

4 (8%) graft limb occlusions treated endovascularly(2) or open (2).

Conclusion: The successful deployment rate and the low mortality rate (2%) compares favourably with data reported in major trials. The EVAR programme in Malta has to date been successful in preventing ruptures in this cohort of patients.

OP5.16

Recurrent varicose veins following surgical treatment in the Maltese population

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Introduction: Varicose veins are associated with the development of significant comorbidity such as venous ulceration. Treatment consumes a significant proportion of health budgets. Recurrences increase the financial burden on the health service and leads to additional interventions. Identifying the cause of recurrences is an important step in reducing the burden on patients and the health service. The aim of this study was to identify the types of recurrent varicose veins presenting to the vascular unit at Mater Dei Hospital.

Methods: Patients with a history of recurrent varicose veins presenting for the first time to the Vascular Unit between June and October 2014 were recruited. Data regarding the patients' past medical history, clinical severity of venous disease, and source and route of venous incompetence was collected through clinical and ultrasonographic examination.

Results: 53 limbs from 46 patients with recurrent varicose veins were included. Half the limbs (52.3%) had skin changes. In 92.3% surgery had been performed to the groin. The saphenofemoral junction was the most common source (69.8%), while the great saphenous vein was the most common route of incompetence (60.4%). A completely intact great saphenous vein was present in 30.2% of limbs while a residual great saphenous vein stump was present in 32.1% of limbs. Nonsaphenous incompetence was identified in 26.4% of limbs.

Conclusion: Technical errors, mainly inadequate ligation of the saphenofemoral junction and incomplete stripping of the great saphenous vein, were the dominant cause of recurrence. This highlights the importance of meticulous preoperative duplex ultrasound assessment coupled with correct technical execution of the intervention.

OP5.17

Preliminary results of radiofrequency vein ablation programme at Mater Dei Hospital

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Introduction: During the past decade, international practice guidelines for the management of varicose veins of the lower limb have recommended endovenous thermal ablation (radiofrequency or endovenous laser ablation) over open surgery as the first line treatment for varicose veins associated with truncal reflux. The aim of this review is to audit the introductory results of venous radiofrequency ablation (RFA) at Mater Dei Hospital.

Methods: Patients referred with symptomatic primary/recurrent varicose veins under the care of the vascular surgery team were evaluated with Duplex ultrasonography. Patients were deemed suitable for treatment with RFA if: evidence of truncal reflux; deep veins were patent and competent,

target vessel was not tortuous, less than 2mm in diameter and over 5mm below the skin. All patients underwent clinical examination and ultrasonography 6-10 weeks postoperatively to assess for: occurrence of DVT, success of target vein occlusion.

Results: In the period between February and July 2015, 71 patients underwent lower limb venous RFA with a total of 74 veins being treated. Male to female ratio was 1:3 (24% male vs 76% females). A total of 69 long saphenous veins, 4 short saphenous veins and 1 anterior accessory vein were treated. 95% of patients were treated with simultaneous phlebectomies. 21 of the above patients have till date undergone post-operative duplex ultrasound examination. 100% of treated veins were successfully occluded with resolution of truncal reflux. No cases of post-operative DVT (symptomatic/asymptomatic) occurred.

Conclusion: Early results of venous RFA at Mater Dei hospital are encouraging although more cases are needed to compare to international practices.

OP5.18

Survival after lung cancer surgery in Malta

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Introduction: The aim was to determine the operative rate for lung cancer in Malta and to measure survival after lung cancer surgery in Malta and to calculate the factors affecting survival.

Methods: Theatre registers were used to identify patients undergoing resection for lung cancer in Malta. These were collated with pathology reports and survival data from the hospital's patient archiving system. Kaplan-Meier plots and log rank testing were used to assess survival according to age, cancer subtype, gender, lymph node status and disease staging. A Cox regression analysis was also performed using these variables.

Results: Based on the annual lung cancer incidence of 149 patients in 2012, the resection rate was 8.95%. Kaplan-Meier plots showed survival post lung cancer surgery of 78% at 1 year, 69% at 3 years and 65% at 5 years, with survival maintained for a further 2 years. Log rank test showed that lymph node status, $p=0.001$, and disease staging were statistically significant predictors of survival, $p=0.001$. Cox regression analysis confirmed that staging was the most important predictor of outcome.

Conclusion: Post-op survival after lung cancer surgery in Malta is good, with a 65% 5-year survival. The resection rate of 8.95% is similar to that in UK. Further improvement will require investment and an effort to decrease the waiting time to surgery – in 2006 only 33% of operated patients received surgery within 2 months of initial referral, whilst the targets for lung cancer treatment in the UK are to decrease from 2 months to 4 weeks by 2020.