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The Linkman Conference report
Aeromedical management of mass casualty incident
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These courses are organised by Regional Anaesthesia UK (RA-UK) in conjunction with SonoSite Ltd for training in ultrasound guided regional anaesthetic techniques. Previous experience in regional anaesthesia is essential.

**Course Dates**
- 6 – 7 January
- 13 – 14 April
- 9 – 10 July
- 20 – 21 September
- 30 November – 1 December

**Location**
- Newcastle (A)
- Bristol (A)
- Brighton (A)
- Liverpool
- Nottingham (A)

**Organisers**
- Dr Ian Harper
- Dr Barry Nicholls – co-organiser
- Dr Tony Allan
- Dr Susanne Krone
- Dr Steve Roberts
- Dr Nigel Bedforth

10% Discount for ESRA members – 15% Discount for RA-UK (FULL) members. Cost: £400 / £500 (A) including a CD with presentations and course notes.

Pre-course material can be downloaded once registered on the course – including US physics, anatomy of the brachial / lumbar plexus, current articles of interest and MCQ’s. A pre course questionnaire will be sent 30 days before each course.

**Programme**

**Day 1**
- Ultrasound appearance of the nerves
- Machine characteristics and set-up
- Imaging and needling techniques
- Common approaches to the brachial plexus / upper / lower limb
- Workshops – using phantoms / models / cadaveric projections (A)

**Day 2**
- Consent / training and image storage
- Upper / lower limb techniques
- Abdominal / thoracic techniques
- Cervical plexus / spinal / epidural / pain procedures
- Workshops – using phantoms / models / cadaveric projections (A)

(A) – Anatomy based courses /with cadaveric projections

For further information and to register logon to www.sonositeeducation.co.uk
And so the end is near

And so we come to the end of another year. It feels as though 2011 has been rather momentous – there have been so many great events both globally and on a smaller scale that it is too daunting a prospect even to list them. One massive issue which I feel has perhaps not been given as much prominence this year as it deserves is climate change.

The AAGBI has been doing its bit – we have a robust environmental policy for which Steve Yentis is the council lead, but on the global stage it seems that the environment is not at the top of people’s agendas. Dr Stuart White (consultant anaesthetist, Brighton) recently attended a high-level conference on climate change at BMA house, and the following is an excerpt from his report to the RCoA of that conference:

‘Whilst natural processes have always changed the planet’s climate over geological timescales, human activity is warming our planet at an accelerating rate. This change is far in excess of the natural variation expected over time, and its extent and speed far greater than our biosphere can tolerate. There is overwhelming scientific consensus on these facts. Despite awareness of these facts and the absolute urgency with which they need to be addressed, there has been little progress in reducing carbon emissions at an international or national level. There are several reasons for this:

1. A well-funded and well organised minority lobby, having learnt from the ‘tobacco wars’, has been very effective in subverting political and media thinking towards denial of both climate change per se, and man’s role in the problem;

2. The world economic crisis (‘buy more stuff or we’re all in trouble’) demands a diametrically opposite solution to the world climate crisis (‘buy less stuff or we’re all in trouble’). Politicians repeatedly fail to comprehend that ‘green’ solutions are synonymous with ‘cheap’ solutions, the economic benefits of which are likely to increase as fossil fuels run out;

3. As the broadcaster John Snow (mediating the morning symposia) commented ‘this is just not news anymore’ – media interest has declined, and with it the proportion of the population who think that climate change is a serious problem (currently only ~50%);

4. Intergenerational disagreement within the climate change debate, with the (more politically powerful) over 40s less likely to accept that there is a problem and that their generation might have significantly contributed to it, and the (less powerful) under 40s more likely to accept the problem and demand solutions, because they (and their children) have a greater vested interest.’
Dr White has proposed that the RCoA and AAGBI should set up a Joint Climate Action Group, and his proposal will be debated by AAGBI council this month. I am sure you will hear about it in due course. Meanwhile, I am buying less stuff – both at home and at work (too bad for my kids, whose taste for ridiculously expensive handbags and electronic gadgetry remains undimmed but is less likely to be satisfied by my Christmas presents, which I intend to make myself this year).

One event I would like to mark, small as it may seem in relation to the global turmoil of this year, is the passing of John Inkster. Dr Inkster was a noted paediatric anaesthetist who worked in the same department as I do; though we never met as he had recently retired when I arrived. He is always spoken of with great respect locally, and we will carry an obituary about him next month.

We have lots of fascinating articles this month. I must apologise to readers whose submissions are still waiting to be published – we have received a lot of excellent material and I am struggling to find space for everything. The recent members’ survey will be reported on in January, but it revealed that most (69%) respondents read Anaesthesia News every month. I have to say I was a bit surprised by that – I cannot claim to have been an avid reader at all stages of my career…. Many thanks to all of you for both reading and contributing to Anaesthesia News over the last year – it is always a pleasure to hear from you. It truly is your magazine!

I hope you all have an excellent festive season, and that you manage to have some time off even if you have to work at some point over the holidays. I am on call on Christmas day, so I will raise a glass of fizzy water to toast those of you who are also working.

Happy holidays!

Val Bythell

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**Effect of magnesium sulphate on bleeding during lumbar discectomy.**

The effect of magnesium sulphate on bleeding is somewhat controversial. Some studies suggest that it increases bleeding time, however its direct vasodilatory effect can cause hypotension and reduce blood loss. These authors have examined these pros and cons of magnesium in the context of lumbar discectomy. I think we can all agree that controlling blood loss during lumbar discectomy is important for patient care, but also to improve surgical operating conditions.

Patients were randomised to receive either 50 mg.kg⁻¹ magnesium over 10 min, followed by a continuous infusion of 20 mg.kg.h⁻¹ or the equivalent in normal saline, with syringes blinded. There were 20 patients in each group. Intra-operative blood loss was measured using graduated suction bottles and weighing the swabs.

The results strongly favoured the magnesium group. The mean (SD) estimated blood loss was 190 (95) in the magnesium group and 362 (170) ml in the saline group. The surgical assessment score for bleeding also favoured the magnesium group. Magnesium infusion did not affect coagulation parameters or the bleeding time. However, the bolus of magnesium had a slight effect on heart rate and blood pressure, but only in the short term. These results are encouraging for the use of magnesium for controlling blood loss, though this is quite a small study.

**C. M. Blandford, B. C. Gupta, J. Montgomery and M. E. Stocker.**

**Ability of patients to retain and recall new information in the postanaesthetic recovery period**

Our first paper this month asks whether patients can recall new information 30 minutes later, during recovery from anaesthesia. A good question, we all wander up to patients in recovery and tell them things. Surgeons indeed may tell them quite important stuff. Even aside from the question as to whether this is the right time, will they remember?

This is a reasonably large study. 200 patients having day case surgery were given a simple word list memory test, one group did the test early (as soon as they could hold a conversation with a nurse) and the second group 40 minutes later. As I say, recall of the objects listed was tested 30 minutes later. The authors compared performance with a control group of 100 patients, not having sedation, age and gender matched.

The result, though not entirely unexpected, was clear: 23% of patients tested early didn’t even remember being given the word list! This fell to 1% in the late tested group. In addition, the mean number of objects remembered was 1.8 when tested early, 3.4 when tested late and was 4.4 in the control group.

The group investigated was well chosen: patients having day case surgery do have to remember information as they are going home. Staff just don’t have opportunities to reinforce things. However, as the authors point out, patients may better remember personal information, as they are just more motivated. The authors message? Give important information as close to discharge as possible and supplement with written information. The authors have changed their practice based on these results.

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**Professor Judith Hall**

**Editor**
President’s Report

The Annual Congress in Edinburgh this year was outstanding and I would like to thank all those who organised, spoke or contributed to the event, and to everyone who supported the AAGBI by attending. The atmosphere was really buzzing, helped by the first class facilities on offer at the conference centre. The dinner in the newly refurbished National Museum of Scotland was a great success followed by a lively ceilidh.

I was delighted that John May, an anaesthetist from Inverness, piped us in to dinner. So many of the lectures were brilliant, but I particularly enjoyed the account given by Olivia Giles of being on the receiving end of medical care, and the importance of empathy with patients. By supporting AAGBI events, you support your own Association as all profits are put back into the running of 21PP and your membership services. This is quite different with commercial meetings where profits go towards the company organising the meeting. If you would like a particular topic or type of meeting arranged, please come and talk to us or send an email to secretariat@aagbi.org and we shall get back to you.

Thanks to all who replied to the Membership questionnaire, the analysis was presented to Council in November and will be published shortly in Anaesthesia News. The outcome helps guide AAGBI Council in our strategy. I think most of us were surprised in England when ACCEA announced national awards at the end of September. Many had been forecasting cancellation of the scheme as in Northern Ireland and Scotland. In fact, a similar number of national awards were made as there were in 2010, which was around half the number in 2009. As a specialty anaesthetists received far fewer awards than might be expected. In total in 2011 anaesthetists received 18 awards (12 Bronze, 3 Silver, 2 Gold, 1 Platinum) compared with physicians who received 100 (49/32/11/8) and surgeons with 58 (29/18/7/4). The fact that there are such stark differences between specialties is very disappointing. If the scheme continues after the outcome of the DDRB review, or is overhauled for the future, the AAGBI will make our concerns clear with ACCEA.

The major news on the NHS front is with the Health and Social Care Bill set to produce major changes in the NHS, and the relentless drive for increasing financial efficiency to find the Nicholson £20b. Healthcare costs are rising throughout the world. Better treatments often cost more; less invasive, slower surgery and increasing age and dependency do not sit easily with reduction in spending. Efficiency can be looked at in a number of ways. I am sure I could increase my throughput by 5% if everything in the system lined up on the day, but I find it difficult to see how I can do the same amount of work with 5% less resource. So many of our costs are relatively fixed, and lists are organised by others. I am concerned however that the NHS is being set up to fail, so that “any willing provider” can come in, take away the easy work and experienced staff, leaving the NHS fractured and inefficient.

In my hospital we work hard at theatre efficiency and most of the time things work well, but I had a frustrating week recently when two patients were cancelled, one aged 84 years who had sat around all day waiting and then was cancelled when we unexpectedly ran out of female orthopaedic beds, and the other who needed a 6 hour procedure, which was impossible after a difficult first case finishing at 1530 with several theatres over-running.

Frustrating for all concerned, but particularly so for the patients. I hope that events such as these do not become accepted as fair.

Members will be aware of the requirement by the NPSA to introduce new neuraxial connectors into the NHS by 1 April 2012. Councils of the AAGBI, and those of the RCoA, OAA, APA and RAUK are concerned that the 5 different connectors on the market have not been independently tested before replacing the Luer connector in spinal anaesthesia. We believe a new connector will increase safety in anaesthesia, but mainly by preventing local anaesthetics being given IV in error by infusion or injection. A position statement by our Councils can be found on our website. We are very keen to hear your views and experiences about the new connectors. Email us at neuraxial@aagbi.org

NAP5 will look at accidental awareness associated with general anaesthesia and will be a joint project between the Royal College and ourselves. Dr Jaideep Pandit from Oxford has been appointed as Clinical Lead - congratulations! Watch for further developments soon.

I hope that you all enjoy Christmas and New Year and have some time to relax with families. I look forward to seeing as many of you as possible at the Winter Scientific Meeting in London in January. Sam Shinde is in charge, so it will be brilliant!

Iain Wilson  AAGBI President

All photos from Annual Congress 2011

Anaesthesia News December 2011 Issue 293
Pain Management in Low and Middle Income Countries (LMIC)

Just Put Up With It?

Over the last couple of years we have had the privilege of travelling to and working in a number of resource-poor countries exploring pain attitudes, knowledge and treatment options. In this article, we will present our perspective on pain in these countries and give an overview of a pain management course we have developed, which uses a framework we have called RAT (Recognise, Assess, Treat).

The physiological processes of acute nociception from the periphery to the brain are the same in all humans, irrespective of where they live. The causes of pain are varied:

- Pain from multi-trauma following a motor vehicle crash (an increasing drain on medical services in many countries).
- Postoperative pain following a laparotomy for a perforated duodenal ulcer.
- Lumbar spine pain from a pathological vertebral fracture in a woman with carcinoma of the cervix.
- The first dressing change in a 3-year-old child following extensive burns from a cooking fire.
- Labour pain in a teenager struggling through her first delivery.

Apart from the humanitarian aspects of treating acute pain and decreasing the stress response, the benefits of early mobilisation, ability to self care and quicker hospital discharge would seem to be of value in resource poor countries.

Cancer is a common cause of chronic or acute on chronic pain in LMIC. According to the WHO, a disproportionately high number of new cases occur in the developing world with 80% being incurable at the time of diagnosis. Extrapolating from Australian data, it is probable that at least 75 percent of these cases will experience moderate to severe pain during the course of their illness. This is a very strong argument for the development of palliative care services, including effective pain management.

On the surface, it appears that many people in LMIC accept pain as an unavoidable part of life. Patients may have little or no knowledge that certain treatments are available. Nursing and medical staff, for a variety of reasons, may not offer treatment, reinforcing patient and societal low expectations about pain relief.

Stoicism appears to reign supreme, and individuals appear never to complain because there seems to be no point. It is often difficult to tease out the role that cultural factors play in the way patients express their pain - pain and suffering may be seen as a test of faith, while some societies will be fatalistic about pain. Doctors’ and nurses’ attitudes and knowledge about pain seem to suggest that pain is a symptom of a disease process that they either can or cannot do something about, rather than a symptom that can be treated. For example, there is still a strong belief that treating acute abdominal pain will obscure the diagnosis; therefore the pain is frequently left untreated.

**Addressing the problem**

There has been significant effort by the WHO to prevent cancer and address cancer pain treatment. There have also been huge international efforts to prevent and treat HIV/AIDS and this has had some spin-off benefits for palliative care and pain management of other terminal diseases.

Morphine was included on the WHO’s Essential Medicines List back in 1977. Then, in a major advance for cancer pain management, the WHO introduced the Three Step Analgesic Ladder in 1986. Unfortunately however, there are still many places in the world where oral morphine is not available. This is despite its vital role in the treatment of cancer pain, its low cost and ease of preparation. A number of organisations have campaigned for the global availability of morphine and a good overview of some of the issues relating to the unavailability of morphine was recently published in the BMJ.

**Improving pain knowledge**

Staff knowledge and attitudes are important factors when it comes to recognising pain and treating it effectively. We strongly believe that education plays a vital role in improving pain management and we appear to be lagging in our efforts to provide effective pain management to our global patients.

Consequently we developed a one-day workshop called Essential Pain Management (EPM) with initial funding from the Australian and New Zealand College of Anaesthetists (ANZCA). The course emphasises low cost management strategies and how quality of life can often be markedly improved with very simple treatments. Delivery of the course in the Western Pacific Islands, Papua New Guinea, Mongolia and recently Tanzania has been generously supported by the IASP WFSFA and private donations.

The EPM course structure is modelled on the successful Primary Trauma Care (PTC) course. It comprises a one day (8 hour) interactive course and a half-day (4 hours) teach-the-teacher course for “local champions” identified during the initial one-day course. Identification of local enthusiasts to continue the educational programme is an essential component of the model – it encourages local ownership of issues and promotes a culture of continuing education and teamwork.

EPM is principally designed for medical and nursing staff, but can be easily modified for other groups of healthcare workers such as pharmacists and nurse aides. The workshop is highly interactive and comprises a series of short lectures, brainstorming sessions and case discussions. Morning topics include the classification of pain, basic physiology and pharmacology which includes time on non-drug treatments, reasons to treat pain, and pain management barriers. Most of the afternoon is devoted to a series of case discussions illustrating different pain problems, followed by a brainstorming session looking at ways to overcome local barriers.

ABC (Airway, Breathing, Circulation) has proved very successful as a teaching tool in trauma and resuscitation. In EPM, we have coined our own acronym, HAI, standing for Hecognize, Assess, Treat. This simple framework has proved very popular with course participants and provides a good structure (along with subheadings) for the case discussions.

The four-hour instructor workshop is also highly interactive and covers relevant teaching principles and practical issues relating to the running of an EPM workshop.

Participant feedback about EPM has been very positive. One measure of success of the workshop will be whether the course is taken up by local health workers. Since running two workshops in Papua New Guinea in April 2010, several EPM workshops have since been organised and taught by local instructors and the course has also been incorporated into the undergraduate nursing programme.

EPM is in its infancy but we hope it will prove to be an important tool for improving pain knowledge and practice in developing countries.

**Roger Goucke**

PERTH Western Australia

**Wayne Morriess**

CHRISTCHURCH New Zealand

**References**

2. BMJ 2010;341:c3800
COMING SOON: THE NEW AAGBI TRAINEE NETWORK
Let’s Get Connected…

As part of expanding communication within training in Anaesthesia, ICM and Pain Medicine, the GAT committee at the AAGBI are in the process of setting up the AAGBI Trainee Network. We will have contacted school and rotation coordinators before Christmas 2011 with a request to propose a motivated trainee to act as an AAGBI ‘Network Link’ for their region. The first Network Links will act in post until August 2012. Thereafter a term will run for 12 month periods (August to August). The GAT committee aim to establish a functional network for communication between the AAGBI and those involved in training at a regional level, as well as offering a means for trainees to access links across regions.

For further information on the Trainee Network please contact secretariat@aagbi.org or go to the Trainee section of the AAGBI website www.aagbi.org/trainees.

THE WYLIE MEDAL
UNDERGRADUATE PRIZE 2012

The Wylie Medal will be awarded to the most meritorious essay on this year’s topic of *Perioperative Patient Safety* written by an undergraduate medical student at a university in Great Britain or Ireland.

Prizes of £500, £250 and £150 will be awarded to the best three submissions.

The overall winner will receive the Wylie Medal in memory of the late Dr W Derek Wylie, President of the Association 1980-82.

For further information and an application form please visit our website: www.aagbi.org/undergraduate-awards or email secretariat@aagbi.org or telephone 020 7631 8807

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Our camp was a two-hour trek from base camp. Cut off from the rest of the world, we were there for a one-week stint to undertake scientific research. We still had radio communication with base camp and the local Honduran guides had an analogue radio tuned into a nearby Guatemalan radio station. This meant that later on in the expedition we didn’t miss the news that Michael Jackson had died or of the turbulent political situation and military coup that was engrossing the rest of Honduras at the time. Jungle camp life was bliss – lush green surroundings, a stunning river to bathe in, good chat around the camp fire, and the company of a family of Quetzals just outside our camp – the most beautiful bird that I have ever seen. We were well aware of the presence and danger of venomous snakes in the area and the inclusion of two reptile-studying herpetologists on the team was reassuring.

It had rained the previous three nights in a row. On the night in question the weather was dry. The two scientists who were studying bats took advantage of the break in precipitation and headed out at 8pm with the intention of spending most of the night up working. Their destination was two miles further into the jungle and they took a guide and radio with them. As had become the norm during my previous three weeks in the jungle, I found myself retiring to my tent around 9pm to delight in the pleasures of Bill Bryson’s tales before turning in for an early night. An hour later, I was awoken by someone shouting my name shortly followed by an urgent sounding unzipping of my tent. A worried looking face appeared and told me that they had just heard via the radio that one of the scientists out in the jungle had been bitten by an unidentified snake.

I dressed swiftly, remembering that I was quite likely to be up for most of the night, and raced down to the dying campfire where most of the team were assembling. Trying to remain cool, calm, and collected I gathered some medical kit together. The camp manager instructed us that she wanted only the Honduran guides and myself to go and find the scientist in question and bring her back to camp. Having spent the past few weeks avidly reading the gruesome medical sections of the herpetology books lying around base camp, I ran off into the jungle secretly terrified about what I might face when I reached the

Niall McCann, biologist, adventurer, and friend, recently found himself part of an emergency rescue and helicopter evacuation of a student who had been bitten by a venomous palm viper in the Honduran jungle. Fortunately for the casualty involved it was a dry bite and the student came to no harm. Hearing about what Niall had been up to bought back uncomfortable memories for me. Just over two years ago I was working as a medic with Niall and a team of scientists in exactly the same spot of Honduran jungle and found myself faced with what I thought was a similar situation.
victim. It was dark, the paths treacherous from the recent rain, and the journey there was mostly uphill. I arrived at the scene sometime later, escorted by a guide, huffing and puffing having slipped over several times en route. The other guides had arrived well before me and had assembled a make shift hammock stretcher on to which the hysterical victim had been placed. The 23-year old girl in question was bilingual in English and Spanish. I could not get her to speak any English to me and she would not listen to anything that I said. She was hyperventilating, tearful and freaking out in Spanish. I tried to make an assessment of her snakebite and physiological state. I found a single fang mark on her right hand with the surrounding skin looking healthy. She was tachycardic but I couldn’t find any other worrying signs of impending cardiovascular collapse. I splinted and bandaged her right arm and cannulated a vein in her other arm. I decided that the best course of action was to leave the scene and get her back to camp. The hammock stretcher was useless along the steep downhill and narrow paths and soon the guides resorted to piggy backing the victim. The speed of the group picked up considerably and I found myself at the back struggling to keep up and often resorted to sliding down the paths on my backside. At the rear with me was the other scientist who was out that night. She looked shocked at everything that had happened and couldn’t stop shaking. I tried to comfort her as we hurtled along. It was an attempt on my part to do something useful given that I was unable to do very much for the victim at present. She was also the only one I could speak English to.

After what seemed a lifetime we crossed the river and emerged back into the clearing that was camp. The others had been busy whilst I had been away. The fire had been resuscitated, candles had been lit, and from what I understood communication with base camp had been established and the chain of events for getting a helicopter there to evacuate the victim were underway.

People were awkwardly standing around not sure whether to rush over and help or keep out of the way. I took control and told people what help I needed. The victim was beginning to calm down and she started talking to us in English. Her pulse was steadily returning to normal. Happy that she was stable, I jogged over to the camp manager to find out about the helicopter. She looked worried and said that she was "calling it off." I told her that she mustn’t call the helicopter off. We still needed to get the victim to hospital even if she was beginning to look better. She repeated that she was calling the whole thing off and that it had got out of hand. It was at that point that it hit home hard with a punch of realisation that the whole thing has been a practice exercise and there had been no snakebite.

Astounded at all that had just happened, I found that the only way that I could diffuse the now redundant adrenaline pumping around my body was to burst into tears.

This was followed promptly by an overwhelming surge of anger. I was angry with those ‘in the know’ for allowing others and myself to potentially injure ourselves by creating this scenario at night in dangerous conditions. I was angry that I was allowed to go as far as cannulating the victim and in a flash could have given any of the drugs available to me as medic.

It transpired that only the camp manager and the two bat scientists were aware that this was a practice. Everyone else took part in the rescue thinking that it was for real. The camp manager had been instructed by the organisational staff at base camp to run a practice casualty evacuation (casevac) at some point during the week. However, lack of instruction from base camp and the camp manager’s lack of experience resulted in the events described that night. Lessons were learnt and a big debrief the next day helped to draw a line under the incident.

Having a casevac plan is an essential part of pre-expedition planning and putting it into practice with the team once on expedition is time well spent. I have run practice casevacs on previous expeditions with different organisations. Everybody has known that it has been a practice from an early stage. It has not detracted from the point, which is to test the logistics of the plan in place, highlight to other team members what is involved and their role. It demonstrates how difficult it can be to evacuate someone from the wilderness. That night in Honduras proved to me why people should not be kept in the dark during practice casevacs. The same too can be said of simulations that we come across at work as anaesthetists, whether a rehearsal of a major incident plan or simulation of an anaesthetic emergency. I will most certainly never forget the fake snakebite during future expeditions and during my career as an anaesthetist.
From Less Than Full Time Anaesthetist to Less Than Full Time Mother: Aspiring to Dual Accreditation

Jacqueline Davies, Specialist Registrar in Anaesthesia in Mersey Deanery

When my youngest child started Dosbarth Derbyn, or reception class, I found myself with the luxury of two days a week to myself. I didn’t even need to study for exams, having finally passed the final FRCA the previous year. I’m not used to having time on my hands and needed to justify it, to try to do something useful with it. I’m not one for housework, a clean house is a sign of a wasted life, so my options were to go back full time or have another baby, though the latter seemed extreme. I initially found a third option, a part time diploma in medical education. Before I completed it my circumstances had changed in that the credit crunch was threatening my husband’s job and I needed to return to full time work for financial reasons. So I now found myself with increased hours, a daily commute of an hour each way and a couple of 3,000 word assignments to complete for the diploma.
This put a whole new weighting on my work life balance. I now spend a lot less time with my children, but does that mean that I am not a good mother. I needed to know I could be competent as a mother as well as an anaesthetist.

A lot has been written on what makes a good anaesthetist and whether this can be taught and assessed. The RCOA provides a syllabus outlining the skills, knowledge, judgement, attitudes and behaviour that should be possessed at each stage of training. It is easy to forget that there is a lot more to being a good anaesthetist than being technically proficient, such as clinical judgement, team working and keeping calm under pressure.

With any role there is also an unofficial syllabus in which tacit, or implicit, knowledge is acquired. I think that being LTFT over a number of years has given me more opportunities than my full time colleagues to develop this side of the anaesthetists’ role. I tend to focus too much on the official syllabus and become concerned if I think my technical skills aren’t progressing as quickly as I would like. This was particularly true when I was LTFT as I wasn’t exposed to any procedure on a regular basis. I need to perform procedures repetitively and frequently to become competent, both inside and outside of work. I have recently started going to tap dancing classes. If I miss a week out it seems to take me another fortnight to catch up to where I was. When LTFT I may have had a “bad epidural day” and then not had the opportunity to do another epidural for two or three weeks, by which time my confidence had plummeted and so a vicious cycle began.

Now that I am full time I have the opportunity to trainees fail to get their IACC by six months. My experience is that I remained slower to pick up new skills and to familiarise myself with new experiences. One obvious form of appraisal that lends itself to parenthood is multi source feedback (MSF), or how others perceive you and your children. These sources could include teachers, other parents or even the children themselves, it should also include self appraisal. One memorable piece of feedback came from a consultant colleague who had the fortune, or misfortune, of spending an entire weekend with my children in India, including a ten hour bus trip. He said he thought my kids were great. That meant more to me than anything else.

I now spend a lot less time with my children. I have no problem achieving that. I asked my children what made a good mother. My son said “to be a fair person”. I think he was trying to give me the answer that I wanted, rather than what he really felt, he may go far. My daughter, who does not have such a mature outlook in life, replied “one that gives lots of sweets”. If a syllabus for mothers was produced I think that tacit knowledge and non technical skills would feature highly. Indeed, a lot of things I pick up as a mother are used at work and vice versa. Yesterday I had a very distressed, agitated patient in recovery that needed calming down and reasoning with. I went into “mummy mode” as it reminded me of my daughter having a tantrum. She can scream for what seems like an eternity without remembering what it was that upset her in the first place. I have to be sympathetic and patient, yet firm. I knew that I didn’t want to resort to drugs with the patient, although it would be tempting if I had access to drugs at home!

I don’t know whether I can deal with these situations better at work because I am exposed to them at home or whether it is the other way around.

I needed to know I could be competent as a mother as well as an anaesthetist.

So how can I assess my performance as a mother? Could workplace based assessment tools be applied to parenthood? It would be possible to perform DOPS, especially when you are a new mother. For example, can you bath, feed and dress a baby? Most mothers do undertake case based discussions and peers reviews. We share anecdotes and learn from reflecting on our own and each others’ experiences. One obvious form of appraisal that lends itself to parenthood is multi source feedback (MSF), or how others perceive you and your children. These sources could include teachers, other parents or even the children themselves, it should also include self appraisal.

I do get bad feedback though, often from the children. My daughter often complains that I never pick them up from school any more and they always have school dinner, never a packed lunch, (to avoid having to cook a meal for them in the evening). Last month my son’s teachers were worried that he was tired a lot and was drinking lots of water. I felt awful, I had been on call a lot in the few weeks running up to this but surely I would have recognised if he had diabetics (he doesn’t). He recently got really upset at school, he told his head-teacher the reason he was tired was because he lay awake at night waiting for me to come home and I was never there. It turned out he was just upset because he had been moved to sit at another table and he was just making excuses up. But like one of those rogue comments on an MSF that you’re supposed to ignore, I’ll always know it was said. My greatest critic in my competency as a mother is probably myself. I feel like I am never at home and turning into a man from the 1950s, coming home to expect my children fed, bathed, ready for bed and my dinner to be cooked for me. I could have a “bad line day” at work, come home tired, feeling like an incompetent anaesthetist. The company is messy, I shout at the children for the smallest reason, it all escalates out of control and now I feel like an incompetent mother as well. However, these sort of days are getting more infrequent and I have several of them when I was LTFT as well. I don’t think the amount of time that I spend with them is that important, to use a cliché, it’s quality time that counts.

The crucial thing is that they know that they are loved, whether they are with me, their father or one of their grandparents.

Having juggled LTFT training with a family took a lot of organisation. Working full time does not take that much additional planning and prioritising, but I do rely on a lot more support at home. So will I get dual accreditation? Hopefully I’ll get my CCT in anaesthesia next year, I’m not sure if I ever will get one in motherhood. I don’t think the training in that ever finishes, probably not even when the children get to eighteen. We’ll just have to wait and see what they turn out like. I don’t think I’m doing a bad job though.

References
Training less than full time (LTFT) in anaesthesia is an option for those doctors who need time to care for dependents, or to manage their own ill health or disability, and for those who wish to pursue other non-work related commitments. It should make a reasonable work life balance for these individuals more achievable. For some, however, it can be a daunting prospect and available information has often been varied and confusing. GAT recently published an A to Z guide to LTFT training on its webpage which gives a comprehensive overview of all LTFT issues (figure 1) far beyond the scope of this article. In addition there are other recent articles and resources available that may be of interest to LTFT trainees. In this article we will highlight some of these and emphasise the recent changes to training that are particularly relevant to LTFT trainees. We also give a summary of the application process for anyone considering LTFT training. We hope this information will be of use to both trainees interested in part time working and the trainers who support them.

**Eligibility and Application for LTFT Training:**

The eligibility criteria for applying for LTFT are summarised in box 1. Trainees in category one will be given priority. The vast majority of trainees working LTFT are women who have childcare responsibilities. There are a number of recent articles explaining maternity rights, pregnancy and the anaesthetist and organising work LTFT following children.

The application process for LTFT training may vary between Deaneries and your Human Resources contact will be able to give you the application forms. The process may take several months to complete and so it is important to start this as soon as you think you might wish to start training part time. Involve your Training Programme Director (TPD) early so that they are aware of your plans. They should also be able to introduce you to the local LTFT Training Advisor for Anaesthetics who will be able to offer advice regarding your future training needs and importantly introduce you to other local LTFT trainees.

**Types of LTFT Training Programmes**

The types of LTFT Training Programmes available are summarised in box 2. The vast majority of trainees will work in a slot share. Usually each trainee undertakes 0.5 or 0.6 of the post. As a 0.6 slot-share it will take you twenty months of training to complete the equivalent of a year full time (FT). Training LTFT therefore does significantly increase your trainee years. If your circumstances change it is possible to return to full time training, although you may have to wait until there is an available slot on your rotation. Again early discussion with your TPD and LTFT Training Advisor should smooth this transition.

**Slot-share:** A training placement divided between two trainees, so that all the duties of the full-time post are covered by two trainees. The two LTFT trainees are employed and paid as individuals for (usually) 0.6 whole time equivalent (WTE). Thus a department benefits by having two LTFT trainees working 1.2 WTE in one full time slot. This arrangement is NOT a job share. The trainees share a place on the rota but not a contract and may overlap sessions. The other person in your slot share can change from post to post, i.e. you do not need to move around departments together. Funding is provided by both the Deanery and the host trust.

**Supernumerary:** These posts can be offered where LTFT training is needed at short notice or a slot share is not suitable. Applications will usually only be granted to doctors with differing needs in extenuating circumstances, such as ill health or becoming a single parent. Supernumerary posts are additional to the normal complement of trainees on a rota. The proportion of hours worked and out of hours commitment will be arranged on an individual basis. Funding is provided by the Deanery alone. Financial constraints make these posts uncommon.

**Returning to Work after a Prolonged Absence**

Often the decision to train LTFT will be accompanied by a period away from training. This time away from work may compound the difficulties associated with adapting to new working arrangements. The Association of Anaesthetists of Great Britain and Ireland...
still does not reflect the optimum number of hours required to achieve clinical confidence. Whatever your proportion of hours worked, it is very important to keep the RCoA Training Department up to date with this information including any periods of absence in order that they can recalculate your Certificate of Completion of Training date.

Training programme

Regardless of the number of hours you work each week it is important to make the most of your training time. Your training is to a large extent your responsibility so it is important to be organised and notify your TPD and flexible training advisor of your training needs early in order that you receive suitable rotational placements. Early communication with each department to inform them that you are an LTFT trainee should ensure that you get the appropriate length of training blocks as you will need longer than your FT colleagues to complete all the learning outcomes and competencies required during a module of training.

You will still undergo annual appraisal and ARCP or RITA assessments. Although this may seem like an additional burden of paperwork it should be used to your advantage to evaluate your training needs and identify any problems early. It will also ensure that your case mix, responsibilities and out of hours work are not significantly different to the FT equivalent. There should not be an expectation that in a year you will have achieved the same goals clinically, in workplace based assessments or in continuing professional development as someone training FT. These goals should be calculated realistically on a pro-rata basis according to percentage of FT worked.

Sitting exams whilst training LTFT with other commitments to contend with will undoubtedly be hard, requiring high levels of organisation and commitment. The RCoA exam regulations have changed over recent years, uncoupling the individual parts of the exam and allowing a pass in any part to be valid for two years. This has recently been increased to three years for the primary MCQ. However, it is important for LTFT trainees to note that the clock does not stop for exam validity during any periods out of training e.g. sick leave and maternity leave14.

The recent implementation of the RCoA 2010 curriculum may have implications for a few LTFT trainees still on the 2007 curriculum. If you are unable to complete the 2007 curriculum before midnight on the 31st December 2015 then you should transfer to the 2010 curriculum now as the 2007 curriculum will cease to exist as a training programme after this date15. If you are unsure if this affects you then the RCoA Training Department should be able to advise.

On-going Support

It is important that you know where to seek guidance when training LTFT. From personal experience fellow LTFT trainees are a valuable resource, and many deaneries have formalised LTFT trainee forums alongside the Anaesthesia LTFT advisor for sharing experiences and resolving common problems. As it is impossible in this short article to cover all relevant training issues we would urge you to access the GAT website where “LTFT training: An A to Z Guide” is available to download. Here you will find more detailed information on all the above topics and many more (http://www.aagbi.org/professionals/trainees/training-issues/lft-training).

In addition, the GAT LTFT representative, Sarah Gibb, can be contacted for advice or support at gat@aagbi.org.

References:

3. Pidgeon H. Getting the Balance: A Personal View of Life+1 Training, Anaesthesia News 2011; Mar: 13-14

Declaration regarding possible conflicts of interest: The authors of this article are also the authors of the A to Z Guide to LTFT Training mentioned.
The 36th Annual Linkman Conference was held at the Edinburgh Conference Centre on Tuesday 20th September 2011, the day before Annual Congress. 92 linkmen attended and it was a great meeting and a valuable opportunity to network and discuss concerns from around the country. In the words of one linkman – ‘there were some good honest sessions’. The electronic voting system provided some entertainment, and was particularly useful to obtain instant feedback from the audience.

The first session of the meeting related to political issues and was chaired by Richard Griffiths. AAGBI Council member Sean Tighe gave a robust presentation on working arrangements for consultants, and particularly emphasised the importance of job planning using reliable diary evidence to support this process. He echoed the words of anaesthetist Mark Porter, current chair of the BMA Consultant and Specialists Committee - it is important that you are paid for the work that you do and that you do the work that you are paid for. Enlist your local hospital local negotiating committee (LNC) if necessary, but the bottom line advice – keep a good diary!

**Working arrangements for consultants**

The consultant contract allows a maximum of 30 days study leave in any three years, with pay, but undefined support for expenses – 10% of departments represented at the meeting appear to have unrestricted study leave expenses, the majority (45%) a maximum £1000 per year. For those few departments where there is no budget, or very limited study leave budget, it would be useful to define your CPD requirements for revalidation in your annual appraisal meeting, with an estimation of study leave expenses if possible, and apply for expenses in advance. If expenses are refused this can then be addressed in your annual appraisal and your concerns escalated from there. You can apply for tax relief for study leave expenses, but only if you undertake private practice.

Professional leave allowance needs to be negotiated with your local medical director, and should also be discussed in your annual appraisal. A few trusts have a fixed allowance (usually 5-10 days per year), but in the majority of trusts, professional leave is by arrangement. It would be sensible to ask the sponsoring organisation to write to your Chief Executive to explain the importance of this type of activity to the wider work of the NHS. If your professional leave exceeds your annual allowance, it may be possible to annualise your job plan, use your SPA time flexibly (but professional activity should not take the place of SPA activity), or you may need to resort to taking annual leave. Expenses should be paid by the sponsoring organisation.

There seems to be an increasing requirement for anaesthetists to act down to cover SpRs who are off at short notice – it appears that in 19% of trusts this work is not recognised, in a few it is paid at the usual PA rate with or without time off in lieu, but in the majority this activity is recognised by payment at 2-3 times normal PA rate, with or without additional time off in lieu. You should make sure that you have a local agreement in place as to how this work is recognised (enlist the help of your LNC), and you should only act down with executive approval after all alternative arrangements such as locums have been exhausted. If you are on-
call, another consultant will be required to take over your on-call duties, and you should receive compensatory rest, in accordance with EWTD regulations.

Some consultants are being asked to undertake shift work out of contracted hours – if you have been appointed to a job plan that does not include shift work, for instance at the weekend, you need only undertake this if it is by mutual agreement between yourself and your employer. This arrangement may suit some, for instance those who wish to annualise their contract or come off the on-call rota. In contrast, resident on-call for consultant anaesthetists is not cost effective, is not supported by the BMA, and leaves very little time within your working week for elective lists. Remember, all time within the hospital is working time, and one night resident on-call should attract the equivalent of 4PA in payment.

Payment for extra duties such as waiting list initiatives was discussed – it is important to insist on parity with surgeons for waiting list work. If you are paid for extra duties during your SPA time, you will need to declare when and where your SPA activity will be undertaken. Most agreed that they would like to work in Chester where waiting lists are paid at £750 per session – the national average is much lower than this!

Phil Das is a linkman from Peterborough and was able to share with the meeting the protracted negotiations and difficulties encountered when changing their trainee on-call rota to reduce the number of trainees resident at night. Top tips included a great deal of patience, the need to spend time to communicate with all interested parties, identify the financial implications of various options, the importance of gathering evidence from other trusts, and of piloting changes before implementation.

Andrew Hartle, AAGBI Honorary Secretary discussed how consultants should make best use of their SPA time, and must be seen to be doing so, particularly in these times of financial constraint. The NHS employs 40,000 consultants on an average salary of £110,000 pa – the total bill for salaries is £4.4B, and for consultant SPA time a staggering £1.1B per year. SPA time is an easy target for those wishing to make savings within the NHS – if every consultant were to reduce their contract by 0.5 SPA this would result in a saving of £1.1B over 5 years, or by 1 SPA, of £2.2B over 5 years, that is, 10% of the savings required in the NHS over the next five years. Anaesthetists are particularly vulnerable as we form a large proportion of the consultant workforce, and thus contribute to a large proportion of the SPA budget.

Andrew echoed the advice to keep a diary, and recommended the Outlook electronic diary so that SPA time can be recorded. It is important to demonstrate the outcome from SPA activity through audits etc – and to work together as a department to ensure equal allowance across the department. The LNC should be contacted if you feel that anaesthetists are being targeted unfairly – there should be no differentiation between specialties in SPA allowance.

The majority of anaesthetists at the conference had 2.5 SPA in their contract (55%), 24% had 2 SPA and 15% had 1 SPA. The AAGBI and the RCoA believe that all anaesthetists should have a minimum of 1.5 SPA in their contract, which is the minimum required for revalidation, personal development and clinical governance. An additional SPA (rarely more) should be available by mutual agreement with your employer, agreed at your job plan, and assessed at your annual appraisal. There are many roles to be fulfilled within the average anaesthetic department, described in the March 2011 AAGBI glosary ‘Working Arrangements for Consultant Anaesthetists in the United Kingdom (see www.aagbi.org) – but you need to be up front about when you do your private practice. SPA time is not a day off!

NHS pay and pensions
Cait Seaf presented the BMA view on NHS pay and pensions. There is a two-year pay freeze across the public sector from 2011 for those earning salaries >£21,000 per year. The current round of evidence to the independent Doctors and Dentists Review Body is underway but there is unlikely to be any change in remuneration. Foundation Trusts are not bound by national terms and conditions, and are only likely to recommend pay progression if a consultant has met trust objectives, for instance relating to mandatory training. The BMA has made robust representation to the government about the latest proposals affecting the NHS pension scheme, likely to result in young doctors starting their careers paying more into the pension scheme whilst receiving a lower pension when they retire. Private pensions may be a good idea in addition to, but not instead of the NHS pension scheme – you are advised to take expert advise on this.

AAGBI update
Sam Shinde (new Education Committee Chair) introduced the session on AAGBI matters – the exciting news delivered by the outgoing chair Richard Griffiths is the launch of the new AAGBI video platform – see www.aagbi.org. A new eEducation group has been formed and there will be a variety of ‘e initiatives’ to follow! One of the website areas we will develop over the coming months is a forum for the general membership and also the linkmen – we will keep you posted via the eNewsletter. We have a new general manager at the AAGBI, Karin Pappenheim who will be key to developing our strategy in the future, and is very keen to make best use of the linkmen.

Bernie Liban gave an update on the activities of the Independent Practice Committee. 70% of AAGBI consultant members are active in private practice, and anaesthetists represent the largest specialty in private practice. The AAGBI conducted a survey on independent practice which was published on the website in October (http://www.aagbi.org/news/latest-news), and formed the basis of the AAGBI submission to the Office of Fair Trading market survey of private healthcare. The outcome of the OFT investigations have not been published to date, but we will keep you informed via Anaesthesia News and the eNewsletter.

The Linkman question time provided some lively debate, not least on the name of the group – the overwhelming consensus of the mixed audience was that the name ‘linkman’ should stay, at least for the time being. Other topics included professional regulation of PA(A)s (there is a voluntary register) and whether time should be paid back where an audit half day fell on a direct clinical care day (educational meetings are strictly speaking SPA activity). One hospital had an innovative solution whereby all SPA activity was on-site on a Friday afternoon, and the displaced clinical activity was shifted to a Tuesday.
evening. A common tension within departments is fair allocation of annual leave, particularly during peak times. A number of trusts use a computerised system of booking for annual leave, and identify peak times within the year, allowing colleagues to book one of these times each year on the basis of ‘first come first served’. The advice was to find a solution from within – this is a ‘heart sink’ topic for management and only we understand the complexity of the skill mix.

Isabeau Walker provided an update on Safety activities of the AAGBI. We have published two addenda to the ‘Standards of Monitoring during Anaesthesia and Recovery’. The first addresses the problem of the non-cycling blood pressure monitor in theatre; the second is ‘The Use of Capnography Outside the Operating Theatre’ to address the findings of NAP4, updated guidance on monitoring during resuscitation, and to address concerns regarding monitoring during sedation. This guidance has also been presented to industry and we hope that it will influence development of equipment in the future.

We are particularly concerned about the safety implications regarding the introduction of new neuraxial connectors, and will be updating the safety section of the website on a regular basis. The AAGBI, RCoA, APA, RA-UK and RCoA Patient Liaison Group have recently published a position statement on the website that we encourage you to read.

Rob Sneyd is the outgoing vice president of the AAGBI and in-coming vice president of the RCoA, and very well qualified to provide an update on revalidation - bottom line, it will be happening in a hospital near you, most likely starting in late 2012. Responsible officers have mostly been appointed, and are mostly medical directors. There are a number of useful publications to support revalidation from the DH (a guide for NHS Trusts), the GMC (including guidance on multisource feedback) and the RCoA. (CPD requirements – 50 points per year, 20 internal, 10 from clinical governance meetings).

The meeting was concluded by an expert summary by AAGBI president Iain Wilson who emphasised that we are living in difficult times, but that we should not lose sight of improvements in healthcare over the last few years achieved as a consequence of increased funding in the NHS. The bottom line messages of the meeting were:

• Be organised.
• Get the details of your contract right; get involved, get the LNC involved, and share your experiences via the AAGBI Linkman website.
• Keep a diary! Particularly to record your SPA activity to support your job planning process.
• Work together as a team - ‘management’ will not be interested in your department if the service is covered. Try to address differences within the department and do not let them become conflicts. Make use of your LNC, and maintain your membership of the BMA.
• Make best use of the available educational resources – the AAGBI has just launched the new eEducation platform, and presentations from all our meetings and seminars will be available on-line in the near future.
• There have been a number of developments in private practice with the involvement of the Office for Fair Trade – information will be made available to you via the eNewsletter as we receive it.
• Revalidation is coming soon – we are aiming to deliver structures to facilitate capture of the information you require for revalidation – our motto is ‘keep it simple’.
• We have serious concerns regarding the introduction of new neuraxial connectors that we have published on the AAGBI website.
• We value our linkmen greatly and would particularly value hearing from you as to how we can improve services for the future. We would also be grateful if the Linkmen could encourage all new trainees to join the AAGBI!

The meeting was concluded by an excellent dinner at Ghillie Dhu, which was greatly enjoyed by all. Many thanks go to Ellen O’Sullivan, the outgoing Honorary Membership Secretary and the events team for organising such an excellent meeting. Particular thanks to Ellen for all her hard work over the last three years - I will endeavour to keep up the high standards! The next linkman meeting will be held in Bournemouth the day before Annual Congress, and we look forward to working closely with our linkmen in 2012 and seeing you at the next Linkman Conference.
It was also a great success for exhibitors with work from no fewer than 19 people, ten of whom had never exhibited at Congress before. 85 varied pieces were submitted – from accomplished paintings and inspiring photographs; through quilts, lace, an exquisite worked evening bag and some beautiful stained glass; to a delightful group of papier mache glove puppets.

First prize – through popular vote – was awarded to Peter Wallace with a painting entitled ‘French Harbour’. Peter also submitted several other acrylics that were almost as popular and was successful in selling on piece entitled ‘Plockton’ for the charity. Second and third prizes went to photographs: Birgit Roessner’s ‘Cyclist’ and Bernie Liban’s ‘Autumn’.

Such was the vote that a higher number than usual ‘Highly Commendeds’ had to be awarded. A stunning stained glass sun-catcher, ‘Tree and Landscape’ from Andrea Weigert; ‘Clean Hands’, a beautiful study in oils from Joanna MacDonald; Ruth Spencer’s amazing photograph, ‘Organ Pipes at the Sagrada Familia; Paul Hayse-Gregson’s glorious photo, ‘Chalfont Beeches’ and an atmospheric acrylic from Peter Wallace called ‘Evening Tram’ that caused many Glaswegians deep nostalgia!

Just under a thousand pounds was raised for the two charities, the AAGBI OAF and Royal Medical Benevolent Fund, by sale of raffle tickets and art works kindly donated by exhibitors, and £78 raised in sale of OAF Christmas Cards.

A big thanks once again to everyone who helped make the exhibition a success. In particular Julie Gallagher for putting the catalogue together and seeing to the safe transport of exhibits from Portland Place, Association Staff present at Congress, all our visitors to the stand, everyone who bought a raffle ticket, cards or art works and of course all our exhibitors without whom we would have no exhibition.

And to all those (and there were many) with a variety of excuses as to why they had not submitted (left it too late again, will definitely bring something next year, couldn’t get it on the aeroplane, didn’t think they were good enough etc. etc.) start thinking about Bournemouth now! We all have a talent, it is fantastic to have your work appreciated in an exhibition and it is all in two very good causes!

Stephanie Greenwell and Di Dickson
The meeting will be of interest to both consultants and trainees for the High Risk surgical patient throughout the peri-operative period. A one day meeting situated in the heart of York examining all aspects of caring for the High Risk Surgical Patient.

- **BOURNEMOUTH AND RESEARCH PRIZE**
- **SAS AUDIT**
- **ENHANCED RECOVERY AND ICU**
- **FLUID THERAPY AND OPTIMISATION**
- **FAILURE**
- **HEART DISEASE AND CARDIAC**
- **BETABLOCKERS AND STATINS**
- **TESTING (INC. LIVE DEMO)**
- **CARDIOPULMONARY EXERCISE**
- **PRE-OFFERATIVE ASSESSMENT**

**TOPICS INCLUDE**

**CLOSING DATE FOR ENTRIES:** FRIDAY 13 JANUARY 2012

*For information, application form and programme go to [www.survivingsurgery.net](http://www.survivingsurgery.net)*

**FEE:** £150

If you have any additional enquiries, please contact 020 7631 8812/8807.

Please email entries along with full contact details of the author to entries@aagbi.org

If you have any additional enquiries, please contact 020 7631 8812/8807.

**CLOSING DATE FOR ENTRIES:** FRIDAY 13 JANUARY 2012

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**SAS Audit and Research Prize**

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) invites applications for the SAS Research and Audit Prize. This is exclusively for SAS doctors to encourage them to undertake research and audit. Entries will be judged by the Research Committee of the AAGBI. All SAS doctors who are members of the AAGBI are eligible to apply for the prize.

An audit project should have been approved by the Trust. A research project should have been approved by the local ethical committee and Trust.

Applicants should submit a summary of their audit or research of no more than 1000 words, 3 figures and 3 tables. It should be presented in the style of the journal Anaesthesia.

The winning entrant will have an opportunity to present their work at a national scientific meeting held by AAGBI. Other entrants may be asked to display a poster at the same meeting (as judged by the Research Committee of the AAGBI). Please note that work must not have been previously published, either as an abstract or as a full paper in a journal or website or presented at another meeting.

Please email entries along with full contact details of the author to secretariat@aagbi.org

If you have any additional enquiries, please contact 020 7631 8812/8807.

**CLOSING DATE FOR ENTRIES:** FRIDAY 13 JANUARY 2012
By using the word “breeding”, I am not indicating that our academic friends are actually reproducing, although I am assured that quite a few of them are aware of the biological practicalities of mammalian procreation, and that some are still capable of the necessary physical acts, but I am seeking to indicate that their numbers are multiplying by other means. Ten years ago, we had but one Professor of Medicine and one Professor of Surgery. The former was at the extreme end of the Asperger’s spectrum and found it enormously difficult to engage in a conversation with anything more animate than the current month’s issue of the Proceedings of the Physiological Society. The latter had a combination of a psychotic personality disorder and a wholly distorted view of his own technical abilities that meant that when he needed a vasectomy, he decided that he would only entrust his genital tract to the best surgeon in the world, and promptly performed the operation on himself using a syringe of lidocaine, a mirror and a massive ego. The truth of the matter is that the number of professors in the hospital now seems to be increasing with every passing week. At the latest count, I tallied 26 of them – it will soon be easier to count those consultants who are not professors than those who are. It all started very innocently, with a couple of really quite inoffensive and reasonably academic physicians who already wore bow ties starting to use the title “Professor”. I was told that they had been awarded “personal chairs”, which I understand translates into some form of bribe from the local university to toe the political line, support the Vice Chancellor and part with a hefty chunk of their hard-won research grant income for “administration, accommodation and university overheads”. However, not long after this, a very ordinary vascular surgeon with a regional accent and questionable manners started to call himself “Professor”. He immediately ceased all NHS clinical work in order to devote himself to strategic away-days, overseas travel and private practice. Days after this, the even more unthinkable happened. The orthopaedic trainees started to call one of their consultants “Prof!”. I was gobsmacked. Our orthopaedic surgeons are nice enough chaps but if you put any three of them in a room, you would still not have a sufficiently high combined IQ to produce one proper professor. Professor Bone, as I will call him, is a decent chap, slaps in a jolly good hip and can get round the local 18 holes in less than 78 shots, but an academic he is most certainly not. I often find myself thinking it remarkable that he managed to struggle through the whole of a basic medical degree course, let alone acquire the higher degrees that I thought were necessary to be admitted to the ranks of the academically gifted and titled. Although I would not go so far as to call him simple, it is undoubtedly true that the only branch of medicine that would not consider him to have special needs is orthopaedic surgery. Peter Bone a Professor? I could not believe it. I thought the world had gone mad and could not get any madder – but then I met our new Director of Nursing and realised that world’s capacity for utter insanity was much greater that even I had thought.

I was ambling along one of the dullest corridors of the hospital when Tom, the Deputy Medical Director in charge of beating the crap out of the consultant body, grasped me by the forearm and introduced me forcibly to the new Director of Nursing. I looked at her and wondered whether, when he got round to shutting up about her manifest roles and achievements and actually gave me her name, it would be prefixed with “Ms”, “Mrs” or “Miss”. She appeared far too straight-laced ever to have been too old to accept the soubriquet “Ms” and far too straight-laced ever to have been married, so I had arrived at the provisional conclusion of “Miss” when the bombshell hit me – Tom introduced her as “Professor Andrea Bultitude”. How on God’s fair earth can a nurse be a professor? Once again gobsmacked, I stood there with my mouth opening and closing wordlessly, looking for all the world like a startled goldfish. As if in answer to my unspoken question, the female creature in front of me told me that she was the “Professor of Advanced Nursing Theory at the University of South East Cheshire”. If there exist degrees of gobsmackedness, then I was, at that precise moment, very nearly maximally gobsmacked. Never in my 30-year career in medicine had I ever actually heard the words “Advanced” or “Theory” in direct apposition to the word “Nursing”. There is nothing advanced about nursing; neither can there be anything theoretical about it. Nursing is a practical, personal, humane, caring, compassionate, skilled, admirable and wholly wonderful career but it is not and will never be an academic subject. My credulity had already been strained coming to terms with antonymic couplets like “Military Intelligence” and “Academic Surgery”, but the idea of “Academic Nursing” made me want to scream. Furthermore, what may I ask is the University of South East Cheshire? More than a little confused and upset, I was determined to find out what all this nonsense was about, so I contacted the Fount of All Knowledge – a chum who is a proper academic at a proper university and whom I shall call Jagdeesh, although this is not quite his name. Jagdeesh shared his intelligence with me, and I present it to you here.

There are in this country some 28 Professors of Anaesthesia; there are apparently around 280 Professors of Nursing. This is, to say the least, an extraordinary imbalance – how did we get to this sorry state? Well, once upon a time all universities were proper universities, and all nurses were proper nurses. Then someone said: “why don’t we make nursing a degree course?”. The proper universities would not touch this idea with an academic bargepole, so the courses found themselves lodged in polytechnics. Then someone else said: “why don’t we call all the polytechnics universities?”. Overnight, people who were teaching holistic bedpan management in unremarkable quasi-academic institutions in unattractive parts of the country became heads of academic departments in a university and were therefore offered the title of “Professor” – and many accepted it.

We therefore have two ongoing erosions of the true concept of a professor: the surgeons and physicians who sell their souls for a “personal chair” and those awarded chairs by a new generation of unacademic academic institutions. “But who is entitled to call themselves professor?”, I asked Jagdeesh, and the answer came back: “Anyone – it is not a protected title”. The title “doctor” is protected – albeit not very well from dentists – but not “professor”. I have therefore, in typical Victorian style, been having a little fun.
By dint of the authority invested in me by the University of my Back Garden in East Sheen, I immediately awarded every consultant anaesthetist in the hospital a personal chair, and insisted that their academic titles appear on all operating lists. This caused a great stir – mainly amongst those with dubious professorships. Professor Bone was incandescent with rage and, to my absolute delight, Professor Bultitude was doubly so. Interestingly, the few proper professors in the hospital did not bat an eyelid, secure in the knowledge that they were known to be proper professors by those people whose opinions they value.

My academic plans are expanding rapidly. I have offered personal chairs to the department secretary, two of the operating theatre domestics, the rather pretty girl in the Costa Coffee shop on the ground floor who always gives me a wink when she hands over my skinny latte in the morning, and my neighbour’s cat. When will all this end? The answers are: when we stop calling ourselves “professor” altogether like the Americans have, when everyone and his neighbour’s cat is a professor, or perhaps even when we go back to using the title properly – and sparingly. I live in hope that we move towards the third of these scenarios, although I will bet you my Chair in Advanced Obstetric Anaesthetic Theory that this will never happen.

Keep well,

Victor

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Cambridge Anaesthesia Courses 2012
Cambridge University Hospitals NHS Trust, Cambridge

**Final FRCA Course**
30th January – 2nd February 2012
A three-day intensive revision course for the final exam. Lectures are based on key topics, including VIVA, SAQ & MCG Practice

“Excellent topic selection, very useful for the exam”
“Very good layout for the exam in terms of anaesthesia goals and pathophysiology”
Registration Fee: £400.00

**Final FRCA VIVA DAY**
June & November 2012
Consultant-led, intensive VIVA preparation course giving trainees Extensive VIVA practice for the exam. The aim of the day is to provide candidates with at least 8 hours VIVA practice to give the required preparation and confidence to pass the exams.

“A very good course with lots of exposure to all aspects of finals exam”
Registration Fee: £250.00

**Cambridge Airways Course**
29th February / 16th April / 11th September 2012
A full-day course for Anaesthetists to refresh and update skills in managing patients with difficult airway
Registration Fee: £170.00

**Obstetric Crisis Resource Management**
26th March / 3rd July / 2nd October 2012
Learn how to manage obstetric emergencies using a high-fidelity computerised medical simulator. The course is suitable for all grades of Obstetrician, Anaesthetist and Midwife
Registration Fee: £170.00

For further information on the above events, please contact:
Mr Jonathan Northrop, Postgraduate Medical Centre, Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP
Tel: 01223 217059 Email: jpn33@medschl.cam.ac.uk

The International Relations Committee (IRC) offers travel grants to members who are seeking funding to work, or to deliver educational training courses or conferences, in low and middle-income countries.

Please note that grants will not normally be considered for attendance at congresses or meetings of learned societies. Exceptionally, they may be granted for extension of travel in association with such a post or meeting.

Applicants should indicate their level of experience and expected benefits to be gained from their visits, over and above the educational value to the applicants themselves.

For further information and an application form please visit our website:
http://www.aagbi.org/international/irc-fundingtravel-grants
or email secretariat@aagbi.org
or telephone 020 7631 8807

Closing date: 29 February 2012

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Anaesthesia News December 2011 Issue 293
In 1846 the first successful demonstration of ether anaesthesia took place. Before this few surgical operations could be performed. In the 1840s sniffing gases and vapours for fun had become popular. This paved the way for the introduction of agents that enabled surgery to be performed painlessly.

This was one of the most important discoveries in medicine. However, it was soon recognised that these drugs could be dangerous in the wrong hands.

Our new temporary exhibition explores how one of the most important advances in medicine can be misused and the expertise of anaesthetists who administer them safely.
African Union

The African Union was established in July 2002. Amongst its objectives are the promotion of peace and security in Africa, and the promotion of democratic institutions, good governance and human rights. As such, it has been sending soldiers to Somalia since March 2007 with a view to supporting transitional governmental structures. This is termed the African Union Mission to Somalia (AMISOM). There are currently thought to be a little over 8,000 troops from the AU in Mogadishu. The troops are derived exclusively from Uganda and Burundi. In July 2010, following the 74 deaths caused by suicide bombers in Kampala, the AU agreed to extend its role in Mogadishu to peace-enforcing from peacekeeping, thus involving Al-Shabbab more directly.

Al Shabbab

Al Shabbab (‘The Lads’) is an Islamic insurgent group aiming to overthrow the transitional government of Somalia. It imposes an extreme version of sharia law, and has been compared to the Taliban with regards to its disregard for human rights and suppression of women. At the beginning of 2011 it had control over much of Southern and Central Somalia, and also controlled much of Mogadishu. 2011 has seen them lose ground in Mogadishu, and also in the Southern parts of Somalia.

AMREF

The African Medical and Research Foundation was set up in 1957. It is a nongovernmental organisation focused on providing health education and strengthening health communities within Africa. Its Flying Doctors service is the aeromedical branch of AMREF and is based at Wilson Airport, Nairobi, Kenya. It is the largest aeromedical service in the region, and performed 782 medical evacuations in 2010. It provides aeromedical services to AMISOM allowing evacuation of patients to a hospital which can provide definitive care.

Evacuations from Mogadishu

Aeronautical Considerations

Prior to flights departing the AMREF base at Nairobi clearance must be verified from the Kenyan Ministry of Foreign Affairs. UNSOA (United Nations Support Office for AMISOM) are also informed as they are responsible for maintaining the security of the flight, along with AMISOM who maintain security at Mogadishu Aden Abdule International Airport. On receiving a call from AMREF confirming the evacuation plans, the AMREF staff then arrange for the logistics and coordination of the evacuation.

Background

Somalia is a country located in the Horn of Africa which has been affected by civil war since 1991. The ongoing unrest has caused Somalia to become an extremely dysfunctional and unstable country, ranked number one in the 2010 failed state index. The war started as unrest between tribal factions following the fall of Siad Barre in 1991, but has evolved in recent years into a clash between militant Islamists and peacekeeping forces which are currently derived from the African Union. The conflict is centred around the capital city of Somalia, Mogadishu, and is characterised by an enemy that blends into the civilian population, and utilises a combination of guns, mortars, rocket propelled grenades, landmines and suicide bombers.
flight departure, UNSOA launch patrol boats to ensure the flight safety over the sea. The planes use a low altitude approach over the sea to minimise the risk of being targeted by insurgents with rocket propelled grenades. On landing, the plane is secured on the ground by AMISOM troops. AMREF staff aim for a turnaround time of thirty minutes from landing to take off to minimise the chances of being attacked by projectile explosives. During the period of intense fighting and increased evacuations multiple flights were sent in a clay. AMREF staggered these flights, aiming to not have more than one plane on the ground at a time in Mogadishu.

Medical Considerations

As well as the challenge of treating injuries associated with war zones, the medical crew have other roles to perform. The transfer of the patient from the armoured people carrier to the aeroplane requires the medical personnel to coordinate the AU soldiers in moving the patient. It is important that any medical care given on the ground is kept to a minimum and performed as quickly as possible due to the insecurity of the location. During the evacuation of mass casualties the medical crew also have to triage the patients, and decide which patient to evacuate and which to leave behind.

Incident

In mid-late February 2011, the AU launched a major offensive against Al-Shabbab in Mogadishu. This led to a Mass Casualty Incident. 82 soldiers were killed in the 10 days between February 23rd and March 4th, and several hundred injured. Between 19th February and 1st March AMREF evacuated 140 patients from Mogadishu, more than we had evacuated from Mogadishu in the previous 14 months, and took them to Nairobi and Mombasa (Kenya) and Entebbe (Uganda). Injured soldiers were taken to the Mogadishu AU field hospital where they were triaged and treated. Patients with minor injuries were treated there and once recovered, returned to work. Patients were more serious injuries requiring anything other than basic surgery were evacuated from Mogadishu to areas with more sophisticated medical care. Some patients underwent emergency surgery to stabilise them prior to transfer. AMREF provided the aeromedical evacuation services for all of the soldiers who required further medical care.

Method

We retrospectively analysed the notes of the 140 patients evacuated in the 10 days between 19th February and 1st March, looking at age, type, severity and mechanism of injury, and what treatment they received, and what level of care they required.

Results

Figure one demonstrates the spike of activity witnessed at the start of 2011. 141 patients were evacuated in one month (February 2011) from a previous monthly maximum of 33.

I went onto analyse the data from the period of increased activity (19th February-3rd March). In this period 140 patients were evacuated, all male, with a mean age of 33.

Table one demonstrates the pattern of injuries sustained. It can be seen that close to 50% of patients sustained long bone fractures, and 13% sustained significant abdominal or thoracic injury. Of the 140 patients, 105 had sustained gunshot wounds, 27 had sustained injuries from bomb blasts (including shrapnel injuries), 2 patients had sustained gunshot wounds and bomb blast injuries, 3 patients had non trauma related surgical diagnoses, and 3 patients had sustained injuries from mechanical falls.

84% (n=117) of patients required level one care, with 13.6% (n=19) requiring HDU and 3% (n=4) requiring ICU admission. This correlated well with the NACA score (see appendix 1) of patients, with 80% of patients having a score of 3.

Analgesia techniques were similar during the mass casualty incident. 77% of patients received an opioid, and 8% received ketamine, figures which were similar and slightly higher respectively than in the time period prior to 19th February.

Table two – NACA scores of patients evacuated from Mogadishu between 19th February and 3rd March 2011

<table>
<thead>
<tr>
<th>NACA SCORE</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>3</td>
<td>112</td>
<td>80.0%</td>
</tr>
<tr>
<td>4</td>
<td>24</td>
<td>17.1%</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Table one – pattern of injuries from patients evacuated between 19th February and 3rd March 2011

<table>
<thead>
<tr>
<th>INJURY (COMBINED)</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper + lower limb fractures</td>
<td>2</td>
<td>1.4%</td>
</tr>
<tr>
<td>Upper limb fractures</td>
<td>33</td>
<td>23.6%</td>
</tr>
<tr>
<td>Chest injuries</td>
<td>8</td>
<td>5.7%</td>
</tr>
<tr>
<td>Lower limb fractures</td>
<td>32</td>
<td>22.9%</td>
</tr>
<tr>
<td>Limb amputations</td>
<td>3</td>
<td>2.1%</td>
</tr>
<tr>
<td>Soft tissue injuries</td>
<td>48</td>
<td>34.3%</td>
</tr>
<tr>
<td>Head injuries</td>
<td>18</td>
<td>12.9%</td>
</tr>
<tr>
<td>Genital injuries</td>
<td>2</td>
<td>1.4%</td>
</tr>
<tr>
<td>Psychological trauma</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Abdominal injuries</td>
<td>10</td>
<td>7.1%</td>
</tr>
<tr>
<td>Neurological damage</td>
<td>1</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
Discussion

A mass casualty incident (MCI) is defined as a situation that places a significant demand on medical resources and personnel. In the ten days between 19th February 2011 and 31st March 2011, AMREF Flying Doctors evacuated 140 soldiers from the conflict in Mogadishu. This represents a more than 6-fold increase on our normal workload. We also found that the injuries sustained were more severe and level of care required was higher during this period of time.

The increased workload led to several responses from our organisation. It also meant that the medical practitioners had to adapt their practice due to the large number of casualties. The increase in the number of casualties meant that the medical staff on the ground had to triage patients and the focus of care had to change. Instead of doing what is best for the individual patients there was a focus on doing what was best for the largest number of patients. We adapted the almost universally accepted “color-coded triage” technique.

**Red Triage Tag**: Patients whose lives are in immediate danger and who require immediate treatment

**Yellow Triage Tag**: Patients whose lives are not in immediate danger and who will require urgent, not immediate medical care

**Green Triage Tag**: Patients with minor injuries who will eventually require treatment

**Black Triage Tag**: Patients who are either dead or who have such extensive injuries that they cannot be saved with the limited resources available.

During the spike of activity there was a small increase in the amount of ketamine used. This was partly due to an increase in the severity of injuries, but also due to its safety in the setting of mass casualties.

We chartered a larger plane (Dash 8) with the capacity to transport 16 patients, 13 more than the Citation jets that we usually use.

This MCI was a valuable learning experience for both myself and for AMREF flying doctors as an organisation. AMREF have been commended by UNSOA for their role during this period of increased activity and we feel that we have contributed to minimising casualties during this period of conflict.

Rhys Clayton

ST5 North West rotation, North Manchester General Hospital.

Inside a larger aeroplane (Dash 8) needed to evacuate larger numbers of patients during the mass casualty incident.

During the incident period 67% of patients were transported by the Dash 8. Using a larger aeroplane brought its own challenges. The conditions were cramped, making moving about in flight difficult for medical personnel. The increased number of patients made monitoring patients more difficult. The logistics of unloading and offloading 16 patients were also challenging, particularly giving and receiving a medical handover.

Normally AMREF evacuates patients to Nairobi, but within a few days of the MCI occurring the hospitals in Nairobi were becoming full. This led to some of the flights being chartered to Entebbe, Uganda where patients were taken a medical hospital. Further flights went to Mombasa, Kenya.

The UN made attempts to relieve the strain that was put on the hospitals in Nairobi by transporting patients from Nairobi to South Africa for further treatment after they had been stabilised. These evacuations were also carried out by AMREF leading to further demands upon our organisation.

This MCI was a valuable learning experience for both myself and for AMREF flying doctors as an organisation. AMREF have been commended by UNSOA for their role during this period of increased activity and we feel that we have contributed to minimising casualties during this period of conflict.

Rhys Clayton

ST5 North West rotation, North Manchester General Hospital.

References


Appendix One NACA (National Advisory Committee for Aeronautics) Scoring System

<table>
<thead>
<tr>
<th>NACA 0</th>
<th>No injury or disease (often deleted and incorporated into NACA I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NACA I</td>
<td>Minor disturbance, no medical intervention required</td>
</tr>
<tr>
<td>NACA II</td>
<td>Slight to moderate disturbance. Requires medical care but not hospital admission</td>
</tr>
<tr>
<td>NACA III</td>
<td>Moderate to severe but not life threatening disorder</td>
</tr>
<tr>
<td>NACA IV</td>
<td>Serious incident which may lead to deterioration of vital signs</td>
</tr>
<tr>
<td>NACA V</td>
<td>Acute danger</td>
</tr>
<tr>
<td>NACA VI</td>
<td>Respiratory or cardiac arrest</td>
</tr>
<tr>
<td>NACA VII</td>
<td>Death</td>
</tr>
</tbody>
</table>

Committee for Aeronautics) Scoring System


Top tips for out of programme experience (OOPE) in a developing country

Developing world experience is encouraged in a report by Lord Crisp ‘Global Health Partnerships, the UK contribution to health in developing countries’ and by Professor Sir John Tooke in Modernising Medical Careers ‘Aspiring to Excellence’. The RCoA and AAGBI are also strongly supportive of this, and up to 6 months may be counted towards the General Duties higher module (ST 5-7) as an ‘Anaesthesia in Developing Countries’ unit of training in the 2010 RCoA Curriculum (Out of Programme Training (OOPT). http://rcoa.ac.uk/index.asp?PageID=1479 then see Annex D, page 46-48. Alternatively, a period of developing world experience may be taken out of programme (OOPE) which may be a period of up to 1 year, although prospective approval may allow 6 months to count toward training. Rebecca Jones

Top Tips:

1 Plan early:
Plan as soon as you’ve got your final. The recommended time to go out of programme is ST 6, but it is possible to go in ST 5 or 7. The last 6 months of training needs to be in the UK.

2 Where are you going to go?
This depends on what experience you hope to gain, the country’s language, climate, safety etc. Speak to other trainees and consultants who have worked in the developing world. Useful links to organisations may be found on the AAGBI website: http://www.aagbi.org/ international/international-relations-committee/ international-links The Going Overseas website is also useful http://goingoverseasnetwork.org. It was launched in 2010 to facilitate participation and training in the developing world. It requires a free sign-up but then allows inter-specialty discussion and advice from experienced volunteers.


3 How long are you going for?
This depends on several factors including how much time you are prepared to take out of training (unless it is all OOPT), your hospital rotation placements, the experience you hope to gain and your finances as most posts are voluntary and may require you to pay for flights, accommodation etc. It may be possible to get financial support from charities and other organisations; the International Relations Committee of AAGBI awards travel grants up to £1000 for visits to developing countries where it can be shown that the host country will benefit. http://www.aagbi.org/ international/irc-funding/travel-grants

It is important to consider how much time you may be able to cope with away from home and family commitments.

4 Who to contact?
Apart from liaisoning with the organisation or hospital, if you are planning to take some time as OOPT, you need to liaise with a supervising consultant. You also need to:

Contact your regional advisor – this need to

be done about 1 year in advance. If other trainees have already made plans, the rota can’t be undermined and so you may have to be flexible, e.g. defer a year.

Inform the RCoA Training Department of the dates of all OOPE so that prospective completion dates (CCF) can be revised (college approval is not required for this out of programme experience) Discuss the options and consequences of taking time out of programme with their Educational Supervisor, College Tutor and Training Programme Director.

5 Modules to complete before you go:
It helps to have completed higher obstetric and paediatric training, along with having confidence with difficult intubations. For OOPT, the 2010 Curriculum recommends having completed obstetric, paediatric, ICU medicine and general surgery/urology/gynaecology.

6 Anaesthesia courses to help you prepare:
One day developing world anaesthesia courses are run in London (by the Nuffield Department of Anaesthesia) http://www.nda.ox.ac.uk/announcements and in Bristol http://www.aagbi.org/sites/default/files/poster.pdf

The Nuffield course is supplemented by an annual 5-day practical course on draw-over anaesthesia and managing in scare resources in Uganda. Other courses include the Diploma of Tropical Medicine and Hygiene in Liverpool or London, which run twice a year for 3 months (expensive but useful).

7 Think of your health:
Start planning 6 months ahead. Ensure you have the correct vaccinations and if a malarial area, antimalarials, mosquito net and DEET spray. See National Travel Health Network (and Centre) http://www.nathnac.org/

Take a travel health kit for yourself including antiseptic ointment, oral rehydration solution, anti-diarrhoea medication and an antibiotic such as ciprofloxacin, which GPs should be happy to prescribe.

Strongly consider taking HIV post-exposure prophylaxis in case of sharps injury – available from Interhealth at discount prices if travelling with an affiliated charity to most developing countries. Some organisations require a medical examination.

8 Insurance:
As well as travel insurance, ensure you have indemnity insurance. Contact your defence union and let them know your plans. If you will be driving abroad, ensure that you are insured.

9 Documentation:
Ensure you have relevant visas and certificates proving yellow fever status (for countries requiring it for entry). Photocopy documents such as your passport, medical certificates and driving license. Give a copy of these and your travel details to a close friend or family member in the UK along with details of your insurance policy. Take phone numbers of the nearest British embassy.

10 Donating equipment:
It has been estimated that less than 30% of donated used anaesthetic equipment is ever used, due to lack of maintenance and uncertainty how to use it. The organisation/hospital should be asked what equipment they require so that no unnecessary equipment is taken. Equipment should be safe and if reusable, should be easy to maintain locally, with an instruction manual/leaflet. The quality of an item should be as good as if it were used in the donor country.1 Equipment may be obtained from your hospital (with permission), drug companies or by emailing Aid to Hospitals Worldwide ( nto@a2hw.org.uk) or the International Medical Equipment Collaborative (imec@imeccamerica.org)

Reusable equipment that several people have found useful on OOPE if the hospital where you are going does not have them are Ambu bag(s), paediatric endotracheal tube, paediatric laryngoscope, paediatric cannulas and a bougie.

Useful link
AAGBI – organising your year abroad (advice from the GAT Committee) http://www.aagbi.org/sites/default/files/organising_year_abroad09.pdf (General advice page 1-17, Developing country section page 32-36)

Reference
Failed intubation – it is rocket science
(How an anaesthetic may have changed the history of the world.)

There’s a reasonably good chance that you’ve never heard of Sergei Korolev, yet his achievements will be very familiar to you. Korolev was the engineer in charge of the Soviet side of the ‘Space Race’, and was directly responsible for the first satellite, the first man in space, the first pictures of the far side of the moon – the list goes on. His successes were broadcast to the world, however fears that foreign agents would assassinate him meant that the Kremlin kept his identity a closely guarded secret right up to his death in 1966.

Korolev was born in 1907, and originally trained as a pilot. He was fascinated by aircraft design, which he studied in Moscow, and started showing promise as a designer – he was responsible for Russia’s first liquid fuelled rocket – but his career was interrupted when he fell victim to Stalin’s ‘Great Purge’ in 1938. Four secret service men came to his home and dragged him off into the night, leaving behind a wife and a three-year-old daughter who were allowed no further communication with him. (There is some evidence that he suffered facial trauma during the arrest – a point which will become important later).

He was forced to confess to crimes of treason, and was sentenced to ten years hard labour in the Kolyma Gulag. Most people who were sent to Kolyma died there. It was harsh: there were regular beatings, during one of which he sustained a fractured mandible. He was luckier than most, however. Having been there for less than a year he was transferred to Moscow, where he was allowed to work with other scientists and engineers – all of whom were still prisoners. During all this time, his fascination with spaceflight continued. These days, when you can look up and see the International Space Station passing overhead on a clear evening, it’s difficult to imagine how much of a fantasy spaceflight was considered at the time.

Korolev’s luck began to change at the end of the Second World War. Germany had shown that rockets were not only possible, but could be used with precision; America had developed nuclear weapons; the country which could control both technologies could potentially take over the world. Interestingly, Germany had attempted to develop a nuclear weapon, but had failed. A Russian Missile Project was begun with Korolev as one of the leading engineers – in spite of the fact that he was still technically a prisoner. He was aware that the same technology needed to create an intercontinental ballistic missile could put a satellite – or indeed a manned spacecraft – into orbit. And what better way to demonstrate your rocket capabilities? What the world knew as the space race was a contest between two superpowers trying to demonstrate that they had the upper hand in missile technology.

America had spirited away all of Germany’s best rocket scientists at the end of WWII but it took Korolev’s successful launch of Sputnik 1 in 1957 to galvanize them into action. More Soviet successes followed: they showed that animals could survive in space; Gagarin became the first man in orbit in 1959. All the while the Americans seemed to be lagging behind. The first American in space was on a sub-orbital flight – which was essentially boosted just outside the atmosphere to show that it could be done.

All fascinating stuff, but by now I imagine you’re wondering what the anaesthetic angle is. Korolev had neglected his health for years, and in 1966 was eventually persuaded to undergo surgery for intestinal polyps. His surgery wasn’t taken lightly – even though it was planned to be a simple endoscopic polypectomy, his surgeon was the minister for health. (Say what you like about the Russians, they did at least think that the Minister for health should know something about healthcare). The operation was planned for 14th Jan 1966.

Doing a pre-operative assessment for an operation that took place half a century ago is an interesting exercise, and it’s fascinating what clues there are. We know that Korolev’s health had been described as poor, he had renal disease, and he had suffered at least one heart attack. He had suffered facial trauma during his arrest, and a broken jaw in the Gulag. He was described as ‘stocky’ “burly” and ‘a bear of a man’, all of which suggest a short neck. (There are few pictures taken of him in later years, but those there are appear to confirm this.) More interestingly, his neck movement was severely limited: “He could not turn his neck, but had to swivel his upper torso to look people in the eye”. His mouth opening was poor: “nor could he open his jaws wide enough to laugh out loud”, probably due to the fractured mandible. It’s safe to assume that he was going to be both a difficult intubation and an aspiration risk.

Surgery didn’t go as planned. A large tumour was found and bled; a laparotomy...
was performed. Intubation had failed, and at this point a tracheostomy was considered but decided against – the bleeding was profuse, and the haemorrhage was considered more pressing than considerations of the airway. The operation took eight hours, and for all that time his airway was maintained on a facemask\(^1,4,5\).

The operation was successful but after surgery was finished his breathing became laboured\(^5\). At this point a tracheostomy was done, but Korolev never regained consciousness. From the scant data we have, he seems to have aspirated. His daughter – herself a respected surgeon – was always of the opinion that he should have been intubated\(^1\).

The soviet missile programme never recovered from the death of the man that most Russians knew only as the ‘Chief Designer’. He was given a hero’s funeral, and laid to rest in the Kremlin wall, where Russian leaders are buried.

And the Americans went to the moon

So did a failed intubation change the world? Probably not. America had far more money to spend, while Korolev was on a very meager budget. He had fallen out with Glushko\(^5\), Russia’s best rocket engine designer, and had to rely on engineers who were less talented. Many of his later ‘successes’ were simply tricks: he put the first rocket to carry three men into orbit (this was essential technology for a moon mission) but to do this he simply stripped out a two-man spacecraft and crammed three seats into it. The cosmonauts didn’t even have enough room to wear spacesuits\(^5\). What was seen by the west as another success was little more than a gimmick.

On the other hand, it’s worth pointing out that now that the Shuttle Programme has ended, Russian rockets are the only way to get to and from the Space Station\(^2\); and the rocket they use was developed from a design by Korolev – the booster section is externally identical to Gagarin’s. If Korolev had lived, the Americans might still have won the race to the moon, but the race might not have ended there.

Jason Walker
Consultant Anaesthetist
Betsi Cadwaladr University Health Board
Wales

References:
Caught in the Octopus Trap

They say that in the majority of cases the disorder is precipitated by stress. If that’s so, I put much of the blame on the email from middle management that popped up in my inbox in late March. There it was, flagged “high importance”, and I could feel my heart rate climbing steeply even before I opened it. I knew what it would be, and I was right: a request to resume a weekly all-day paediatric dental list in a small rural hospital 140kms away.

A bit more stress - this time self-inflicted – came my way that weekend. Our daughter’s 125cc motorbike had been gathering dust in the garage since she’d gone to university in Christchurch. Somehow it had been suggested that perhaps I could learn to ride it, and get my motorbike licence. Now at 50kg, and 60 years old, I am not exactly standard bike material, but I was tempted; I’m confident on my 50cc moped, and how hard could it be? However within 20 minutes on that Saturday afternoon my score was: bike started x 3, stalled x 3, fallen over x 2, taking me with it x 1. I’d lifted the bike back onto its wheels myself the first time it fell over; the second time I chickened out and got my husband Nick to do it. When I tried to start it the fourth time and the engine wouldn’t even turn over I called it a day and wheeled it back into the garage, where it has remained ever since.

That evening I took the dog for his usual walk. On the way back it registered that my normal brisk pace was making me feel uncomfortable. I couldn’t have described it as chest pain, but there was a dull retrosternal ache that went away if I slowed down and returned if I resumed my usual pace. Curious, I thought. But out of the question that it could be myocardial ischaemia; five years earlier, after a couple of episodes of chest pain, I’d had a coronary angiogram, and had been told cheerfully by my cardiologist that I had “coronary arteries like drainpipes”. So it had to be something else.

That night the dog woke me with a volley of excited barks. It sounded like a bit more than the usual “Hey, there’s a possum in the silk tree”, so I dragged on a dressing gown and went downstairs to have a look. I could not see or hear anything amiss, but on returning to my warm bed realised that I was ridiculously tachycardic for the trivial effort of walking down and back up a single flight of stairs. Not only that, but I was noticing what seemed to be ectopics – quite a lot of ectopics. Curious again. But after some moments the tachycardia settled, the ectopics diminished and ceased, and I went back to sleep.

Next day I tackled my usual weekend routine of cleaning the house, and remarked to Nick that just wiping down the kitchen work-tops was making me feel quite exhausted. However, I plodded on and that afternoon tackled the unlovely chore of shovelling horse manure out of the paddocks where I graze my three miniature horses. Normally I would do this in one solid hours, as I had to keep stopping for a rest. I could not even propel the empty wheelbarrow on the level for more than about 80 metres without pausing. Something definitely wasn’t right. On returning with the dog that evening I saw some tempting field mushrooms in a paddock by the road verge, and clambered over the fence to pick them. It took me two tries to climb back, and then I had to cling to our neighbour’s mail-box for a few moments before I could tackle the walk up our 200 metre drive. This was odd, to say the least of it.

Mulling over these observations with Nick, I wondered what was amiss. I’d had a couple of weeks of a niggly head cold and sinusitis, could I have developed a viral myocarditis? Should I get a troponin done?

Next morning – Monday – I wasn’t feeling any better but neither was I any worse. So I hopped on my trusty moped and went to work, where Jenny, my anaesthetic technician, (equivalent to the UK ODP) had already collected the hospital car. The programme for that Monday was an 85km drive north to Te Kuiti, and an all-day paediatric dental list in the day surgery unit of the small hospital there. With Jenny driving I could relax, and on the way we swapped accounts of our respective weekends. I mentioned my peculiar symptoms and Jenny threw me a searching sideways glance and muttered something about an ECG, so I back-pedalled quickly. That Monday was Jenny’s birthday, and I knew – although she didn’t – that it wasn’t going to go unacknowledged. The plan was to complete the list as expeditiously as possible, and then settle down to a celebratory afternoon tea, replete with all the home-baked goodies for which the DSU staff were renowned. I had no intention of derailing this attractive schedule, especially as Nick was in on the secret and would be coming to join us as soon as I texted him to say we had started the last case. In the event he got phoned a bit sooner than that…

When we reached TeKuiti the DSU tea-room was in darkness, erupting into a kerfluffle of balloons, streamers and birthday greetings as soon as Jenny opened the door. Judging that she was sufficiently distracted I snuck away, changed into scrubs, checked out the first patient and was drawing up drugs in the anaesthetic room when Jenny marched in, shoulder to shoulder with the DSU boss Rae. Without preamble they told me that the list wasn’t starting until I’d had an ECG. I put it to them that we could do the list first and then the ECG, but to no avail; two minutes later I was recumbent on a trolley in the transfer bay while Rae connected the leads. I was watching her face as the print-out rolled off, and knew at once that I was in trouble. “Heather”, she said, in suddenly serious tones, “I don’t think you should be working…”

I sat up and looked at the ECG. ST abnorm-
abilities, T-wave inversions right across the lateral, anterior & inferior leads, QT prolongation, and an asterisked automatic interpretation declaring “probable MI!”. This was a bit of a shock. I had, if I was to be honest, already accepted that something wasn’t right, but a MI? What had happened to the “coronaries like drainpipes”? However, I wasn’t being given time to cogitate, for Rae was chivvying me to the lab for a troponin. I walked out of the DSU, with Rae at my elbow, and headed for the stairs. “No you don’t!” she told me, “In the lift!” I obeyed meekly, but by this time Rae herself was so stressed that she took us to the wrong floor twice – and there was only a choice of three! (This being Te Kuiti hospital’s “tower block”…) The troponin came back raised – not alarmingly so, but within the MI spectrum. I found myself in ED, having an IV cannula inserted. Te Kuiti hospital, like many small hospitals in New Zealand, is covered by the local GPs; to my great good fortune, among them was my own lovely GP David, who had been called to take charge of my care. He told me that I’d probably had a MI, would be off work for at least a month and that he wanted me transferred to Waikato Hospital in Hamilton for an angiogram and probable stenting. The hospital manager, Thia, came to tell me I was to focus on getting better, and not to worry about anything. I was given subcut Clexane (which stings!) I phoned Nick, gave him a resume of events thus far, and instructed him as well as Jenny’s birthday card and present he needed to bring me some overnight essentials. And my laptop. And some reading material.

David returned to report that I’d chosen a bad day to have a cardiac event. There were no beds in Waikato, and over a dozen patients with cardiac symptoms in a holding pattern ahead of me. Given that my condition was essentially stable, it was unlikely that I would get there before the morning. I put it to him that I could be monitored just as well in the DSU tea room as on the ward. Having extracted his agreement I returned there to enjoy in Jenny’s honour what was quite a lavish smorgasbord lunch. Nick arrived to join us, greeted with much affection by staff who had missed him since his retirement four months earlier. I realised I was still lacking some essentials; it is no part of the staff’s duty to worry about this. In the evening, I added my name to a single flight of stairs, and found that just towelling my hair dry was enough to bring back the chest discomfort, but I was fine so long as I remained quite relaxed.

The next morning I’d just had breakfast when I learned that a bed was available in Waikato, and I was to be transferred at once; I was also instructed to remain fasting, in the expectation of an angiogram later that day. I found myself in a busy cardiac care ward, waiting patiently for the angio, which – the catheter lab being heavily overbooked – did not actually take place until the following afternoon. However, on the Wednesday – my third day as a patient, and nearly four days from the onset of symptoms – I found myself being prepared for angiography via the femoral artery. Having had this done before it held no particular alarms for me, and I politely declined the lorazepam premix. The cardiologist turned out to be the son of a gynaecologist whose cases I had anaesthetised regularly some 19 years earlier – now that did make me feel old! He injected the dye and studied the screen intently; after a moment he said thoughtfully “Your coronary arteries look pristine…” I was just drawing breath to ask what, in that case, had caused the signs and symptoms I’d exhibited when he went on in tones of triumph, “Ahah! You have Takotsubo cardiomyopathy!” I arranged my feature into what I hoped was an expression of learned comprehension, whilst inwardly feeling thankful that I had my laptop with me, and would be able to Google this complaint as soon as I was back on the ward.

Once I was allowed to sit up – it is very difficult to Google anything when flat on one’s back, forbidden to even lift one’s head off the pillow – I logged on and found out what I could. It all fitted together very neatly, and I felt a huge sense of relief that I had actually had an infarct. I spent a bit of time transmitting the news to family and friends – thank heavens for Facebook!

With the diagnosis made, I rather hoped I might get home the next day, but the cardiology team wanted to start me on a beta-blocker and keep any eye on me for another 24 hours. They also wanted to confirm the diagnosis with an echocardiogram. And I had to admit that my exercise tolerance was almost back to normal. My anterior lead T-waves are still inverted, and my exercise tolerance is almost back to normal. I read it through, realising not for the first time that I ticked just about all the boxes, and reflecting that is was four weeks to the hour from when I’d been lying on the table in the catheter lab and hearing the diagnosis.

It’s now over six weeks since I came out of hospital. My ECG is improving, although the anterior lead T-waves are still inverted, and my exercise tolerance is almost back to normal. I still find myself tiring a trifle more than I’d been used to, but whether this is residual cardiomyopathy, the effect of beta-blocker, or six weeks of getting out of condition I am not sure.

It was heartening – choice of words deliberate! – to have such a wealth of support and good wishes from family, friends, colleagues and neighbours; Nick and I are so grateful to all of them. Even to the ones who are still scolding me if I try to overextend myself… I rather suspect that this “uncommon cardiomyopathy” may be commoner that has been thought, and I am conscious that the literature declares that it doesn’t usually recur, but may do so if the precipitating event recurs. Maybe all I need to do is sever communication with middle management.

Dr Heather Cosh Taumarunui, New Zealand
Prevention of Intraoperative Awareness in a High-Risk Surgical Population

NEJM 2011;365(7):591-600

Unintended conscious awareness, defined as the explicit recall of sensory perceptions during surgery, affects up to 1% of patients at risk for this complication; with post-traumatic stress disorder arising in up to 70% of patients as a result. Bispectral index (BIS) monitors measure and process raw electroencephalograph data to produce a dimensionless number from 0 to 100 that indicates a patient’s level of consciousness where 100 indicates a fully awake state and 0 an isoelectric EEG.

In this multi-centre, prospective evaluator-blinded trial, 6041 adults were randomly assigned to receive depth-of-anaesthesia monitoring by BIS or standard end-tidal anaesthetic-agent monitoring (ETAC) protocols. The study had 87% power to detect a clinically significant reduction in the incidence of awareness with BIS compared to ETAC.

High-risk patients for awareness were defined as those with at least one risk factor from the following: planned open heart surgery, aortic stenosis, pulmonary hypertension, use of opiates, benzodiazepines or anticonvulsant drugs, daily alcohol consumption, ASA IV status, end-stage lung disease, previous history of awareness, history of or anticipated difficult intubation, cardiac ejection fraction < 40% or marginal exercise tolerance. Audible alarms were triggered when the ETAC or BIS values were outside the ranges considered adequate for surgical anaesthesia (0.7 - 1.3 age-adjusted MAC for ETAC and between 40 - 60 for BIS). Intra-operative awareness was assessed at interview within 72 hours after surgery and 30 days after extubation.

The primary outcome measured was the incidence of intraoperative awareness. In total, 36 patients experienced awareness. The incidence of definite awareness was 0.24% in the BIS group compared to 0.07% in the ETAC group (a difference of 0.17 percentage points, 95% CI –0.03 to 0.38; p = 0.98). The incidence of definite or possible awareness was 0.66% in the BIS group and 0.28% in the ETAC group (a difference of 0.38 percentage points 95% CI 0.03 to 0.74; p = 0.99). Contrary to expected, there were fewer cases of awareness in the ETAC group (10) compared to the BIS group (26) demonstrating no superiority of the BIS protocol. Importantly, 41% of the cases of awareness occurred when the ETAC or BIS values were within the target ranges.

Previous studies have shown conflicting results regarding the superiority of BIS over ETAC monitoring and this study furthers the debate. The authors recognize that a protocol based on both BIS and ETAC alerts may well perform better than those based on either approach alone; a sensible deduction given the multifactorial and incompletely understood nature of consciousness and the brain’s response to hypnotic agents.

Samantha Perera

References


Effect of caudal epidural steroid or saline injection in chronic lumbar radiculopathy: multicentre, blinded, randomised controlled trial.

BMJ 2011; 343: d5278

The lifetime prevalence of lumbar radiculopathy is 5.3% in men and 3.7% in women, and up to 30% will still have symptoms at one year, and 20% will be out of work. Lower back pain is the leading cause of disability in the world. There is conflicting research about the use of steroid and saline epidural injections in the treatment of this.

116 of 461 assessed patients were included in this study. Included patients had suffered from unilateral lumbar radiculopathy for more than twelve weeks, and the intensity of leg pain, radiating from the back to below the knee was comparable or worse than the back pain. Patients with cauda equina syndrome, severe paresis, severe pain history of spinal injection or surgery, deformity, pregnancy, ongoing breast feeding, warfarin, ongoing treatment with NSAIDs, a BMI > 30, poorly controlled psychiatric conditions with possible secondary gain or possible comorbidity were excluded. MRI or CT scans were performed on all included patients, and patients with severe intraspinal pathology were excluded. Patients were encouraged to engage in physical activity and stop NSAIDs.

Patients were randomised to receive subcutaneous injections of 2ml 0.9% saline, caudal epidural injections of 30ml 0.9% saline or caudal epidural injections of 40mg triamcinolone acetonide in 29ml 0.9% saline. Anatomical landmarks were used to identify the sacral hiatus, and ultrasound was also used. The primary outcome was effect on Oswestry disability index, which assesses limitations on activities of daily living (scale 0-100). Secondary outcomes measured included a change in the European quality of life measure, visual analogue scale for lower back pain, and the visual analogue scale for leg pain. A blinded physiotherapist and doctor followed up patients at 6, 12 and 52 weeks.

The study was powered to detect a difference between one of the two epidural injection groups and the subcutaneous saline injection group, of 10 points over time. Based on a standard deviation of 18, a significance level of 5%, a power of 80% and a correlation coefficient of 0.6 between the three follow-up measurements, the number of patients in each intervention group needed to be 37. They failed to include this many patients – 109 patients were assessed at 6 weeks, 105 at 12 weeks and 99 at 52 weeks.

No serious complications were detected from any of the interventions. The treatment groups did not differ significantly at baseline, except that there was a higher presence of ankle tendon reflex difference amongst patients in the caudal epidural saline group. The subcutaneous saline group had the shortest duration of symptoms at baseline, and the caudal epidural saline group the longest duration, but this difference was not statistically significant. There was no statistically significant difference in Oswestry disability index, leg pain or low back pain between the subcutaneous saline and either of the epidural groups at any of the follow ups. Fear avoidance belief scores decreased significantly from baseline to 52 week follow up in all three groups, but did not differ between the groups. There was also a significant reduction in patients receiving sickness benefit in the patients receiving subcutaneous saline, but not in either of the epidural groups.

This study suggests that there is no benefit to caudal epidural steroid or saline injections in chronic lumbar radiculopathy. This result is in conflict with slightly more than half of previously published controlled trials. Possible explanations for the lack of a positive result in this study include low dose steroids, high volume injection, injection site far removed from areas targeted, and inclusion of too few patients.

Wendy Brown

References

The perioperative dialogue reduces postoperative stress in children undergoing day surgery as confirmed by salivary cortisol.


In day surgery, it is unusual for anaesthetic staff to meet patients before the day of surgery. The time for explaining forthcoming events is therefore reduced, possibly increasing perioperative stress. Serum cortisol concentration has been used to assess anxiety levels in children undergoing preparation programs. The aim was to evaluate the efficacy of 'the perioperative dialogue (PD)' by analysing salivary cortisol, in 5 to 11-year-old children undergoing day surgery.

Methods

Children (n=93) scheduled for elective day surgery requiring general anaesthesia were randomly recruited into three groups:

1. Control group (n=31); standard perioperative care
   - Preoperative information given on the day of surgery only
2. Standard perioperative care including preoperative information (n=31)
   - Preoperative information given at the surgery outpatient department appointment and on the day of surgery
3. Perioperative Dialogue (n=31); a model and complement to standard perioperative care with emphasis on creating continuity in children’s nursing
   - The patient meets, is cared for, and receives on-going dialogue by the same nurse in the surgery outpatient department and throughout the perioperative period.

Primary outcome was salivary cortisol concentration. Saliva was sampled for cortisol analysis at four specific points: (1) surgery outpatient department, (2) attending day of surgery (baseline), (3) before induction of anaesthesia and (4) postoperative recovery.

Secondary outcomes included postoperative pain, intravenous morphine and duration at the post-anaesthesia care unit (PACU).

Results

The PD group had significantly lower salivary cortisol concentrations postoperatively than children who received standard care with (P=0.006) or without (P=0.003) preoperative information. Moreover, it continuously decreased during the day of surgery compared with the other two groups (P<0.01). The cortisol concentration decreased from baseline to postoperative recovery in 96% (23/24) of children in the PD group compared to 72% (13/18) in the control group and 63% (12/19) in the perioperative information group. There were no statistically significant differences in pain score between the groups. Among the children who received analgesics, the PD group received significantly less morphine/kg (P=0.014). Duration at PACU did not differ between the groups.

Conclusion

This study concludes that 5 to 11-year-old children who received continuity of care through PD exhibited statistically significant lower levels of salivary cortisol concentrations postoperatively than the groups of children who received standard perioperative care with or without preoperative information. To reduce perioperative anxiety, the PD's different steps of caring, continuity, and on-going dialogues by the same anaesthetic nurse may serve as a complement to standard perioperative care in children undergoing day surgery.

Dr Jacqui Parker,
SpR 4, John Radcliffe Hospital, Oxford

References


Spinal anaesthesia for ambulatory arthroscopic surgery of the knee: a comparison of low-dose prilocaine and fentanyl with bupivacaine and fentanyl.


Regional anaesthesia has been shown in a meta-analysis to provide both reduced postoperative pain scores and analgesic requirements for day case patients. This has lead to the development of a low dose spinal technique involving a smaller than usual amount of local anaesthetic with the addition of fentanyl. Bupivacaine and lidocaine have been extensively studied but reports of neurotoxicity and transient neurological symptoms make lidocaine unsuitable.

Prilocaine has a similar potency and duration of action to lidocaine and is not associated with adverse neurological effects when used intrathecally. This paper compares low dose spinal anaesthesia with bupivacaine and fentanyl, with prilocaine and fentanyl.

Methods

In this randomised, double-blinded, controlled trial, 49 patients (ASA I – III, age 23-80) undergoing elective knee arthroscopy were recruited. 23 received 20mg prilocaine with 20mcg of fentanyl and 26 received 7.5mg bupivacaine with 20mcg fentanyl. Sensory level was measured every 2.5 minutes with an ice pack until the block was stable and subsequently every 5 minutes after this. Motor block was similarly measured using the Bromage score for the non-operative limb. Baseline non-invasive blood pressure was measured and then repeated with the neurological measurements. A patient comfort score was measured (1 - complete absence of sensation to 4 - requires additional analgesia). Time to micturition was recorded if it occurred prior to discharge. The following day the anaesthetist telephoned the patient and a patient satisfaction score was recorded (1 – highly dissatisfied to 5 – highly satisfied).

Results

There was no significant difference in the maximum level of the block for the two groups. Onset time was significantly faster for the group receiving prilocaine, median time 11.3 minutes compared with the bupivacaine group, median time 20 minutes. Regression of the sensory block to L4 was significantly quicker in the prilocaine group (median time 97 minutes) compared with the bupivacaine group (median time 280 minutes). Motor block resolved more quickly in the prilocaine group; at 1 hour 75% of the prilocaine group had a Bromage score of zero (free movement of leg) compared with 0% in the bupivacaine group. Median time to micturition was 205 minutes in the prilocaine group compared with 275 minutes in the bupivacaine group. A drop of >20% from baseline blood pressure occurred in 32% of the prilocaine group compared with 73% in the bupivacaine group. There was no significant difference in the patient comfort scores or patient satisfaction scores of the two groups.

Conclusions and limitations

Spinal anaesthesia with prilocaine with fentanyl is superior to bupivacaine with fentanyl for knee arthroscopy, offering faster onset of sensory block, quicker block regression with greater haemodynamic stability and earlier micturition.

This paper did not measure time between administration of the drug and starting surgery or time to discharge, both of which are clinically important. Plain bupivacaine was used and it may be useful to make a comparison between prilocaine and heavy bupivacaine in the future.

Dr Charlotte Oliver
CT2 Anaesthetics, Gloucester Royal Hospital

References

Dear Editor

Novel way to track the ultrasound machine!

We would like to share our experience with tagging the ultrasound machine with a relatively inexpensive tracking device Loc8torR.

We work in a busy hospital with a theatre complex consisting of 15 operating rooms. The use of ultrasound machines for central venous access and regional anaesthesia is ever increasing. We found that people were finding it hard to locate the ultrasound machine and checking in every anaesthetic room is time consuming, frustrating and could be a nuisance for the patients and the staff.

One way to get around that problem of finding the USG machine is to use a tracking device. We tagged our two USG machines with a ‘tag and track’ device called the Loc8torR (available on the high street). It comes with a very small pendant-like tag which weighs around 5 grams, and can be attached to the USG machine and a hand held credit-card sized tracker which shows the direction of the tag with an increasing audible signal and a visual signal.

This particular device has a range of 400 feet (122metres). We can tag up to four USG machines with one tracking device. On average, for a new user it takes about five minutes to track the machine in our large theatre complex. This tracking device does not interfere with any of our monitoring equipment and our hospital medical physics department have cleared us for using this device in our modern theatre complex. We have found it very useful.

Dr. Meyyappan Nachiappan  
SpR Anaesthesia, Pinderfields Hospital, Wakefield  
Dr. Sameer Bhandari  
Consultant Anaesthesia, Pinderfields Hospital, Wakefield

Dear Editor

We read with interest Dr. Ercole’s article in July’s Anaesthesia News discussing the role of anaesthetists in pre-hospital immediate care [1]. We commend the author for championing this exciting and rapidly evolving speciality, and are keen to enter the discussion by reinforcing that pre-hospital care demands a broad base of clinical knowledge and skills, encompassing a wide gamut of parent specialties that includes anaesthesia and critical care.

Our local audit data has identified that on both road-based and rotary-based shifts, approximately one third of incidents require doctors to perform an ‘advanced procedure’ (an intervention above that of a paramedic staffed service). Whilst securing a definitive airway is required in a number of these cases, a range of other clinical issues – such as fracture management, chest interventions, advanced analgesia and complex triage or decision making processes – is frequently encountered.

We feel strongly that the ‘ideal’ pre-hospital care physician should have a breadth of training and experience to enable them to carry out the range of tasks required of them. Undoubtedly, advanced airway management must feature in this mix, but equally the ability to rapidly assess and institute treatment in patients of any age with severe medical conditions or traumatic injuries must be assured.

Given the changes to UK post-graduate medical training over recent years, there appears to be a reduction in exposure of some trainees to allied specialties that may be considered key to pre-hospital care. We feel it is important that those wishing to pursue a career in pre-hospital care (from whichever parent specialty) must gain and maintain the necessary breadth of experience to allow them to successfully achieve competency based outcomes that reflect the diversity of work carried out by those undertaking pre-hospital care.

Dr. Simon Ward  
Senior Clinical Fellow – Pre-Hospital Care  
Yorkshire Ambulance Service  
Dr. Andrew Pountney  
Consultant – Emergency Medicine and Pre-Hospital Care  
Mid-Yorkshire Hospitals NHS Trust  
Dr. Jez Pinnell  
Consultant – Anaesthetics and Pre-Hospital Care  
Calderdale and Huddersfield NHS Foundation Trust

References:  
Dear Editor

I am prompted to write by two phrases I noted in my most recent copy of Anaesthesia News (August 2011). Firstly, The President writes that “the NHS is under very significant financial pressure” and Dr Michael Ward suggests that he may have worked during a “golden age of anaesthesia”. I am very aware of the former statement and agree with Dr Ward having commenced my training a year later (1971). I am content to have lived a peripatetic anaesthetic life for some 40 years and to have witnessed the amazing surgical advances that have occurred during those years. I have a granddaughter who had the “switch” operation aged eight days for total correction of transposition of the great vessels. That operation had not been devised when I qualified: in 1968 she would have lingered for some days and then died.

As for costings, thiopentone, gas, oxygen, morphine and halothane were proportionately no more expensive in 1970-71 than the propofol, sevoflurane and fentanyl which is the common currency of today’s anaesthetic world. The electronic wizardry, which so overflows anaesthetic machines, and which did not exist in 1971, is probably more expensive than the drugs used when taken on an annualised cost basis. I was never really made aware of the cost of in-hospital treatment until I was a senior registrar; this rank, in 1980, included a little “management”. What costs today, when 80% of surgery is done on a day case basis, so eliminating the “hotel costs”, is the success of the advances in surgical technique—I well remember my first exposure to a laparoscopy—and the huge level of patient’s expectations. Add to this the ability of the anaesthetic world, still using ether derivatives and a few drugs costing pence, to care for octo and nonogenerians and the size of the patient pool expands almost exponentially.

One man’s care will serve as an example: just before Easter this year the father, aged 86, of a colleague had a laparoscopic removal of a colon cancer: he took the ether badly but soon recovered and returned home to resume driving. He had undergone some oncological pre-operative treatment prior to his surgery and remains well.

In the ten years preceding his carcinoma this chap had had two new knees, two new hips and an elective repair of an abdominal aortic aneurysm. Add this to his colectomy and factor in that a significant percentage of the lifetime’s health care spend on any one person occurs in the last three months of their life, then my colleagues father has had about two hundred thousand pounds spent on him—with yet more costs to come as he enters the last phase of his life.

Just what percentage of the above costs are to be put down to anaesthetics I am not sure: perhaps between 2 to 2.5%, but what am I am sure of is that the Baby Boomers who, to quote Prime Minister Harold MacMillan “never had it so good”, are set to retire on their final salary pension plans and will expect as much as, if not more, from the NHS than my colleague’s elderly father.

My question is simple: can the nation, bankrupt as it is and sinking into a double dip recession, continue to provide care at the level received by my colleagues father? And if not, how is care to be rationed?

During the “golden era” consultant surgeons, as part of their position within the service, managed their own waiting lists: general practitioners were free to telephone the great man to talk up their own patients. Today the managerial tail wags the admission criteria and “Waiting List Initiatives” with fly-in staff endeavour to cut the politically expedient time frame. A reversion to the status quo ante of surgical oversight is probably impossible: the current managerial system has failed to keep waiting lists under control.

Here in New Zealand—so often seen as an exemplar of medical correctness—patients wait in pain for their “points” to rack up prior to having their long awaited operation. The mechanism of part self payment for this treatment is frequently resented by these self-same patients who invariably know many others who have cheated the system. Is an insurance system in the UK, as exists in France, acceptable to generate surgical/in patient payment monies?

So will the British government just have to phone its broker and try to sell some long dated “British Health Bonds” to find the money to retain the current level of care? I do hope so as Dr Ward and I may need that care ere long!

Richard Knight
Consultant Anaesthetist. Taranaki Base Hospital, New Plymouth, New Zealand.

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Dear Editor

We wish to report an event that occurred recently as we believe that all professionals involved in the provision of anaesthesia should be aware of the potential hazards.

We were involved in administering sedation to a patient undergoing a carpal tunnel decompression. The anaesthetic assistant was asked to prepare a Hudson mask and tubing in order to administer supplemental oxygen during the procedure. On first look, the oxygen set-up appeared to be familiar. However, on closer inspection, there was a small piece of clear plastic around the mask connector. When the mask was disconnected from the tubing, it was apparent that the tubing had been connected to the mask prior to removing the plastic wrapping, thereby coring out a piece of plastic that had occluded the end of the tubing. It is clear that if this had not been noticed, the consequences could have been severe to the patient, potentially rendering them hypoxic.

Dr Marc Wittenberg
ST5 in Anaesthesia, Royal Free Hospital, London

Dr Julie Watts
Consultant in Anaesthesia, Royal Free Hospital, London

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Dr Richard Knight
Consultant Anaesthetist. Taranaki Base Hospital, New Plymouth, New Zealand.
Dear Editor

I would like to bring your attention to the following safety concern I have regarding anaesthetic machines. Isoflurane was mistakenly given instead of Sevoflurane. The yellow hospital equipment identity sticker (see photograph) confused the trainee half-glancing as he turned on the vaporiser, who then only noticed the mistake when he looked back a few minutes later to change the setting. Though there were not any clinical consequences it is easy to see that they could occur. I propose that the appearance of the front of vaporiser should not be altered.

John Gardner
CT1 Anaesthesia,
Leighton Hospital,
Mersey Deanery

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