7 Minute Presentation & 3 Minute Discussion

1. **11.00** Simultaneous versus staged resection of rectal cancer with synchronous liver metastases
   **Angela Canas-Martinez**, Ben Creavin, Anna Heeney, Eanna Ryan, Emir Hoti, Donal Maguire, Justin Geoghegan, Sean Martin, Ronan O’Connell, Desmond Winter
   Centre for Colorectal Disease, St. Vincent’s University Hospital, Elm Park, Dublin, D04 T6F4, Ireland

2. **11.10** Surgical implications of de-functioning stomas; An unappreciated surgical issue?
   **Ronan Michael McKenna**, William Joyce
   Department of Surgery, Galway Clinic, Doughiska, Galway, Royal College of Surgeons Ireland, Galway, Ireland

3. **11.20** Ileoanal pouch anastomosis in Ireland - how to be better
   **Jack Horan**, Ronan Cahill, Ann Brannigan, Jurgen Mulsow, Conor Shields
   Department of Surgery, Mater Misericordiae University Hospital, Eccles Road, Dublin, D07 R2WY, Ireland

4. **11.30** The appropriateness of colonoscopy requests at University Hospital Limerick: A prospective study
   **Muhammad Fahad Ullah**, Muhammad Al Zarog, Rishab Sehgal, Kah Hoong Chang, John Calvin Coffey, Gerard Byrnes
   Department of Colorectal Surgery, University Hospital Limerick, St Nessan’s Road, Dooradoyle, Limerick, V94 F858, Ireland

5. **11.40** The impact of laparoscopic converted to open colectomy on short term and oncologic outcomes for colon cancer
   **Bhavesh Lakhwani¹**, Patrick Jordan², Emmet Andrews²
   ¹University College Cork, College Road, Cork, T12 K8AF, Ireland
   ²Department of Colorectal Surgery, Cork University Hospital, Wilton, Cork, Ireland

6. **11.50** Should routine bowel-prep for colonoscopy be adjusted according to body mass index (BMI)?
   **Brian Fahey¹**, Munyaradzi Nyandoro², Mary Teoh³, Alfredo Noches-Garcia⁴
   ¹Department of General Surgery, St John of God Murdoch Hospital, Perth, WA, Australia
   ²Department of General Surgery, Fiona Stanley Hospital, Perth, WA, Australia
   ³University of Notre Dame, Fremantle, Australia
   ⁴Department of General Surgery, Rockingham General Hospital, WA, Australia

7. **12.00** Twenty years of restorative proctocolectomy with ileal pouch anal anastomosis in Beaumont Hospital
   **Kevin McKevitt**, Paul Ryan, Deborah McNamara, Joseph Deasy, John Patrick Burke
   Department of Colorectal Surgery, Beaumont Hospital, Beaumont Road, Beaumont, Dublin, D09 FT51, Ireland
8. **12.10** Evaluation of the outcome of “telephone clinic” in the follow-up of surgical patients: Innovative use of technology for the convenience and improvement of service for patients

*Yasir Bashir*, Bernadette McGovern, Abidur Rehman, Paul Neary, Josh Olanyi, Josh Skeens, Tim Cronin,

1Department of Surgery Tallaght University Hospital, Tallaght, Dublin, Ireland

2Trinity College Dublin, Dublin, Ireland

9. **12.20** Evaluation of the effects of negative pressure dressings on wound complication rates following stoma reversal

*Patrick Jordan*, Catherine Cronin, Peter O’Leary, Fara Hassan, Shane Killeen, Morgan McCourt, Emmet Andrews

Department of Colorectal Surgery, Cork University Hospital, Wilton, Cork, Ireland

10. **12.30** Prognostic indicators effecting outcomes of neuromodulation in faecal incontinence – A single centre fifteen year experience

*Christopher Charles Kearsey*, Claire Fung, Joan Dowling, Helen Blackwell, Shakil Ahmed, Paul Carter

Department of Colorectal Surgery, Royal Liverpool and Broadgreen University Hospital Prescot Street, Liverpool, Merseyside, L7 8XP, United Kingdom

11. **12.40** Colonic stenting as a bridge to surgery in malignant large bowel obstruction: Oncological outcomes

*Noel Edward Donlon*, Michael Eamon Kelly, Paul Hugh Mc Cormick, Fady Narouz, John Larkin, Brian Mehigan

Department of Colorectal Surgery, St. James’ Hospital, James Street, Dublin, D03 VX82, Ireland

12. **12.50** Should surgical site infection wound bundles become mandatory in colorectal surgery? A meta-analysis

*Deirdre Foley*, Michael Sugrue, Madga Bucholc, Randal Parlour, Caroline McIntyre, Alison Johnston

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13. **13.00** Review of anal squamous cell carcinoma over seventeen years in a tertiary referral centre

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Department of Surgery, St James Hospital, St James Street, Dublin, D03 VX82, Ireland
AB035. 120. Simultaneous versus staged resection of rectal cancer with synchronous liver metastases

Angela Canas-Martinez, Ben Creavin, Anna Heeney, Eanna Ryan, Emir Hoti, Donal Maguire, Justin Geoghegan, Sean Martin, Ronan O’Connell, Desmond Winter

Centre for Colorectal Disease, St. Vincent's University Hospital, Dublin, Ireland

Background: Morbidity of rectal cancer surgery has led to apprehension in undertaking combined resections of synchronous rectal cancer and liver metastases. This study aims to review a single tertiary referral centre’s experience of simultaneous resection in rectal cancers with synchronous liver-only metastasis.

Methods: Patients with rectal cancer and liver-only metastases who underwent curative intent multimodal therapy were identified from prospectively maintained databases. Following complete staging and multidisciplinary team (MDT) discussion, patients were referred for neoadjuvant therapy, and reassessed 6–8 weeks post treatment for suitability for a simultaneous or staged resection. Outcomes were compared with patients undergoing staged rectum and liver resection. Short term outcomes consisted of 30-day mortality along with minor and major morbidity.

Results: Between January 2005 and July 2015, 39 simultaneous resections were included and compared with 50 staged resections. Minor complications were more common in the simultaneous group (9/39 simultaneous vs. 15/50 staged, P=0.47), while major complications were similar (11/39 simultaneous vs. 12/50 staged, P=0.65). Major liver resections did not influence overall (P=0.84) or major morbidity (P=0.82) in either group. Neoadjuvant radiotherapy did not significantly impact overall morbidity or severity thereof in the simultaneous (n=25, overall morbidity, P=0.99; severity of complication, P=0.49) or staged resection groups (n=39, overall morbidity, P=0.16; severity of complication, P=0.71). Thirty-day mortality was encountered in 1/39 simultaneous resections and 2/50 staged resections.

Conclusions: Simultaneous resection of rectal cancer and synchronous liver-only metastases is feasible in select patients, and facilitates both treatment of primary and metastatic disease in a single procedure with acceptable morbidity and mortality.

Keywords: Adenocarcinoma; hepectomy; neoplasm metastasis; proctectomy; rectal neoplasms

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AB036. 123. Surgical implications of de-functioning stomas—an unappreciated surgical issue?

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Background: Surgical implications following closure of de-functioning stomas remains a common surgical problem. Loop ileostomies are now thought to be the preferred surgical option with probable fewer complications to loop colostomy. However, few studies have shown such benefits.

Methods: We reviewed all stomas performed over a 10-year period from a single surgeon dedicated colo-rectal database. This resulted in the formation of a 109 stomas of which 52 were temporary loop colostomies.

Results: Forty-four of 52 (84.6%) of the temporary stomas were reversed over a period of 2–14 months (mean: 5.1, median: 3). No significant immediate post-operative complications occurred. At follow up over a period of 1 month to 10 years (median: 6 months), 6 of 44 (13.6%) reversed developed symptomatic incisional hernias. Three other stoma patients had incisional hernias seen on follow up CT but were clinically insignificant and asymptomatic.

Conclusions: Temporary loop colostomy is still a safe and effective method of de-functioning the large bowel and is associated with little morbidity and complications. It is also associated with fewer incisional hernias and other complications following closure when compared to closure of loop ileostomies.

Keywords: De-functioning; incisional hernia; stoma

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Cite this abstract as: McKenna RM, Joyce W. Surgical implications of de-functioning stomas—an unappreciated surgical issue? Mesentery Peritoneum 2019;3:AB036.
AB037. 132. Ileoanal pouch anastomosis in Ireland—how to be better

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Background: Ileal pouch-anal anastomosis (IPAA) restores bowel continuity for patients with ulcerative colitis (UC) who have needed total colectomy with end ileostomy. While recent international guidelines suggest best outcomes in centres performing over 10–20 IPAA operations annually, data related to procedural frequency and outcomes in Ireland are sparse.

Methods: First, an in-institution retrospective study from examining patient outcomes over a 16-year period (Jan 2002 to Jan 2018) was performed using data from our inflammatory bowel disease database, hospital in-patient enquiry (HIPE) codes and clinical chart review. Second, a registry and literature search regarding IPAA outcome studies in Ireland was undertaken to provide context.

Results: A total of 34 patients had IPAA for UC were identified (2.3 IPAA/year) and found to have had pouchitis and 10-year pouch failure rates of 52.9% and 17.6% respectively. No Irish centre contributes to the Association of Coloproctology of Great Britain and Ireland (ACPGBI) pouch registry. Three other centres have published studies reflecting annual experiences of between 3.8 and 8.2 IPAA/year with associated pouchitis rates of between 31% and 49%. None reported failure rates. Estimating national incidence of IPAA from catchment areas of these centres suggests annual pouch formation rates of approximately 50 operations per year in Ireland.

Conclusions: Ireland currently has no centre reporting long-term outcomes in any readily available fashion and none currently meeting international guidelines related to volume/frequency. Our data readily suggests ways that this could be advanced without significant resource implications opening opportunity for outcome improvements and trials but will likely need intergroup co-operation and collaboration to make real sense.

Keywords: ileal; pouch; surgery

doi: 10.21037/map.2019.AB037

AB038. 157. The appropriateness of colonoscopy requests at University Hospital Limerick: a prospective study

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Background: Waiting times for colonoscopies still exceed three months in the current economic climate within the health system. Furthermore, performing a colonoscopy carries an overall serious adverse event rate of 2.8 per 1,000 procedures. Therefore, it is imperative to perform such procedures on patients with appropriate clinical indications. One of the criteria for requesting colonoscopy was developed by the European Panel on the Appropriateness of Gastrointestinal Endoscopy (EPAGE) in 1999 and revised in 2008 (EPAGE II). The aim of this study was to assess the appropriateness of colonoscopy requests in an Irish tertiary referral centre.

Methods: One hundred consecutive colonoscopies were evaluated between April and August 2017. The endoscopist doing the procedure was blinded to the clinical indication for the procedure. Another clinician assessed the appropriateness of requests using the EPAGE II criteria encompassing four categories: (I) appropriate and necessary; (II) appropriate; (III) uncertain and (IV) inappropriate, and then data analysis was performed.

Results: Out of the 100 (male/female: 52/48, average overall age 58.05±16.47 years) colonoscopies performed, most referrals came from out-patient clinic (37%) followed by GP referrals (28%). Based on EPAGE II criteria, 25% referrals qualified as appropriate and necessary, 23% were appropriate, and 26% were inappropriate. The most common indications for an inappropriate colonoscopy in follow-up patients was untimely surveillance post polypectomy. The most common indications for an index colonoscopy was abdominal pain, bleeding PR and altered bowel habit.

Conclusions: The EPAGE II criteria can be utilized to avoid unnecessary, untimely and potentially hazardous colonoscopies. Such criteria can streamline resource allocation and service provision and provide timely access to lower GI-endoscopy.

Keywords: Colonoscopy; appropriateness; European panel on the appropriateness of gastrointestinal endoscopy (EPAGE II)

doi: 10.21037/map.2019.AB038
Cite this abstract as: Ullah MF, Al Zarog M, Sehgal R, Chang KH, Coffey JC, Byrnes G. The appropriateness of colonoscopy requests at University Hospital Limerick: a prospective study. Mesentery Peritoneum 2019;3:AB038.
AB039. 175. The impact of laparoscopic converted to open colectomy on short term and oncologic outcomes for colon cancer

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Background: There is controversy regarding the perioperative and long-term survival outcomes of patients that undergo conversion from laparoscopic to open colectomy for colon cancer and the impact of septic complications on cancer recurrence. To address this, a study was designed to evaluate the short-term complications and oncologic outcomes of converted cases compared with successful laparoscopic procedures and to identify if sepsis or other risk factors are predictors of survival.

Methods: This is a descriptive cohort study of 70 consecutive patients who underwent colectomy for histologically verified adenocarcinoma of the colon under the colorectal service in Cork University Hospital between January 2010 and December 2014. These patients were grouped as successful laparoscopic colectomy (LAP) or conversion to open (CONV). Data pertaining patient morbidity, clinical and perioperative parameters, pathologic features and oncologic outcomes are being collected.

Results: A total of 57 patients were included in the study (49 LAP, 8 CONV). There is no significant difference between the mean length of hospital stay of patients in the LAP group (12.4±9.7 days, P=0.538) and the CONV group (14.8±11.0 days, P=0.583). In terms of long-term outcomes, there was no significant difference in the 5-year overall survival (OS) in the LAP group compared to the CONV group (81.4% vs 75%, P=0.59). A multivariate analysis showed that conversion (P=0.774), gender (P=0.300) and age (P=0.399) were not independent predictors of lower OS.

Conclusions: CONV colectomy from an initial laparoscopic approach does not worsen the 5-year overall survival in patients with non-metastatic colon cancer

Keywords: Colectomy; conversion; outcomes; oncologic; sepsis

doi: 10.21037/map.2019.AB039

AB040. 25. Should routine bowel-prep for colonoscopy be adjusted according to body mass index (BMI)?

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Background: There is a lack of research assessing individualised regimes of bowel preparation pre-colonoscopy based on patients’ body mass index (BMI). Most Centres use a ‘one-size-fits-all’ approach. We carried out this study to investigate whether BMI is an independent predictor of inadequate bowel prep in elective outpatient colonoscopies.

Methods: Comprehensive, retrospective cohort study looking at elective colonoscopies carried out in three tertiary hospitals in Perth, WA, between January 2015 to June 2018. Patient demographics, indication for colonoscopy, type of prep used, procedural outcomes and reported adequacy of bowel preparation were analysed to determine relevant associations using SPSS Software (version 24) for statistical analysis.

Results: We looked at 534 elective colonoscopies across the three tertiary hospitals. Mean age at admission was 58.2, mean weight was 88.9 kg and mean BMI was 28.8 kg/m². Multivariate logistic regression analysis showed that being obese [odds ratio (OR) of 1.8, P=0.017], being overweight (OR of 1.6, P=0.057) and being male (OR of 1.5, P=0.035), are significantly and independently associated with inadequate bowel preparation, after modelling for potential confounding factors age, type of prep used and year of procedure.

Conclusions: Increase in BMI is significantly and independently associated with poor bowel preparation. It may be time we start to individualise bowel-prep according to BMI. As to how much adjustment is needed, we hope to answer this question in a subsequent prospective, multicentre randomised control trial (RCT).

Keywords: Body mass index (BMI); bowel-prep; colonoscopy

doi: 10.21037/map.2019.AB040

Cite this abstract as: Fahey B, Nyandoro M, Teoh M, Noches-Garcia A. Should routine bowel-prep for colonoscopy be adjusted according to body mass index (BMI)? Mesentery Peritoneum 2019;3:AB040.
AB041. 32. Twenty years of restorative proctocolectomy with ileal pouch anal anastomosis in Beaumont Hospital

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Background: An ileal pouch anal anastomosis (IPAA) is the treatment of choice in selected patients to restore intestinal continuity following proctocolectomy. Data on IPAA in Ireland is lacking and surgery for IPAA has evolved over time. The aim of this retrospective study was to report our institutional outcomes from IPAA over a 20-year period.

Methods: Data were retrospectively collated from consecutive primary IPAA cases between 1998 and 2017 at Beaumont Hospital. Patient demographics and operative approach were examined and pouch failure was estimated using the Kaplan-Meier method.

Results: A total of 95 patients underwent IPAA over the study period with a mean follow-up of 9.4±5.6 years. The mean age at IPAA was 35.9±10.0 years and 58.9% were male. The majority were performed in 3 stages (78.9%), were performed to treat ulcerative colitis (66.3%), were of a J-pouch configuration (96.8%), and had a stapled anastomosis (70.5%). On follow-up, 28.4% reported experiencing at least 1 episode of pouchitis and the 10-year pouch failure rate was 14%. In the last decile of the study period the mean number of IPAA performed per year increased to 10.5±2.1 (P=0.013), the age of IPAA formation reduced (P=0.049), and the proportion completed in a minimally invasive manner increased (P<0.001).

Conclusions: Acceptable long-term outcomes were observed by our institution. A recent increase in institutional volume, reduction in patient age and increase in the proportion of cases performed laparoscopically has been identified.

Keywords: Ileal pouch anal anastomosis (IPAA); proctocolectomy laparoscopic surgery

doi: 10.21037/map.2019.AB041

AB042. 113. Evaluation of the outcome of “telephone clinic” in the follow-up of surgical patients: innovative use of technology for the convenience and improvement of service for patients

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Background: Government funded health systems are the hallmarks of welfare states. They always suffer from overburden and are underfunded. This results in painful waiting lists and long clinics. In-order to reduce the sufferings of patients attending surgical outpatient clinic, innovative initiative of telephone clinic was taken 5 years ago. This study was conducted to assess success and find areas or groups requiring attention.

Methods: A retrospective analysis of prospectively maintained database was done. First 1,000 patients given appointment from January 2015 in telephone clinic were found using the Hospital In-Patient Inquiry (HIPE) reporting system. Characteristics regarding age, gender and procedure performed were recorded and the effect of these characteristics on attendance and outcome of clinic was analyzed to find any relation.

Results: The mean age of the patients in the study was 50.6 years with 477 males and 523 females comprising 47.7% and 52.3% respectively. The largest group was of 402 given appointment to outline their endoscopic findings followed by 198 patients who underwent laparoscopic procedures like appendicectomies, hernias and adhesiolysis etc. Analysis found that out of the patients who attended the telephone clinic 71.5% were discharged after first appointment. There was no relation found between attendance, discharge based on gender P=0.51 and 0.60 respectively. But a statistically significant relation was found between attendance, discharges and “millennial generation” P=0.029 and 0.002 respectively.

Conclusions: Telephone clinics are safe, cost-effective, convenient and a patient friendly alternative to conventional clinics. They are safe and convenient alternative to conventional clinic with comparable attendance.

Keywords: Millennials; telephone clinics; waiting lists; waiting time

doi: 10.21037/map.2019.AB042

AB043. 222. Evaluation of the effects of negative pressure dressings on wound complication rates following stoma reversal

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Background: Stoma closure is associated with a high rate of surgical site infection (SSI). Purse-string closure has been shown to result in lower SSIs but potential additional benefits of negative pressure dressing application are understudied. The aim of this study was to assess the overall complication rate, wound infection, time to wound healing and frequency of outpatient attendance after stoma reversal surgery and influence of dressing types on these factors.

Methods: A retrospective analysis was done of all reversal of stoma using purse-string closure from July 2016 to November 2018. PICO and NANOVA were used as negative pressure dressings (NPD). Complication rate, SSI rate and frequency of dressing clinic attendance post-op was assessed and compared between colostomy versus ileostomy and conventional dressing versus NPD.

Results: In total, 84 patients had stoma reversal surgery in the period. 68 were ileostomy reversal. The median age was 60.5 years (range, 21–87 years); 41 (48.8%) patients had negative pressure dressings, 43 (51.2%) had betadine wick dressing. SSI rate was higher in colostomy reversal versus ileostomy (6/68 vs. 3/16). There was no significant difference in wound infection rates in ileostomy reversal with NPD versus conventional dressing. Time to wound healing was similar in both groups however NPD group required less dressing clinic follow up (1.87 visits vs. 2.16, P=0.682).

Conclusions: This analysis shows a low rate of overall complication following stoma reversal surgery at our institution. NPD may be useful to reduce point of care visits but did not affect time to wound healing or infection incidence.

Keywords: Colostomy; ileostomy; negative-pressure; reversal

doi: 10.21037/map.2019.AB043

AB044. 231. Prognostic indicators effecting outcomes of neuromodulation in faecal incontinence—a single centre 15-year experience

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Background: Neuromodulation such as sacral nerve stimulation (SNS) is increasingly popular as a treatment option for faecal incontinence. We report our 15-year experience of SNS at a major tertiary referral centre and investigated the prognostic indicators that influence the outcomes.

Methods: Data was collected between January 2002 to December 2017. A total of 169 patients who tested for temporary SNS were included. A successful test of >50% decrease in four incontinence symptoms qualified for permanent SNS. Failure of SNS was defined by removal of the device ± alternative treatment. Age, gender, presence of colitis, neurological disease, diarrhoea, previous surgery, obstetric trauma and Wexner score were analysed as independent variables. A binary logistic regression was undertaken using SPSS 24 (P<0.05 was considered as significant).

Results: Of 169 samples, over a median follow up of 5.3 years (range, 0.5–13.8 years), 8 subjects failed the test period. Three subjects died during the follow-up period. Median age of the samples was 62 years (range, 29–91 years) with the ratio of females to males of 27:1. Of the 158 cases who had permanent SNS placed, 19% (n=30) failed in symptom improvement. Regression showed a statistically significant increase of failure with diarrhoea as the main incontinence symptom (OR 4.54, 95% CI: 1.3603–15.1562; P=0.0139). A >90% reduction in Wexner produced a significant reduction in likelihood of failure (OR 0.3310, 95%CI: 0.1093–1.0030; P=0.0500).

Conclusions: Predominant symptom of diarrhoea in incontinence is an independent poor prognostic indicator in SNS and only >90% reduction in Wexner score produces a significant reduction in the risk of failure.

Keywords: Faecal incontinence; pelvic floor; sacral nerve stimulation (SNS)

doi: 10.21037/map.2019.AB044

AB045. 7. Colonic stenting as a bridge to surgery in malignant large bowel obstruction: oncological outcomes

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Background: Stenting of obstructing colorectal cancers obviates the need for emergency surgery, reducing initial morbidity and mortality rate associated with emergency surgery and facilitates full staging of the neoplastic process with an opportunity to optimize the patient for surgery. Some recent publications have suggested however, this approach may be associated with higher local recurrence rates. We examined our outcomes following colonic stenting as a bridge to resection.

Methods: A database was reviewed (2006–2018) of patients presenting with acute colorectal obstruction that proceeded to endoscopic stenting. We assessed the bridge to surgery strategy, its success, complication rate and impact on recurrence and survival.

Results: Of a total of 103 patients who presented with acute malignant large bowel obstruction over this time period, 26 patients had potentially curable disease at presentation, and underwent stenting as a bridge to surgery. The technical success rate for stenting in those managed as a bridge to surgery was 92% (n=24/26) with 7.69% (n=2/26) having a complication. There was one stent related perforation. Median follow-up of this cohort was 31 months, with a 5-year overall survival of 53.5%.

Conclusions: Colorectal stenting as a bridge to resection is a successful management strategy for those presenting with obstructing colorectal obstruction. Selective use is associated with lower rates of stoma formation, greater rates of laparoscopic resections with low complication rates and acceptable oncological outcomes.

Keywords: Colorectal cancer; colon stents; oncological outcomes; survival

doi: 10.21037/map.2019.AB045

**AB046. 40. Should surgical site infection wound bundles become mandatory in colorectal surgery?—a meta-analysis**

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**Background:** The global impact of surgical site infection (SSI) is increasingly recognized, both in terms of post-operative complications and oncological outcomes. Reducing SSIs is multi-factorial, with a cumulative additive benefit of each bundle element. While other meta-analyses have been performed looking at surgical wound bundles most relate to interventions before 2016. This study therefore undertook an up to date meta-analysis looking at existing bundle impact on SSIs.

**Methods:** An ethically approved PROSPERO-registered (ID: CRD42018104923) meta-analysis following Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines and using databases PubMed, Scopus and Web of Science, from January 2008 to July 2018, was undertaken. Articles scoring ≥17 using MINORS criteria were included.

**Results:** A total of 5,104 articles were reviewed and 27 studies met inclusion criteria. There was a significant decrease in SSI rates with implementation of a wound bundle (17.5% vs. 9.7%). Sub-analysis showed a significant reduction in superficial SSIs by 54% (P<0.00001) and in organ-space SSIs by 42% (P=0.0006). The use of a wound bundle also significantly reduced hospital lengths of stay (MD =−0.79; P<0.00001).

**Conclusions:** This meta-analysis shows that use of an evidence-based, surgical care wound bundle in patients undergoing colorectal surgery significantly reduces the risk of SSI and length of hospital stay. They should become mandatory.

**Keywords:** Colorectal surgery; prevention bundle; surgical site infections (SSI); surgical wound infection; wound bundles

AB034. 51. Review of anal squamous cell carcinoma over 17 years in a tertiary referral centre

Megan Power Foley, Michael Eamon Kelly, Anthony McBrearty, Fady Narouz, Paul McCormick, John Larkin, Brian Mehigan

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Background: Anal cancer is a rare condition, accounting for 1.5% of all lower malignancy. Globally, there has been a reported increase in incidence of anal cancer over the last few decades.

Methods: We performed a retrospective review of cases of anal squamous cell carcinoma (anal SCC) carcinoma managed at a tertiary unit over a 17-year period. We examined patient demographics, management strategies and patient outcomes. In addition, we also assessed time-related changes in incidence of Anal SCC.

Results: Sixty-seven cases of anal SCC were treated overall. Median age at presentation was 56 years (range, 32–88 years). Incidence of anal cancer increased over the 17-year study period. 97% (n=65) of patients were managed with curative intent. 60% (n=41) had > T2 disease and 25% (n=17) had node positive disease at diagnosis. Three patients had metastatic disease at presentation. 59% (n=40) had long course chemoradiotherapy (LCCRT) as initial treatment. Six patients (9%) had an abdominoperineal resection (APR) as part of their management. Five of these were salvage procedures after local recurrence. R0 resection was achieved in 66.6%. Three-year overall survival for all stages was 58.8%.

Conclusions: The incidence of anal SCC is increasing. Chemoradiotherapy remains the mainstay of initial management. A small proportion of patients will require salvage surgery. We have demonstrated salvage APR is associated with acceptable outcomes and satisfactory survival rates.

Keywords: Anal squamous cell carcinoma (anal SCC); review; abdominoperineal resection (APR); chemoradiotherapy

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