INSIDE THIS ISSUE:

Core Training: A survival guide

AAGBI’s Environmental Policy Statement

Irish Standing Committee Report
Editorial

It might as well rain…

As I write, the rain is positively slogging down over my garden (already sodden), and the halcyon spring we had, with all that hysteria about droughts, seems incredible. After reading in May’s edition of Anaesthesia and Analgesia that gatherings of paediatric anaesthetists are strongly associated with rain (the odds ratio of rain on the first day of the US Society of Pediatric Anesthesia meeting in a variety of locations over 23 years (compared with historic data for same day) was 2.63 (P value 0.006, 95% CI 1.32-5.22), I am driven to suspect that we simply have too many of these wonderful people in Newcastle1,2. This outstanding paper is a great tonic if you are tired of grappling with randomised controlled trials, p values and so on, and reminds us all of the extraordinary power of chance; the sheer unpredictability of life, the universe and everything, and I strongly urge you to read it. Strangely enough, we feel that the weather is usually pretty good for the AAGBI’s annual congress (further analysis and umbrella plot to follow); so book your place in Bournemouth now if you haven’t already done so!

The May edition of Anaesthesia and Analgesia also carried an editorial and a number of articles relating to ‘sustainable anaesthesia’3. In this edition of Anaesthesia News we report on the AAGBI’s progress towards sustainability at 21, Portland Place, and publish our new environmental policy. The most important aspect of this is surely the call to members to ‘exert their influence within their organisations to militate against climate change and environmental degradation, and to lead by example’4. I have to confess to not really having made much effort towards this yet. This is partly because it is difficult to know what to do for the best – is a propofol-based anaesthetic better for the environment than an isoflurane-based one for example? Isoflurane is a greenhouse gas, whilst propofol is not degraded in nature and is toxic to aquatic organisms. Whatever, I suspect that the three R’s ‘Reduce, re-use, recycle’ is as good a place to start as any, and there is an increasing...
amount of evidence to help with the detail – visit our website www.aagbi.org/about-us/environment. To encourage us in our efforts I’m going to propose to the AAGBI Council that we make an annual award for efforts to improve sustainability – I’ll let you know if that comes to anything.

Recently, Mr Bythell and I have been contemplating working overseas perhaps in a less economically developed country (LEDIC), as part of a ‘phased retirement’, and so I have been reading the many reports we receive from those of you who have taken time out to work or train overseas with particular interest. This month we publish two such reports describing very different approaches. David Johnston describes his short but clearly rewarding experience in Ethiopia highlighting the many differences compared to our profession. David Johnston is a consultant anaesthetist, has been elected to take over from Dr Harsh Melotra as Chair of the BMA Council. This is good news for our profession, and we offer our hearty congratulations to Mark.

This is probably a wise benchmark for overseas experience as well, and there are a number of other caves such as having an educational supervisor, and ensuring you have attended a relevant course. All this can be translated to my situation I think – I will need to update my paediatric anaesthetic practice and one of two courses. All this can be translated to my situation I think – I will need to update my paediatric anaesthetic practice and one of two courses. This is probably a wise benchmark for overseas experience as well, and there are a number of other caves such as having an educational supervisor, and ensuring you have attended a relevant course. All this can be translated to my situation I think – I will need to update my paediatric anaesthetic practice and one of two courses. This is probably a wise benchmark for overseas experience as well, and there are a number of other caves such as having an educational supervisor, and ensuring you have attended a relevant course. All this can be translated to my situation I think – I will need to update my paediatric anaesthetic practice and one of two courses. This is probably a wise benchmark for overseas experience as well, and there are a number of other caves such as having an educational supervisor, and ensuring you have attended a relevant course. All this can be translated to my situation I think – I will need to update my paediatric anaesthetic practice and one of two courses.

TRAVEL GRANTS/IRC FUNDING

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-funding/travel-grants or email secretariat@aagbi.org or telephone 020 7631 8807

Closing date: 30 September 2012

Val Bythell

References
2. Shuter and Dexter. Publication bias, retrospective bias, and reproducibility of significant results in observational studies. Anesthesia and Analgesia 2012; 114:931

Abstracts for presentation at WSM London 2013

You are invited to submit an abstract for poster presentation at WSM London 2013. The deadline for submission is midnight on Monday 17th September 2012 and full instructions, including a template abstract and submission form, can be found on our WSM microsite: www.wsm-london.org and the AAGBI website: www.aagbi.org/education/events

After the deadline, a preliminary review of the abstracts received will determine which ones are accepted for poster presentation.

All abstracts accepted will be published in Anaesthesia in the form of a freely referenceable online supplement. In addition, the best ones, selected by a judging panel at the meeting, will be printed in the hard copy version of the journal. The Editor-in-Chief reserves the right to refuse publication, e.g. where there are major concerns over ethics and/or content.

Authors of the best poster(s) will be awarded ‘Editors’ Prizes’.

If you have any queries, please contact the AAGBI Secretariat on 020 7631 8812 or secretariat@aagbi.org

Deadline for submissions: 17 September 2012

These are my final few months as convenor for the Irish Standing Committee and in November I will handover to Dr Geraldine Maloney, the current West of Ireland representative. With the health service in Ireland undergoing multiple metamorphoses, the AAGBI has a unique and independent role. Its wealth of advice, guidelines and safety standards allows significant solidarity among Anaesthetists in these Islands.

The past year has been busy for committee colleagues with six full business meetings in 2011 and a similar number is planned for 2012. The current committee is formed by very interested people and they have dealt with a number of important topics. Apart from a commitment to review the care of the critically-ill child in Irish Hospitals with the Faculty of Paediatrics, ROPI, the Irish Standing Committee has also been advisory to other fora e.g. the development of paediatric surgery and adult critical care in Ireland.

The Irish standing committee successfully represented its concerns to the Irish Health Service employers on conditions for some overseas junior doctors with a satisfactory resolution of the matter. Specific specialty concerns were also brought by the committee to the professional negotiating bodies (the Irish Hospital Consultant’s Association and the Irish Medical Organisation) on the health service’s method of measurement of anaesthesia activity. Improved and accurate data was suggested but the Dept of Health and its Health Service are caught between trying to maintain and improve services during necessitated change. As part of this change, separate but interdependent clinical programmes have been created, including one for critical care and lately another for anaesthesia. The committee is eager to monitor the delivery of these programmes’ goals and advise on any potential impact on standards or patient safety.

The committee is eager to maintain a positive, progressive but independent opinion on our health service here. Council’s advice and support through its standing committee continues to be appreciated.

Finally, the committee wishes to congratulate Dr Ellen O’Sullivan, AAGBI Vice-President, on her election as President of the College of Anaesthetists of Ireland.
Environmental Initiatives

We have been making steady progress in the battle to improve our environmental impact at 21, Portland Place, though it isn’t always plain sailing:

### Paper use

The figures to 30 April 2012 are shown in the graph. In total, paper consumption has risen by 5% in 2011-12, in comparison with 2010-11. However usage remains 14% lower than in 2009-10.

### Recycling

- Regular collections continue with Paper Round for paper recycling and their summary report for 2011-12 is shown. While the amount of recycling is flagged up as being high per member of staff this is not unexceptional as there was a major clean up exercise before Christmas in which staff were encouraged to recycle as much old paperwork as possible. This generated a significant amount of additional recycling.
- We continue to use Westminster Council for general recycling of as much waste as possible from day-to-day activities. Toner cartridges and any redundant PC equipment are also recycled via appropriate suppliers.
- The introduction of our new in house finance management system allows remittance advices and receipts to be e-mailed rather than printed and posted.
- Environmental impact and sustainability has been considered in the revamp of the catering menus with our current supplier, and their credentials in these areas will now be included in the menu brochure.
- The facilities team is investigating the introduction of plumbed in water coolers to replace the bottled water coolers. This will cut the need for bottles completely thus reducing the amount of bottles that will need to be recycled and will remove the need for regular deliveries.
- Intersurgical is the first manufacturer to be listed on the environment section of the website (www.aagbi.org/about-us/environment/manufactures) with details of their environmental activities.

Seeking ways in which to minimise environmental impact is an ongoing project and the staff team and Council continue to look for any further improvements that can be made. To that end, we have agreed an environmental policy.

### Environmental Policy Statement

We (the Council and Staff of the AAGBI) recognise that our actions have an impact on the environment around us and regard sustainability and climate change as a key strategic issue. If climate change is to be contained in any meaningful way, urgent and drastic action by every organisation and individual is required. The AAGBI is committed to providing services in a way that ensures a safe and healthy workplace and minimises the potential impact on the environment.

- Integrate the consideration of environmental concerns and impacts into our decision-making and activities
- Publicise our actions to produce meaningful and sustained reductions in greenhouse emissions from our buildings and activities, and call upon other professional organisations to do the same.
- Wholly support and comply with or exceed the requirements of current environmental legislation and codes of practice.
- Reduce waste through reuse and recycling and by purchasing recycled or recyclable products and materials where these alternatives are available, economical and suitable.
- Minimise energy and water usage in our building in order to conserve supplies and minimise consumption of natural resources, especially where they are non-renewable.
- Purchase and use environmentally responsible products that have been selected based on low toxicity or environmental hazard, durability, use of recycled materials, reduced energy and/or water consumption, reduced packaging and ability to be recycled, refilled or refurbished at end of life.
- Assess the environmental impact of any new processes or products we intend to introduce.
- Ensure that all employees understand our environmental policy and conform to the high standards it requires.
- Call upon AAGBI members to exert their influence within their organisations to militate against climate change and environmental degradation, and to lead by example.
- Strive to continually improve our environmental performance by annually reviewing our environmental policy.

www.aagbi.org/about-us/environment
Recent changes to the FRCA exams

The written component in both the Primary and the Final FRCA now includes 30 Single Best Answer Questions (SBAs), which requires a broad response to the 6 options, where a maximum 4 marks can be awarded for each correct response. This is in addition to 60 multiple true-false questions (MTFs), which are no longer negatively marked. The Short Objective Structured Examination (SOE) comprises 12 questions, each marked out of 20, making a maximum of 48 marks available. The written component in both the Primary and the Final FRCA examination consists of a long case, 3 medium-fidelity simulator, a resuscitation manikin, airway trainers and demonstration of the required task. Example equipment includes a medium-fidelity simulator, a resuscitation manikin, airway trainers and demonstration of the required task.

The Primary OSCE exam has 18 stations for each candidate, with 1 minute to read and prepare, and 5 minutes examination and feedback. The Final OSCE exam is set up of 16 or 18 stations, ideal with a mix of topics and questions that the candidate can work on prior to the exam. Feedback from the course candidates following the exam is immensely helpful in maintaining the realism of the course and its content. The course needs to keep up with current hot topics, as well as the favourite exam questions. The most important element of the course is ensuring the material is regularly updated.

For the written papers, practice at as many papers, with a timed mock examination (especially for the SOA) improves confidence and familiarity. Marking may be done by the candidates, or if time and resources allow, by the course organisers. With the recent introduction of single best answer questions, software such as Turning Point™ allows candidates to anonymously select their answer using a keypad, allowing candidates to see the spread of the responses, and feedback from the medical equipment can be provided in the form of e-learning. For the OSCEs, to set up the tables and to collect and collate the marks, feedback, feedback, feedback is the key. This aids constant improvement of the course, and comparison to the real exam, including keeping up with on going exam changes. Quality assurance and improvement can be done through mock examination sets, so that the candidate can work on prior to the exam. Feedback from the course candidates following the exam is immensely helpful in maintaining the realism of the course and its content. The course needs to keep up with current hot topics, as well as the favourite exam questions. The most important element of the course is ensuring the material is regularly updated.
The Obstetric Anaesthetists’ Association (OAA) launched its new Smartphone and tablet application for information for mothers (in 35 different languages) at its Annual Conference in Liverpool in June 2012. As we reported previously, this development should improve access to information for mothers and their birth partners during the antenatal period or whilst in labour. This will be possible either via their own devices or via tablets shown to them by a midwife, even where there is no internet connection.

More than 20% of women delivering in the UK originate from overseas, and many do not speak English. The most recent Confidential Enquiry into Maternal Deaths (http://bit.ly/JiAS2d) emphasises the importance of good communication with women and their partners and the need for translation services, but provision of interpreters within the NHS is expensive and often impossible outside normal working hours or in emergency situations where minutes count.

The new app means that non-English speakers will be able to understand what pain relief and anaesthesia options are available to them in labour, and to compare the risks and benefits.

Dr David Bogod, OAA President, said: “This is an excellent example of the use of patient-friendly technology to improve the quality and safety of our maternity services, especially for the increasing number of our service users who do not speak English and who often come from communities with poor access to NHS care”. The apps are based on the widely used information cards and leaflets, covering pain relief options in labour and anaesthesia for Caesarean section that are available on the OAA website (via a direct link www.oaaformothers.info) and include: Pain Relief in Labour; Your Anaesthetic for Caesarean section; Epidural Information Card; High Body Mass Index and more recently a Headache after Epidural leaflet and a Regional Anaesthesia for Unplanned Caesarean Section Card.

The app can be found (by searching “OAA pain relief”) at the AppStore for iPhone or iPad or at GooglePlay (the new name for Android Market) for Android devices. Alternatively, users can follow the link for smart devices at www.oaaformothers.info.

For those who do not wish to download the app containing all translations, the individual language versions can still be downloaded separately at www.oaaformothers.info. There is also a multilingual poster advertising the translations, which can be placed in antenatal clinics or can be inserted as a flyer in women’s hand held notes.

About the OAA

The OAA is a charity with over 2000 members worldwide. The majority of members are anaesthetists with a special interest in the care of pregnant women and at and around the time of childbirth. www.oaa-anaes.ac.uk

CMACE Saving Mothers’ Lives report – reviewing maternal deaths

The Confidential Enquiry into Maternal Deaths is a 3-yearly report into all maternal deaths in the United Kingdom which has been running since 1952, making it the world’s longest running audit of medical practice. It is currently produced by the Centre for Maternal and Child Enquiries. View the latest report ‘Saving Mothers’ Lives’ 2006-2008

• Full report: http://bit.ly/gX6aQ

• Executive summary: http://bit.ly/lq2QHg


Languages available

A full list of the 35 languages available can be found at http://bit.ly/lAS32d

The list of translations will continue to increase.
In response to the article ‘Anaesthesia in Tanzanian mission hospital’ by Dr Kietzmann and Dr Jankiewicz in January’s Anaesthesia News,1 as a specialist trainee anaesthetist with an interest in regional anaesthesia, I had a fantastic opportunity to complete two weeks of providing anaesthesia for orthopaedic operations in a missionary hospital in Ethiopia. I applied to and was accepted to work in CURE hospital, Addis Ababa.2 A pressing need for anaesthesia cover was presented at this hospital due to the resident anaesthetist handing in his resignation at short notice to return to India. The two weeks I worked there served to fill the vacancy during the changeover period.

In the UK, training is built around hands-on learning environment in theatres supervised either locally or at a distance by a consultant. However, since there was an urgent need for cover in this hospital I became the only anaesthetist available during this two-week period. I therefore needed to learn the discipline of prioritisation, communication, organisation and paying attention to detail when delivering anaesthesia to patients. I would like to share my experience and demonstrate some of the challenges and cases that I was involved with.

BACKGROUND to CURE

Ethiopia is a country that has been decimated by wars, coups, uprisings and droughts producing massive refugee problems. In many areas there is inadequate food, shelter and medical services. This is especially true in the capital Addis (population of approximately 3.5 million). There are many ethnic groups in the countryside surrounding Addis and children from these families travel many miles to get treatment at CURE hospital.2 A pressing need for anaesthesia cover was presented at this hospital due to the resident anaesthetist handing in his resignation at short notice to return to India. The two weeks I worked there served to fill the vacancy during the changeover period.

CURE hospital provides children with free health care at clinics and in theatres 4 days a week. This is funded by various US charitable organisations and supplemented by privately paying adults having knee or hip replacements on the Tuesday of each week. This funding enables the hospital to provide modern standards and equipment such as ECG machines, pulse oximetry, anaesthetic gas monitoring, C-arm mobile X-ray units and lab services.

In contrast to the conditions initially experienced by Dr Kietzmann and equipment knowledge but was less familiar with the basics of anaesthetists and recovery. He had very good technical skills and equipment knowledge but was less familiar with the basics of anaesthesia and take the patient to recovery. This was a whole new experience of leadership and required ensuring open channels of communication. Furthermore it increased my awareness of the skills and information needed when handing over a patient.

EXPERIENCES

I arrived in Addis a day and a half late (with my luggage arriving 4 days later!) because I missed the plane out of Heathrow due to a delay leaving Belfast. After a walk round the theatre complex with the medical director of the hospital I made acquaintances with the theatre staff. Immediately an alarm bellowed and we were called to evacuate the building because of a fire that had started around the electrical circuitry within the hospital’s mains power room! My initial fear was that theatres would be out of action for the two weeks I was there. Thankfully an engineer worked solidly for 24 hours and we were up and running the following day.

One of the attributes of good patient care is to anticipate problems and have management plans in place before they arise, and to communicate these plans with the rest of the team. Because I was the only anaesthetist present in the hospital, I learnt to improve this ability and ‘always having a plan B’ was an important aspect of running two theatres in this manner.

I learned this the hard way: following induction of anaesthesia for a patient requiring a complicated femoral osteotomy, it became apparent that the consent form had not been completed correctly for the proposed operation. The operation was therefore cancelled. As a long operation had been planned, I had given a general anaesthetic including an intravenous dose of vecuronium. I asked the PA to continue ventilating the patient whilst monitoring return of neuromuscular function with instructions to reverse using neostigmine/glycopyrrrolate at the appropriate time. After twenty-five minutes, I returned to a frenzy of a coughing patient and dramatic myoclonic jerking. I looked at the anaesthetic machine and the end-tidal isoflurane concentration was zero. The vapour had been immediately discontinued as soon as I had initially left. Despite a midazolam bolus, the patient unsurprisingly had explicit awareness of the endotracheal and ambient conversation. Having completed a recent anaesthetic non-technical skills (ANTS) course I was aware that many skills I learnt during this (e.g. situation awareness, decision-making, teamwork, leadership, the build up and management4) were implemented in the recognition and management of this error. I had assumed that the PA would continue the anaesthetic until neuromuscular recovery was present. This preventable incident served to remind me of care needed when giving instructions to AP during unfamiliar events.

Following the anaesthetic, I went with an interpreter to give some counselling to the patient. She was very understanding whilst having some discomfort in her throat expressed no other concerns. She subsequently completed the consent form appropriately and underwent her operation under neuraxial anaesthesia.

I also took time in theatre and at lunch to do teaching sessions with the AP on difficult airway algorithms, anaphylaxis and MH etc. The AP had worked initially as a technician and progressed into assisting anaesthetists and recovery. He had very good technical skills and equipment knowledge but was less familiar with the basics of physiology and pharmacology.

In contrast to the conditions initially experienced by Dr Kietzmann in Tanzania, I found CURE hospital to be very well equipped. Many of the same drugs, syringes, anaesthetic machines and monitoring devices that facilitated anaesthesia delivery was in line with the recommendations by the AAGBI ‘Standards of monitoring during anaesthesia and recovery’ (guidelines 2007). The main commonly used drugs that were not available were nitrous oxide, levodopa/paivacine, rucuronium, and the range of anti-emetic drugs that we have at our disposal in the UK.

Pre-assessment clinics were run by the AP in the afternoons. Any problems flagged up by the questionnaire were brought to my attention. There were facilities for simple lab tests, malaria treatments, chest radiograph, ECG and transthoracic echocardiogram.

I write in response to the article ‘Anaesthesia in Tanzanian mission hospital’ by Dr Kietzmann and Dr Jankiewicz in January’s Anaesthesia News.1 As a specialist trainee anaesthetist with an interest in regional anaesthesia, I had a fantastic opportunity to complete two weeks of providing anaesthesia for orthopaedic operations in a missionary hospital in Ethiopia. I applied to and was accepted to work in CURE hospital, Addis Ababa.2 A pressing need for anaesthesia cover was presented at this hospital due to the resident anaesthetist handing in his resignation at short notice to return to India. The two weeks I worked there served to fill the vacancy during the changeover period.

The anaesthetic equipment and monitoring facilities were excellent in CURE hospital.

The theatre team group picture

SCHEDULE

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EXPERIENCES
During the two-week period I anaesthetised 30 children (aged between 10m to 16yrs) and 9 adults (Aged >16). The operations included femoral, ilial and humeral osteotomies, contracture releases, triple arthrodesis (in the children) and hip and knee arthropathies in the adults. Eleven cases were under regional anaesthesia with the remainder either general anaesthesia or sedation. With an old nerve stimulator I was able to perform adiery branchal plexus, femoral and sciatic nerve blocks along with saphenous and a total of nine caudal blocks.

CONCLUSION

This experience was of much greater value than I had anticipated as I was leaving Northern Ireland. Despite having a well stocked anaesthetic drug cupboard with much of the same medical equipment I would be used to in the UK, I still found giving ‘remote’ anaesthesia in CURE hospital challenging but also rewarding.

The skills and technical abilities of the APs really impressed me and aided my delivery of anaesthesia in an unfamiliar environment. However, their lack of knowledge of emergency drills and the limited ability to adapt to a back-up Plan B when needed caused some concern, and confirmed the need for an anaesthetist’s supervision.

I would thoroughly recommend anyone who is interested in giving anaesthesia in developing countries to pursue this. The training experience gained is more than the numbers in a logbook. It helps one discover the ANT skills of leadership, organisation, maintaining open channels of communication and planning for problems. It serves to broaden the horizons, meet new people and learn from the way medicine is practised in different environments.

Dr David Johnston
MB BCh BAO FRCA
Dr A Bodenham and Dr A Johnston

ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS

Date and venue:
21 September 2012 (code: F33), RCoA London
Registration fee: £235 (£175 for registered trainees and affiliates)
Approved for 5 CPO credits
Event organisers:
Dr A Bodenham and Dr A Johnston

CASELOAD

Intensive Primary FRCA viva courses. 7th & 8th September 2012
30th November & 1st December 2012
Western General Hospital, Edinburgh.

Candidates will be examined in small groups and in paired vivas, by tutors who hold full FRCA or equivalent.
Course fees set at 2010 prices

For more information and an application form contact:
edinburgh.viva.course@ed.ac.uk
Or phone Keith Kelly 0131 537 1652

£300- includes lunches, refreshments and course dinner.
Early application recommended.

References

Kathleen Ferguson put together a superb programme for the 11th Open Meeting of the SSC. An imaginative blend of clinical, political and historical sessions made up the programme which was enthusiastically received by the audience. The venue was the stunning Discovery Point in Dundee in the shadow of Captain Scott’s famous ship RRS Discovery.

The SSC was formed in 2001 in response to Scottish Devolution, and continues to thrive. Thankfully, the Scottish NHS continues to be a different beast to its counterpart south of the border, so the SSC is more relevant than ever.

Ian Johnston, who was a member of the inaugural SSC, opened the meeting and welcomed guests. AAGBI President Elect Wil Harrop-Griffiths, Honorary Secretary Andrew Hartle and Honorary Secretary Elect, Richard Griffiths. Philip Gately chaired the 1st session.

The next lecture was given by Neil Soni and entitled ‘Myths in anaesthesia’. Neil gave an entertaining and sometimes contentious talk on a wide range of anaesthetic and intensive care topics. Evidenced based medicine, RCTs and Meta analyses were first to be banned, followed by Cordic pressure, ultrasound for CVC insertion and Thopentone and Pearl Harbour excess mortality myths. The harmful effects of N2O were next to be demolished, and other beliefs held up to scrutiny included the BIS monitor - Does it work?, the Swan Ganz catheter. Fluid optimisation, Awake v asleep epidural placement and CPX testing. His parting shot was a quote from JFK ‘Breach in myths allows the comfort of opinion without the discomfort of thought.’

Next up was Simon Valley from Manchester on the Emergency Laparotomy Network. This was another thought provoking lecture and he presented data from a national audit of 1853 emergency laparotomy patients in England and Wales. Simon stated his belief that consultants of ASA greater or equal to 3 should be managed by consultant anaesthetists and surgeons. This audit found that anaesthetic consultant presence was influenced by time of day (75% during the day but only 41% overnight). Food for thought indeed.

In 2011 Royal College of Surgeons stated that if predicted mortality is >10% consultant surgeon and anaesthetist should be involved. He also said that these patients should return to a level 2 or 3 care unit. Trusts should formalise their care pathways for unscheduled adult general surgical care.

The future of the ELN will involve setting governance standards, and participating in future research.

The next session was another trio of trainee M&M presentations which David Ray chaired, on the theme of fluids and resuscitation. Anne Wake from Grampian presented a case of hyper-colluric ketoacidosis, pneumonia and sepsis which was under resuscitated. Anne-Marie Docherty from Lothian presented a case of 14 yr old with...
abdominal trauma who ended up being fluid overloaded and Megan Dale from Tayside presented a case of massive obstetric haemorrhage which required surgery, interventional radiology and 2 doses of recombinant factor VIIa.

After lunch the traditional question time to the panel was chaired by Alastair Michie, the SSC Convener. Richard Griffiths, Andrew Hartle and William Harrop-Griffiths completed the line up. Questions from the floor on the contentious sub consultant grade and future changes in the way consultants work particularly out of hours were tackled.

Then, Harry McFarlane introduced Peter Johnston who is Associate Postgraduate Dean for the North of Scotland (and also Kathleen Ferguson’s husband) gave an excellent talk entitled “ABC of XYZ. Generations, expectations and implications”. He presented data from Scottish medical student cohort medical career choices and how they alter as students progress through their undergraduate careers. The contrasting attitudes and expectations of doctors of different generations were also fascinating, and while being generalisations, struck a chord with the audience. The Baby Boomers, Generation Y and Z all have different attitudes to work and life which need to be understood when recruiting doctors. Medical students’ expectations have changed. They want to live and work not just to work. Employers and educators need to be aware of these changes.

Charles Saunders, who is the deputy chairman of the Scottish BMA gave the final talk, provocatively titled “how the government plans to rob you”, which outlined the NHS pension changes which are to be introduced. It was all a bit depressing for the audience.

We finished an excellent day with a drinks reception on board RRS Discovery and look forward to returning next February for the 12th Open Meeting of the SSC.

Dr Alastair Michie in front of RRS Discovery

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Matthew Checkettts, Secretary SSC AAGBI

South West Regional Anaesthesia Course

26th & 27th November 2012
Derriford Hospital, Plymouth

• Popular 2 day course with experienced faculty
• Ultrasound guidance for upper & lower limb, abdominal and neuroaxial blocks
• Sonoanatomy and scanning practice on live models
• Lectures and workshops
• Needling practice and competency assessment
• Suitable for all grades

Cost: £250
Register early – strictly limited to 30 participants

For details & online registration visit: www.sowra.org.uk
Or email: RAcourse@sowra.org.uk
The Association of Anaesthetists of Great Britain and Ireland invites applications for the 2013 AAGBI Prize for Innovation in Anaesthesia and Critical Care. This prize is open to all Great Britain and Ireland based anaesthetists, intensivists and pain specialists. The emphasis is on new ideas contributing to patient safety, high quality clinical care and improvements in the working environment.

Applicants should complete the application form that can be found at the AAGBI website www.aagbi.org/research/innovation. The closing date for applications is Monday 15 October 2012. Shortlisted entrants will be invited to present their work at the Winter Scientific Meeting in London 16-18 January 2013 where the prize will be announced.

www.aagbi.org/research/innovation

The Annual AAGBI Prize for Innovation in Anaesthesia, Critical Care and Pain

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1. Get to know each other, meet regularly and share those embarrassing stories. Anaesthetics can be a lonely specialty, especially if you are based in a large department / teaching hospital. You can go a long time without seeing the same people.
2. Get used to people watching you and teaching you different things, take it on board and don’t let it upset you. It won’t be long before you are confident enough to try different things, find what works for you and be able to justify it.
3. Be organised – plan in advance – write lists so you know what needs done when. Plan when you want to do the exam, what courses you want to go on, when you want to take your holidays, and get all the dates booked early.
4. Spend the first few months finding your feet and getting used to the job and the new people. Try to go to social events and meetings to get to know the other trainees.
5. Try to get things like audits completed early before you start focussing on the exam so you can give it your full attention.
6. Look out for and grasp opportunities when they arise – CME meetings, MMM’s and journal clubs are fairly easy places to do a presentation but don’t involve too much effort.
7. Don’t take on too much. Lots of different people will start suggesting audits or projects – don’t be afraid to say no, you have too much on or you just want to concentrate on one thing at a time.
8. The Primary – this is going to occupy a massive amount of the next 2 years:
   i) Don’t underestimate this exam – it is a tough exam and it requires 100% commitment
   ii) Don’t feel pressurised into doing it too early, before you are ready or if you know a specific sitting is not a good time for you due to other commitments. It is not only miserable to fail but you then have to come to work everyday and face colleagues asking you what went wrong.
   iii) Equally, don’t leave it too late – think about when is realistic for you and plan for it. The need to pass the primary prior to ST3 applications means there really is a limited time to get this exam.
9. Most importantly, don’t be afraid to ask for help – whether it be work, exams or anything else that’s bothering you.

Joelene Moore
SR3 Anaesthesia, Aberdeen Royal Infirmary

Anesthesia Meet August 2012 • Issue 301

Surviving Core Training in Anaesthesia

You will be fully supervised for the first few months. I found it difficult to get used to having someone watching my every move to start with. You will spend a lot of time looking at the monitor thinking “have they noticed that, or are they waiting for me to do something about it”. It feels similar to being in an OSCE exam every day.

People are going to leave you. They will go to the toilet and disappear for what feels like ages. Meanwhile the blood pressure will start to drop and you will be staring at the monitor wondering what to do. Or alternatively, everything will be fine until the minute you are alone and the consultant will walk back in whenever in flashing red all over the screen.

You are going to do daft things too… spill fluids all over the floor, squint drags all over your consultant, don’t worry, everyone else did them too. That’s where my first bit of advice comes in – get to the other trainees you start with, find each other in the corridor or at lunch, get together for a coffee and tell each other all the embarrassing things you have done – because it really helps when everyone else nods and laughs and you discover they have done exactly the same thing.

You will soon realise that everyone does things differently and you will just be getting used to one way when people will say “why are you doing that” and “don’t do it like that, do it like this”. After a couple of months, you are going to start getting your competences signed off. Don’t leave this too late but equally don’t start too early, give yourself time to find your feet.

At 3-4 months in you will be getting into the swing of things and discover you can give an anaesthetic all by yourself. Then you will get your own lists and be doing on-calls and the fear will start all over again. Those first few nights alone in the hospital are particularly scary and you will find yourself wondering what you should be doing on your own and what you should be doing your own with. For those first few calls to resus will be particularly scary. Don’t be afraid to call for help even just some advice, your seniors would rather you called for help than did something you are not comfortable with.

By about 8 months people will start to ask when you are sitting the primary exam and the ARCP will start looming and a frenzy of getting things signed off will start and you will realise that Oops - you were meant to do an audit and a presentation and pass the exam etc and the stress will start all over again. And that’s CT1 finished already.

By now you will feel reasonably confident at giving a straightforward anaesthetic so it’s time to send you off to ITU to start something new… and just when you are getting used to that its Obstetrics next… and then back to general theatres and then how do I give an anaesthetic again… Think some more exams and study into the mix and well that’s 18 months down and time to apply for ST3 jobs. See how quickly it goes.

So here are my tips for survival and success:

1. Get to know each other, meet regularly and share those embarrassing stories. Anaesthetics can be a lonely specialty, especially if you are based in a large department / teaching hospital. You can go a long time without seeing the same people.
2. Get used to people watching you and teaching you different things, take it on board and don’t let it upset you. It won’t be long before you are confident enough to try different things, find what works for you and be able to justify it.
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The Gambia is situated in West Africa comprising a strip 400km long surrounded on either side by Senegal. There are six tertiary hospitals in The Gambia, five of which perform surgery. The largest of these is the Royal Victoria Teaching Hospital (RVTH). Anaesthetic services are limited, with only three doctor anaesthetists in the whole country, none of whom are Gambian.

The anaesthetic challenge

Dr Anuraag Guleria, was being part of a cleft lip and palate team that visited The Gambia in 2011, and was keen to return and tell the Anaesthetic Nurse would benefit from a teaching program. She envisaged holding a conference similar to those that Dr Keith Thomson had previously run very successfully in Liberia and the Ivory Coast. These conferences have comprised a series of presentations and workshops, and a feedback form. A conference booklet was put together for each of the delegates, comprising the programme, summaries of all presentations and workshops, and a feedback form.

Royal Victoria Teaching Hospital (RVTH)

This is a 550-bed government hospital conducting approximately 4000 procedures and 6000 deliveries per year. It comprises an:• Outpatient clinic (including HIV clinics), male and female wards• A+E divided into medical and surgical following triage• Audit and critical incident reporting• Difficult airway management• Paediatric anaesthesia• Paediatric and neonatal units• Radiology with a CT scanner funded by a partnership with Taiwan.

Anaesthetic challenges

Doctors in The Gambia tend to be more attracted to surgical specialties due to better pay and the perception that Anaesthesia is a “nurse” specialty. As a result, the anaesthesia service is delivered primarily by anaesthetic nurses. Their training is 18 months duration and retention following training is a major problem. Once trained, a large majority leave The Gambia and some leave anaesthesia altogether. The main reasons for this are poor pay and poor working conditions, often due to staff shortages. Nurse anaesthetists work long hours in a resource-poor setting and are often faced with extremely difficult cases with little or no senior support.

In terms of pharmaceuticals and equipment, anaesthetic machines were available in the main and maternity theatre. Halothane is the only available volatile agent, and endotracheal tubes and laryngoscopes are re-used until they are no longer functional. Anaesthetic drugs are limited with an intermittent supply of local anaesthetics and opiates. Routine GA induction for caesarean section comprised thiopentone and suxamethonium, with ketamine following delivery. Government maternity services are free of charge in The Gambia. As in many African countries, equipment maintenance is an ongoing problem and much of the equipment that we saw was no longer working or awaiting repair. This included a defibrillator, several monitors and ICU ventilators.

PRE-CONFERENCE PLANNING

Adequate planning was the key to success (Table 2). We were extremely fortunate to benefit from the combined wealth of experience of Dr Thomson and Dr Guleria. The UK team comprised three anaesthetic consultants, seven anaesthetic trainees from the North Western and Wessex Deaneries, a paramedic, a midwife, an ODP and two technicians. Together, we planned a series of lectures and workshops to be delivered over three days at the Royal Victoria Hospital in Banjul, Gambia’s capital. Planning started with the arranging of leave and securing of funding from both the AAGBI International Relations Committee and the trainees’ respective schools of Anaesthesia. A number of anaesthetic textbooks were very kindly donated by the AAGBI. Through previous contacts, Dr Guleria was able to liaise with local nurse anaesthetists who were able to facilitate the logistical arrangements. Mr Baro in particular, was one of the first trained Gambian anaesthetists and is now involved in teaching current students. A conference booklet was put together for each of the delegates, comprising the programme, summaries of all presentations and workshops, and a feedback form.

THE 1ST GAMBIAN ANAESTHETIC NURSE CONFERENCE

The conference was held between 21-23rd February and was well attended by 43 delegates from Gambia’s hospitals. The opening ceremony included addresses by the RVTH Medical Director, Chief Medical Officer. Public relations Officer and Dr Keith Thomson who then introduced the lectures with an overview of anaesthesia in Africa. The first day was primarily trauma orientated whilst the second day focused on obstetrics and nine midwives joined us. The final day was aimed at paediatrics, service improvement and patient safety. The following topics were covered in presentations and workshops over the course of the conference:

- Obstetric emergencies and cardiac arrest
- Trauma management
- Adult and neonatal IV support
- Recognition and management of sick patients
- Paediatric anaesthesia
- Difficult airway management
- Pain management and recovery issues
- WHO surgical checklist
- Audit and critical incident reporting

In addition there were trauma and major haemorrhage moulages, which were well received and helped greatly with group interaction. We found that delegates were initially reluctant to contribute, but over the course of the conference they became much more willing to share their experiences which helped both parties.

There was a daily quiz, an extremely realistic blood loss estimating game, and an essay-writing prize. At the end of the conference Dr Thomson made a vote of thanks, prize winners were announced and all delegates received certificates and textbooks donated by the AAGBI.

The Gambia is a small landlocked country comprising a strip 400km long surrounded on either side by Senegal. There are six tertiary hospitals in The Gambia, five of which perform surgery. The largest of these is the Royal Victoria Teaching Hospital (RVTH). Anaesthetic services are limited, with only three doctor anaesthetists in the whole country, none of whom are Gambian (Table 1). The most common causes of adult morbidity are malaria, respiratory conditions, skin disorders, cardiovascular diseases, diabetes and cancers.

Table 1. Comparison of population demographics for The Gambia and the UK
(Source: UNICEF 2009)

<table>
<thead>
<tr>
<th>The Gambia</th>
<th>UK</th>
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<tbody>
<tr>
<td>Population (million people)</td>
<td>1.7</td>
</tr>
<tr>
<td>Life expectancy (years)</td>
<td>56</td>
</tr>
<tr>
<td>People living below poverty line (&lt;1.25 per 3% per day)</td>
<td>103</td>
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<tr>
<td>Child mortality rate (per 1000)</td>
<td>556</td>
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<tr>
<td>Maternal mortality rate (per 100,000)</td>
<td>21</td>
</tr>
<tr>
<td>Number of doctor anaesthetists</td>
<td>3</td>
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<tr>
<td>Number of anaesthetic nurses</td>
<td>10</td>
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Table 2. Factors to consider when organising an anaesthetic conference in Africa.

<table>
<thead>
<tr>
<th>Key points for planning an African conference</th>
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<tbody>
<tr>
<td>Conference team</td>
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<td>Conference aim</td>
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<td>Venue facilities</td>
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Educational |
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<tr>
<td>• Consider delegates’ learning needs and present information in a way that they can assimilate</td>
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<tr>
<td>• Interactive workshops are generally better received than lectures</td>
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<tr>
<td>• Consider the possibility of offering a paper based on your own experience</td>
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Equipment |
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<td>• Consider equipment that is not too expensive</td>
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Travel health |
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On the second day in The Gambia, some of the team had an opportunity to become involved in a medical outreach clinic which had been arranged at short notice at a local church; the idea being that churchgoers could simultaneously seek medical care. We were able to prescribe some medicines (e.g. paracetamol, diclofenac, amoxicillin, metronidazole, vitamins, and bendrofluazide) that were sponsored by international partners. This experience provided an interesting insight into some of the more common medical issues at the community level, and gave us an idea of issues surrounding limited resources and inequitable access to healthcare. In total we saw approximately 150 patients over the course of the morning, some of whom were referred to hospital, although there was no formal system in place for this. Common complaints included low back pain, headaches, worms, psychiatric disorders, haemorrhoids, chest infections, and Dr Thomson saw one lady with a large fungating breast tumour. Although this was the first of its kind, we believe it would be beneficial to run this again in the future with a little more prior preparation including names of doctors to refer patients to in Banjul.

**FUTURE DIRECTIONS**

From the delegate feedback we received, the conference was well received. There was a request for teaching on spinal anaesthesia and delivering safe anaesthesia in common diseases states seen in The Gambia. Ideally we would like to run an annual conference of this type in Banjul in addition. Dr Thomson has been liaising with the RVTH Medical Director to try to establish links for UK anaesthetic trainees to spend a few months working in The Gambia as part of the "Developing World Anaesthesia" training module.

**ACKNOWLEDGMENTS**

Finally, we would like to thank the AAGBI and The North Western and Wessex Deans for their invaluable support for this project.

Dr Arunaga Gabria (Consultant Anaesthetist)
Dr Keith Thomson (Consultant Anaesthetist)
Dr Emma Hallward (Consultant Anaesthetist)
Dr Liz Sherly (SpF 5 Anaesthetic Trainee)
Dr Inese Kulma (SpF 5 Anaesthetic Trainee)
Dr Richard Ramsaran (SpF 5 Anaesthetic Trainee)
Dr Matthew Jackson (ST4 Anaesthetic Trainee)
Dr Lorna Hoes (ST4 Anaesthetic Trainee)
Dr Clare Khagani (ST3 Anaesthetic Trainee)
Dr Zisi Smith (CT2 Anaesthetic Trainee)
Jem Reddix (Anaesthetic Trainee)
Louise Emmett (Midwife)
Rebecca Thomson (Paramedic)
Jonathan Remmer & Duncan Thomson (Technicians)

**Details & Bookings:**

- Georgina Hall
  Tel.: (0151) 522 0259
  Mob.: 07901 717 380
  E-mail: medsymp@btinternet.com

**Registration Fees:**

- Consultants: £345
- NCCG: £345
- SpR & SHO: £275
- Nurses: £195

**Comprehensive Trade exhibition**
Hear about & see the new & existing Acute Pain related products

**Informal Delegate Dinner - Brazilian Restaurant**
A wonderful relaxed and friendly evening.
A favorite amongst those who have attended before

8 CPD points from the Royal College of Anaesthetists applied for
As mentioned in previous articles of recollections and reflections, I retired about five years ago having spent 37 years as an anaesthetist, during which I now think could be described as the ‘Golden Age’ of modern anaesthesia. At that time it was normal for patients to be admitted at least the day before surgery even for relatively minor procedures such as inguinal hernia repair in a fit adult.

This admission policy allowed the surgical houseman to come in on the evening of the premedication. Choosing the right time to call was always a problem. I would recite the next day’s list and it’s order and to take his further instructions for prescription and to jointly the Senior Surgical Registrar and myself and then submitted to Consultants on those Monday morning lists coming in before the patient personally, although of course some might have done so after my call, or perhaps on the Monday morning early, but I doubt it. One second thoughts perhaps they did come into the Private ward if there were any patients from there.

What premedication was ordered? For adults the favourite then was ‘Om and Scop’ (Omnopon with Scopolamine). Papaveretum (a mixture of the alkaloids of opium) was largely morphine (253 parts), with the addition of papaverine (2 parts) and codeine (20 parts). In combination with scopolamine (hyoscine), papaveretum was undoubtedly the most commonly used premed at the time. It provided a 2 ml ampoule containing the equivalent of 20mg of morphine and 0.4mg of hyoscine. A full ampoule was the norm for a burly south London labourer, and the dose was proportionally reduced for women and slighter patients. It was almost invariably given intramuscularly one hour before surgery and provided a pleasant and relaxed patient with a dry mouth, some blurring vision and minimal cardiac protection against the brady-cardiac induced by the then commonly inhalation agent, halothane. It was also believed that the addition of scopolamine assisted in reducing post operative nausea and had some significant sedative and amnestic effects which could reduce the consequences of awareness.

The premed was regarded very much as an integral part of the anaesthetic technique - ‘softening up’ the patient and keeping them calm for the induction, and the pharmaceutical use of the drug was the same used for a guillotine and had some of the potentially harmful side effects of the agents used. Woe betide you if you tried to use Etuber without a good anti-sialogogue.

Om and Scop is still available, but rarely used today, which in my view is a shame as it was a very good premed. I recall several patients with previous experience of it who complained that they had not received it as in their view it’s effects were the only really good part of the anaesthetic experience - it fell out of fashion with the increasing availability and popularity of oral sedative drugs such as benzodiazepines, which initially did not need the same storage and administrative complications of Controlled Drugs, in my opinion, not as satisfactory because of their unpredictable effect. The final nail in the Om and Scop coffin was hammered in when research showed the incidence of birth defects in children of women who had received it. This was put down to one of the last of the very few doctors of Omnopon - derived as it was from a natural poppy source. A more puritan formulation is now available. A variety of scopolamine is still widely used in the form of ‘Buscopan’ for intestinal cramp, and as transdermal patches for motion sickness.

Hyoscymus niger

For premedicating children, or others for whom a needle was undesirable or an anaesthetist’s view was given orally. It was then routine practice (once I access had been achieved following a gas induction) to give an appropriate anti-convulsion and cholinergic antagonist generally atropine.

Later in my career as a Senior Registrar in East Grinstead (the famous Burns and Plastic Surgery unit) in 1977, the routine paediatric premedication was renal peritoneal, which worked like a dream and produced, provided the timing of the administration was right, a child who was virtually anaesthetised on his/her arrival in the anaesthetic area. Its use to produce ‘basal narcosis’ was first described in 1936.

As an anaesthetic trainee in 1970 I was told by a senior anaesthetist that the post-operative visit is absolutely essential, as it provides feedback as to how well we are doing our jobs; his view was that it was much more important than any preoperative visit. In his view, he may have had a point there. The idea that anaesthetists should assess all their patients before surgery came in during the early perioperative model and was part of the increasing workload of the houseman, and the increasing number of non-Consultant anaesthetists being being called out. Whatever the reason, it has increased the presence of the anaesthetist on the ward if there were any patients from there. The Anaesthetist’s view is a shame as it was a very good premed. I recall several patients with previous experience of it who complained that they had not received it as in their view its effects were the only really good part of the anaesthetic experience - it fell out of fashion with the increasing availability and popularity of oral sedative drugs such as benzodiazepines, which initially did not need the same storage and administrative complications of Controlled Drugs, in my opinion, not as satisfactory because of their unpredictable effect. The final nail in the Om and Scop coffin was hammered in when research showed the incidence of birth defects in children of women who had received it. This was put down to one of the last of the very few doctors of Omnopon - derived as it was from a natural poppy source. A more puritan formulation is now available. A variety of scopolamine is still widely used in the form of ‘Buscopan’ for intestinal cramp, and as transdermal patches for motion sickness.

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Hunayamnia

Consultant opinion, or just didn’t trust the surgical view of the ward if there were any patients from there.

After a few spoilt weekends, I got the hang of it. I would recite the next day’s list and it’s order and to take his further instructions for prescription and to jointly the Senior Surgical Registrar and myself and then submitted to Consultants on those Monday morning lists coming in before the patient personally, although of course some might have done so after my call, or perhaps on the Monday morning early, but I doubt it. One second thoughts perhaps they did come into the Private ward if there were any patients from there.

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After a few spoilt weekends, I got the hang of it. I would recite the next day’s list and it’s order and to take his further instructions for prescription and to jointly the Senior Surgical Registrar and myself and then submitted to theatre for typing. It was then my job to call the Consultant anaesthetist at home to inform him (or her, but at that time it was exclusively male) of the list and it’s order and to take his further instructions for prescription of the premedication. Choosing the right time to call was always a bit tricky. I was rarely ready to call before 6pm, unless the list had a fit major or two and no other patients, but for one of the regular consultants that was Church time, for another it was his supper and he wouldn’t come to the telephone.

If you left it too late then he might be out, or just settling down to watch one of the highlights of the Sunday evening television programmes, Sunday Night at the London Palladium, or a early Police thriller such as ‘Fibian of the Yard’ for example. It was a bit of a risk. If I didn’t get there at the right moment, it was still my responsibility to inform them and so it would hang over me like the Sword of Damocles all evening.

After a few spoilt weekends, I got the hang of it. I would recite the next day’s list and it’s order and to take his further instructions for prescription and to jointly the Senior Surgical Registrar and myself and then submitted to theatre for typing. It was then my job to call the Consultant anaesthetist at home to inform him (or her, but at that time it was exclusively male) of the list and it’s order and to take his further instructions for prescription of the premedication. Choosing the right time to call was always a bit tricky. I was rarely ready to call before 6pm, unless the list had a fit major or two and no other patients, but for one of the regular consultants that was Church time, for another it was his supper and he wouldn’t come to the telephone.
Evidence Based Practice and Research for Anaesthesia

Teesside University, Middlesbrough
6th - 7th September 2012
Teesside University, Middlesbrough
An inter-professional meeting designed for anaesthetists, nurses and all healthcare professionals involved in the preoperative assessment process.

Topics include: Enhanced Recovery Programme, Management of Preop Anaemia, Assessment of patient with Renal Disease, Assessment and Implications of Alcohol, and Consent for Anaesthesia and Surgery

Call for Abstracts
Abstracts are invited for oral or poster presentations. Best abstracts will be published in the Journal Anaesthesia

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Approved for 5 CEPD points

Annual Conference
Thursday 15th November 2012
The Royal College of Surgeons of England, London

Preface

My Management Project

In the southwest peninsula senior trainees can take a period of “out of programme experience”. My tutor suggested a management module. I needed a supervisor and a project. Our current medical director is an anaesthetist and has been involved in education and management for a decade, so I approached him.

He suggested I work with the new GP referral management service. My task was to liaise between hospital clinicians and GPs to develop referral guidelines. The guidelines are intended to ensure that only appropriate patients are referred to secondary care. The referral must contain enough information, it should be directed to the right specialist and relevant tests and treatments should have been done before referral. GPs are employed to review referrals. Those that do not meet the guidelines and have no explanation as to why they are not returned to the practice.

Why have a Referral Management Service?

Overall NHS funding is being maintained, however healthcare inflation (the rising cost of drugs, new treatments, salaries, new national guidelines, patient expectation, medico-legal claims) means the NHS needs more money to deliver an equivalent service year on year. The Primary Care Trust sees referral management as an opportunity for saving money. The commissioning GPs will inherit the accumulating debt when the PCT disbands.

GPs want to drive up the quality of referrals, get patients referred promptly to the correct services and build relationships with secondary care to deliver the services their patient ask for. Some GPs find guidelines as to what services are available useful - especially if they are working in a locum position.

Some consultants wanted to alleviate their over-working clinics. Many complained about patients being referred to their clinics that they couldn’t help or just referred straight on to another specialist. One department had tackled it very successfully with their own system. Non-consultant clinical leads (such as physios and audiologists) were keen and all healthcare workers involved in the preoperative process.

Some GPs are adverse to what they see as a challenge to their clinical autonomy. Some consultants were cynical, “It’s just about saving money.” “A GP doesn’t know enough to yet my referrals.” “My job is to make GPs and they all hate it.” “Seeing more patients generates income for the department.” “It is a waste of money.” We have produced guidelines before and the GPs take no notice”. Some criticisms were fair and some reflected a distrust of yet more change. Some said that getting a consultant job will be harder than it has been for a long time. Some consultants wanted to alleviate their overflowing clinics. Many said that getting a consultant job will be harder than it has been for a long time.

Before I did this, I felt pressured to become a consultant. Now I accept that getting a consultant job will be harder than it has been for a long time. I will just do my best – and if that isn’t enough, I will feel that I didn’t fail, just suffered from bad timing. Besides, the NHS is asking for more of its consultants - several stressed consultants have expressed their frustrations to me and it doesn’t inspire me to be one of them.

Not everyone thinks referral management is a good idea

Some GPs are averse to what they see as a challenge to their clinical autonomy. Some consultants were cynical, “It’s just about saving money.” “A GP doesn’t know enough to yet my referrals.” “If I have a patient I won’t refer to the department.” I have produced guidelines before and the GPs take no notice”. Some criticisms were fair and some reflected a distrust of yet more change. Some said that getting a consultant job will be harder than it has been for a long time. Some consultants wanted to alleviate their overflowing clinics. Many said that getting a consultant job will be harder than it has been for a long time.

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I learnt a lot from some very skilled professionals. As clinicians it can be difficult to understand the value of management as a discrete role. Professional managers are described as ‘pen pushers’, or ‘they’. ‘They’ are the obstacle to getting on with the real job. I heard a criticism of a medical director in the context of a discussion of changes in acute medicine: “he’s an anaesthetist, what would he know?” You can imagine what was said about managers who were recruited from Sainsbury’s. I think the NHS needs clinicians to take our part in running it whilst we should also value the skills of the professional managers around us. Most importantly I learnt a bit about myself. I normally take it whilst we should also value the skills of the professional managers around us. Most importantly I learnt a bit about myself. I normally take it
1. Do it! Rather than being frustrated at the state of your working environment you can change it (or at least understand it's current state). Starting management for the first time as a consultant must be intimidating. Loss is expected of a trainee.

2. Being known in the hospital really helps. Everyone loves to hate a manager – being a familiar clinician is better.

3. Spread out your time – 2.5 days a week for 6 months will be a lot better; don’t write e-mails at all, just ‘happen’ to bump into people.

4. Be careful how you word e-mails - change is threatening. Even manager – being a familiar clinician is better.

5. Don’t be too upset about what you fail to achieve - have several managers.

6. Expect some flak – often for things that are not your fault and you can’t change.

7. Do an in-house management course – the contacts are as useful as the taught information.

8. Consider straying away from your usual area of expertise – it stops you getting lost in the detail. Not being directly employed by those above you means the goals of the project should not conflict with your career goals.

9. Choose an area where you have credibility – being a doctor helps, being an anaesthetist in an outpatient project does not!

10. Don’t be too upset about what you fail to achieve - have several managers.

I hope so, we’ll see in time.

Kate Teare, Specialist Registrar in Anaesthetics, Royal Cornwall Hospitals

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**SAS Travel Grant 2012**

The Association of Anaesthetists of Great Britain and Ireland invites applications for the SAS Travel Grant for 2012. This is a grant (up to a maximum of £2000) exclusively given for SAS doctors to visit a place of excellence of their choice for two weeks. This is not meant for attending a meeting or a conference. All SAS doctors who are members of the AAAGBI are eligible to apply for the grant.

Applicants should complete an application form and return it to the AAAGBI. The successful applicant will be expected to submit a report of the visit which may be published in Anaesthesia News.

If alternative funding becomes available for a project already supported by the AAAGBI, the AAAGBI should be notified immediately.

For further information and an application form please visit our website:

http://www.aagbi.org/research/awards/sas-grade-anaesthetists

or telephone 020 7631 8807

Closing date: Monday 22nd October 2012

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**Evelyn Baker Medal**

An award for clinical competence

The Evelyn Baker Medal was instituted by Dr Margaret Broadhurst in 1968, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the 'unsung heroes' to the memory of one of her former patients at the Royal Brompton Hospital. The medal is expressed as a technical proficiency, consistently reliable clinical practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainees colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation. Nominees should normally still be in clinical practice.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontypridd) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Philip Simmons (Exeter) in 2001, Dr Meilun Evans (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005, Dr Martin Coates (Plymouth) in 2006, Dr Keith Clayton (Southampton) in 2007, Dr Sudheer Medakkar (Torquay) in 2010 and Dr Fred Roberts (Southampton) in 2011. Nominees are now elected for the award to be presented at WSMC London in January 2013 and may be made by any member of the Association to any practising anaesthetist who is also a member of the Association. Examples of successful previous nominations are available on request, and should include an indication that nominee has broad support within their department.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at honesec@aaagbi.org by 5pm on Monday 17th September 2012.

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**The AAGBI is now connecting with members through online networks Facebook and Twitter.**

According to our recent membership survey, over 70% of you use a Smartphone and over 40% use you have Facebook – so this is another opportunity for you to keep up-to-date with news from the industry and the AAGBI!

@AAGBI  F AAGBI

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**3rd Annual Scientific Meeting**

The Society for Ultrasound in Anaesthesia (SuA) and RA 1st – 2nd October 2012

Derby Conference Centre, Derby, DE24 8UX

Workshops to include:
- ICU and Emergency Medicine Ultrasound, Regional Anaesthesia, Chronic Pain Ultrasound
- Master classes
- Overview of Ultrasound in the Emergency Situation
- Ultrasound as a routine examination tool
- Future For Ultrasound: Where can our imagination take us?
- Pushing the Frontiers-Shoulder Surgery under Regional Block alone
- Controversy in Practice-Ati cogulant & Regional Blockade

**Registration fee:**
- SUA Members-£260 incl refreshments, lunch & carriage dinner
- Non SUA Members-£300 incl refreshments, lunch & dinner

All 3300  t o  3300  l

To submit a poster on the subject of “Think different, think out-of-the-box, think Ultrasound!” please visit the www.usgan.org website for further details.

For further details and to book a place, please contact Mrs Sam Thurlow, Conference Manager

Te: 0116 2002035 Email: sam.thurlow@uht-notts.nhs.uk
Association between anesthesiologist age and litigation.


The threat of being sued is a concern for all practitioners. This paper from North America investigates whether there is any association between the age of an anesthesiologist and the frequency of litigation brought against them.

With institutional research ethics approval, the billing data for all procedures performed by specialist anesthesiologists was obtained from British Columbia, Ontario and Quebec for the 10-year period January 1993 to December 2002. The data was stratified into three age groups: < 55 y, 55-64 y and > 65 y. These ranges were chosen to represent post-residency to mid-career, mid-career to late career and late career to retirement respectively. Data was also obtained from the Canadian Medical Protective Association, for the same time period, for all cases (including disability weighted claims) in which an anesthesiologist was cited to be at least partially responsible for the adverse event leading to the complaint.

RESULTS

With univariate analysis, and utilising the rate in the < 51y group as the reference category, the litigation rate for the > 65y group was 1.31 (95% CI: 0.95-1.80) and the > 65y group to have a 1.94 (95% CI: 1.41-2.67) relative increase in disability compared with the > 55y group.

CONCLUSIONS

The authors conclude that a higher frequency of litigation and greater severity of injury occurs in patients treated by anesthesiologists in the > 65y group. In addition, according to the billing data, anesthesiologists 65y and older had a higher frequency of litigation and greater severity of injury occurrence in the > 65y group. This information is valuable for the anesthesiology community.

Methods

The authors conducted a retrospective search of electronic medical records of all patients 18 years or older who underwent spinal anaesthesia at the Mayo Clinic, Rochester from 2006 to 2010. The primary outcome measure was documented presence of new or progressive neurological deficits within seven days of spinal anaesthesia, identified using a free-text electronic query of terms. Neurological complications were defined as new or progressive neurological symptoms within one week of spinal anaesthesia identified in the progress notes. Two anesthesiologists and one neurologist independently reviewed all cases. Cases were considered ‘possibly’ related if the neurological signs and symptoms were localized to lumbar or sacral nerve roots or if they did not meet criteria for ‘unlikely’. The clinical course and recovery was also noted.

RESULTS

11,095 patients received 12,465 spinal anaesthetics with CHG skin antisepsis. 1,188 potential neurological complications were identified. However, only 57 cases met the inclusion criteria for a new/neuroprogressive neurological deficit. Of these, 52 cases were considered ‘unlikely’ to be related to the spinal anaesthesia. Five potential cases were ‘possibly’ related to the spinal anaesthetic, giving an incidence of 0.04% (95% CI; 0.00%-0.08%). However, there was no significant difference in the number of complications (seriousness, aseptic meningitis or diffuse lumbar plexopathy), consistent with neurotoxicity and the neurological deficits resolved within 30 days.

DISCUSSION

Previous investigations have described the efficacy of CHG skin antisepsis. Animal studies have demonstrated neurotoxic effects from CHG, however there are no reports in humans. The incidence (0.04%) of neurological complications possibly associated with spinal anaesthesia after CHG skin antisepsis is 1,188 times lower than the reported incidence of 0.08% for spinal anaesthesia. None of the neurological complications were consistent with CHG neurotoxicity; in view of the risk of infection complications from spinal anaesthesia, the benefits of using CHG skin antisepsis appear to outweigh the risks. Overall, these results support the hypothesis that CHG skin antisepsis can be used before spinal anaesthesia without increasing the risk of neurological complications.

Lucy Evans

ST6 Anaesthetics

North East Thames Rotation

References


Pip Pip

Victor

It all started with policemen. They just got younger and younger; once they were respectable contemporaries; next decade they were prepubescent plods. But it’s gone on from there. Nurses look younger; so even do anaesthetic trainees - except after a night on call. Recently it’s got worse still: now chief executives look young. What’s more, they all seem to be on a Youth Training Scheme. They come to us for a few months, look around briefly, cause mayhem, and then pop off to cause chaos elsewhere. (I say ‘chaos’, but our recent lot would make Shiva the Destroyer look mild).

Anyway, Chief Executives came to mind the other day when I heard trumpets, and bugles, and even the odd crumphorn. (It wasn’t that recent lot would make Shiva the Destroyer look mild).

I didn’t retort "so that’s a stethoscope, I’ve heard of those, but not one with a Stethophone. when did anyone ever look with one? It’s not a Stethoscope, it’s a Stethophone." I say "Stethophone", but our recent lot would make Shiva the Destroyer look mild.

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Dear Editor, 

We would like to bring to your attention an episode which we feel highlights difficulties with interpretation of hospital guidelines by some patients. On a recent pre-operative visit for elective surgery, it was noted that the patient was diabetic and was smoking of alcohol. No history of alcohol abuse was offered by the patient. On direct questioning about alcohol use that day, the patient told one author that he had been drinking vodka until the previous night with the explanation that he was told he could drink “clear fluids until 7.30am.”

Hazardous drinking is defined by the World Health Organisation as ‘a pattern of alcohol use that increases the risk of harmful consequences for the individual and society’. It can occur in patients with a wide range of medical conditions, including hip surgery in western nations. In addition to long-term effects of alcohol on the liver (cirrhosis, pancreatitis, insulin resistance, haemostasis), acute intoxication may also affect the pharmacokinetics of many of the drugs administered during anaesthesia. Up to one quarter of surgical patients will present with a metabolic acidosis; this is a significant increase in the endocrine stress response to surgery, in both the operative and post-operative phases among hazardous drinkers. This is most evident in measured concentrations of adrenaline, neuropeptide Y and cortisol.

A 2008 British Medical Association report highlighted that the UK is one of the highest alcohol-consuming nations in Europe and this is a significant factor of morbidity and mortality. The report suggests actions for the health service, including reducing pricing, and availability of alcohol, education and health promotion.

The majority of our patients inherently know not to drink on the day of an operation, and not present with such issues. However, if we acknowledge the size of the problem the country faces, perhaps it is time to be more implicit in our guidance; explicitly stating that clear fluids do not include alcohol and that patients should abstain from alcohol at least on the day of their operation.

Dr Navsal Bahal
Anaesthesia Specialty Registrar, Oxford University Hospitals
Dr Luis Barbera-Martin
Consultant Anaesthetist, Oxford University Hospitals

References
1. World Health Organisation Lexicon of alcohol and drug terms. Available at www.who.int
3. Adams C. Anaesthetists’ implications of acute and chronic alcohol abuse. 5 4th annual Int Anesthesia Consensus Conference 1990

Dear Editor

We would like to congratulate the large team that was involved in the recent FOCUS study. We acknowledge the immense amount of work that must have taken place in the 47 centres. Despite all of our effort, on the bone/the anaesthetic/the infection.

The authors of the FOCUS study wished to demonstrate the effect of a transfusion in patients who had cardiovascular disease. As acknowledged by the authors, this was achieved in only 63% of the study population; we suspect that the change in recruitment criteria resulted from poor take up into the study in the initial stages. A more robust method would be to include all patients over the age of 75 with a hip fracture and document the hospital stay and rehabilitation comprehensively.

The authors do comment on the difference between the two data analysis levels in the two groups before transfusion. We wonder if the authors wish to offer some explanation for this discrepancy, when the demographics of the patient populations are so tight in comparison.

The study data provide useful additions to previous research which are worthy of comment, particularly the “hidden blood loss” that occurs in hip fracture patients (table 2). Both groups had a 2.3 g/l fall in haemoglobin level from before surgery to eligibility screening, despite the reported blood loss at surgery being less than 250ml in each group. This confirms the results of two other studies and should be highlighted so that appropriate vigilance is taken in this patient population around the whole perioperative period.

There is no comment about the significant difference in cardiovascular complications, which resulted in transfusion because of symptoms, highlighted in table 2. A three-fold difference in ischaemia or hypotension in the restrictive group compared to the liberal group must warrant some explanation. This does confirm the findings of the 44 patient pilot study for FOCUS. As with all trials, it is important that results are extrapolated unequally beyond the original trial populations. This study refers to postoperative transfusion, with inclusion up to 3 days after surgery and does not therefore address the question of pre- and intra-operative transfusions.

In summary, we do not feel that the results of this study can justify the statement that transfusion can be withheld even in elderly patients with underlying cardiovascular risk factors. If anything, the data suggest that pre-operatively I try to put them at ease to the best of my ability - I say, “Relax, don’t worry, this is all straight forward.” They say, “Have you ever had a general anaesthetic?” We can’t always empathise, but a few words to acknowledge a patients’ situation can go a long way. So I think you have thought with this study. Should all anaesthetists have a general anaesthetic? Should all orthopaedic surgeons spend a week on crutches (breaking of a limb optional), and should all radiologists spend two hours in an MRI scanner? No. But next time you see a patient, appreciate it from their point of view.

Peter Keogh
CCT2 Trainee in Anaesthetics, Darent Valley Hospital, Dartford, Kent

Send your letters to the editor via email: anaeenews@aaa.org.uk

Please see instructions for authors on the AAGBI website

References

Dear Editor

After an informal coffee room chat with one of my colleagues who uses the technique of percutaneous intracaval injection of 1% lidocaine via a 20G safety cannula to anaesthetise the airway for awake laryngeal intubation, we debated the merits of macromolecular devices (such as the MADgic® Wolfe Tory Medical, Inc.)

He postulated that a 20G cannula connected to a 2 litres/min O2 flow via standard tubing produces the same effect if lidocaine is injected through the side port. In order to test his theory I dyed a bag of Hartmann’s solution with food colouring and using 1ml of solution attempted “to paint” as much of an A4 sheet of paper first with a MAD device and subsequently with a 20G safety cannula connected to wall oxygen running at 2 litres a minute. In both instances I kept the tip of the delivery device 3-4 cm from the paper. It was noticeably easier to control the painting with the 20G cannula rather than the MAD device.

The results can be seen in the attached pictures. As can be seen the 20G cannula (1/5th of the cost of the MAD device) produced a much better spread and droplet size (top photograph).

It must be pointed out, however, that the cannula is not CE marked for anaesthetising the airway and does not have the advantage of being long enough to introduce deep into the oropharynx as is the case with the MAD device.

Dr Patrick Christie
ST7 Anaesthetics, Southern General Hospital, 1345 Covan Road, Glasgow. G51 4TF

Dr John Crawford
Consultant Anaesthetist, Southern General Hospital, Consultant Anaesthetist May Hodgson, Southern General Hospital, Glasgow
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  - Shirley.Goddard@derbyhospitals.nhs.uk
  - Tel. 01332 787195
- Royal Derby Hospital, Anaesthetic Office, Uttoxeter Road, Derby DE22 3NE

Course starting September 2012.

We are excited to announce the launch of the UK’s first higher degree qualification in Regional Anaesthesia by Norwich Medical School at the University of East Anglia.

With support from the FICUA, AASA and RA-UK, this specialist postgraduate course offers part-time work-based study using e-learning and distance learning methods, combining a high standard of teaching along with flexibility.

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- enquiries@uea.ac.uk
- www.uea.ac.uk/med/courses

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6th Annual Paediatric Anaesthesia Meeting
Friday 12th October 2012 8.45am – 4.15pm (TBC)

VENUE
Holywell Park, Loughborough University
Loughborough, Leicestershire, LE11 3TU

Course Director - Dr Elsa Dekker

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Difficult Paediatric Airway: Equipment and emergency airway
Obesity in children
Children and Consent
Spinalis for neonates
Anaesthesia for congenital cardiac defects
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Mrs Sam Thurlow, Conference Manager
Tel: 0116 2502305 Email: sam.thurlow@uhl-tr.nhs.uk

5 CPD Points to be applied for from the Royal College of Anaesthetists

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- Scalp Nerve Block
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- Rob Sneyd
- Max Jonas
- oglis@uea.ac.uk
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