TOO MUCH OR TOO FRAIL: A REVIEW OF DECISION MAKING IN COLORECTAL CANCER

NWRC: North West Research Collaborative

Presenting author: Nick Heywood

Aim: Of approximately 30,000 patients diagnosed with colorectal cancer between April 2014 and March 2015, 37% did not undergo major resection. In 11.8%, there was too much cancer and in 4.7% the patients were too frail with a large variation across trusts (0 32%). 2 year survival in those not undergoing major resection is only 30%. This study is designed to review the decision making process for those patients who are deemed to be too frail. How are patients being assessed for surgery? Is the decision process robust?

Patients: All patients diagnosed with colorectal cancer through their first discussed at the MDT would be identified and included. Intervention: As a prospective multicentre observational study, there would be no intervention, however, patients will be divided into groups; those undergoing major resection (R) and those not undergoing major resection (NR), the second group being subdivided by reason; too much (TM) cancer, or too frail (TF).

Primary Outcomes: 1 & 2 year survival

Secondary outcomes: Mode of presentation (Emergency vs elective), Rockwood Frailty Score, anaesthetic assessment (performed or not, and type (i.e.CPEX)), review by geriatrician, patient decision, comorbidities, length of stay, Quality of life score , chemotherapy, colonic stenting, repeated blood transfusions, readmission with cancer complications.

All eligible patients identified at MDT will be included and have prospective data collected. Frailty scores, if not routinely used for MDT decision, will be collected posthoc and remain blind to the original MDT decision.

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RISCS 2 RISKS IN SPINAL CONSENTING FOR SURGERY 2: CONSENT WITHDRAWAL RATES FOR MAJOR SPINAL OPERATIONS BASED ON THE AWARENESS OF RISKS

SARCO:Severn Audit & Research Collaborative in Orthopaedics

Presenting author: James Fletcher

Patient centred consent is enshrined in GMC Guidance and the Montgomery ruling. However, a recent trial involving spinal injections has shown that current assumptions regarding patient decisions are incorrect. Patient decisions are uninfluenced by the severity of risks for minor procedures whilst encyclopaedic risk explanation may be harmful as it generates increased anxiety. Further work is warranted with more invasive procedures to confirm these findings to best inform clinical practice.

We propose a multicentre, noninferiority, controlled trial randomising 500 patients receiving spinal surgery (requiring a general anaesthetic) to either a medical centred consent process (control) involving material and frequently occurring risks for that procedure, or a legally centred consent process (intervention), involving all associated risks found in the literature.

The primary end point is consent withdrawal. Secondary endpoints include questionnaires assessing if anxiety levels change due to either process. This is scheduled to take twelve months.

This trial will challenge the stance generated by Chester vs Asfhar and help refine where consenting processes should be to account for patient expectations and their benefit. It will ensure that consenting processes are fit for purpose whilst maximising patient benefit and minimising unnecessary anxiety.

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SWARM: SOUTH WEST ANAESTHESIA RESEARCH MATRIX ACCELEROMETERS FOR ANAESTHESIA RESEARCH (AFAR); WEARABLE MOVEMENT SENSORS TO MEASURE RECOVERY FROM DAY CASE SURGERY: A FEASIBILITY STUDY FROM SOUTHWEST ANAESTHESIA RESEARCH MATRIX IN COLLABORATION WITH OPEN LAB AT NEWCASTLE UNIVERSITY

Presenting author: Anna Ratcliffe

Aim: Wearable movement sensors (accelerometers) are a novel technology that may have utility to measure patientcentred endpoints such as activity levels. We propose to investigate their feasibility to track recovery after day case surgery. We aim to gain experience with this technology and test a methodology that could be deployed at scale across a trainee research network.

Patients: The SWARM trainee network will recruit 50 consecutive functionally able adult patients from two NHS trusts, booked for urology, gynaecology or general day case surgery that requires general or neuraxial anaesthesia but does not in itself restrict mobility.

Comparator: We will compare a postoperative recovery profile of each patient to his or her own baseline preoperative activity profile. We will also investigate validity of this measure by comparing patients recovery profile against their sequential daily scores on a validated quality of recovery questionnaire (Q0R15), administered by phone call.

Outcomes: Participants will be asked to wear wrist devices for a week before and after surgery so that 7day baseline activity and postoperative recovery profiles can be characterized. Computer scientist collaborators from Open Lab at Newcastle University use raw movement data from the Axivity AX3 device to generate multiaxial parameters, quantifying movement in more than one dimension.

Our candidate measures are:

- step count
- intensity of activity
- aggregate sleep duration & quality
- energy expenditure
- character of activity.

We will compare the correlation between these and daily QoR15 score. Acceptability will be explored with a PPI group. Feasibility for future study will be checked by recording data about recruitment rate, wear time (compliance), device return rate, proportion of lost/unusable data.

Study design: Prospective, observational study.

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BNTRC: BRITISH NEUROSURGICAL TRAINEE RESEARCH COLLABORATIVE UNDERSTANDING CAUDA EQUINA SYNDROME

Presenting author: Julie Woodfield

Introduction: Cauda equina syndrome (CES) is a rare but potentially devastating condition caused by compression of the cauda