ANAESTHESIA POINTS WEST

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THE SOCIETY OF ANAESTHETISTS OF THE SOUTH WESTERN REGION

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Editorial

As I sit with the wind howling outside, the logburner filling the air with particulates and a glass of red on the go, the hottest summer in decades seems like a lifetime ago. As the country heads towards an orderly Brexit/no deal disaster/bid for freedom/second plebiscite (delete as you see fit), change is also in the air for APW. A little over three years ago, I used this column to tell the story of an innocent post CCT trainee approached by a senior colleague who suggested that editing the regional journal would be 'good for the CV and show commitment to the region'. Approaching at the less sober end of the SASWR dinner seemed to do the trick and here I now sit penning another editorial for this esteemed publication. Having learnt a valuable lesson from Dr Pitman, I spotted the locum consultant in the department with eyes on a substantive post in the region and took my opportunity. I am happy to report that I caught Johannes Retief at a suitably vulnerable moment and that from the next edition he will take over as editor.

This issue continues where the last left off. Sporting injuries abound (I'm looking at you Dr Holmes), Exeter seem to be dominating the prizes from previous meetings and a shortage of staff and resources are common throughout the region.

Despite local points no longer being pensionable, our regular wine correspondent has transformed his piece into a true work of basic science in an attempt to convince his local committee that these articles represent a genuine service to the NHS. I feel sure that his advise is taken considerably more than often than recommendations from many other articles from journals with impact factors that may surpass ours. I'd be happy to write in to support you Tom.

In fact, given that the region now houses the author of *Anaesthesia's* article of the year, I hope that all of the scientific submissions to the journal are squeaky clean. I'm sure that all of the excellent submissions in this edition would pass the 'Carlisle Test' with flying colours. We also see the second part of a round up of 'Everything you wanted to know about blood thinners but were afraid to ask'.

That's all from me. It's been a pleasure to be involved with SASWR over the last few years. I wish Johannes and the rest of the committee the best of luck.

Ben Ivory - Editor

Future Meetings of the Society

Winter 2018
Bath 6th-7th
December 2018

Spring 2019
Barnstaple
Date TBC

The new SASWR Travelling Bursary

Open to trainees and other non-consultant doctors from December

Kick-started by an anonymous consultant member of SASWR who gave a sum of money to be used 'to support trainees', the SASWR committee have decided to provide ongoing annual finance for a travelling bursary to support members of the society to **travel overseas to work for the benefit of others in a voluntary or low-paid capacity.**

Up to £1000 a year will be made available and will usually go to one individual (in exceptional circumstances the bursary may be split);

All trainees and non-consultant grade anaesthetists who are members of SASWR are eligible to apply. (Anaesthetists employed in the South West region may join SASWR in order to make themselves eligible.)

Applications (to the Honorary Secretary via email) must be received by May 1st each year. The application should be around 300 words and should outline the nature of the work to be undertaken, and details of any other funding sources;

A decision will then be made by the Hon Sec in consultation with other committee members and the award made over the summer – and announced at the following autumn meeting. We will try and make the funds available as soon as they are needed, once a decision has been made.

The recipient will be expected to write an article for Anaesthesia Points West about their experiences on their return.

That's all the boring stuff. This is great news for members of SASWR and we are really grateful to the anonymous benefactor (only they and I know who they are!) who has inaugurated this bursary and enthused us to support it in years to come. Please tell your colleagues about it. We look forward to a flood of applications after the autumn meeting in Bath, where the bursary will be formally announced.

Ed Morris
Honorary Treasurer
SASWR

News of the West

Barnstaple

Greetings from North Devon. Let's see what we have been up to for the last quarter? Shock horror Andy (Special Agent) Walder took a day off sick! This following his heroic rescue of their new puppy from the murky waters of Mannings Pit, wading chest deep in the swirling brine to carry his Labrador to safety after she unwittingly fell in. Not to go unmentioned is the now slightly historic but nevertheless tragicomic episode of Jorge da Fonseca's overnight incarceration in his storage container. Jorge popped down to the storage yard to inspect his belongings, parked the car and, radio still playing and engine idling, stepped into the container. An idle wind blew the door shut, so there he was, in the dark, with no way out and no one nearby to hear his attempts to raise the alarm. Add to this an uncharged mobile phone and his imprisonment was complete. I believe he whiled away the hours calculating the remaining oxygen from the capacity of the container and listening to Radio 4 blaring from the car. It must have been a long night but he was finally freed in the early dawn by a surprised attendant. He may have been a bit late for work that morning!

I'm hiding away in the room of a holiday cottage in Sennen dodging my two raucous nephews and the cooking rota, in a self-appointed mission to complete this news roundup before the deadline, as a gesture of goodwill to the newly appointed Editor and previous North Devon trainee Johannes Retief, congratulations Johannes! Dave Beard was passing around pamphlets at our last business meeting in a shameless attempt to promote his "Round Lake Victoria by bike in 12 days" charity ride this November. I've asked Dave to provide a photo of himself, his mate James Lewis and their bikes, to attach to this rag, but not much luck! Lots of grinning selfies but none with them both together with their bikes. I'm pretty certain they will both be looking a bit leaner on their return. If you would like to contribute to their cause or follow them have a look online at https://www.cyclelakevictoria.com. Dave has been in training since the Spring meeting of SASWR. Both Dave and I cycled from Barnstaple on a glorious day in May hoping to join forces with Andy Burgess and co. We finally managed to meet up with Andy Burgess and crew, namely Scott Fergusson and Lauren Barker, quite by accident a couple of miles outside Taunton, after they had taken a quite significant detour! Lauren just shrugged and grinned in resignation.

We have been very fortunate to appoint two new Intensivists, namely Gorki Sacher and Gareth Moncaster, and the plan is to go to a system of Intensivist of the week which we hope will set us up for the bright new future of modern Intensive Care. Nick (spreadsheets) Love (or spread the sheets love!) has been working tirelessly to come up with a workable rota. Jeremy Preece

is settling in well and already taken up the role of day case lead, relinquished a number of years ago by the recently retired Gary Henry. Gary now spends his time fishing with enthusiasm out of Instow harbour with partner in crime Peter Grant. Due to start with us in November is Rob Conway who will become our new Paediatric lead. His wife is a breast surgeon and a welcome replacement for the recently retired Mr John (I operate all night) Groome.

Jan and Jana Hanousek have sadly headed off to the Czeck Republic to try and head off, in Jan's words "any attempt by the Czecks' to embark on their own version of Brexit". They drove off in their van brimming with Jan's junk and a now quite pregnant Jana, (congratulations!!) into a brave new future. Ariana Ungureanu has joined the SAS group and Christiane Schub has returned from Germany and happily fitting in again to the rigours of the middle grade rota. Laurie Marks has been locuming for us for a month or so and is due to return shortly to Zimbabwean politics and runaway inflation. He just shrugs philosophically and gets on with it. Vinod Gupta is also one of our regulars who adds another dimension to the cut throat world of self-employment having recently undergone a tracheostomy and stent placement to treat his OSA.

Annelina Sacher is doing sterling work educating the Foundation trainees in Simulation while she continues her human factors course through Plymouth. Mel Hawkins, our other ace Sim Fellow, has moved on, full of drive and enthusiasm. I'm sure Simon did his best to convince her to stay in North Devon but sadly she has more compelling reasons to stay in Exeter. Simon Hebard has been doing a great job promoting NDDH Anaesthesia and thanks to his tireless efforts we are well staffed and under control of our workload for the first time in living memory. Being lead clinician is a thankless task and he has unfortunately decided to complete his tour of duty in the new year.

Tony Laycock's still here in body but so relaxed he slept through the last business meeting. The merry go round of trainees has removed Charlotte Beresford, Nick Stafford, Alice Siese and Alice Bryant, off to Taunton (lucky them! Taunton, I mean), Max Coupe-King headed off to Exeter, Dan Watson to Bangor to play in helicopters and Sam Nugent to a Core Trainee job in the Midlands somewhere. The enigmatic Martin Paul has taken up our regional anaesthesia fellowship. Pete Rogers is still with us and Sam Cockburn (congratulations on her recent engagement to Gareth) is creating her own career path, at the same time securing a Leadership fellow position (no flies on Sam). Sasha Carter is doing something similar, perhaps a mix of ED and ITU, who knows? It's hard to keep up these days! As hard as conventional training schemes try to straight jacket trainees into rigid career paths, just as quickly it all appears to unravel.

Lotte Lindenbaum is doing some ITU with us en route to her article 14 ED job and Helen Edwards (nee Fothergill) is hinting at returning to part time acute

hospital medicine/ITU/ED to supplement her General Practice. Juan Parra does the odd stint on ITU now while new trainees are not yet on the on call rota. I just wonder where we are going to accommodate the new IMT trainees who need three months ITU experience in the not too distant future.

Newly arrived are Stuart Frankland, Edmund Gerrans, Michael Ruiz, Auni Yahaya, Shun Yamanka, Ben Eldridge and last but not least (the even more seriously organised and effective than Alice Bryant) Aislinn Brown. A good bunch and we are lucky to have them. Sadly though, big cities, bright lights and mortgages seem to hold more sway with trainees now days and excellent performance in the GMC National Trainee Survey doesn't appear to count for much.

Please save the date for the next Spring meeting of SASWR which will be held at Saunton Sands Hotel on the 20th and 21st of June 2019. It's a great venue for meetings (see also SODIT 2018 and 2019) and we promise to put on a good show. That's all for now folks!

Guy Rousseau

Bath

New Beginnings and the End of Two Careers

Courtesy of some unexpected bad news, I write this iteration of the 'Bath Update' from the highveld in South Africa. I left Bath as the leaves were turning and the nights were drawing in, to arrive in Johannesburg to the blooming buds of spring. I am struck by the transient nature of our lives, by the fact that as some people are starting their lives or their careers, others are coming to an end.

We have had quite a few new additions to anaesthetic families in Bath. We welcome new babies to Andy Ray, Matt Gibbins, Charlie Pope, Ben Hearne, Kate Nickell, Rob Penders, Tom Cloke and Rob Axe. I was envious to see that none of them appeared to gain the weight I did during our pregnancy. We have also had the pleasure of four new novices starting their time in anaesthesia and welcome Alice Quayle, Lucy Whitton and Heather Churchill. We also welcome Rebecca Gayner, Alice Gerth, Neil Choudhuri, Amelia Davies and Abigail Harper as core trainees and Mark Shiels and Lauren Simmonds as specialist registrars in anaesthesia. Congratulations to Tom Saunders, Andy Savva, Ben Savage and Graham Walkden for success in their primary exams and to Paul Watson on obtaining his FRCA. Well done also to Fiona Oglesby on securing an ST3 post and to Claire Kaloo on her Locum Consultant post in Swindon.

Ben Plumb won second prize at a National Preoperative Conference for his work introducing BNP testing in Bath, Lesley Jordan's QSIR work was shortlisted as a finalist in the HSJ awards and Professor Cook gave his inaugural lecture at the University of Bristol. Not content with a mere inaugural lecture the greatest showman was also proud to pose with

our new C-Mac video laryngoscopes, proof positive that today's luxury is tomorrow's necessity.

Prof Cook

2018 also marks the end of two lifelong careers in the provision of anaesthesia. John Hughes, senior ODA retired this past October after 40 years of service in the NHS. He was a font of knowledge, a reliable go-to-guy for technical issues and generally a good egg. He will be sorely missed.

John Hughes

Dr Andy Lim

Also retiring in 2018 is our very own Dr Lim. If memory serves me well, he started anaesthesia sometime in the early 1980's and has finally decided to call it a day and head for sunnier climes. We wish both John and Andy a happy and fulfilled retirement.

Malcolm Thornton

BRI

The days of austerity are over at the BRI. As we career headlong into Brexit and the financial uncertainty that it pertains we have also started the substantive careers of 6 new consultant colleagues since we last imparted news of the trust. Many congratulations are due to Drs Matt Bell, Adam Duffen, Liz Hood, Rachel Mckendry, Emma Riley (nee Bell-Chambers) and Jess Webster who all started recently. The dining in was a suitably raucous affair, with much heckling during the speeches, and a poetic stroke of genius by Liz who had clearly been trained in Su Underwood's School of anaesthetic literature. We look forward to

welcoming Emma after a well-earned 'break' (which will follow the imminent arrival of her second child...)

Su Underwood has now finally left the building - we wish her all the best for the future. I did chance upon her in the department several times after her actual retirement date; apparently, she was waiting for people to stop throwing events in her honour before she felt able to make the break. That predictably took some time given her legacy. The Bristol ACTACC meeting formed part of her swan song. The success of this meeting as a whole was in stark contrast to the success of the Molyneux running component which was widely attended by a single individual who couldn't actually run. Molyneux bravely pressed on through and, having performed a CPET with fairly reasonable numbers, brimming with confidence he entered the school swimming gala (a parent event, although he has previously tried to compete against children to improve his chances of winning). Sadly, he received a thrashing of embarrassing levels, calling into question the validity of his VO2 peak. Anyone who knows Mol will recognise that he isn't a particularly competitive chap, but he has taken this to heart. Kaj has had to lend him the entire back catalogue of X-Men films so he can learn how to grow gills…

On the other side of the channel in the world of Intensive Care there is the ongoing Trump style discussion of building a physical bridge (this will involve knocking down a wall) between the general and cardiac departments. Presumably this will help if we ever get an influx of immigrant patients from the south?

Finally, the departmental summer party was a well-attended affair. Our chairman provided a strong venue in Ryder Towers, the swimming pool providing suitable amusement for the very junior members of the team (Molyneux was notable in his absence - his fear of water having not yet rescinded). Good fun was had by all, with one youngster asking 'are we coming here every weekend?' With skills like those you would have thought Dr Ryder should go into the business of nursery care...

Alex Middleditch

Cheltenham and Gloucester

In a highly unusual turn of events our way in recent times, there are no new appointments to report. However, we have welcomed Nishi Patel back from maternity leave having had Luca, which feels like a new appointment as she pretty much walked out of her interview and onto labour ward. Great to have you back Nishi! Matt Martin and Marcin Pachucki took up their posts over the summer and were welcomed with a night out at 101 in Cheltenham and a great night was had by all.

June saw the Midsummer Ball and a strong turnout for the return of Tom Perris as the energetic front man of Dural Tap and a particularly

enthusiastic Stereophonics rendition. As ever, a highly talented brass section with Henry Murdoch on trombone and Andy Foo on trumpet were complemented by Steve Twigg on sax. Many solos and more than able guitar skills from Chris Roberts on lead and Julian Phelps on bass gave the crowd much to dance and cat call too! The night also provided a good opportunity for the ICU charity to raise some funds.

Chris Roberts hung up his stethoscope for the final time over the summer which was celebrated in style with a summer party and BBQ. Chris is already enjoying retirement and continuing work as a trustee of the ICU charity.

Under the headline of 'Bunch Of Wallys' in the prestigious Irish Examiner newspaper, fame was poured on the department from an unlikely source. A motley bunch of Gloucester based Where's Wallys turned out for the annual Dragon Boat Regatta at the Gloucester docks. One of 30 teams racing in 40ft long canoes, Messers Price, McCrirrick, Murdoch and Hunton were ably assisted by other theatre staff and made it across the course without swimming, somehow. No silverware but full marks for effort and enthusiasm.

Bunch of Wallys

Irish Examiner 14 May 2018

Teams take part in the Gloucester annual Dragon Boat Regatta, where around 30 teams battled it out and race across the historic docks in 40-foot dragon boats. This particular team opted for the 'Where's Wally' look.

The summer social took the form of walking and team building exercises in Timbercombe woods. The regular and highly competitive 'protect the balloon around your ankle' game was fought to the death with the spoils going to Dr Chandar for the second year running.

Summer social

Protect the balloon…

Trainees have joined and left and as ever our grateful thanks to a sterling bunch; good to have around and achievements a plenty. Jane Donald managed to secure a highly coveted Severn ST3 post and a huge congratulations to her, well deserved.

Undoubtedly the highest achievement on the training front came from Dr Hunton, who managed to secure the hugely prestigious post of National Lead College Tutor after a keenly fought election. His dedication to all things training and trainees, hugely approachable personality, boundless energy and enthusiasm have clearly seen him master the dark art of the college tutor role. We're all very proud of him, even though he openly admits Dr Stedeford has to mother him.

Christmas greetings to all and looking forward to the meeting in Bath!

Sam Andrews

Exeter

All is quiet in Exeter. We have basked in the sunshine of the summer, and we are still enjoying an Indian summer. We have had a change of leadership in our department, with Mark Daugherty moving up to become AMD, and in the process exchanging his A4 notebook for a pocket-sized notebook, which is harder to leave everywhere. Quentin Milner has stepped up to become the new CD (a post which was replaced by clinical lead, not so long ago), and now we are looking for a clinical lead. It's all go. Rebecca Appelbaum has stepped down as CL for ITU, after almost 2 years of sterling work, and Harry Pugh is stepping down as college tutor after what certainly feels like more than 3 years of hard work on behalf of the trainees in Exeter.

We have appointed a gaggle of new consultants - welcome to Mark Pauling and Kath Haynes, and 3 more, who are so hot off the press that I don't even know their names yet, apart from Simon Marshall. Welcome also to Suzi Baldwin and Mel Hawkins, who have joined our SAS ranks. I am sure they will prove to be vital members of our department, along with their hardworking SAS colleagues, who often keep the evening and bank holiday work covered single handedly. Thank you to all of you.

As always, we have had the seasonal change of trainees. Good luck to all who have moved on to better things, and welcome to all our new arrivals, some of whom started their anaesthetic training with us and have now almost finished. How time flies. Marina, one of our chattiest PAAs, has had a rush of blood to her head, and has run away to sea for a year. She is joining a cruise ship, and waited until her leaving drinks night out to practice not drinking too much on a night out. Good luck with that, and with this latest chapter in her life. We look forward to hearing Marina's tales on her return.

The Royal Devon and Exeter is about to embark upon a new project – MyCare (also known as EPIC). Nick Batchelor and Al Martin have been seconded to lead the project, and according to Nick (and Al, but in a less scary, born again sort of way) it will be MAR-VEL-OUS darling. Luckily other Trusts have already tried it, and generously shared their learning points with us, so what could possibly go wrong? Watch this space….

Paul Thomas generously hosted the summer party as his house again this year (giving Sally time to recover from the last summer party he hosted). The turnout was good, the home brewed beer was better, and the entertainment was exceptional. There are some hidden musical talents in the department, which need a voice periodically.

Well that's all from me. Merry Christmas to you all.

Pippa Dix

North Bristol

So I'm going to come right out and say it - "generally speaking we're a happy bunch at NBT". Right, now that's out there I feel the need to justify it as that's quite a left field statement in a world of ever lengthening waiting lists, lack of pay rises, pension raids etc etc. Sure there are the usual gripes about this and that but Dr Tolchard deals with most of the Mr Angry e mail writing so that takes the pressure off the rest of us so we can go about our usual business secure in the knowledge that at the very least someone is incensed.

At the recent NBT Excellence awards Dr Smith won yet again. He now has so many prizes that structural engineers were recently seen entering his house, no doubt to shore up his mantelpiece. Dr Kirkham was also nominated for her work around the elective theatres - congratulations to you both. No prizes were awarded for quality of dancing at the after party.

We now have one fewer military doctors within our ranks as Dr Hooper is now back on civvy street after a long and distinguished (injury littered) career. He has already joined the 'bearded wonder' craze but hasn't yet lost all his sartorial elegance. We await the 'Vietnam veteran' look at some point in the future.

Our ITU has benefitted from an outbreak of 'stickering' by Dr Robinson ably abetted by the loosening of Dr Soar's hand on the charitable purse. They are a great success and make

our Unit look slightly less austere and scary for visitors. To replenish the coffers and to repeat what was a huge morale boosting experience ICU / Anaesthetics walking club is back in business. This time we are going all in with our ED colleagues and will attempt to walk all 186 miles of Pembrokeshire Coast Path. Colleagues from around the region are most welcome to join us.

Other sporting exploits continue to be largely cycling and running dominated. Dr Pyke swears its ginseng that's keeping him so fast - we all know its EPO and Dr Martindale still astounds, this time completing a short swim, cycle , jog around Alpe D'Huez leaving orthopaedic surgeons and others trailing in her wake. Dr Kidd one of our excellent Severn trainees organised a conference (serious work, no fun, honest) in Majorca (called CLEAT so you get the real intention) at which NBT was unsurprisingly, well represented. The follow up event is already booking up fast with many extending their stay (to read journals) either side of the main event. Drs Shinde and Burrows cycled to Dublin for the AAGBI meeting and Dr Davies (Keith) cycled to Paris.

There was an excellent turnout at the recent Guy Jordan Memorial ride (see photo) with fortuitous weather dodging courtesy of Dr Whittle's weather app. Dr Griffiths won the prize for most coordinated outfit and Dr Thomas (Matt) for bike in worst condition. Talking of Dr Whittle he is once again looking for volunteers (not victims) to accompany him sailing at the NHS regatta. He promises there's great fun to be had and he won't crash (this time).

The only controversy to dog the department is the small yet significant matter of paying for the biscuits. One of the secretaries noted that a colleague (we all know who they are) had not paid their subs for the last 3 years and were caught red handed at the biscuit barrel in the process of opening yet another packet of chocolate digestives. We are awaiting update on payment and hope that this matter will shortly be put to rest. We are all concerned, none more so than Dr Donald who is hoping against hope that it doesn't delay our Departmental Anaesthesia Clinical Services Accreditation (ACSA) attempt. Dr Nickells and Marsh both remain sane and in charge of Anaesthetics and ICU respectively. Dr Marsh worries a lot so it's just as well that all his hair fell out long ago.

Our trainees remain universally excellent and have even told the Deanery they quite like us as well. They should be even more pleased as they have now had a chance to enjoy their new departmental sleeping arrangements. In the last missive I

reported on the commandeering of a clinical waste room for their sleeping quarters. I am delighted to say we dispensed with that as a plan and Dr Thompson spent our hard earned cash on two "sleeping pods" that now sit in the office. Dr Robinson is extremely excited at the thought of them being "christened" (and he's not talking about just being slept in). I'm assured that even I could fit in one but fortunately resident consultant on call is still more a threat than reality.

If there's any other scandal worth reporting then I've missed it but don't worry - there's always next time

Dr Ben Walton

Plymouth

The spectacular summer weather has led to a feeling of contentment across the department only broken by the realisation that this has brought its own problems with the ED being busier than the previous winter, and the resultant impact on operating lists. Some will have noticed the subsequent partnership with the local ISTC as part of the winter (*Really?)* plan to cope with the ever-increasing demands for acute beds. We will wait to see how this relationship blossoms and flourishes.

The serenity of a proper summer has resulted in a let up in the departmental procreation with only two new additions to anaesthetic parents. Congratulations to Gemma Crossingham (baby boy) in April and Kerensa Chapman (baby girl) in September. Rumours that Gemma was still working on *Learning from Excellence* stuff during her labour and throughout her maternity leave may not be entirely fictitious. I'm not sure that I remember having that much free time with a new born baby.

We have had two new consultant starters and it is a delight to welcome Andrew Biffen and Steve Copplestone, although Steve is still committed to a career in ICU as well. They are both brilliant additions to the department and their smiling faces bring cheer wherever they go. We look forward to their contribution in the service of the patients of Plymouth.

There have been some great successes in the exams and congratulations on passing the final FRCA to Craig Holdstock, Geoff Tavener, Kate Smurthwaite, Matt Julian, Iain Robinson and Alex Coombs. Notable attainment of the written part of the Final FRCA in October goes to Zach Jeffery, Jeremy Hunter, Chris Gillett, Anna Ratcliffe and Juleen Fasham. A big thank you to faculty from across the region who continue to provide excellent teaching to trainees both in hospitals and at the regional exam courses.

The summer BBQ in July was hosted by Paul Youngs (well, his wife really) and helped by the wonderful weather a large turnout. The chefs (?) did a sterling job in feeding the masses and any concerns about potential food poisoning for a large part of the department were completely unfounded. No event would be

complete without some sporting activity and there was a healthy commitment to the soccer, surprisingly without too much competition and surprisingly no injuries. This may have been limited by the hot weather leading to the players' considerable thirst and necessary rehydration by the consumption of fine ale.

The department was celebrated in the 'NHS 70 Years Pride of Plymouth Awards' with the rightful recognition of the sustained commitment to improving care of Lorraine Alderson ("Above and Beyond"), Helen Anderson, Cath Ward (both "Commitment to Improvement"), Jemma Edge ("Living the Values") and Rob Sneyd ("Lifetime Achievement Award"). This reflects only some of the great work that goes on across the department and provides an insight into the values that are supported by the inimitable leadership of Dave Adams.
The SWAVES conference was a cracking success and continues to deliver an exceptional educational experience. Unfortunately, the fluid flow and dynamics practical demonstration did not pass without injury. The physics of waves has been well studied by numerous committed anaesthetists over the years and Kate Holmes's commitment to furthering this knowledge is commendable. Unfortunately, when a hefty shore break catches one unexpectedly and tosses one like flotsam on to the beach there is a significant transfer of force. Whilst we may all try to stretch the space-time continuum at times the ankle and leg are still required to move at the same speed and when they don't the result can be a source of significant discomfort ("It was a bit hurty"). Fortunately, sufficient orthopaedic knowledge was present to know that what was needed was to apply traction although doing so by dragging the Kate up the beach may appear to be unconventional.

Working on an (un)even suntan?

Rob Sneyd's retirement do was a fitting celebration of his career with an afternoon symposium and dinner at Stonehouse Barracks organised to celebrate his career. As his citation for his lifetime achievement stated: *"Rob is outstanding in a ridiculous array of arenas: he is a colossus of medical education, an international figure in anaesthesia research, a prolific writer of scientific papers, a charismatic leader, administrator and national statesman.*

When Rob started his own medical training there were no medical schools in the west country. Now there are both a medical and a dental school in Plymouth, and Rob has had a crucial role in both". The dinner at the Barracks was a wonderful location for the celebration of his career with the regal splendour leaving some colleagues literally lost for words about how to convey Rob's achievements over the years.

Professor Sneyd's retirement dinner. Left to right: Chris Seavell, Steve Bree, Lalit Hamal

Professor Sneyd

It is not just Rob who is leaving but Kevin "the yo-yo" Patrick is heading back to New Zealand again. We hope that the experience will be similar to last time and he will miss the department too much and be back with us before too long! His leaving do will be starting in the Dolphin and there may not be quite so much silver on the tables, but I am sure that there may be an inability to put their thoughts onto words at points during the evening.

Rumours of other imminent departures into the sunset of other big-names in the department have yet to be confirmed, partly due to the uncertainty that Brexit is generating about the future costs of kitesurfing and windsurfing kit. Apparently, the price of lycra is unlikely to be affected.

Matt Hill

Swindon

Recent months have been spent increasing the amount of intravenous iron given to our pre-operative patients. It turns out that iron deficiency anaemia is very common in the surgical population so correcting this is a time and money consuming problem. Is it money well spent? I hope so! Many years ago as a medical SHO in Cheltenham my offer of a blood donation was declined as I was found to be borderline anaemic. My colleagues ribbed me for having 'a girl's Hb'. This year I attended Andrew Klein's anaemia day at the AAGBI only to find, via a non-invasive Hb meter, that I continue to be anaemic at 12. It was suggested that I would benefit

from some oral iron…I decided on an alternative treatment approach. In the last couple of months, I have been to Ireland twice. Firstly, to Dublin for the AAGBI meeting then, a month later, off to Dingle for a Perioperative Medicine conference. My prescription was for three pints of Guinness per day and vegetable free meals for breakfast, lunch and dinner. Guinness, though very tasty, only contains 0.3mg of iron per pint but black pudding contains 6.4mg per 100g serving. Therefore, the main role of the stout was to wash down the nutrients. Swindon consultants Simon Davies, James Andrew and Mark Yeates joined me at the International Conference Centre in Dublin. They stayed in luxurious hotels and offset the late nights with complementary spinning classes. My AirBnB turned out to be in the Bronx of Dublin. I had planned to go the local pub – Nocters. If you Google 'Noctors/ roughest pub in Dublin' you'll see why I had a cup of tea in my room…

Back in Swindon things are tickling along nicely, as long as you don't need a hospital bed. Senthil Vijayan has joined us as a new pain consultant whilst Speciality Doctor Zdenek has left with a plan to travel the world. Who can blame him! Jill Dale, college tutor, is on a high after completing a mountain medicine diploma. Trainees are coming and going. Exam congratulations to Jonny Harrison and Maddie Storey. Matt Govier is now married and is off to South Africa on safari. Ed Gomm and Ed Miles proudly brought in their vomiting mannequin to challenge our airway skills. Trainees and consultants tested their abilities to deal with (literally) litres of fake vomit flowing up the oesophagus. All managed admirably but it was noticed that that while the trainees asked for help the consultants poured out a string of expletives! Artificial vomit was created using paint but memories of Dublin could be recreated using Guinness instead.

Mind the vomit

Dr Jill Dale and friends

Ed Bick

Taunton

Births: Richard Allan and his partner Clare are celebrating the birth of their daughter Isla. A slightly early arrival

but both Mum and baby are doing well. Ian Davies and his wife Charlotte Battle have also safely delivered their third child, a daughter called Eve. Congratulations all of you!

Richard and Clare with Isla

Appointments: Not an appointment, but we welcomed back Abi Hine into the department after maternity leave. We also had four new Consultant colleagues join the department over the summer. Mark Abou-Samra, Tom Teare and Tom Barrett were appointed in March, started work in June, July and August and are all making a strong start in the department. Mark and Tom T. have both been trainees at Musgrove Park, having trained in the South West. Tom B. arrives from Severn `Deanery. Adam Hatalyak was also appointed as a locum ITU Consultant. We are very lucky to have such high calibre colleagues in our midst.

Trainee news: We said a fond farewell to Tom Judd, Kate Smith, Debbie Webster, Chris Sajdler, Jing Wang, Aislinn Brown and Shun Yamanaka in August. All have continued training in the region and we wish them all the best for the next year. Exam successes for Aislinn, Shun, Kate (Primary FRCA) – congratulations everyone, we know how hard you worked for this!

Other news: Justin Phillips has been appointed to Associate Medical Director in the Trust. This is his first senior management role and we would like to congratulate him on this fine achievement. We are now looking forward to receiving our new job plans with a bottom line pay rise and 3 SPAs each!

Simon Marshall

Torbay

Torbay has comfortably basked in the fantastic sunshine this year has had to offer. All the locals have been back swimming in the sea, on their bikes, boats and barbequing frantically.
The summer tradition of the Tuckenhay Paddle attracted record numbers this year from all walks of life, overwhelming the little pub somewhat, but it was a glorious evening enjoyed by all (apparently – I was on call!). Our joint meet-up with our Derriford friends was also a great success down at Bigbury, with some of our more adventurous trainees kipping the night on the beach (bums).

Mel Hearne and Sammy Saad had an awesome leaving do with well over 100 attendees at a local hotel. They wowed us all with a fabulous dance duet worthy of Strictly and then the rest of us ripped up the dance floor (literally) with music

provided by one of our own surgeons in his band – thank you Mr Mitchell. Some of the anaesthetic department and ODP's murdered a personalised version of Bohemian Rhapsody just for the occasion.

Now for part two of the leaving pair (as I covered Sammy in the summer edition). As the turn-out at her party suggested, Mel will be much missed. Her contribution to the development and strengthening of the department over her years working here cannot be underestimated. Her huge enthusiasm for simulation teaching in its early days really helped to put Torbay on the map as a centre for innovation in this area. As a committed educationalist she was a regular on the specialty training committee and ARCP panels so many of us benefitted from her experience and wise advice. It will be strange to be in Torbay without her enormous energy and the community dental team are missing her hugely already – no one seems to be able to do it quite how she did!

We said goodbye to Paul Sampson and Tamsin Lane to Derriford, Emma Shacklock to GP land, and Ruth Addison and Rachel Varnam back to ED. We wish them all the best. We welcome Will Spencer, Andrew Woodgate, Jonathan Carter, Ciska Uys, Greg Warren and James Womersley. We are looking forward to teaching them the dark arts of 'TIVA for all'.

Congratulations to our fantastic trainees who have had 3 children between them. Anna Ferguson has had a little boy, Rory, Vicky Lewis a little girl, Clara and Simon George, a little girl, Jessica.

Huge congratulations have to go to John Carlisle for winning the official *Anaesthesia* 'article of the year' 2018 for his work on data fabrication in published RCT's. We are expecting him to be approached by MI6 soon (but we won't let them have him!)

Our periop team with Mike Swart at the helm are venturing bravely out onto the wards for a trial of perioperative ward rounds which we are hoping will become embedded in the future.

Sadly, some of our theatres continue to crumble becoming either too hot, too cold or too humid (they were always too small) and debates are ongoing as to the best way to proceed so we are all keeping our fingers crossed for a timely, pragmatic solution. Please let it be more day surgery theatres, please! So, for now, we will continue to work with our hard hats on and keep our fingers crossed that the winter pressures of last year can be mitigated somehow.

Theresa Hinde

Truro

Cornish HQ (aka the anaesthesia resource and structured education room) has had a makeover already! Now it actually has important resources: running water, fridge, fake foliage, Tom Bevir's journal club, and for the moment James P's cafetière. Much debate about an appropriate industrial strength coffee machine has perhaps gone too far…a joke about barista service may actually come to

fruition! Paul Carpenter has already picked his man - just hope he can do personalised foamy latte art!

If you need some good feedback about your work for appraisal it's best to rope in the family. Sam Banks' keen eye noted Roger Langford's clan had the 'Wonderwall' of complimentary comments under control!

Picture 2. Who's the best anaesthetist of them all?!

Ali Moore, after years of sterling work, has stepped down as CD to concentrate on being mother of the bride for the second time - possibly a more demanding role! Meanwhile, management structure changes and now we look forward to care group formation of a triumvariate…a powerful threesome as far as I can gather. Meanwhile, Ali P only administers an anaesthetic within a secure triad of muscles.

Picture 3. No messing Lomas and Garland AR security

Do first impressions count?! Tom Blincoe had not been in the department a week when he discovered some interesting products in the pigeon holes, needless to say he's been 'working late' ever since.

Picture 4. Lubrications of choice

We are delighted to introduce a gaggle of new gasmen to #Cornwallanaesthesia. Kerry Elliot is Olly Petroni's better half and after training in London she is joining the Pain service. They also finally tied the knot in glorious weather over the summer! Lucy French is a Devon girl who trained in Wales. She enjoys obstetrics and will be imparting her skills in simulation and teaching after a fellowship in Perth, Australia. We hope to improve her surfing skills and Cornwall will only enhance her photography and painting passions.

Kate Sharpe is dual accredited and is proud to be appointed in anaesthesia and PHEM - working on the Devon air ambulance. She loves trauma

and hopes to develop services in the Peninsula. A keen sailor, she has already organised a motley crew and a boat for the NHS regatta next year!

Tom Blincoe is a kayaking fisherman with smallholding dreams. In his spare time is going to help with our CPET service after developing an interest in all things perioperative in Wessex.

Last but not least Lewis Connelly has kept it Celtic, having trained in Wales and now starting a consultant post in Cornwall. If you ever meet him keep this in mind:

'Hi I'm Lewis. Yes I am tall. You're very observant for noticing.
I am 6'8" (Yes, really. No, I'm not kidding)
Yes, my parents are tall.
No, I do not play basketball.
I like surfing.
Yes, the weather is nice up here.
This has been a great conversation.'

On the trainee front Suzy Grenfell has had gorgeous baby boy. We welcome Ian Densham and Sam Spinney on fellowships, and back for more are Danny McLaughlin, Libby Fontaine and 'Pritch'.

Becky Brooks

Yeovil

By default (unwittingly finding myself sitting next to the editor of this publication at an organ donation regional collaborative) I now appear to be the Yeovil linkperson for SASWR which gives me the (un)enviable task of writing our section of this next instalment of APW. An email request for exciting news and photos of social activities resulted in zero replies, so I'm afraid the following is all my work…

We have been unrepresented in this forum for some time so there may be some news to catch up on. Last in the alphabet behind every other hospital in the region – I give credit to you for reading this far! Despite being a fantastic place to work (most of the time) and in a beautiful part of the countryside, for many reasons YDH is rarely at the top of the list for prospective consultants, and recruiting to backfill retirement in the current climate is challenging. So, it is with sadness and not a small degree of trepidation that we have waved/are waving goodbye to some of our more mature colleagues: Rob Daum left us about two years ago and Stephen Hunter shortly after. Paul Greig had only been with us for a year but decided that, instead of being able to afford a five-bedroom house with two acres in Somerset, he would rather a two bedroom flat in Chelsea with no acres. Each to their own I say. Chris Elsworth is eyeing the exit in the way that one might the emergency door of a plane on fire. Also, we say goodbye to one of our Associate Specialists, Bernice Ansell.
These are big shoes to fill. Going someway to doing so is Bozena Lassota-Korba who joined us from CareUK back in January 2017 and who has rapidly made a really positive impact on the department. We have

also recently recruited Rob Bruce-Payne from Bermuda. Apparently, the sub-tropical climate, perfect trade winds and favourable taxation system were not enough. Their loss is our gain. Also, we have said goodbye to some excellent middle grade doctors who have been with us for several years: Manpreet Singh (India) left us about three years ago and is now (I think) ST6 in the Midlands. He very kindly backfilled his own position with a friend - Gauravjit Paik (India). He too has now left us, recently moving to the North-East due to his wife getting a training number. Juraj Chovan (Slovenia) has followed in the footsteps of two other Yeovil middle grades (Jarek Potemski (Poland) and Beata (not sure of surname (before my time)) to become a consultant in Stornoway. Yeovil was not dark, wet or windy enough in the winter for them. We have also waved goodbye to Andres Jiminez (Colombia), Dimitrious Xarchoulakos (Greece), and Mohammed Gheith (Egypt).

As you can see – we are a truly multinational department. Recruiting from Europe (post-Brexit vote) is now extremely difficult. There is a much longer time-lag to recruit from outside Europe due to visa applications and so forth. I'm sure we are not alone in finding this a challenging time in terms of recruitment to middle grade rotas.

In terms of other departmental news: At some unspecified future date we are expecting our first GIRFT visit. Due to more accurate data collection however, our ICU unit adjusted mortality has plummeted from the dizzy heights of 1.19 to 0.69. So perhaps the eye of Mordor may fall upon some other unsuspecting department, who has yet to sort out their data capture (thus finding themselves in the wrong part of the funnel plot), and we may be waiting longer than anticipated.

Our newly refurbished pre-operative assessment unit opened last month. This gives us five full sized clinic rooms, as well as admin support and a useful proximity to the Clinical Investigation Department. It is also on the ground floor which means I don't have to climb any stairs on the mornings I am in clinic.

Socially things have been quiet over the summer months. Unlike many departments in the region we are not overwhelmed by Lycra in the changing rooms (me being the notable exception). Golf tour is yet to happen, and our esteemed colleague Dr Scull is now medical director and claims to be much better behaved. I personally have decided to spend the summer demolishing my house only to rebuild it more or less the same (don't ask). As a result, I am short on money and short on time. From the ashes (rubble) will rise the phoenix (I hope). If not then I shall be filing for personal bankruptcy and this may be my first and last instalment for this publication.

Joe Tyrrell

Author's house being demolished

Joe Tyrrell

Report on the Spring Scientific Meeting, Taunton, 24-25th May

Pippa Dix Honorary Secretary

The spring meeting was held at the Somerset Cricket Club, in Taunton. In a break with tradition, the meeting was held on a Wednesday and Thursday, to avoid the need to brave the M5 on the Friday before half term. For some brave souls, the meeting began on Tuesday, as they cycled to SASWR. Most remarkable was Becky Brooks, who not only cycled from Truro to Taunton, but also cycled back, via North Devon. Andy Burgess and Scott Ferguson cycled from Plymouth, and met up with Lauren Barker from Exeter. After a few orbits of Tiverton they managed to escape the gravitational pull and continued north. By a quirk of fate, they bumped into Guy Rousseau and Dave Beard, who were making their way from North Devon, and happened to stop at the same pub for a rest. They all seemed remarkably sprightly by the start of the meeting the next day.

The first session began with Richard Gibbs, local intensivist, updating us on the perils of acute perioperative kidney injury. Up to 40% of surgical patients are affected, it costs the NHS up to a billion pounds per year, it increases the risk of death, morbidity and chronic renal disease, but urine output and creatinine are poor markers for early detection. His suggestions for prevention include identifying high risk patients and instituting a perioperative care bundle, liberal fluids are probably best, although hypo and hypervolaemia are both bad, balanced crystalloids are better than saline, and keep MAP above 65.

Mike Walburn, consultant anaesthetist in Taunton, then shared his top tips for success in QI. He described QI as the triple aim of better care, improved health and reduced cost. Success is based around 7 steps: Problem (what do we want to solve), Aim (what will a great outcome look like), Measurement (how will we know if change is an improvement), Driver diagram (what is the plan to achieve our aim), Improvement ideas ((which ideas will you test), Tests of change (test using PDSA), and Implement and Spread (spread what works, and discard what doesn't). Simple!

After coffee, Nick Kennedy, Commissioning Board member for Bristol and Devon, brought us up to date with commissioning and what it might mean for anaesthetists. Once again we heard about the Triple Aim. He ran through the roles of STPs, Integrated Care and Strategic Commissioning. His opinion was that we would still have work, but we will also be affected as we depend on surgical services. However, anaesthetics and ITU are not currently on the radar. Nick suggested that changes in commissioning might present opportunities for anaesthetists interested in POAC, pain management,

frailty, shared decision making and appropriateness of surgery.

The final session of the morning was Richard Reed, who works in military and civilian prehospital medicine. He compared and contrasted between civilian and military prehospital medicine, in terms of patients (old, frail, comorbidities, single organ damage, head injuries vs. young, fit), trauma (RTA, high energy blunt trauma vs. blast injury – significant coagulopathy, brain injury, life threatening haemorrhage, traumatic amputations), treatment platforms (ambulance, vs. very variable transport, which may not be primarily for medical transport, but very big). He reflected on communication, which tends to be good in civilian prehospital medicine, as it is relatively quiet, while in a helicopter the role of Time Out to summarise, prioritise and allocate tasks is vital. There is a common training path for civilian and military PHEM, with extra military training added afterwards, and there is increasing similarity between the two disciplines, with lessons in clinical leadership being learnt from military PHEM. Also, the military medical personnel have to treat dogs.

The afternoon session began with John Carlisle, consultant anaesthetist in Torbay, speaking about fraud. Fraud is relatively easy, as there is a problem in communication between journals. If a journal rejects a paper due to dodgy data, there is no way of preventing submission of the same paper elsewhere, unless the journal publishes and retracts the paper on the same day. Fraudulent data should be relatively easy to detect, as people are stupid, so the vigilant might be able to spot identical pictures which have been rotated and copied, identical graphs, wrong p values, etc. I fear this is a task for people such as John. Of the 20 authors with the most retractions in biomedical sciences, numbers 19, 2 and 1 are anaesthetists – a sobering thought. However, John ended by saying that usually false research findings are usually due to bad science rather than fraud.

Dr Katherine Grant, a former ST7 in anaesthetics who now works as a solicitor, followed John. She was speaking on whistle blowing. While we clearly all have a duty to report behaviours and practices that risk patient safety, there are complex reasons why we don't. Her tips on how to raise a concern about a colleague, were to follow the correct procedure where you work, be specific with your examples of concerns, keep records of conversations and emails, and if appropriate raise concerns as a group.

The final speaker before tea was Anna Baverstock, a community paediatrician, speaking on compassion fatigue and burnout. There is no clear definition of burnout, and no absolute cut-offs for defining who has burnout or is at risk. However, it is estimated in Taunton that 21% of consultants are at high risk and 37% at moderate risk. Her suggestions to reduce risk were to think HALT – take a break when you are Hungry, Angry, Late or Tired. Also

remember to focus on the positive and excellent things at work, as well as the negatives (M&M, for example).

James Coulson, a surgeon in Taunton, began the final session of the day, with a talk on human factors in decision-making. His main focus was on cognitive bias, and how we are all prone to it (to the advantage of supermarkets). We are guilty of overconfidence, believing we know more than we do, confirmation bias and anchoring – over reliance on the first piece of information.

Stuart Walker followed, speaking on learning from a cluster of never events. On average a trust has 1-2 never events per year. Systems are needed to prevent never events, and trusts need to engage and empower local staff. People aren't rational, and we all over estimate negative risk and under estimate positive risk. He pointed us towards the NHSI Just Culture Guide, enabling a blame free approach to investigating a never event.

The final speaker of the day was Richard Telford, consultant anaesthetist in Exeter, with an update in vascular anaesthesia. He focused mainly on the recent GIRFT for vascular surgery. Using the hub and spoke model, fewer centres are doing low numbers of AAA repairs, and high volume centres are getting the best results. For carotid surgery, the recommendation is to reduce the time to operate from 14 to 7 days, 2/3 of cases in the UK are done under GA, measures to manipulate blood pressure are common under GA, and LA might be better if both carotids are occluded. Outcomes are improving. AAA screening has led to a reduction in mortality, if the AAA is repaired electively at 5.5cm. Approximately 70% of patients are suitable for an EVAR, but they need to be kept under surveillance forever, due to the risk of leak or rupture around the graft. Therefore an open repair is preferable if the patient is fit enough.

The society dinner was held at Hestercombe House, on a beautiful evening, which emphasised the fabulous views. After a drinks reception on the terrace, food was followed by ceilidh dancing. John Lee wore his Evelyn Baker medal, but couldn't be persuaded to dance, and even snuck off early. That's what happens when you retire. Luckily a good group danced vigorously, despite not really knowing what we were doing, and risking dizziness and falling over. It took 2 weeks before I could breath deeply and move my arms normally after one particular dance that tested my (inadequate) pecs.

Thursday dawned with rain, but at least this encouraged people to look at the excellent display of trainee posters, and the trade stands belonging to our generous sponsors. The first session was by Simon Marshall, a Taunton consultant, speaking on laryngoscopy. He outlined the history of laryngoscopy from 400BC (when it was almost uniformly fatal) to the present (when it is not).He put the case for having a classification scheme for

laryngoscopes, and emphasised the importance of recording your view of the larynx, including the blade used and the context.

Mr Warwick Heale followed, with a discussion of the ethics and law around healthcare rationing for obese patients and smokers. A third of CCG have at least one mandatory threshold to care, based on smoking or BMI, which is arguably unlawful. However, the NHS must provide a comprehensive service, within the budget, while allowing all patients equal access to care. Against this, patients do not have a right to any treatment. The NHS constitution has a summary of the law around rationing.

Dr Ramani Moonsinghe presented the final session before coffee, on national perioperative research. She spoke about the importance of looking at large patient populations, and touched on the findings of NAP6, and SNAP2, and the on going NELA and PQIP audits. There is plenty of new stuff coming, including the global health research strategy to help low-income countries, CASAPP (NELA for children), and new registries and databases, e.g. FONA.

The pre-lunch session began with Geer Hubregste, consultant anaesthetist in Taunton, giving us his advice on efficient tax and pension planning. I admit that I come over a bit vague as soon as money is mentioned, but the worst income seems to be £100 to £150K as you effectively pay 60% tax on this income. Our defined benefit pension scheme is still good, even if not as good as it was in the past. You are at high risk of exceeding your Annual Allowance for your pension if you have 5 year increment in your salary, or you receive a CEA or national award.

Appropriately the next session before lunch was entitled, “are you really what you eat? Surviving your operation” by Dr Stuart Collins, recently retired consultant from Taunton. After giving up medicine, he took up endurance sport. While he was looking at ways of improving his performance, he began to wonder whether similar principles could be applied to medicine. We have enough fat to run 28 marathons, but enough glucagon for about 2 hours of exercise. Your anaerobic threshold and ability to withstand higher lactate levels improves with training. VO2 max is relatively fixed, and can only be improved with specific training. Not everybody can improve their VO2 max with training. Your VO2max reduces with age, but can be maintained by keeping fit. Foods that are likely to improve performance include celery and beetroot, both high in nitrate, and chicken, which is high in beta aniline and carnisine (I think). Perhaps perioperative nitrate supplements would improve perioperative recovery. There are a number of supplements that improve sporting performance, which might be of benefit perioperatively. Cheap orange juice is best, braeburns are the best apples, and broccoli is better preserved in plastic (but obviously has detrimental effects on the plastic problem).

The final session before lunch was

presented by Joe Silsby, consultant in Taunton, with a presentation of his trip to Nepal following the recent earthquakes. To illustrate the power of the earthquakes, Everest was shifted 1.18 inches south west, when it usually moves 1.5 inches northeast per year, and some parts of Kathmandu ended up 1m higher than previously. The trip clearly was rewarding and nerve-wracking. He recommends always checking the contents of the drawers of the airway trolley (as they may not contain any airway equipment). While there were many limitations whilst working in Nepal, the blood transfusion service was surprisingly excellent.

After lunch we held a debate between Mr Richard Welbourn, bariatric surgeon, and Dr Rhodri King, consultant diabetologist. They agreed on the burden obesity places on health care, with 27% of the UK population being currently obese, 1 in 5 11 year olds, and 600,000 patients admitted to secondary care. In favour of surgery, Mr Welbourn argued that as obese people lose weight their energy expenditure falls and thus weight loss plateaus. If your BMI is over 40, there is a 1:1000 chance of achieving a normal BMI within 9 years by dieting. Surgery on the other hand produces good weight reduction and improved glycaemic control, which is maintained, it improves QOL, it is safe, diabetes medication costs are reduced, the risk of death from diabetes complications is reduced within 3.5 years of surgery, and it is more cost effective than both smoking cessation programmes or prescribing statins for secondary prevention. Despite all this evidence for the marvels of surgery, Dr King pointed out that the controls for the evidence of the benefits of surgery often have variable or even no medical management of their weight. Also, the best medical management for diabetes is insulin, which causes weight gain. There are complications following surgery, including nutritional deficiencies, hypoglycaemia, abdominal pain, osteoporosis, operative risk and the poor cosmetic effects of loose skin. The GLP-1 agonists are able to achieve weight loss of 15% or more, and have a good improvement in glycaemic control, which is equal to surgery. And there are more and better drugs in the pipeline. At the final vote, the debate was declared a draw.

The trainee poster prize, generously sponsored by Aguettant, was won by Dr Vicky Ormerod from Exeter, with a poster entitled, “Improving management of intravenous lines after anaesthesia”. The runner up was Dr Hannah Crofton, with a poster entitled, “Introducing a new PVC recycling scheme into theatres and recovery”.

After the final tea break, Mr Jonathon Bradshaw gave us advice on walking to the South Pole. For 10 years he was a soft ware company owner, but he gave it all up to undertake extreme activities. After some warm up extreme activities he found himself agreeing to join a team which was planning to walk to the south pole. Physically it is equivalent to running 60 marathons, but the biggest challenge is mental, with days

of nothing to see. The journey took 58 days, with either blizzard conditions or clear skies and only snow in every direction, sleeping in a tiny tent with the same person every night. And the answer to how to navigate, when your compass is too close the south pole to work, is by using your leg length and knowing which direction you tend to veer to when walking – well done Fiona Martin. I think I won't be trying it any time soon.

That brought the meeting to a close. Many thanks to Helen Hopkins and Rachel Brown, and the rest of the organising team. Well done on an excellent scientific programme, an excellent venue, and a superb evening event.

I am now looking forward to the autumn scientific meeting in Bath. Next time I will try to remember to take some photos.

Improving Management of Intravenous Lines After Anaesthesia

Dr Victoria Ormerod- ACCS CT3 Royal Devon and Exeter Hospital

Introduction

The presence of residual drug in cannulae and line attachments is a known risk after anaesthesia. Recent national patient safety alerts have highlighted this as an area that requires increased awareness and clinical improvement, with 58 incidents being reported in the UK over a 3 year period. 1,2

This project aims to address this safety issue on a local level by establishing current practice of line management post anaesthesia. These results will then be used to identify methods of optimising patient safety and bringing current practice in line with AAGBI recommendations for verbal and written handover to recovery staff.3

Methods

In January 2018 all patients entering main theatre recovery over a 3 day period were included in the study. Standards were taken from AAGBI guidelines for line flushing, removal of y-connectors, and handover to recovery staff in both verbal and written form.

Recovery nurses were asked to record if a verbal handover of 'flushed lines' was given from the anesthetist without prompt. Additional data was collected regarding documentation of line flushing in the anaesthetic chart, presence of superfluous y-connectors, and any visual residual propofol in cannulae ports (taken as an indication of un-flushed lines).

The residual volume of cannulae and y-connectors was determined using a 1ml syringe. This was used to establish the potential residual drug in unflushed lines, providing clinical context (figure 1).

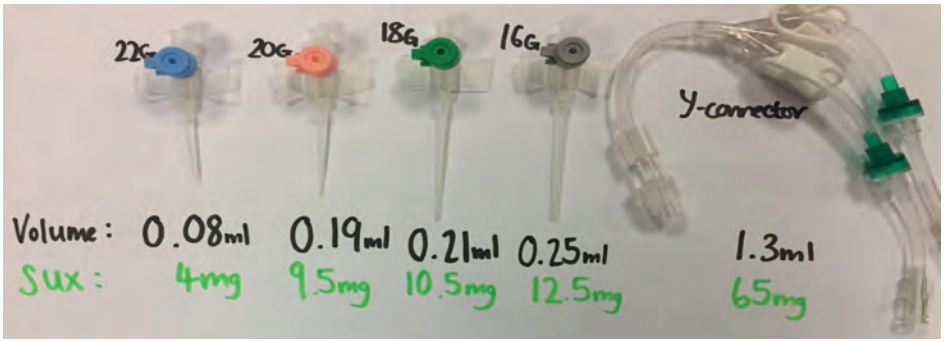


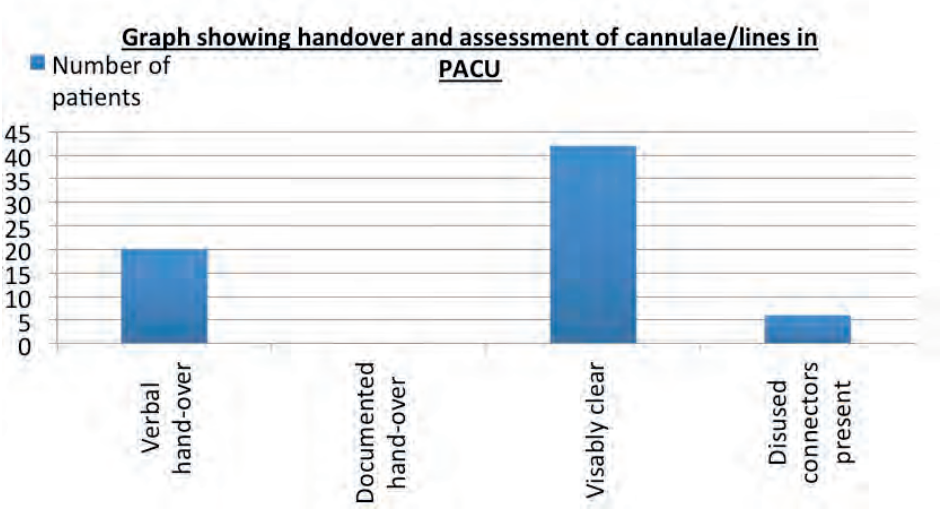
Figure 1: Residual volumes in lines/connections with corresponding suxamethonium dose.

Results

48 cases were included in the initial audit; 36 adults and 12 children. A verbal hand over of flushing was given in 42% of cases, but documented handover was not present for any patient.

88% (n=42) of cannulae were visually clear from propofol, with the rest having residual drug in the injection port, suggesting a lack of flushing since induction.

Six patients had y-connectors still attached from surgery, posing the additional risk of larger volumes of residual drug if unflushed.



Discussion

This initial study confirms the need for improved management of intravenous lines after anaesthesia. Nationally, there have been 18 cases of respiratory arrest over 3 years attributed to residual anaesthetic drug in lines2. It is therefore important that we are pro-active in our own institutions to reduce patient risk.

In the majority of cases, cannulae ports were visually clear from propofol. This was used as an indication of flushing, however it does not exclude the presence of other colourless agents (e.g. opiates), and may therefore be an overestimation of the level of flushed cannulae.

Testing the residual volumes (fig 1), demonstrated a significant proportion of drug could remain within single device. The corresponding doses of suxamethonium relate this clinically, with a y-connector and standard 20G cannulae having a combined dead space of 1.49mls, or 74.5mg suxamethonium, close to an adult intubating dose.

Handover to recovery staff was consistently poor, requiring a significant

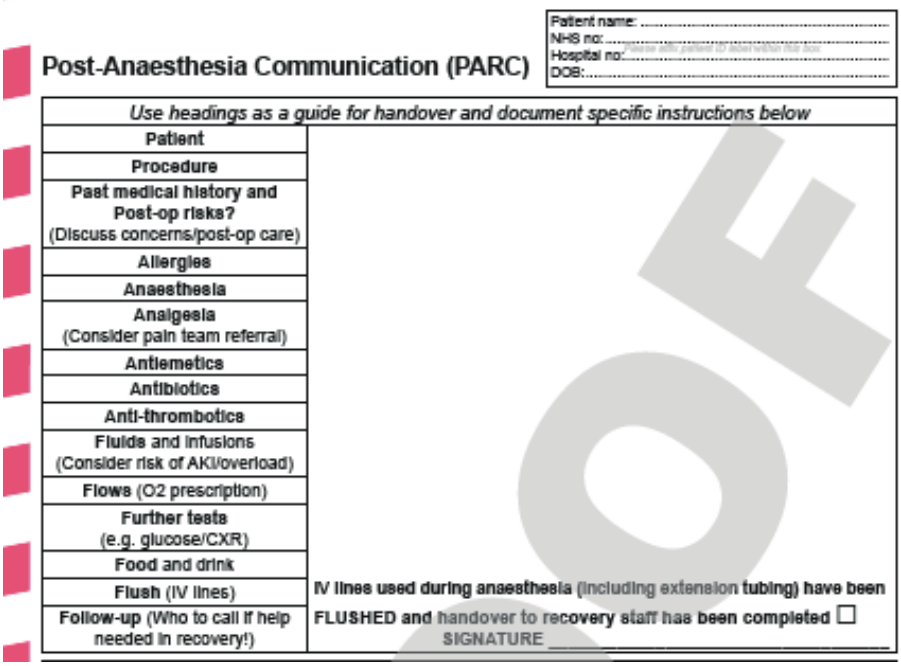
improvement to comply with national guidelines and safety standards. Standardising the handover process amongst clinicians may help to reduce overlooking this important area, and ensure awareness of its necessity.

Interventions

Based on these results, several interventions were implemented. These included educating the anaesthetic department on current practice, recent national critical incidents, and national guidelines, to start the drive for improvement.

As an aid to optimising recovery handover, line flushing and removal of superfluous connectors, a standardised handover checklist was created as part of a new anaesthetic chart. This aide-mémoire was added to prompt anesthetists and recovery staff to important tasks, with 'flushing' of particular note to this project. The AAGBI recommend a designated area for documenting line flushing and management. This has been achieved as part of the new chart, via a tick box, and signature area acknowledging that this action had been performed. This intervention aims to make the process an active part of clinical practice before the patient leaves the anaesthetic area (see figure 2).

At the time of writing, the updated anaesthetic chart has been approved by the local documents committee, and is awaiting a trial period to confirm its effectiveness.



Post-Anaesthesia Communication (PARC)

Patient name: .....
NHS no: .....
Hospital no: .....
DOB: .....

Use headings as a guide for handover and document specific instructions below	
Patient	
Procedure	
Past medical history and Post-op risks? (Discuss concerns/post-op care)	
Allergies	
Anaesthesia	
Analgesia (Consider pain team referral)	
Antiemetics	
Antibiotics	
Anti-thrombotics	
Fluids and infusions (Consider risk of AKI/overload)	
Flows (O2 prescription)	
Further tests (e.g. glucose/CXR)	
Food and drink	
Flush (IV lines)	**IV lines used during anaesthesia** (including extension **tubing) have been FLUSHED and handover to recovery staff has been completed** ☐
Follow-up (Who to call if help needed in recovery!)	**SIGNATURE** _____

Figure 2: Handover tool (back of updated RD&E anaesthetic chart)

Conclusion

Residual drug in intravenous lines and attachments can risk serious potential complications after anaesthesia. The introduction of a handover tool aims to reduce the risk to patient safety and standardise clinical practice. This low cost intervention is easily reproducible, and we suggest application on a wider scale.

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Come around to recycling: make a positive change

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Environmental sustainability is achieving increasing prominence within anaesthesia. Studies have looked at the impact of everything from drug trays (1) to LMAs, from breathing circuits (2) through to life cycle assessments (3). Evidence suggests that most anaesthetists support recycling in the operating theatre, and would like to see more of it. But how many of us work in a hospital with an established recycling scheme? In a survey of anaesthetists in England, New Zealand and Australia only 11% of respondents stated that waste recycling occurred in their operating theatres (4).

We know we should do more, and for good reason. The scale of the problem is terrifying. In 2009 the NHS was responsible for more than 18 million tonnes of CO2 each year. This was 25% of public sector emissions and 3.2% of emissions in England. (5) In 2008 the UK government introduced the Climate Change Act, which commits the UK to cutting carbon emissions by at least 80% by 2050, and 26% by 2020. As one of the largest employers in the world, the NHS has an unavoidable role to play in helping to achieve this target. In 2008, the Department of Health published a carbon reduction strategy with the widespread support of NHS organisations and staff. (5, 6) As a result of this strategy, in 2015 the NHS was ahead of target, with a reduction in carbon emissions of 11% from the 2007 baseline. This is all the more impressive considering that activity in the healthcare system has increased by 18% (7).

There is however a long way to go. A further reduction of 6.6 million tonnes of CO2 by 2020 is needed to reach the milestone set by the Climate Change Act. So, what can we do? There is no doubt that introducing any form of change into theatres, let alone a sustainability change, is hard. It takes effort and patience. But given a small amount of time, there are things we can do that benefit the environment, hospitals and our patients.

In this article, we share our experience of introducing a PVC recycling scheme into theatres. This message is of particular relevance to trainees, who in the past may have looked at such schemes as too big and overwhelming

to take on. Hopefully by the end of this article we will have changed your mind.

What is RecoMed?

Plastics are classified into five types; one of these is PVC (polyvinyl chloride). PVC is used to make 40% of medical devices a large proportion of which is found in anaesthetic facemasks, post-operative oxygen masks and fluid administration sets. All of these can be readily recycled. Established in 2014, RecoMed is a national collection scheme that provides an alternative, sustainable disposal route for waste medical items made from high-quality medical grade PVC.

RecoMed recycling bins are provided free of charge, along with educational posters, stickers, training sessions and communication materials. These special collection containers are sited next to non-infectious clinical waste bins, and staff are given clear instruction on what items can be accepted for recycling. Bags are collected by the RecoMed team and delivered to a specialist recycler. The recycler granulates the material, which is then treated at a temperature that denatures all biological residues. This granulated plastic is used in making 100% recycled products for the horticultural industry, such as tree ties. While it is not possible to use recycled content in new medical devices yet, the plastic can be given a second lease of life in in other types of products.

Introducing change in Swindon

The desire to introduce change came from two places. First, I (Philip) had recently worked at a hospital in Bath with a strong recycling culture. Having started a new placement, I took some of this enthusiasm for sustainability with me. Second, I had edited an *Anaesthesia News* article about a company that recycles used anaesthetic PVC facemasks [5]. This was the first time I had considered getting involved in any kind of sustainability project. PVC facemasks are such a commonly used item, it seemed that by recycling them, we could do some real good.

In August 2016, I contacted a PVC recycling company to enquire about the feasibility of recycling facemasks. This was confirmed in the September and I approached a supportive consultant (Hamish) with the idea. I then contacted the Trust Sustainability Lead, Head of Theatres and Head of Recovery and organised a meeting of the following staff members to discuss the project further:

- Recycling representative
- Anaesthetic consultant and myself
- Clinical Lead – theatres
- Clinical Lead – recovery
- Waste Co-ordinator
- Health and Safety Lead
- Clinical Governance Co-ordinator

Two months later we all met. I was pleasantly surprised by the amount of enthusiasm for the scheme. The meeting ended with an agreement to trial PVC recycling early in 2017. I wrote a standard operating procedure that described the aim, scope and procedure for PVC recycling in

theatres. Specific recycling bins to be used in recovery were chosen in conjunction with infection control.
We presented the scheme to the Anaesthetic Department at the local clinical governance meeting in January 2018. Once again, there was widespread support. It was undoubtedly helped by the fact that all anaesthetists needed to do was bring their anaesthetic facemask with the patient to recovery at the end of the case.

The recovery staff members were educated about what could be included in PVC recycling in March. Shortly after this, the project went live.

As of August 2017, the Great Western Hospital in Swindon had been recycling all PVC facemasks used in theatres and recovery for 6 months. By March 2018, we had recycled 222kg of PVC. Overall the scheme has been a great success, with great participation from all involved, and is still running today.

Get involved!
If you are a trainee, staff grade or consultant anaesthetist who wants to do the same thing, where do you start? The timeline described in Box 1 can be used as a blueprint for introducing the scheme elsewhere. Below is some advice on what to do and not do, based on our experiences in Swindon.

Box 1. Process for setting up a recycling scheme where you work

Step 1. Approach and secure the support of a senior member of your team

Step 2. Contact a recycling company to enquire about the feasibility of recycling items used in theatres

Step 3. Organise a meeting of key people (sustainability lead, head of theatres, head of recovery, clinical leads, health and safety lead, etc) to discuss your plans

Step 4. Write a standard operating procedure

Step 5. Select appropriate recycling bins and discuss their collection and transport with waste management

Step 6. Create educational materials about recycling (e.g. posters)

Step 6. Engage with and educate staff about the scheme

Step 7. Feedback the results of the scheme to keep people engaged

Below is some advice on what to do and not do, based on our experiences in Swindon.

No Man/Woman Is An Island.
You aren't going to be able do this on your own. For the scheme to take hold and continue when you move on, first and foremost you need the support of your anaesthetic department. The best way to achieve this is to find a supportive consultant with an interest in sustainability and ask for their help.

Keep Your Friends Close…
The trust sustainability lead is your new best friend and a natural ally. They are a great starting point when trying to establish exactly whom you need to contact to get the project started. Get

in touch with them early, listen to their advice and sit next to them in any and all meetings.

Patience Is A Virtue.
This is not a project you are going to complete in a month. It will involve a lot of different people that work in different areas of the hospital. There are obvious individuals such as anaesthetists, ODPs and recovery nurses that will need to be informed, but also people you are unlikely to have met before. This includes theatre management, waste management, porters, infection control and sustainability leads. They all need to be involved and on your side for the project to work. My advice is to contact the relevant people and arrange a meeting. This will allow everyone to discuss the project and how best to start implementing it.

Show Them the Money!
Or more importantly the savings. There is evidence that improved sustainability correlates with cost savings in health care (8). The RecoMed PVC recycling scheme is no different. PVC facemasks are normally disposed of in clinical waste bags that either go to deep landfill or are incinerated. This is expensive. RecoMed provide a PVC recycling scheme that removes this expenditure, with no cost to the trust. Admittedly the savings will be modest, but how many oxygen masks does a hospital use in a year? The savings can start small, but grow over time. This is a logic that is hard to argue against.

Education Station.
Even the most beautifully organised recycling scheme will be a waste of time if nobody knows what they can and cannot recycle. Anaesthetists, ODPs and recovery staff all need to know what goes in the bins and where they are. In addition to presenting the scheme at clinical governance days, we utilised signs in theatres and recovery reminding everyone to use the PVC recycling bins.

So was it worth it? Whilst at times it was a frustrating process, we have learnt an incredible amount. We met people working in roles that we didn't even know existed. It was a great management experience, and gave us a much better insight into the complex workings of a hospital. Overall we were amazed and encouraged by the general level of enthusiasm for the project, and how quickly and easily it was introduced.

Anaesthesia prides itself on being at the forefront of patient safety. Given the devastating effects of climate change, perhaps it is time that we broaden our concept of what that means. We can no longer ignore the impact that our actions and healthcare as a whole has on the environment, and people's health as a consequence. Change is needed, even if it is difficult. We must be realistic: this change will not happen all at once but will be a series of small steps in the right direction. As anaesthetists, we have a responsibility, and are in an ideal position to drive this change. Could PVC recycling be the first step that ushers in a more sustainable mindset in your anaesthetic department?

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Reversal Options for Anticoagulants

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Given the vast array of anticoagulant options in use in modern day practice it is important to have a grasp on effective reversal strategies for patients with uncontrolled bleeding or for those requiring emergency procedures. In particular there has been a lot of work in developing specific agents to reverse the effects of direct oral anticoagulants, the use of which has grown rapidly in the last few years. With the advent of idarucizumab, andexanet alfa and ciparantag, managing major haemorrhage in patients on DOACs may become much less of a headache in the future. In this section we hope to present strategies for reversing different anticoagulant agents and discuss some of the evidence surrounding the newer treatment options. As management of bleeding with traditional anticoagulants is well established in most NHS trusts we will aim to focus more on reversal of the direct thrombin and factor Xa inhibitors.

Principles of managing bleeding (Adapted from British Society of Haematology Guidelines)

Non pharmacological management of bleeding can be simple and may avoid the use of haemostatic agents. Following initial recognition and activation of major haemorrhage protocols where appropriate, the patient should be resuscitated according to ABCDE principles. Assessment and control of the bleeding site using manual, endoscopic, radiological and surgical techniques can be considered. Clearly cessation of the anticoagulant in question is important, as is an estimation of it's half life and likely clearance from the circulation. In some cases plasmapheresis or haemofiltration may be an option to increase clearance of less protein bound drugs [4].

As specific reversal methods are not always available in emergency situations, general haemostatic agents may be useful. Tranexamic acid has proved efficacious in bleeding associated with trauma but is also recommended for non traumatic major haemorrhage[5]. Other agents available include fresh frozen plasma (FFP), prothrombin complex concentrate (PCC), activated prothrombin complex concentrate (aPCC) and recombinant activated factor VIIa (rFVIIa) amongst others. With the exception of FFP and PCC in the treatment of vitamin K antagonist (VKA) associated bleeding, there is limited evidence for use of other therapies although rFVIIa is often considered an intervention of last resort[6]. Treatment should be guided by local protocols, the clinical picture, blood results and haematologist advice. We will go on to discuss reversal strategies for specific anticoagulants below.

Unfractionated Heparin

Unfractionated heparin (UFH) is easily reversed using protamine, an effect monitored using aPTT [7].

The recommended dose of which is usually quoted as 1mg per 100 units of heparin[8]. However, given the pharmacokinetics of heparin and it's rapid elimination, protamine only usually has to be given heparin administered in the preceding few hours. Protamine itself doesn't come without risks, and is known to cause anaphylactic reactions and must be administered slowly to avoid bradycardia and hypotension[9].

Low Molecular Weight Heparins

Unfortunately protamine has a more limited effect on low molecular weight heparins (LMWH)[10] but is still demonstrated to reverse approximately 60% of the anticoagulation effect seen in animal studies. The British Society of Haematologists recommends administration of protamine at the usual dose if LMWH given within 8 hours of the time at which reversal is required [4]. There is also some limited evidence for use of prothrombin complex concentrates, activated PCC and recombinant activated factor VIIa if there is ongoing bleeding despite protamine and which is within the time frame for an LMWH to still be exerting an effect.

Vitamin K Antagonists

Haemorrhage in patients treated with vitamin K antagonists (VKA), most commonly warfarin, is a relatively common occurrence and effective treatment strategies usually incorporate a tiered approach depending on severity of bleeding, urgency of indicated procedure and INR level. Guidelines recommend initially withholding the VKA and then replacing vitamin K either orally or intravenously (replacement ratio 5:1)[4]. Given that the coagulopathy associated with VKAs is related to factor depletion (II, VII, IX & X), the mainstay of urgent treatment involves the replacement of those factors. Fresh frozen plasma (FFP) is given commonly but cannot compete with four-factor PCC in this context. Relatively large volumes of FFP are required, it has been associated with transmission of infection, there is a risk of transfusion related acute lung injury and it requires cross-matching [8].

Prothrombin complex concentrates (e.g. Beriplex, Octaplex) consist of factor IX with a variable amount of II, VII and X. Usual administration doses alongside vitamin K for major haemorrhage secondary to VKAs are between 25-50 units/kg (see BNF). These products don't need to be cross matched, aren't associated with an infection risk and can effectively reverse VKA anticoagulation within 30 minutes [11].

Direct Thrombin Inhibitors

Of the direct thrombin inhibitors (DTIs) available Dabigatran, given orally, is by far the most commonly encountered in day to day practice. The parenteral agents (e.g. Bivalirudin, argatroban) generally have short half lives and cessation of the anticoagulant should be sufficient in most cases of bleeding.

In general, haemorrhage associated with Dabigatran should be managed according to the principles discussed above. As with all of the direct oral anticoagulants, as long as renal function is preserved, plasma half life is relatively short and cessation of the

offending medication may be enough. There is evidence that activated charcoal can be administered if within two hours of a dose[12]. As Dabigatran is not highly protein bound, haemodialysis can aid clearance of the drug if facilities are available [13]. Other general measures include administration of PCC at similar doses given in reversal of VKA.

Dabigatran is the only direct oral anticoagulant with a specific reversal agent licensed for use. Idarucizumab (Praxbind) is a monoclonal antibody fragment that binds dabigatran with high affinity and neutralises it's activity within minutes [14]. In the largest clinical trial so far, idarucizumab effectively reversed the anticoagulant effects of dabigatran in patients with serious bleeding and those requiring an emergency procedure without any increase in thrombotic events [14]. There is evidence of a rebound anticoagulant effect if too low a dose of idarucizumab is given; the recommended dose is 5g [15], and there are a few case studies suggesting incomplete dabigatran reversal despite full dose idarucizumab16.

Direct Factor Xa Inhibitors

Apixaban, Rivaroxaban and Edoxaban are all orally administered inhibitors of factor Xa. Following initial basic management, activated charcoal is again recommended to reduce uptake of any doses within the previous six hours (apixaban), or eight hours (rivaroxaban)[17]. As these agents are highly protein bound, it is unlikely that they would be dialysable.

The mainstay of management included in local guidelines after initial measures consists of administration of prothrombin complex concentrates although evidence for this is limited8. Animal and limited human studies have shown improvement in coagulation parameters following administration of PCC, aPCC and rFVIIa[18] but there have not been any large clinical trials in humans and use of PCC in this context remains unlicensed.

Andexanet alfa is a decoy factor Xa molecule which is reported to bind with high affinity to both oral and intravenous factor Xa inhibitors (e.g Fondaparinux) neutralising them. In the ANNEXA-A and ANNEXA-R trials, administration of the andexanet alfa to healthy volunteers successfully reduced both rivaroxaban and apixaban anticoagulant activity within minutes without any increase in thrombotic events[19]. It is currently undergoing further clinical trials, but initial results from the phase III trial in patients with major bleeding on rivaroxaban/ apixaban seem promising [18].

Finally, ciraparantag is another molecule in development which seems to bind heparin, LMWH, direct thrombin inhibitors and factor Xa inhibitors non-covalently thereby neutralising their anticoagulant effects[8]. It has been proved safe in small groups of healthy human volunteers[20], and has been fast-tracked by the FDA although still awaits larger clinical trials.

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An unusual cause of acute increase in oxygen requirements - A massive organoaxial gastric volvulus

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Introduction

Gastric volvulus is an abnormal rotation of the stomach over 180 degrees and has a mortality of up to 50%[1]. It can result in ischaemic necrosis, perforation and severe cardiorespiratory compromise. Presenting symptoms can be vague making it a difficult diagnosis to make. The hallmark features of chest/epigastric pain, retching without vomiting and an inability to pass a nasogastric tube are known together as Borchadt's triad. It is rare but can be diagnostic when all these features are present[1,2]. If left untreated gastric ischaemia may progress to necrosis and perforation leading to overwhelming sepsis and haemodynamic compromise which is often fatal.

Case presentation

A 79–year-old male with a history of Ischaemic heart disease and previous coronary artery bypass graft presented to the emergency department with epigastric pain after vomiting large volumes of brown liquid. Within the preceding five weeks he had been investigated for an upper gastrointestinal bleed and his upper gastrointestinal endoscopy had shown a sliding hiatus hernia and paraoesophageal hernia with no gastritis or ulceration. 12 hours after admission he developed progressive and severe respiratory failure with a rapid increase in oxygen requirement. He was referred to the Intensive Therapy Unit (ITU) team with suspected pulmonary aspiration. On assessment he was alert and orientated, in respiratory distress with a respiratory rate of 18 breaths per minute. He was peripherally shutdown with a blood pressure of 190/81 mmHg and pulse rate of 117 beats/minute. Respiratory examination demonstrated reduced air entry to the left lung base with a dull percussion note and reduced vocal fremitus. Chest radiograph showed an air- fluid level behind the heart (Figure 1). Arterial blood gas analysis on 15litres of oxygen delivered via a reservoir bag mask showed a pH of 7.53, pO2 9.2kpa, pCO2 5.83kpa, HCO3- 30.5mmol/L and a lactate of 3.1mmol/L. Over the next 40 minutes the patient became increasingly tachycardic and tachypnoeic.

Title: Figure 1. Chest radiograph

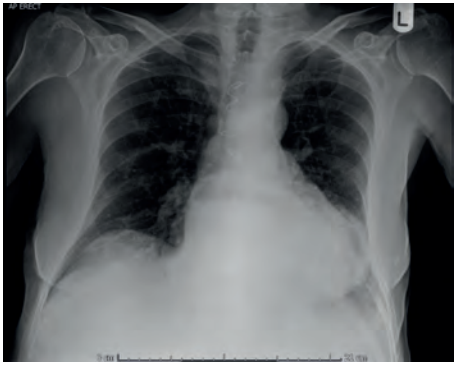

Figure 1- Chest radiograph with fluid level posterior to the heart

The patient underwent an urgent computed tomography (CT) scan of the thorax and abdomen with intravenous contrast (Figure 2 & 3). This demonstrated a giant hiatus hernia with gastric organo-axial volvulus and potential gastric wall ischaemia. The oesophagus was dilated and fluid filled. Immediately after the CT scan, a large calibre nasogastric tube was inserted, draining over 2 litres of gastric contents. The patient's physiology and oxygen requirements improved rapidly. He was taken to the High Dependency Unit (Level 1) to be observed overnight and was discharged to a level 0 ward within 48 hours to await surgery. Surgery was performed via a laparoscopic approach. The gastric volvulus and hiatal hernia were fully reduced. The peritoneal hernia sac was reduced completely and excised. The oesophagus was mobilised to deliver a 3cm tension-free length of intra-abdominal oesophagus. The short gastric vessels were divided. Anterior and posterior vagus nerves were identified and preserved. The crural defect was repaired using interrupted 0 Ethibond sutures. A 360 degree Nissen fundoplication was performed. The patient made an uneventful recovery and was discharged home on postoperative day 5. At follow up 4 weeks later he was eating a normal diet without dysphagia and had returned to full activities.

Figure 2. Coronal CT scan of thorax and abdomen

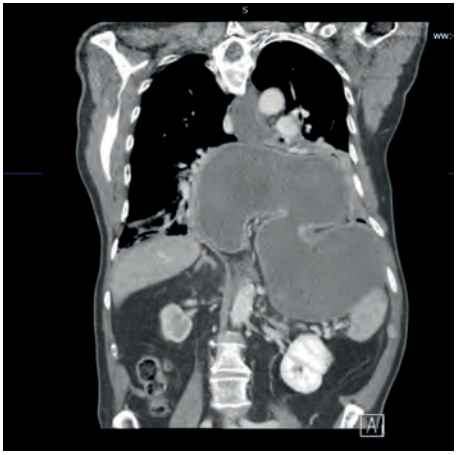

Figure 2 - Coronal CT scan of the thorax/abdomen showing massive organo-axial gastric volvulus and fluid in oesophagus with fluid adjacent to the gastric wall.

Figure 3. Transvers CT scan of thorax and abdomen

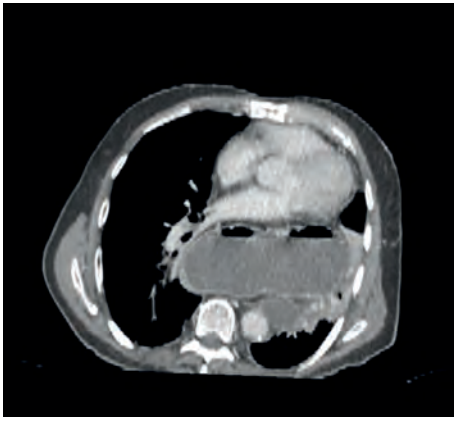

Figure 3 – Transverse CT scan of the thorax- , demonstrating a giant hiatus hernia and organoaxial gastric volvulus.

Discussion

Gastric volvulus is a rare but life-threatening condition which can often be difficult to diagnose due to its vague symptoms [1,2]. It can be classified according to the axis of rotation. Rotation around the longitudinal axis (traversing gastro-oesophageal junction and pylorus) is termed organoaxial volvulus. Rotation perpendicular to this around the horizontal axis is termed mesenteroaxial volvulus. Organoaxial volvulus is the most common subtype occurring in 60% of cases [1,2],is associated with para-oesophageal hernias3 and has a peak incidence in the fifth decade of life4. The risk of vascular compromise and necrosis of the stomach resulting in mortality is high [5], thought to be 30-50% [1]. This case highlights both the importance of early consideration of this rare diagnosis at presentation and immediate attempt at decompressing the stomach by insertion of a nasogastric tube. A thorough history and spotting subtle signs such as a fluid level behind the heart on the chest radiograph and understanding the arterial blood gas findings (alkalosis due to vomiting despite a raised lactate from gastric ischemia) are important. This case also demonstrates that being able to pass a nasogastric tube and therefore a presentation not fulfilling Borchadt's triad should not rule out the diagnosis of gastric volvulus. It is thought that only 70% of cases have all three elements of the triad [1]. Nasogastric tube decompression should always be attempted, however, if unsuccessful, emergency endoscopic or operative decompression will be required. Definitive management in the form of surgical reduction of the volvulus and repair of the hernia are required in patients fit for surgery.

Conclusion

The mortality of gastric volvulus is high [1]. Cases require prompt recognition with supportive management in an appropriate setting such as a High Dependency Unit to await surgical intervention. Prompt diagnosis is dependent on a thorough history, examination and timely radiological investigation. Plain radiographs may be useful and CT scanning is diagnostic. Simple supportive management in the correct setting can ensure a good outcome even in those presenting with severe acid-base and electrolyte imbalance or cardiorespiratory compr

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SWARM update

Dr Debbie Webster
SWARM Chair

Its been another successful and busy year. Well done and thank you to all the hard-working bees who've kept up the momentum and to outgoing chair Johannes Retief for steering the swarm. We are excited to welcome two new consultant directors to the hive; Charly Gibson and Tom Clark. Both made significant contributions to SWARM as trainees and it is great to have their input and enthusiasm.

Andrew Woodgate is SWARM fellow this year and is on the cusp of launching COMPASS (Cognitive Monitoring in Planned Arthroplasty Surgery Study) at Torbay and Derriford. This feasibility study aims to use an online tool to map cognitive function in patients undergoing arthroplasty surgery and in matched controls.

Anna Ratcliffe won the Regional Training Symposium Hive of Ideas in 2017 with hers plans for AFAR (Accelerometers for Assessing Recovery). She has subsequently secured an Academic Clinical Fellowship, ethical approval, NIAA funding and CRN portfolio status. No mean feat! Recruitment will start at Derriford and Truro in the next couple of months.

DALES (Drug Allergy Label in the Elective Surgical population), a RAFT study (Research and Audit Federation of Trainees), completed recruitment earlier this year (results eagerly awaited). PAPAYA, a PATRN (Paediatric Anaesthesia Trainee Research Network) study looked into rates of unplanned paediatric day case admission.

SWARM are a named collaborator on the SNAP-2 EpiCCS study published in the BJA in September. This paper caused quite a stir in national headlines citing high rates of cancelled operations, a concerning lack of operating capacity and inadequate numbers of postoperative surgical and intensive care beds.

SWARM continue to collaborate with STAR. The bi-regional ATOMIC (Assessment of Tracheostomy Insertion and Care) study showed relatively high rates of tracheostomy complication and variable practice across the South West. Consequently, ATOMIC 2 has been adopted as a RAFT project and should be running next year.

2018 Hive of Ideas project will assess the incidence of perceived inappropriate intensive care provision. Increasing evidence links this to workplace stress and burnout so we would like to see how significant a problem inappropriate care is within our intensive care units. We hope to collaborate with STAR to collect data across both Peninsula and Severn.

As you can see, SWARM is busy, but more project ideas are very welcome. If you have ideas or want to get involved with any of the projects due to start recruitment, please contact your site lead (Torbay – Will Hare, Truro – Dave Kotwinsky, Barnstaple – Aislinn Brown, Exeter – Tom Woodward, Taunton – Owen Thomas, Derriford – Jo Burrows (or me!)).

Date for your diaries – the SWARM Research Training Symposium will be held on 18th March 2019 at Buckfast Abbey. Get your study leave requests in! Keep SWARMing.

STAR Update

Dr Katie Samuel – STAR executive chair

2018 has been an exciting year for STAR, with some great studies completed, and more planned on the way.

Our inaugural STAR study day was held at Southmead Hospital in July - a brilliant day with excellent feedback from those attending. We welcomed both Regional and National speakers to come together to talk all things research related. Both Dr Arun Sahni and Dr Sam Clark came from London to give excellent talks on PQIP (Perioperative Quality Improvement programme) and RAFT respectively, whilst Jerry Nolan spoke about his newly published PARAMEDIC2 trial. Following the success of the day, we are planning to host a larger STAR day in 2019 which will be open to all doctors in the region to attend – date to be released soon so keep an eye out! It will cater to those with a general interest in research (or looking to get research modules signed off), people looking to get involved with research locally or nationally, and trainees considering academic careers.

The DALES (Drug Allergy Labels in the Elective Surgical population) study has been our major focus for the year, and has been a great success. As the RAFT national project for 2018, it has surpassed all expectations in recruiting over 21,000 patients and 5,000 anaesthetists, making it the largest consenting study conducted in the UK. In Severn, the project was led by Jon Bower, and involved all seven trusts with close to 50 trainees being involved during the study period starting in May 2018. We are now conducting some local work into trainee experience of research following DALES – results to be published shortly.

ATOMIC-2 (Assessment of TracheostOMy Insertion and Care) continues in its planning and development as the next RAFT national project. This project builds on an initial regional audit of tracheotomy insertion and care which found variable practice and complication rates across the region. ATOMIC2 will comprise both research and audit elements and aims to build on these findings to describe the national picture. STAR ICM lead Aggie Skorko continues to lead and develop this study, along with the rest of the steering committee including Bob Goss from SWARM.

Our new STAR research fellow, Sethina Watson, has made an excellent start to the year. Based at NBT, Sethina has not wasted time getting stuck into projects. Her main focus will be working on the Delphi process for the GALORE trial - General, Local, and Regional Anaesthesia in Emergency Surgery (GALORE); A project to develop mode of anaesthesia as an intervention in emergency surgery and inform future trials. She is also continuing the work of our previous fellow with the FLO-

ELA trial as a co-investigator at NBT, as well working on a QI project relating to the 'theatrecapchallenge'.

Our new STAR website (www.anaesthesiaresearch.org) is completed, and our transition over to a website based membership database is well underway. Our new secure 'members' area' for trainees continues to develop, with local STAR leads gaining the ability to add details of local research and QI projects – a great resource for and trainees starting at a new Trust and looking for projects to get involved with.

We have an active following on Twitter (@STAResearch and @STAR_Research) with over a thousand followers! Follow us for research and QI updates as well as the odd comedic tweet. If you would like to join STAR and be involved in great research projects (medical students and foundation doctors also now eligible) just sign up for free via our website.

Have an idea to pitch? Want to get more involved with STAR? Drop us an email at stargroupresearch@gmail.com.

The Wine Column

Tom Perris

The Science Bit

So, apparently my 28 publications (so far) in this august journal don't count towards a clinical excellence award. They're not scientific enough according to the powers that adjudicate. At least they're not fiction though, I courteously pointed out unlike most of the applications I've read. Still no use.

Short of becoming lead clinician for Costa and sitting on my arse (you know who you are!) I am therefore forced into a deliberate attempt to combine science and wine. You leave me no choice……

The combination of yeast and sugar solution will result in the production, via fermentation, of alcohol with a by product of carbon dioxide which normally escapes from the fermentation vessel by evaporation and diffusion. Grapes contain sugar and the skins are covered in natural yeasts. Crush those grapes and wait a bit, you'll get wine. Take your vineyard far enough north in Europe and pick slow ripening varieties and the chances are that winter will intervene before your fermentation has finished leaving residual sugar in the wine. You can drink it a bit sweet if that pleases you or, like they do in champagne (Europe's most northerly fine wine area), bottle it and wait for spring when rising temperatures restart the fermentation but this time enclosed by a cork.

Obviously central heating and global warming interfere with this retardation-by-cold so it's artificially simulated nowadays. But the principal persists. A bit of extra sugar and a secondary fermentation in bottle produces significant amounts of CO2 which due to it's relatively high solubility coefficient (0.231mmol/lite/KPa at 37 celsius) , twenty times that of oxygen, dissolves to saturation point in the liquid wine. It forms an equilibrium with the air above with the pressure rising as more CO2 forms to approximately 6 atmospheres. Sufficiently high pressure to require the classic wire cork closure and to give the deeply satisfying pop upon release. If you can restrain yourself before pouring, you may notice gentle curls of cloud forming at the mouth of the bottle. Rapidly lowering the pressure and allowing evaporation of large amounts of CO2 lowers the temperature and causes precipitation of the water vapour also present above the liquid forming a delicate cloud.

The connoisseurs will tell you that the quality of the champagne can be judged upon the size and quantity of the bubbles which form in the glass. however there is a great deal of science present in the analysis of this foam. The opening of a bottle results in the dis-equilibrium of the solution allowing gas to leave the

liquid in large quantities. The molecules, chiefly of carbon dioxide, form small bubbles which enlarge due to the supersaturated gas leaving solution and diffusing down its concentration gradient into the bubbles. These bubbles cling to the sides of the glass on imperfections on the surface or, more often, fragments of dust and other debris present in the glass. When the archimedian thrust of the bubble surpasses the adhesive surface energy of the glass, the bubble detaches and rises to the surface. If the surface energy of the glass is high, the sides will be well wetted by the wine such as happens when the glass is very clean and of quality crystal. In these conditions, the bubbles detach quickly and thus are small. A dirty glass or, God forbid, a plastic one and the bubbles stick longer, become larger and the delicate mousse is lost. So, it's not snobbish, it's science! Interestingly, if you use a completely clean glass in a clean room devoid of all air particles and organic matter, no bubbles form at all. (Lehudé and colleagues, University of St-Gobain)

When you pop your cork and start to pour, using of course a crystal flute, the champagne foams and then subsides. But what influences the rate of subsidence or indeed the quality of the foam? Surfactant is what. Proteins and amino acids present in wine have hydrophobic and hydrophilic portions which align and coat the bubbles stabilising them and allowing the foam to persist longer in the glass. Filtration of your wine sometimes is performed by wine makers to remove precipitated acid salts and yeast fragments improving the clarity. However, it must be done with care. Even a ten percent reduction in total protein content will reduce the persistence of the foam by fifty percent. Wine normally has around 10mg/litre of protein. It is the larger colloidal macro-molecules at around 10000 molecular weight that supply the majority of bubble-stabilising capacity. Selecting a larger filter pore preserves foam quite effectively. (A. Maureen et al. University of Reims 1990). Beer has much more protein in it and can be filtered with impunity and retain it's fizz.

Should you not consume your bottle of champagne in its entirety at one sitting but prefer to revisit it the next day, firstly, what's wrong with you?
Secondly, should you believe the, oft quoted, theory that a silver teaspoon inserted in the neck of the bottle will conserve the fizziness?

In short, no you should not. A cork is effective as measured by Valade and colleagues (Vignerons Champegnois, 1992) as is a crown-closure cap (like on a beer bottle) but a spoon is equally ineffective as leaving the bottle entirely open. Incidentally, silver teaspoons are no better than steel ones. Can't say the French aren't thorough!

Conclusions: there is a lot of science in wine. The French are obsessed and have too much time on their hands and I deserve more pay.

Enjoy!

Notice to Contributors

All articles should be sent by email to the editor (see below for address). Scientific articles should be prepared in accordance with uniform requirements for manuscripts submitted to biomedical journals (British Medical Journal 1994; 308: 39-42) i.e. as used by Anaesthesia. Please ensure that references are complete and correctly punctuated in the required style. The approved abbreviations will be used for journal titles. Photographs should be sent as separate attachments. All articles should be sent as Word documents, and especially not PDFs, pages documents etc. Please send photos separately and label appropriately. The deadline for submissions is usually 10 weeks before the next meeting of the society.

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