An Update from the GAT Committee

"Time flies when you are having fun", so the saying goes. I can hardly believe that the time has come for my final Update article during my year as GAT Chair. But the deadline looms and time for nostalgia and reminiscence is short, so off with the rose-tinted spectacles and down to business…

The GAT Committee had another full, enjoyable and productive meeting at Portland Place on Friday March 12th. For the first time we sampled the delights of technology which allowed our member from the North East (Dr Beckingsale) to participate by telephone for part of the morning session whilst also working nights. It provided a great opportunity for the airing of views which would otherwise have gone unheard, although it certainly provided an extra challenge in my role as meeting chair. A full meeting report can be found, as usual, on our GAT web-pages.

By the time this issue of *Anaesthesia News* drops onto your doormat, our Annual Scientific Meeting (ASM) will be mere weeks away. However, it is not too late to register for our flagship event and come along to Cardiff from Wednesday 30th June to Friday 2nd July. The full scientific programme can be found on our web-pages; highlights include a session on Peri-operative Optimisation, an Intensive Care Medicine session sponsored by the Royal Society of Medicine, Professor Irene Tracey speaking about her work on Functional MRI, and the annual Pinkerton Lecture by Dr Patricia Oakley entitled "Planning for the future Anaesthetic workforce - a research agenda". Combine this with the usual ingredients of entries to the Registrars' and Audit Prizes, the Anaesthesia History Prize, fantastic social events each evening and of course Cardiff's reputation as a capital city (not to mention the guaranteed summer sunshine) and the lure will be hard to resist. If you have not yet registered I urge you to do so as soon as possible.

The GAT Committee submitted written evidence to the recent ME(E) "Review of the Impact of the European Working Time Directive on the Quality of Training". A copy of this can be found on our web-pages. We were not invited to present oral evidence to this process. Our recent interim position statement on the EWTR is awaiting an update, but we are reluctant to do this without some more concrete data on which to base our opinions. We will be attempting some data collection of our own, utilising our Annual Survey conducted at the ASM. However, if you are unable to attend the ASM but feel that you have something to add or share with us on this matter then please e-mail me at gat@aagbi.org so we can make our statement as representative of you, our members, as possible.

Our redesigned GAT web-pages will hopefully be launched in the near future, and the Committee members should be congratulated on all their hard work turning their ideas into reality. Do go on-line and have a look, and again let us know if you have any comments, questions or new ideas for further content. We are particularly keen to develop an on-line Events Calendar into an essential trainee resource and would value your feedback on this.

Watch out for our soon-to-be-published booklet "Who is the anaesthetist?" – our modern take on the previous "Your Career in Anaesthesia" publication aimed at medical students and junior doctors interested in anaesthesia. An accompanying poster board is currently under construction which will be unveiled at the BMJ Careers Fair in October 2010.

The GAT Committee, AAGBI Council and RCoA Council continue to try to find a solution to the issue of GAT losing its position on the RCoA Council last July. The latest proposal involves the formation of a new representative group at the RCoA which will include the GAT Chair in its composition. Keep an eye on the websites of both parties for more information on this. GAT continues to co-opt an RCoA Council trainee representative and we are proud to report that, despite some technical difficulties this year, we have maintained an excellent working relationship with them.

We get a number of requests for help each year with performing audits/surveys, both via our e-mail database and at the ASM. Our policy is to always decline these requests to prevent a deluge of e-mail traffic to members' in-boxes. We will also admit to a certain degree of self-interest in the matter, after all we want our members to reply first and foremost to our own surveys (which we limit to a maximum of two per year) to enable us to function as a representative body. However, if you have an idea for a topic that you think we should be addressing then please do not hesitate to get in touch to discuss the matter with us. We will always reply to any e-mails we receive through our gat@aagbi.org address.

Congratulations must go to Dr Rob Broomhead who has been elected to take over the GAT Chair position at the ASM in July. I am sure he will do an excellent job of leading the Committee and I wish him every success in the future. An election for the position of Honorary Secretary will take place shortly. The Committee will also have two new elected members joining at the ASM. Dr Liz Shewry, our Vice Chair, is taking a six month sabbatical, and elected member Dr Emma Anderson is taking a one year sabbatical, both to Australia. Dr Anderson should be particularly commended for her work on establishing a link between the AAGBI International Relations Committee who have links with trainees in Uganda, and GAT – discover more about this in Cardiff. Our usual practice is to co-opt a replacement for any Committee member who is away for a year.

It just remains for me to keep on encouraging anaesthetic trainees to join up to the AAGBI and therefore to GAT. We have traditionally represented over 90% of anaesthetic trainees and would like to continue to do so. Please go to the website to find out a full list of advantages of membership of the AAGBI and join today.

See you in Cardiff – please come and make yourself known to me!

Felicity Howard
GAT Chair

Particles

Particle

Bacterial Meningitis After Intrapartum Spinal Anesthesia - New York and Ohio, 2008-2009

JAMA. 2010;303(11):1026-1028

This report describes two clusters of meningitis affecting five patients in New York and Ohio. In four patients, the cause was streptococcus salivarius, a normal oral commensal.

The first cluster involved 3 patients who developed meningitis within 24 hours of combined spinal-epidural anaesthesia during labour administered by anaesthesiologist A. Standard aseptic precautions included use of a facemask. S. salivarius was not isolated from the anesthesiologist.

In the second cluster, 2 patients developed meningitis after intrapartum spinal anaesthesia administered by anaesthesiologist B. A facemask was not worn during spinal anesthesia. S. salivarius was identified by PCR in the anaesthesiologist's oropharynx.

Extensive investigations by the hospitals, state departments of health and the CDC were carried out. In both clusters the anaesthesiologist was found to be the common factor. The accompanying CDC editorial note postulates that S. salivarius was transmitted by droplet transmission directly from the anaesthesiologists' oropharynx or via contaminated sterile equipment.

In 2007, The Healthcare Infection Control Practices Advisory Committee (HICPAC) in America recommended that clinicians performing spinal procedures wear facemasks. This has also been recommended in the UK in the AAGBI safety guideline (Infection Control in Anaesthesia Oct 2008).

In 2006, the American Society of Regional Anesthesia and Pain Medicine recommended the use of surgical masks during regional anesthesia procedures.

The use of surgical facemasks in operating theatres remains a contentious issue. Current guidance would suggest that during the performance of central neuraxial blockade the operator should wear a facemask as part of standard aseptic technique.

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