

**Method:** Retrospective analysis of groin hernia procedures performed over 2 years. Paediatric procedures were excluded. Data were collected through OPERA<sup>®</sup> and Trackcare<sup>®</sup> system.

**Result:** Out of 450 groin herniae (443 inguinal, 7 femoral), 422 were males (94%) with average age of 65(25–95). 395 elective comparing to 55 emergency procedures. 123(27.3%) Laparoscopic procedures of which 92(74.7%) were unilateral. Average referral to procedure time was 219 days for elective Vs 12 days for emergencies. 6 elective referrals required emergency procedures. most laparoscopic hernias were day-case procedures. 8.4%Overall complication rate. No statistical significance difference between referral to surgery and complications or readmissions ( $p=0.319$ ).

**Conclusion:** laparoscopic inguinal hernia repair is feasible with comparable complication rate. We recommend a UK based groin hernia registry, structured Laparoscopic hernia training and competency in laparoscopic hernia surgery as an essential requirement for certification at the end of the surgical training.

#### 0868: IMPROVING PATIENTS SAFETY ON THE ROAD: PROVISION OF DRIVING ADVICE FOLLOWING ELECTIVE INGUINAL HERNIA SURGERY - A CLOSED-LOOP QUALITY IMPROVEMENT PROJECT

R. Kabariti\*, U. Mohamed, C. Arun. *Nevill Hall Hospital, Abergavenny, UK.*

**Aim:** Driving following surgery may induce an increased risk to the patient's safety and the safety of others on the road if not recovered appropriately. The GMC, DVLA and RCS(eng) have produced guidelines on the provision of driving advice to patients post-operatively. Therefore, our aim was to audit whether patients who had an elective inguinal hernia repair surgery had appropriate driving advice upon discharge.

**Method:** Data was collected over 3 weeks for all elective patients who had an elective inguinal hernia repair surgery for each cycle. Documentation of driving advice on operation notes or discharge summaries were recorded. Following 2 audit cycles and interventions, a health board-wide patient information leaflet on driving post-operatively was subsequently created and distributed accordingly.

**Result:** The provision and documentation of driving advice based on the aforementioned guidelines has improved from 0% to 11% to 62% respectively.

**Conclusion:** Through this project, using simple measures, we were able to both improve the provision of driving advice post-operatively for our patient cohort and also improve the quality of documentation of such advice for GPs to be aware of and to follow the GMC good medical practice guidelines.

#### 0874: WALK IN WALK OUT HERNIA SERVICE - A NEW ERA FOR HERNIA REPAIR

N. Rajaretnam\*, R. Bhutiani. *Northwick Park Hospital, Harrow, London, UK.*

**Aim:** To show that open hernia repair under Local Anaesthetic (LA) is a more cost-effective and necessary alternative to repair under General Anaesthetic (GA) for elderly patients with severe co-morbidities.

**Method:** Retrospective analysis of a prospective database of hernia repairs performed under LA of 696 operations between May 2006 and December 2013 under supervision of a single consultant in the Walk-In-Walk-Out (WIWO) hernia service in one NHS Trust. Data collected included patient demographics, co-morbidities, operation details, complications and cost-effectiveness.

**Result:** Of the total 696 repairs, there was no mortality and only five recorded complications. Cost-effectiveness analysis showed that with open hernia repair under LA, our Trust saved £411.00 per patient; £561.00 if overnight stay; and £861.00 when compared to overnight stay under GA.

**Conclusion:** Nearly 78% of surgical repairs are repaired under general anaesthetic (GA). With our aging population living with an increasing number and severity of co-morbidities, open hernia repair under LA is not only superior but also the safest option. Age and co-morbidity should not be an absolute contraindication to surgery for symptomatic herniae. Repair under LA as a WIWO procedure can offer significant financial savings for the NHS whilst maintaining the same high standard of patient-centred care.

#### 0916: ELECTIVE DIVISION OF ILIOINGUINAL NERVE DURING OPEN MESH INGUINAL HERNIA REPAIR - A METAANALYSIS OF PROSPECTIVE, RANDOMISED CONTROLLED CLINICAL TRIALS

M. Charalambous\*<sup>1</sup>, C. Charalambous<sup>2</sup>. <sup>1</sup>Imperial College Healthcare NHS Trust, Charing Cross Hospital, London, UK; <sup>2</sup>Blackpool Victoria Hospital, Blackpool, UK.

**Introduction:** Chronic post-operative groin pain is a significant complication following open mesh inguinal hernia repair. The exact cause of this pain is still unclear, but the ilioinguinal nerve, which is normally encountered during the operation, has been implicated in its pathogenesis. Elective division of this nerve during the operation has been proposed in an attempt to reduce the incidence of chronic groin pain.

**Method:** A meta-analysis was performed of the thirteen prospective randomised controlled clinical trials comparing preservation versus elective division of the ilioinguinal nerve during this operation.

**Result:** Overall, there was a reduction in the relative risk of groin pain at 1 month ( $n=1484$ ,  $RR=1.27$ ,  $95\%CI=0.94-1.72$ ,  $p=0.12$ ), 6 months ( $n=1155$ ,  $RR=2.15$ ,  $95\%CI=1.14-4.05$ ,  $p=0.02$ ), and 12 months ( $n=800$ ,  $RR=1.46$ ,  $95\%CI=0.63-3.37$ ,  $p=0.38$ ) following surgery, when the nerve was divided. There was an increase of subjective groin numbness when the nerve was divided both at 1 month ( $n=1484$ ,  $RR=0.78$ ,  $95\%CI=0.56-1.09$ ,  $p=0.15$ ) and 6 months ( $n=1255$ ,  $RR=0.57$ ,  $95\%CI=0.37-0.88$ ,  $p=0.01$ ) post-operatively, as well as of objective groin sensory changes or loss at 1 month ( $n=1233$ ,  $RR=0.70$ ,  $95\%CI=0.47-1.04$ ,  $p=0.08$ ).

**Conclusion:** At present we cannot advocate the routine elective division of the ilioinguinal nerve during open mesh inguinal hernia repair.

#### MAXILLOFACIAL SURGERY

##### 0089: THE ROLE OF CORE NEEDLE BIOPSIES IN THE MANAGEMENT OF NECK LUMPS

A. Kalra\*, A. Hussain, R. Bowley, G.M. Prucher, S. Hodges. *King's College Hospital, London, UK.*

**Background:** King's College Hospital has proudly provided a one-stop neck lump clinic since 2012. These multidisciplinary clinics allow for rapid diagnoses due to in-clinic investigations. In April 2013, ultrasound-guided core needle biopsies (CB) were introduced as an alternative/adjunct to fine needle aspiration cytology (FNAC) and open biopsies for obtaining histological diagnoses.

**Aim:** To assess the impact of CB on the diagnosis of neck lumps compared to FNAC and open biopsies between April 2015 and May 2016.

**Method:** Data was collected prospectively between April 2015 and May 2016 and analysed for numbers of FNAC, CB and open biopsies performed and diagnoses made.

**Result:** 190 patients were seen on the clinic. 51 had a FNAC and 19 gave a diagnosis. Out of the remainder of these patients, 21 had a CB, and 12 gave a diagnosis. 8 only had a CB, of which 5 gave a diagnosis. 10 had an open biopsy; 4 had a previous FNAC and CB, 3 only a CB, 2 had neither and 1 had a FNAC.

**Conclusion:** The introduction of CB has reduced the number of open biopsies performed. With increasing acceptance of this minimally-invasive technique, CB appear to be forming the key diagnostic investigation in patients with neck lumps.

##### 0364: TEMPORAL ARTERY BIOPSY...DOES IT REALLY ALTER MANAGEMENT OF TEMPORAL ARTERITIS?

A. Dewar\*<sup>1</sup>, A. Shafi<sup>2</sup>, V. Cook<sup>1</sup>. <sup>1</sup>Victoria Hospital, Fife, Scotland, UK; <sup>2</sup>Queen Elizabeth University Hospital, Glasgow, Scotland, UK.

The gold standard for investigation of temporal arteritis is the temporal artery biopsy (TAB). This audit evaluates the diagnostic outcome of TAB carried out in a district general hospital in relation to local referral protocol established in 2010.