BRITISH ASSOCIATION OF DAY SURGERY ANNUAL CONFERENCE

ABSTRACT BOOKLET

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MORBIDITY AND MORTALITY IN PATIENTS REQUIRING OVERNIGHT ADMISSION FOLLOWING INGUINAL HERNIA REPAIR

Introduction

Target day case rates for all suitable procedures in the UK are set by the British Association of Day Surgery and published in the Directory of Procedures. Day case surgery is associated with improved patient outcomes, reduced hospital bed use, lower healthcare costs and less environmental impact. Day case performance is monitored locally by trusts, regionally by integrated care boards and nationally by organisations such as GiRFT.

Aim

This audit aimed to investigate the relationship between overnight stay and patient morbidity and mortality.

Methods

All patients undergoing inguinal hernia repair surgery between May 2024 and April 2025 in a single UK NHS Trust were identified. Data were collected on patient demographics, diagnosis, procedure, operative approach (open, laparoscopic or robotic), morbidity (including readmissions) and mortality. The relationships between overnight admission following surgery and morbidity / mortality were investigated.

Results

917 patients were identified. 818 patients (89.2%) were discharged on the same day as surgery and 99 patients (10.8%) stayed at least one night. Patients were followed up for an average of 15.5 months (range 9-21). During this period 12 patients died (1.3%). Mortality in patients staying overnight was 3.0% (3/99) compared 1.1% (9/818) in daycase patients (P=0.13). 319 patients (34.8%) had at least one readmission. 45 (45.5%) patients staying overnight were readmitted compared with 274 (33.5%) daycase patients, (1.4-fold increase, P= 0.025).

Conclusions

Patients requiring overnight stay after inguinal hernia surgery showed a trend towards 2.8-fold increase in mortality and a 1.4-fold increase in overall readmissions compared with daycase patients.

Authors

David Bunting, Leen Nesnas, Imran Ali, Saqib Ali, Pranab Munankami
North Devon District Hospital, Barnstaple, United Kingdom

FROM BADS BENCHMARKS TO SYSTEM REFORM: SCALING SAME-DAY SURGERY ACROSS NSW HEALTH, AUSTRALIA

Introduction

In 2025, NSW Health presented its early experience implementing BADS benchmarks, demonstrating how international best practice could be translated into large-scale reform. Initiated following attendance at the 2024 conference, the work rapidly evolved from a targeted improvement initiative into a core pillar of NSW Health's statewide surgical strategy, responding to persistent access pressures, inpatient bed constraints, and rising demand for planned surgery.

Methods

NSW Health adopted a data-driven approach to normalize same-day surgery across hospitals. High-volume, low-complexity procedures were identified using statewide activity, length-of-stay, and readmission data to ensure clinical safety and scalability. Clinician-led engagement supported local implementation, while performance measures were embedded into dashboards. Critically, same-day surgery metrics were formally integrated into Service Level Agreements (SLA), shifting day surgery from discretionary practice to a system-level expectation with executive accountability.

Results

Since 2025, a further 14 procedures have been identified for inclusion in SLAs for FY26/27. In FY24/25, the reform delivered 15,000 bed days against a 14,000 target, equating to approximately AUD $16.1 million in system savings and materially improving access to elective surgery. Performance is now reviewed at Chief Executive level and recognised in an Auditor-General report as an effective access strategy. International collaboration has strengthened, with engagement between the NSW Health Deputy Secretary and the BADS President.

Conclusion

Our experience demonstrates that embedding BADS principles into governance and performance frameworks deliver sustained, system-wide reform in surgical access and is transferable to other large health systems.

Authors

Sarah-Jane Waller, NSW Health, Australia
Prof. Neil Merrett, NSW Health Australia, Western Sydney University Australia, University NSW Australia

OUTCOMES & PATIENT SATISFACTION UNDERGOING TOTAL ANKLE REPLACEMENT, HINDFOOT AND ANKLE FUSIONS FOLLOWING ESTABLISHMENT OF A FOOT & ANKLE DAY CASE SURGERY PATHWAY AT THE SOUTH WEST AMBULATORY ORTHOPAEDIC CENTRE, EXETER

Introduction
After its successful implementation of ambulatory hip/knee arthroplasty, SWAOC has expanded to offer day case foot and ankle surgery including total ankle replacements (TAR), hindfoot and ankle fusions.

Method
The Foot & Ankle surgery pathway has standardised components: pre-operative preparation; pre-medication; anaesthetic technique including nerve blocks; surgical local infiltration analgesia; post-anaesthetic recovery; secondary recovery; therapy input; and discharge medications. This is designed to ensure patients have the best opportunity for smooth recovery following day case surgery.

Results
A retrospective analysis of data between 2022 and 2026 was performed. 1174 Foot & Ankle procedures were performed, including 27 TAR, 1 hindfoot fusion, and 11 ankle fusions.
98.2% of Foot & Ankle cases were discharged on day of surgery; the rest discharged on day 1. The day case rate of TAR was 74% (LOS 0.3 days vs BADS benchmark of 1.7), and 100% in hindfoot and ankle fusions (vs 10.2% national median). Both benchmarked as top performing centre nationally (Model Hospital) 74% of TAR patients reported mild or no pain, the rest with moderate pain. Hindfoot & ankle fusion patients reported mild or no pain. Overall satisfaction with the service was rated as very good by 92% of TAR patients and 100% of those undergoing hindfoot and ankle fusions. There were no readmission to hospital within 30 days.

Conclusion
The standardised pathway in SWAOC has led to excellent and safe patient care following Foot & Ankle surgery. Enhanced recovery protocols have helped facilitate satisfactory day case TAR and hindfoot procedures

Authors
Beatrice Ho, Al-Amin Kassam, Will Reeve, Nick Talbot, Ian Sharpe, Mike Dean, Jason Van Heerden, Adrian Hughes
Royal Devon & Exeter Hospital, Exeter, United Kingdom

Mary Stocker, Hannah Bradman, Guy Wansbrough
Torbay and South Devon N.H.S. Foundation Trust, Torbay, United Kingdom

DAY-CASE HIP AND KNEE ARTHROPLASTY: THE WALSALL MANOR PILOT

Introduction

Day-case total hip (THA) and knee arthroplasty (TKA) is an emerging NHS initiative with potential to reduce waiting times and cost while maintaining safety. A preceding trust audit identified our mean length of stay (LOS) as 5.4 days for TKA and 4.3 days for THA, providing impetus for a day-case pilot at our NHS district general hospital.

Methods

We retrospectively anaylsed a 179 patient cohort, March 2024 - January 2026. All elective arthroplasty patients (ASA 1-4) with primary or aseptic revision THA and TKA were included. Our pilot utilised standardised anaesthetic, surgery and post-operative protocols. Primary outcome was LOS, with subgroup analyses determining discharge-delay and patient safety relationships.

Results

Mean patient ASA score was 2.24 with 31.8% ASA >2. Overall, 35.8% (95% CI 28.7–42.8%) were day 0 discharges and 71.5% (95% CI 64.9–78.1%) day 1. THA yielded higher day 0 and 1 discharge than TKA (40.8% day 0 (95% CI 31.1–50.5%), 75.5% (95% CI 67.0–84.0%) day 1 vs 29.6% (95% CI 19.7–39.6%) day 0, 66.7% (95% CI 56.4–76.9%) day 1). Mean overall LOS was 1.5 (95% CI 1.14–1.86) days with 9 re-admissions within 1 year (5%).

Conclusion

Day case hip and knee arthroplasty has had a significant positive effect on LOS and cost efficiency in our NHS district general hospital while maintaining patient safety. Wider adoption within large and small NHS centres is feasible, practical and represents a significant positive effect on efficiency in elective orthopaedics while maintaining high patient safety standards.

Authors

Jack Dufficy, Alex Kurowski-Ford, Chelsea Street, Fahad Hossain, mohmad salim Thomas Moores Walsall Manor Hospital, Birmingham, United Kingdom

RISK MITIGATED DAY CASE TOTAL THYROIDECTOMY FOR THYROTOXICOSIS: ANALYSIS OF FACTORS ALLOWING SAME DAY DISCHARGE

Introduction

The day case potential of total thyroidectomy has been limited by three primary risks: post-operative haemorrhage, recurrent laryngeal nerve injury with subsequent airway embarrassment and symptomatic hypocalcaemia. In response to rising elective backlogs, transitioning to a day-case model offers significant resource optimisation and improved patient satisfaction. We present the initial outcomes of a pilot day-case total thyroidectomy pathway within an NHS Trust.

Methods

Five consecutive patients underwent total thyroidectomy under a standardised day case protocol. The pathway prioritised:

- Patient selection and education: strict surgical, anaesthetic and social criteria, informed consent and education around day case management.
- Pre-operative Optimisation: Prophylactic loading with oral calcium and alfacalcidol.
- Surgical Strategy: Meticulous surgical strategy (advanced bipolar techniques, haemostatic adjuncts, and Valsalva manoeuvres) to avoid drain insertion.
- Biochemical Monitoring: Immediate post-operative PTH and serum calcium measurement.
- Intended same day discharge: minimum post-operative stay 6 hours and until 20:00.
- Post-operative Safety Net: Discharge on a calcium/alfacalcidol regimen with day one telephone follow-up and mandatory 48-hour biochemical review.

Results

The pilot achieved a 100% same-day discharge rate (n=5). No post-operative haemorrhages or hematomas occurred. One patient was readmitted following the 48-hour review for mild hypocalcaemic symptoms, requiring one night of oral optimisation. The remaining four patients remained asymptomatic with stable biochemistry.

Conclusion

Preliminary results suggest day-case total thyroidectomy is feasible for selected patients when supported by a pathway that mitigates post-operative anaesthetic and surgical risks. While hypocalcaemia remains a concern, prophylactic supplementation and structured follow-up facilitate safe management in an ambulatory setting.

RISK MITIGATED DAY CASE TOTAL THYROIDECTOMY FOR THYROTOXICOSIS: ANALYSIS OF FACTORS ALLOWING SAME DAY DISCHARGE

Authors
Martin Crossdale, Graham Walkden, Churunal Hari
Shrewsbury and Telford Hospitals NHS Trust, Telford, United Kingdom

USING DIGITAL MESSAGING VIA THE NHS APP TO REPLACE POST-OPERATIVE PHONE CALL FOR DAY SURGERY PATIENTS

Introduction

The British Association of Day Surgery / Getting It Right First Time / Centre for Perioperative Care National Day Surgery Delivery Pack states “a process is in place to support patients following discharge and to collect data on patient outcomes”. For many years at The Rotherham Foundation Trust (TRFT), patients were phoned by the Day Surgery Unit (DSU) nursing staff the day following their surgery. Increases in case load and reduced staff availability meant this became no longer sustainable.
In response to this, in October 2024, TRFT DSU introduced a digital post-operative follow-up service.

Methods

A post-operative patient survey was created, consisting of an introduction, nine questions and a closing statement. The topics included pain, nausea and vomiting and overall experience of the pathway. All patients discharged from the DSU (excluding surgical termination of pregnancy cases) are sent a notification (via the NHS App/SMS) the following morning. Any survey which scores ≥1 triggers an email to an account monitored by DSU nursing staff who then phone the patient.

Results

After introduction in 2024 the digital survey had an 82.0% completion rate with 32.4% of these scoring ≥1 and requiring a phone call. In 2025, these figures improved to 84.6% and 22.6% respectively.

Conclusions

Using a digital follow-up service has resulted in an effective and efficient way of following up day-case patients. It has provided both qualitative and quantitive data that can be presented on a dashboard for stakeholders and clinicians to view and use to drive improvements in care.

Authors

Zoe Andrews, Kim Russon, Sally Atkinson, Tammy Hayward
The Rotherham Foundation Trust, Rotherham, United Kingdom

CLEARER LANGUAGE IN A PATIENT INFORMATION LEAFLET AND MULTI-DISCIPLINARY ENGAGEMENT TO SHAPE PATIENTS' EXPECTATIONS CAN INCREASE THE DAY CASE RATE IN ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMIES

Introduction

The BADS benchmark day case rate is 75% for elective Laparoscopic Cholecystectomies citing patient and trust benefits. We proposed that using clearer language in a pre-operative patient leaflet and multi-disciplinary engagement could improve day case rate.

Methods

Retrospective closed-loop audit of elective laparoscopic cholecystectomies at Royal Hampshire County Hospital over a 6-week period. Following the first cycle, an intervention of an updated patient leaflet, focusing on post-operative expectations and emphasising the likelihood of day case surgery, was sent to patients pre-operatively. The pre-assessment team and ward staff were made aware of its contents. Secondary aspect included a patient questionnaire evaluating if the patients received the leaflet and its efficacy. The day case rate was then re-audited.

Results

The first cycle day case rate was 62.7% (n=32). 44% (n=4) of those who were admitted, cited post-operative pain or nausea but went home the following day. Following the intervention, the day case rate increased to 78.1% (n=25) and no patients cited post-operative pain or nausea as the reason for admission. One third of patients responded to the patient survey. Of those 82 % had received the leaflet pre-operatively, with an overall ‘helpful’ score of 8.7/10. Of these responders, 88% (n=8) were day cases.

Conclusions

Day case rate increased to meet BADS benchmark. Questionnaires showed the patient leaflet was well received, with a high day case in those who had received the leaflet.

Targeted patient information and multi-disciplinary awareness can help improve elective laparoscopic cholecystectomy day case rate in a DGH setting.

Authors

Jenny Hobbiss, Salisbury Foundation Trust, Salisbury, United Kingdom
David Hou, Royal Hampshire County Hospital, Winchester, United Kingdom

IMPACT OF INTRODUCING SAME-DAY PRE-ANAESTHESIA ASSESSMENT CLINICS ON BREAST SURGERY: A TWO-CYCLE PRE- AND POST-ANALYSIS

Introduction

Pre-anaesthesia assessment clinics (PACs) optimise patients' medical and psychological readiness for surgery. Traditionally, PACs are conducted via scheduled appointments. At the Royal Victoria Infirmary, Newcastle, same-day walk-in PACs and telephone assessments were introduced to enhance day-surgery efficiency, reduce surgical delays, and minimise hospital visits.

Methods

Breast surgery patients attending clinics between October–December 2024 (scheduled PACs, n=129) were compared with those attending October–December 2025 (walk-in PACs with telephone reviews when required, n=127). Patients were identified via clinic diaries, and data were collected from electronic patient records and clinic letters.

Results

Walk-in PACs significantly reduced the referral-to-assessment interval, with 92% of patients assessed on the day of referral. Early assessment enabled prompt identification and optimisation of patient-related barriers, resulting in earlier theatre sign-off and improved care coordination. Post-implementation, 100% of patients experienced no surgical delays compared to previous 97%. Over 90% required no additional hospital visits due to same-day assessments or telephone PACs. The average interval between PAC and surgery increased from 6.45 to 24.65 days, allowing earlier optimisation and preventing delays.

Conclusions

Introduction of same-day PAC services for breast surgery improved day-surgery efficiency, reduced surgical delays, minimised hospital visits, and enhanced patient experience through earlier perioperative optimisation.

Authors

Aasiya Mannan, Yasmin Hassen, Robert Thomas
Royal Victoria Infirmary, Newcastle, United Kingdom

CAUSES OF DAY-OF-SURGERY CATARACT CANCELLATIONS: A ONE-YEAR AUDIT OF PHACOEMULSIFICATION PROCEDURES

Introduction

Cataract surgery is the most commonly performed operation worldwide, with more than 9.5 million procedures undertaken annually. In the UK, a cancelled cataract operation costs the National Health Service approximately £911 per patient, highlighting the financial impact of late cancellations. Optimising theatre utilisation is therefore an important target for quality improvement. This audit aimed to quantify cancelled phacoemulsification procedures and identify modifiable factors contributing to cancellations.

Methods

Data was collected for all day-of-surgery cancellations at King's College Hospital South Sites involving phacoemulsification cataract surgery (including combined surgeries) between January 2025 and January 2026. Cancellations were categorised into five primary groups based on underlying cause: medically unfit patient, ocular condition unsuitable for surgery, patient-related, administrative or logistical factors, and surgeon-related factors. Categories were further subdivided to identify specific causes.

Results

Between January 2025 and January 2026, 387 phacoemulsification procedures were cancelled on-the-day. Administrative factors accounted for 111 cancellations (28.7%). Patients who were medically unfit or had an ocular condition unsuitable for surgery accounted for 112 cancellations (28.9%); with over half of these (62/112) reflecting factors such as raised blood pressure, blood glucose, or anticoagulation identified on the day. Patient-related factors such as non-attendance or acute illness accounted for 77 cancellations (19.9%), while surgeon-related factors accounted for 64 (16.5%).

Conclusions

Administrative factors were a major contributor to cancellations. Additionally, over half of patients deemed medically-unfit had potentially optimisable factors identifiable during pre-operative assessment. Addressing these areas represents an important opportunity to reduce avoidable cancellations and improve efficiency in high-volume cataract services.

Authors

Hussein Al-Kazwini, Sara Memon

King's College Hospital NHS Foundation Trust, London, United Kingdom

INTRODUCTION OF PRE-PRINTED FENTANYL STICKERS IN RECOVERY: A LOW COST DAY SURGERY INITIATIVE IN A DGH

Introduction

The use of short-acting opioids such as fentanyl to facilitate same-day discharge is supported by organisations including the British Association of Day Surgery and Getting it Right First Time. Compared with morphine, fentanyl is associated with fewer side effects that may delay discharge, including post-operative nausea and vomiting (PONV) and post-operative urinary retention (POUR). A paper prescribing system currently exists for post-operative analgesia in recovery, with pre-printed morphine stickers readily available. In contrast, fentanyl prescriptions require full handwritten instructions. We evaluated whether introducing standardised fentanyl prescription stickers could remove this barrier and increase its use in recovery.

Methods

A retrospective snapshot review of one week of elective surgeries was undertaken to assess post-operative fentanyl prescribing compared with morphine. Paediatric, orthopaedic, sedation and ophthalmic cases were excluded due to different post-operative pathways. Standardised pre-printed fentanyl prescription stickers were introduced, followed by a repeat snapshot review two weeks later.

Results

There were 134 cases in the first cycle and 63 in the second. Morphine prescribing decreased from 73.1% to 39.7%, while fentanyl prescribing increased from 23.1% to 58.7%. PONV episodes reduced from 9 to 1, and POUR from 2 to 0.

Conclusions

By removing a prescribing barrier, we enabled colleagues to consider and use fentanyl in recovery more which has led to a reduction in complications which may delay or prevent same day discharge. Simple, practical and low-cost solutions can bring about impactful changes which promote successful day surgery.

Authors

Christian Perkins, Mui Liu
Luton & Dunstable Hospital, Luton, United Kingdom

THINK LOCAL! : IMPROVING ABSCESS OUTCOMES WITH A DEDICATED ABSCESS SERVICE

Introduction

Acute subcutaneous abscesses are a common surgical presentation, managed with incision and drainage(I&D). Existing pressure on emergency theatre lists results in longer waiting times, glycaemic abnormalities due to prolonged fasting, bed shortages and patient dissatisfaction. Many cases are suitable for I&D under local anaesthesia (L/A), which can improve efficiency through a dedicated ambulatory pathway.

Methods

A baseline audit of 158 patients with subcutaneous abscesses from January to March 2025 identified low L/A use for I&D, unnecessary admissions and long wait times. An abscess leaflet and abscess pathway with emphasis on L/A for non-septic patients with subcutaneous abscesses in all locations except breast, pilonidal, perianal and intraabdominal were introduced. Post-intervention data was collected on 139 patients from September to December 2025 and compared to the baseline.

Results

Following implementation, 42.16% of eligible abscesses were drained under L/A, representing a 59% increase from a baseline of 26.38%. Median time spent in hospital for patients who had L/A was 4.5 hours compared to 26 hours in patients who had general anaesthesia with improved patient satisfaction. The recurrence rate of 8.3% was comparable to standard rates, with no allergic reaction to L/A. The service reduced reliance on emergency theatre capacity and avoided unnecessary admissions.

Conclusion

A dedicated local abscess service is a safe and effective model that improves patient flow and access to care. Increased use of L/A significantly reduces waiting times and hospital resource utilisation, while maintaining acceptable clinical outcomes.

Authors

Afua Agyei, Sadaf Khalid, Gaurav Maheshwari
Medway Maritime Hospital, Kent, United Kingdom

DAY CASE SPINAL SURGERY PATHWAYS AT SWAOC (SOUTH WEST AMBULATORY ORTHOPAEDIC CENTRE)

Introduction

SWAOC is a dedicated surgical hub at the re-established Nightingale Exeter, created to support elective recovery across Devon.
Originally focused on high-volume, low-complexity hip and knee arthroplasty, the service has expanded to include a broader range of ambulatory subspecialty procedures including spinal surgery.
The spinal service delivers a variety of decompressive procedures, including bilateral single-level and unilateral two-level decompressions, discectomies, and microdiscectomies aiming for day case pathways.

Method

The project aimed to standardise pre, peri and postoperative pathways, first developed within the HVLC arthroplasty programme and then adapted for other subspecialties.

For spinal surgery, standardisation covered eight MDT components: pre-operative preparation; pre-medication and warming; anaesthetic approach; surgical LIA; post-anaesthetic recovery; secondary recovery; therapy input and discharge medications.

Results

A total of 191 patients underwent spinal surgery with a day case rate of 94% compared with the BADS benchmark of 30%.
Patient feedback was highly positive: 94% of patients were contacted the day following surgery of whom 88% rated their experience as good or very good.
Pain outcomes were also excellent, with 70% reporting mild or no pain and 27% reporting moderate pain.

Conclusion

SWAOC has standardised care pathways for this surgical group, achieving outstanding day case rates.

Enhanced analgesic protocols have improved immediate postoperative pain control, supporting earlier mobilisation and better therapy engagement.
As a dedicated elective hub with no trauma or medical outliers, SWAOC consistently delivers safe, effective and efficient care while maximising productivity and achieving excellent patient outcomes.

DAY CASE SPINAL SURGERY PATHWAYS AT SWAOC (SOUTH WEST AMBULATORY ORTHOPAEDIC CENTRE)

Authors
Katharine Littlejohns, Royal Devon University Healthcare Trust, Exeter, United Kingdom

Olivia Haynes, Royal Devon University Healthcare Foundation Trust, Exeter, United Kingdom

Dr Mary Stocker, Royal Devon University Healthcare Foundation Trust, Exeter, United Kingdom & Torbay and South Devon NHS foundation Trust, Torbay, United Kingdom

Exeter Spinal Team, Royal Devon University Healthcare Foundation Trust, Exeter, United Kingdom

DAY CASE AND SHORT STAY HIP AND KNEE ARTHROPLASTY PATHWAYS AT THE SOUTH WEST AMBULATORY ORTHOPAEDIC CENTRE

Introduction

SWAOC was established from a former Nightingale COVID hospital as a protected elective orthopaedic surgical hub to support the NHS England elective recovery programme in Devon. It was designed as a centre for ambulatory hip and knee arthroplasty and as a “test of change” for innovative care pathways consistently delivering day-case and short-stay joint replacement surgery.

Method

Standardised preoperative, perioperative, and postoperative pathways to ensure safe, efficient, and high-quality outcomes for high volume low complexity arthroplasty surgery were implemented. Standardisation encompassed multidisciplinary team components, including preoperative preparation, anaesthetic technique, surgical local infiltration analgesia, analgesic protocols, post-operative pathways, therapy input, and discharge medication.

Results

3183 hip and knee replacements have been undertaken since opening in 2022: 1,481 total hip replacements (THR) and 1,702 total or partial knee replacements (TKR/PKR), 857 (27%) were undertaken robotically. Day case rates are 60% THR, 62% TKR 72% UKR. Over 99% patients were discharged by day 1. 80% of patients rate their experience as very good and 55% reported mild or no postoperative pain. The 30-day postoperative readmission rate was 2.6%, reflecting a low incidence of complications and effective care pathways.

Conclusion

SWAOC has demonstrated that by embracing best practice pathways, implementing standardised protocols and engagement of the multidisciplinary team, we can improve pain control, facilitate mobilisation and therapy engagement, and deliver the highest day case rates in the UK. In addition, pathways have been replicated in four acute sites in Devon and across the UK following engagement from 461 visitors representing 74 organisations.

DAY CASE AND SHORT STAY HIP AND KNEE ARTHROPLASTY PATHWAYS AT THE SOUTH WEST AMBULATORY ORTHOPAEDIC CENTRE

Authors
Olivia Hayes, Katharine Littlejohns
Royal Devon University Healthcare Foundation Trust, Exeter, United Kingdom

Dr Mary Stocker, Royal Devon University Healthcare Foundation Trust, Exeter, United Kingdom & Torbay and South Devon NHS Foundation Trust, Torbay, United Kingdom

Exeter, North Devon and Torbay Hip and Knee Teams, Royal Devon University Healthcare Foundation Trust, Exeter, United Kingdom & Torbay and South Devon NHS Foundation Trust, Torbay, United Kingdom

IN THE SAME VEIN: COMPARING COMPLICATION RATES BETWEEN THEATRES AND PROCEDURE ROOM FOR VARICOSE VEIN PROCEDURES

Introduction

Moving varicose veins treatments from a theatre based procedure to office-based/procedure rooms has proven efficacious, brought large cost savings and a better patient experience. Since moving varicose veins to a procedure room, we have monitored outcomes to ensure this is the case in our hospital.

Methods

217 varicose veins procedures were carried out in a procedure room in the 12 months from January 2025. From September 2024 to January 2025 62 procedures were performed in theatre.

Electronic patient records (EPR) were reviewed at eight weeks post procedure, assessing for any unscheduled care in relation to their procedure.
This data was compared to assess complication rates. Complications included: venous thromboembolism (VTE) including endothermal heat induced thrombosis (EHIT); thrombophlebitis requiring intervention; haematoma and infection.

Results

Analysis demonstrated a 4.15% complication rate from the procedure room compared to a 4.84% complication rate from theatres.
Of the complications from theatres 66.6% were VTEs: 33.3% deep vein thrombosis (DVT), 33.3% EHIT, 33.3%, 33.3% were thrombophlebitis requiring intervention.
Comparatively from the procedure room, 66.6% of the complications were VTEs (33.3% EHIT, 66.6% Pulmonary embolism), 22.2% Haematoma, 11.1% Infection.

Conclusions

The procedure room has demonstrated a comparable complication rate to the procedures being performed in theatre. Demonstrating that this not only more financially viable in a cash strapped National Health Service, but most importantly of equal safety. We acknowledge that whilst the complication rate is comparable there was a higher rate of VTEs, root cause analysis showed that patient factors played a considerable role.

Authors

Naomi Lee, Alice Jones, Ryan Trickett
Cardiff and Vale University Health Board, Cardiff, United Kingdom

FROM TELEPHONE TO TEXT: IMPROVING POST-OPERATIVE FOLLOW-UP IN ELECTIVE DAY SURGERY THROUGH DIGITAL INNOVATION

Introduction

Post-operative anaesthetic follow-up after day-case surgery is essential for detecting complications and assessing recovery. Traditional models relying on patient-initiated contact and routine telephone calls are labour-intensive and may fail to reliably reach patients. With rising day-case surgeries, scalable and efficient solutions are needed. We evaluated an SMS-based follow-up survey integrated within an existing patient portal and electronic patient record to improve access, efficiency, and patient engagement.

Methods

A prospective quality improvement project introduced an automated SMS survey at 24 hours post-surgery, with responses accepted to 72 hours and a reminder at 48 hours. The survey assessed symptoms and recovery, with a predefined escalation threshold (>40) triggering clinician telephone review. Outcomes included patient engagement, escalation rates, and clinician workload.

Results

228 surveys were sent over two weeks, with 139 responses (61%). No responses triggered clinician-initiated follow-up, with one high score appropriately excluded due to inpatient admission. Most patients reported no (21.3%), mild (39.6%) or moderate (32.5%) pain; 6.5% reported severe pain, with 92.4% finding analgesia effective. Functional pain assessment showed 89.9% patients reported no breathing difficulties, 9.4% mild, and 0.7% severe, indicating minimal functional limitation from pain. Patient feedback was highly positive, highlighting satisfaction with care with minor themes of pre-operative information gaps.

Conclusions

SMS-based follow-up provides a safe, scalable alternative to telephone review, enabling reliable patient contact without increasing workload. Integration within existing digital infrastructure supports rapid implementation. Outcomes were comparable to national benchmarks and align with national priorities to increase day surgery capacity through modern, efficient & standardised pathways.

Authors

Katherine Gallagher, Sade Okutubo, Vaibhav Nagar
Homerton Healthcare NHS Foundation Trust, London, United Kingdom

GLP-1 THERAPIES IN DAY-CASE SURGERY: EMERGING PERI-OPERATIVE RISKS AND EVOLVING GUIDANCE

Introduction

Glucagon-like peptide-1 (GLP-1) receptor agonists and dual GIP/GLP-1 agents are increasingly used for obesity and type 2 diabetes across NHS and independent healthcare settings. Within day-case surgery, a key concern is delayed gastric emptying, increasing risk of pulmonary aspiration under anaesthesia and same-day cancellations. This review examines current evidence and guidance to support peri-operative decision-making and provide recommendations on medication cessation and resumption.

Methods

A narrative review was performed incorporating international and UK guidance, including anaesthetic recommendations, NHS policy documents, NICE guidance, and clinical reviews. Key areas included pharmacological mechanisms, reported aspiration events, reliability of fasting protocols, and strategies for peri-operative risk stratification and pathway optimisation.

Results

Evidence demonstrates that GLP-1 and dual GIP/GLP-1 therapies delay gastric emptying and may result in retained gastric contents despite adherence to standard fasting guidance. Management is increasingly individualised, favouring continuation with risk stratification, enhanced pre-operative assessment, modified fasting or dietary measures, and adjustment of anaesthetic technique. Consensus supports treating higher-risk patients as having a “full stomach”, particularly those in the dose-escalation phase, with gastrointestinal symptoms or other risk factors for delayed gastric emptying. Increasing private prescribing raises concern regarding incomplete drug histories and inconsistent peri-operative advice, contributing to avoidable day-of-surgery disruption.

Conclusions

GLP-1 therapies present a growing challenge for safe and efficient day-case surgery. Pre-assessment screening, clear medication disclosure, and standardised cessation and resumption protocols are essential. Proactive identification and management of GLP-1 use can reduce aspiration risk, minimise same-day cancellations, and support safe ambulatory surgical pathways within an evolving prescribing landscape.

Authors

Matthew Oh, Tamer Hasablla, Basim Al-Robaie, Shameen Jaunoo
East Sussex Healthcare NHS Trust, Hastings, United Kingdom

DAY CASE MASTECTOMY AS DEFAULT PRACTICE: A COMPLETED AUDIT CYCLE ACHIEVING AND SUSTAINING NATIONAL BADS STANDARDS

Introduction

The British Association of Day Surgery (BADS) increased its day case mastectomy key performance indicator from 50% to 75% by 2024. This completed audit cycle evaluated compliance with the revised standard and the safety and sustainability of pathway changes in an NHS breast unit.

Methods

A retrospective audit was undertaken over six months (July–December 2024), followed by a six-month re-audit (March–August 2025). Seventy elective mastectomy patients were included (33 audit, 37 re-audit), with a BADS 2024 standard. Following the initial audit, targeted interventions were introduced, including pathway optimization and peri-operative practice modifications. Categorical variables were analyzed using chi-square or Fisher's exact tests, continuous variables with Mann-Whitney U tests, and multivariable logistic regression identified independent predictors of same day discharge.

Results

Same day discharge rose from 12.1% (4/33) to 81.1% (30/37) (χ^2=33.21, p<0.001), with a significant reduction in length of stay (p<0.001). The re-audit cohort comprised older patients, higher BMI, more ASA III–IV cases (13 vs 5), male patients, and more complex procedures including immediate reconstruction (n=8). Readmission rates were 3.0% vs 13.9% (p=0.020), and complication rates 24.2% vs 10.8% (p=0.205) in audit and re-audit cohorts, respectively. On multivariable analysis, the re-audit period was independently associated with higher odds of same day discharge (OR 52.9, 95% CI 7.23–387.21, p<0.001).

Conclusions

Targeted, low-cost pathway changes delivered a substantial, statistically significant increase in day case mastectomy rates, exceeding BADS standards even in older, more complex population.

Authors

Sumbul Naz, Jane Hornsby, Amir Bhatti, Abby Russell, Lucy Bookless
County Durham and Darlington NHS Foundation trust, Darlington, United Kingdom

COBLATION FOR THE MANAGEMENT OF HEREDITARY HAEMORRHAGIC TELANGIECTASIA-RELATED EPISTAXIS: A CASE SERIES AND LITERATURE REVIEW

Introduction

Hereditary haemorrhagic telangiectasia (HHT) is a rare autosomal dominant vascular disorder in which fragile nasal telangiectasias cause recurrent epistaxis, anaemia, and quality-of-life impairment. Laser photocoagulation, particularly potassium titanyl phosphate (KTP) laser, is the standard ablative modality but is limited by high operating temperatures (> 400°C), cost, and laser-specific safety requirements. Radiofrequency coblation delivers energy at lower temperatures (60–70°C), offering effective haemostasis with reduced collateral mucosal injury and improved suitability for day-case management pathways.

Methods

A retrospective case series was conducted at a United Kingdom district general hospital to evaluate the efficacy, safety, and durability of coblation for HHT-related epistaxis. Patients were identified from electronic records; primary outcomes included one-year recurrence (need for further surgical intervention) and documented complications. A narrative literature review was performed using PubMed/MEDLINE and Google Scholar (inception–July 2025) to identify studies reporting outcomes of coblation and laser photocoagulation for HHT-associated epistaxis.

Results

Five patients underwent coblation; for procedures with at least 12 months' follow-up, the one-year recurrence rate was 25% (1/4), with no documented intraoperative or postoperative complications. Across published series, coblation demonstrated haemostatic efficacy comparable to KTP laser photocoagulation, with symptom-free intervals ranging from 12 to 30 months. Coblation was associated with reduced postoperative nasal obstruction, crusting, and pain, with no reported septal perforations.

Conclusions

Coblation is a safe, effective, and pragmatic alternative to laser photocoagulation for HHT-related epistaxis. Its low-temperature mechanism limits thermal injury, while lower consumable costs and simplified safety protocols facilitate efficient day-surgery pathways, particularly in resource-constrained settings.

COBLATION FOR THE MANAGEMENT OF HEREDITARY HAEMORRHAGIC TELANGIECTASIA-RELATED EPISTAXIS: A CASE SERIES AND LITERATURE REVIEW

Authors
Harikalan Rajeswaran, Frimley Health NHS Foundation Trust, Wexham, United Kingdom

Jerocin Vishani Loyala, Oxford University Hospitals NHS Foundation Trust, Oxford, United Kingdom

Muna Ahmed, Surrey and Sussex Healthcare NHS Trust, Surrey, United Kingdom

Sharaf Sheik-Ali, University Hospitals of Northamptonshire NHS Group, Northamptonshire, United Kingdom

Roland Hettige, Frimley Health NHS Foundation Trust, Wexham, United Kingdom

AUDIT OF PERIOPERATIVE PRESCRIPTION OF LMWH IN SPINAL SURGERY AT THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL

Introduction

Spinal surgery patients are at increased risk of venous thromboembolism (VTE) due to prolonged operative times and reduced postoperative mobility. Conversely, early administration of low molecular weight heparin (LMWH) increases the risk of spinal or epidural haematoma with potentially devastating neurological consequences. Appropriate timing of LMWH is therefore critical. This audit aimed to evaluate compliance with local guidelines for postoperative LMWH timing in spinal surgery patients at a tertiary orthopaedic centre.

Methods

A retrospective audit was conducted using electronic patient records over a four-month period (August–November 2025). Postoperative surgical plans and medication charts were reviewed to assess whether LMWH was administered within the locally recommended postoperative timing window. All adult patients undergoing spinal surgery during the study period were included. Compliance was defined as LMWH administration within the prescribed timeframe documented in the postoperative plan.

Results

Twenty-seven patients were included. LMWH was administered within the correct postoperative timeframe in 22 patients (81.5%), demonstrating good overall compliance with local guidelines. Five patients (18.5%) experienced delays in LMWH administration. Timely administration was consistently associated with clear documentation of LMWH timing and effective nursing handover. Delays were mostly linked to inconsistent documentation and communication gaps during handover.

Conclusions

While compliance with LMWH timing guidelines was high overall, nearly one in five patients experienced delays, representing a clinically significant safety risk. Targeted interventions including standardised postoperative documentation, strengthened handover processes, staff education, and electronic prompts are planned. A re-audit will assess the impact of these measures on guideline adherence and patient safety.

Authors

Sarah Elmadbouh, Kamil Kose, Moustafa Ibrahim, Naila Begum
Royal National Orthopaedic Hospital, Middlessex, United Kingdom

ARE ROBOTIC-ASSISTED COLECTOMIES SUPERIOR TO LAPAROSCOPIC COLECTOMIES IN REDUCING POST-OPERATIVE COMPLICATIONS? A SYSTEMATIC REVIEW

Introduction
Robotic-assisted colectomy is increasingly adopted in colorectal surgery; however, its benefit over laparoscopic colectomy in reducing post-operative complications remains debated. This systematic review evaluated whether robotic-assisted colectomy offers superior short-term outcomes.

Methods
A systematic search of PubMed, Embase, and Cochrane databases from 2000 to 2025 identified studies comparing robotic-assisted and laparoscopic colectomy. Randomised controlled trials, cohort studies, meta-analyses, and systematic reviews were included. Case reports, hybrid procedures, non-colectomy colorectal operations were excluded. Outcomes assessed included overall and specific post-operative complications, conversion to open surgery, operative time, blood loss, and length of hospital stay.

Results
Fifteen studies comprising over 200,000 patients were included. Robotic-assisted colectomy demonstrated consistently lower overall post-operative complication rates, with reductions of 22–38% and odds ratios ranging from 0.62 to 0.78. Wound infection rates were lower in robotic procedures compared with laparoscopic procedures at 4.7% versus 6.4%. Conversion to open surgery occurred significantly less frequently with robotic techniques, with odds ratios between 0.34 and 0.56. Robotic colectomy was also associated with reduced intraoperative blood loss of approximately 16–19 mL and shorter hospital stays of 0.6–0.8 days. No significant differences were observed in anastomotic leak rates, mortality, reoperation, or readmission. Operative times were longer for robotic procedures, with mean increases of 39–53 minutes and higher associated costs.

Conclusion
Robotic-assisted colectomy is associated with reduced overall post-operative complications and improved perioperative outcomes compared with laparoscopic colectomy, though at the expense of longer operative time and increased cost. Further high-quality randomised studies are required internationally

Authors
Olivia Adams, Saffren Colbourne, Chloe Stevenson
University of Buckingham, Buckingham, United Kingdom

A CLOSED LOOP AUDIT ON THE USE OF ANTIBIOTICS PERIOPERATIVELY FOR UNCOMPLICATED SKIN ABSCESSES IN OUR GENERAL SURGERY DEPARTMENT

Introduction

To assess our unit's use of antibiotics perioperatively for uncomplicated skin abscesses. Current literature states that Trimethoprim-sulfamethoxazole (TMP-SMX) or Clindamycin can be used in addition to incision and drainage, leading to reduced pain and potential reduction in abscess recurrence. However, Incision and drainage remains the primary treatment.

Method

We retrospectively reviewed all incision and drainage of uncomplicated skin abscesses performed under general anaesthesia in our unit, over a combined total of 6 months. For each procedure we identified the location of the uncomplicated skin abscess, whether antibiotics were prescribed post-operatively, the type of antibiotic prescribed if applicable, whether a pus swab was utilised and its culture result. Complicated skin abscesses were identified by factors such as signs of systemic illness, immunosuppression, widespread cellulitis, necrosis and vascular involvement.

Results

Incision and drainage of uncomplicated skin abscesses were performed 70 times between May 2025 and July 2025 in comparison to 63 times between October 2024 and December 2024. In both audit cycles antibiotics were prescribed post-operatively in 55% of cases. Flucloxacillin and Co-amoxiclav were the most commonly used antibiotics overall, but prescribing patterns varied by anatomical site. For instance, Metronidazole was the most common antibiotic prescribed for uncomplicated skin abscesses located in the perianal region.

Conclusion

We will continue to assess the use of antibiotics as an adjunct to incision and drainage of uncomplicated skin abscess, on an individual basis. By working with our microbiology team, we will develop an antimicrobial guideline for uncomplicated skin abscesses based on their anatomical location.

Authors

Zain Akhtar, Hannah Kingston, Alexander Blackmore
Blackpool Victoria Hospital, Blackpool, United Kingdom

FEASIBILITY AND EARLY OUTCOMES OF ROBOTIC TRANSANAL MINIMALLY INVASIVE SURGERY (RTAMIS): A SINGLE-CENTRE EXPERIENCE

Introduction

Transanal minimally invasive surgery (TAMIS) is a well-established technique for local excision of rectal lesions. We evaluated the feasibility and early outcomes of robotic TAMIS (rTAMIS) following its introduction at our institution.

Methods

A retrospective analysis was performed of consecutive rTAMIS procedures undertaken over six-month period. The primary outcome was technical feasibility. Secondary outcomes included quality of excision, peri-operative outcomes and safety. Patient demographics, lesion characteristics, operative metrics, pathological outcomes and short-term oncological surrogates were analyzed.

Results

Twenty-one patients underwent rTAMIS (median age 76 years; 40% ASA III–IV). Median lesion size was 3.0 cm (range 2–9 cm), with a median distance from the anal verge of 6.1 cm, extending up to 11 cm. Median operating time was 32 minutes with minimal blood loss. All lesions were successfully excised robotically, with no conversions. En-bloc resection was achieved in 95% of cases, and complete (R0) resection was confirmed in 100% following surveillance assessment. No peri-operative complications or readmissions occurred and 90% patients were discharged the same day. Eight malignant lesions were treated, including six pT1 cancers managed with surveillance and two pT2 cancers in non-operative candidates. One local recurrence (4.7%) was detected on surveillance and managed appropriately. Outcomes were comparable to published TAMIS systematic review data.

Conclusion

Robotic TAMIS is technically feasible and safe, even for larger and more proximal rectal lesions in a high-risk cohort. Early outcomes demonstrate acceptable procedural completion, low morbidity and rapid recovery, supporting adaption as viable organ-preserving approach with enhanced dexterity, stability and ergonomics.

Authors

Afifa Naseer, Michail Klimovskij, Yesar El-Dhuwaib
Conquest Hospital, Hastings, United Kingdom

INFORMATION BOOKLET TO ENHANCE UNDERSTANDING OF FOUNDATION DOCTORS IN MANAGING POST-OPERATIVE PATIENTS: A QUALITY IMPROVEMENT PROJECT

Introduction

This quality improvement project aimed to achieve a ≥10% improvement in foundation doctors' understanding of post-operative patient management on surgical wards. We hypothesised that a written information booklet would improve understanding more effectively than verbal explanations alone. Foundation doctors are often responsible for the initial assessment and management of post-operative surgical patients, particularly out of hours. Limited understanding of common post-operative issues may result in delayed escalation, inappropriate investigations, and suboptimal patient care. This project aimed to assess and improve foundation doctor knowledge and confidence in managing post-operative patients.

Methods

Foundation doctors (n=20) completed a baseline questionnaire to identify high priority topics for inclusion in the information booklet. Participants rated how informed they felt across key domains of post-operative management (including analgesia, fluid prescribing, monitoring observations, recognition of complications, and escalation) using a 0-5 Likert scale. An information booklet was co-designed, distributed, and the foundation doctor questionnaire repeated.

Results

Prior to booklet distribution, mean self-rated understanding of post-operative management was 3.5/5. Following distribution, this increased to 4.7/5 exceeding the project aim of ≥10% improvement.

Conclusion

This Project demonstrates that an evidence-based booklet is an effective and sustainable intervention for improving understanding and confidence around managing post-operative patients. By providing clear guidance aligned with local protocols, the booklet supports safer clinical decision-making and potential for wider adoption across surgical specialties and training programmes. The booklet is due to receive further feedback and final modifications.

Authors

Mashal Farooq, Guy's and St Thomas' Hospital, London, United Kingdom

INPATIENT VS OUTPATIENT ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY: PATIENT CHARACTERISTICS AND OUTCOMES IN A COHORT STUDY

Introduction

Endoscopic Retrograde Cholangiopancreatography (ERCP) is a key therapeutic procedure in gallstone disease. Outpatient ERCP reduces inpatient pressures, but patient selection remains challenging. No validated criteria currently guide suitability for outpatient ERCP. This study aimed to identify factors associated with inpatient versus outpatient ERCP and to determine characteristics predictive of complications.

Methods

A retrospective cohort study included demographics, comorbidities, Clinical Frailty Scale (CFS), ASA classification, presenting diagnosis, and initial and peak bilirubin. Logistic regression assessed factors associated with inpatient ERCP; variables with $p<0.10$ on univariate analysis were included in multivariate models. ERCP-related complications were recorded, and univariate and multivariate regression analyses identified predictors of complications. Receiver Operating Characteristic (ROC) curves evaluated predictive performance, reported as area under the curve (AUC).

Results

Over one year, 112 patients met inclusion criteria. On univariate analysis, elevated bilirubin levels, ASA, and ascending cholangitis were significantly associated with inpatient ERCP ($p<0.05$). Following multivariate adjustment, no factors remained statistically significant (all $p>0.05$), indicating no independent predictors for the choice of inpatient versus outpatient ERCP. Complications occurred more frequently in outpatients. Multivariate analysis identified age, CFS, ASA, and initial bilirubin as independent predictors of complications. ROC analysis demonstrated limited discriminative performance, with AUC ≤0.65; age and initial bilirubin had the highest predictive accuracy.

Conclusions

No independent clinical variables predicted the choice of inpatient versus outpatient ERCP. Age, frailty, ASA, and initial bilirubin were associated with post-ERCP complications. Higher complications in outpatients highlight the value of structured patient-selection criteria. Larger prospective studies are needed to validate these findings.

INPATIENT VS OUTPATIENT ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY: PATIENT CHARACTERISTICS AND OUTCOMES IN A COHORT STUDY

Authors
Annika Parmar, Marium Quaunine, Rebecca Bradley, William King, Karis Harbertson, Reeza Khan
Queen Elizabeth Hospital, London, United Kingdom

VIRTUAL REALITY TRAINING VERSUS CONVENTIONAL TRAINING FOR LAPAROSCOPIC SKILLS ACQUISITION IN GENERAL SURGERY: A SYSTEMATIC REVIEW AND META-ANALYSIS PROTOCOL

Introduction

Day surgery depends on efficient, safe laparoscopic practice delivered by surgeons who achieve technical competence early in training. Reduced operative exposure and service pressures challenge traditional training models. Virtual reality (VR) simulation offers an immersive, scalable, and reproducible approach to laparoscopic skills training, with potential to improve preparedness for day surgery.

Methods

A systematic review was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. PubMed, Embase, and the Cochrane Library were searched from January 2010 onwards. Eligible studies included surgical trainees undertaking laparoscopic surgery training using VR simulation, compared with conventional methods including box trainers and standard curricula. Outcomes assessed included Objective Structured Assessment of Technical Skills (OSATS), Global Operative Assessment of Laparoscopic Skills (GOALS), task completion time, and error rates. Risk of bias was assessed using the Cochrane Risk of Bias 2 tool, and certainty of evidence using Grading of Recommendations, Assessment, Development and Evaluations principles (GRADE).

Results

Thirty-seven studies demonstrated consistent benefits of VR training. Task completion time improved by 10-40%, error rates were reduced by up to 50%, and validated technical performance scores showed moderate-to-large improvements. Several studies demonstrated skill retention for up to 16 weeks. Enhanced feedback modalities, including three-dimensional (3-D) vision, were associated with further gains in efficiency, accuracy, and trainee confidence.

Conclusions

VR-based training accelerates laparoscopic skill acquisition, reduces errors, and improves readiness for independent practice. These findings support integration of VR simulation into national surgical training pathways to improve efficiency, safety, and standardisation in day surgery.

Authors

Ethan Alford, Sophie Hong, Gareth Chionh, Amr Metwalli
University Hospital Southampton Faculty of Medicine, United Kingdom

CLINICAL OUTCOMES OF ARTHROSCOPIC BANKART REPAIR VERSUS LATARJET REPAIR FOR SHOULDER INSTABILITY: A SYSTEMATIC REVIEW AND META-ANALYSIS

Introduction

Recurrent anterior shoulder instability is a common clinical problem, and the optimal surgical intervention remains debated. Arthroscopic Bankart repair and the Latarjet procedure are widely performed, yet comparative outcome data continue to evolve. This systematic review and meta-analysis aimed to compare clinical outcomes between these two procedures.

Methods

A systematic literature search of MEDLINE, CINAHL, and Scopus databases was conducted up to June 2022 in accordance with PRISMA guidelines. Eligible studies compared arthroscopic Bankart repair with the Latarjet procedure for anterior shoulder instability and reported at least one relevant clinical outcome. Pooled analyses were performed using risk ratios (RRs) for categorical outcomes and mean differences (MDs) for continuous variables, with 95% confidence intervals (CIs).

Results

Five cohort studies comprising 3,145 patients were included. Arthroscopic Bankart repair was associated with significantly higher rates of recurrence (RR 3.09, 95% CI 1.96–4.87) and redislocation (RR 3.74, 95% CI 1.94–7.22) compared with the Latarjet procedure. Functional outcomes, assessed using the Rowe score, favored the Latarjet group (MD 7.94, 95% CI −13.00 to −2.87). Conversely, Bankart repair demonstrated a significantly lower postoperative infection rate (RR 0.14, 95% CI 0.05–0.42). No significant differences were observed between the two procedures regarding revision surgery or hematoma formation

Conclusion

The Latarjet procedure provides superior shoulder stability and functional outcomes compared with arthroscopic Bankart repair, albeit with a higher infection risk. Surgical decision-making should be individualized, taking into account patient-specific factors, bone loss, and surgeon expertise.

Author

Wei Lun Lui, James Cook University Hospital, Middlesbrough, United Kingdom
Hemant Sharma, Darlington Memorial Hospital, Darlington, United Kingdom

ASSESSMENT FOR ANALGESIC PRESCRIPTION ON DISCHARGE LETTERS OF ARTHROPLASTY PATIENT: NOVEL CONCEPT OF ARTHROPLASTY PACK FOR ARTHROPLASTY PATIENTS IN DAY SURGERY

Introduction:

Adequate postoperative analgesics are essential in the recovery and rehabilitation of lower-limb arthroplasty patients via ERAS Protocols. Optimal analgesics include multimodal analgesics as per NICE Guidelines. In our department, Inadequate postoperative pain relief lead to increase in post op FU visit, stiffness and phonecall enquiries. In this study, we assess the effect on Strong Analgesics in Satisfactory Discharge of Arthroplasty patients

Methods

This QIP was conducted in Arthroplasty Ward, T&O Department in UK DGH. Total 100 patients were included. 50 patients operated in January 2024 were included, 25 had THR and 25 had TKR. The patients were called on 28th day of operation to evaluate pain score. After Intervention, similar data Collectied of 50 patients from July 2024 and pain evaluated again at 28 days to evaluate patient satisfaction after implementing interventional changes.

Results

During the first cycle, analgesic prescription efficiency was 45 percent when benchmarked to NICE Guidelines and similar were patient satisfaction percentages. Changes implemented Most importantly were creation of electronic Arthroplasty Discharge pack that contained adequate analgesics, VTE Prophylaxis, Laxatives tailored as per patients' need, Secondly SHO teaching and lastly counterchecking TTO via Nurse incharge. When closing the loop, the efficiency was increased to 91 % with 89% patient satisfaction.

Conclusion

We have proposed the step ladder pattern of analgesics, in which strong opioids should be given to aid in pain relief. Additionally, Arthroplasty discharge pack should be implemented to prevent prescribing errors, and a virtual consultation by an arthroplasty nurse within one week of operation

Authors

Raja Mussab, Russell Hall Hospital, Dudley, United Kingdom

Prakash Palaparthy, Shehanshah Arqam
Russell Hall Hospital, Dudley, United Kingdom

IMPACT OF PROLONGED CASTING ON OUTCOMES FOLLOWING VOLAR PLATE FIXATION OF DISTAL RADIUS FRACTURES: A RETROSPECTIVE COHORT STUDY

Introduction

Distal radius fractures are the most common upper limb fractures globally. Management depends on injury characteristics & patient factors, with non-operative treatment typically involving below-elbow casting & operative management most commonly involves open reduction and internal fixation (ORIF) using volar plating, often supplemented by short-term postoperative immobilisation where fixation or bone quality is a concern. This study evaluates postoperative outcomes in patients undergoing ORIF who experienced prolonged casting (>10 days) in the pre- or post-operative period.

Methods

This retrospective cohort study was conducted at Epsom and St Helier Hospital UK.150 patients who underwent volar plate fixation for distal radius fractures between July 2024 and December 2025 were included. Patient demographics, fracture characteristics, and operative details were extracted from electronic medical records. Postoperative outcomes, specifically stiffness was assessed using clinic documentation at 3-month follow-up.

Results

54 patients (36%) demonstrated postoperative stiffness and swelling at 3 months. Prolonged casting (>10 days), either preoperatively due to a trial of non-operative management and/or surgical delay, or postoperatively due to plaster immobilisation, was the most consistently identified factor associated with these outcomes. No consistent association was identified with fracture pattern, patient comorbidities, tourniquet time, operating surgeon grade, or implant type.

Conclusions

NHS England estimates OPD follow-up costs at £125–£150 per visit, excluding investigations. Prolonged casting may delay early mobilisation, contributing to stiffness & increased follow-up requirements, with functional & financial implications. Our Study findings support timely surgical fixation in line with BOAST guidance & advocate early postoperative mobilisation without routine casting to improve outcomes & reduce healthcare burden

IMPACT OF PROLONGED CASTING ON OUTCOMES FOLLOWING VOLAR PLATE FIXATION OF DISTAL RADIUS FRACTURES: A RETROSPECTIVE COHORT STUDY

Authors
Raja Mussab, Epsom and St Helier University Hospital, London, United Kingdom & Russell Hall Hospital, Dudley, United Kingdom

Alexandra Manoliu, Komalpreet Kaur, Youssef Ghazouli, Najab Ellahee
Epsom and St Helier University Hospital, London, United Kingdom

REASONS FOR OVERNIGHT STAY IN PATIENTS HAVING INGUINAL HERNIA REPAIR

Introduction

Target daycase rates for all suitable procedures in the UK are set by the British Association of Day Surgery. Daycase surgery is associated with improved patient outcomes, reduced hospital bed use, lower healthcare costs and less environmental impact. Day case performance is monitored locally, regionally nationally

Aim

This audit aimed to identify reasons for planned and unplanned overnight stay in patients undergoing inguinal hernia repair.

Methods

All patients undergoing inguinal hernia repair surgery between May 2024 and April 2025 in a single UK NHS Trust were identified. Data were collected on patient demographics, diagnosis, procedure, operative approach (open, laparoscopic or robotic), reasons for planned overnight stay and reasons for unplanned overnight stay.

Results

917 patients were identified. 863 patients were planned daycase and 54 patients were planned overnight stay. 818 patients (89.2%) were discharged on the same day as surgery and 99 patients (10.8%) stayed at least one night. Of the latter, 40 were planned admissions and 59 were unplanned admissions. Most common reasons for planned admissions were patient co-morbidity, social reasons, procedure complexity, and frailty. Most common reasons for unplanned overnight stay were pain, peri-operative complexity/complication, social reasons, urinary retention, and medical reasons.

Conclusions

Day case rates for inguinal hernia surgery were in line with national benchmark standards. The reasons for overnight stay were evaluated and strategies for reducing these developed including a discharge with catheter protocol for urinary retention, a default to daycase booking policy and a protocol for managing patients with no carer at home.

Authors

David Bunting, Abdul-Rahman Suleman, Lauren Ramage, Caoimhe Peregrine, Lily Ridehalgh, North Devon District Hospital,, Barnstaple, United Kingdom

SOCIAL MEDIA IN PLASTIC AND RECONSTRUCTIVE SURGERY - A BIBLIOMETRIC ANALYSIS OF THE 100 MOST CITED ARTICLES

Introduction

Social media plays an increasingly prominent role in plastic surgery, shaping patient expectations, marketing practices, and professional engagement. Despite its influence, the evidentiary landscape underlying this digital shift remains poorly characterised. This bibliometric study analyses the 100 most cited publications on social media in plastic surgery to identify thematic trends, publication patterns, and methodological quality.

Methods

The 100 most cited publications addressing social media in plastic and reconstructive surgery were identified using Web of Science and Scopus (December 2024). Extracted variables included citation count, publication characteristics, journal source, and thematic focus. Study quality was assessed using the Oxford Centre for Evidence-Based Medicine Levels of Evidence (LOE).

Results

The included articles accrued 4,278 total citations (range 16–180; mean 42.78 ± 31.99), with Montemurro et al. (2015) the most cited. Most studies were published in the 2010s (n = 63) and originated from the United States (n = 64). Marketing and physician behavior were dominant themes, with Plastic and Reconstructive Surgery and Aesthetic Surgery Journal serving as primary publication venues. Most studies were low-level evidence (LOE 5 n = 26; LOE 4 n = 34; LOE 3 n = 34; LOE 2 n = 5), with a single LOE 1 study. Patient-reported outcome measures appeared in only one publication.

Conclusions

Highly cited social media scholarship in plastic surgery is dominated by lower-level evidence, reflecting a disconnect between digital influence and methodological rigor. Strengthening study design, outcome reporting, and ethical digital communication is essential to align online visibility with evidence-based practice.

Authors
Nikita James, Imperial College Medical School, London, United Kingdom

Arnav Umranikar, GKT School of Medical Education, Kings College London, London, United Kingdom

Harun Arain, School of Population Health and Medicine, University of Sheffield, Sheffield, United Kingdom

Gulled Bulhan, School of Medicine, Imperial College London, London, United Kingdom

Sebastian Mitchell, Royal Infirmary of Edinburgh, NHS Lothian, Edinburgh, United Kingdom

José Antonio Arellano, Department of Plastic Surgery, University of Pittsburgh Medical Center, Pittsburgh, Pittsburgh, Argentina

HYBRID TECHNIQUE FOR ABDOMINAL WALL HERNIA REPAIR: DESCRIPTION AND EARLY RESULTS

This study explores a hybrid surgical approach for ventral hernia repair, combining the strengths of laparoscopic and open techniques to improve patient outcomes. Conducted at Princess Royal University Hospital, it included 67 patients with clinically and radiologically confirmed ventral hernias treated between March 2020 and March 2023.

The hybrid approach involved laparoscopic techniques for hernia sac reduction and defect identification, followed by open defect closure and laparoscopic mesh placement. This method allowed precise repair while minimizing complications, such as bowel injury, seroma formation, and postoperative bulging.

Key findings included a median operative time of 67 minutes and no hernia recurrence during the follow-up period. Most patients were mobilized within two hours post-surgery, with nearly all discharged the same day. The hybrid technique proved particularly advantageous for complex cases, such as patients with high BMI or multiple defects, addressing limitations associated with standalone laparoscopic or open methods. Clinically, this approach demonstrates significant benefits by enhancing surgical precision, reducing postoperative complications, and improving recovery time. The combination of techniques ensures a robust repair by leveraging the strengths of both methods, offering a safe and effective alternative for ventral hernia management.

The study emphasizes the importance of tailoring surgical techniques to individual patient needs, contributing to better patient satisfaction and outcomes while setting a foundation for further refinement in hernia repair practices. This hybrid method showcases its potential to reduce recurrence rates, improve cosmesis, and provide superior results, particularly in challenging cases, making it a valuable addition to hernia repair strategies

Authors
Doaa Al-Maliki, Shamsi El-Hasani, Mohit Bhatia, Sharmilla Vigayan, Elia Azir
Kings College Hospital, London, United Kingdom

DO ALL ELECTIVE ARTHROPLASTY PATIENTS REQUIRE ROUTINE POSTOPERATIVE BLOOD TESTS?

Introduction

Routine day-one postoperative blood tests are commonly performed following elective total hip replacement (THR) & total knee replacement (TKR) to detect complications like anaemia, electrolyte imbalance & acute kidney injury. However, the clinical value of routine testing for all patients remains uncertain. This study aimed to evaluate whether postoperative blood tests influence management & to identify patient factors needing clinically actionable results.

Methods

A retrospective observational study was conducted of 770 consecutive patients undergoing THR or TKR at a single centre. Data collected included ASA grade, body mass index (BMI), comorbidity burden, preoperative anticoagulant use, postoperative length of stay. The primary outcome was whether postoperative blood results led to a clinical intervention, including blood transfusion, intravenous fluids, or electrolyte correction. Logistic regression analysis was used to identify independent predictors of actionable results, & receiver operating characteristic (ROC) curve analysis assessed predictive performance.

Results

All patients received routine postoperative day-one blood tests. Only 60 patients (7.8%) had results that led to clinical intervention, while 710 patients (92.2%) had no actionable abnormalities. Clinically relevant results were significantly more common in patients with ASA grade 3–4, higher BMI, multiple comorbidities, & preoperative anticoagulant use. Logistic regression identified ASA grade as the strongest independent predictor of actionable results. ROC analysis demonstrated an area under the curve of 0.76, indicating fair discriminative ability.

Conclusion

Routine postoperative blood testing following elective arthroplasty rarely alters management. A targeted, risk-stratified approach may safely reduce unnecessary investigations, improve staff efficiency, & reduce healthcare costs. Prospective validation of a clinical risk score is recommended.

DO ALL ELECTIVE ARTHROPLASTY PATIENTS REQUIRE ROUTINE POSTOPERATIVE BLOOD TESTS?

Authors

Raja Mussab
Hywel Dda Health Board, Carmarthen, United Kingdom & Epsom and St Helier Hospital, London, United Kingdom

Hamid Daud, Fouzia Khan, Htett latt, dean kamiyab, Jehan Zaib
Hywel Dda Health Board, Carmarthen, United Kingdom.

AN ASSESSMENT OF PRE-OPERATIVE MID-STREAM URINE SAMPLES FOR TRANSURETHRAL RESECTION OF THE PROSTATE ON POST-OPERATIVE INFECTION OUTCOMES AT A DISTRICT GENERAL HOSPITAL

Transurethral resection of the prostate (TURP) is a day-case surgical procedure for management of lower urinary tract symptoms (LUTS). Using 'Getting it right first-time' (GIRFT) criteria all pre-operative assessments should have a mid-stream urine (MSU) sample two weeks before procedure. Rationale was due to recent identification of patients requiring intensive care admission due to post-operative sepsis requiring vasopressors which subsequently resulted in patient death.

Retrospective assessment of data was used, incorporating hospital and GP records from 28th April 2025 to 1st August 2025. All TURPs were done with prophylaxis IV antibiotics; no complications or adverse events were post-operatively recorded.

40 patients were identified with a range of ages (55-83), 23 experienced LUTS and 17 for urinary retention. 2 patients were concurrently treated for cystolitholapaxy. Only 2/40 had an MSU as per GIRFT. 8 patients experienced symptoms of urinary tract infection and treated with antibiotics. 5 confirmed on MSU with different pathogens identified (1 - Klebsiella oxytoca, 1 - Pseudomonas aeruginosa, 1 - Serratia marcescens,1 - Proteus mirabilis and 1 - E.coli). 3/8 were diabetic which can increase infection risk. There was no post-operative sepsis requiring hospital +/- Intensive care admission.

There was a 20% post-operative infection rate for patients undergoing TURPs within the period April-August 2025 with only a 5% adherence to GIRFT criteria. Therefore, recommendations are to increase MSU rates pre-operatively to see if this impacts post-operative infection rates and to standardise post-operative safety netting on discharge summaries. Reaudit is needed to see if infection rates are impacted.

Authors
Bethany Tremain, Mohamed Hassan, James Akman
Kings Mill Hospital, Mansfield, United Kingdom

LONG-TERM OUTCOMES FOLLOWING FEMORO-POPLITEAL STENTING: INTERWOVEN NITINOL VERSUS DRUG-ELUTING STENTS

Introduction

The treatment of femoro-popliteal peripheral arterial disease (FP-PAD) often involves endovascular stenting. Interwoven nitinol stents (Supera Peripheral Stent, SPS) and drug-eluting stents (DES) are commonly used devices, but long-term comparative outcomes remain unclear.

Objective

This study aimed to compare long-term outcomes, including mortality and re-intervention, between SPS and DES in a single tertiary vascular centre.
Methods: A retrospective analysis of patients with Chronic limb threatening ischaemia (CLTI) who underwent femoro-popliteal stenting with either SPS or DES from 2013 to 2018 was performed. Data were extracted from a prospectively maintained institutional database. Outcomes were analysed over a median follow-up of 10 years.

Results

From the analysed cohort, the median overall survival was 81 months. SPS cohort reported 62 months and DES cohort 91 months (log rank, p=0.0055). Forty-one patients (13%) had undergone a major amputation. The overall amputation free survival is 28% with no significant difference between SPS 21% versus DES (paclitaxel) 33% (p=). Re-intervention rates remain the same between SPS vs DES 24% and 27%, respectively (p=).

Conclusion

At 10 years, follow-up mortality was higher after deploying bare nitinol stents (SPS) to treat femoropopliteal occlusive disease. The amputation and re-intervention rates did not significantly differ between the cohorts. Further extensive prospective studies are recommended to determine if a significant difference in mortality, amputation-free survival, and re-intervention rates exists.

Authors

Keisha Kellman, Vickna Balarajah, Angel Jose
Guy's and St. Thomas' NHS Foundation Trust, London, United Kingdom

DAY CASE RATES IN PATIENTS HAVING OPEN AND MINIMALLY INVASIVE INGUINAL HERNIA REPAIR

Introduction

Inguinal hernia repair is a common operation with around 70,000 being performed each year in the UK. Target day case rates set by BADS are 86%-90%. Minimally invasive approaches offer the potential for improved outcomes and higher same day discharge rates.

Aim

This audit aimed to compare day surgery and readmission rates inpatients having open and minimally invasive inguinal hernia repair.

Methods

All patients undergoing inguinal hernia repair surgery between May 2024 and April 2025 in a single UK NHS institution were identified. Data were collected on patient demographics, diagnosis, procedure, operative approach (open, laparoscopic or robotic), morbidity (including readmissions) and mortality. Day case rates were compared in patients undergoing open surgery (OS) with patients undergoing minimally invasive surgery (MIS, laparoscopic or robotic).

Results

917 patients underwent inguinal hernia repair in the 12-month period. 818 patients (89.2%) were discharged on the same day as surgery. Patients were followed up for an average of 15.5 months (range 9-21). Day case rates were higher in patients having MIS compared with patients having OS (93.8% and 87.8% respectively, $P<0.008$). Bilateral hernias were more common in those having MIS than OS (27.3% vs. 4.1% respectively, $P<0.001$). Recurrent hernias were more common in those having MIS compared with OS (11.7% vs. 5.9% respectively, $P=0.003$). Readmission rates were similar in MIS and OS groups ((7.4% vs. 8.1% respectively, $P=0.61$).

Conclusions

Day surgery rates were higher in patients having MIS compared with those having OS. Readmission rates were similar in MIS and OS groups.

Author

David Bunting
North Devon District Hospital, Barnstaple, United Kingdom

UROLOGY DAY CASE RATES: AN AUDIT

Introduction
Day case surgery is recognised as the preferred pathway for many elective surgical procedures, offering clinical benefits of reduced hospital time as well as system benefits of more effective use of healthcare resources. Day cases should be considered the default pathway for most surgical procedures, and national guidelines recommend achieving high day case rates where clinically appropriate. However, optimal day case rates are not always achieved. Here, we audit the surgical day case rates in the Oxford University Hospitals Urology department and investigate the reasons for which optimal day case rates are not achieved.

Methods
We completed a retrospective electronic medical record review or urological day cases performed in October 2024. We evaluated the rates of day cases compared to the British Association of Day Surgery (BADS) targets. Where planned day cases were admitted overnight, we reviewed the patient records to identify the reasons and context for admission.

Results
Of 88 planned day cases in October 2024, 13 cases were admitted. Of these 7 were considered avoidable admissions. Reasons for such admissions included transport, social, chronic pain, and late start resulting in an overnight trial of void.

Conclusions
This audit demonstrated an overall high day case success rate, however 53.8% of unplanned admissions were considered avoidable. These findings highlight opportunities to improve pre-operative planning and patient selection to reduce avoidable surgical admissions.

Authors
Tishan Wellalagodage, Oxford University Hospitals Trust and Department of Physiology, Anatomy and Genetics, University of Oxford, Oxford, United Kingdom

Anika Schwarze-Chintapatla, University of Oxford, Oxford, United Kingdom

Soumitra Ghosh, Nuffield Department of Anaesthesia, Oxford University Hospitals NHS Trust, Oxford, United Kingdom

PAIN EDUCATION IN TRAUMA AND ORTHOPAEDIC SURGERY: CLINICIAN PERCEPTIONS AND BARRIERS TO PREOPERATIVE COUNSELLING AND IMPLICATIONS FOR DAY-CASE PATHWAYS

Introduction

Unrealistic pain expectations are a recognised contributor to delayed discharge, unplanned admission, and reduced satisfaction in day-case surgery. In trauma and orthopaedic procedures, often performed to relieve chronic pain, patients may hold high expectations of postoperative pain relief. Despite this, responsibility for pain education within perioperative pathways is frequently diffuse. This study explored clinician confidence, perceived ownership, and barriers to pain education in T&O care.

Methods

A cross-sectional convenience sample survey was conducted among 28 T&O perioperative clinicians at a single surgical centre (17 consultants, 6 registrars, 5 senior fellows). A purpose-built questionnaire assessed self-reported confidence in predicting and managing postoperative pain, perceived responsibility for patient education, and barriers to structured pain counselling. Closed responses summarised descriptively; free-text responses underwent structured narrative synthesis.

Results

Most clinicians reported high confidence in predicting (23/28, 82%) and managing (25/28, 89%) postoperative pain. However, only 11/28 (39%) identified pain education as a defined component of their own consultation or consent process. Commonly cited barriers included time constraints (21/28, 75%), assumptions that education occurred elsewhere in the pathway (18/28, 64%), and lack of standardised resources (16/28, 57%). Lack of clinical knowledge was rarely cited as a barrier (3/28, 11%).

Conclusions

Despite high clinical confidence, preoperative pain education in T&O surgery is inconsistently delivered, with diffuse team ownership and system-level barriers. These findings are relevant to day-case perioperative pathways, where unmet pain expectations contribute to delayed discharge. Clarifying responsibility and embedding structured pain expectation discussions within consent are practical quality improvement targets.

Authors

Shruti Sundar, John Va Faye, Rashida Seimu, Nickisha Patel, Vatsala Padmanabhan, Rajasekhar Gowni, Royal Orthopaedic Hospital, Birmingham, United Kingdom

DOES ANAESTHETIC CHOICE MATTER FOR EARLY MOBILISATION AFTER ARTHROPLASTY? A RETROSPECTIVE COHORT STUDY

Introduction

Enhanced recovery pathways for primary hip and knee arthroplasty aim to reduce length of hospital stay (LOS) and promote early mobilisation[1]. The influence of anaesthetic technique, including choice of spinal agent, on these outcomes remains unclear. This study examined whether anaesthetic type affects LOS and time to first mobilisation following primary hip and knee arthroplasty.

Methods

A retrospective analysis of ARISE[2] data was conducted over three months. All patients undergoing primary hip or knee arthroplasty were included. Anaesthetic techniques were grouped into general anaesthesia (GA) and spinal anaesthesia, with spinal agents subdivided into heavy bupivacaine, plain levobupivacaine, and prilocaine. Outcomes were LOS and mobilisation on the day of surgery (DOS).

Results

A total of 481 patients were analysed: 169 received GA and 312 spinal anaesthesia. Mean LOS was shortest in the GA group (2.0 days), compared with heavy bupivacaine (2.22 days), levobupivacaine (2.31 days), and prilocaine (2.22 days). DOS mobilisation occurred in 44.4% of GA patients, 40.8% with heavy bupivacaine, and 42.9% with levobupivacaine. The highest rate of DOS mobilisation was observed with prilocaine (56.3%), although numbers were small. Conversion from spinal to GA was uncommon.

Conclusions

Anaesthetic technique was not associated with clinically significant differences in LOS. Prilocaine spinal anaesthesia showed a higher proportion of same-day mobilisation, suggesting potential benefit within enhanced recovery pathways. We suggest that preoperative education and optimisation may exert greater influence on LOS and mobilisation. Larger prospective studies are needed to clarify the impact of spinal agent selection on early postoperative recovery.

Authors

Kieran Lafferty, Lorna McEwan
Victoria Hospital Kirkcaldy, Kirkcaldy, United Kingdom

VANCOMYCIN GRAFT PRESOAKING IN ANTERIOR CRUCIATE LIGAMENT RECONSTRUCTION SURGERY IS ASSOCIATED WITH A LOWER RISK OF GRAFT RERUPTURE AS COMPARED WITH NO VANCOMYCIN PRESOAKING: SYSTEMATIC REVIEW AND META-ANALYSIS

Introduction

To determine whether there is any difference in graft rerupture rates and clinical outcomes between cases having vancomycin graft presoaking vs. no vancomycin presoaking in anterior cruciate ligament (ACL) reconstruction (ACLR).

Methods:

Systematic review and meta-analysis. PubMed, Embase, CINAHL, and Cochrane CENTRAL were searched. Full published studies reporting on the relation between vancomycin graft presoaking and rates of graft rerupture and/or clinical outcomes in ACLR surgery vs. no vancomycin graft presoaking were included. Meta-analysis was conducted using a random effects model.

Results

The literature search identified 907 records. After removing duplicates and those not meeting inclusion criteria, 8 studies were included. Meta-analysis showed that the estimated risk of hamstring graft rerupture was lower in cases presoaked with vancomycin vs. those having no presoaking (3.2% vs. 6.2% rerupture rate, risk ratio [RR] = 0.507, 95% CI, 0.39-0.737, $p < 0.001$). Similarly, the estimated risk of graft rerupture was lower in cases presoaked with vancomycin vs. those having no presoaking when the analysis included various ACL graft types (2.7% vs. 3.9% rerupture rate, RR = 0.557, 95% confidence interval [CI], 0.403-0.771, $p < 0.001$).

Conclusion

Vancomycin graft presoaking is a safe practice and does not compromise ACL graft rerupture rates or clinical outcomes.

VANCOMYCIN GRAFT PRESOAKING IN ANTERIOR CRUCIATE LIGAMENT RECONSTRUCTION SURGERY IS ASSOCIATED WITH A LOWER RISK OF GRAFT RERUPTURE AS COMPARED WITH NO VANCOMYCIN PRESOAKING: SYSTEMATIC REVIEW AND META-ANALYSIS

Authors

Charalambos P Charalambous, Blackpool Teaching Hospitals NHS Trust, Blackpool, United Kingdom & School of Medicine, University of Central Lancashire, Preston, United Kingdom

Emadeldin M. Ahmed, Blackpool Teaching Hospitals NHS Trust, Blackpool, United Kingdom

Fatima Kayali, Mersey and West Lancashire NHS Teaching Hospital, Prescot, United Kingdom

Hritik Nautiyal, Watford General Hospital, Watford, United Kingdom

Kenan BA Kuršumović, The Royal Melbourne Hospital, Melbourne, Australia

Paul M. Sutton, Northern General Hospital, Sheffield, United Kingdom

CAN ARTIFICIAL INTELLIGENCE REVOLUTIONISE SURGICAL DECISION-MAKING FOR APPENDECTOMY? A NARRATIVE REVIEW

Introduction:
Acute appendicitis is a common cause of acute abdomen in secondary care. Despite advancements in diagnostics, misdiagnosis and negative appendectomies remain significant. Artificial Intelligence (AI), particularly machine learning (ML) and deep learning, shows promise in improving diagnostic accuracy.

Methods:
A literature review using PubMed and Cochrane databases included studies on AI's role in diagnosing and prognosing appendicitis. Studies relying solely on clinical or radiology reports were excluded.

Results:
AI models, particularly random forest (RF), logistic regression (LR), and neural networks (NN), demonstrated high diagnostic accuracy, with RF outperforming others. Machine learning methods like SVM and XGBoost (XGB) were effective in predicting appendicitis prognosis, especially in distinguishing complicated cases. AI models outperformed traditional diagnostic scores, such as the Alvarado score.

Conclusion:
AI has significant potential to enhance the diagnosis and prognosis of acute appendicitis, but challenges in data requirements and standardisation must be addressed for widespread clinical use.

CAN ARTIFICIAL INTELLIGENCE REVOLUTIONISE SURGICAL DECISION-MAKING FOR APPENDECTOMY? A NARRATIVE REVIEW

Authors:
Ali Murtad, Glan Clwyd Hospital, Rhyl, United Kingdom

Marco David Bokobza De la Rosa, Lancaster Medical School, Lancaster, United Kingdom

Fatima Kayali, Mersey and West Lancashire NHS Trust, Prescot, United Kingdom

Albert Mensah, University Hospital Sussex, Worthing, United Kingdom

Shuaiyb Majid, Diana Princess of Wales Hospital, Grimsby, United Kingdom

Samuel N.S. Ghattas, Glan Clwyd Hospital, Rhyl, United Kingdom

Samuel S.S. Rezk,Glan Clwyd Hospital, Rhyl, United Kingdom

Ian Williams, University Hospital of Wales, Cardiff, United Kingdom

Damian M. Bailey, Neurovascular Research Laboratory, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, United Kingdom

Matti Jubouri, Hull York Medical School, York, United Kingdom

Mohamad Bashir, Neurovascular Research Laboratory, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, United Kingdom

HOW ROBOTIC PLATFORMS ARE REVOLUTIONIZING COLORECTAL SURGERY TECHNIQUES: A COMPARATIVE REVIEW

Introduction

In the last two decades, robotic technology has fundamentally transformed the field of colorectal surgery by providing surgeons with unprecedented levels of precision and control. Nevertheless, robotic surgery presents certain challenges such as prolonged operating times, high costs, limited accessibility, and the necessity for specialized training.

Methods

This comparative review analyzes the impact of robotic platforms on colorectal surgery and its outcomes, with the expanding market of this technology. The major databases including PubMed, Scopus, and Google Scholars were searched using the key term 'robotic assisted surgery,' 'robotic platforms,' and 'colorectal surgery' to identify relevant articles as of August 2024. The most utilized robotic platforms currently available on the market - Da Vinci, Versius, Senhance, and Revo-I - are compared through their peri- and post-operative outcomes, including operative duration, blood loss, hospitalization period, oncological outcomes, and cost.

Results

Da Vinci is the most globally utilized robotic platform to date. It has shown promising clinical outcomes, including hospitalization length, number of lymph nodes harvested intraoperatively and positive circumferential resection margins. Versius has also shown promising results with 20,000 cases since its first introduction 5years ago. It reflected similarly low length of stay and conversion rates. Lymph node resection was positively reported, with multiple studies reporting 0% positive circumferential resection margin.

Conclusion

Robotic surgery significantly improves patient outcomes, including shorter postoperative recovery times and effective cancer resection margins. However, challenges faced with these platforms include longer intraoperative times, arm clashing, the need for bedside assistance, and cost.

Authors
Mariam Hussain, Hull York Medical School, York, United Kingdom

Mona Jaffar-Karballai, Department of Medicine, Chelsea and Westminster NHS Trust, London, United Kingdom

Fatima Kayali, Mersey and West Lancashire NHS Trust, Prescot, United Kingdom

Matti Jubouri, Hull York Medical School, York, United Kingdom

Abedalaziz Omar Surkhi, Faculty of Medicine, Al-Quds University, Jerusalem, Palestine

Mohamad Bashir, Neurovascular Research Laboratory, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, United Kingdom

Ali Murtada, Department of General Surgery, Betsi Cadwaladr University Health Board, Rhyl, United Kingdom

EXPLORING THE USE OF AI-ENHANCED VIRTUAL REALITY IN TEACHING AND EVALUATING COMMUNICATION SKILLS IN UROLOGY: A PILOT STUDY

Introduction

Effective communication is a core competency in healthcare, yet traditional training methods often face limitations in realism, scalability, and learner engagement. This study evaluated the perceptions of healthcare professionals regarding the use of artificial intelligence (AI)-enhanced virtual reality (VR) simulations for communication skills in urology .

Methods

A total of 45 healthcare professionals participated in this study using (AI)-enhanced virtual reality (VR) haematuria role play via Bodyswaps© software. Participants completed pre and post-simulation questioners to measure perceptions of AI-VR's potential to improve communication skills, usefulness of the simulation, agreement with AI-generated feedback, realism compared to clinical practice, and overall enjoyability. Descriptive statistics , tow-sample test and one-sample t-tests were used to analyse the data, with significance set at $\alpha = 0.05$.

Results

Participants reported a moderate belief in the potential of AI-VR to improve communication skills prior to the simulation ($M = 3.844$, $SD = 0.9034$, $t(44) = 28.55$, $p < 0.0001$). Post-simulation evaluations showed significantly increased perceptions of usefulness ($M = 4.636$, $SD = 0.6851$, $p < 0.0001$). High levels of agreement with AI feedback ($M = 4.2$, $SD = 0.9195$) and its usefulness ($M = 4.5$, $SD = 0.6949$) were also reported. Participants positively rated the realism of the simulation ($M = 4.159$, $SD = 0.9135$) and found the experience enjoyable ($M = 4.465$, $SD = 0.8549$), with all results reaching statistical significance ($p < 0.0001$)

Conclusion

The findings suggest that AI-enhanced VR simulations are a highly potential effective and engaging tool for communication skills training in healthcare.

Authors

Aleece Warner, Mohammed Saad
Newham University Hospital, London, United Kingdom

FOLLOW-UP COLONOSCOPY IN ACUTE DIVERTICULITIS: A RETROSPECTIVE AUDIT OF GUIDELINE ADHERENCE

Introduction

This retrospective audit evaluated compliance with follow-up colonoscopy guidelines in patients with acute diverticulitis, specifically adherence to the recommended 6-8 week follow-up for complicated cases. Current guidelines from the World Society of Emergency Surgery and European Society of Coloproctology advise colonoscopy 6-8 weeks after resolution of complicated diverticulitis to rule out malignancy. Colonoscopy is not routinely recommended for uncomplicated cases unless malignancy is suspected.

Method

The audit was conducted in two cycles. The first cycle (September 2023–March 2024) included 51 patients: 23 with complicated and 28 with uncomplicated diverticulitis. The second cycle (September 2024–March 2025) included 46 patients: 24 complicated and 22 uncomplicated cases. Colonoscopy rates, timing, and findings were recorded and compared. Malignancy rates and the need for emergency surgery were also assessed.

Results

In the first cycle, only 1 of 21 colonoscopies was performed within the 6-8 week period, and 1 malignancy was detected. After staff training and awareness initiatives, 6 of 18 complicated cases in the second cycle received timely colonoscopy, representing a significant improvement. No malignancies were detected in the second cycle. Overall, 46% of complicated cases had timely colonoscopy, compared to 5% in the first cycle.

Conclusions

The audit shows significant improvement in colonoscopy compliance for complicated diverticulitis. Given the low malignancy risk, routine colonoscopy for uncomplicated cases should be reconsidered. Future recommendations include enhancing discharge procedures and prioritizing colonoscopy for complicated cases.

Authors

Mohab Elsalahi, Mohammad Saduddin Sajol, Shagufta Jabeen, Mohamed Omar Elsllabi, Asad Toor

NHS Lanarkshire, Glasgow, United Kingdom

DURABILITY OF BARD LIFESTENTS IN DAY-CASE ENDOVASCULAR INTERVENTION FOR PAD

Introduction

Peripheral Arterial Disease (PAD) involving the superficial femoral (SFA) and popliteal arteries often requires intervention to restore blood flow. While traditional bypass surgery offers high durability, it is highly invasive and requires prolonged hospitalization. In contrast, endovascular stenting using the Bard LifeStent—a self-expanding Nitinol system—provides a minimally invasive alternative. This approach is ideal for day-case or single overnight stays, significantly accelerating patient recovery.

Methods

A retrospective cohort study was conducted at Cumberland Infirmary to audit the durability of Bard LifeStents over a 2-year period (March 2021 to November 2023). Cases were identified via interventional radiology systems and the Picture Archiving and Communication System (PACS). The study evaluated 57 total stents, including 48 Bard LifeStents, 3 drug eluting and 6 bare metal stents focusing on primary and secondary patency.

Results

The audit evaluated 57 total stents, achieving a 1-year primary patency rate of 77.2%. The assisted primary patency rate was 86%(n=6). In the specific subset of 48 Bard LifeStents, the 1-year primary patency rate was 77% (n=37), while the secondary patency rate reached 90%(n=5) with 6 cases requiring assisted patency. These findings closely align with the landmark RESILIENT trial, which reported 81% primary patency and a 90% secondary patency at 12 months.

Conclusion:

Rapid technical evolution has revolutionized the treatment landscape for PAD, enabling clinicians to address more severe arterial occlusions through a minimally invasive approach. The Bard LifeStent system delivers consistent clinical outcomes that mirror international trial standards while facilitating a fast-track, day-case surgical model.

Authors

Sam Bloomer, Shafayat Imteaz, Theo Ojimba
Cumberland Infirmary, Carlisle, United Kingdom

OPTIMISING POST-OPERATIVE FOLLOW-UP AFTER ELECTIVE SKIN SURGERY THROUGH AI-SUPPORTED EDUCATION AND PATIENT EMPOWERMENT: A SERVICE EVALUATION AND QUALITY IMPROVEMENT PROJECT

There are currently no national guidelines for post-operative follow-up after elective skin surgery. Although NICE provides general wound care advice, follow-up practices vary locally. Patients are typically discharged to self-care, GP review, or Plastic Dressing Clinic (PDC). High volumes of elective skin surgery place significant logistical/financial pressure on GP services (£13.25/GP nurse appointment). This study aimed to evaluate/improve post-operative follow-up in a plastic surgery unit.

A retrospective service evaluation was conducted across two hospitals. Cycle 1(C1) included patients operated in November 2024, and Cycle 2 (C2) included patients from July 2025. Outcomes assessed included surgical site infection (SSI) rates and follow-up destination.
Two interventions were introduced. First, patients with low-risk surgical wounds were supported in self-care. Second, randomly selected patients received education using AI-generated images, with knowledge and confidence regarding SSI assessed before and after intervention.

C2 included 362 patients compared with 207 patients in C1 (472 vs 274 surgical sites). SSI rates reduced from 2.9% to 1.9%. Discharge to self-care increased from 21% to 48%. GP follow-up reduced from 65% to 36%. PDC reviews remained similar (15.5% vs 14%).
AI-generated images improved familiarity with infection signs (23% to 60%), confidence in recognising infection (70% to 90%), and confidence in seeking medical help (73% to 90%). 90% patients rated the information as helpful/high quality.

AI-supported Patient education and self-care safely improved knowledge and reduced GP follow-up burden. These interventions have projected NHS savings of £21,000/annum and could reduce travel-related carbon emissions, leading to sustainable practice.

Authors
Muhammad Khawar Abbas, Maria Martha Galani Manolakou, Richard Kwasnicki, Kuen Yeow Chin
Frimley Health NHS Foundation Trust, Slough, United Kingdom

DAY CASE RATES IN MASTECTOMY AND WIDE LOCAL EXCISION COMPARED TO BRITISH ASSOCIATION OF DAY SURGERY WITHIN NHS TRUST - A TWO CYCLE AUDIT

Aim
To evaluate day case rates and unplanned hospital admissions following mastectomy and wide local excision (WLE) against British Association of Day Surgery (BADS) standards within NHS trust over a two-cycle audit, and to assess the impact of targeted service changes between cycles on the performance.

Background
BADS recommends day case rates of 75% for mastectomies and 95% for WLE within NHS trusts.

Methods
A retrospective audit of all patients undergoing mastectomy or WLE over two six-month periods (July–December 2024 and June–November 2025) was undertaken. Data were collected from theatre booking systems and discharge summaries, supplemented by discussion with the breast specialist nurse. Outcomes included day case rate, reasons for planned and unplanned overnight stay.

Results
In 2024, 103 patients underwent surgery; 19% required admission and 80% of these were unplanned, with common reasons including clinical deterioration, late operating lists and communication issues around planned admission. Day case rates were 62% for mastectomy and 91% for WLE, below BADS targets. Following interventions (improved communication between pre-assessment and booking teams and prioritising mastectomies early on operating lists), 2025 data demonstrated improved day case rates of 85% for mastectomy and 93% for WLE, meeting BADS standards for mastectomy. Most remaining admissions were due to patients being clinically unwell.

Conclusion
Targeted pathway changes led to a meaningful improvement in day case mastectomy rates, achieving national standards while maintaining patient safety. Residual admissions largely reflected unavoidable clinical factors, suggesting that further gains may be limited without compromising quality of care.

Authors
Sabrina Poppy Barnes, Victoria Brown
Salisbury District Hospital, Salisbury, United Kingdom

TO BIOPSY OR NOT TO BIOPSY: EVALUATING THE NEED FOR TEMPORAL ARTERY BIOPSY IN GIANT CELL ARTERITIS

Introduction

Giant cell arteritis (GCA) is a vasculitis affecting medium- and large-sized arteries and can lead to complications like vision loss. Temporal artery biopsy (TAB) remains the diagnostic gold standard but has recognised limitations, including reduced sensitivity due to skip lesions and prior corticosteroid use. Increasing interest in non-invasive imaging and clinical classification criteria challenges the ongoing role of TAB in clinical practice. This audit assessed whether TAB results influence long-term management of GCA and evaluated the role of non-invasive imaging and classification criteria.

Methods

A retrospective clinical audit was conducted of patients undergoing TAB for suspected GCA at Southport and Ormskirk Hospitals between January 2020 and November 2025. Demographic data, presenting symptoms, investigation findings, biopsy results, and corticosteroid management were collected from clinical records. Participants were scored using the ACR/EULAR classification criteria for GCA, excluding biopsy results. Descriptive statistics, chi-squared and logistic regression analyses were performed.

Results

Data from 112 participants were analysed. 22% had positive TAB. No significant association was identified between biopsy and ultrasound results. 79% of participants met ACR/EULAR classification criteria for GCA without biopsy results. Logistic regression demonstrated significant associations between CRP level and biopsy outcome ($p=0.039$), and between ACR/EULAR score and biopsy positivity ($p<0.001$).

Conclusion

TAB results had limited impact on long-term management, as many patients continued corticosteroid therapy despite negative biopsy. Clinical presentation, inflammatory markers, and classification criteria may play a greater role in guiding management, supporting increased use of non-invasive diagnostic approaches in suspected GCA.

TO BIOPSY OR NOT TO BIOPSY: EVALUATING THE NEED FOR TEMPORAL ARTERY BIOPSY IN GIANT CELL ARTERITIS

Authors
Gabriela Stanislavova, Southport and Formby District General Hospital, Southport, United Kingdom

Theodore Marples, Whiston Hospital, Prescot, United Kingdom

George Maroufidis, Southport and Formby District General Hospital, Southport, United Kingdom

Frank Mason, Southport and Formby District General Hospital, Southport, United Kingdom

IMPROVING POST-OPERATIVE INTRAVENOUS FLUID MONITORING DOCUMENTATION: A CLOSED-LOOP QUALITY IMPROVEMENT AUDIT IN GENERAL SURGERY

Introduction

Intravenous fluid therapy is a critical component of post-operative care. Inappropriate prescribing or monitoring can contribute to complications including acute kidney injury and electrolyte imbalance. The National Institute for Health and Care Excellence guideline CG174 outlines standards for safe intravenous fluid prescribing and monitoring. Local concerns suggested inconsistent documentation of post-operative intravenous fluid management in surgical patients.

Methods

A closed-loop audit was conducted in the General Surgery department at Wye Valley NHS Trust. Twenty elective post-operative patients were reviewed over a two-week period. Compliance with NICE CG174 standards was assessed for four parameters: presence of intravenous fluid prescription, documentation of indication, completion of fluid balance charts, and documentation of daily fluid review in medical notes. Following baseline analysis, targeted interventions were introduced including junior doctor teaching, awareness posters in ward areas, and addition of a “Fluids reviewed” tick-box to the daily handover sheet. A second audit cycle was performed four weeks later using the same methodology.

Results

Baseline compliance demonstrated documentation gaps: intravenous fluid prescription present in 40% of patients, indication documented in 64%, fluid balance chart completed in 60%, and daily review documented in 36%. Following interventions, fluid balance chart completion improved to 100% and documentation of daily review increased to 70%. Fluid prescription documentation was 30% and indication documentation 40% in the re-audit cycle.

Conclusions

Targeted low-cost interventions improved documentation of key aspects of intravenous fluid monitoring. Closed-loop auditing remains an effective method for improving adherence to national standards and supporting safer post-operative care.

Authors

Manas Atre, Juan Loque Solano, Ludmila Joaquim Branda, Mayank Bhandari
Wye Valley NHS Trust, Hereford, United Kingdom

CRACKING THE CODE: ACCURACY AND IMPLICATIONS OF DISCREPANCIES IN THEATRE OPCS CODING WITHIN A DAY SURGERY UNIT

Introduction

Accurate surgical coding is essential for hospital reimbursement and clinical audit. The OPCS system standardises procedure recording within the NHS, but discrepancies can arise anywhere between booking and final clinical coding. This study evaluated the accuracy of theatre-assigned OPCS codes and their financial implications.

Methods

A retrospective review of all elective General Surgery and ENT procedures over two weeks at a single day surgery unit. Booking and theatre-assigned OPCS codes were compared with final codes assigned by clinical coding. Discrepancies were categorised as alternative, incorrect, omitted or extraneous codes. Financial impact was estimated using NHS Payment Scheme tariff ranges. Fisher's exact test compared discrepancy rates between specialties ($p<0.05$).

Results

58 procedures were analysed (37 General Surgery, 21 ENT). In General Surgery, 31/37 procedures (84%) contained discrepancies: mainly due to alternative codes (32%), and omitted additional codes (37%). In ENT, all 21 cases (100%) demonstrated discrepancies, most commonly due to alternative (76%) and omitted codes (71%). Discrepancies were more frequent in ENT than General Surgery (100% vs 84%; $p=0.047$). Financial modelling estimated a mean tariff difference of £197 per case (95% CI £115–£279), corresponding to an estimated total financial variance of £11,426 (95% CI £6,670–£16,180) over the study period. Extrapolated to annual activity, discrepancies may result in an estimated financial variance of £296,000 (95% CI £173,000–£421,000).

Conclusion

Significant discrepancies exist between theatre-assigned and final OPCS coding. Improved operative documentation, targeted staff education, and collaboration between theatre teams and coding departments may improve accuracy and reduce financial risk.

CRACKING THE CODE: ACCURACY AND IMPLICATIONS OF DISCREPANCIES IN THEATRE OPCS CODING WITHIN A DAY SURGERY UNIT

Authors
Amy Smith, Surgical Hub Llandough, Cardiff and Vale University Health Board, Cardiff, United Kingdom

Arwel Poacher, Cardiff University, Cardiff, United Kingdom

Naomi Lee, Surgical Hub Llandough, Cardiff and Vale University Health Board, Cardiff, United Kingdom

Ryan Trickett, Cardiff and Vale University Health Board, Cardiff, United Kingdom

AUDIT OF COMPLIANCE WITH NICE NG89 GUIDANCE ON EXTENDED VTE PROPHYLAXIS IN ADULT CANCER PATIENTS UNDERGOING MAJOR ABDOMINAL SURGERY AT A DISTRICT GENERAL HOSPITAL

Introduction

Venous thromboembolism (VTE) is a significant and potentially preventable post-operative complication, particularly following major abdominal surgery for cancer. NICE guideline NG89 recommends 28 days of extended pharmacological VTE prophylaxis in this cohort. Despite clear guidance, compliance remains inconsistent across institutions. This audit aimed to evaluate NG89 adherence at a District General Hospital (DGH), assess documentation of clinical decision-making, and determine whether targeted interventions improve compliance.

Methods

A two-cycle retrospective audit of adults undergoing major abdominal cancer surgery was conducted at a DGH in Greater Manchester. Cycle 1 (November 2024–February 2025; n=30) established baseline compliance. Following analysis, interventions were introduced including multidisciplinary education, ward-based visual reminders, and proposed system level changes. Cycle 2 (April–July 2025; n=28) assessed post-intervention outcomes. Data were collected from electronic records, drug charts and discharge summaries. Primary outcome was to assess compliance with NG89. Secondary outcomes evaluated documentation of clinical reasoning and 30-day post-operative VTE incidence. Statistical analysis used Chi-squared and Fisher's exact tests ($p<0.05$).

Results

Baseline compliance was 60% (18/30). Among patients not receiving prophylaxis (n=12), 50% had documented justifications. Following intervention, compliance improved significantly to 96% (27/28) ($\chi2(1)=9.06$, $p=0.0026$; Fisher's exact $p=0.0011$). Documentation improved by 16 percentage points but was not statistically significant ($p=0.13$). 30-day VTE incidence decreased from 3% (1/30) to 0% (0/28).

Conclusion

Simple, low-cost interventions significantly improved adherence to NG89, supporting safer perioperative care and improved outcomes for cancer patients. These interventions are scalable and could be implemented in larger centres to maximise patient safety improvements.

AUDIT OF COMPLIANCE WITH NICE NG89 GUIDANCE ON EXTENDED VTE PROPHYLAXIS IN ADULT CANCER PATIENTS UNDERGOING MAJOR ABDOMINAL SURGERY AT A DISTRICT GENERAL HOSPITAL

Authors
Aidan Baker, Benedict Green, Iqra Noor, Ali Javaid
Tameside general Hospital, Manchester, United Kingdom

IMPROVING THE DETECTION AND INITIAL MANAGEMENT OF PHANTOM LIMB PAIN POST-AMPUTATION: A CLOSED-LOOP AUDIT

Background

Phantom limb pain (PLP) affects up to 80% of patients following major limb amputation and can develop within days post-operatively. Poor early recognition and management may result in chronic pain syndromes, impairing rehabilitation, prosthesis use, and psychological recovery. Despite national guidelines recommending early neuropathic assessment and treatment, post-operative care often prioritizes wound management over this.

Aim

To assess compliance with national standards for PLP management on the vascular ward, focusing on:

1. Frequency of PLP assessments
2. Timely initiation of neuropathic agents
3. Continuity of care, including discharge planning and dose review

Methods

A retrospective and prospective audit of patients undergoing knee amputations was conducted using documentation and prescribing records. Cycle 1 established baseline compliance (n=48). An intervention consisting of targeted education for resident doctors was implemented. A re-audit (Cycle 2, n=27) evaluated changes.

Results

Compliance with key standards remained suboptimal across both cycles.

- PLP assessment within 48 hours decreased - 44% to 33%
- Neuropathic agent initiation decreased - 42% to 37%
- Pain team referrals improved - 52% to 67%
- Discharge planning - minimal improvement (21% to 22%)

Notably, numerical pain scoring demonstrated 0% compliance in both cycles. Overall, education alone failed to produce meaningful improvement.

Discussion

This audit highlights a significant gap between guidelines and clinical practice. Reliance on clinician memory represents a low-reliability intervention, particularly on high-pressure wards. Failures in pain assessment and medication continuity suggest systemic rather than individual shortcomings.

Conclusion

Current practice does not meet national standards for PLP management. Educational interventions alone are insufficient to drive sustained improvement

Authors

Nicholas Suteu, Zainab Akbar, Callum Sefton
Royal Preston Hospital, Preston, United Kingdom

IMPROVING ADHERENCE TO PREOPERATIVE LONG-TERM MEDICATION PRESCRIBING IN ELECTIVE HPB SURGERY: A CLOSED-LOOP AUDIT

Introduction

Safe perioperative prescribing is essential to maintain chronic disease control&reduce avoidable complications. NICE perioperative care guidance recommends preoperative assessment and optimisation that considers co-morbidities and medicines. BNF treatment summary on surgery and long-term medication notes that stopping long-term medicines may risk loss of disease control. This audit assessed adherence to the guidelines in elective hepatobiliary and pancreatic(HPB) surgery and evaluated change following intervention.

Methods

A retrospective closed-loop audit was undertaken in HPB surgery wards at a tertiary care centre. Electronic patient records were reviewed for elective patients admitted the day before surgery, and regular medications were compared against Trust guidance on medicines to continue or omit preoperatively. Cycle-1 ran from 25 April to 8 May and Cycle-2 from 24 October to 5 November. Included patients were elective admissions taking regular medications; those not taking regular medicines were excluded. Eighteen cases were reviewed in Cycle-1 and 15 in Cycle-2. Between cycles, poster summarising medications to continue and omit preoperatively was introduced.

Results

In Cycle-1, some eligible medicines, including beta blockers, inhalers and thiazides, were prescribed, whereas many medicines suitable for continuation, including proton pump inhibitors, statins, calcium channel blockers, antidepressants, thyroid medications and antiretrovirals, were omitted. Compliance improved from 5.5% to 13.1% following intervention, although overall adherence remained poor. Reported barriers included short staffing and clerking by locum doctors.

Conclusion

Adherence to preoperative prescribing guidance in elective HPB surgery was poor, with only modest improvement after intervention. Improved medication review, documentation and targeted staff education may improve compliance.

Authors

Anushka Jindal
Barts Health NHS Trust, London, United Kingdom

IMPROVING ADHERENCE TO AN ENHANCED RECOVERY AFTER SURGERY PATHWAY FOR ELECTIVE HEPATECTOMY: A TWO-CYCLE CLINICAL AUDIT AT A TERTIARY HEPATOBILIARY CENTRE

Introduction
Enhanced Recovery After Surgery (ERAS) pathways improve perioperative recovery, reduce complications, and shorten hospital stay after hepatectomy. At a tertiary care centre, an ERAS pathway for liver resections was introduced, but earlier audit cycles identified poor uptake and inconsistent adherence, particularly around preoperative carbohydrate loading, postoperative nutritional support, physiotherapy review, and follow-up.

Objective
To assess adherence to the hepatectomy ERAS protocol across two audit cycles and evaluate the impact of targeted service improvements.

Methods
This clinical audit reviewed elective open and laparoscopic hepatectomies meeting local ERAS inclusion criteria. Extended hepatectomies, emergency operations, diabetic patients, and combined procedures were excluded. Cycle-1 evaluated cases from January to March; Cycle-2 assessed cases in June after interventions addressing previously identified barriers. These included workflow changes across clinic, preoperative, perioperative, postoperative, and discharge phases, alongside resolution of EPIC integration issues in June 2024.

Results
In Cycle-1, 31 hepatectomies were performed and 24 met ERAS criteria. Only 8/24 patients were managed on ERAS pathway. Barriers included limited ERAS nurse capacity, clinic space constraints, poor communication, inconsistent prescribing/documentation & EPIC workflow limitations. In Cycle-2, four hepatectomies were performed, with three eligible cases and 100% adherence to ERAS. Activity during this period was affected by multiple case cancellations related to the Synnovis cyber-attack.

Conclusion
Initial ERAS uptake for hepatectomy was low but improved markedly following targeted organisational and electronic workflow changes. Sustained consultant engagement, timely ERAS booking, and protected preassessment capacity may help maintain compliance.

Authors
Anushka Jindal, Bart's Health NHS Trust, London, United Kingdom

REDUCING THEATRE DEPENDENCY IN THE TWO-WEEK WAIT ENDOMETRIAL CANCER PATHWAY: A MULTI-SITE NETWORK QUALITY IMPROVEMENT RE-AUDIT

Introduction

Referrals for suspected endometrial cancer continue to rise, placing increasing pressure on hysteroscopy services to deliver timely diagnosis while meeting the NHS Fast Diagnostic Standard. Hysteroscopy remains central to the assessment of postmenopausal bleeding. This project evaluated the two-week wait hysteroscopy pathway across the South East London network following service changes to expand outpatient capacity.

Methods

A retrospective re-audit was conducted between January and March 2025 across five hospitals, following a 2024 audit cycle. Data were analysed for 674 patients referred via the two-week wait pathway. Outcomes included outpatient hysteroscopy utilisation, time to investigation and time to discharge. Cross-site benchmarking was used to identify variation and inform service improvements.

Results

Outpatient hysteroscopy increased from 52% to 66% (27% relative increase), reducing reliance on theatre-based procedures. Median time to outpatient hysteroscopy improved from 27 to 18 days, and to general anaesthesia hysteroscopy from 35 to 24 days.

Median time to discharge improved from 35 to 16 days following clinic sampling and from 42 to 23 days following outpatient hysteroscopy. Overall, 69.6% of patients were discharged within 28 days. Failed outpatient hysteroscopy (15%) remained the main cause of delay, with median discharge at 49 days.

Conclusion

Expanding outpatient hysteroscopy improved pathway efficiency and reduced theatre dependency. Variation across sites highlighted opportunities for standardising patient selection, counselling and analgesia to reduce outpatient failure.

Authors

Nishita Mehta, Guys and St Thomas Hospital Trust, London, United Kingdom
Laura Onwubalili, King's College Hospital Trust, London, United Kingdom

THERAPEUTIC OPTIONS FOR OVER GRANULATED SURGICAL WOUNDS - A SYSTEMATIC REVIEW

Introduction

Overgranulation is a common complication of cutaneous wound healing, and is seen when normal healthy granulation tissue exceeds beyond the peri-wound surface. It represents a risk factor for infection, scarring, and chronic wound development. Multiple modalities of treating these wounds are described but currently no systematic review reporting on the evidence behind the various management strategies employed for hypergranulated wounds exists in the literature

Methods

We performed a systematic review of all available primary evidence for management of hypergranulation in adult human cutaneous wounds. Search methodology was curated with an experienced health librarian across multiple bibliographic databases.

Result

We identified 2910 studies on initial search from 1974 to 15th January 2025. on screening 55 studies met our inclusion criteria. Studies were assessed against inclusion/exclusion criteria by two reviewers (YF, SM).

Conclusion

There is currently a lack of evidence in hypergranulation management for cutaneous wounds. Current studies are limited by low sample populations, subjective outcome measures, and mostly limited to observational studies and case reports with few controlled trials. Assessment of literature is limited by heterogeneity in treatment modality and outcome reporting. Topical steroids represented the most common method reported in management of overgranulation, further research is required before recommendations can be made.

Authors

Yamen Al-Fathil, University of Galway, Galway, Ireland

DEVELOPING A STRUCTURED COMPETENCY FRAMEWORK FOR NURSING STAFF IN A REGIONAL ANAESTHESIA BLOCK ROOM

Introduction

The introduction of regional anaesthesia (RA) block rooms has transformed perioperative care by enabling parallel processing, improving theatre efficiency, and expanding access to awake day case surgery for higher-risk patients. Safe, sustainable delivery requires a skilled nursing workforce with clearly defined competencies, including recognising complications and providing monitoring under delegated responsibility, as outlined by RA-UK (Neilly & Womack, 2024) and the Royal College of Anaesthetists GPAS Chapter 8 (RCoA, 2025). A standardised, reproducible competency framework was developed alongside launch of a new local block room service.

Methods

A multidisciplinary team developed a competency framework aligned with national guidance and local standard operating procedures. Training included consultant-led tutorials, mandatory online modules, and supervised clinical practice. Core competencies encompassed patient preparation, monitoring, aseptic technique, ultrasound safety, recognition of complications such as local anaesthetic systemic toxicity (LAST), and escalation of concerns. A simulation session on LAST management was incorporated, with pre- and post-teaching questionnaires evaluating nursing confidence and preparedness.

Results

The framework was successfully implemented across nursing staff transitioning into the block room role. Following the SIM session, nurses reported improved confidence in managing block room emergencies. All 26 post-teaching respondents rated the session as ‘Very Good’ or ‘Excellent’, and all would recommend it to colleagues.

Conclusions

A competency-based framework provides a safe, scalable, and reproducible approach to training nursing staff in a regional anaesthesia block room. Simulation-based learning enhanced nursing confidence and supported self-reflection. This model promotes service sustainability and offers a transferable template for centres developing block room services.

Authors
Sharon Smith, New Stobhill Hospital, Glasgow, United Kingdom
Carole McIntosh, New Stobhill Hospital, Glasgow, United Kingdom
Nicola Mackay, New Stobhill Hospital, Glasgow, United Kingdom
Lee-Ann Prior, Glasgow Royal Infirmary, Glasgow, United Kingdom
Christiana Page, Glasgow Royal Infirmary, Glasgow, United Kingdom
Lindsay Hudman, Glasgow Royal Infirmary, Glasgow, United Kingdom
David Macpherson, Glasgow Royal Infirmary, Glasgow, United Kingdom

UNPLANNED OVERNIGHT ADMISSIONS FOLLOWING INTENDED DAY-CASE GENERAL SURGERY: A ONE-YEAR AUDIT AND QUALITY IMPROVEMENT ANALYSIS

Day-case surgery is widely advocated in the UK due to its benefits in efficiency, reduced healthcare costs, and improved patient experience. National policy recommends that approximately 75% of elective procedures be performed as day-cases, with unplanned overnight admission rates ideally below 2–3%. This audit evaluated the rate and causes of unplanned admissions following intended day-case surgery within a cohort of general surgical procedures and identified opportunities for service improvement.

A retrospective audit was conducted of patients undergoing procedures listed in the British Association of Day Surgery (BADS) directory between January 2024 and January 2025. The cohort comprised 423 intended day-case procedures, including appendicectomy, cholecystectomy, hernia repair, anorectal surgery, pilonidal sinus surgery, and abscess drainage. Overall, 393 patients (93%) were discharged on the day of surgery, while 30 (7%) required unplanned overnight admission. Clinical records for these admissions were reviewed to determine causes and assess whether same-day discharge was feasible.

Among the 30 admissions, three were due to documentation errors where patients had been discharged but incorrectly coded. Nine were clinically appropriate due to significant postoperative or medical concerns. The remainder were associated with potentially modifiable factors: late theatre scheduling (7), uncontrolled postoperative pain (7), urinary retention (3), and postoperative nausea and vomiting (PONV) (1).

Although most admissions were justified, the overall unplanned admission rate exceeded recommended benchmarks. Several potentially preventable factors were identified, highlighting opportunities for quality improvement through optimised theatre scheduling, enhanced anticipatory analgesic strategies, formal risk stratification for PONV, and improved perioperative measures to reduce urinary retention.

Authors
Ernest Olszewski, Rob Schofield
Countess of Chester Hospital, Chester, United Kingdom

ACUTE LIMB ISCHAEMIA IN A YOUNG PATIENT WITH AN ATYPICAL PRESENTATION: A DIAGNOSTIC CHALLENGE IN EMERGENCY MEDICINE

Introduction

Acute limb ischaemia is a time-critical vascular emergency classically associated with older patients and established risk factors. Atypical presentations in younger individuals are rare but may result in diagnostic delay, particularly in emergency settings where risk stratification guides decision-making. Failure to recognise such presentations can lead to significant morbidity.

Methods

A 27-year-old previously healthy female presented with an acute onset of left leg pain following exercise. She was an active cyclist with no significant past medical or family history of thromboembolic disease. Initial clinical assessment was unremarkable, with preserved peripheral pulses and capillary refill, and she was discharged with a presumed musculoskeletal diagnosis. She re-presented with persistent, worsening pain; duplex ultrasound was normal. On further presentation, she developed contralateral leg swelling, progressing to bilateral symptoms. Repeat ultrasound imaging remained inconclusive.

Results

In the context of ongoing symptom progression despite multiple attendances, CT imaging was performed, demonstrating three arterial emboli in the left lower limb. The patient underwent urgent surgical intervention. Subsequent history identified the use of the combined oral contraceptive pill as a potential prothrombotic risk factor.

Conclusions

This case highlights the diagnostic challenge of acute limb ischaemia in young, low-risk patients. Cognitive biases, including anchoring to initial benign diagnoses, may contribute to delayed recognition. The patient reported feeling unsupported and required persistent self-advocacy to obtain CT imaging. Persistent or evolving symptoms should prompt early reconsideration and advanced imaging, as delays may result in avoidable morbidity.

Authors

Aadya Prakash, University of Leeds, Leeds, United Kingdom

PRIMARY HIP AND KNEE ARTHROPLASTIES: A DAY CASE INITIATIVE

Introduction
Post-operative mobilisation and discharge can be expedited using short-acting local anaesthetics (e.g. prilocaine) for day-case lower limb arthroplasties performed under spinal anaesthesia. This audit evaluated prilocaine use in primary elective hip and knee arthroplasties and its association with same-day discharge.

Methods
A two-week, retrospective audit in a small district general hospital examined primary hip and knee arthroplasties performed under spinal anaesthesia. Fifteen cases (nine hips and six knees) met the inclusion criteria (primary hip and knee arthroplasties with a surgical time <80 minutes and <70 minutes, respectively). Cases using general anaesthesia were excluded. The primary outcome was the number of cases that could have used prilocaine. Secondary outcomes included time to mobilisation and timing of physiotherapy discharge.

Results
Only one of fifteen cases used prilocaine: the only case achieving same-day discharge. Based on surgical duration, all other cases could have used prilocaine. Among these fourteen patients, ten were discharged within 24 hours, two within 48 hours, and two after more than 48 hours. Reasons for prolonged stay included vasovagal episodes (3/15), uncontrolled pain (4/15), and patient preference (1/15). The average time from spinal administration to knife-to-skin was 23.6 minutes.

Conclusions
Despite patient eligibility for prilocaine, utilisation was minimal. Expanding prilocaine use appropriately may support day-case arthroplasty pathways and enhanced recovery. However, other unanticipated barriers to discharge were identified within pre-operative assessment (patient selection and setting expectations), peri-operative care (list order and analgesia) and post-operative recovery (physiotherapy). Addressing these factors would be crucial to optimise the benefits of prilocaine use.

Authors
Rosalind Rashid, James Cairn, Judit Eross
United Lincolnshire Teaching Hospitals NHS Trust, Lincoln, United Kingdom

PATIENT-REPORTED URINARY AND SEXUAL OUTCOMES: AQUABLATION VERSUS HOLEP

Introduction

Surgical management of benign prostatic hyperplasia (BPH) can negatively affect urinary continence and sexual function, key determinants of post-operative quality of life. We compared patient-reported urinary continence and sexual outcomes following Aquablation and Holmium Enucleation of the Prostate (HoLEP) in single-centre cohort.

Methods

This retrospective single-centre study included men undergoing Aquablation or HoLEP for BPH between January 2023 and June 2025. Patients were contacted by telephone and completed validated post-operative questionnaires assessing urinary incontinence (ICIQ-UI Short Form), erectile function (SHIM), and ejaculatory function (MSHQ-EJD-SF). Baseline demographics and clinical variables were recorded and compared between groups.

Results

A total of 284 procedures were identified (118 Aquablation,166 HoLEP), with completed questionnaires from 66 Aquablation and 99 HoLEP patients. Median follow-up was 20 months (IQR 10-28). Baseline characteristics, including age, BMI, ASA score, IPSS, and Qmax, were comparable. Mean prostate size for Aquablation and HoLEP was 61cc (±31.5) and 97cc (±70.3) respectively.

Aquablation was associated with significantly better urinary continence (mean ICIQ-UI 1.79 vs 3.73, $p=0.007$) and superior ejaculatory preservation (mean MSHQ-EJD-SF 6.03 vs 3.64, $p<0.001$). A negative impact on sexual function was reported by 17.7% of Aquablation patients compared with 55.7% following HoLEP (OR 5.82, 95% CI 2.71-12.51, $p<0.0001$). Erectile function was similar between the two groups (mean SHIM 13.18 vs 15.48, $p=0.085$).

Conclusions

Aquablation demonstrates significant advantages over HoLEP in urinary continence and ejaculatory outcomes without compromising erectile function. Our data supports Aquablation as a quality-of-life focused surgical option for appropriately selected men with BPH and should inform shared decision-making.

PATIENT-REPORTED URINARY AND SEXUAL OUTCOMES: AQUABLATION VERSUS HOLEP

Authors
Husam Al Maliki, Urology department, Norfolk and Norwich University Hospitals, Norwich, United Kingdom & University of East Anglia, Norwich, United Kingdom

Simon Mcgurk, Shiv Sarna, Shaun James, Sachinka Ranasinghe, Johann Boaz, Mark Rochester, Urology department, Norfolk and Norwich University Hospitals, Norwich, United Kingdom

PREDICTORS OF CONVERSION FROM LAPAROSCOPIC TO OPEN CHOLECYSTECTOMY: A RETROSPECTIVE STUDY AT MUHIMBILI NATIONAL HOSPITAL

Introduction

Gallstone disease is a common surgical condition. Laparoscopic cholecystectomy is the gold-standard treatment; however, conversion to open surgery may be required due to intraoperative difficulties. Identifying predictors of conversion is important to improve surgical planning and outcomes.

Methods

A retrospective cross-sectional study was conducted at Muhimbili National Hospital, Tanzania. Medical records of 230 patients who underwent laparoscopic cholecystectomy between January 2022 and January 2024 were reviewed. Demographic, clinical, and intraoperative data were analysed using chi-square tests and logistic regression. A p-value <0.05 was considered significant.

Results

Among 230 patients, 77.8% were female, with a mean age of 47 years. The conversion rate was 9.2%. Cholelithiasis was the main indication (89.1%). Significant predictors of conversion included higher body weight ($p=0.04$), lower surgeon experience ($p=0.02$), and intraoperative findings such as inflammation and dense adhesions ($p=0.001$).

Conclusions

Conversion remains a challenge in the surgical practice. Higher patient weight, limited surgeon experience, and difficult intraoperative findings increase the risk of conversion. Early identification of high-risk patients may improve operative planning and outcomes.

Authors

Esra Hady, Muhimbili National Hospital
Dar Al Salam, Tanzania, United Republic of University of Medical Science and Technology, Khartoum, Sudan

USING DATA TO DEVELOP A GUIDELINE FOR DAY CASE LAPAROSCOPIC CHOLECYSTECTOMY AT THE ROTHERHAM NHS FOUNDATION TRUST (TRFT) - A DISTRICT GENERAL HOSPITAL

Introduction

TRFT Model Health System data for Elective Laparoscopic Cholecystectomies (ELCs) from September to November 2025 showed a day case rate of 54.1% against a peer median 67.6% and BADS/GIRFT benchmark 75%. One month of ELCs were reviewed to identify the reasons for low day case rates and propose a local pathway to improve performance.

Methods

All ELCs in December 2025 were reviewed using electronic records and scanned anaesthetic charts. A guideline was then produced based on the BADS Day Case Laparoscopic Cholecystectomy booklet which was presented and agreed at department audit March 2026. Data will be reaudited in May against the guideline.

Results

ELCs in December n=25. Day case rate was 72% (admission n=7). n=5 planned: n=2 medical, n=1 surgical, n=2 scheduled last on list. n=2 unplanned, one due to nausea and one due to unexpected surgical difficulty. 76% not given non-steroidal anti-inflammatory drug (NSAID) premedication and 96% not given repeat paracetamol dose after initial premedication. 33% needed rescue antiemetic, becoming 45% with use of morphine intraoperatively. Patients spent less time on DSC ward the more antiemetics given (r=-0.30); and with higher total intraoperative opioid dose (r=-0.35).

Conclusion

Model health system data identified the need to improve the local ELC pathway. Review suggested that some standardisation of approach may improve day case rates: use of pre-medications, Fentanyl instead of morphine and appropriate scheduling. We intend to re-audit in May 2026 against the agreed guideline aiming for an improvement in day case rates and reduction in unplanned admissions.

Authors

Matthew Spoor, Kim Russon, Matthew Rigby
The Rotherham NHS Foundation Trust, Rotherham, United Kingdom

SIM-PLY THE BEST: IMPROVING PATIENT SAFETY THROUGH INTERPROFESSIONAL SIMULATION TRAINING IN A DAY SURGERY HUB

Introduction

Simulation training has been shown to improve patient safety and feed into culture improvement which is associated with better rescue-outcomes for patients with post operative complications.

Methods

Simulation training was done covering a variety of post operative complications over the course of two days. 15 members of staff participated including medical, nursing and auxiliary staff in the Surgical Hub. Pre and post intervention questionnaires were completed by participants. These utilised Likert scales to rank the subjects confidence levels in the identification and management of nine different post operative complications that would require immediate/prompt identification and initiation of management by nursing staff.

Simulation scenarios were done in situ on the day surgery ward. The participants worked in small groups consisting of different professions, working in real time, with simulated members of the medical team, resuscitation/medical emergency team and patient at risk team to escalate to.
Debrief with feedback and further learning was performed after the end of each scenario.

Results

100% of participants reported that simulation training helped them to deliver safer patient care. Compared to those who did not participate in the training there was a demonstrated improvement in confidence in the recognition and management of post operative complications.

Conclusions

Simulation training has shown to improve the nursing staff's confidence in the recognition and management of post-operative complications with real life application in the day surgery setting. Following these findings we have implemented regular Surgical Hub simulation study days to develop and maintain clinical knowledge and skills.

Authors

Naomi Lee
Cardiff and Vale University Health Board, Cardiff, United Kingdom

A 2 YEAR AUDIT OF DAY CASE PROCEDURES AT A DISTRICT HOSPITAL

Introduction
Progressive revolution in surgical techniques and anaesthesia have contributed to day case procedures being the preferred and recommended mode for hospitals.

Methods
An audit of day case procedures at the Royal United Hospital in Bath, United kingdom was done. This included all day case procedures from January 2023 to December 2024. The data obtained included the age, surgeries performed, mode of anaesthesia and outcomes including length of hospital stay and recovery.

Results
The RUH is a 540 bedded hospital with 17 theatres. It provides care for half a million people in the local area. In 2023 and 2024, there were 586,608 outpatient appointments with 98,602 A&E attendances. 3,566 operations were performed and 164,571 diagnostic tests were done.

2,318 (65%) cases were done with the intention of being day-cases. Majority of the cases (97%) were electives. Age range of patients was 3 - 96 with a mean of 53.2 ± 18.4. 85.8% of the cases were done under general anaesthesia. In theatre duration ranged from 0 to 834 mins (with a mean of 73.8 ± 44.7). Mean duration of recovery was 82.3 ± 99.4 minutes. 95.2% of cases spent less than 24 hours in the hospital.

Conclusions
A large number of operations carried out at RUH are performed as day cases. This has been beneficial for patients and it proffers a much more efficient use of NHS resources.

Authors
Adedoyin Ojo
Royal United Hospital, Bath, United Kingdom

FEASIBILITY OF ONE-DAY STAY GASTRIC BYPASSES

Introduction
Gastric bypass is a common bariatric surgery. The feasibility of an overnight discharge pathway for bypass patients has limited evidence.
This study aims to evaluate the feasibility of a safe overnight (23-hour stay) pathway for gastric bypasses.

Methods
Data for this observational cohort study was retrospectively collected from a UK bariatric center. Data was collected for all patients undergoing gastric bypass surgery between February 2023 and December 2025. Outcomes included length of stay (LOS), inpatient analgesia, pain scores, post-discharge complications, and percentage weight loss at 3 months.

Results
77 patients were included. Overall, 65 (84.42%) patients were discharged after an overnight stay. Mean age was 45.10±9.36. 73 (93.6%) patients were women.
One patient discharged after a one-night stay was readmitted for dehydration. (1.54%)

Conclusion
It is safe and feasible to implement a single overnight stay (23-hour discharge) pathway for patients undergoing gastric bypass.

Authors
Sarmad El Samad, Yasser Abdelaal, Matyas Fahvari, William Lynn, Haythem Ali
Maidstone and Tunbridge Wells NHS TRUST, Maidstone, United Kingdom

FEASIBILITY OF AN OVERNIGHT DISCHARGE PATHWAY FOR SLEEVE GASTRECTOMY

Introduction
Sleeve gastrectomy is a common operation. Evidence supporting the feasibility of an overnight discharge pathway remains limited.
This study aims to evaluate the feasibility of a safe overnight (23-hour stay) pathway for sleeve gastrectomies.

Methods
This retrospective cohort observational study was conducted at a UK bariatric centre. Data were collected from all patients undergoing sleeve gastrectomy surgery between May 2024 and December 2025.

Outcomes included length of stay (LOS), complications / discharges.

Results
200 patients were included.
Overall, 184 (92%) patients were discharged after a single overnight stay. Mean age was 43.07±10.5 years. 185 (92.5%) patients were women. Patients discharged after a single overnight stay and those with prolonged stays had no significant differences in opioid use (120 (65.22%) vs 14 (87.5%); p=0.07), complication rates (4 (2.17%) vs 0 (0.00%); p=1.00), and 3-month weight loss (15.05±8.02% vs 13.21±3.24%; p=0.10). None of the complications required a return to theatre.

Conclusion
A single overnight stay (23-hour discharge) pathway is safe and feasible for patients undergoing sleeve gastrectomies.

Authors
Sarmad El Samad, Yasser Abdulaal, William Lynn, Matyas Fehervari, Haythem Ali
Maidstone and Tunbridge Wells NHS Trust, Maidstone, United Kingdom

OTITIS MEDIA WITH EFFUSION (OME) IN CHILDREN UNDER 12

Introduction

Otitis media with effusion (OME), or glue ear, is a leading cause of hearing impairment in children under 12. It involves fluid accumulation in the middle ear without acute infection and can negatively impact speech, language development, and educational outcomes.

Method

A retrospective audit was conducted over two six-month cycles. Data collected included referral indications, audiological findings, management plans, and follow-up intervals before and after surgery. The first cycle was assessed against pre–August 2023 guidelines. Following this, results informed targeted interventions. The second cycle evaluated practice against updated guidelines, with additional analysis of cost-effectiveness and clinical benefit within the local patient population.

Results

Cycle one revealed inconsistent intra-operative documentation and incomplete adherence to recommended peri-operative follow-up intervals. After implementing targeted improvements, cycle two showed enhanced documentation quality, increased rates of audiological assessment within six weeks prior to grommet insertion, and better compliance with post-operative audiology and ENT follow-up recommendations.

Conclusion

Initial findings demonstrated suboptimal documentation and adherence to observation guidelines, alongside evidence of antibiotic underprescribing. Introduction of standardized templates for OME consultations and operative notes improved compliance in the second cycle. A third audit cycle is ongoing to further evaluate adherence to updated guidance, expand sample size, and better assess clinical outcomes and cost-effectiveness of implemented changes in the West midlands patient demographic.

Authors

Mohanad Nasreddine, Mustaffa Junaid
Sandwell and West Birmingham Hospitals, Birmingham, United Kingdom

FROM ANXIETY TO EFFICIENCY: A CO-DESIGNED VR TOOL FOR PAEDIATRIC SURGICAL PREPARATION

Introduction
Evaluating the impact of preoperative anxiety on theatre efficiency in paediatric surgical patients, leading to development of a co-designed virtual reality (VR) tool to reduce anxiety and improve preoperative experience.

Methods
Retrospective analysis of 203 day-case surgical patients aged 4-13 years at a tertiary paediatric centre. Anaesthetic room time, Post Anaesthesia Care Unit (PACU) duration, and theatre turnover times were compared between children with or without anxiolytic premedication.
Further project engaged Children and Young People (CYP), via structured virtual focus groups, to inform VR anaesthetic room development. CYP feedback guided creation of a minimum viable product incorporating interactive features, virtual guide, with both rendered, and 360° environments.

Results
Premedicated children demonstrated significantly longer anaesthetic room time (18.7 vs 16.4 minutes, p=0.040) and PACU duration (33.9 vs 25.6 minutes, p=0.003), indicating a measurable impact of anxiety on operative flow. Theatre turnover times were not significant (14.7 vs 12.1 minutes, p=0.146), due to data unavailability. CYP identified ‘uncertainty’, ‘unfamiliar environments’ and ‘equipment’ as key drivers of anxiety, and expressed strong support for VR preparation. 75% reported that the VR environments would ‘definitely’ or ‘probably’ reduce anxiety. Their input shaped content, interactivity and accessibility features.

Conclusions
Preoperative anxiety is associated with reduced theatre efficiency and prolonged post-operative recovery. This co-designed VR preparation tool already demonstrated strong potential as an engaging, patient-centred approach to familiarising children with the surgical pathway. Going forward, further evaluation in larger cohorts, alongside continued refinement and iterative testing, will establish its effectiveness in reducing anxiety and enhancing efficiency.

Authors
Adit Bassi, UCLH, London, United Kingdom

POST-OPERATIVE URINARY RETENTION FOLLOWING ELECTIVE INGUINAL HERNIA REPAIR SURGERY: A SINGLE NHS CENTRE EXPERIENCE

Introduction

Post-Operative Urinary Retention (POUR) is the inability to void despite having a full bladder and requiring catheterisation. It can lead to discomfort, infection and delayed discharge. According to the international-multicentre-study (RETAINER-I-2023), POUR was reported in 5.8% of men and 2.97% of women who underwent inguinal hernia surgery (IHR). This audit has explored our experience in this context.

Methods

This retrospective study was conducted at the Princess Royal University Hospital between October-2023 and February-2026. It has included adults who underwent elective (open or laparoscopic) day-case IHR under general anaesthesia over the study period. We have excluded recurrent hernia, spinal/local anaesthesia, paediatric and emergency cases. Patients` comorbidities were also reviewed.

Results

The initial cohort included 629 patients; of which, 15 patients (2.3%) had POUR.14/15 (93.3%) patients were >50 years old. 14/15 (93.3%) were male and 1/15 (6.7%) was female. Procedures were performed by senior surgeons in 73.3% of the cases. The mean anaesthetic time was 68 minutes, and the mean time to discharge was 2.3 days. The most common comorbidities in the POUR group were hypertension (46.7%), neurological pathologies (33.3%), chronic kidney disease (13.3%), and diabetes (6.7%).

Conclusion

The incidence of POUR following elective day-case inguinal hernia repair was 2.3%, which lies within the international published figures. Independent risk factors were age >50 years, operative duration of >60 min, and multiple comorbidities. Increased awareness of the modifiable risk factors may help to identify patients at increased risk of POUR. The formal consent process should always include POUR as a possibility.

Authors

Katherine Falcon, Beebee Mubarak Jan, Ahmad Al-Samaraee
King's College NHS Foundation Trust, Bromley, United Kingdom

IMPACT OF PRE-OPERATIVE ERCP ON LAPAROSCOPIC CHOLECYSTECTOMY DAY-CASE OUTCOMES: A SINGLE-CENTRE RETROSPECTIVE COHORT STUDY

Introduction

Guidelines for the management of symptomatic gallstone pathology advise for bile duct clearance and cholecystectomy, but give no clear directive of preference between endoscopic retrograde cholangiopancreatography (ERCP) followed by laparoscopic cholecystectomy (LC), as opposed to LC with bile duct exploration (LCBDE). The impact of pre-operative ERCP on operative outcomes and day-case suitability is unclear, despite this being a key service target.

Methods

A retrospective cohort study was performed at a high-volume centre. In this study, patients with pre-operative ERCP were compared to those undergoing emergency cholecystectomy. Outcomes included length of stay (LOS), intra-operative BDE, complications, and conversion to open or partial cholecystectomy.

Results

- 353 patients were included (69 ERCP, 284 emergency cholecystectomy)
- There was no significant different between BDE (7.25% vs 4.9%) or overall complications (8.7% vs 7.4%)
- However, patients with prior ERCP were significantly more likely to require conversion to open or subtotal cholecystectomy (7.2% vs 1.1%, $p<0.05$)
- Length of stay was longer in the ERCP group (median 0, IQR 0-3 vs 0-1)
- Rates of same-day discharge were similar between groups (55.07% vs 54.58%)
- Of patients undergoing ERCP, 47.8% had no documented features of acute obstruction

Conclusion

Pre-operative ERCP is associated with increased conversion rates and subtotal cholecystectomies without improving overall complication rate or same-day discharge when compared to emergency cholecystectomy alone. These findings, alongside potential overuse of ERCP in patients without acute obstruction, support consideration of a stronger recommendation for emergency cholecystectomy as the initial management for symptomatic gallstone disease.

Authors

Catherine McKeever, Teri Toi, Bhaskar Gopakumar
Norfolk and Norwich NHS Foundation Trust, Norwich, United Kingdom

REDUCING ON-THE-DAY CANCELLATIONS IN DAY SURGERY THROUGH TARGETED PATHWAY INTERVENTIONS: A TWO-CYCLE AUDIT

Introduction

Same-day cancellation of elective surgery is a persistent challenge in peri-operative care, negatively impacting theatre efficiency, healthcare costs, and patient experience. A proportion of these cancellations are avoidable. This audit aimed to identify key causes of on-the-day cancellations in a day-surgery unit and assess the impact of targeted pathway interventions.

Methods

A retrospective two-cycle audit was conducted in the Surgical Day Care Centre of a district general hospital. Cycle 1 reviewed same-day cancellations between April and September 2024 (n=102), excluding procedures under local anaesthesia. Contributing factors were analysed to identify avoidable causes. Interventions included enhanced patient and staff guidance, pre-operative telephone confirmation, 24-hour theatre list validation, and introduction of reserve patient lists. Cycle 2 re-audited cancellations between July and December 2025 (n=109).

Results

Cycle 1 identified avoidable causes including non-attendance, inadequate fasting, and failure to follow pre-operative instructions. Following intervention, fasting-related cancellations reduced by 50% (4 to 2), and patient attendance improved with pre-operative confirmation calls. In Cycle 2, cancellations were predominantly due to non-modifiable factors, particularly acute patient illness, indicating a shift away from avoidable causes. Theatre overruns were most frequent in gynaecology, while some ENT procedures were deemed unnecessary on the day. Anaesthetic staffing contributed to 12 cancellations.

Conclusions

Simple, low-cost pathway interventions were associated with a measurable reduction in avoidable cancellations and a shift towards non-modifiable causes. These findings support the implementation of structured pre-operative processes to improve theatre utilisation, operational efficiency, and patient experience in day-surgery settings.

Authors

Aruna Muthulingam, Bipin Malkania, Sukhpal Bijral, Larisa Maris
Medway Maritime Hospital, Gillingham, United Kingdom

MAXIMISING DAY-CASE TRANSURETHRAL RESECTION OF BLADDER TUMOUR (TURBT): THE IMPACT OF DEDICATED DAY SURGERY PATHWAYS

Introduction

The Getting It Right First Time (GIRFT) programme recommends increasing day-case TURBT rates due to benefits in cost efficiency, patient flow, and environmental impact. A target day-case rate of 60% is advocated, supported by the British Association of Day Surgery (BADS). We evaluated our current practice and identified opportunities to optimise day-case delivery.

Methods

A retrospective review was conducted of all patients undergoing TURBT between October 2025 and January 2026. Data including patient demographics, tumour size, operative setting, and postoperative outcomes were collected and analysed.

Results

84 TURBTs were performed, with an overall day-case rate of 64.3%. 22 procedures were undertaken in the Day Surgery Unit (DSU) and 62 in main theatres. Day-case rates were significantly higher in the DSU compared to main theatres (90.9% vs 54%).

Patients who were managed as inpatients were older (mean 78 vs 71 years), had higher ASA scores (median 3 vs 2), and larger tumours (mean 3.2 cm vs 1.9 cm). Among inpatient cases (n=30), admission was most commonly due to clinical (43.3%) and social (16.7%) factors.

Day-case TURBT demonstrated a low 30-day readmission rate (5.5%).

Conclusion

TURBT performed in a DSU setting achieved higher day-case rates. Optimising patient selection, particularly with respect to comorbidity and tumour size, may further increase day-case pathway utilisation and support GIRFT targets.

Authors

Hermione Tsoi, Hadis Reyhani, Mohammed Quraishi, Edward Calleja
Eastbourne District General Hospital, East Sussex, United Kingdom

FEASIBILITY OF SAME-DAY DISCHARGE FOLLOWING ROBOTIC-ASSISTED LAPAROSCOPIC PROSTATECTOMY

Introduction

Robotic-Assisted Laparoscopic Prostatectomy (RALP) is evolving towards a day-case model to reduce NHS bed pressures and surgical backlogs. Same-day discharge (SDD) RALP offers potential cost and efficiency benefits without compromising patient safety or satisfaction. This audit evaluates perioperative modifications to support transition towards SDD.

Methods

A retrospective audit of 57 RALP procedures (January 2025 to February 2026) compared outcomes between general anaesthesia (GA, n=36) and combined general anaesthesia with spinal (GA+SP, n=21). Outcomes assessed included pain scores, opioid and antiemetic requirements, mobilisation time, and length of stay (LOS).

Results

Mean LOS was 39.4 hours (GA) and 42.4 hours (GA+SP). The principal barrier to early discharge was delayed physiotherapy-led mobilisation (29.4 vs. 27.6 hours). Pain control was comparable between groups, with a reported median of 0 across both GA and GA+SP in recovery (0.9 vs. 1.16) and on the ward (1.05 vs. 1.40). Antiemetic use was marginally higher in the GA+SP group (14.3% vs. 11.1%). Opioid requirements were comparable between groups.

Conclusion

RALP can be delivered efficiently with effective pain control through optimised surgical, anaesthetic, and postoperative strategies. With structured perioperative pathways and improved multidisciplinary coordination, SDD is achievable. To realise economic and capacity benefits, this centre will implement preoperative education, an enhanced ERAS pathway, and targeted improvements in physiotherapy and nursing workflows to pilot SDD RALP.

FEASIBILITY OF SAME-DAY DISCHARGE FOLLOWING ROBOTIC-ASSISTED LAPAROSCOPIC PROSTATECTOMY

Authors
Asher Hayes, The University of Nottingham, Nottingham, United Kingdom

Yogit Wagh, University Hospitals of Derby and Burton NHS Foundation Trust, Royal Derby Hospital, Derby, United Kingdom

Sachin Doijodenagaraj, University Hospitals of Derby and Burton NHS Foundation Trust, Royal Derby Hospital, Derby, United Kingdom

Elizabeth Dreher, University Hospitals of Derby and Burton NHS Foundation Trust, Royal Derby Hospital, Derby, United Kingdom

Idil Dhabahaye, The University of Nottingham, Nottingham, United Kingdom

Priyansha Sheel, The University of Nottingham, Nottingham, United Kingdom

Aly Elmeligy, The University of Nottingham, Nottingham, United Kingdom

IMPROVING DOCUMENTATION IN SKIN CANCER EXCISION: A CLOSED-LOOP AUDIT

Background

Accurate operative documentation is essential for continuity of care, outcome assessment, and compliance with national standards. The British Association of Dermatology (BAD) 2023 guidelines mandate documentation of excision margins and use of loupe magnification with bright theatre lighting. Baseline variability in operative note quality prompted a closed-loop audit of registrar-led day surgery lists.

Methods

A two-cycle closed-loop audit was conducted across registrar-led day surgery lists. Cycle 1 captured 42 primary skin cancer excisions (September–December 2024). Following introduction of a standardised digital operative note template (/skinop) and targeted departmental education, Cycle 2 prospectively captured 23 excisions (May–June 2025). Outcomes included peripheral and deep margin documentation rates, loupe/light documentation, and histological clearance. Standards were set at ≥90% for documentation and ≥95% for histological clearance.

Results

Peripheral margin documentation improved from 88.1% to 100%, and deep margin documentation from 83.3% to 91.3%, both meeting the ≥90% standard. Histological clearance improved from 92.9% to 95.7%, surpassing the target. Loupe and lighting documentation increased from 4.8% to 34.8%, though this remained below standard.

Conclusion

Implementation of a standardised digital proforma significantly improved operative documentation quality and histological clearance rates in registrar-led day surgery skin cancer lists. Digital templating offers a practical, scalable intervention to standardise communication and uphold national guidelines in ambulatory surgical settings.

Authors

Fezan Mughal, Benjamin Wood, Bernard Robertson
NHS Lothian, Edinburgh, United Kingdom

FACTORS ASSOCIATED WITH EARLY DISCHARGE POST-ARTHROPLASTY IN AN ELECTIVE HUB

Introduction
Same-day (Day-0) discharge following hip and knee arthroplasty is increasingly encouraged to improve patient flow and reduce hospital bed utilisation. However, concerns remain regarding patient preferences and potential impact on outcomes. This study aims to identify factors associated with accelerated discharge and explore patient preferences.

Methods
A retrospective cohort study was conducted at the Hampshire Orthopaedic Centre, from September 2025. Variables included demographics, operative details, and patient-reported outcome measures via telephone. Operations were limited to hip and knee arthroplasties. Statistical analysis performed with Mann-Whitney U and Fisher's exact tests.

Results
Of the 50 patients who responded, 23 (46%) were discharged Day-0. Although 56% of patients preferred Day-0 discharge, only 54% received their preferred discharge date. Afternoon surgical start times was significantly associated with delayed discharge ($p = 0.016$). Patient-reported readiness at time of discharge strongly correlated with preference for Day-0 discharge ($p < 0.001$). Higher satisfaction ($p = 0.016$) and better pain control ($p = 0.033$) were also linked to Day-0 preference. Knee arthroplasty patients showed a trend towards preferring same-day discharge. However, notably 24% received no physiotherapy follow up. Patients cited worries about transport, potential complications, and pain control as primary reasons for delaying discharge.

Conclusion
There is a gap in patient preference versus actual discharge date. Surgical timing is the primary determinant of discharge timing, whilst patient preference is significantly influenced by pain control, satisfaction, and perceived readiness. Addressing gap in list management, pre-operative assessment, and post-operative pain control may improve outcomes and uptake of same-day discharge.

Authors
Adrien Alexandre, James Finnigan, Thomas Ranaboldo, Shilpith Shetty
Hampshire Hospitals NHS Foundation Trust, Basingstoke, United Kingdom

A RETROSPECTIVE ANALYSIS OF VAGAL NERVE STIMULATOR IMPLANTED PULSE GENERATOR CHANGES: FEASIBILITY AND ECONOMIC BENEFITS OF PERFORMING IN A STANDALONE DAY-CASE SURGERY UNIT

Introduction

Vagal nerve stimulators (VNS) help seizure control in patients with intractable epilepsy. They require a battery or implanted pulse generator (IPG) to function, and surgical exchange once the battery has degraded. Whilst most centres use an inpatient facility, we have moved these cases to a dedicated day-case surgery centre (DSC). Our study assesses the feasibility of this move, and the impact it has had on patients and productivity.

Methods

We collected data on all inpatient and day case IPG changes over three years, all performed by the same surgeon. Data included demographics, epilepsy syndrome, IPG model, length of surgery, time to discharge, and complications. Economic analysis was done separately.

Results

29 patients underwent inpatient IPG changes, with 56 in DSC. Mean age was 40 and 44 respectively, with 38% of inpatients and 59% at DSC female. 17% in the inpatient cohort had intellectual disability, whilst this was 42% in the DSC cohort. Mean cases performed on inpatient lists were 3, and this was 7 at DSC. Length of surgery was comparable at 23 and 20 minutes. Average time to discharge was 12 hours for inpatients, but 2.3 hours for DSC patients. There were no on-the-day complications or conversion to inpatient care for DSC patients.

Conclusion

Not only is IPG change feasible in a standalone DSC unit, it has improved our productivity and time to discharge significantly even across a more challenging cohort of patients. Our practice reflects this now to IPG changes only being performed at a standalone DSC.

A RETROSPECTIVE ANALYSIS OF VAGAL NERVE STIMULATOR IMPLANTED PULSE GENERATOR CHANGES: FEASIBILITY AND ECONOMIC BENEFITS OF PERFORMING IN A STANDALONE DAY-CASE SURGERY UNIT

Authors
Mohammed Ashraf Patel, Hull University Teaching Hospitals NHS Trust, Hull, United Kingdom

Julieta O'Flaherty, Livanova, York, United Kingdom & University of York, York, United Kingdom

Lorraine Laws, Hull University Teaching Hospitals NHS Trust, Hull, United Kingdom

Mohsin Iqbal, Livanova, Manchester, United Kingdom

Adam Razak, Hull University Teaching Hospitals NHS Trust, Hull, United Kingdom

POSTPARTUM ACUTE ABDOMEN: PERFORATED APPENDICITIS WITH APPENDICEAL ENDOMETRIOSIS FOLLOWING CAESAREAN SECTION

Acute appendicitis in the postpartum period is uncommon and may present atypically, often leading to diagnostic delay and increased morbidity. We present the case of a 32-year-old woman who developed perforated appendicitis with histologically confirmed appendiceal endometriosis three weeks following elective Caesarean section.

She initially presented with fever and progressively worsening right iliac fossa pain and was treated empirically for presumed gynaecological infection. Ongoing symptoms prompted re-presentation, where imaging with CT abdomen and pelvis demonstrated findings consistent with perforated appendicitis with an appendicolith and inflammatory mass. Despite initial conservative management with intravenous antibiotics, persistent sepsis necessitated surgical intervention. The patient underwent emergency laparoscopic limited right hemicolectomy with washout. Intraoperative findings revealed a dense inflammatory mass with multiple pus cavities and extraluminal faecoliths. Histopathological examination confirmed perforated appendicitis with multiple foci of endometriosis within the appendiceal wall. The postoperative course was complicated by superficial wound infection, managed conservatively.

This case highlights the diagnostic challenges of acute abdominal pathology in the postpartum period, where symptoms may be misattributed to obstetric or gynaecological causes. Appendiceal endometriosis is a rare entity and an infrequent finding in appendicectomy specimens, with an uncertain role in the pathogenesis of appendicitis. Its presence in this case likely represents coexistence rather than causation.

Early cross-sectional imaging, a high index of suspicion, and timely surgical intervention are essential to prevent complications and optimise outcomes in postpartum patients presenting with persistent abdominal pain.

Authors
Lakshmi Malvika Atluri, RCSeD, Edinburgh, United Kingdom
Kenneth Chongg, Royal Blackburn Hospital, Blackburn, United Kingdom
Azzam Al-Amin, Royal Blackburn Hospital, Blackburn, United Kingdom

INTRODUCING AN AMBULATORY TONSILLITIS PATHWAY TO A SURGICAL SAME-DAY EMERGENCY CARE (SSDEC) AT A DISTRICT GENERAL HOSPITAL

Introduction

Tonsillitis is a high-volume, often low-acuity presentation to emergency departments contributing to patient flow pressures. An ambulatory tonsillitis pathway was introduced to sSDEC aiming to improve treatment and patient care, and decrease admissions.

Methods

A retrospective observational study was conducted over 12 weeks (October 2025–January 2026) followed by the implementation of a tonsillitis pathway using Plan-Do-Study-Act (PDSA) methodology over a 4-week period. sSDEC streamed suitable patients from A&E where the Advanced Clinical Practitioner (ACP) and ENT team used a structured proforma to clerk and manage patients, escalating those with red flag features. Following the Portsmouth Protocol, patients received standardised treatment and were reviewed after 2–4 hours. Haemodynamically stable patients tolerating oral intake were discharged with antibiotics, a patient information leaflet, and seven-day open access to sSDEC.

Results

Preliminary data demonstrates a 100% reduction in ED four-hour breaches (17/62 27.4% vs 0/9 0%). Treatment protocol compliance has increased from 22.6% (14/62) to 89% (8/9). Whilst a percentage increase in admissions was noted (14/62 22.6% vs 5/9 56%), the average length of admission (hours) has decreased (31.8 vs 31.1). No significant safety concerns or adverse events have been identified so far.

Conclusions

With strict inclusion criteria, an ambulatory tonsillitis pathway is an effective and safe approach to managing tonsillitis improving adherence to evidence-based management, reducing ED congestion, and shortening length of stay. Second PDSA cycle interventions will include earlier referral cut-off times to sSDEC and addressing specific reasons for admission despite active observation.

Authors

Fahad Ahmad, Annalie Baker, Nicola Wooles, Emma Green
Warwick Hospital, Warwick, United Kingdom

COMPARING PREDICTED AND REPORTED PAIN SCORES IN LOCAL ANAESTHETIC SKIN LESION EXCISIONS

Introduction
Patients attending for local anaesthetic day-case procedures to excise skin lesions often report their greatest concern is the local anaesthetic. We set out to investigate the differences between predicted and reported pain scores of having local anaesthetic infiltrated.

Methods
All plastic surgery patients undergoing excision of skin lesions across a three-week period in one centre were offered a questionnaire post-operatively. 44 patients recorded predicted and reported pain scores on an unhatched 100mm Visual Analogue Scale, scoring pain of injection, pain intraoperatively and expected pain in 24 hours. Operation notes were inspected for details on injection site, anaesthetic choice and any adjunctive measures. 12 patients were excluded due to errors in their questionnaires.

Results
We found a positive correlation between predicted and reported pain scores (Pearson $r = 0.592$, $p<0.001$). Median predicted pain score was 37.0 (IQR 40.3), median reported pain score was 18.0 (IQR 37.5). There was a statistically significant difference between individuals' predicted and reported pain scores (paired student t-test = 2.17, $p<0.05$). There were no differences between different local anaesthetics. There was no correlation between predicted or reported scores and expected pain at 24 hours.

Conclusions
Patients having skin lesion excisions under local anaesthetic are predicting infiltration will be more painful than it is. Some are predicting and reporting pain scores up to 90/100, suggesting significant anxiety around this element of day-case surgery. Further research should investigate the benefits of reassurance, distraction, anaesthetic adjuncts and nerve blocks to help alleviate anxiety and reduce pain on infiltration.

Authors
Will Clay, John Kiely
Mid Yorkshire Teaching NHS Trust, Wakefield, United Kingdom

TRUE DORSALIS PEDIS ARTERY ANEURYSM PRESENTING AS A FOOT LUMP: IMPLICATIONS FOR ELECTIVE DAY-CASE VASCULAR SURGERY

Introduction
True aneurysms of the dorsalis pedis artery are exceptionally rare, with fewer than 30 cases reported in the literature, and may present as a dorsal foot mass, often mimicking benign conditions. With increasing emphasis on ambulatory surgery, there is a need to evaluate the suitability of uncommon vascular pathologies for day-case management. This case, alongside a literature review, explores peri-operative considerations relevant to elective day surgery pathways.

Methods
We present a case of a patient with a progressively enlarging, pulsatile dorsal foot mass. Diagnosis was established using duplex ultrasound and computed tomography angiography. Elective surgical repair was performed. A review of previously reported cases was undertaken to assess presentation, operative management, and outcomes.

Results
Imaging confirmed a true dorsalis pedis artery aneurysm with mural thrombus. Surgical repair was successfully performed with preservation of distal perfusion and an uncomplicated recovery. Review of the literature identified fewer than 30 reported cases, with consistently favourable surgical outcomes. However, no studies specifically addressed peri-operative pathways or suitability for day-case management.

Conclusions
This case highlights the potential for selected peripheral vascular procedures to be incorporated into elective day-case pathways. Key considerations include adequate distal perfusion, limited comorbidity, procedural complexity, and the ability to meet criteria-led discharge. Recognition of such cases may support the expansion of ambulatory vascular surgery while maintaining patient safety.

Authors
Syed Saad Ali, Matthew Popplewell
NHS, Wolverhampton, United Kingdom

AN AUDIT OF SURVEILLANCE FLEXIBLE CYSTOSCOPY IN LOW-RISK BLADDER CANCER PATIENTS

Introduction

Follow-up flexible cystoscopy (FC) for low-risk bladder cancer should be offered at 3 and 12 months. If there is no recurrence, patients can be discharged.

Methods

Clinical practice at a district general hospital was audited. Inclusion criteria were (1) histology-confirmed diagnosis of low-risk bladder cancer and (2) transurethral resection of bladder tumour (TURBT) within specified timeframes in 2012-2013 (cycle 1, n = 51) or 2020-2021 (cycle 2, n = 35). Data was collected via electronic records. In cycle two, records were additionally screened for documentation of (1) reasons for deviation in follow-up duration and (2) size and number of lesions. Data was analysed at least 72 (cycle 1) and 50 (cycle 2) months post-TURBT.

Results

Cycle one showed an average follow-up of 58 months, with an average 4.57 extra FCs. Only 27% of patients had been discharged at the time of audit, none of them at 12 months. Average follow-up reduced to 21 months in cycle two, with an average 1.39 extra FCs. 46% of patients had been discharged at the time of audit; 18% at or before 12 months. Number and size of lesions at TURBT were documented in 69% and 51% of cases, respectively.

Conclusion

Cycle one showed poor concordance with NICE guidance, with no patient being discharged at the recommended time point. This improved to 18% in cycle two. However, average follow-up duration remains longer than recommended. As the cost of FC has been estimated at £386.00, there is a savings potential in improving surveillance practice.

Authors

Katharina Keogh, Kristian Arak, Marshall Wang
Rotherham NHS Foundation Trust, Rotherham, United Kingdom

POST-MARKETING SAFETY SIGNALS OF ALVIMOPAN (ENTEREG) IN SURGICAL PATIENTS: A PHARMACOVIGILANCE STUDY USING THE FDA ADVERSE EVENT MONITORING SYSTEM (AEMS)

Background

Alvimopan is a peripherally acting μ-opioid receptor antagonist approved to accelerate gastrointestinal recovery following bowel resection surgery. Concerns regarding cardiovascular safety, including myocardial infarction, have been raised in post-marketing surveillance. This study aimed to characterize adverse events associated with alvimopan using the FDA data base.

Methods

Reports listing alvimopan (Entereg) as a primary suspect drug were extracted from the FDA Adverse Event Monitoring System (AEMS) and analyzed. Demographic characteristics, annual reporting trends, and reported adverse events were evaluated. Adverse events were categorized using Medical Dictionary for Regulatory Activities (MedDRA) preferred terms, and frequencies were calculated.

Results

A total of 233 FAERS reports involving alvimopan were identified, including 215 reports for Entereg and 18 reports for generic formulations. Males accounted for 39.9% of cases (n=93), females 35.6% (n=83), and sex was unspecified in 24.5% (n=57). Most reports involved patients ≥65 years of age (n=73), followed by patients aged 18–64 years (n=63).The most frequently reported adverse events were myocardial infarction (21 cases), abdominal pain (14), nausea (13), acute myocardial infarction (12), and anastomotic leak (11). Other commonly reported events included vomiting, diarrhea, tachycardia, and post-procedural complications. Reporting peaked in 2010 (52 cases) and 2011 (41 cases), with a decline observed after 2016.

Conclusion

Analysis of FAERS reports identified cardiovascular events, particularly myocardial infarction, among the most commonly reported adverse events associated with alvimopan. Gastrointestinal and postoperative complications were also frequently reported. These findings highlight the importance of continued pharmacovigilance when using alvimopan in surgical populations, particularly among older adults.

Authors

Soroush Farsi, Mayo Clinic, Rochester, USA

PRIMARY ISOLATED SUBCUTANEOUS HYDATID CYST OF THE SCAPULAR REGION MIMICKING LIPOMA: A RARE CASE REPORT

Introduction

Hydatid disease caused by Echinococcus granulosus most commonly involves the liver and lungs, whereas primary soft tissue and subcutaneous involvement is rare. Scapular region localization is exceptionally uncommon and may mimic benign lesions such as lipoma or sebaceous cyst, making preoperative diagnosis difficult. Awareness of this entity is important in endemic regions to avoid unexpected intraoperative complications.

Methods

A 27-year-old woman presented with a slowly enlarging left scapular mass first noticed in July 2025, with subsequent increase in size and pain prompting referral. Physical examination revealed a mobile, well-circumscribed, soft subcutaneous lesion measuring approximately 4×4 cm. Preoperative imaging performed at an outside center demonstrated a septated cystic lesion on ultrasonography, an anechoic cystic lesion on Doppler ultrasonography, and a lesion reported as compatible with sebaceous cyst on magnetic resonance imaging. Thoracoabdominal computed tomography showed no additional pathology. Surgical total excision was performed under local anaesthesia.

Results

The lesion was removed completely without rupture or spillage. Histopathological examination demonstrated findings consistent with hydatid cyst, and a lipomatous tissue component was also identified within the same specimen. Albendazole therapy was initiated. Additional thoracic and abdominal imaging showed no other organ involvement, confirming primary isolated subcutaneous disease. No recurrence was detected during 3-month follow-up.

Conclusions

Primary subcutaneous hydatid cyst of the scapular region is extremely rare and may mimic common benign soft tissue masses. In endemic settings, hydatid disease should be included in the differential diagnosis of cystic or soft tissue lesions to guide safe surgical management and appropriate postoperative evaluation.

PRIMARY ISOLATED SUBCUTANEOUS HYDATID CYST OF THE SCAPULAR REGION MIMICKING LIPOMA: A RARE CASE REPORT

Authors
Abdulhakim Yıldız, Akdeniz University Faculty of Medicine, Department of General Surgery, Antalya, Turkey

Kübra Şimşek, Akdeniz University Faculty of Medicine, Department of Pathology, Antalya, Turkey

Muharrem Sarkın, Akdeniz University Faculty of Medicine, Department of General Surgery, Antalya, Turkey

Zeki Demirok, Akdeniz University Faculty of Medicine, Department of General Surgery, Antalya, Turkey

Muhittin Yaprak, Akdeniz University Faculty of Medicine, Department of General Surgery, Antalya, Turkey

MONITORING OF PARAMETERS FOR PATIENTS WITH BLUNT CHEST WALL INJURIES - CYCLE 1 AUDIT

Introduction

Chest Wall Analgesia guidance was updated on 21.03.2025 by Royal Infirmary of Edinburgh (RIE) to triage and manage blunt chest wall injuries. It highlights four monitoring parameters important for assessment at least four times a day; pain, ability to cough effectively, ability to deep breathe and SpO2/O2 requirement. This audit investigated if monitoring requirements were met for the first three days of admission into wards.

Methods

This cycle 1 audit collected retrospective data from patients admitted to Cardiothoracic Surgery and Major Trauma wards of RIE over 6 weeks. NEWS charts and Trak notes to collect monitoring data.

Results

Monitoring documentation did not meet the standards outlined for the 24 patients who met the inclusion criteria. Over the three days of admission, zero patients had documentation of all four parameters monitored at least four times in a day. Pain was documented, per standards, for five patients on day 1, six patients on day 2 and five patients on day 3. Ability to deep breathe was documented for zero patients on all 3 days. Ability to cough effectively was documented for one patient on day 1 and zero patients on days 2 and 3. SpO2/O2 requirement was documented for fourteen patients on day 1, nineteen patients on day 2 and twenty-one patients on day 3.

Conclusion

A quality improvement project was started to implement changes so monitoring standards can be made. A re-audit will start from April assess if the changes implemented have made a significant difference to the monitoring documented.

Authors

Priyanka Bhandari, Walid Elbakbak
Royal infirmary of Edinburgh, Edinburgh, United Kingdom

DAY-CASE MASTECTOMY IN A DUAL-SITE BREAST UNIT: IDENTIFYING MODIFIABLE BARRIERS TO SAME-DAY DISCHARGE

Background

Day-case mastectomy is a safe, cost-effective pathway endorsed by the British Association of Day Surgery (BADS) and Getting It Right First Time programmes (GIRFT). Despite this, uptake remains inconsistent across UK breast units. This study evaluates day-case rates and identifies modifiable barriers to same-day discharge.

Methods

A retrospective evaluation of all mastectomies performed at Royal Stoke University Hospital and County Hospital (October 2024–September 2025) was undertaken. Data included procedure type, reconstruction, axillary surgery, admission status, and reasons for inpatient stay. Patients were categorised as day-case, planned, or unplanned admissions.

Results

Seventy-two mastectomies were analysed. Day-case surgery was achieved in 18 cases (25%), while 54 (75%) required admission. Of these, 43 (79.6%) were planned and only 11 (20.4%) unplanned.

Planned admissions were predominantly due to comorbidity/age (n=14) and reconstruction (n=13). Procedure-specific analysis demonstrated high inpatient rates for reconstruction (83%) and axillary clearance (87.5%), whereas simple mastectomy had a day-case rate of 26%, highlighting a key target group.

Unplanned admissions were infrequent and largely avoidable, most commonly due to late theatre finish; true complications were rare (2.8%).

Conclusion

Day-case mastectomy rates exceeded the national GIRFT average but remain below BADS benchmarks. Importantly, most admissions were planned and driven by modifiable factors rather than complications.

Targeted interventions including pathway standardisation, early theatre scheduling, and improved pre-operative planning could safely increase day-case rates to 35–40%, delivering significant efficiency gains without compromising patient outcomes.

Authors

Rahi Karmarkar, Sadaf Jafferbhoy, Sekhar Marla

University Hospitals North Midlands, Stoke, United Kingdom

PANCREATITIS RISK WITH GLP-1 AND DUAL GLP-1/GIP THERAPIES: IMPLICATIONS FOR DAY-CASE SURGERY AND EMERGING EVIDENCE

Introduction

Glucagon-like peptide-1 (GLP-1) receptor agonists and dual GLP-1/GIP agents are increasingly prescribed for obesity and type 2 diabetes. Concerns remain about a possible link with acute pancreatitis. This review summarises current evidence and assesses whether pancreatitis represents a clinically relevant adverse effect influencing peri-operative assessment, patient selection, and suitability for day-case surgery.

Methods

A narrative review was undertaken including observational studies, post-marketing surveillance data, regulatory safety communications, and systematic reviews. Evidence was drawn from pharmacovigilance databases, randomised controlled trial safety analyses, and real-world cohort studies evaluating pancreatic outcomes in patients receiving GLP-1 and dual GLP-1/GIP therapies.

Results

Early post-marketing reports and case series described acute pancreatitis in temporal association with GLP-1 therapy. Large randomised trials have not shown a significant increase in pancreatitis incidence but were not designed to detect rare events. Observational and pharmacovigilance data suggest a small but consistent signal, particularly in patients with risk factors including gallstone disease, hypertriglyceridaemia, or rapid weight loss. In the peri-operative setting, unrecognised pancreatitis may present with non-specific symptoms, contributing to late cancellations, diagnostic uncertainty, or unplanned admission after attempted day-case surgery. Proposed mechanisms include pancreatic ductal changes, increased exocrine activity, and gallbladder hypomotility.

Conclusions

The link between incretin-based therapies and pancreatitis remains uncertain but is increasingly recognised as a peri-operative concern. A cautious approach is advised, particularly in higher-risk patients. Pre-operative risk assessment, patient education on symptoms, and early investigation of suspected cases are recommended. Awareness may improve patient selection, reduce unplanned admissions, and support safe, efficient day-case surgical pathways.

Authors
Matthew Oh, Tamer Hasablla, Basim Al-Robaie, Shameen Jaunoo
East Sussex Healthcare NHS Trust, Hastings, United Kingdom

UNDERUTILISATION OF SURGICAL OFFLOADING: A RETROSPECTIVE AUDIT OF ADHERENCE TO UPDATED IWGDF 2023 OFFLOADING GUIDELINES IN A DIABETIC LIMB SALVAGE SERVICE

Introduction

Diabetic foot ulceration (DFU) is associated with significant morbidity and a 2.5-fold increase in mortality. The updated 2023 International Working Group on the Diabetic Foot (IWGDF) guidelines recommend both surgical and non-surgical offloading techniques, including day-case procedures such as digital flexor tenotomies, to reduce ulcer progression. This audit evaluated adherence to the guidelines within the Diabetic Limb Salvage Service (DLSS) with a focus on surgical offloading.

Methods

A retrospective audit was conducted of patients attending the DLSS between 01/05/2023 and 01/09/2023. Data was collected on adherence to three non-surgical and two surgical IWGDF offloading recommendations. Offloading strategies, alongside patient demographics, and ulcer characteristics, infection status, and surgical interventions, were analysed. Adherence was defined as implementation of at least one recommended intervention.

Results

59 patients met the inclusion criteria (mean age 70.6 +/- 10.4 years, male:female 2.2:1). Digital ulcers were the most prevalent (n=35). Overall, 69.5% of patients received at least one offloading intervention, with a mean adherence across all IWGDF recommendations of 12.1%. Adherence to removable offloading (recommendation 2) was highest (59.3%). Adherence to both surgical recommendations was 0%. Documentation of offloading counselling was present in only 8.4% of cases.

Conclusion

Adherence to the IWGDF guidelines remains inconsistent, with underutilisation of gold-standard and surgical management techniques, including day-case procedures. Suboptimal documentation split between two IT systems further limited assessment of compliance. These findings highlighted key targets for service improvement. Since auditing, standardised electronic documentation, clerking proformas and targeted clinician education were implemented, with a re-audit underway to evaluate improvement.

UNDERUTILISATION OF SURGICAL OFFLOADING: A RETROSPECTIVE AUDIT OF ADHERENCE TO UPDATED IWGDF 2023 OFFLOADING GUIDELINES IN A DIABETIC LIMB SALVAGE SERVICE

Authors
Mohima Begum, Christopher Ashmore
Leeds Teaching Hospitals Trust, Leeds, United Kingdom

AWAKE UPPER LIMB SURGERY: A RETROSPECTIVE EVALUATION OF CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE

Background

Maximising day surgery rates for upper limb procedures requires optimising recovery and mitigating risks, particularly in patients with comorbidities who may otherwise require inpatient admission. Awake surgery under regional anaesthesia avoids general anaesthesia (GA) and facilitates rapid, safe discharge. This project evaluates the clinical effectiveness and patient experience of an awake shoulder and hand surgery.

Methods

A patient information leaflet (PIL) was developed, approved, and distributed during preoperative assessment. Patients who underwent upper limb surgery under regional anaesthesia (with or without sedation) between September 2024 and August 2025 at Milton Keynes University Hospital were identified. Of 43 patients contacted, 27 responded to a structured telephone survey. Data collected included procedural timings, type of surgery, anaesthetic technique, and patient-reported outcomes, including comfort, pain, satisfaction, and overall experience.

Results

The average anaesthesia-to-surgery time was 34 minutes. Patients received a regional block with (63%) or without (37%) sedation. While 33% did not receive the preoperative leaflet, 83% of those who utilised it felt prepared, and 66% reported reduced concerns. Intraoperatively, 92% of patients were comfortable (70% very, 22% somewhat), and the experience matched expectations for 85%. Postoperatively, there were zero complications (0/27), and 86% achieved a good night's sleep. Overall, 92% were satisfied with their care, and 85% would recommend awake surgery to others

Conclusion

Awake upper limb surgery is a safe, effective pathway with high patient satisfaction. Standardising preoperative information and developing a Standard Operating Procedure may further streamline the care and enhance patient experience.

AWAKE UPPER LIMB SURGERY: A RETROSPECTIVE EVALUATION OF CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE

Authors
Adel Emam Amer, Milton Keynes University Hospital, Milton Keynes, United Kingdom & Frimley Health NHS Foundation Trust, Frimley, United Kingdom

Anushaprasath Uthayasingh, Milton Keynes University Hospital, Milton Keynes, United Kingdom

Alistair Lee, Milton Keynes University Hospital, Milton Keynes, United Kingdom

Anwar Rashid, Milton Keynes University Hospital, Milton Keynes, United Kingdom

Girgis Abadi, Frimley Health NHS Foundation Trust, Frimley, United Kingdom

EARLY REAL-WORLD SAFETY PROFILE OF SUZETRIGINE (JOURNAVX): A PHARMACOVIGILANCE ANALYSIS OF FDA ADVERSE EVENT DATA

Background

Effective postoperative pain control remains a critical component of surgical care, with increasing emphasis on identifying analgesic options that provide adequate pain relief while minimizing adverse effects. Suzetrigine (Journavx), a novel selective sodium channel (NaV1.8) inhibitor, has emerged as a promising non-opioid alternative. We aimed to evaluate early post-marketing safety signals associated with suzetrigine to assess its potential as a well-tolerated postoperative analgesic.

Methods

Adverse event reports listing suzetrigine as the primary suspect drug were extracted from the Food and Drug Administration (FDA) post-marketing surveillance datasets (FAERS/AEMS). Demographics, temporal trends, and adverse events were analyzed, and event frequencies were summarized descriptively.

Results

A total of 875 reports were identified, reflecting early adoption in clinical practice. Reporting peaked in 2025 (n=633, 72.3%) with continued reporting in 2026 (n=242, 27.7%). The most frequently reported adverse events were pruritus (11.2%), rash (7.7%), paraesthesia (7.3%), nausea (6.9%), dizziness (6.4%), and muscle spasms (5.3%). Adverse events were predominantly dermatologic and neurologic in nature. Reports of drug ineffectiveness (4.0%) and off-label use (19.1%) were also observed, reflecting evolving real-world utilization patterns. Importantly, no strong signal for major cardiovascular events was identified.

Conclusion

Suzetrigine demonstrates a favorable early safety profile with predominantly mild adverse events and no significant cardiovascular signal, supporting its role as a well-tolerated postoperative analgesic. Continued surveillance is warranted as clinical use expands.

Authors

Hadi Rezaei, Moe Abou Chaar, Shahd Mansour, Soroush Farsi, Bradley Peters, Veljko Strajina, Daniel Stephens
Mayo Clinic, Rochester, USA

A SCALABLE PATIENT INFORMATION INTERVENTION TO ENHANCE PERIOPERATIVE COMMUNICATION AND SAFETY IN BREAST SURGERY

Background

Clear perioperative communication is essential for patient safety and surgical efficiency. This quality improvement project (QIP) evaluated the impact of a patient-centered "Roadmap to Your Breast Surgery" leaflet designed to standardize the perioperative pathway, empower patient preparation, and reduce logistical errors.

Methods

This closed-loop QIP evaluated a patient-centered intervention through pre- and post-implementation multidisciplinary surveys. The information leaflet was benchmarked against RCS Good Surgical Practice, NHS Accessible Information Standards, and national quality improvement frameworks. Alongside the leaflet, targeted staff education was provided. Data were analyzed using Microsoft Excel, and a re-audit was undertaken to measure clinical impact and procedural sustainability.

Results

Following the intervention, staff rating perioperative pathway clarity as "extremely" or "very clear" increased from 35% to 85%. Staff reporting that patients received sufficient information rose from 60% to 100%. Significant improvements were noted in awareness of preoperative reporting venues (55% to 95%) and day-of-surgery locations (75% to 100%). Satisfaction with preoperative assessment rose from 40% to 100%, while understanding of postoperative care improved from 40% to 95%. Furthermore, staff perceived a reduction in day-of-surgery cancellation rates.

Conclusion

This low-cost, scalable intervention delivered measurable system-level improvements in communication, patient preparedness, and perioperative efficiency. Its success led to rapid trust-wide adoption. The "Roadmap" model serves as a high-impact, transferable lever for enhancing surgical safety and can be easily adapted across diverse surgical specialties to optimize patient outcomes.

Authors

Sonal Kapoor, Northern Care Alliance NHS Foundation Trust, Salford, United Kingdom
Serena Ledwidge, Barts Health NHS Trust, London, United Kingdom

POST-OPERATIVE PAIN ASSESSMENT AND MANAGEMENT IN PAEDIATRIC ORCHIDOPEXY

Introduction

Orchidopexy is a common paediatric day-case procedure associated with predictable post-operative pain. Effective pain assessment and management are essential to minimise distress and enable timely discharge. This audit aimed to evaluate whether post-operative pain in children undergoing orchidopexy was appropriately assessed, managed, and reassessed, and to identify opportunities for improvement.

Methods

This retrospective audit included children under 18 years undergoing elective orchidopexy, with a total of 42 patients analysed. Data were collected from anaesthetic charts, drug charts, recovery records, and ward notes. The audit focused on pain score documentation, identification of elevated pain, the clinical response to elevated pain and reassessment following intervention and prior to discharge.

Results

Pain scores were documented within 30 minutes of ward arrival and prior to discharge in 100% of patients. 14% percent of patients had elevated pain scores, all of whom received appropriate rescue analgesia and 75% were reassessed within 60 minutes.

Conclusion

Post-operative pain assessment and management were performed consistently to a high standard in line with national guidance. Care could be further optimised by prioritising nerve blocks in bilateral or older/heavier children, ensuring pre-operative paracetamol and ibuprofen for baseline analgesia, and reinforcing reassessment documentation through continued staff education. Re-audit will help sustain compliance and identify future opportunities for improvement. Standardised and proactive pain management effectively reduces post-operative distress, with targeted interventions required for high-risk patients to eliminate the residual ‘pain gap’.

POST-OPERATIVE PAIN ASSESSMENT AND MANAGEMENT IN PAEDIATRIC ORCHIDOPEXY

Authors
Swarnalakshmi Raghavan, Walsall Healthcare NHS trust, Walsall, United Kingdom & Royal Wolverhampton NHS trust, Wolverhampton, United Kingdom

Shubhi Ratra, Royal Wolverhampton NHS trust, Wolverhampton, United Kingdom

Miranda Roberts, Royal Wolverhampton NHS trust, Wolverhampton, United Kingdom

SYMPTOM ONSET AND REVISION STATUS PREDICT FUNCTIONAL AND AESTHETIC OUTCOMES AFTER SEPTORHINOPLASTY: A PROMS-BASED COHORT STUDY

Introduction

Predicting outcomes after septorhinoplasty remains challenging. This study examined whether age of symptom onset and revision status influence functional and aesthetic outcomes, with relevance to patient selection and counselling in day-case ENT surgery.

Methods

A retrospective cohort study was performed of all septorhinoplasty patients at a single institution between June 2022 and February 2026. PROMs, including NOSE and ROE scores, were collected pre- and postoperatively in line with GIRFT recommendations. Of 158 eligible patients, 122 had paired NOSE data and 88 paired ROE data. Patients were grouped as Early-Onset (≤16 years), Late-Onset Primary (>16 years, no previous nasal surgery), and Late-Onset Revision (>16 years, previous surgery).

Results

Baseline NOSE scores were similar across groups ($p = 0.345$). Postoperative functional improvement was greatest in Early-Onset patients, with 73% NOSE improvement compared with 63% in Late-Onset Primary and 41% in Late-Onset Revision cases ($p = 0.013$). Aesthetic improvement followed the same pattern ($p = 0.002$), with mean ROE increases of 44, 32, and 15 points, respectively. MCID success rates (>24-point NOSE reduction) were 98.2%, 82.6%, and 60.0% ($p < 0.001$).

Conclusions

Age of symptom onset and revision status strongly predict septorhinoplasty outcomes. Early-Onset patients achieve the greatest functional and aesthetic benefit, while revision cases demonstrate a clear revision penalty. These findings may improve counselling, expectation setting, and resource planning for day-case rhinoplasty services.

Author

Harikalan Rajeswaran, Frimley Health NHS Foundation Trust, Slough, United Kingdom
Mohamed Rayane Mejri, Royal Berkshire NHS Foundation Trust, Reading, United Kingdom
Roland Hettige, Frimley Health NHS Foundation Trust, Slough, United Kingdom

INVESTIGATING THE EFFECT OF LAPONITE NANOCLAY ON CHONDROGENIC DIFFERENTIATION

Introduction

The avascular and aneural nature of cartilage limits its capacity to self-repair, rendering degenerative cartilage diseases largely irreversible. Laponite, a synthetic nanoclay, has demonstrated bioactivity and potential in promoting cartilage formation, representing a promising biomaterial for cartilage regeneration. One hypothesis is laponite's degradation products acting through ion-mediated cellular pathways.

Methods

ATDC5 cells were seeded in 20 µL droplets of 50,000 cells and cultured for 7 days in chondrogenic media at varying laponite concentrations: 0, 10, 50 and 100 µg/mL. Parallel experiments used ionic solutions equivalent to those released by 100 µg/mL laponite. Alcian blue staining assessed GAG concentrations, and gene expression of SOX9 and COL2 was analysed using RT-qPCR. Images were taken using light microscopy, and intensities quantified by CellProfiler.

Results

Alcian blue staining increased dose-dependently with laponite concentration. Quantitative analysis showed intensity increased from 0.5458 ± 0.1220 (n=3) to 0.9108 ± 0.0169 (n=3) at 100 µg/mL, a 1.67-fold increase. One-way ANOVA showed this was significant ($p<0.0003$).

Degradation ions did not increase staining, with the 100 µg/mL laponite sample significantly higher ($p<0.0022$).

RT-qPCR showed no significant differences. However, SOX9 expression increased ~4.7-fold and COL2 ~1.7-fold at 100 µg/mL.

Conclusion

Laponite appears to promote chondrogenesis, but its charged nature may increase Alcian blue uptake. Degradation ions had no effect. Gene expression showed non-significant upregulation. Laponite's chondrogenic effect remains inconclusive

Authors

Pedro Caballero
Southampton University, Southampton, United Kingdom

IMPROVING PRESCRIBING ACCURACY AND VTE COMPLIANCE IN SURGICAL SAME-DAY EMERGENCY CARE: A CLOSED-LOOP AUDIT AT A UK TERTIARY CENTRE

Accurate prescribing at clerking is fundamental to patient safety in Same Day Emergency Care (SDEC), where omissions can result in rapid clinical deterioration. A two-week audit in a surgical SDEC unit at Norfolk and Norwich University Hospital identified significant safety gaps, with overall prescribing compliance of just 40%.

Critical omissions included regular medications for chronic conditions such as diabetes, epilepsy, and hypertension, alongside inconsistent prescribing of analgesia and antiemetics. Compliance with venous thromboembolism (VTE) risk assessment and prophylaxis was also poor, exposing patients to preventable harm. Notably, inappropriate prescribing was also identified, including cases where patients with bowel obstruction were prescribed laxatives, highlighting risks associated with non-standardised prescribing.

A targeted intervention was implemented, addressing both system and behavioural factors. This included a standardised gastrointestinal surgical prescribing protocol embedded within the Electronic Prescribing and Medicines Administration (EPMA) system, structured teaching sessions, incorporation into junior doctor induction, and visual prompts within clinical areas.

On re-audit, overall prescribing compliance improved from 40% to 85%. VTE risk assessment completion increased from 45% to 90%, with appropriate prophylaxis rising from 50% to 88%. Prescribing of regular medications improved markedly. This project demonstrates that targeted, low-cost interventions can deliver rapid and substantial improvements in prescribing safety within high-turnover surgical pathways. By combining system standardisation with early clinician education, this model is highly scalable and directly aligned with national priorities for safer, more efficient day-case care. We saw the greatest improvement through the addition of the prescribing protocol.

Authors
Zlatin Milanov
Norfolk & Norwich, Norwich, United Kingdom

THE ANAEMIC BLIND SPOT: TRANSITIONING FROM EDUCATIONAL TO SYSTEMIC INTERVENTIONS IN HAEMATURIA CARE

Introduction

While acute bleeding in haematuria is routinely managed, resultant iron deficiency anaemia (IDA) is chronically overlooked, despite national guidance mandating iron studies for anaemic surgical patients. With UK haematuria inpatient stays increasing to 10 days, failing to optimise IDA misses a critical opportunity to reduce transfusion burdens. This project aimed to evaluate and rectify IDA management in a tertiary urology centre

Methods

A two-cycle closed-loop audit at a tertiary urology centre assessed adult haematuria admissions (Cycle 1: n=30; Cycle 2: n=21). Practice was benchmarked against the Centre for Perioperative Care and British Society for Haematology standards, aiming for ≥90% compliance in iron studies and management plans. Post-Cycle 1, a targeted clinical education intervention regarding iron protocols was delivered to junior doctors.

Results

Visible haematuria accounted for 100% of presentations, primarily driven by malignancy. Baseline anaemia prevalence was high (87% vs 76%). Initial assessment was deficient: only 17% had ferritin or transferrin saturation (TSAT) measured, and 7% received iron. Post-intervention, ferritin measurement doubled to 33%, TSAT recording reached 43%, and iron administration climbed to 33%. Despite process improvements, transfusion rates paradoxically increased (23% to 56%), and mean length of stay remained prolonged (6.5 vs 7.14 days).

Conclusions

Anaemia in haematuria represents a neglected clinical domain. While education doubled diagnostic screening, it proved inadequate for optimising outcomes or reducing transfusion reliance. Sustained improvement requires a paradigm shift from human-reliant education to automated forcing functions. Future cycles will implement mandatory electronic "Haematuria powerplans" at admission to systematically close this care gap.

Authors

King Hei Anthony Fong, Kashmir Gaddu, Waris Abdul Rashid, Rifat Hussain, Chaitya Desai

Midland Metropolitan University Hospital, Birmingham, United Kingdom