree, Liverpool, UK; 2University of Liverpool, Liverpool, UK

**Introduction** The debate as to how to best manage patients presenting acutely with complications of gallstones continues—whether to consider early emergency surgery or not. Perceptions of increased risk and greatly increased cost still persist about the early approach. We report on our experience from a regional hepatobiliary centre.

**Methods** A retrospective clinical study was conducted of all patients admitted with acute biliary symptoms, and who underwent cholecystectomy between January 2008 and August 2011. Costing data were calculated for each patient on an individual basis, including all theatre consumables, drugs and calculated cost for length of stay. A decision tree analysis economic model was created, using input data derived from the clinical study as well as the individual patient level costs, and uncertainty in this model tested with probabilistic sensitivity analyses. Categorical data were analysed using the χ² test.

**Results** Of the 1888 patients who had a cholecystectomy during this period, 89 had an emergency or early laparoscopic cholecystectomy (eLC) and 310 patients presented acutely with biliary disease and then went on to have a delayed cholecystectomy (dLC). Overall median length of stay (LoS) for the eLC group was 6 days, and for the delayed group was 7 days (p=NS), including the primary admission for medical treatment. The emergency readmission rate for all patients on the waiting list was 15% with a median stay of 4.5 days. Post-operative readmission rates were equivalent for both eLC (8%) and dLC (9%) (p=NS). Mean operating time was longer in the eLC group than the dLC group—120 min vs 60 min (p=0.05). Post operative ERCP rates were 5% for the eLC group and 0% for the dLC group (p=NS), post operative fluid collections requiring intervention were 6% for the eLC group as opposed to 0% for the dLC group (p=NS). The baseline cost difference between the eLC and dLC groups was around £150 more expensive for the eLC group. After complications and readmission costs were calculated and inputted into the decision tree analysis, this difference decreased to a cost of £52—more expensive for the eLC pathway.

**Conclusion** Early cholecystectomy on the index admission appears to be safe, with overall hospital stay slightly shorter. The difference in costs between the early and delayed pathway was essentially cost equivalent. But with NHS tariff (around £3650 for eLC and £2900 for dLC)