Methods: Patients aged 65 years and above, with histologically proven angiosarcomas were identified from a prospective database. Case notes were retrospectively analysed.

Results: From 1998 to 2012 46 patients in the selected age group were identified to have angiosarcomas. 21 were female, 25 were male. Mean age at time of referral was 77 years (range 65–93).

21 (46%) tumours were in the head and neck; 13 (28%) limbs and spines, 6 (13%) both thorax and abdomen. Majority of tumours were cutaneous (38, 83%) and primary (44, 96%) in origin. 11% of patients had prior exposure to radiotherapy at tumour site and 7% had lymphoedema. 32 (70%) patients had localised disease only at time of diagnosis.

Primary treatment modalities included curative surgery (26, 57%), palliative radiotherapy (8, 17%) and palliative chemotherapy (4, 9%). 2 patients died before treatment.

12 (46%) patients who underwent surgery with curative intent returned with negative microscopic margins whilst 6 (23%) received adjuvant radiotherapy. Recurrence rate was 50%.

The average follow-up time was 3 years (range 0–8). Majority of patients (37, 80%) are deceased. The estimated 5-year absolute survival rate is 11%.

Conclusion: Our 15-year experience of these rare tumours at the East Midlands Sarcoma Service demonstrates a high recurrence rate following surgery and poor absolute 5-year survival for patients in the older age groups.

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Use of the Enhanced Recovery After Surgery (ERAS) programme in an onco-plastic surgical setting

Daniel Jordan, Helen Richards, Chelliah Selvasekar, Gary Ross
The Christie NHS Foundation Trust, Manchester, UK

Introduction: The Enhanced Recovery After Surgery (ERAS) programme is well established in many specialties. Since February 2012 we have implemented the ERAS programme across four specialties, including its use in Plastic Surgery, which has not been documented before. We would like to present our successful integration of this programme to our onco-surgical unit and in particular its ongoing use in Onco-plastic surgery.

Methods: Our audit involved the comparison of a group of patients entered onto the ERAS pathway versus a similar population of patients who underwent surgery pre-ERAS. In particular we focus on the patients who have undergone plastic and reconstructive surgery in relation to a primary oncological diagnosis.

Results: 88 patients have been entered through the ERAS programme at the Christie Hospital. When compared against a similar population of 119 patients treated prior to the ERAS programme introduction, we have found a statistically significant reduced length of stay post-surgery across four specialties, from a median 8 to 6 days (unpaired student's t test p value 0.0092) with reduced re-admission rates. In regard to the onco-plastic subgroup, patients' hospital stays reduced from 8 to 5 days (unpaired student's test p value 0.013)

Conclusion: ERAS pathways have shown success in elective colorectal surgery across the UK. We have implemented this across Colorectal, Gynaecology, Urology and Plastic Surgery specialties with positive results including a statistically significant reduced hospital stay as well as lower re-admission rates. In addition, we believe ourselves to be the first unit using an ERAS pathway in the Onco-plastic field.

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Does height of rectal cancer influence oncological outcome?

Aneel Bhangu, Alistair Slesser, Manish Chand, Paris Tekkis
Royal Marsden Hospital, London, UK

Background: The influence of low height of rectal cancer on oncological outcome in the context of high quality surgery remains controversial. This study aimed to determine the influence of low rectal cancer from a programme of standardised surgery in a specialised rectal cancer service.

Method: Review of a prospectively maintained, dedicated rectal cancer database. Patients undergoing surgery for primary cancer from 2006-May 2013 were included; those requiring complete clearance of an adjacent pelvic compartment were excluded. Low rectal cancer was defined as <5 cm from the anal verge, assessed by the best available clinical, radiological or pathological evidence. The main endpoint was 3-year survival (overall, local recurrence free and disease free: OS, LRFS, DFS).

Results: From 395 rectal resections performed during the period, 309 patients were included with 150 low cancers (49%). There were 265 (86%) restorative and 44 (14%) non-restorative procedures. The overall positive resection margin rate was 3.2% (n=10); this was significantly higher with low versus middle/high cancer (6% versus 0.6% respectively, p=0.008). Patients with low cancer were significantly more likely to receive neoadjuvant therapy. There was no significant difference between low and middle/high cancer for 3-year OS (96% versus 97% respectively, p=0.713), LRFS (96% versus 97%, p=0.907) and DFS (84% versus 84%, p=0.874). For low cancer only, there were no significant differences between restorative and non-restorative procedures for resection margin positive rate (5.7% and 6.8% respectively, p=0.522) or survival.

Conclusion: Patients with low rectal cancer are at a higher risk of positive resection margins. However in the context of high quality, standardised surgery and specialist multidisciplinary care, height of rectal cancer and operation type are not predictors of outcome.

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Inaccurate coding of complex breast surgery may lead to misleading surgeon specific outcomes

Kenneth Keogh, Dominique Twelves, Rebecca Monkman, H.Y. Chan
Cheltenham General Hospital, Cheltenham, UK

Introduction: The Department of Health has decided to publish surgeon specific data to improve surgical standards and facilitate an informed choice by patients and GPs. This requires accurate coding of procedures, particularly those with increased complexity and potential for complications.

Aims: To compare the accuracy of hospital coding systems in a DGH to the actual practice of a consultant breast surgeon for complex oncoplastic procedures.

Methods: HES data were obtained for patients having a) mastectomy with immediate latissimus dorsi (LD) reconstruction, b) revision of breast reconstruction, or c) therapeutic mammoplasty under a single consultant in 2008–2013. These data were compared to the consultant's operating diaries.

Results: The operating diaries identified 76 NHS patients, who had mastectomy with immediate LD reconstruction. Only 18/76 (23.7%) of these reconstructions were identified on HES data. 21 women had revision of reconstruction and 4/21 (19.0%) were identified on HES. 44 women had a therapeutic mammoplasty according to the operating diaries; none (0%) of these cases were identified on HES.

Conclusions: These data show very significant failings in the quality of data coding in our hospital. It is highly unlikely that our hospital is the only unit within the UK which has significant flaws in its coding systems. Inaccurate coding is financially damaging and will skew data on surgeon specific outcomes significantly, particularly if complex procedures are not coded accurately. Major overhauls in hospital coding systems may be required before surgeon specific outcomes can be accurately ascertained in complex breast surgery.

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