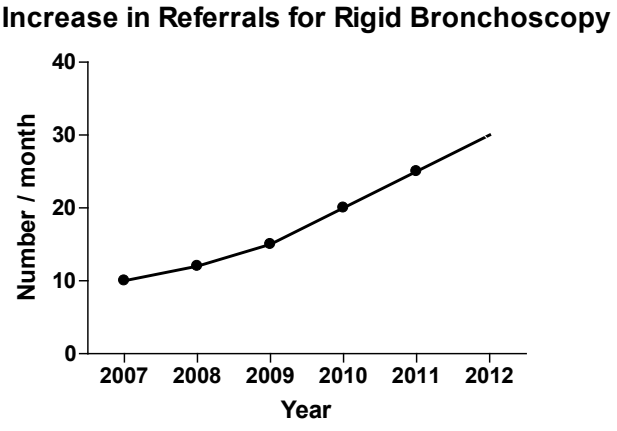
rigid bronchoscopy at a tertiary referral centre and to review the referral frequency over the last 6 years.

Methods We reviewed monthly referrals for rigid bronchoscopy since 2007 and analysed indications, physiological parameters and outcomes for the last 500 cases.

Results Referrals and consequently the number of rigid bronchoscopies have risen from 10 to 30 per month over the last 6 years (see graph 1). Of the most recent 500 consecutive referrals only one case was considered unsuitable (requesting therapeutic intervention for a small subsegmental tumour with end stage interstitial lung disease and pulmonary hypertension). Indications were: laser of granulation tissue n=180; biopsy of proximal tumour n=166 (100% diagnostic); insertion of stent (bronchial and tracheal) n=86; dilation of stricture n=24; percutaneous tracheostomy insertion n=16; stent removal n=11; bioglue administration n=10 and foreign body removal n=7. Median preoperative PaO_2 was 7.8 kPa (range 6.4–11.8kPa) and CO_2 5.9 kPa (range 4.9–7.2kPa). There were no fatalities and 2 patients (0.4%) were transferred to intensive care post procedure. Three procedures were complicated by pneumothorax (2 required drain insertion) and 5 resulted in haemorrhage >100mls (100, 200, 250, 400, 600mls). Haemostasis was achieved in all cases. No other complications were observed.

Conclusions The annual referral rate for rigid bronchoscopy has been rising since 2007. These results demonstrate the varying diagnostic and therapeutic modalities available and highlight the favourable morbidity rates and 100% diagnostic rates for this safe procedure, despite many patients with respiratory failure. It is important that respiratory physicians are aware of the potential benefit that large airway intervention can offer.



Abstract P200 Figure 1

P201 SINGLE-PORT VATS LOBECTOMY. MINIMISING MINIMALLY INVASIVE SURGERY

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Introduction Only around 10% of lobectomies in the UK are performed by VATS via 3 or 4 incisions. We now offer routinely VATS lobectomy via a very novel single port access to our patients.

Methods We aim to evaluate the early outcomes of our initial experience with Single-Port VATS lobectomy. From December 2011 until July 2012, 24 cases [13 male and 11 female, age 68 (45–85) years] were intended to undergo lobectomy via Single-Port technique. Data in Median (Range).

Results Thoraco score was 1.57 (0.1–11.8)and FEV_1 was 74 (34–157) % predicted. Thirteen operations were right-sided (5 upper, 2 middle and 6 lower lobectomies), and eleven left-sided (6 upper and 5 lower).

Operations lasted 127 (65–194)minutes. One intercostal drain was used in all cases, and it was removed at 3 (1–9)days. Patients were discharged home at 3 (range 1–21) days. There was one post-operative death in our experience, a patient who was ready for discharge 3 days after surgery when he suffered a dense middle cerebral artery stroke that led to his death by contralateral pneumonia 20 days later. One case was converted to thoracotomy due to bleeding and another case a retractor was used in the incision to enable safe suture of a branch of the pulmonary artery after partial failure of the stapler.

In 10 of the 24 patients the patients started oral analgesia on the day of surgery without the use of epidurals or paravertebral catheters.

Conclusion Single-Port VATS lobectomy is feasible and safe. It is becoming our approach of choice for early stage lung cancer due to its low incidence of complications and the very fast recovery with some patients going home as early as the day after surgery. This technique will make the case for surgery against newest techniques of radiotherapy for lung cancer.

P202 RISK FACTORS FOR EARLY MORTALITY AFTER LUNG CANCER RESECTION: A STUDY OF THE UK NATIONAL LUNG CANCER AUDIT

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Introduction Surgical resection is the best chance of cure for most patients with non-small cell lung cancer (NSCLC), for whom 5-year survival is otherwise poor. Selection of patients for surgery should include an estimation of the likely post-operative mortality risk but the tool often used in UK practise is a predictive score that was developed using a French database of thoracic surgical procedures, not specific to lung cancer.

Methods We used data from the National Lung Cancer Audit linked with Hospital Episode Statistics to estimate the influence of pre-operative patient and tumour factors, and the type of procedure on the odds of death at 30 and 90 days after potentially curative surgery for NSCLC. We used logistic regression to determine which factors were associated with early post-operative mortality and then calculated the percentage of patients who died within 90 days of surgery, stratified by the strongest predictors of early post-operative mortality.

Results We identified 12,096 patients who had potentially curative surgery for NSCLC in England between January 2004 and March 2010. Three per cent (n=387) and 6% (n=792) of patients died within 30 and 90 days respectively. Of the 12 clinical and socio-demographic factors assessed, age and type of procedure were consistently the most important predictors of early post-operative mortality: Odds ratio (OR) for death at 30 days for pneumonectomy compared with lobectomy 3.03, 95% confidence interval (CI) 2.32–3.94; and for each year increase in age OR 1.06, 95% CI 1.04–1.07. Performance status, co-morbidity score and sex and were also significantly associated with the outcomes. Table 1 shows the percentage of patients who died within 90 days of either lobectomy or pneumonectomy, stratified by age and performance status.