East & North Hertfordshire NHS Trust
Poster Competition 2016

Abstracts Of Posters
Presented On The
30th June 2016
At The Lister Education Centre, Lister Hospital, Stevenage
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Maternally Inherited Diabetes And Deafness, Myopathy And Statins: A Case Report Of An Under Recognised Association?

Abstract

Case Study
A 38 year old Caucasian male, whose brother and mother had diabetes mellitus (DM) presented with osmotic symptoms, weight loss and fasting hyperglycaemia (14.4 mmol/l) and glycated haemoglobin (HbA1c) 75 mmol/mol.

He also reported limb weakness and muscle wasting. He was considered to have Type 2 DM and commenced on diet and gliclazide. After 4 months HbA1c was 39 and FBG 6.2 and he was discharged to care of his General Practitioner who initiated atorvastatin.

Two years later he was re-referred with deteriorating glycaemic control (HbA1c  68) and weight loss despite maximum doses of sulphonylurea and insulin therapy was commenced. He now had been diagnosed with bilateral sensorineural hearing loss. Following development of chronic kidney disease, muscle pain after exercise was noted with elevated creatinine kinase (1837). Statin myositis was diagnosed and atorvastatin stopped.

Given the patient’s family history of DM, deafness, renal and visual impairment Maternally Inherited Diabetes and Deafness (MIDD) was considered and confirmed by genetic testing.

MIDD is itself associated with exercise induced muscle cramps resulting from reduced oxygen uptake, reduced oxidative phosphorylation, early anaerobic glycolysis and elevated muscle lactate. This can be exacerbated by statins which inhibit ubiquinone (CoQ) increasing lactate:pyruvate ratios and, anecdotally and can be improved by exogenous CoQ. Given the routine use of statins in people with DM, the association of MIDD with statin-induced muscle damage deserves wider recognition.

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Cadaveric Simulation: A New Development At The Lister Education Centre (LEC)

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Abstract:

Introduction
As a Level 2 Trauma centre, managing chest trauma and performing chest drain insertion are particular learning needs for junior doctors working at Lister Hospital.

Historically, simulation has been used to address those learning needs using synthetic models. However, these models can lack realism. As a result, a feasibility study was performed for using ex-vivo (cadaveric) porcine tissue for skills training at the LEC.

Method
This free-to-attend training course comprised two interactive lectures on chest trauma management and chest drain insertion, followed by a practical workshop. Eight candidates practiced chest drain insertion on both synthetic and cadaveric models whilst under close supervision from two senior faculty members. Senior surgical trainees were subsequently led through advanced scenarios in the practical management of thoracic trauma.

Candidates provided structured feedback on the synthetic and cadaveric models immediately following the end of the session, anonymously, using a mixed-method questionnaire.

Two junior doctors analysed the data independently, using both quantitative and qualitative techniques.

Results
Candidates represented three different departments at Lister Hospital and a range of training grades. Qualitative analysis of candidate responses identified the importance of being able to practice a key practical skill without risk to a patient; and understanding the anatomy and steps of such a procedure in a learner-centred environment.

Quantitative responses were measured on a Likert Scale, where a score of 1 represented strong disagreement and 5 represented strong agreement. All candidates strongly agreed that the course was relevant to their training (Mean = 4.9 +/- 0.35, Standard deviation) and materials were appropriate (4.9 +/-0.35).

All Candidates confirmed that the cadaveric model enabled a better understanding of the anatomy for learning chest drain insertion compared to the synthetic model (Mean 4.5 +/- 1.0) and this resulted in more effective learning (4.3 +/- 0.96). This was corroborated on both positive and negative questioning. Furthermore, there was strong disagreement amongst the candidates (Median = 1, Range=1,2) that the use of a cadaveric model caused any distress.

Conclusion
Cadaveric simulation is a new development at the LEC. Whilst ethical approval and strict infection control precautions are required, this feasibility study suggests that it is an educationally rich training method that should be explored further locally.
Obstructive Sleep Apnoea In Older People

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Abstract:

Introduction
Obstructive Sleep Apnoea (OSA) increases in prevalence as we age, (1) most likely due to physiological and physical changes that occur with ageing (2). Additionally, OSA is associated with comorbidity and its subsequent polypharmacy, which may increase with increasing age. OSA is associated with serious outcomes in younger people and, likewise, older people (3). Thus, identification, diagnosis and treatment of OSA is important irrelevant of age. This case describes a typical presentation of OSA in older people.

Case Description
A 73 year old man was referred as his wife reported that he has been sleepy for a couple of years, falling asleep shortly after waking and while he is eating breakfast. His self-reported Epworth Sleepiness Scale score was 10/24. He is known to snore, but they slept in separate rooms, and the snoring was not an issue, there were no witnessed apnoeas and he was not aware of choking or gasping episodes.

He has normal sleep hygiene and routine but wakes two to three times during the night to go to the toilet. He is an ex-smoker and drinks minimal alcohol. He drinks two cups of coffee a day. He is retired but live independently, he uses a mobility scooter and continues to drive.

Past medical history includes secondary progressive multiple sclerosis and recurrent urinary tract infections.

Medication
Tolterodine 4 mg MR od, Calcium/Vitamin D supplements, Lansoprazole 15 mg od, and Tizanidine 4 mg tds.

General examination was unremarkable, BMI 23.9 kg/m² collar size 38 cm.

Investigations
Overnight pulse oximetry confirmed oxygen saturation 92.7% with a 4% oxygen desaturation index of 43 events/hr.

Discussion
Many factors contribute to sleep disruption and the subsequent symptom of excessive daytime sleepiness may be multifactorial in older people, hence obscuring the interpretation of symptoms related to OSA. Additionally the presentation of OSA in older people may be atypical. Older people report different levels of sleepiness for the same level of OSA severity compared to younger populations (4). Additionally older OSA patients typically have a lower body mass index and neck circumference, compared to younger patients with similar disease severity (5).

Conclusion
OSA is common and its prevalence increases with age. Despite the high prevalence, OSA is frequently unrecognised and undiagnosed in older people. There is now evidence to support the use of continuous positive airway pressure therapy in older patients with OSA (6). Age should not be considered a barrier to assessment and treatment of OSA in older patients.
Obstructive Sleep Apnoea In Older People

References


Can A Sleep Service Successfully Establish Commercial Drivers On CPAP Therapy Within 4 Weeks Of Referral?

Abstract:

Introduction
Excessive daytime sleepiness due to Obstructive Sleep Apnoea Syndrome (OSAS) can impair driving. The DVLA guidelines states that those with excessive sleepiness having, or likely to have, an adverse effect on driving should cease driving until they have been investigated and treated, and may resume only after satisfactory symptom control (1). Due to the fear of length of referral and investigations this may deter commercial drivers from seeking treatment due to the financial implication of not working while investigations are completed. The OSA partnership group launched a four week wait campaign to raise awareness of the concerns felt by commercial drivers. A dedicated fast track service was offered to diagnose OSAS and successfully establish vocational drivers on CPAP within 4 weeks of referral.

Methods
The service was advertised to local GPs, encouraging identification of vocational drivers at point of referral. Patients were seen by a nurse specialist who completed an assessment and investigations (domiciliary respiratory polygraphy study). Those who were not identified via the GP referral letter were fast tracked from first identification.

Results
Between January 2014 and April 2016, 30 drivers (29 men) were referred or identified as fast track referrals. 24 referrals were from GPs. 2 patients did not attend. 23 had the type of license recorded, and 11 were group 2 license holders.

At presentation, the mean age was 50(11) years, mean Body Mass Index was 36.9(7.4) kg/m$^2$ and neck circumference 17(2) inches, mean Epworth Sleepiness Score was 13(6). All patients who attended completed a diagnostic investigation, 25 patients successfully completed a respiratory polygraphy study and 3 oximetry studies. There was only 1 unsuccessful oximetry study. The mean oxygen desaturation index (ODI) was 41.3 (29.1) events/hr. 13 patient had severe OSAS. 21(70%) of patients were subsequently commenced on CPAP therapy.

The overall mean time from referral (or first identification) to being seen was 13(18) days. Of those patients who were diagnosed with OSAS the mean number of days between being given the diagnosis and commencing CPAP therapy was 6(7) days. The mean time from referral (or first identification) of patients with OSAS to being successfully established on CPAP therapy was 15(16) days.

Discussion
The fast track service was practical and successful at diagnosed and established vocational drivers on CPAP therapy with in the recommended time frame.

Key Message
It is vital that GPs are aware of this service and refer patients as vocational drivers.

All data as mean (standard deviation)

References
DVLA Assessing fitness to drive – a guide for medical professionals March 2016 www.gov.uk/dvla/fitnesstodrive
**Impact Of Embedded Diabetes Care For Patients On A Satellite Hemodialysis Unit**

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**Abstract:**

**Background**
Diabetes is a major cause of end stage renal failure and is therefore particularly prevalent in patients receiving hemodialysis. For diabetic patients on haemodialysis a high number of routine multidisciplinary appointments are an additional burden and this frequently results in low adherence to recommended monitoring practice such as HbA1c measurements, routine foot care, and retinal screening. Latest evidence suggests that effective integration of diabetes support and screening for its complications such as retinopathy or diabetic foot disease can reduce morbidity, mortality and can have a positive impact on quality of life.

Aim of this study: We introduced a diabetes specialist nurse-led clinic in a satellite dialysis unit and investigated its impact on the diabetic care of dialysis patients.

**Methods**
- A retrospective data analysis of diabetic patients attending our dialysis unit was performed. The specialist nurse proactively identified diabetic patients who were then reviewed. Data on the consultation content and actions taken were collected through a proforma and HbA1c levels were extracted from the pathology reporting system.

**Results**
Integrated diabetic specialist nurse clinics were held in our satellite dialysis unit from November 2013 until December 2015. The prevalence of diabetes in the dialysis population was 47% percent (38/80) at the end of the study period. In total 22 patients (13 male, median age 68 years) were reviewed. Lack of follow-up was highlighted for diabetic care, retinal screening and podiatry in 27% (6/22), 18% (4/22) and 32% (7/22) respectively. Diabetic treatment was optimized by active changes to medication in 50% (11/22). The diabetic nurse specialist (DSN) arranged diabetic clinic follow-up for four patients, ophthalmology for one patient and podiatry review for five patients. HbA1c levels were obtained for all patients at the time of DNS review (median: 60 mmol/mol). For 12 patients subsequent measurements were available five months post diabetes nurse specialist review (median: 58 mmol/mol). A significant drop in HbA1c levels was not observed but in five cases initially abnormal HbA1c levels were subsequently found to be within the recommended range of 42.1 to 74.9 (mmol/mol).

**Conclusion**
Embedding nurse led diabetic review in regular dialysis appointments improves the care of diabetic patients. It provides an opportunity to highlight deficiencies in diabetic management and lack of screening arrangements such as for diabetic foot disease, which is associated with a high morbidity and mortality in this patient group. This patient-centered approach can be achieved time-neutrally for patients and is cost effective through no additional transport costs and the potential avoidance of hospital admissions. Further work to determine whether this intervention translates in a reduction in amputations is needed.
**Abstract:**

The natural outcome of acute pulmonary embolism is near-complete resolution that does not result in significant residual abnormalities. However, a minority of patients will go on to develop chronic thromboembolic pulmonary hypertension (CTEPH) (1,2). According to various reports, it occurs in 0.57 to 3.8% of survivors of acute pulmonary embolism and more than 10% of those with recurrent pulmonary thromboembolism (3-6). Patients with untreated CTEPH are likely to develop right heart failure and are at high risk of dying from it. Therefore all patients should be considered for treatment. Medical therapy is not curative for this condition; surgery is the only definitive treatment (pulmonary thromboendarterectomy).

We present a young male with breathlessness secondary to CTEPH (as published as a case report in the December 2015 edition of the Hertfordshire Journal of Medicine).
Pathological Femoral Fracture: A Rare Initial Presentation Of Uterine Leiomyosarcoma

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Abstract:

Introduction
Uterine leiomyosarcoma is a very rare condition (1-2). Here we describe an unusual presentation which leads to a number of important learning points.

Case Description
A previously independent 71-year-old post-menopausal female, with a two month history of progressively worsening left hip pain radiating to knee, presented to the emergency department following a mechanical fall onto her left hip. She had no previous history of gynaecological symptoms or procedures. She had been taking tibolone as hormone replacement therapy (HRT) for 10 years.

Femoral radiographs revealed a lucent lytic lesion within the proximal left femoral shaft with an associated pathological fracture suggesting metastasis. CT scan was performed to look for a primary malignancy. This showed a bulky uterus suggestive of fibroids and no focal primary; therefore a CT guided biopsy of the femur was performed. The histology was suggestive of a high grade uterine leiomyosarcoma. Subsequent MRI of the pelvis confirmed a uterine primary with an adjacent fibroid.

Discussion
Known uterine leiomyosarcoma has been reported to metastasise to the femur (3-4). However it has only been reported on 3 previous occasions as the presenting complaint (5-7). Unlike our patient, all 3 cases had a previous history of gynaecological symptoms leading to hysterectomy.

There is very little data as to whether tibolone increases the incidence of uterine leiomyosarcoma (8-9). There is some evidence that HRT increases recurrence of a pre-existing tumour (10-11). More research in this field is indicated.

Conclusion
This unusual case leads to a number of learning points. A lesion that initially appears to be a fibroid may be a much rarer condition and interpretation should be carried out in light of the complete clinical picture. The information obtained from CT scans and MRI scans of the same region can be very different. Uterine leiomyosarcoma does not always present with gynaecological symptoms. It is important to consider uterine leiomyosarcoma in the presence of a bulky uterus and a pathological fracture, despite no other clinical evidence of a uterine primary in this patient population.

References
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Capsular Warning Syndrome

**Abstract:**
Capsular Warning Syndrome (CWS) can occur dramatically, and with limited literature available on pathophysiology and management; this case represents an important clinical syndrome to recognise.

**Introduction**
Capsular Warning Syndrome (CWS) can occur dramatically, and with limited literature available on pathophysiology and management; this case represents an important clinical syndrome to recognise.

**Case Description**
A 50-year-old engineer, normally fit and well - with no relevant stroke risk factors, presented with left-sided facial droop and left-sided limb weakness. His symptoms resolved after a few minutes, but he subsequently developed similar symptoms a further seven times, each lasting 2-5 minutes. An urgent CT head was performed, which was unremarkable, after which aspirin 300mg was administered. An eight episode occurred, which lasted 45 minutes. The on-call stroke consultant was contacted, however as his symptoms settled, thrombolysis was not performed.

A CT angiogram of the head demonstrated no vessel dissection or acute thrombus. The following afternoon, he developed 0/5 left arm weakness and left facial droop, for which he was successfully thrombolysed. Urgent MRI head with diffusion-weighted-imaging demonstrated a small area of diffusion restriction in the right internal capsule, which confirmed the ischaemic origin of the symptoms.

**Discussion**
CWS, first described by Donnan et al, consists of a collection of recurrent transient ischaemic attacks (TIAs) due to ischaemia in the internal capsule. It is typified by a sudden onset of symptoms followed by complete resolution between episodes. The clinical features of CWS are unilateral motor/sensory deficits involving two out of three of face, upper limb, and lower limb, with no evidence of cortical signs. The commonest presentation is pure motor hemiparesis. It accounts for 1.5% of TIAs; however, it has 42-71% risk of complete capsular infarct.

The exact pathophysiology is unknown, but the most likely cause is obstruction of one of the penetrating lenticulo-striate arteries, by either microatheroma or lipohyalinosis. This is exacerbated by hypotension or hypovolaemia. Other theories include vasospasm, and emboli of a cardiac or arterial source.

A similar occurrence has been demonstrated in the Pons – Pontine Warning Syndrome. There is limited evidence on best management of this syndrome and generally, it is quite refractory to all available treatment modalities. Long-term prognosis is good and recurrence rate is low.

**Conclusion**
CWS describes recurrent lacunar TIAs with a high risk of developing a completed infarct. Due to debated pathophysiology, there is no agreement on effective management for CWS. Further research is required in this area.
Supine Nephrostomy Experience: Technique, Complications And Benefits

Abstract:

Introduction
Percutaneous Nephrostomy (PCN) placement is a uroradiological technique used to decompress the obstructed renal tract. The technique normally requires the patient to lie in the prone position. This is thought to be easier and safer given the retroperitoneal position of the kidneys.

Acutely unwell, obese and elderly patients are often unsafe to manage in the prone position: compressing the rib cage reduced lung compliance; reduces venous return and makes emergency airway management very challenging. The safety of PCN in the supine/supine-oblique position is well described in the literature with both cadaveric dissection and over 14000 cases in reported. The reported complication rate is similar to prone nephrostomies with no recorded incidence of colon injury.1–3

This is a description of a single center experience of 12 cases of PCN insertion performed in the supine position on a cohort of elderly patients with malignant ureteric obstruction.

Methods
All patients with ureteric obstruction were considered for supine PCN. Supine approach was attempted in cases with multiple cardiopulmonary comorbidities and/or anaesthetic review. CT scans were reviewed to confirm conventional anatomy. Posterior axillary line was marked and ultrasound guided puncture used in all cases. Patient positioned supine with 30 degrees elevation of the ipsilateral flank, using lateral supports positioned at the shoulder and hip.

Results
12 cases were eligible (8 bilateral nephrostomy; 1 case the contralateral side was abandoned due to other patient factors)
Mean age 76 years old (range 72 – 87)
In all cases were of malignant obstruction, secondary to pelvic tumors
• Operation time not significantly longer than prone PCN (37 minutes needle-to-skin in supine position vs 34 minutes).
• No incidences of colon perforation/haemorrhage.
• Good access views for ultrasound and optimal puncture angle achieved.
• Management of the cardiopulmonary physiology is facilitated Reduced image quality secondary to overlying lumbar spine; combatted by angling the x-ray tube.

Conclusion
Supine oblique position for PCN position is well described in the literature. This institution has found the technique has several benefits in elderly patients with malignant ureteric obstruction and multiple comorbidities.
References


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B3—Pathological Femoral Fracture: A Rare Initial Presentation Of Uterine Leiomyosarcoma

References


Current Practice In Antibiotic Prophylaxis In Cataract Surgery, East Of England

### Abstract

**Introduction**
Current European guidelines recommend intracameral cefuroxime for antibiotic prophylaxis in cataract surgery; and this has now been widely adopted in the UK. However, in patients who have an allergy to penicillin practice varies because of existing concerns of cross-reactivity. The purpose of this study is to assess current practice in antibiotic prophylaxis of post-operative endophthalmitis in cataract surgery, in the East of England.

**Methods**
Anonymous survey of ophthalmologists within Health Education East of England. Questions addressed routine antibiotic choice in cataract surgery, prescribing for patients with allergies, and local guidelines. Responses were received from 27 surgeons; 11 independent and 16 in training, from teaching (32%) and district general hospitals (68%). Data analysed using Microsoft Excel.

**Results**
Twenty-one of 27 surgeons routinely give intracameral cefuroxime in cataract surgery, 5 give intracameral vancomycin and 1 reports giving only topical chloramphenicol. For patients with a penicillin allergy the number giving intracameral cefuroxime falls to 3 in those with a history of anaphylaxis. This is replaced with intracameral vancomycin, subconjunctival gentamicin, or topical antibiotics. Twenty-three respondents work in a department without a policy or are not aware of a policy.

**Discussion**
Variability exists in the practice of antibiotic prophylaxis of endophthalmitis post cataract surgery in the East of England. This is even greater for patients with a penicillin allergy. This variability within one region may be replicated throughout the country in a significant way.

**Conclusion**
This assessment of current practice in antibiotic prophylaxis of post-operative endophthalmitis in cataract surgery, in the East of England shows substantial variability which suggests a need for a nationwide study.
## CCOT Shadowing Programme For Final Year Medical Students

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### Abstract:

**Introduction**
Experience of managing sick and deteriorating patients are:
- a prerequisite of all final year medical students’ curricula
- a GMC requirement for newly qualified doctors (1)

But having the opportunity to take advantage of this experience is unpredictable and dependant on variable factors in final year placements.

Critical Care Outreach Teams (CCOT) function as a referral service to escalate deteriorating patients, aiming to ultimately improve outcomes for patients with acute illness. (2) CCOT shadowing programme for final year medical students was set up in this Trust in 2014.

**Method**
All final year students on placement from May 2015 - May 2016 were offered the opportunity to shadow CCOT.

The programme was designed with 9 pre-set objectives for assessment, management and escalation of deteriorating patients within a MDT.

Students were asked to document their desired learning objectives for the experience.

One student at a time shadowed the CCOT nurse, who encouraged the student to take the lead in patient assessments and management, giving some experience of autonomous decision making processes, within a safe framework.

Students were surveyed pre and post experience and the pre-set objectives and students desired learning objectives for the experience were analysed as achieved or not.

**Results**
91 students took part in the CCOT shadowing programme.

All students who submitted a feedback form stated that they felt better prepared to manage deteriorating patients as an FY1.

All students surveyed said their desired learning objectives were achieved.

Qualitative data collected post experienced included statements such as,

“I was able to take responsibility for acutely unwell patients but in a safe learning environment.”

“My confidence assessing patients, recognising deteriorating patients, making plans, escalating care to seniors and handing over has improved. It has been invaluable preparation for FY1, my very first on-call shift will be slightly less of a shock”
Hands-on experience at a cardiac arrest was the single set objective that was not always achieved.

**Conclusion**
CCOT shadowing goes beyond the remit of a simulated exercise. It is an authentic and invaluable, hands-on experience in the process of preparing final year medical students to manage sick and deteriorating patients.

Evaluating the effectiveness of acute illness teaching is essential, as this ultimately will impact on patient outcome and survival (3). A future exercise in establishing if the CCOT shadowing program did in fact influence the behaviours of these future doctors would be of great value.

**References and reading list**


### DR ABCDE Teaching Program

#### Corresponding author details

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#### Abstract:

**Introduction**

Simulation is a technique for practice and learning that can be applied to many different disciplines and types of trainees. It is a technique to replace and amplify real experiences with guided ones, often “immersive” in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion.¹ We recognised a need for more simulated teaching in the students’ curriculum and designed a teaching program for undergraduate medical students to help them feel more prepared when faced with acutely unwell patients.

**Methods**

We designed and delivered a regional teaching program aimed at final year medical students from UCL and Cambridge. These revision sessions focused on the systematic DR ABCDE approach to an acutely unwell patient. Each student had the opportunity to assess an unwell patient under strict OSCE conditions. The remainder of candidates were in a separate room, where they could observe a participating candidate. After each scenario, both students and teachers would give constructive feedback to a candidate. This ensured that students had an opportunity to learn from each other and experience a variety of real-life scenarios. We ran two sessions, with a total of sixteen students.

**Results**

All students felt they would benefit from further sessions and that it would improve their knowledge and confidence in practice. In particular, they enjoyed having the sessions in strict OSCE exam conditions and having the opportunity to perform under time constraints. The feedback we gave was tailored to the student and included positives remarks, with a focus on areas for improvement.

**Conclusion**

We conclude, simulated teaching in the form of a structured teaching program such as DR ABCDE is an invaluable, effective way of improving knowledge, skills and confidence. It provides a systematic approach for managing acutely ill patients.

**Reference**

Characterising The Hospital Experiences Of Adults With Learning Disabilities (Healed): A Mixed Methods Study

Abstract:

**Introduction**

People with learning disabilities (LD) are known to face difficulties in accessing appropriate healthcare services and experience substantial inequalities in health outcomes. Consequently, Acute hospitals have supported the widespread implementation of LD specific initiatives, such as: employing specialist LD liaison nurses and providing mental capacity act training to their staff. The aims of the research are:

1. To investigate whether recent initiatives designed to improve the hospital experiences of adults with LD are leading to discernible and meaningful improvements.
2. To provide those actively campaigning for better hospital care and treatment for adults with LD with information gathered from empirical research.

**Methods**

*Part 1:* Health episode statistics were obtained from two NHS hospital trusts and analysed to describe the hospital use / outcomes of adult inpatients with LD (over a two year period).

*Part 2:* The medical records of 30 recently discharged patients with LD from two NHS hospital trusts were summarised using a Journey Mapping Tool. These “maps” are being qualitatively analysed to identify instances of good practice, and areas for improvement.

*Part 3:* Multi-perspective in-depth interviews (*n* = 90), and subsequent qualitative analysis, will explore the experiences of: patients with LD in two acute hospitals; their carers and support workers; and the healthcare providers based at each hospital.

**Results and Conclusion**

Although the study is ongoing, we expect to produce a multi-perspective view of hospital care for adults with LD, which will document positive actions and highlight ways in which services might be improved.
Malnutrition Audit: A MUST Is A Must!

Abstract:

Introduction
Malnutrition is a state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes adverse effects on body function and clinical outcome\(^1\). It is a major risk factor for increased morbidity and mortality; and it costs the NHS £7.3 billion per year\(^3\). A national audit found that malnutrition is extremely common affecting one in three patient admitted to hospital\(^2\). This clearly highlights the need for early detection and treatment of malnutrition in patients.

British Geriatric Society (BGS) guidelines\(^4\) suggest all patients admitted should have nutrition screening and admission weights recorded. East and North Hertfordshire trust utilize the Malnutrition Universal Screening Tool (MUST), which is a nationally validated nutrition screening score used to identify patients at risk of malnutrition.

The audit aims were to evaluate and improve the nutritional screening compliance with the national BGS guidance on Ashwell Frailty Unit.

Methods
Cycle 1 of the malnutrition audit, reviewed 50 patients’ MUST scores retrospectively on Ashwell ward. The following parameters were collated: Compliance of MUST scoring completion, average time taken to completion, methodology of completion (weight or MUAC) and reasons for an incomplete score. A “completed” MUST Score was defined as stage 1,2,3 had to all be completed either using Weight or MUAC. Malnutrition awareness posters and lectures were provided to healthcare professionals to highlight the importance of malnutrition, following cycle 1.

Cycle 2, reviewed 59 Patients MUST scores and utilized the same methodology in cycle 1 to obtain the audit data.

Results
Completed nutritional screening compliance in cycle 2 increased by 7% to 79.31%. Furthermore the average time taken to complete nutritional screening fell by 1.13 days to 1.65 days. The most common cause (71%) of incomplete MUST scores were due to missing values. 45.6% of MUST scores were completed with weight rather than MUAC.

Cycle 2, reviewed 59 Patients MUST scores and utilized the same methodology in cycle 1 to obtain the audit data.

Results
Completed nutritional screening compliance in cycle 2 increased by 7% to 79.31%. Furthermore the average time taken to complete nutritional screening fell by 1.13 days to 1.65 days. The most common cause (71%) of incomplete MUST scores were due to missing values. 45.6% of MUST scores were completed with weight rather than MUAC.
Conclusion
Malnutrition plays a pivotal role in patient morbidity, mortality and cost, if not tackled early. Highlighted awareness via posters and lectures, improved compliance of malnutrition screening and reduced time to screening completion.
Incomplete forms were likely secondary to its complex structure, and thus the plan is to implement a mandatory e-learning module to help train healthcare professional in completing the MUST score.
Modest weight completion was likely due to the demographic of patients admitted to Ashwell ward and ease of methods to weigh patients. We aim to standardise admission-weighing protocols by implementing hoist and mandatory BIMs weight parameters to improve BGS compliance.

The final outcome of this audit is to implement an annual cycle to ensure nationally mandated BGS compliance in nutritional screening; and most importantly improve the early detection and treatment of malnutrition.

References
1. Malnutrition screening in the elderly population Dylan Harris, MB MRCP1 and Nadim Haboubi, MD FRCP2
Simulation Training- A Novel Area In Community Paediatrics

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Abstract

Introduction
Simulation in medical education aims to recreate a real-life scenario to teach medical students and doctors about how to deal with clinical situations before they encounter them in their actual practice. Although simulation has been extensively used in acute paediatrics, its use in community paediatrics is still suboptimal. We believe that simulation will create help to create a better rapport between doctors and families, minimise complaints and increase the confidence of doctors dealing with difficult cases in the community. Our aim was to assess the viewpoint of paediatric trainees on the application of simulation teaching in community paediatrics.

Methods
We performed a cross-sectional study to look at the perception of level 2(ST4-ST5) and level 3 (ST6-ST8) on the use of simulation teaching in community paediatrics. We collected the responses from trainees using the online survey tool on SurkeyMonkey. The figures were analysed on Microsoft Excel, and the qualitative data was collated on Microsoft Word.

Results
27 paediatric trainees responded to our survey, of whom 24(89%) had used simulation previously. Only 1 trainee had used simulation as part of community teaching. The others stated that they had come across simulation as part of their neonatal and acute paediatric training. 83% of trainees stated that the concept of simulation in community paediatrics had never been introduced to them.

18 trainees(67%) expressed their wish to have simulation teaching as part of their community training and stated that it would be beneficial in a number of areas such as breaking bad news, safeguarding cases, discussions about developmental delay to parents and adoption cases.

We noted that 20(74%) of trainees have received some form of training as simulation instructors.

From our survey, we also noted reluctance from some trainees regarding the use of simulation in community teaching. Trainees commented that it would be hard to simulate a community case as simulations work best for emergencies. Others pointed out that it is impossible to recreate bruises on manikins which would be similar to those on a real child.

Conclusion
From our study, we have noted that the majority of trainees wish to integrate simulation as part of their community training. Making this a valuable learning exercise for them will require putting in place a robust simulation instruction programme. We believe that this can be achieved by enlisting the help of simulation educators at the University of Hertfordshire to move this programme forwards.
Developing Consultant Supported Peer Led General And Vascular Surgery Departmental Teaching

Abstract:

Introduction
Teaching is a key requirement of the GMC’s Duties of a Doctor. Supporting evidence is required for junior doctors’ training portfolios and continuing professional development. However, insufficient general and vascular surgery departmental teaching was identified by the GMC training survey 2014/15.

Methods
Consultant supported, peer led, teaching was developed and piloted within the general and vascular surgery department at Lister Hospital using a rolling rota. Surgical teams were asked to prepare and deliver sessions that included a 30-minute presentation on a surgical emergency and a 30-minute journal club. Both presentations were uploaded to the shared drive for e.g. reference/ self-directed learning. In general, the emergency session was prepared by the Foundation Year Two or Core Trainee and the journal club session by the Specialty Trainee, although not exclusively.

Attendance and anonymous feedback were collected prospectively, using an evaluation form with a visual analogue scale from 1 (poor) to 10 (excellent) and space for free text comments.

Results
Nine peer led sessions were delivered from February to May 2016. The median attendance per session was 12 (1-20) doctors, with all grades from Consultant to Medical Students represented, particularly Foundation Trainees.

Journal club feedback received 8.79±0.51 (mean±sd) on the visual analogue scale and emergency teaching feedback received 8.86±0.75 (mean±sd) on the visual analogue scale.

Positive comments include:
“V. good initiative. Great for surgical development”
“Good discussion, worth having consultant presence for discussion and feedback”
“Really helpful exploration on study validity, bias and study power”
“Interesting analysis of paper”
“Engaging and good use of clinical cases to help visualize limb ischaemia”

Discussion
Consultant supported, peer-led, teaching in our general and vascular surgery department has been well attended and received excellent feedback. These sessions have provided an educational benefit for both those delivering and attending the teaching. It is anticipated that this will be reflected in the GMC training survey 2015/16.

Key Message
This pilot demonstrates that peer led teaching can support doctors in training to achieve their surgical teaching and training objectives. This model could be used do develop a pan-surgical grand round.
History-Taking In Paediatric Asthma. Do We Need More Breathing Space?

**Abstract:**

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**Introduction**

Children with acute asthma exacerbations commonly present to the Children’s Assessment Unit. Taking a comprehensive history is essential to assess the background asthma control, predict disease severity and initiate discharge-planning. Key areas include personal history and family history of atopy, the background medication used and the severity of previous exacerbations. However, these areas are often not well explored in asthmatic children who acutely present to hospital and may impact negatively on the care that we provide to them. Our aim was to assess our performance in history-taking in acute paediatric asthma.

**Methods**

We performed a retrospective audit, reviewing notes for children seen acutely in hospital between March 2014 and March 2015. The gold standard was for all children to have the above important demographics documented on the admission proforma. The data was collated and analysed on Microsoft Excel.

**Results**

15 sets of notes were obtained from medical records. We noted that 73% and 80% of admission notes included information about family history of atopy and pet history respectively. Smoking habits were explored only 40% of cases. None of the cases had a personal history of food allergies or best peak flow documented. The use of reliever and preventer medication was documented in 47% and 40% of notes respectively. Markers of prognosis of the acute exacerbation such as number of courses of steroids required in the last year or previous high dependency and intensive care admissions were documented in 33% and 67% of cases respectively.

**Conclusion**

Important information from the history, which helps us guide management of asthma exacerbations and predict the severity, is often lacking in our current history-taking practice. We aim to hold educational update sessions for GP trainees, and paediatric doctors about the relevance of inquiring about these key factors in the history. This will enable us deliver a better and safer care to our paediatric patients.
CT Head Timeline

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**Abstract**

**Introduction**
Ct head request form Emergency Department (ED) is becoming more and more common to investigate acute head injuries. There are well recognised guidelines for the indications for a CT head, but with the increasing demand it is important radiology departments are able to maintain their standards also in relation to efficiency and timing.

**Methods**

**Aims:**
- To collate a week of ED CT head requests
- Determine time the patient has the CT head
- To discover the time the report is released
- Calculate timings between each of the above.

**Method**
- iCRIS software: collate a CT head requests from ED between dates 11/01/2016 and 17/01/2016.
- PACS software: time of scanograms
- iCRIS: time of reports & addendums
- Excel: calculate time differences
- Compare in house to telemedicine reporting times.

**Results**

**Average (n=132)**

- 100% are scanned within 1 hour
- 95.4% are reported within 1 hour
- 11 reports breeched the hour time limit; 4 were not indicated for the hour limit, 1 was justified as imagine was assigned to the wrong list and the remaining 6 had no reason.

- Request → scan 00:13:53
- Scan → report 00:28:06
- Request → report 00:41:59

- There was no significant time difference between in house and telemedicine reporting. Every report done out of hours by medicare was checked by a consultant within 24 hours; 4 had notes added to their report; minor additions in relation to the previous information.

**Conclusion**

- This department is coping well with the increasing workload on the radiology department and deserves recognition.
- It should be made clear that delays in reports are documented on the system.
- Dual reporting raises serves many purposes such as in hospital trust between clinicians and radiologists, audit purposes and standards. Contrary to that it may be seen as unnecessary extra work
- Importance of clinical information is reinforced as this dictates if the hour limit is to be met.
Artery Of Percheron Occlusion

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**Abstract**

**Introduction**
The artery of Percheron is a rare anatomical variant in which a single artery arises from the posterior cerebral artery to supply the bilateral paramedian thalami and mid-brain (figure 1). In this case, we describe a patient who had presented with symptoms characteristic of an artery of Percheron infarct.

**Case**
A 77 year-old gentleman, presented to A&E being found unresponsive by his carer. His GCS was 7/15 (E1V1M5). His past medical history included dementia and hypertension. He was intubated in A&E and went on to have an urgent CT head. His GCS improved within a matter of hours and was extubated. On examination his vital were stable, pleasantly confused, had right sided ptosis, pupils were 2mm in size, equal and reactive to light. No signs of a gaze palsy. The rest of the neurological and systemic examination was unremarkable. MRI Head showed acute bilateral thalamic infarct consistent AOP infract.

**Discussion**
The incidence of AOP infarction is rare (varied from 0.1 to 2% in all ischaemic strokes), and 4-18% in thalamic infarction (1).

The condition classically presents with a triad of symptoms altered conscious state, vertical gaze palsy and memory impairment. In our case, the patient presented with a low GCS and memory impairment. Diagnosing an artery of Percheron infarction is critical for directing the appropriate time sensitive management. Early diagnosis is best made by MRI DWI sequence. Different treatment options including intravenous thrombolysis and/or endovascular revascularisation can be considered.

The prognosis of an AOP infarct is generally good. However is differs from one patient to another, depending on the underlying aetiology and associated disease. In this case our patient’s conscious level recovered quickly, his persistent confusion is likely secondary to his dementia.

**Conclusion**
This is the case of a gentleman presenting with acutely impaired consciousness and on investigation was found to have an AOP occlusion. The artery of Percheron (AOP) is a rare anatomical variant and infarction of the artery can produce a classical triad of symptoms: impaired consciousness, memory impairment and a vertical gaze palsy. The most common cause is cardio embolism. This type of infarct has a favourable prognosis. (3)

It’s important to consider AOP in the differential diagnosis of patients presenting with acute onset of unexplained coma so that time critical treatments like thrombolysis can be offered.
The Demographics Of Patients In The Heart Failure Clinic At The Lister Hospital

### Abstract

**Introduction**
Chronic heart failure is a serious, common condition associated with frequent hospitalisations and a high mortality. Heart failure with preserved left ventricular systolic function has become increasingly recognised and its prevalence has increased with aging of the population. It is associated with outcomes similar to that with reduced left ventricular systolic function. However, unlike heart failure patients with impaired systolic function, no therapeutic interventions have been shown to confer prognostic benefit in patients with preserved systolic function.

In this study we sought to determine the frequency of patients with heart failure due to preserved left ventricular systolic function under follow up in our Heart Failure Clinic at The Lister Hospital as well as to review the demographics of our heart failure clinic population.

**Methods**
The cause of heart failure as well as demographics of all patients seen in heart failure clinic between October 2014 and December 2015 were reviewed. Each patient was included once, although they may have been seen multiple times during the 15 month period. Patients were referred to the heart failure clinic from different sources including follow up after an acute admission and from general cardiology outpatient clinics.

**Results**
415 patients were seen in the heart failure clinic at The Lister Hospital during this 15 month period. 73% were male. Ages ranged from 30 – 99 years. 68% of patients were over 70 year old. 92% were confirmed to have impaired left ventricular systolic function. 47% of patients were found to have atrial fibrillation. 7% had cardiac resynchronisation therapy and 7% had an AICD alone. 3.9% had bradycardiac pacemakers. 6.5% of patients died during the 15 month period.

**Conclusions**
The vast majority of patients had impaired left ventricular systolic function as a cause of their heart failure. The patients were predominantly male and predominantly over 70 years old. Our data show that patients with preserved left ventricular systolic function are a very small minority in our heart failure clinic, despite its increasing prevalence. This may be explained by the lack of prognostic evidence for any therapeutic intervention in these patients.

A higher percentage of patients had atrial fibrillation than would be expected. The mortality rate was lower than expected and may reflect the improved trend in survival documented for these patients in recent years.
Major Lower Limb Amputations: Improving Mortality And Optimising Outcomes

Abstract

Introduction
Peripheral arterial disease affects approximately 20% of adults over 55 in Europe and North America. This population often have multiple co-morbidities and a high mortality, with some reports suggesting 38% to 48% will die within one year. The vascular society produced a Quality Improvement Framework (QIF) in 2010 aiming to improve the care and outcomes in major lower limb amputations, with their highest priority set out to reduce the high operative mortality rates. The NCEPOD (National Confidential Enquiry into Patient Outcome and Death) review in 2012-13 has highlighted that a number of aspects of the QIF are not being implemented.

Method
This audit assesses whether patients undergoing major lower limb amputations in 2015 received care in accordance with guidance from the 2010 vascular society QIF and review by NCEPOD. Key standards focused on are operations being carried out in normal working hours, on elective lists where possible, with appropriate seniority and without delay in addition to optimum use of interventions for limb salvage. Information sources primarily utilised were theatre lists, discharge letters and pathology records.

Results
The total of vascular amputations was 22. Four operations were undertaken out of hours, three of which were true emergencies. All operations were undertaken by either Consultants or CCT (Certificate of Completion of Training) surgeons. Fifteen amputations were on the emergency list, seven of these were true emergencies.

Nine (41%) of the group underwent amputations within five or fewer days from admission of which six patients died. Seven patients had operations carried out between days 6 to 14 from admission, of which two died, and 6 had operations over 14 days into hospital admission.

Seven patients underwent preceding interventions for revascularisation (all angioplasty) and two of this group died during the admission. For fifteen patients limb salvage was not possible as they were unfit for surgery, had no surgical options possible or the limb was not salvageable. Seven of these patients died (of a total of nine mortalities).

Discussion and Conclusion
Our data supports that overall the recommendations for operative procedures were adhered to for our sample. Limb salvage was attempted in all for whom this was viable. However where clinically appropriate and possible, the guidance may be better met by increasing the number of amputations carried out on elective lists.

References
Abstract

Introduction
Several scores have been developed to inform the prognosis of patients who present with ruptured abdominal aortic aneurysms (AAA). These are based on their comorbidities and clinical situation on admission. Most recent studies support the ‘updated Glasgow Aneurysm Score (GAS)’, which also takes into account the type of repair, as the most accurate at predicting likelihood of survival.

Methods
Patients were identified who presented in 2015 with ruptured AAA. Twelve patients were identified, ages varying from 67 to 99. Six underwent open repair, 2 had EVAR and 4 had no intervention. They were scored using the updated GAS and ranked according to their score. Outcomes and intervention (EVAR, open repair, no intervention) were identified to establish which interventions were carried out on the higher scoring patients and whether those with higher GAS scores were more likely to have a poor outcome.

Results
We show the different scores obtained by these patients in all three interventions. Our data also found that those with the highest scores were most likely to have a poor outcome in terms of survival as the 7 patients with the highest scores did not survive.

Conclusion
Despite our small series, the validity of the scoring systems suggests that we should be using one of them as a guide during the initial management of patients presenting with ruptured AAA. An objective analysis of these complex and high-risk patients could be used to help inform decisions about intervention, in conjunction with patient wishes and clinical judgment and experience.
Acute Aortic Syndrome: A New Dimension In Managing Chest Pain

Abstract

Introduction
Acute aortic syndrome (AAS) is an under-recognised but important heterogeneous spectrum of aortic pathologies which present with similar symptomatology: primarily, acute chest pain. It consists of a triad of classic aortic dissection, penetrating atherosclerotic ulcer (PAU) and intramural haematoma (IMH).

Methods
An 86-year-old lady with hypertension was admitted with sudden onset central chest pain radiating to both shoulders and neck which was subsequently diagnosed as AAS. The case report includes contrast-enhanced CT aortogram images of PAU and non-enhanced images of the IMH to illustrate these pathologies. It also includes post-mortem findings of haemopericardium secondary to ruptured ascending aortic aneurysm with underlying complicated atherosclerosis.

Results
A literature review of AAS explores the interlinked pathologies namely aortic dissection, ulceration and haematoma. The clinical presentation of AAS is reviewed along with investigative work up and management. Risk factors for AAS and poor prognostic factors are explored.

Conclusion
The key learning points include:
- AAS should be considered in the differential diagnosis of acute chest pain
- Classic aortic dissection represents only part of a spectrum of aortic disease
- Contrast-enhanced CT aortogram is the imaging modality of choice
- Blood pressure control is pivotal in both prevention and treatment
- AAS generally carries poor prognosis

Acknowledgements
With thanks to Dr Bertrand Annan, consultant radiologist, for assistance with preparing the images.

Consent
Patient deceased. Fully anonymised case report.

Disclosures
None.

References
No Health Without Mental Health”. Improving Physical Health Monitoring Within A Frail And Functional Inpatient Psychiatric Ward: A Quality Improvement Project.

Abstract

Background
It is well documented that patients with psychiatric illness have higher rates of physical morbidity and mortality, compared with the general population (1). The majority of studies suggest there are significant inequalities in uptake and provision of medical services for psychiatric patients (2). Our audit looks at the quality of physical health monitoring for patients on a frail and functional ward at Kingfisher Court Psychiatric Hospital. Our aims were two-fold; to explore whether the level of physical health monitoring and escalation was accurate and safe for patients; and to implement a teaching program for nursing staff to improve quality of physical health monitoring.

Methodology
A retrospective medical note audit was conducted over a one week period in early 2016. Data was collected on frequency, completeness and escalation of abnormal physical observations using current charts. A trawl of written medical notes was then conducted to identify if medical staff were informed of abnormal vital signs. A questionnaire was also designed and distributed to gauge knowledge surrounding recording and escalation of monitoring. This data was then utilised to direct two teaching sessions. The audit cycle was completed by the same process post-teaching sessions.

Results
From a total of 16 patients on the ward, data was available for 13 patients in the pre-teaching audit and 15 patients post-teaching. Post-teaching intervention we implemented new NICE approved NEWS physical monitoring charts. Pre-teaching there were 20 separate abnormal physical observations that would have required escalation to medical staff, yet only 4 documented escalations. Post-teaching 7 out of 18 abnormal vitals were documented as escalated, an improvement of 19%. Abnormal heart rate was the most frequent vital observation that needed escalation, both pre- and post-teaching. Despite teaching intervention, plotting errors were prevalent, particularly the absence of respiratory rate. Overall, nursing staff rated the teaching to have improved their knowledge.

Conclusions
It is clear that simple interventions such as structured teaching sessions can significantly improve accurate physical health monitoring. NEWS charts appear to have improved documentation, and are more standardised than previous methods of documentation. Further work needs to be done on this area to improve monitoring and assessment of physical health, in particular respiratory rate documentation. Our recommendation would be that regular teaching sessions would continue to improve confidence and knowledge around monitoring of physical health. This could lead to more timely identification of physical health problems, leading to prompt treatment and more favourable health outcomes.

References
Unusual Case Of Respiratory Embarrassment Secondary To Tracheal Compression By A Dilated Oesophagus In A Patient With Recurrent Achalasia

Abstract

Introduction
Achalasia is a motility disorder of the oesophagus, characterised by high lower oesophageal sphincter resting tone and impaired oesophageal peristalsis. Respiratory symptoms are a well-recognised complication. However, tracheal compression by a massively dilated oesophagus is particularly rare, especially in patients who have undertaken surgical management in the form of a Heller’s cardiomyotomy.

Case Description
We present the case of a 79-year-old woman with recurrent achalasia following a laparoscopic Heller’s cardiomyotomy. The patient presented to the emergency department, with epigastric pain, severe dyspnoea and profound type respiratory acidosis. She required intubation and ventilation followed by gastric decompression with nasogastric tube and the administration of intravenous antibiotics for a lower respiratory tract infection. Once stable, she underwent a CT scan revealing a massively dilated oesophagus causing marked tracheal compression. She received a period of continuous positive airway pressure ventilation while on the intensive care unit, for persistent low saturations; however, this was promptly ceased due to exacerbation of gastric dilation and fears over perforation. The patient responded well to conservative measures and was discharged home 18 days later awaiting follow-up with operating consultant surgeon.

Discussion
Despite respiratory symptoms being relatively common, tracheal compression with resulting respiratory compromise is very rare, particularly in patients who have previously undergone cardiomyotomy. The first reported case of achalasia and tracheal compression was in the 1950s since then, there have been sporadic cases reported in the literature. In addition, there have been no documented cases of tracheal compression in patients with recurrent achalasia following laparoscopic Heller’s cardiomyotomy surgery. Rapid diagnosis is essential in the management of these patients and usually takes the form of a chest radiograph followed by a CT scan if the patient is stable. Early recognition allows for early management and the key treatment strategies are respiratory support and decompression of the gastrointestinal system by placement of a nasogastric or Ryle’s tube.

Conclusion: In conclusion, upper airway obstruction due to a dilated oesophagus is a rare but potentially lethal complication of achalasia. Prompt radiological imaging, high index of clinical suspicion and early gastric decompression are key to successfully managing this condition.

References
Broad Ligament Hernia: A Rare Cause Of Small Bowel Obstruction

Abstract

Introduction
The broad ligament is a peritoneal fold attaching the fallopian tubes, ovaries and uterus to the wall and floor of the pelvis: herniation of abdominal viscera through a defect in this structure is rare.

Case Description
We present the case of a 73-year-old woman with no prior surgical history who presented to the emergency department with a four-day history of abdominal distension, bilious vomiting and not opening her bowels. Computed tomography (CT) scan of abdomen and pelvis showed a dilated small bowel with a transition point in the distal ileum with no definite cause of obstruction identified. As conservative management did not relieve her symptoms she was consented for a diagnostic laparoscopy, which revealed internal herniation of distal ileum through a defect in the broad ligament of the uterus.

Discussion
There are various types of internal hernias described in the literature; most commonly reported in 53% of cases are paraduodenal. Others examples include pericecal (13%), transmesenteric (8%), and epiploic foramen hernias (8%). However, intestinal herniation through the broad ligament is the least common and only accounts for 4% of all internal hernias. Causes of these are either congenital or acquired in nature: usually due to obstetric trauma, abdominopelvic surgery, or pelvic inflammatory disease. Clinically and radiologically internal hernias are very difficult to diagnose and a diagnostic delay is reported to have a mortality rate of approximately 50% due to the high risk of strangulation.

Conclusion
Small bowel obstruction due to internal herniation through a defect in the broad ligament is very rare. This diagnosis should be considered in women presenting with signs of small bowel obstruction where radiological imaging is inconclusive. Early recognition is extremely important to reduce the risk of intestinal strangulation, which has a high mortality rate.

References
Effect Of Intra-Dialytic Exercise On Inflammation, Blood Endotoxin And (1→3)-β-D Glucan Levels In Haemodialysis Patients

**Abstract:**

**Introduction**

Exercise on dialysis is proposed to have anti-inflammatory effects in haemodialysis patients, however exercise-induced inflammation due to intestinal bacterial endotoxin translocation from gut barrier dysfunction has been described in the healthy population. The large blood volume changes experienced during dialysis may lead to gut ischaemia and increased gut permeability potentially exacerbating endotoxemia and the inflammatory effects of intra-dialytic exercise. The aim of this study is to study the effect of a single bout of intra-dialytic exercise on inflammation in relation to blood endotoxin levels.

**Methods**

Ten HD patients were recruited for this study. Blood samples were collected on two separate HD sessions – in one session patients were asked to undergo their routine intra-dialytic exercise programme (exercise HD day) and in a second session patients were asked to abstain from exercise (non-exercise HD day). Blood samples were collected pre- and post-dialysis and measured for pro-inflammatory cytokines (IL-6 and TNF-α) and endotoxins using the Limulus Ameobocyte Lysate (LAL) assay. Since the LAL assay is not endotoxin-specific and may be activated by (1→3)-β-D glucan (BG) – a component of fungal cell walls, blood samples were measured twice for endotoxin using - 1) Standard LAL and 2) LAL reconstituted with a BG-blocking buffer to block out false positive signals from BG. Blood samples were also measured for BG.

**Results**

A single HD session on a non-exercise HD day resulted in a significant rise in IL-6 from 6.3pg/mL to 10.9pg/mL. This rise was attenuated on an exercise HD day with no significant difference between pre- and post-HD levels of IL-6. For TNF-α, there was no significant difference in pre- and post-HD TNF-α levels on a non-exercise HD day, but on an exercise HD day, post-HD levels of TNF-α were lower than pre-HD levels (11.7 vs. 8.8pg/mL; p<0.01). Using the standard LAL assay, endotoxemia was detected pre-dialysis in 20-40% of patients. The proportion of patients with detectable endotoxemia did not differ pre- and post-dialysis for both exercise and non-exercise HD days. On repeat measurement for endotoxin using a BG-blocker, only one patient had detectable endotoxemia on a post-HD sample. BG were elevated in a significant proportion of patients (mean BG level 50.1-66.8pg/mL), but there was no significant difference between pre- and post-HD BG levels for both exercise and non-exercise HD day. There was no significant correlation between BG, IL-6 and TNF-α.

**Conclusion**

Intra-dialytic exercise may ameliorate the pro-inflammatory effects of HD. The mechanism is not endotoxin or BG-mediated. Endotoxemia detected in HD patients may be due to false positive activation of the LAL from BG. BG was significantly elevated in HD patients (normal range 10-40pg/mL), the source and significance of raised blood BG levels warrants further investigation.
An Audit Of Elective Surgical Weekend Handover At Lister Hospital

Abstract:

Introduction
An effective surgical handover is vital for patient safety and continuity of care, especially at the weekend where doctors may only know a small proportion of inpatients. Indeed, this process is variable, has potential to misconvey vital information in turn and cause harm or reduce clinical effectiveness. Surgical weekend handover at the Lister Hospital currently consists of a weekend list created by juniors on Fridays and used by the FY1 and Registrar for the weekend.

Methods
31 surgical doctors who worked an elective weekend shift were asked to audit specific details such as handover, number of patients, wards visited, pre-identification of sick patients and concerns regarding weekend handover. This led to the creation and implementation of a surgical “weekend checklist” which was put in place and audited over 5 consecutive weekends by 10 doctors (5 FY1s, 5 SpRs). All information was collected between November 2015- April 2016, uploaded to a central database (excel) and analysed independently by two junior doctors.

Results
In the original audit 70% (n=27) of those surveyed had concerns regarding weekend surgical handover. Although there were no adverse events there was one report of a near miss. Post-intervention, 50% respondents reported that the checklists were present in patient’s notes during their weekend and all reported the checklist to be useful. Indeed, elective ward round time was reduced from an average of 5.7 hours to 4.7 hours with no difference found in number of inpatients or wards visited. In addition, the number of respondents with concerns was reduced from 70% to 40%, with no reports of near misses or adverse events. Pre and post intervention it was found that there was inadequate handover of “sick patients” (35% and 23.8% were pre-identified, respectively).

Conclusion
Despite uptake not being optimal, we can conclude that the new weekend checklist was found useful by respondents. Implementation of the weekend checklist reduced original concerns regarding weekend handover and the average time of the ward round. The weekend checklist has now been implemented in the general surgical department, although further methods to increase effectiveness and safety of weekend handover are still required. Future work should concentrate on solutions to pre-identify “sick patients” including potential escalation plans to maximise patient safety over the weekend.
Treatment Escalation Pathway

Abstract:

Introduction
Treatment escalation plans are recommended along with resuscitation status when patients are admitted to hospital. The resuscitation council and the Royal College of Nursing, supported by many organisations are developing a system that will be available throughout the UK. A Working Group made up of patient representatives, health professionals, and organisations have developed the Emergency Care Treatment Plan documents for this consultation. Junior doctors often cover multiple wards out of hours therefore they are often unfamiliar with patients. If a patient suddenly deteriorates, doctors can struggle to establish appropriate treatment escalation plan and ceilings of care without senior support. This is particularly important for junior or less experienced doctors. It has become apparent that a DNACPR form is not enough to establish an appropriate treatment escalation plan and ceilings of care. We designed a proforma for medical notes to document medical escalation plans made by consultants, should a patient deteriorate and need medical intervention out of hours. The proforma should be a guide to clinical decision making, categorising patients into specific pathways, prompting thinking and advance planning of care.

Methods
We collected data on current documentation of escalation plans on an elderly care ward. Only two patients had an escalation plan out of thirty. We designed a proforma to document escalation plans of patients on an elderly care ward to remind doctors to establish a plan for each patient and to make documentation easy to find and read. We surveyed doctor’s opinions on escalation plans and their documentation. We then educated doctors on the ward as to using the proforma. After introduction of the proforma we re-assessed escalation plan documentation on the ward.

Results
Initially only two out of thirty patients had a treatment escalation plan documented in the notes. One week after the introduction of the proforma, the number of escalation plans increased by ten percent, to five out of thirty patients. A month later, seventeen out of thirty patients had an escalation plan documented. These results have motivated other wards to initiate the proforma to improve care of patients. We aim to re-audit the proforma use on more wards with a view to using the proforma universally in the Hospital.

Conclusion
Treatment escalation pathways are a useful tool for recording escalation plans for patients and for improving patient care. By re-auditing when more wards initiate proforma, we will be able to evaluate the proformas’ universality and efficacy.

References
Hydroxychloroquine Induced Retinopathy; Time To Open Our Eyes To Screening?

Abstract:
A 43 year old woman with a background of Systemic Lupus Erythematosus (SLE) and secondary Sjögren’s syndrome, developed an acute hydroxychloroquine (HCQ) retinopathy following treatment with HCQ 200mg BD for 9 years. This resulted in significant impairment of visual acuity. She had regular optician review while taking HCQ.

Methods
This case has led us to scrutinise the variability of routine referral for ophthalmology assessment in HCQ patients in our Trust, beyond baseline optician tests and recommendation for annual optician review. Hydroxychloroquine is known to cause retinopathy; initial changes are reversible, but not once visual impairment has occurred.

Results
The Royal College of Ophthalmologists (RCO) published guidance in 2009 that did not recommend routine ophthalmology screening, due to the rarity of retinopathy and lack of a reliable test, at the time, to detect it at a reversible stage.

The incidence of HCQ-related retinal toxicity may be more common than previously thought, possibly exceeding 1% after 5-7 years of use. This rises towards 2% between 10 and 15 years of continuous usage.

In addition, the emergence of more sensitive diagnostic techniques such as Fundus Auto Fluorescence (FAF) have suggested that retinal changes may be detected at an earlier stage, potentially avoiding late progression of retinal toxicity and visual loss.

In light of these developments, the American Academy of Ophthalmology updated recommendations to include baseline examination before treatment and annual testing by an ophthalmologist after 5 years of therapy. Current evidence suggests that retinopathy is very unlikely to occur until the total cumulative dose is beyond 1000g (7 years of 400mg per day). Therefore dose reduction to 200mg daily, where possible, may reduce risk of retinopathy development.

Conclusions
We propose that in order to detect retinopathy at an early stage, prior to visual impairment, all patients treated with HCQ are referred to ophthalmology specialists for screening no later than 5 years after starting therapy.

We suggest that the current RCO recommendations remain unchanged for the first 5 years of treatment, as baseline retinopathy testing, prior to initiation of HCQ, is unlikely to be logistically feasible. This might otherwise cause unacceptable treatment delay for patients with autoimmune rheumatic diseases, therefore a pragmatic balance must be struck.

Furthermore, in order to reduce the chance of HCQ retinopathy, clinicians should aim to reduce dose in patients with well controlled rheumatic disease.

References
*PLEASE SEE PAGE 53
Oropharyngeal Cancer – A Patient’s Perspective Of Treatment: ‘I Didn’t Think It Would Be This Bad’

Abstract:

Up to 7,600 new cases of oropharyngeal cancer are diagnosed every year in the UK and incidence has increased by 92% since the 1970s. Five year survival is approximately 40% but achieving cure necessitates a tough treatment regime. This can include major surgical resection, neoadjuvant chemotherapy and radical chemo-radiotherapy.

Throughout the course of their treatment regime, patients face challenges such as painful swallow, thick mucous secretions and weight loss. Whilst they attend clinic prior to undergoing treatment, and are informed about possible side effects, a number of patients that have been admitted to the inpatient wards at Mount Vernon Cancer Centre have stated ‘I didn’t think it would be this bad’. The significant effects of treatment on people’s lives make this an important topic to review.

This poster presents a case study of L, a 58 year old male, undergoing intensive chemo-radiotherapy for squamous cell cancer of his left tonsil. He discusses his journey from initial diagnosis to the end of chemo-radiotherapy and its after effects. His progress represents a typical case of oropharyngeal cancer that is seen on the inpatient unit of a specialist cancer centre.

I discuss the importance of being aware of the side effects of treatment in oropharyngeal cancer and how cases may present to primary, secondary and tertiary care. It is likely that, with increasing incidence of oropharyngeal cancer, more of us will come across patients who have this disease during our career.

It is essential to remember the impact that both the disease and its treatments can have on a patient’s life. Having the knowledge about the available treatments and their side effects will allow us to manage symptoms pre-emptively, meaning we can lessen the burden on our patients.
Atypical Small Acinar Proliferation (ASAP) And High Grade Prostatic Intraepithelial Neoplasia (HGPIN)-Should We Be Concerned?: An Observational Cohort Study With A Minimum Follow-Up Of 3 Years

**Abstract:**

**Introduction**

ASAP and HGPIN are considered precancerous with guidelines (1) recommending re-biopsy in all cases of ASAP and widespread HGPIN. Given the morbidity associated with biopsy (2), we monitored clinical parameters (mainly PSA) in patients and re-biopsied only given progression. Our primary objective was to measure the rate of repeat biopsy and adenocarcinoma in patients with ASAP and HGPIN, while the secondary objective was to identify any clinico-pathologic parameters at diagnosis of ASAP/ HGPIN that are predictive of adenocarcinoma at a later stage.

**Methods**

Patients with a diagnosis of ASAP/ HGPIN with no previous or concomitant cancer were identified from a prospective pathological database. An electronic clinical database was reviewed retrospectively for data. PSA and/ or MRI changes were monitored. Patients were re-biopsied at the clinician's discretion.

**Results**

19 patients were diagnosed with ASAP and 17 with HGPIN. 7 of the 19 patients with ASAP (37%) and 6 of the 17 patients with HGPIN (35%) underwent re-biopsy. 3 (16%) patients with ASAP and 5 patients with HGPIN (29%) were diagnosed with adenocarcinoma. The difference in cancer detection rates between ASAP and HGPIN was not significant ($p=0.35$). 5 patients (14%) in total required definitive therapy for adenocarcinoma. 64% did not undergo repeat biopsy. A range of clinico-pathologic parameters at diagnosis of HGPIN and ASAP, including PSA, free/total PSA, prostate volume, PSA density, abnormal DRE changes and the number and proportion of cores positive for either HGPIN or ASAP, were compared between the cancer and non-cancer cohorts with none found to be predictive of adenocarcinoma.

**Key message**

The relationship between ASAP/ HGPIN and adenocarcinoma is unclear. By monitoring PSA and/or MRI changes, we managed to spare two-thirds of our patients the morbidity of unnecessary prostate biopsy. Further evaluation is necessary to characterise the true malignant potential of these lesions.

**References**


Mastoid Obliteration – A Case Series Review Of Our Practice And A Financial Case To Do More?

### Abstract:

**Introduction**
The chronically discharging ear after open mastoid surgery for Cholesteatoma (keratinising epithelium within the middle-ear or mastoid) can be problematic to manage for the Otolaryngologist. Requiring numerous appointments, contact time with clinicians and embarrassment to the patient. In the current climate of cost saving within the NHS, we must balance clinical evidence and cost. We review our practice of Mastoid obliterations in our district general hospital in the UK over the last 10 years to look at both success and cost.

**Methods**
All the notes of patient who had mastoid obliteration over the last 10 years were reviewed. The cases were found by going through the theatres scheduling records for the last 10 years. We reviewed the preoperative, intraoperative and postoperative course of each patient. We report on our technique, the success rate of drying the ear up, audiogram changes and complications. We compare the monitory costs of the patient’s preoperative costs versus the operation and postoperative costs.

**Results**
There were 14 patients, 6 male and 8 female with a mean age of 46.7 years. They had been listed for mastoid obliteration due to chronically discharging ear. The mastoid cavity was obliterated with cartilage, bone dust, fascia lata and fat grafts. The patients reported their symptoms had improved for discharging ear, debris, vertigo and some also reported quality of life improvement including confidence and embarrassment in social situations. Subjectively patient’s reported their hearing had improved and leaving a small dip in the obliterated cavity of the external auditory canal for a conventional ear-level hearing aid was a bonus for the patients. Patient’s preoperative costs and therefore presumed continued costs justify the operative and postoperative costs.

**Conclusions**
Our technique has shown great benefits for the patient’s symptoms, and savings in cost for the NHS. We conclude that in the correct patient group mastoid obliteration is beneficial to the patient and the NHS.
An Expanding Posterior Auricular Lump

Abstract:

Introduction
We present a case of posterior auricular swelling. We discuss the management of this rare tumour of which there have been just over 130 documented cases.

Case Report
A Caucasian twenty-two (22) year-old engineer complaining of an expanding lump in the posterior auricular area. This was preventing her from wearing her sunglasses and causing discomfort over a period of six months. The patient reported having a lump as a child but not causing any discomfort.

The patient denied any hearing, balance or meningitic symptoms. No constitutional symptoms were reported. Otherwise, her past medical history included anorexia and is a non-smoker. There was no family history of any cancers.

On examination, a 3-4cm, well demarcated circular, firm to hard, non-mobile, non-pulsatile tumour with no fixity to the surround structures. There were no signs of inflammation or lymphadenopathy. Cranial nerves were normal. Examination of the Oro-Naso-Laryngopharynx was unremarkable.

A Computed Tomography (CT) of both mastoids demonstrated a well circumscribed sessile dense bony growth from the outer cortex of left mastoid processIt has a wide base/stalk. No soft tissue component. A diffusion weighted Magnetic-Resonance-Imaging (MRI) did not find any futher soft tissue changes.

A diagnosis of Mastoid Osteoma was made based on clinical and imaging findings and managed with excision of the tumour. An operative bony specimen measuring 25x20x10mm had macroscopic appearance of bony tissue. Microscopy showed sections of bone including Haversian canals. There were no features of malignancy.

Discussion
A good functional outcome has been achieved with no recurrence. This management is in line with current practise in the literature review.

With less than 150 cases world wide, a Mastoid Osteoma is uncommon. The clinical approach remains similar to any tumour. As well as differentiating between benign and malignant nature of any tumour, In this case it is important to be aware of multisystem syndromes such as Gardner’s syndrome which present with multiple Osteoma’s as well as Gastrointestinal and Cutaneous pathology.
Osteochondral Fracture Of The Patella With Successful Fixation

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### Abstract:

**Case Report**

A 15 year old girl presented with knee pain, inability to extend and weight bear after a twisting injury to the knee leading to dislocation and spontaneous reduction of the patella. A 3×3cm osteochondral defect was identified over the medial facet of patella with a loose osteochondral fragment with very little osteochondral bone attached to the large cartilaginous part. Medial patellofemoral ligament and medial retinaculum were intact. This unusual fracture was fixed using four biocomposite suture anchors and a bioabsorbable pin. Three months after the surgery she was mobilising full weight bearing and full range of motion with satisfactory outcome.

Usually such fractures occur due to an impaction injury of the medial patellar facet over the lateral femoral condyle, during the relocation phase of an injury. In this case the patella was dislocated and then reduced spontaneously without injury to the medial structures. There are very few case reports in the literature with successful repair of this type of patellar fracture and a good patient outcome.
Patient Bedside Environment Audit; Compliance With Safety

**Abstract:**

**Introduction**
In a 16-bedded Specialist Palliative Care Unit drug rounds, personal care and meals were hindered by obstacles on/or around bed areas. The amount of equipment/clutter around patients’ bed areas is often excessive and time consuming to tidy-up in order to deliver care.

**Methods, aims and objectives**
To assess appropriate use of patients’ immediate environment and bed-side space in line with H&S, tidiness, and to facilitate unobstructed healthcare delivery. Objective domains: patient table (position, accessibility, height, content), call bell (within reach), drinks (available, accessible, fresh), tidiness (uncluttered, free from unwanted devices/obstacles), Health & Safety (positioning of: wires/cables, chairs, mobility aids, TVs, stools, free from obstacles/hazards/spillages). Identify concerns and explore opportunities for making improvements.

Using a purposefully designed pro-forma the auditor observed key criteria. ‘Yes/No’ were used for ‘Area Tidy’ and ‘Health & Safety’, categories were rated as ‘Yes’, ‘No’ or ‘N/A’ in relation to how ‘good’ they were. Occupied bed areas were observed twice daily. Data were covertly collected during the auditor’s shifts. Standards were based on how ‘good’ each domain achieved, thus, as Excellent (95-100%), Acceptable with room for improvement (75-95%), and Poor and needs improvement (below 75%).

**Results**
Data were collected during a 6 week period; 384 observations. In the five domains, table, bell and drinks were all ‘Excellent’, whereas, H&S and tidiness were ‘Poor and needs improvement’. Factors leading to ‘poor’ included: trailing cables/wires, mobility equipment, fluid spillages, free-standing obstacles on lockers, litter, chairs and medicine pots. Reasons why some areas were considered ‘untidy’ were not quantified as this was deemed subjective, for example, patients may be surrounded by their personal effects which may appear ‘cluttered’ to the observer but of great importance to the patient/family. The need for personal possessions as a “security blanket” provides a sense of belongingness, especially those approaching end of life. In the acute setting patients are deterred from bringing personal possessions into hospital, however, in end-of-life care they are necessary in order to provide physical and psychological comfort.

**Conclusion**
Immediately raise staff awareness of the risks and hazards, encourage them to be more diligent, convene a group to identify improvement in H&S, introduce regular formal surveillance, re-audit in 3-6 months. It is reassuring that so many patients had easy access to their table, call-bell and drink/s, however, up to 5% of patients did not; it is not known why. Improvements in H&S and tidiness need to be made with some urgency.
Multidisciplinary Retrospective Audit On Abdominal Pain In Children At Lister

Abstract:

Introduction
Abdominal pain is a common presenting symptom amongst the paediatric population. The A+E, General Surgical and Paediatric departments assess children with abdominal pain suggesting ?appendicitis on a near daily basis. The paediatric appendicitis score (PAS) can help clinicians identify children with likely appendicitis requiring referral to the surgeons for review - particularly if they score very low (≤2 helps rule out diagnosis, ≥7 helps confirm diagnosis). The trust policy, Acute Abdominal Pain in Children, dictates the relevant examinations and investigations required to produce a PAS for each child with this presentation. A clinical audit was conducted with the objectives of reviewing the management of children with abdominal pain and adherence to the PAS system across different departments.

Method
All paediatric patients presenting with acute abdominal pain not related to a chronic condition and producing appendicitis as a differential, were identified in the month of September 2015 (n=16). This was carried out using previous inpatient lists. Audit standards were the steps as detailed in the policy to produce a PAS. A PAS should be produced in all cases except where a GP refers directly to the surgeons.

Information on each child was collected on an audit proforma.

Results
In all 16 cases there was no documentation to suggest full use of the policy/creation of a PAS. 11/16 cases were non-direct referrals to surgeons (i.e. the PAS should have been used). In 6 of these 11 cases parameters needed to calculate a PAS were documented but a final PAS had not been calculated. Of these 6 cases, only 2 cases were the work of non-surgical clinicians i.e. pre-referral to surgery. None of the 16 patients returned to hospital within 24 hours and there were no missed cases of appendicitis.

Conclusion
There is a low level of adherence to the trust’s policy on acute abdominal pain in children, particularly amongst non-surgical clinicians. Use of the PAS will help clinicians from multiple specialties more efficiently identify children at high risk of appendicitis, or those who pose a low risk and could be sent home with safety netting advice. This would likely assist junior clinicians in their clinical reasoning whilst their experience of this paediatric presentation remains very small and reduce the risk of future incorrect diagnoses in ambiguous cases.

Reference
Can We Reduce Complaints? An Audit Of The Complaints Received By The Care Of The Elderly Department In 2015

Abstract:

Introduction
Since April 2011, all Foundation Trusts have been required to supply data on written complaints. We wanted to analyse complaints involving the Care of the Elderly department in order to identify common contributing factors leading to complaints as well as improvements instituted by the Trust in response. Using this approach, we hoped to learn from past complaints and deliver teaching sessions to the department with respect to strategies to avoid complaints.

Methods
All complaints received by the department during 2015 were included. Complaints were analysed for contributing factors such as lack of communication or miscommunication, problems with discharge coordination, discharges felt to be inappropriate by family members, end of life care, nursing concerns, poor staff attitude, loss of patient dignity, poor documentation standards, poor environment and concerns involving clinical procedures.

Results
36 complaints were received by the department in 2015. The median age of the involved patient was 89.5 (range: 72-98). 52.8% of patients were female. The majority of patients were based on wards specialising in Elderly Care (9B 31%, 9A 25% and Ashwell 19%). The median length of inpatient admission was 11 days (range: 1-42). The median length of time from the initial complaint to the response from the Trust was 94 days (range: 1-441).

Figure 1: Chart depicting distribution of complaints by contributing factors. The 'y' axis shows the proportion of complaints pertinent to each contributing factor.
As shown in Figure 1, the majority of complaints involved communication (28/36), mainly focusing around discharge coordination (16/28), inappropriate discharge (7/28) or care of the dying patient (7/28). 61% (22/36) involved nursing concerns with poor attitude (14/22), discharge coordination (8/22) and loss of patient dignity (7/22) playing significant roles.

While TTOs were largely prescribed by doctors prior to discharge, those involving imminent discharge needed to be marked as 'URGENT'. An option to involve the Practice Standards Matron has also been proposed when discharges need to be fast-tracked. A new role of 'part-time ward liaison officer' has been introduced on certain wards to facilitate discharge. With respect to concerns surrounding nursing, a number of measures including clinical shifts undertaken by Matron to oversee junior staff and unannounced visits by the Director of Nursing and senior nursing team have been instituted.

**Key message**
Complaints largely revolve around communication at the time of discharge and concerns regarding nursing. Teaching sessions focusing on reducing complaints should focus on strategies to combat the same.
Introduction
Funding has been available locally for the treatment of refractory vasculitis and SLE with rituximab for a number of years prior to the formation of NHSE. Since April 2013 treatment of AAV and SLE with rituximab has been commissioned through NHSE. Experience of the use of rituximab in non-commissioned indications is growing. Over a two year period (2012-2014) our trust administered a total of 126 rituximab infusions to 45 patients. 20 patients had a diagnosis of AAV, 6 with SLE and 19 with non-commissioned diseases.

Method
Here we describe the use of rituximab over the 24 month period in 19 of these patients with non-commissioned indications. Patients were routinely screened for hepatitis B, and immunoglobulins were checked prior to administering rituximab to ensure hypogamaglobulinaemia was not present. All patients had relapsed on conventional therapies. Urine PCR, albumin and CD19 levels were measured and the data collected retrospectively.

Results

<table>
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<td>2</td>
<td>M</td>
<td>28</td>
<td>Pred, CyA 3yrs, mmf 3yrs</td>
<td>1g x 2</td>
<td>10 days</td>
<td>R 4 months</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>20</td>
<td>Pred, CyA 2yrs</td>
<td>375mg/m² x 2</td>
<td>6 weeks</td>
<td>R 1 month</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>64</td>
<td>Pred, ponticelli, CyA 1yr, tac 3yr, mmf 4/12</td>
<td>1g x 1</td>
<td>Not checked</td>
<td>R 11 months</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>29</td>
<td>Pred, tac 7yrs</td>
<td>1g x 2</td>
<td>Not checked</td>
<td>R 11 months</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>24</td>
<td>Pred, CyA 4yrs. Tac 4/12</td>
<td>1gx2 + 1g @ 6/12</td>
<td>10 days</td>
<td>R 5 months</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>64</td>
<td>Pred</td>
<td>1g x 2</td>
<td>Not checked</td>
<td>Too early</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>46</td>
<td>Pred, tac 3/12, mmf 3/12</td>
<td>375mg/m² x 4</td>
<td>Not checked</td>
<td>R 1 month still R at 2 years</td>
</tr>
</tbody>
</table>

Cost of a 1g rituximab dose = £2136.34 including drug, pre-med, staff time, disposables.

Discussion
There is a requirement for a fully-fledged and funded renal immunomodulatory service to accommodate this expanding need. The cost of the drug and nursing time is perceived to be more than compensated by the increase in quality of life for the patient due to reduction in relapse rate, reduction of clinic visits and potentially reduced need for dialysis in the future.
Successful Audit-Guided Multidisciplinary-Based Antimicrobial Stewardship (AMS) In A Nephrology Department: Experience At A Large District Hospital

**Abstract:**

**Introduction**
The aim of this study is to investigate whether an audit-guided Multidisciplinary-based AMS program leads to reduction in antimicrobial use without compromising patient outcomes.

**Methods**
An antimicrobial stewardship program (AMS) was introduced in the Nephrology department in a large district hospital. The intervention consisted of an audit of broad-spectrum antibiotic use and the introduction of new empirical antimicrobial guidelines specific for this cohort and based on local epidemiology data of infections in renal patients. The new guideline saw the introduction of temocillin as a broad spectrum-sparing agent. The AMS also included weekly involvement of a microbiologist and renal pharmacist in the renal multidisciplinary meetings and ward rounds. Data on broad-spectrum antimicrobial consumption (daily defined dose, DDD) and cost were collected and compared with the period prior to the intervention. The clinical outcome of those patients treated with temocillin was also formally investigated.

**Results**
Reduction of broad-spectrum antibiotic use was observed after the implementation of the AMS program. The higher reduction was seen with Ertapenem achieving 55.7% reduction in DDD and 62% in cost followed by Tazocin with a reduction of 14.7% and 32.7% respectively. The reduction in meropenem DDD (27.8%) and cost (27.8%) was mainly observed after the implementation of the new antimicrobial guidelines. The clinical success of the use of temocillin as broad-spectrum antibiotic was 73%.

**Conclusion**
This study demonstrates that an audit guided stewardship program which is based on consensus building with clinicians during multidisciplinary team meetings can profoundly reduce antibiotic use with no negative effect on patient outcome.
Abstract:

Introduction
Occam’s razor is a problem-solving principle which describes the favouring of simple explanations, where these suffice. When applied to clinical medicine, physicians should always strive to look for the fewest possible causes that account for all the symptoms. Put more colloquially, ‘when you hear hoof-beats behind you, think horses, not zebras’. We describe a patient in which the application of Occam’s razor might well have resulted in trampling by a stampede of zebra.

Methods
A 77-year-old gentleman was admitted with a history of a non-healing traumatic leg ulcer. He had a past history of type II diabetes mellitus, hypertension, and had recently been diagnosed with polymyalgia rheumatica. On admission the patient was unwell with spikes of fever, tachycardic and hypotensive. Following full septic screen, broad spectrum antibiotics were commenced. Admission bloods showed an acute kidney injury (AKI). The working diagnosis was sepsis and secondary AKI. He underwent excision of the infected right leg wound with debridement and washout.

Results
His condition initially improved, however his kidney function continued to deteriorate and he was referred to the renal team. Investigations showed blood and protein in the urine, normal renal ultrasound, and ANCA was positive, PR3 specifically. Subsequent renal biopsy showed a crescentic glomerulonephritis. A diagnosis of ANCA positive vasculitis was made.

Three pulses of methyl prednisolone were given. He initially improved, but he then suffered breathlessness and increasingly severe asthma. Chest x-ray showed bilateral perihilar airspace shadowing, initially reported as pulmonary oedema, however clinical examination and anaemia suggested a pulmonary haemorrhage. Lung-function tests showed a transfer factor of 128% of predicted, which was consistent with this.

The patient was treated with plasma exchange and induction immunosuppression with intravenous cyclophosphamide and rituximab. His condition subsequently improved with resolution of the pulmonary lesion, and a fall in CRP. He is, as of yet, still dialysis dependent, but with improving residual renal function.

Conclusion
This case history demonstrates the need to keep an open mind in clinical practice. This patient apparently presented with AKI secondary to sepsis. It is quite likely that the previously diagnosed ‘polymyalgia rheumatica’ was in fact the prodrome of an ANCA positive vasculitis, and indeed the non-healing leg ulcer, whilst certainly infected, may well have been vasculitic in origin.

Hickam’s dictum maintains that it is prudent to continually test and pursue all reasonable theories, as shown by this case.
Temocillin Use In Renal Patients In A Large District Hospital: A Retrospective Study On The Clinical Effectiveness And Outcomes Of Temocillin In Patients With Renal Disorders

**Abstract:**

**Introduction**
Temocillin, a beta lactamase resistant penicillin antibiotic, is active against Enterobacteriaceae, and is increasingly being used to spare carbapenems. Patients with renal impairment and renal transplants can be more prone to infections, including multi resistant organisms, thus finding effective antibiotics for this patient group is important. We wanted to explore the use of temocillin in patients with renal disorders including chronic kidney disease stages I-V and renal transplants.

**Methods**
‘Renal Plus’, a software used for electronic prescribing, was searched for temocillin use between September 2013 and June 2015 at the East and North Herts NHS Trust. Patients were excluded if temocillin was used for less than 3 days. Patient notes were then analysed for indication for use and clinical and microbiological outcomes, including organisms and sensitivities, and the incidence of Clostridium *difficile* diarrhoea.

**Results**
Of the 40 temocillin prescription episodes identified, 23 had a successful clinical outcome, 3 had a clinical relapse within 1 week of finishing the course, and 2 died within 1 week of finishing treatment from unrelated causes. The remaining 12 cases had a failed clinical outcome, but 5 were identified to have received temocillin incorrectly (e.g.insufficient antibiotic course length, lack of complementary antibiotic, or against guidelines). Accounting for incorrect use and unrelated death, the overall clinical success rate was 69.7% (23/33). Success rate was then analysed according to infection type but no statistical association between source of infection and clinical outcome was found (Chi squared p value=0.892). Of the failures and relapses 2 were under-dosed, compared to 0 cases in the success group, but numbers were too small to comment on significance. Incidence of *C. difficile* toxin positive diarrhoea was 0%.

**Conclusion**
Preliminary data from this study were compared to existing published data, and outcomes suggest that temocillin use in this study of renal patients were comparable to that of other published studies in non-renal patients. Overall we can propose that temocillin, when used for the correct indication, at the correct dose, is a feasible option in a variety of infections to be confidently used in renal patients where carbapenems need to be spared. However larger studies are required to allow more in-depth statistical analysis.
**Sedation Holds In Critical Care**

### Abstract:

**Aims**
Sedation is commonly used in critical care. Patients’ sedation level should regularly be assessed and excessive sedation avoided, as it is associated with negative side effects. Daily sedation holds and reduced levels of sedation have been showed to reduce the duration of ventilation and total ICU stay. (Kress, Pohlman et al. 2000) The aim of the audit was to improve sedation hold sedation practice.

**Methods**
This is a prospective audit of 70 patients at Lister Hospital ICU who had received sedation for >48 hours. Data was collected in two cycles pre and post intervention, each cycle n=35. A sedation hold is contraindicated if: FiO2>60% or PEEP >12, head or C-Spine injury, raised intracranial pressure, vasopressors or muscle relaxants. Interventions were educational sessions for critical care team and changing the time for a sedation hold from 7 am (nursing night shift) to 8am (day shift), and the use of new daily nursing charts. Standards were compared to London critical care network and Intensive Care Society guidance. (Grounds, Snelson et al. 2014)

**Results**
Of the patients that were appropriate for a hold sedation hold requests improved from 57% in cycle 1, and to 78% in cycle 2. The safety of sedation holds improved to meet the standard that 100% of patients having a sedation hold should not have any contraindications. Documentation of outcomes of sedation holds improved from cycle 1 (56%) to cycle 2 (81%). The intervention for changing the sedation hold time from 7am to 8am onwards improved sedation hold compliance. In cycle 1 sedation holds are spread throughout the day, median time 10-11am. Cycle 2 showed a earlier median sedation hold time (9-10am) and a greater proportion of holds occurring at the recommended time of 8am (37%).

**Conclusions**
There is a global improvement in patients receiving sedation holds, timing of holds and documentation. A repeat audit is required to further improve practice and maintain standards.

### References

Can Multidisciplinary Simulation Improve The Care Of Tracheostomy And Laryngectomy Patients?

Abstract:

Introduction
Following a serious incident leading to cardiac arrest in a laryngectomy patient in our trust, it was concluded that human factors played an important contributory part. In order to address this, the simulation faculty was approached to design a training programme aimed at doctors and nurses involved in the care of tracheostomy and laryngectomy patients. The 4th National Audit Project (NAP4) of the Royal College of Anaesthetists also identified shortcomings in the airways management of patients with tracheostomy and laryngectomy.1

Objectives
- To set up high fidelity simulated scenarios for health care professionals that care for tracheostomy and laryngectomy patients
- To provide multidisciplinary (MDT) training in both technical and non-technical skills management in crises

Method
- Six multidisciplinary (MDT) simulation sessions were delivered by experienced simulation facilitators using the Laerdal Essential Patient Simulator and Laerdal Learning Application Software
- The sessions began with an interactive presentation, with emphases placed on the guidelines and algorithms published by the United Kingdom National Tracheostomy Safety Project2
- This was followed by scenarios involving acutely deteriorating laryngectomy or tracheostomy patients
- Video links were used allowing other participants to observe whilst the scenarios unfold
- A whole group focused debriefing technique was used to enhance peer learning opportunity
- Participants completed pre-session and post-session questionnaires in order to evaluate the effectiveness of our training
- Data was collected on a 5-point Likert score and Mann-Whitney U analysis was performed

Results
- We ran a total of 21 scenarios (between August 2014 to December 2015), catering for 25 doctors and 19 nurses
- Our data indicates that our training improves participants’ confidence in the assessment (z score 5.41, p<0.05) and management (z score 6.40, p<0.05) of tracheostomy and laryngectomy patients
- Most encouragingly, the participants also feel that they have increased confidence to trouble-shoot in crises and situations when the patients are in respiratory distress (z score 4.21, p<0.05)
- Participants found the scenarios to be realistic (mean five-point Likert score 4.7/5)
- 95% of participants reported that they would come back to another session and 97% would recommend the training to a colleague
Conclusions
Simulation training can improve both the technical and non-technical skills needed to manage laryngectomy and tracheostomy patients, in an environment in which patient safety is not compromised. Multidisciplinary simulation training may also make scenarios more realistic, and improve team working skills essential for optimal patient care.

References

Continued from page 37

F1—Hydroxychloroquine Induced Retinopathy; Time To Open Our Eyes To Screening?

References
2. The Royal College of Ophthalmologists in association with The British Society for Rheumatology. Hydroxychloroquine and ocular toxicity recommendations on screening. 2009
4. Marmor MF, Hu J. Effect of disease stage on progression of hydroxychloroquine retinopathy. *JAMA Ophthalmol* 2014; 132 (9); 1105-12
External Ear Otalgia Treated With Subcutaneous Methylprednisolone Acetate Injections – A Novel Case Series.

Abstract:

Introduction
Steroids are used in other specialities such as orthopaedics and anaesthetics for pain relief. It is felt that corticosteroids reduce pain by inhibiting prostaglandin synthesis which reduced inflammation and tissue oedema by stopping the reduction in tissue vascular permeability. They have also been shown to reduce spontaneous discharge in an injured nerve with reduced neuropathic pain. Steroids are of ready use in all ENT departments as we use them regularly to help with other symptoms such as hearing loss and vertigo. We present 5 cases of where steroids were used for neuralgic otalgia of the external ear over a 1 year period in an ENT Clinic in a UK district general hospital.

Method
Usual causes of otalgia which can be varied and sinister had to ruled out with full history taking, examination including otoscopy and flexible nasendoscopy and any further imaging decided on a case by case basis. Patients were examined by the consultant under the microscope and tested where their pain on the pinna or external auditory canal was greatest by pressing the areas with the speculum or wax hook. They were then verbally consented and subcutaneous Methylprednisolone Acetate in the form of Depo-Medrone 40mg/ml. The patient’s notes were reviewed and symptoms pre-procedure and post-procedure reviewed and assessed.

Results
Patients all had an improvement on their pain score. Most needed repeated treatment, but were grateful for the temporary relief.

Conclusion
To our knowledge this treatment has not been used in ENT before for managing otalgia. We have had great success with it with small patient numbers and over a short time period. It is easy, safe and practical in perform in the clinic room. We would conclude that large patient numbers and research is needed to assess the reliability, cost analysis and predictability of this procedure in the short and long term.
From Spine To Cochlea: A Case Report Of Post Myelogram Dural Puncture Headache

Abstract:

Introduction

Post Dural Puncture Headache (PDPH) is a recognised complication of neuraxial anaesthesia and lumbar puncture. The cerebrospinal fluid (CSF) leak through the defect in the dura leads to a typically positional, occipito-frontal headache (exacerbated by sitting up or standing) with associated symptoms including tinnitus, photophobia, diplopia, neck stiffness and nausea. The definitive treatment for PDPH is epidural blood patch to stop the dural CSF leak. A less recognised feature of PDPH is hearing loss, thought to be precipitated through a similar mechanism to the headache through the reduction in CSF pressure.

Case Description

A 48-year-old female patient presented with a severe headache and vomiting. Two days previously she had undergone a diagnostic computed tomographic (CT) myelogram via a lumbar approach, for ongoing neurological symptoms following previous decompression of her lumbar spine. CT myelography had been performed instead of MRI due to the presence of an implantable defibrillator secondary to dilated cardiomyopathy. The headache was not postural as might be expected with a PDPH, and other differential diagnoses included migraine and arachnoiditis secondary to the contrast.

Audiography (Figure 1) confirmed mild hearing loss of 25 dB in low (<1000 Hz) and high frequencies. Blood patch was performed by the usual technique with rapid resolution of the patient’s headache, allowing them to be discharged later that day. A repeat audiogram (Figure 2) was performed five days later with significant (>10%) improvement in low frequency hearing range.

Discussion

The symptoms of PDPH are postulated to be secondary to CSF volume loss leading to traction upon pain sensitive structures within the cranium, referring pain via the trigeminal nerve to the frontal region and via the vagus, glossopharyngeal and cervical nerves to the occipital region; and cerebral vasodilatation due to CSF pressure loss, mediated by adenosine.1 The hearing loss associated with CSF leak may be due to a similar mechanism, with reduced CSF pressure transmitted to the inner ear via the cochlear aqueduct. The alteration in inner ear pressure then distorts basilar and vestibular membranes and auditory hair cell function.2 Audiometry can be used as a diagnostic test by identifying the hearing loss associated with PDPH, and post blood patch audiometry can confirm the diagnosis with the reversal of this hearing loss.

Conclusion

The diagnosis of an uncommon complication of myelography, PDPH, was aided by the use of audiometry to confirm low frequency hearing loss. Epidural blood patch led to rapid resolution of the patient’s symptoms. Improvement in the hearing loss was demonstrated on audiometry, helping to confirm both the diagnosis and the efficacy of the treatment. Audiometry should be considered in any patient who is symptomatic following any procedure that can cause a dural puncture.
Figure 1: Pre-blood patch audiogram

Figure 2: Post blood patch audiogram

References
Use Of A Novel Perioperative Heating System For Reducing Perioperative Hypothermia In Elective Major Orthopaedic Surgery

Abstract:

Introduction
Perioperative hypothermia (POH) has multiple adverse consequences such as increased risk of surgical site infection (SSI), wound healing impairment, higher incidence of myocardial ischaemia, and prolonged hospitalization. SSI in particular is of interest to our trust after having been red-flagged for a high SSI incidence in orthopaedic surgery. In the wider context, minimising POH is an evidence-supported way of reducing morbidity and mortality.

Methods
We performed a departmental audit of temperature control in two groups of 25 and 23 patients undergoing elective primary hip and knee replacements. The first group comprised all the patients in a 2-week observation period, and had the standard care available (Bair hugger warming blanket and fluid warmer). Then, over the next 2-weeks, the second group was provided with a novel heated gown (PAWS™, 3M Arizant Healthcare) instead of the Bair hugger. The Peri Anaesthesia Warming System gown was attached to a forced air pump while in the admission area, and the temperature controlled by the patient to their comfort zone. The idea is to prevent heat loss while scantily clad in a cold environment. The anaesthetist set the temperature for the pump during surgery.

In addition to recording the patient demographics, we measured pre-operative, intra-operative and post-operative core temperatures using infrared temporal artery scanner thermometers.

Results
Mean averages of temperatures for each group at each of the 6 time points were compared and found to be closely matched, Table 1:

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
<th>T6</th>
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<td>Standard care</td>
<td>36.52</td>
<td>36.47</td>
<td>36.39</td>
<td>36.45</td>
<td>36.36</td>
<td>36.44</td>
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<td>PAWS</td>
<td>36.63</td>
<td>36.62</td>
<td>36.42</td>
<td>36.4</td>
<td>36.47</td>
<td>36.48</td>
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</table>

Table 1. Mean averages of temperatures for each group. T1 = On arrival to admission area; T2 = pre-departure from admission area; T3 = in theatre, at induction; T4 = in theatre, pre-departure; T5 = on arrival to recovery area; T6 = pre-departure from recovery area.

There were 2 patients in the standard care group who each had one temperature reading below 36.0 degrees Celsius (35.6 at T3 and 35.8 at T5) and one patient in the PAWS group who had one temperature reading below 36.0 C (35.9 at T4, BUT the patient had requested the PAWS to be turned off). Patient experience, based on the spontaneous observations of nursing staff involved, was reportedly better in the PAWS group. Despite normothermia, 3 patients in the standard group needed extra warming blankets postoperatively for subjective cold or shivering. All PAWS patients of course had the option to plug into their warmer post-operatively.
Conclusions
Both groups were found to have good perioperative temperature control. Sample sizes were small, but a small trend was observed towards reduced incidence of POH in the PAWS group. This important topic merits further investigation by increasing the sample size, refining the study design and finding ways of implementing the existing recommendations to minimise POH.

Bibliography
• Hypothermia: prevention and management in adults having surgery, NICE, Published: 23 April 2008 (reviewed April 2015, next review date Sept 2016).
• Perioperative normothermia to reduce the incidence of surgical-wound infection and shorten hospitalization, A Kurz et al. (1996), Vol 334, No 19, 1209-1215.
Excellence In Sustainability - Is It Time For Us To Introduce A 5p Plastic Facemask Levy?

<table>
<thead>
<tr>
<th>Corresponding author details</th>
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<tbody>
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Abstract:

In its 2014 report ‘Facing the future: sustainability for the Medical Royal Colleges’, the Academy of Medical Royal Colleges graded Colleges and Faculties on their actions in ‘Building, energy and procurement’, ‘Staff engagement’, ‘Leadership on sustainability’ and ‘Sustainable practice within the speciality’ [1].

Sustainable healthcare involves ensuring the ability to provide good quality care for future generations by balancing the economic, environmental, and social constraints and demands within health care settings. A sustainable healthcare system maintains population health, reduces disease burden and minimises use of healthcare services.

Increased standards of infection control have produced a surge in the use of disposable, single use medical devices. In response to the duty of ‘sustainable practise within the specialty’ put forward by the Association of Anaesthetists (AAGBI), [2], we note and question the need for the plastic coloured hook-ring found on the Intersurgical disposable facemasks.

We believe these to be a vestigial remnant from a time pre-dating supraglottic airway devices when a technique known as Clausen’s harness was employed, whereby the non-disposable rubber facemask was bridled to the patient with elastic straps fastened to metal hooks on the facemask.

A local straw poll (n=50) showed that only 2 out of 10 Anaesthetists guessed that a possible use of the hook ring on the Intersurgical mask might be for a harness. None employ Clausen’s harness as a technique today.

We await Intersurgical’s response to our query on the purpose of the removable plastic hook ring found on their facemasks and on the number of units sold in the UK per annum.

With a weight of 2g per ring, we question the environmental impact of a redundant piece of equipment that nationally may account for tonnes of preventable NHS waste plastic per annum.

It is imperative that medical devices manufacturers embrace sustainability now. All clinicians should look out for ideas that can design sustainability into all aspects of their practice.

Bibliography