

P162 CT FOLLOW UP AFTER SURGERY FOR LUNG CANCER – SHOULD THE AVAILABILITY OF RADIO-SURGERY PROMPT A CHANGE IN SCREENING PROTOCOL TO DETECT EARLY INTRACEREBRAL RECURRENCE?

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Although routinely performed, the optimal screening regimen for recurrent disease after curative surgery for lung cancer has yet to be agreed. Radio-surgery has improved prognosis for patients with limited intra-cerebral metastases,¹ however screening for intracerebral recurrence has little evidence base. Local protocol is to perform CT head/chest/abdomen pre surgery and CT chest/abdomen at 3, 12 and 24 months after surgery. We proposed that the addition of CT head to the post-surgical protocol would enable earlier detection of intra-cerebral recurrence, facilitating timely treatment.

CT head was added to standard post surgical surveillance programme in February 2015. CT reports were reviewed prospectively and we report data to June 2015. For comparison, retrospective data for all patients currently enrolled in screening was also reviewed.

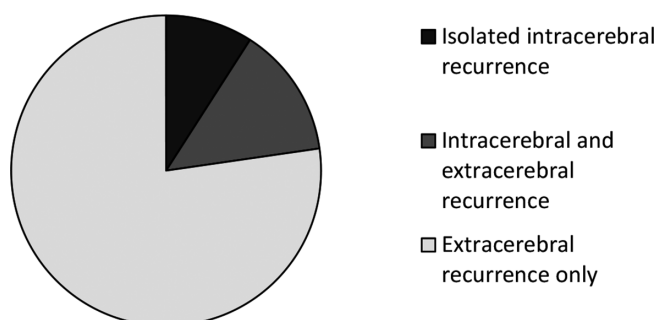
All 222 CT scans for the 115 patients undergoing post-surgical surveillance were reviewed. 28 of these have been performed since our protocol changed to include CT head.

In total, 22 patients (19%) had recurrent disease. 2 patients had isolated intracerebral recurrence. This represents 9% of all patients with recurrent disease and these patients would not be identified on previous screening protocol. This is in line with findings from previous work.²

Four cases of symptomatic intra-cerebral recurrence were identified prior to protocol change. Only one of these patients was eligible for radio-surgery. Since protocol change, one case of asymptomatic isolated intra-cerebral recurrence has been detected through screening; this patient was thereafter treated with radio-surgery.

Our results show that isolated intra-cerebral recurrence would be missed on the previous screening protocol. These preliminary results suggest that the addition of CT head in post operative surveillance enables earlier identification of these patients. The earlier detection of intracerebral recurrence as a result of screening may increase referrals for radio-surgery, with potential for improved survival.

Site of recurrent disease after surgery



Abstract P162 Figure 1

REFERENCES

- 1 Andrews, *et al. Lancet* 2004;**363**:1665
- 2 Yokoi, *et al. Ann Thorac Surg.* 1996;**61**:546

P163 OUTCOMES FROM A NOVEL NURSE LED TELEPHONE CLINIC POST THORACIC SURGERY

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Background Moore *et al.*¹ reported that nurse led initiatives can reconfigure care, making it more responsive to individual needs, increasing patient satisfaction and reducing hospital visits. Nurse-led telephone follow up clinics post surgery have evidence of patient satisfaction and reduction in post-op complications,² but this is not a routine intervention post thoracic surgery. Prior to establishing our clinic, patients were discharged after thoracic surgery with a surgical outpatient appointment at 6 weeks and no routine community follow up. These patients had often undergone complicated surgery, and been discharged with chest drains or on strong opioids.

Methods All patients discharged after surgery were contacted by telephone up to a maximum of a week after discharge with a further follow up call 2 weeks later if needed. A protocol of open questions was used to identify post-op difficulties at an early stage, facilitate referral to community teams, improve patient experience and provide additional information.

Results and conclusion 29 patients were contacted over a 6 month period, following discharge after thoracic surgery; VATs, lobectomy, sleeve/wedge resection, pneumonectomy and pleurectomy. Each call lasted up to 20 min, equating to a maximum 10 h of nurse time.

Telephone clinic highlighted a number of medical issues that required intervention and prevented GP and hospital appointments/admissions. Commonly reported symptoms included pain, shortness of breath, fatigue, constipation, weight loss and inability to sleep. In most cases simple advice and reassurance could be given. In 3 cases, medication was organised (antibiotics, laxatives, analgesia). A referral to the GP or community services was organised in 4 cases. Patient satisfaction was high however further evaluation over a longer period is needed. Additional study is necessary to explore the cost implications and the monetary value of avoiding admissions.

REFERENCES

- 1 Moore S, Corner J, Haviland J, *et al.* Nurse led follow up and conventional medical follow up in management of patients with lung cancer: randomised trial. *BMJ* 2002;**325**:1145
- 2 Young JM, Butow PN, Walsh J, *et al.* Multicenter randomized trial of centralized nurse-led telephone-based care coordination to improve outcomes after surgical resection for colorectal cancer: The CONNECT intervention. *J Clin Oncol.* 2013;**31**:3585–91

P164 SMOKING AT THE TIME OF CURATIVE-INTENT LUNG CANCER SURGERY INCREASES PERIOPERATIVE COMPLICATIONS: IS THERE A ROLE FOR ELECTRONIC CIGARETTES?

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