

ANAESTHESIA POINTS WEST



SPRING 2018
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**THE SOCIETY OF ANAESTHETISTS OF
THE SOUTH WESTERN REGION**

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Editorial

It seems that our little corner of England is sticking to stereotype in this edition. An obsession with the weather predominates the News of the West, no doubt leaving our colleagues from the continent bemused by how a brief snowfall can bring an entire region to its knees. Given that for many in the region, elective work still seems to be a rarity as far into the year as April, it may be that the extension of 'winter' may be bureaucratic as well as meteorological.

Whilst the anaesthetic archetype of describing cycling injuries continues (if we could time all of these for the winter, it would probably help departmental work planning), we seem to have been spared the more graphic pictures of the last edition. Given that many of you may have cycled to the meeting at which you are currently reading this journal, can I please ask as many of you as possible to take some snaps of your more photogenic scrapes and scratches? It makes those of us who have not succumbed to the lure of lycra feel a little better in ourselves....

We seem to have a number of high profile retirements announced this edition, but it seems fitting that I should use this editorial to pay tribute to one particular retiree. Prof Rob Sneyd steps down as dean of the Plymouth Medical School in July of this year. The establishment of a medical school on the peninsula is down, in no small part, to Rob's tenacity and hard work. He leaves following the announcement

of a huge increase in student numbers for both Plymouth and Exeter and his legacy will continue in the hundreds of locally trained medical students who will be looking after us in our dotages. I'm sure that I speak for everyone when I wish him well and remind him that there will always be a spot for him at our society meetings.

Another retirement of note is that of Brian Perriss from his role as the creator of the APW crossword. I would like to take this opportunity to personally thank Brian for his many years of unstinting service to SASWR. His contributions have entertained many an anaesthetist during a long plastics case.

This edition also sees an impressive review of anticoagulants by 3 peninsula trainees. Part 1 is included in this journal, and hopefully will be of use to exam burdened trainees, as well as a useful reminder/update for the more senior members of the society.

The Autumn meeting seems to have been a roaring success. How can a scientific event involving fruit based organic chemistry and an esteemed officer of her majesty's royal navy engaged in crocodilian wrestling be described in other terms? It was particularly impressive that the winner of the intersurgical prize presented a piece that has the potential to relieve ICU bed pressures and allow much needed major elective surgery to proceed without intensive care

support. Victoria Ormerod's paper is well worth reading.

I would like to use this column to ask for submissions on all subjects from anaesthetists across the region. This journal can only be as good as the content that fills its pages. Case reports, local research or slices of life from the varied lives of SASWR members make APW what it is. All emails gratefully received.

To finish, it is exciting to be able to announce a new trainee bursary. In April, the SASWR honorary treasurer was approached by a member who wished to donate £1000 for the society to use to benefit the trainees of the region in whatever way the committee saw fit. This is a hugely generous personal contribution, and

the individual concerned has been profusely thanked.

As the Ross Davis Adventure Bursary came to an end recently it's very likely that the committee will elect to use this money to fund one or more travel bursaries for trainee members of SASWR seeking to go off and do something worthwhile in their spare time. The exact terms and conditions are yet to be worked out but we are delighted to be able to offer this kind of support and very grateful to our donor.

Watch this space – we are likely to launch the bursaries at the December meeting in Bath!

Ben Ivory - Editor



Future Meetings of the Society

Winter 2018
Bath 6th-7th
December 2018

Spring 2019
Barnstaple
Date TBC

News of the West

This is where you are kept up-to-date on all the news and gossip from each department in the South Western region. The name of the correspondent appears at the end of each contribution and he/she is also the SASWR LINKPERSON for that department. Anyone wishing to find out about more about SASWR, or wishing to join, should search out the local link person, who will readily supply details and an application form. In addition to other benefits, each member will receive the twice-yearly edition of APW- free!

Barnstaple

Here goes my attempt at this quarter's creative writing exercise. A round robin email elicited a somewhat predictable result. Simon provided me with a detailed document on the latest departmental head count and Nigel says we are great, please give us some registrars! Tony has yet to send me his latest installment of operation Smile including holiday snaps of charitable beauty queens. He tells me that they are running out of places to go to and the choice is not as good as it used to be (does he mean beauty queens?).

As early spring turned out to be just a bit too early for winters liking and we all got the late white Christmas the kids had been praying for, various members of team Anaesthesia checked into the local staff accommodation (still unchanged from 20 years ago). Charlotte Beresford truly excelled herself by staying for an entire weekend in the Pilton Hilton rather than brave the journey south to join her pining husband. With a bit of imagination you could kid yourself that you were staying in a cheap chalet in Borovits. I managed to get the old snowboard out and teach the kids how not to do it. Cecily was

spotted blowing up a mattress in the Anaesthetic department at 3 in the morning which is highly commendable, and Sasha used the 4X4 service to make it in for her weekend shift. This all while the rest of us stayed at home and built snowmen. Cecily encouraged us all to show our creative sides in a sharing exercise of "what I got up to with the snow when I couldn't make it to work in the morning". Gorki and Annalena Sacher recently arrived from Germany were wondering what all the fuss was about!



Congratulations to Pete Rogers who is engaged to Alice.

We have been twiddling our thumbs whilst the medics have been having their “worst days ever”. CQC have said we need to improve and we have just voted the Medical Director off the premises, so things are looking rosy.

Our very own rota team won a Staff Award. Rated “outstanding”, March 2018. Includes badge, signed letter from Chief Exec and a hamper! Cerys Redif in particular has performed spectacularly in her first ever NHS role.

Jeremy Preece has been appointed as substantive Consultant with interest in peri-operative medicine and regional anaesthesia. He joins us in May from his peri-operative medicine fellowship in Bristol. Rob Conway has been appointed as a substantive Consultant with an interest in paediatric anaesthesia and medical innovation. He joins us from the registrar rotation in the South East where he is also an NHS Clinical Entrepreneur.

Gehane Habib, Gorki Sacher, Christiana Schub, Mohamed Wanas and Adriana Ungureanu have recently joined us as Specialty Doctors. Current substantive staff are being supported by the Trust to progress to Associate Specialist status.

Mohamed is joining Dave Beard and myself on the cycle to Taunton for the SASWR Spring meeting. This is a brave move for a man who fell off (crashed) his newly acquired bike twice in the first week. On one occasion, seduced by the speed of the thing, he failed to anticipate a fast approaching

curb, and he hasn't even tried toe clips yet! On another occasion armed with a GPS he set off in the opposite direction for a lunch date at Felix's place, so by now he is probably fit enough to lead our motley peloton to Taunton! Did you know you can claim 10p per mile if you cycle to your CME.

Melanie Hawkins and Anne-Lena Sacher are performing fantastically as our first Anaesthetic Simulation Fellows and progressing well with their PostGraduate Certificates in Simulation and Patient Safety, making a huge contribution to multidisciplinary and multi-professional simulation training as well as introducing a highly innovative novice epidural training course. Mel has also arranged for the POEMS course to be run here at NDDH so please feel free to go on line and book a place, the date is the 22nd of June hurry or be sorry!

Guy Rousseau

Bath

As I write this I am conscious that I have yet to pack for a three day cycling trip to Mallorca, with my good friend and now Head of School Dr Tom Simpson, leaving tomorrow. I have learned from our last trip across the Pyrenees (it rained for four out of five days) and having checked the weather forecasts, I shall pack slightly more appropriate gear and hope that the forecasts are wrong. If, however, it does rain torrentially, I shall sit in a bar and toast Tom on his new appointment

and wish him well for the future. I shall also quietly ask him about the future of our specialty - it seems to me increasingly competitive for trainees and I'm grateful I came through at a time when a smile and willingness to step up and cover extra shifts was sufficient to ensure career progression. Now, even as a consultant it appears you have to upload the Trust's Core Values to your appraisal documentation to demonstrate your 'professionalism'. Surely you act in a professional manner, consistent with the high values expected by your trust, or you don't. Uploading a document listing those values doesn't make you a better doctor. No more than starting each day swearing allegiance to the minister of health does. I guess that will be next on the agenda though -bring on the new contract. Congratulations, Dr Simpson.

Despite it not being lambing season, there appears to have been a rush on labour ward. Congratulations go to Dr Charlie Pope and his wife on the safe arrival of their twins, Dr Ben Hearne and his wife on the birth of their new daughter, Dr Katie Howells on the arrival of her little girl, Dr Matt Gibbins on his new daughter and also to Dr Kate Nickell on the safe arrival of her son.

We are delighted that Dr Stuart Younie has joined us as a locum consultant. His name does rather disappointingly look too much like Dr Stuart Young. Indeed the first consultant meeting he attended, I spent the initial ten minutes wondering why a medical student had joined us. Sadly, that was really a reflection of how I feel about getting

older. Indeed, when I recently had to 'act down' to cover a shift, I suggested we should amend the 'acting down' policy and call it the 'acting young' policy as it made me feel that much better doing so. In fact, doing that would go some way to repairing the damage done when Dr Richard Edwards suggested all the 'young' consultants go out for a meal, leaving us oldies to reminisce about the good old days. Professor Cook had to console the commander in chief on a trip to the boys room when he realised he was not on the 'young consultants' WhatsApp group. Fortunately, at our age it is no longer a quick trip to the boys room and they had plenty of time to console each other. Again, I digress.



Consolation against porcelain

Dr Younie has set the bar high with regards to cycling attire. Sadly, only someone his age can get away with silver cycling overshoes. I won't even

start on the Lycra.

Congratulations to Marcin Pachucki who has just left us as an advanced trainee on ITU and has successfully interviewed for a consultant post in Gloucester. We wish him well in his future career.

Congratulations also to Nikki Crowther, Emily Reynolds, David Quinn and Ben Savage on passing their primary FRCA and to Lucy Corbett, Tom Saunders and Andy Savva on passing their part one MCQ.

I sincerely hope we all have a wonderful summer and trust that the winter bed pressures don't translate into year round bed pressures. I look forward to our summer BBQ, which this year will be hosted by Dr Marjot and his wife Carol. I sincerely hope the younger consultants don't misbehave.

Malcolm Thornton

Cheltenham and Gloucester Hospitals

Greetings from Gloucestershire and thanks to Dr Gleeson for handing the golden baton over after 10 distinguished years for what is now news from Gloucester and Cheltenham as we are joined by one long A40 shaped corridor.

It's been a season of changes and additions to the department. New consultants a plenty, yes more I hear you say. Special mention firstly

goes to Cath Bryant who mistakenly failed to make the last update having joined us at the end of last summer. Congratulations also on her recent marriage and subsequently making us feel very jealous with pictures of Philippine sands from honeymoon. In another competitive round of appointments more recently Marcin Pachucki joins the ranks on ICU and Matt Martin likewise as a locum consultant. Many congratulations to all, we're very lucky to have you. If I can offer one piece of advice chaps it would be to keep your phone on loud on your first on call...the worst kept secret in all of Gloucestershire, but it did result in Tom Perris spending a few hours on the labour ward in the early hours (first time in 10 years!), I'm told he has earned some honorary CPD points. Please consider this an official apology Dr Perris. Sir.

There's clearly been something in the water in this part of the world with the spirit of multiplication not only hitting the HR department but we've seen the joyous arrival of no fewer than four new babies. Clare Newton-Dunn welcomed Alexander in November, Neil and Jo Kellie had Sebastien to add to their small collection of girls, Nishi Patel had Luca in December, and Tom and Katie Knight had Hugo in February. Congratulations all and especially pleased to see that it's well and truly a myth that Anaesthetists all have girls (apart from me and my three!).

Not content to be left behind, and with human families complete, we've had an impressive number of canine

additions. Families Haslam, Cornes, Price, Gleeson, (Mandy) Rees, and Hunton all welcoming various furry friends. Apparently there is a new 'Doggie' Whatsapp group too. Dr Hunton was particularly enthusiastic until promptly leaving citing 'wrong group sorry'...

We've had three significant dismounts in the department recently. Alex D'Agapeyeff is stepping down from the Specialty Director role. A talisman for the last 5 years who's led the department with strength, clarity and character, with a particularly good taste in new consultants! So far the odd hat has made it near the ring to replace him but none have made it into the ring as yet. Congratulations on his step up to Deputy Medical Director. Mandy Rees has stepped down as Clinical Lead at Cheltenham and been replaced by Owen Bodycombe. Mandy can still be found in her happy place in the Urology theatre and is an ever present cheerful guide for young and old(er) and we are all very grateful for her leadership during her CD tenure. Pete Sanderson is stepping down as CD at Gloucester, with no replacements raising their hands as yet. Many thanks too to Pete for his hard work and leadership.

Ted Rees has recently retired from his Head of School role at the Deanery having been a hugely supportive, insightful and charismatic presence as TPD and most recently Head of School. Many trainees in the region, not least the nine who have reached the ultimate goal of consultant jobs

at Gloucester and Cheltenham, are hugely indebted to his organisation, guidance and good humour, and in many cases openness to the headache of trainees flying off to foreign lands to surf...I mean subspecialise. Thankfully he continues as an anaesthetic colleague and we're all the better for it.

The festive season saw a departmental climbing away day at the Gloucester climbing Centre. Team building skills were developed, remarkably easy apparently even when you're encouraging others over the edge of a 'cliff' and many broke free of their comfort zones! The fastest climber award was keenly fought between David Radley and Alistair McCrerrick. The most improved accolade went to Jane Donald and Sarah Bakewell took the Chief Motivator prize with a standout performance! Much fun was had by all at the Malmaison hotel for the Christmas party which I'm told was a slightly less inebriated affair than last year, sterling organisation from Tom Perris whose shirt will live long in the memory. The annual winter medical ball was also a great success. A whole hospital affair, and a healthy £6000 was raised on the night.





The post-christmas round of Primary FRCA torture was met with triumph for

Mark Dorrance and Emily Hignell in the OSCE/VIVA section, who as ever put in the hard yards and will now relish the prize of the final exam. We've been blessed with a great gaggle of trainees across both sites as always. Keen to get stuck in to the clinical side but also keen to engage in department activities on the non-work front, which is always good to see, although Jim Self will happily admit anything's better than three young children, even locum nights!

Having endured another 'Winter' crisis which we are far from through as yet and with beds, money and staff in equally short supply, (well almost, we do actually have some staff....), it was perhaps without too much surprise that the NHS staff survey showed us that general morale is low. The Beast from the East and his delayed mate brought further challenges and broken bones a plenty, as well as a headache for Dr Murdoch who was likely confident his 'go anywhere' new Land Rover had the tools to get him to work. Not so as it ploughed into a three foot drift and promptly threw in the towel. Too late to return the keys? Hot off the press is news from NHS England that they have approved a capital bid for £39.5m which will go towards increasing capacity at Cheltenham, as well as improving emergency care services and co-location of ambulatory emergency care. At Gloucester money is due to be spent on improving inpatient and outpatient environments as well as redesigning and extending the A&E department and adding a range of Acute Assessment Services to streamline and improve diagnosis

and management of patients. As always we await the detail but a promising start nonetheless. With this and news of pay rises for many staff, a still palpable spirit of goodwill and teamwork (at least in public!) and the odd hint that Spring is finally upon us, we head into Summer with optimism.

Now, back to the unusually quiet on call.....

Sam Andrews

Exeter

All is well in Exeter. The snow has proved a highlight this year, causing mayhem, but looking lovely. People were snowed in at home and snowed in at work. Theatre 7 was turned into a makeshift staff dormitory for 48hours. Emma Hartsilver managed to take charge for both snow falls, and did a sterling job of contacting all the trainees, checking out who couldn't get to work for on calls, and who could stand in at short notice. Thanks to all the trainees who trudged through snow to make it, and stepped in to cover the gaps. We now have a snow emergency plan for the next time we have snow, which is unlikely to be needed before I retire.

We have had the usual brood of babies. Congratulations to Ellie and Toby Nelson, Bob Goss and Will Rutherford. Congratulations also to Harriet Daykin, on her marriage to Will. Best wishes to all the trainees who have moved on, of whom there are too

many to mention. However, I have to make an exception for Lorrie Helliwell, who has been with us for longer than is usual or entirely necessary. He has been a joy to our department, and is a demon at sub tenons. Good luck with ST training. Welcome to the new arrivals, several of who began their anaesthetic careers with us.

Fiona Martin has taken to the rota with ease, and has put me to shame. However, I realise that this is because she has acquired the ring of power to aid her (see picture). She didn't even let me borrow it when she went on holiday, leaving me in charge once again. Perhaps once I wear it, I'll want the rota back again. Daniella and Helen make up the rota dream team, and have both settled in very well.



Socially the Exeter anaesthetic department is falling apart. Our regular Christmas party was cancelled, again due to lack of interest. However, a last minute drinks night was well attended, and I found a reason to wear my Christmas jumper and Christmas glasses. James Pittman decided we needed a night at the Bierkeller, and with his flair for delegation, I found myself organising it. It is surprisingly

hard work to force people to have a good time. My thighs were blue from all the slapping, as I promoted bier, lederhosen and oompah. We had a good turn out, but sadly no oompah. However, I did wear my lederhosen – you'd be surprised at how many lederhosen are for sale on Amazon. As you can see in the picture, 3 of us dressed up, while James turned up in his regular weekend attire (waist coat, shooting breeches, long socks...). Now my attention is turning to the next social event. I need to get my moneys worth from my lederhosen.



Changes are afoot within our department. As I have previously reported, Dave Sanders has retired. Now the ever-youthful Fred Roberts is about to leave us. Fred has been a key member of our department since long before I was born. For many years he was the college tutor, and skilfully guided many SHOs to primary exam success. Fred was also a college examiner for many years, and has terrified many a trainee and consultant with his quizzical look, as we attempt to explain a simple physiological concept. Fred was a worthy recipient of the Evelyn Baker award a few years ago. When the new medical school opened in the Peninsula, Fred joined the academic staff, and became a big hit with the students. Fred also gave me the most useful piece of advice which I received as a new consultant doing my first on call, when he offered (as the ITU on call) to help me with a challenging obstetric case; an offer which I readily accepted. The advice, which I have passed on, was “always spread the blame thinly”. Over the years, Fred has passed on much wisdom, especially pertaining to ENT, obstetrics and football, and he will be a sad loss to our department. However, the medical school will still benefit from his experience for a few more years. We wish Fred well in this next chapter of his life, when he retires in June.

Well, I think that's all for now. Until the Autumn.....

Pippa Dix

North Bristol

There's plenty going on in NBT at the moment. We left special financial measures just as Carillion folded leaving all of us none the wiser as to the financial state of our extremely overcrowded hospital.

Our trainees are great and on call at NBT is pretty busy. It would be nice to think that when there is the occasional small amount of down time that the Trust would provide them with a place to lay their weary heads before the inevitable bleep/polytrauma/ruptured AAA/burr hole merry go round begins again. In true "making NBT a great place to work" style the beds have now been replaced by 'comfy' chairs to be shared with the entire on call medical workforce. Undeterred, the department have commandeered a nearby clinical waste room and have applied for change of use to house the anaesthetic refugees. Drs Nickells and Thompson were last seen in said room, looking furtive, clutching tape measures and muttering about bed-pods. Updates to follow.

On a sartorial front the new craze for beards has not passed NBT by. Those who already had them are now searching for new identities, those who have managed to grow big ones talk more and more of oils and grooming products and those who remain baby faced are divided into two groups, the resolutely clean shaven and those who can manage no more than a wisp or two despite months of trying. Dr Thomas (Ian not Matt), despite his best

efforts wins the prize for baby-faced assassin. It has been noticed that the rise in testosterone prescribing on the ICU and new beards is no coincidence (Dr Lobo)

There are rumours that this love of beards is in honour of Dr Milne who has now officially retired from (but still occasionally appears) at NBT. His retirement party fell victim to the snow but a new venue and date have now been found. We will miss all Dr Milne gave during his time at NBT very much indeed. Renowned for being exceedingly clever, Mike worked in ITU and anaesthetics as well as clutching the managerial poisoned chalice towards the end of his career. Known for the heady triumvirate of wisdom, length of e mail and duration of ICU ward round Mike is heading to the depths of Wales to live off the land and start a loom business. We wish him well for a long a happy retirement.

Talking of ITU we have now welcomed Dr Newell and Dr Crewsdon to the substantive ranks. Chris has started already and Kate begins shortly once her well-earned maternity leave (twins this time) comes to an end. Despite having left ITU Dr Jewkes still attends the weekly ITU Grand Round (the latter once described, unfairly as high in calories but short on educational content) so we all think she's be back for more soon. We are all kept fairly busy but no one has more titles than Professor Lockey who recently found himself attending a meeting at which he found he was the head of 3 of the 4 organisations involved. Dr Matt

Thomas has started a research empire and Dr Campbell continues to win the prize for the longest commute to work.

A group of NBT intensivists went to Liverpool for the State of the Art meeting during which all present were astounded at the ability of Dr Reston Smith to be last man standing on the dance floor yet first to lectures unscathed.

In the last bulletin I reported on the unusual observation that Dr Hooper had escaped injury for over a year. I can now report that the world's natural order has now been restored as he was knocked off his bike last week. While flying through the air he informs me he didn't quite have time to think of something more erudite to say to the driver than f\$&k and I'm glad to say that despite a written off bike Tim is, yet again on the road to full recovery.

On the anaesthetic side there's lots going on. New appointments are in the offing and there are plenty of excellent candidates. Dr Nickells kindly gave Dr Davies his old car only for the latter to write it off within the month and in another act of charity Dr Tolchard drove all the way to the Cotswolds to help Dr Hopson get his car out of the snow so he could come in and do his on call.

Dr Shinde and Dr Donald continue to operate high up in the AAGBI and RCOA respectively and more locally a few more of us have crept into areas of middle-management responsibility / mediocrity.

Fortunately the snow, wind, rain and generally bad behaved weather we

have been having recently abated for a day allowing a group from the department to ride the local Audax. Inspired by Dr Burrows' tales of huge pavlovas at feed stations none were left disappointed. It must be one of the few long distance cycles where all participants finished considerably heavier than when they started.

Dr Halder organised another excellent revision crammer course with much assistance from Jean Moon. Dr Carey continues to head up the new anaesthetic block illuminati and seems to attract new followers with consummate ease. Dr Medniuk (née Darweish) now heads up the acute pain service and Dr Dell still heads the Dellstars (all bookings considered). Drs Onofrei and Dragnea welcomed the arrival of a new addition to the family which meant Dragos missed two whole days of cycling.

Our trainees remain universally excellent and continue to pass exams with monotonous regularity. Fingers crossed they'll like the new sleeping arrangements that are being sorted for them so they'll all apply for the next round of jobs we advertise.

Ben Gupta

Plymouth

As autumn faded into winter a gentleness came to nestle over the department, or it may have been the fact that OPEL 4 was normality which limited the amount of operating that

could be done. The fairy tale feel was completed with rumours that Chris Seavell, complete with pantomime tan, had been sighted in the theatres and hadn't flown south for the whole winter. Chris's thespian role is very minor and only a walk on part compared to the A-list celebrity status of Matt Ward's pantomime villains. That make-up is so hard to wash off before a list the next day and seemed to persist for a very long time after the last performance.

The Christmas party was postponed until January, which still didn't coincide with the snow, but did lead to prolonged festivities and a wonderful night at the Plymouth Gin Distillery. There were slight hiccups in the plans when the penny dropped that having naked flames to cook the hog roast in close proximity to large amounts of flammable product may not have been the best laid plan. After some consideration it was decided that as Dave Adams lived closest to the Gin Distillery (10 yards closer than Richard Struthers) that the pork could be cooked at his house. His vegetarian wife was delighted at the aromas that filled the house on the day and the week afterwards. Everyone had a brilliant evening and an extremely smashing evening was had by some. Considering it was a cocktail bar there was a surprising amount of claret around.

Unrelated to the Christmas party, the offspring continue to arrive and congratulations go to Martin Steynor (baby boy) and Sophie Mathoulin and Tim Warrener (baby girl). They may

have names by now as well. Exam successes and congratulations go to Will Gibbs, Jack Davies and Sam McAleer on passing the Primary, and to Susie Edie, Ian O'Brien and Sean Edwards on passing the Final. It was wonderful to watch the weight lift from their shoulders. Other successes that are shared across the southwest include the regional trainee network SWARM being recognised for its work with a national award 'outstanding contribution of trainee Doctors and trainee networks'.

Meanwhile, Gary Minto has been appointed to the Plymouth 'Research and Development' Director post which we think means that he will be doing less anaesthetics, but will have a much greater understanding of what we should be doing. Further changes to the traditional fabric of the south west have continued with the announcement that Rob Sneyd is retiring as Dean of PUPSMD and is handing over before the expansion in numbers of medical students means that there would be too many names to remember. Jeremy Langton has also stepped down as Vice President of the College and taken over as GPAS editor. Other job changes have involved Steve Bree taking over from Duncan Parkhouse as Defence Consultant Advisor. It is unclear what the job entails apart from being at a distance from theatres, but it will give Steve's arm length a chance to even up as he is no longer carrying bags for a general!

The ever expanding demand for anaesthetic work has led to the further

expansion of the department with the appointment of Ross Vanstone, Teresa Burnett, Tom Bradley and Andrew Biffen. Tom Bradley has decided that some time in Stanford, California is necessary before taking up his post in a year's time. Whatever others may say, he is sticking to the mantra that it isn't just a yearlong holiday. (He has got the job now!) All visitors are very welcome. Further rearrangement within the consultant body has also occurred as Michelle Chopra has decided that after her time in NZ, and a period of readjustment to British ways, full time anaesthesia is the way ahead and has forsaken the land of intensive care for a full time post in Paediatric Anaesthesia.

Whilst some colleagues have been pursuing the usual southwest pursuits with displays of sporting prowess, some have been less fortunate. Simon Martin's surfing extravaganza is not something that he wishes to repeat, but picking a fight with your own surfboard will never end happily. Fortuitously Simon's Scottish ancestry has resulted in his head being just hard enough to ensure his survival. His surfboard although damaged did continue to float and the top tip is that it is much easier to stay on top of the water when you are conscious. Others are still recovering from their injuries and Justine Elliot's (aka Jamie Sommers) rehabilitation continues, and her rebuild as the even more bionic woman (think leaping Derriford in a single bound) is nearly complete.

The trainees assure me that they are

all living a very quiet life and there is nothing to mention from their lives. This may be due to the fact that they can't see past their major consternation as Warrens are taking over the coffee bar that is nearest to theatres. The impact that this will have may only become apparent with time and the price hikes have brought tears to the eyes of many. Worse than this they don't take cards and body parts have been offered in exchange for a sandwich and crisps. This has led to cries that "You are worth more than a pasty". This may not be true across the Tamar.

Matt Hill

Swindon

I'm not saying the NHS is bad but when I gave better anaesthetics in Nepal it did make me wonder...

BRINOs (Britain Nepal Otology Service) has been taking British surgeons and anaesthetists to Nepal since 1988. As a trainee I'd heard about clinicians from Gloucester going, so when I found out about a trip from Swindon I thought why not? Well, there are lots of reasons why not. It's a long way, costs a fortune and involves cycling through miles of dirt roads with stray animals just to start a long day working in a place with frequent power cuts. Our camp was masterminded by our surgeon Angus Waddle who sent comprehensive instructions on surviving in Nepal. I was somewhat surprised by the request to bring enough food for two week's lunch. Apparently the local street food was not

to be trusted and Nepalgunj didn't have any grocery stores with recognisable food. I packed wraps, chorizo, cheese and chutney. The thought of it now makes me slightly queasy.

After a flying to Kathmandu and a dogem's experience in the shuttle bus I arrived at our hotel in Thamel. The next day I took a taxi to the local private hospital and collected a carrier bag full of fentanyl and stuffed it in my rucksack. The term drugs mule comes to mind...



With the others in tow (Swindon anaesthetist Mike Entwistle, Swindon scrub nurse Rose Matthews and Basingstoke surgeon Jonathan Blanshard) we flew to Nepalgunj on the flat Indian border, population 100,000. Day 1 was settling up the operating theatre. In the West we are so used to everything being maintained and prepared for us that it is a humbling experience to unpack dusty kit with no idea whether it is working or not. All stock had to be counted and assessed. If we didn't do it no one else would. By the evening we had found a working monitor circa 1985 and assembled a

circuit powered by a BIPAP machine. Anaesthesia was to consist of air, propofol and fentanyl. Oxygen at induction and emergence came from an oxygen concentrator as our only cylinder was for emergencies only.



During the camp we delivered 26 anaesthetics. Our technique required no vasopressors, gave no PONV and meant all patients could be recovered in a room with no monitoring. Mike's spreadsheet skills meant our anaesthetic charts were electronic and the efficiency of a small team meant no gaps in operating. If only I could give such a good service in Swindon!

Back at the Great Western Hospital things remain much the same i.e. not enough beds – and that was before a flood took out A+E and surgical admissions. Rubbish bags are piling up following Carillion's demise. It's all a bit biblical.

Christmas is a long time ago now but is remembered for a fantastic party at Radka Tesarova's new grand designs style palace. James Andrew and I were the subject of some cruel rumours after it emerged that we shared a hotel room that night. I hope they don't find out about the Valentine's Day we spent at the pictures together. I must

stress that my girlfriend was between us and we were watching the very manly Banff Film Festival.

Trainee news: Julie Barr, Judith Cullumbine and Jack Evans (ACCS) have been lost to ITU whilst new novices Sam Nava, Nicola Trevett and Jessica Woods have joined us. Kate Reeve is very pregnant whilst Layth Tameem's wife is expecting any hour soon. Hussain Lahie and Sarah Wickenden passed their Primary, the latter is making plans for a life involving helicopters and Australia.

Research news: Swindon has seen a rapid loss of teaspoons in the anaesthetic kitchen similar to Lim et al, BMJ;331:1498 'The case of the disappearing teaspoons: longitudinal cohort study of the displacement of teaspoons in an Australian research institute'. Following a rapid quality improvement project involving a drill, chain and some pliers we have seen a clinically significant change.



Ed Bick

Taunton

As we see the back end of the "Beast from the East", for the second time this month we can hopefully look forward to a warmer Spring 2018. As I am sure is the case with all Trusts in the region, the weather has taken its toll, with admissions to the hospital reaching unprecedented levels. This has left us operating with an OPEL-4 bed status, on-and-off, for several weeks. However, the tremendous efforts to keep elective and emergency theatres running during the recent 'snowmageddon' have been extraordinary and greatly appreciated.

Through all the weather turmoil and since the last SASWR newsletter Musgrove Park Hospital our department has a lot of news to announce.

We are absolutely delighted that our hospital has approval and support to develop a new surgical centre, which will include 8 new theatres and a 22 bed critical care unit. The current anticipated completion date is 2023. For our patients and the people of Somerset, it means they will have access to modern, state of the art facilities, that are fit for the future.

Over very many years, colleagues have been performing surgery and providing intensive care in buildings that date back to Musgrove's wartime history as an American military hospital. These buildings were never intended to be permanent and it is a tribute to colleagues that we continued to offer quality and safe care, despite

the surroundings.

Dr. Ian Gauntlett retired in January 2018. Ian was an anaesthetist, CSL, Clinical Director and general font of all knowledge, working as a Consultant in Taunton for 24 years. He leaves a great legacy at Musgrove Park having set up the pre-operative assessment clinic and day-surgery centre. His retirement party was attended by colleagues from past and present and an entertaining review of his career was given by Mike Walburn and Justin Phillips. Ian has left anaesthetics and management to concentrate on the serious business of building up his home small-holding and has recently made his first batch of home-grown cider with the press he received as a leaving gift.



We congratulate Nick Kennedy as he has been appointed as the secondary care clinician on the governing body for the Bristol wide Clinical Commissioning Group. This is in addition to his role

on the NEW Devon CCG. This is an important non-executive advisory role.

After a very competitive selection process in March, we welcomed three new Anaesthetic Consultants to the department; Mark Abou-Samra, Tom Teare and Tom Barrett. They will be starting in July/August 2018 and we look forward to working with them. They will undoubtedly contribute greatly to the department over the coming years and we would like to congratulate all three on their appointment.

We would also like to warmly welcome Charlotte Battle who has joined us as a Specialty Doctor. Charlotte was a trainee in Bristol and has moved to Musgrove to enjoy the countryside and family life.

There will be a mass exodus of middle grades and trainees in August. Kate Bell, Chris James, Tom Judd, Sam Khanna, Chris Sajdler and Jing Wang will be moving on to pastures new. Rose Arkell, Aislinn Brown, Stuart Frankland and Shun Yamanaka are all moving to North Devon District Hospital. We wish them all the best of luck and ask for them to keep in touch with the department.

FRCA exams have been ongoing. Kate Bell, Chris Sajdler and Jing Wang attained the Primary FRCA. Aislinn Brown passed her Primary FRCA MCQ in February and Debbie Webster passed the FICM written paper in January.

The trainees have been busy with quality improvement, audit and research.

Jing Wang presented her Quality Improvement project: An Anaesthetic Plan in Children, at the AAGBI WSM conference in January 2018. Tom Judd had a recent invitation to present in the innovation in medical education conference in Tennessee USA.

The department has the delightful news that in January two of our esteemed colleagues Tim Zilka and Jackie Pullin became grandparents to a healthy little boy named Oliver George. Steve Harris has been blessed with a second son named Henry Jack. Both Becky and new born Henry are doing well.



Simon Marshall

Torbay

I am writing in the aftermath of the

almost unbelievable situation where Torquay attracted 9 inches, yes, 9 inches of snow not once, but twice in 2 weeks. So much for the subtropical microclimate. Predictably, the entire infrastructure of the English Riviera collapsed within 15 minutes and the hospital was subsequently supported by valiant individuals of all grades battling through tricky conditions either on foot or in their trusty 4x4's. However, the Torbay Big Wheel is now re-erected – “hurrah” – and the town is teeming with Grockles again.

Due to the inclement weather, departmental sea swimming has been put on hold, but some of our keenest cyclists continue unheeded. Infact John Carlisle required 'rescuing' when braving the treacherous roads across the moors just before the arrival of the second 'Beast from the East'. Watch out for him in this year's Dartmoor Classic.

Our leadership team is about to change with Andrew Gunatilleke moving from CD to take on the role of Chairman of the medical staff committee. He is being replaced by Omar Islam who has been key to the revolution in Theatre Governance over the past few years. We wish him the best of luck. The recently reconstructed Richard Hughes continues with his boundless energy as Chairman, as does Richard Eve at the helm of ITU.

Winter pressures have hit hard with elective cancellations but the day surgery machine ploughs on regardless. The shiny new ITU has suitably bedded in with the predictable

winter bed crisis. We are now assured that new nurses are coming and the long awaited electronic notes system will be fully operational soon. It has been a mammoth process to get the new unit on line. We're pretty sure that it is responsible for the ever decreasing hairlines of Drs Eve and Walker.

Our social events included a very posh Christmas party including the whole of theatres and ITU. It was held at Dartington Hall this year, a wonderful venue with much fun had by all. Many thanks to Claire Blandford for organising another great do. Prize for the most spectacular accidental fall goes to Nuala Campbell although it wasn't entirely her fault as she was dropped by a gang of boys who all chose the same moment to wander off. Perhaps they were distracted by David Pappin strutting his stuff to the whole back catalogue of Priscilla Queen of the Desert.



My God. There are 2 of him...

In terms of trainee transitions, we welcome Tim Warrener, Louise Schönborn and Simon George and say goodbye to David Levy and Carlen Reed-Poysden who will all be great assets to any department they may grace. Tim Warrener has also had another baby girl (Otilie) congratulations to him and Sophie. On the CT rota we also have Rachel Varnham and Ruth Addison, hot from ED.

To add a further feminine touch to the department two consultant appointments in the form of Cathi Hoyer and myself were made in December. We are both utterly delighted to have (finally) made it onto the books. We have both been a long time in the making and were extremely lucky to have had a lively welcome do arranged for us in Torquay. We felt incredibly warmly welcomed into the department.

And it is with heavy hearts that we are saying goodbye to Nuala Campbell and Sammy Saad who are hanging up their clogs. Firstly, Nuala is skipping off into the Cumbrian sunset and is already planning on filling her time with her much beloved upholstery and creative projects although retaining a second base in South Devon for now. She will be sorely missed throughout theatres with her no nonsense approach to anaesthetics and her 'realistic' views of the state of the world. From ITU to anaesthetics she has been key to the evolution of the department and during her tenure as CD the department saw one of its biggest staff expansions and in all of these appointments we have a lot to be grateful for. She and her family generously hosted a fantastic

leaving do with a lively Ceilidh Band and plenty of warming Scottish Broth, cakes and booze. (Not to be forgotten is the legendary event when the Torbay Anaesthetic Department was banned from the sailing club due to too much table dancing – Nuala. We have never gone back). We wish her all the best.

Sammy is thought to be the person who has, and will probably ever have, anaesthetised the most patients in the history of the department and his phenomenal wisdom and flexibility are already much missed on the rota. His enormous contribution to simulation training from the early days is evident in the excellent training that now exists, especially for trainees. We will all miss his snappy dressing and easy charm.

In the near future Mel Hearn will also be retiring but I will save the review of Mel's career and the news from the eagerly awaited joint party that she and Sammy are planning for the next edition as I am sure it will be 'legend'. Until then...

Theresa Hinde

Truro

I think the Christmas bake off winner Tom Bevir can somehow tell the future through the medium of cake. Snow snow snow!

His show stopping snowman Olaf (from Frozen) apple sponge, laced with Calvados, won over the secretaries! I think this is also his secret to his perfect handling of kids on all those

peads lists!

I have made it clear he is going to bake a large sunny beach scene for next year!



One mouthful and he's got you under his spell

Despite Cornwall actually having some fluffy white powder some people had to venture further afield.....something to do with the apres ski still not being up to scratch in Perranporth?! So off to the Alps all in the name of education and Aperol.



Helen King and Sally Nash wouldn't let an avalanche get in the way of getting 10 CPD points



Team acclimatise to Cornish return!

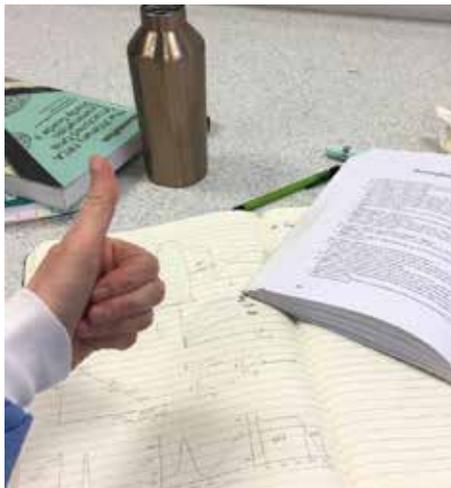


*Making sure the new appointment doesn't injure an ACL before starting!
Gary and Olly*

Somehow the department has been able to acquire a new common room right from under the orthopods' noses ... much to our glee! Our new **Anaesthetic Resource** and **Structured Education** Room has been well received.



*One room : dual purpose.
Anaesthesia relaxation and sleeping
expanse ... #fightingfatigue*



*Not long before it's Trip Advisor's
number one place to be*

Some congratulations are in order for Kate Kendrick, Wendell Storr, Matt Huniack and Rachel McKinnon on their Primary success!

Our new senior trainees are all hard at work. Linsey Arrick , Suzy Grenfell, Sam Spinney and Jo Burrows.

We said a fond farewell to Neil 'newly engaged' Roberts and Chris Pritchett, off to Devon, so Cornish they had rarely crossed the Tamar!

Truro welcomes three new consultants this month.

Russell Evans comes to us from Oxford with 16 years' experience in paediatrics. His wife, three daughters and dog are very much looking forward to spending more time on and by the sea potentially on horseback! (think Poldark galloping scene!)



Russ canoeing from canal to open ocean

Olly Pietroni is now very grateful he does not have to drive down the M5/A30 to get to Cornwall. He is a familiar face returning. A junior trainee here before a stint in North London, recently a locum consultant at the Royal Free Hospital. He loves baking bread, regional anaesthesia, geocaching and his 2 small kids ...as long as they don't have sticky fingers!



Olly and babe off to find dough and leave bread

I am sure Bath is going to miss the lovely Lara Herbert. We are delighted to welcome her, mostly because it sounds like she is the 'action girl' we need to take on Ben Warrick's sporty 'n' dangerous escapades! Watch this space.

Harald Marstaller is our retiree this spring. He has spent many hours in Penzance often modelling a boxing-style towel scarf look to keep the chill off in theatre.

His anaesthesia records are instantly recognisable but require graphologist to decipher! We wish him well in Germany.

I best get on the bike.... Truro to Taunton if I start now I might make the meeting!

Becky Brooks

University Hospitals Bristol

Hello from UHBristol. Firstly, a thank you to all who came to the recent meeting at Mshed Bristol, it was great to have such a good turnout and the local organising committee, headed up by Anoushka Winton and Tom Barrett (more on him later) did a fantastic job I'm sure you'll agree.

So, the babies: Rebecca Leslie has added a fourth, Adam Duffen a third and Helen Howes a first and second simultaneously. Good luck to you all and may the force be with you.

On the retirement front we are very sad to be saying goodbye to Su Underwood. Anyone who has passed through Bristol as a trainee will have benefitted from Su's enormous dedication to medical

education and training. Over the last twenty-five years as College tutor, TPD, Head of School and Regional Adviser in Anaesthesia she has always been keen to teach and support the next generation of anaesthetists. All done, of course, with her trademark pragmatism and humour. She plans to continue as less than full time training advisor for the RCoA. Katie Welham has also left us after many years of service and we wish her well with all future endeavours.

Stage one of Su's 3-part retirement party plan, was a departmental 'Bunkhouse Bonding' weekend in Wales. An excellent if very cold walk took place on the Saturday. Mid-walk the team was split in two however when half the group found some more hills to walk up and down in the freezing cold whilst some took the considerably tougher (in retrospect) option of sitting in the pub and watching the England rugby team humiliated at the hands of Ireland. Outstanding effort of the tip went to Helen Cain who shamed everyone by completing both am and pm walks whilst very pregnant. As the snow fell thick and fast on Saturday night talk inevitably turned to who we would eat first when we ran out of food (Tom Barrett; the most muscle and leaving the department anyway. Win win.) and how long Dr Chauhan would stay in post after he had called the managers on Monday morning to tell them that 20 consultant anaesthetists were stuck indefinitely in mid Wales. In the event, some excellent teamwork, a lot of grit (real not metaphorical, obsv.) and some slightly hairy driving saw everyone get back safely.



We continue to have a fantastic bunch of trainees and clinical fellows who support the work of the department brilliantly and always seem to be chipper despite what seems (to me) to be an increasingly difficult environment in which to secure a local ST3 post. As I write many of them are anxiously awaiting the results of the new national application system and we wish them all luck.

Appointments. We are welcoming Rebecca Leslie and Heather (or 'Hither' as she would say; Kiwi) Short as locum consultants and saying goodbye to Tom Barrett who is off to a consultant post in Taunton. We are sad to see Tom go, but not quite as sad as some of the (mostly female) theatre staff, who's howls of disappointment when he secured the job in Taunton were matched only by the sighs of relief from the male anaesthetists, as the average attractiveness of the department once again regressed nicely back to the mean. Order, as they say, is restored. See you all In Taunton.

Ben Walton

Cartoon by Dr Kathryn Smith

TIME OUT



Report on the Autumn Scientific Meeting, Bristol, 16-17 November 2017

Ed Morris, past Honorary Secretary

I thought I'd written my last meeting report three years ago when I gave up the reins as Hon Sec, but having stepped back in to the role to cover absence for a few months I realised with only days to go that it would fall to me to record for posterity the goings-on at the perennially popular SASWR Autumn Scientific Meeting.

Many thanks to my colleague Gemma Nickols, who diligently took notes during the first morning of the meeting while I was indisposed with a bleeding nasal tumour (not my own) – Gemma does a huge amount of work for SASWR which is not always recognised.

The meeting took place in the ever popular M Shed museum on the waterfront in Bristol. This venue has served us well for several years now although with the increasing popularity of the autumn meeting – this year there were up to 150 delegates – careful organisation was needed.

As always the meeting opened with announcements, presentations and congratulations. Outgoing president Dr Fiona Donald handed over the medal of office (of which more later) to Surgeon Captain Andrew Burgess, the president for the coming year, and also announced that his successor from November 2018 would be society stalwart Mike Kinsella. The society is also delighted that Pippa Dix from

Exeter has taken over as Honorary Secretary from January 2018 – if her ability and good humour in organising the meetings in Exeter is anything to go by, we are entering a new era of efficiency in SASWR.



The first session brought together experts from various disciplines to discuss the management of patients with hip fracture. Stuart White from Brighton brought that area's extensive knowledge of the subject to bear in describing the regional techniques which either alone or in combination with light general anaesthesia provide the best outcomes in this population. Local hip surgeon Sanchit Mehendale

talked through the surgical decision making which follows hip fracture and what that meant in terms of anaesthesia; and consultant physician Rachel Bradley described the efforts made by dedicated 'silver trauma' teams to address the particular medical issues in this group of patients. There was a lively debate at the end of the session – it was obviously a subject which members found relevant to their own practices.

After coffee Professor Tony Pickering talked us through the evidence for some of the recent 'fads' in analgesia including the roles of clonidine, ketamine, magnesium, and so on in the management of acute and chronic pain. Tony has an easy style when describing quite complex pharmacology and brought us up to speed with current thinking. Session chairman Ben Howes fought valiantly to link that talk with the following lecture of the session in which Matt Thomas, the clinical lead for the Great Western Air Ambulance, entertained us with a history of prehospital medicine and the role of aviation in prehospital care – as well as some entertaining video he made the point that the air ambulance is very much justifiable in terms of QALYs and is 'here to stay'.

The afternoon session on perioperative medicine gave the opportunity to be brought up to speed in several areas of internal medicine as they relate to anaesthetic assessment and practice. Dr Yasmin Ismail (cardiology, UHB), Dr Daniel Conway (an anaesthetist from Manchester with an interest in

pulmonary complications), and Dr Amanda Clark (haematology, UHB) provided updates in their particular fields. As preoperative assessment clinics become a regular part of the job plan of many anaesthetists in our region, advice from specialists like this about trends and guidelines in their own areas becomes an important part of CME and the session was well conceived and implemented.

The SASWR trainee prize, sponsored by Intersurgical, is always a popular part of the meeting and attracts trainees to the meeting (not least for the chance of winning a share of the £1000 prize fund). Four very good entries were presented by Charlotte Beresford, Kate Bell, Victoria Ormerod and Helen Howes. First prize went to Victoria for her detailed survey of complications following scoliosis surgery in a DGH and proposal that these patients no longer require routine intensive care; second prize went to Charlotte who had devised an entertaining way of studying molecular structure for novice anaesthetists using a selection of fruits and cocktail sticks to create three dimensional images of common anaesthetic agents. The audience were invited to participate with variable results (see photos!)

The Humphry Davy Lecture was given by London author and GP Dr Youssef El-Gingihy and was entitled 'How to dismantle the NHS in ten easy steps'. He presented his view of the NHS and the factors which threaten it including austerity, private finance initiatives, the internal market and various political

ideologies. Food for thought, and an interesting opportunity to hear Dr El-Gingihy's views at first hand and with the opportunity to question him at the end of the afternoon.

The Society Dinner was held at Bristol Zoo, and was well attended with tables ranging from new trainee members to long retired ones. Ben Gupta's brass band entertained us during the first course, with dancing after dinner courtesy of the Dellstars, who have become something of a fixture at our SASWR meetings. The president, Andy Burgess, gave an entertaining speech in which he pronounced that the practice of medicine, as well as being hard work, should be peppered with 'fun' – a serious point given the war zones in which he has served. He rounded off by inviting us all, 'on spec', to consider cycling from our various departments to the Spring meeting in Taunton – a challenge which we may well know the outcome of by the time this report is published.



Andy's commitment to 'fun' is hopefully illustrated by the attached photograph in which he valiantly wrestled with the resident wildlife in order to protect two of our stalwart trainees. Truly an officer and a gentleman. When asked why he had not accompanied the younger members of SASWR to a Clifton nightclub at the end of the evening he confessed that it was only the fear of losing the presidential medal which stopped him. Anyone who knows Andy well will appreciate the sacrifice this would have been for him and we as a society should be very grateful.



The first session on Friday morning covered three different areas relating to 'The Airway'. Mat Molyneux gave a comprehensive update on thoracic anaesthesia, particularly covering the pathways for referral and treatment of lung cancer, which remains the second commonest cancer in the UK. He described how paravertebral

blocks had virtually replaced the use of epidurals for thoracic surgery, and how video associated less invasive procedures were serving to decrease morbidity and length of stay.

David Vaughan from Northwick Park talked about his experience of managing the obstructed – or obstructing – airway and with some carefully selected examples showed how ‘watchful waiting’ in the right environment might sometimes be the best way to manage such cases. He suggested that the consensus for front of neck access is now that surgical cricothyroidotomy is the method of choice, and that having specialised areas in which to care for cases such as this could calm the nerves of both staff and patient.

Imran Ahmad, of Guy’s Hospital, gave a fascinating demonstration of ‘virtual endoscopy’ – a new tool to enhance assessment of the difficult airway. Using a powerful but readily available piece of software, he showed that CT scans of the airway can be uploaded to a laptop computer and then manipulated to show a 3D, ‘virtual endoscopy’ which allows the user to see in advance what they are likely to see during fiberoptic intubation. He provided evidence that the virtual images correlate strongly with what is seen in ‘real life’ – allowing what he termed a ‘virtual warm up’ before difficult intubation. Remarkable.

After coffee and a chance to look at the 20 or so posters which had been submitted by trainees for the poster

prize, the penultimate session looked at congenital heart disease from two different perspectives. Tim Murphy, a paediatric cardiac anaesthetist, gave a beautifully illustrated talk about the ‘Fontan Circulation’ including its natural history, and the timeline of the development of therapies and operations designed to alleviate or ameliorate its effects. Your correspondent must confess to losing track at one point (through no fault of Dr Murphy!) but the take home message seemed to be that a) enhancing pulmonary circulation is the mainstay of surgical solutions and b) even with very good palliation these patients never have completely normal circulations – it was a fascinating and well researched and delivered talk.

This led conveniently to Neil Muchatuta’s overview of ‘The obstetric cardiac patient’ in which he reminded us that cardiac disease is the biggest cause of maternal mortality and that it is not always known about in advance. He reminded us with several sobering examples that we ignore cardiac symptoms in pregnant patients at our peril – often cardiac disease presents late in this young, generally healthy population.

The poster prize, generously sponsored by local pharma company Aguetant, had been judged by this point and was won by Dr Peters of Weston super Mare for his work on a Quality Improvement Project relating to the diagnosis and treatment of sepsis, with Dr Foy from Bath a close second with her poster on neonatal

and paediatric airway management.

To close the meeting we welcomed two outside speakers both of whom had important messages to give about resilience and the experience of major incidents. Local Cardiothoracic surgeon Gianluca Casali impressed us with a highly personal look at ‘how to be at ease with life’ – covering techniques to avoid burnout by understanding who we really are and what is important while facing the challenges of a professional life.

We were still reflecting on this when Dr Sheila Tose, a neuroanaesthetist from one of Manchester’s main hospitals, shared with us her experience of being the consultant on call on the night of the Manchester terrorist attack of May 2017. Hers was a remarkable talk, as she talked us through the ‘real time’ practicalities of organising services and staff to cope with such an event

during an already busy evening. As well as the practicalities involved, the take home messages were as much about people as they were about equipment, procedures, and logistics. We learned for example that not everyone should ‘come in’ to manage a major incident – as fresh and rested staff will be needed the next day and the day after that – and also that staff involved in such incidents will need time to reflect and to recover for many days and weeks after the event. It was a timely reminder that medicine is about people first and foremost – both patients and those who care for them.

On that note I will close and thank all those who were involved in putting together the Bristol meeting. SASWR is alive and well and providing education, support, and a social network second to none for the growing number of anaesthetists in the South West of England.



Intersurgical first prize winner Scoliosis Surgery- Has it Outgrown Routine Post-Operative Intensive Care?

Dr Victoria Ormerod- CT3 Royal Devon and Exeter Hospital

Introduction

In our 850 bedded DGH hospital, patients undergoing scoliosis surgery have traditionally been booked for postoperative intensive care (ICU), however limited capacity and the non urgent nature of surgery has meant frequent cancellations. Following advances in surgical and anaesthetic techniques it is questionable whether these patients routinely require ICU care.

Aims

This study aims to describe the post-operative requirements of scoliosis patients, whether ICU involvement is always necessary, and identify opportunities to improve this service.

Methods

Retrospective data was collected on all scoliosis surgery patients admitted to ICU over a 5 year period, between January 2012- February 2017.

Documentation from operation notes, anaesthetic charts and patient notes were evaluated for aetiology, patient demographics, comorbidity, operative technique, complications, and post-operative requirements whilst in ICU. Patients were grouped for analysis based

on aetiology of the condition; congenital, idiopathic or degenerative scoliosis.

Results

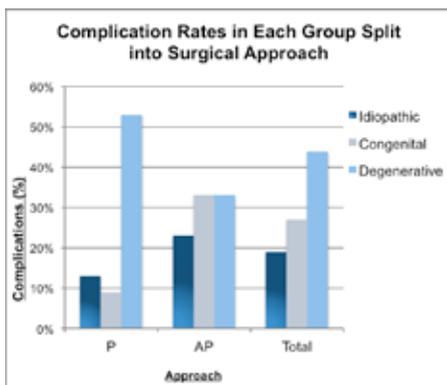
125 scoliosis patients were reviewed; 72 idiopathic, 26 congenital and 27 degenerative. Surgical approaches were anterior, posterior (75%) or antero-posterior. The majority of surgeries (82%) involved only the thoracolumbar spine, and short acting opiates were the intraoperative analgesia of choice. Average patient age was 26 years overall, and 15 years in the congenital/idiopathic groups.

Median length of stay in ICU was 0.8 days. Organ support, excluding arterial line monitoring, was required in 4% (n=5); 1% (n=1) in the idiopathic/congenital group. These included: 4 patients requiring inotropic support, and 1 delayed extubation with central line intravenous access.

Complex pain management was the most common post-operative requirement. Ketamine infusions were used in 83% of patients, for a median of 24 hours. This was usually combined with an opiate PCA, and/or local anaesthetic catheter. Complications were classed as anything unexpected or inadvertent,

despite outcome. These were further examined as to which would benefit from ICU monitoring or care. Complications included acute kidney injury, bleeding requiring blood products, hypotension requiring support, dural tear, unplanned pneumothorax, post-operative pulmonary embolism, myocardial infarction, and delirium.

Overall 20% (n=25) of patients had a postoperative complication, 7 of these classed as benefiting from ICU. Total complication rates in each group were 44% (degenerative), 27% (congenital) and 19% (idiopathic), with those benefiting from ICU involvement being defined as 30%, 4% and 3% respectively. These are in line with other similar studies¹. The significantly higher complication rate in the degenerative scoliosis aetiology was the group also associated with higher comorbidity. Within the idiopathic/congenital groups, low complication rates were further decreased when a single posterior surgical approach was used, highlighting this as the lowest risk surgical group.



Discussion

Only 4% of scoliosis operations required organ support from ICU during their postoperative stay, with average length of stay being under a day, reinforcing the low complexity of these routine admissions.

A major reason for admission is blood pressure monitoring to avoid hypotensive events, which have the potential for delayed neurological defects. A recent study² has shown that after the initial 4 hours post-operatively, the risk of this is minimal. Identifying the immediate recovery period as being the key time for monitoring, rather than the later period spent in intensive care.

Complication rates in the degenerative scoliosis group were significantly higher, correlating to associated comorbidities, with a greater proportion likely benefiting from ICU care, although it is acknowledged that this is not fully objective.

Shan et al³ demonstrated shorter hospital stays and better outcomes for young patients with posterior fixed scoliosis, managed on the ward post-operatively as opposed to ICU.

This study highlights posterior approach idiopathic and congenital scoliosis surgery as a low risk group who could safely be managed in a higher dependency ward environment post-operatively, with the provision for complex pain management. This would offer potential benefits to the

patients, trust, and multidisciplinary team involved.

Conclusion

In a limited resource environment, non-malignant surgery such as scoliosis surgery is at risk of late cancellation due to lack of an ICU bed, having major implications for patients, and the trust emotionally and financially.

We conclude that posterior approach idiopathic and congenital scoliosis surgery has a low risk of complications, rarely requiring any resources from intensive care. From this study we propose a trial of extended stay in recovery, ensuring cardiovascular stability, followed by ward based care as routine for this population.

References

1. Bartley CE, Yaszay B, Bastrom TP et al. Perioperative and Delayed Major Complications Following surgical Treatment of Adolescent Idiopathic Scoliosis. *J Bone Joint Surg Am.* 2017 Jul 19;99(14):1206-1212.
2. Haber LL, Womack ED, Sathyamoorthy M, Moss JA, Shrader MW. Who Needs a Pediatric Intensive Care Unit After Posterior Spinal Fusion for Adolescent Idiopathic Scoliosis? *Spine Deform.* 2018 Mar-Apr;6(2):137-140.
3. Shan, L. Skaggs, DL. Lee, C. et al. Intensive Care Unit Versus Hospital Floor: A Comparative Study of Postoperative Management of Patients with Adolescent Idiopathic Scoliosis. *J Bone Joint Surg Am.* 2013. 95:e40(1-5).

Intersurgical second prize winner

Organic Pharmacology

Dr Charlotte Beresford – CT1 North Devon District Hospital

Background

A great challenge in medicine is effective learning in a limited time frame.

Medical educators have studied learning styles of undergraduates and postgraduates in order to deliver efficient and targeted teaching. A survey of undergraduate and postgraduate level students using VARK (Visual, aural, read/write and kinesthetic) and ASSIST (The Approaches to Study Skills Inventory for Students) questionnaires has demonstrated that students at the start of medical training prefer a multimodal learning style, while postgraduate students develop into unimodal learners(1).

Simulation, used often in medical education, draws from elements of all 4 learning styles (2). Simulation has been widely used in the teaching of certain topics of the anaesthetic curriculum including airway management, anaesthetic emergencies and transfer training in the first few months alone. Simulation sessions have been shown in current literature to enhance learning experience and retention of knowledge independently of their level of fidelity(3). This suggests that the physical process of learning a task and the practical completion of it helps to cement it in the student's memory, drawing on both immersive and experiential aspects of learning.

The Fellow of the Royal College of Anaesthetists (FRCA) Primary Examination covers a vast breadth of topics which novice trainees need to become familiar with. Some of these subjects, including Physics, Pharmacokinetics, Pharmacodynamics and Organic Chemistry, do not lend themselves well to high fidelity lab based simulation. For these subjects our body of novice trainees have been tasked with preparing talks and presenting them to our peers.

Methods

In view of variable learning styles and immersive/experiential learning, anaesthetic trainees were surveyed for their preferred learning style, ascertaining whether they identified themselves as visual, aural, read/write or kinaesthetic learners. Following this a teaching session on Organic Pharmacology was designed to suit their learning style.

A month following the teaching session the trainees were tested with a 5 point quiz on molecular structure to test retention.

Results

Learning styles of trainees prior to the session self identified as 100% kinaesthetic learners.

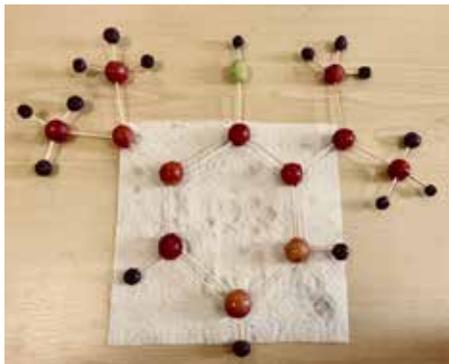
Drawing on chemistry A-level teaching of molecule building kits, I adapted this

to teach basic principles of Organic Chemistry. We used blueberries to represent hydrogen atoms, grapes (green, red and black) to represent carbon, nitrogen and oxygen with interconnecting toothpick covalent bonds.

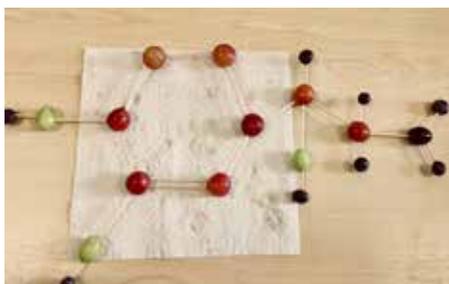
We built amino acids, sugars, catecholamines, barbiturates, benzodiazepines, opioids and propofol. The non-depolarising muscle relaxants were a bit tricky as too many grapes had been eaten by then!

The photos below show the 8 of us, all novice anaesthetic trainees building our edible molecules, by the end of the session informal feedback was that the trainees had a better understanding of medicinal chemistry. Our limiting factor to the number of molecules we built being the number of punnets I purchased.

A month later, the teaching session was followed up. A brief test of retention was sent to the trainees who participated in the teaching session. Trainees correctly identified 90% of common induction agents by their structure and labelled ester, amine and phenol groups.



Propofol



Noradrenaline

Conclusion

We transformed a usually dry topic, into a somewhat more sticky and messy but evidently more memorable and educationally valuable session.

References

1. Samarakoon, L. et al. 2013 Learning styles and approaches to learning among medical undergraduates and postgraduates. *BMC Medical Education* 13(42)
2. Honey, P., and Mumford., 1986 *A Manual of Learning Styles* 3rd Ed. Word Press
3. Aggarwal et al. 2010 Training and simulation for patient safety. *BMJ Quality and Safety* 19 (34-43)



Anticoagulants and anaesthetics – part 1

Dr William Hare, Dr Jessica Muchmore and Dr Natalie Smith

Torbay District Hospital

Introduction

Half a million deaths related to venous thromboembolism occur in the European Union per year. It is important that review of thrombotic risk and management of anti-coagulant medication is completed as part of peri-operative assessment. Development of new medications and guidelines has made this subject challenging. This article aims to explore anti-coagulation and anti-platelet options, their mode of action, pharmacology and importantly anaesthetic implications.

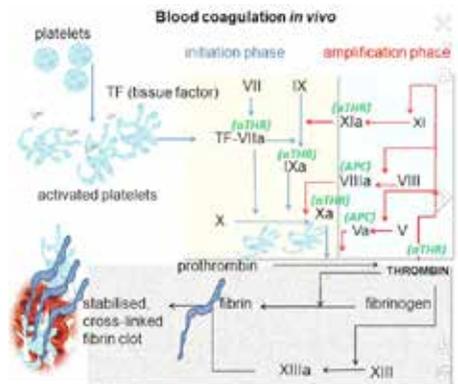
Coagulation and anti-coagulations

To understand how anti-coagulants and anti-platelet medications work it is important to understand how homeostasis works. Crudely it can be divided into platelet aggregation and the coagulation cascade, but in reality the two systems work synergistically.

After a vessel is damaged, von Willibrand Factor (vWF) and collagen in the subendothelial layers become exposed. On platelets glycoprotein 1 adheres to vWF to cause a confirmation change and degranulation. This releases many factors including ADP, ATP, calcium and Thromboxane A. Thromboxane A provides stimulus for further platelet aggregation and development of a platelet plug. ADP causes a change in the Glycoprotein

IIb/IIIa receptor allowing deposit of fibrinogen onto the platelet surface. Thrombin then changes the fibrinogen to fibrin to stabilise the clot. Anti-platelet medication is designed to target one or more of these receptors. If the process of platelet activation and aggregation is stopped a platelet plug will not form. Anti-platelet medications target one or more of these processes to inhibit aggregation and clot formation.

The coagulation cascade is the release of a series of factors, each one stimulating the release of the next leading to a final common pathway. The final common pathway leads to production of thrombin and fibrin, which stabilizes the formation of a clot. See illustration below.



Credit – Wikipedia Commons

Anti-coagulation medications can

prevent the activation of the cascade at many levels. Commonly factor Xa and Thrombin are inhibited.

Anti-Coagulants

Warfarin

A commonly used oral anti-coagulant, although it is starting to go out of fashion with the development of newer options. It is a coumain derivative available in variety of doses. Its high bioavailability and low volume of distribution make it a reliable option. Warfarin is metabolised in the liver to inactive renally excreted metabolites.

Its mechanism of action is as a vitamin K antagonist. Vitamin K is oxidised during the production of clotting factors II, VII, IX and X. It is then changed back to its reduced form, making it available for use in synthesis of further factors. Warfarin irreversibly prevents the reduction of Vitamin K thereby inhibiting the production of new clotting factors. Warfarin increases the prothrombin time and the INR on coagulation studies. Testing the prothrombin time allows warfarin's effect to be measured. It requires regular monitoring and dose adjustment. Warfarin has multiple food and drug interactions, which can increase or reduce its efficacy. This occurs either by effecting warfarin's protein binding (usually 99%) or by altering liver enzymes which changes the rate of metabolism. This can lead to inadvertent sub therapeutic anticoagulation or haemorrhage. Rarely genetic polymorphisms can affect efficacy. Warfarin is teratogenic so should be avoided in pregnancy.

Heparin

Is a naturally occurring mucopolysaccharide, which is used in its unfractionated and fractionated form.

Unfractionated heparin

Commonly used anti-coagulant which can be administered subcutaneously (SC) or more routinely intravenously (IV).

Reversibly binding to anti-thrombin III it inhibits the activity of factors XII, XI, X, IX, plasmin and thrombin. It also inhibits platelet activation by fibrin. This leads to an anti-coagulant state within the clotting system.

IV unfractionated heparin is widely used for bridging therapy as a continuous infusion or as bolus doses in vascular and cardiac surgery.

Pharmacokinetically the time taken to reach peak plasma concentration is dependent on route of administration, 3 minutes if given IV and 4 hours SC. The half time of heparin is variable in part due to its excretion. Heparin is excreted via two mechanisms. A saturable system via the reticulo-endothelial system and a non-saturable route via renal excretion. At lower doses half time dependent on rate of removal by the reticulo-endothelial system, whereas at higher doses when this system is saturated its plasma half time is dependent on rate of renal excretion. This gives unfractionated heparin a dose dependent half life and explains why its effects are amplified in renal impairment.

Its effect can be measured using activated Partial Thromboplastin Time (aPTT) and at the bedside using Activated Clot Time (ACT) aiming for 1.5-2.5 control times.

Heparin can be reversed using protamine needing approximately 1mg for every 100 units.

The main side effects of unfractionated heparin are Heparin Induced Thrombocytopenia (HIT) and osteoporosis. HIT is defined as thrombocytopenia caused by the administration of heparin. There are two types: Type 1 occurs two days after commencement of treatment and resolves with continuation of treatment. Type 2 is an immunological response where antibodies to platelets develop. This does not resolve until treatment is stopped.

Fractionated or Low Molecular Weight Heparin (LMWH)

Examples include Dalteparin, Enoxaparin, Tinaparin.

As their name suggests these are the smaller molecules of heparin 2000 – 10 000 daltons. Compared to unfractionated heparin, LMWH has a greater affinity to inhibit factor Xa than thrombin.

It is administered subcutaneously in fixed doses according to ideal body weight and has a predictable dose response curve owing to its 90-100% bioavailability. It has a predictable onset, reaching peak plasma concentration 2-4 hours after SC injection with a half life of 3 -4 hours. It relies on renal excretion requiring dose adjustment for patients with renal impairment where its half life will be extended.

It can be monitored using anti factor Xa activity although this is rarely required. Owing to its reliability LMWH is first choice in thrombo prophylaxis for inpatient and those awaiting investigation. It is ideal for bridging

therapy as it can be administered by patients at home. Using larger doses it can be given in treatment of myocardial infarctions, pulmonary embolus and deep vein thrombosis.

Factor Xa Inhibitors

An increasingly popular group of anti-coagulants. They are used for thrombophylaxis following orthopaedic surgery and stroke prevention. Danaparoid is licensed in use with patients with previously diagnosed HIT. There are oral and parental options. Their mechanism of action is to inhibit the coagulation cascade at factor Xa which prevents the conversion of prothrombin into thrombin and consequently prevents clot formation. Although rarely required, its activity is assessed directly by anti factor Xa activity or using aPTT and PT times. They are difficult to remove by heamofiltration but have been successfully removed using plasmapheresis.

Rivaroxaban

A Morpholine and throphene derivative, which is available as a once daily oral dose. It is absorbed mainly in the stomach and its oral bioavailability is high at over 80% when taken with food, this is reduced in fasting. It has a large volume of distribution and is highly protein bound. It reaches peak effect in 1-4 hours with elimination half life of 5 – 9 hours. Rivaroxaban is metabolised by the cytochrome P450 mechanism and by other, undefined, CYP450-independent routes. Its inactive metabolites are excreted in the urine and faeces. Due to its reliance on hepatic excretion it is contra-indicated in patients with liver disease

and its effect can be prolonged into those with renal impairment.

Apixaban

Not as widely used as Rivaroxaban, Apixaban is another orally administered factor Xa inhibitor. It is rapidly absorbed, reaching peak plasma concentration in 1-2 hours. It is metabolized by the cytochrome P450 system. Like Rivaroxaban will be effected changes in induction or reduction of enzymes within this system, particularly important as 75% is excreted via the hepatic system.

Fondaparinux

Is a synthetic pentasaccharide which selectively inhibits factor Xa. It is administered subcutaneously reaching peak levels in 2 hours. In some trusts it is the treatment of choice for prophylaxis of medical and surgical patients. It relies on renal excretion with a half life of 17-21 hours, this is significantly increased in renal impairment.

Danaparoid

Danaparoid is an indirect factor Xa inhibitor, direct IX inhibitor with some effects on anti-thrombin III. It is a glycosaminoglycan mixture, containing 84% heparan sulfate, a low molecular weight heparinoid devoid of heparin. Like LMWH, it is administered subcutaneously.

Significantly it is chemically distinct from heparin so has only 5.2% cross reactivity causing Heparin Induced Thrombocytopenia, HIT).

Like other anti-coagulants it has 100% bioavailability and is reliant on renal excretion.

Thrombin Inhibitors

These anti-coagulants inhibit thrombin on the final common pathway of the clotting cascade. They prevent thrombin from converting fibrinogen to fibrin preventing clot formation and stabilization. The oral preparation Dabigatran is becoming more readily available, however the parental versions are usually limited to patients unable to tolerate other anti-coagulants.

Their use requires monitoring using aPTT or ecarin clotting times.

Dabigatran

Orally administered Dabigatran is a pro-drug. Once absorbed from the gastrointestinal tract, it is converted by esterases into its active form. In its active form it is a reversible, competitive direct thrombin inhibitor. It reaches peak plasma concentration after 2 hours with an 8hour half life. The oral bioavailability can vary significantly, being delayed by co-ingestion of food, reduced by co-administration of proton pump inhibitors, and being significantly increased when not taken capsule form. It relies on renal excretion, up to 80%, and is contraindicated in renal insufficiency.

Argatroban

A thrombin inhibitor whose use is primarily reserved for those patient diagnosed with HIT requiring percutaneous procedures. It is administered using a continuous intravenous infusion reaching steady state within 1 hour, with a plasma half life of 35 minutes and the aPTT returning to baseline levels in 2 hours. It is eliminated through the liver so doesn't accumulate in renal insufficiency.

Hirudins

Examples include Desirudin, Lepirudin and Bivalirudin.

These are direct thrombin inhibitors. They are licensed for thromboprophylaxis after surgery, however due to their secondary bleeding risks and need for IV administration their use has been widely replaced by the factor Xa inhibitors.

Anti-platelets

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

NSAIDs inhibit cyclooxygenase 1 in platelets which prevents the production of prostaglandin and thromboxane. There are many NSAIDs available but only aspirin is used as an anti-coagulant. If acute reversal is necessary a platelet transfusion and Desmopressin may be required.

Aspirin

Aspirin directly and irreversibly inhibits cyclooxygenase, by acting as an acetylating agent. This results in inhibition of platelet aggregation for the platelet's life span. This is different to other NSAIDs (Ibuprofen, Diclofenac) who are reversible inhibitors. Aspirin is completely absorbed orally, mainly in the acidic environment of the stomach where it is unionized. About 50-80% is protein bound. It is hydrolysed in the liver to form salicylic and glucuronic acid. These pathways can become saturated, with larger doses metabolism switches first order to zero order kinetics. Renal excretion becomes increasingly important to prevent toxicity. If a very high dose of aspirin is ingested treatment will be

required to prevent secondary damage to hepatocytes leading to liver failure. Aspirin's anticoagulant properties mean it is used for secondary prevention of cardiovascular disease, and in the management of myocardial infarction, stroke and transient ischaemic attacks. It is also used for anticoagulation in patients with atrial fibrillation or prosthetic heart valves. It also has analgesia, anti-pyrexia and anti-inflammatory properties.

Despite its problems in overdose, Aspirin is still a very popular anti-platelet medication due to its wide indications for use, its ease of availability and low cost.

Thienopyridine Derivatives

This group includes Clopidogrel, Prasugrel and Ticagrelor. They all inhibit the binding of Adenosine Diphosphate (ADP) in platelet aggregation. They are used in the prevention and treatment of acute coronary syndrome and frequently used alongside Aspirin in dual anti-platelet therapy. Their effect can be measured using platelet mapping which assesses clot strength. Platelet transfusion may be required for acute reversal.

Clopidogrel

Presented as pro-drug, Clopidogrel is rapidly metabolized in the liver by cytochrome P450 into its active metabolite, reaching steady state after 3 – 7 days. Platelet aggregation inhibition can reach up to 60% with platelet function returning in 3 – 5 days.

Prasugrel

Often used as an alternative to

clopidogrel for patients requiring percutaneous coronary intervention. Prasugrel requires metabolism in the liver to its active form before it can irreversibly inhibit ADP. This metabolite is further metabolized by cytochrome P450 into an inactive form, which is eliminated in urine and faeces.

Ticagrelor

Ticagrelor is a reversible ADP receptor antagonist. Although not widely used it can be used as an alternative to clopidogrel during percutaneous coronary intervention. It requires a twice daily dose, with increasing age and liver impairment effecting plasma concentrations.

receiving anti-coagulants is an important issue. There are two main issues for an anaesthetist. Is stopping the anti-coagulant going to put the patient at a higher peri-operative risk and therefore will bridging therapy be required. And secondly when is it safe to perform procedures for example spinal anaesthesia. AAGBI have guidelines for patients requiring regional anaesthesia who has coagulation abnormalities. The following table has been adapted from the AAGBI table of recommendations and addresses central neuroaxial blockade (for more information see https://www.aagbi.org/sites/default/files/rapac_2013_web.pdf)

Anaesthetic Considerations:

Anaesthetic management of patients

Drug	Time to peak effect	Acceptable time after dose to perform block	Acceptable time after block performance or catheter removal for next dose
Heparin			
Unfractionated, IV treatment dose	<5 min	4 hr or normal aPTT	4 hr
LMWH SC prophylaxis	3 - 4 hr	12 hr	4 hr
LMWH SC treatment	3 - 4 hr	24hr	4 hr
Heparin alternatives			
Danaparoid prophylaxis	4-5 hr	Avoid, consider anti-Xa levels	6 hr
Danaparoid treatment	4- 5 hr	Avoid, consider anti-Xa levels	6 hr
Fondaparinux prophylaxis	1 - 2 hr	36 - 42 hr	6 - 12 hr
Fondaparinux treatment	1 - 2 hr	Avoid, consider anti-Xa levels	12 hr

Anti-platelets			
NSAIDs	1 - 12 hr	No additional precautions	No additional precautions
Aspirin	12 - 24 hr	No additional precautions	No additional precautions
Clopidogrel	12 - 24 hr	7 days	6 hrs
Tirofiban	<5 mins	8 hrs	6 hrs
Dipyridamole	75 mins	No additional precautions	6 hrs
Oral anticoagulants			
Warfarin	3 - 5 days	INR <1.4	After catheter removal
Rivaroxiban prophylaxis	3 hr	18 hr	6 hr
Rivaroxiban treatment	3 hr	48 hr	6 hr
Dagibatran (CrCl>80ml/min)	0.5-2 hrs	48 hr	6 hr
Dagibatran (CrCl 50-80 mls/min)	0.5-2 hrs	72 hr	6 hr
Dagibatran (CrCl 30-50 mls/min)	0.5-2 hrs	96 hr	6 hr
Apixaban prophylaxis	3-4 hrs	24-48 hr	6 hr
Thrombolytic drugs			
Streptokinase, alteplase etc	< 5 mins	10 days	10 days

The decision to stop anti-coagulation peri-operatively and the use of bridging therapy is more complex. It involves balancing the risk stopping against the risk of bleeding if continued. There is some variation between trusts, so local guidelines should always be checked. From the British Society of Haematology suggest patients who are at high thrombotic risk requiring

bridging therapy. These patients include those with a recent (less than three months) thromboembolic event, Atrial Fibrillation with a recent stroke, mechanical heart valves (excluding bileaflet aortic valves) will requiring bridging therapy. Bridging therapy is usually with a factor Xa inhibitor such as Dalteparin.



SWARM update



Anaesthesia Points West Spring 2018

Johannes Retief (SWARM Chair) and SWARM Committee

Award Success

We are delighted that SWARM has been recognised for its work with a national award. SWARM won the 2017 Trainee Network category of the joint Royal College of Anaesthetists and Clinical Research Network awards. These awards recognise outstanding contributions of trainee doctors and trainee networks who are active in research. SWARM has also recently been shortlisted for the 2018 HSJ Value awards, with the ceremony due to take place in June. We would like to thank every trainee and other anaesthetists that have contributed to SWARM over the last few years and hope to work with many more of you in the future. It is the true collaborative effort that makes success like this possible.

2018 Research Training Symposium

We have recently had another successful annual meeting. Held at Buckfast Abbey Conference Centre on 12 March, we were honoured to have renowned speakers join us to share their knowledge and vast experience, as well as updates on recent and ongoing projects. Mark Edwards is chief investigator for the FLO-ELA trial and chair of the HSRC Patient and Public Involvement (PPI) group and gave excellent talks on these two subjects. Sandy Jack, associate professor of clinical exercise science at Southampton, gave a fascinating insight into setting up WesFit, a

comprehensive prehabilitation study that has received STP funding. In addition, our very own Gary Minto enlightened us with his expert views on shared decision making. Congratulations also to Debbie Webster who won the 'Hive of Ideas' session for her project pitch looking at attitudes surrounding futility in intensive care. We are looking forward to helping develop this study looking at this important issue.

DALES: The next national RAFT project

The next national RAFT project is DALES (Drug Allergy Labels in the Elective Surgical population). Data collection is due to take place over three days during the time window of 21 May to 2 July. This project explores the prevalence of patient-reported and documented allergy to drugs relevant to anaesthesia and to learn more about anaesthetists' knowledge and attitudes to allergy. Please contact your local SWARM DALES lead for more information and/or visit: <https://www.rafttrainees.com/project-summary.html>

Other Projects

We continue to make progress on our projects looking at cognitive monitoring in the perioperative period (COMPASS) and use of accelerometers to assess post-operative recovery (AFAR). For COMPASS we have been successful in a national peer reviewed competitive

grant application, meaning the study will be adopted onto the NIHR portfolio. A big thank you also to all those who helped facilitate the PAPAYA study in the region (unplanned admission following day case paediatric surgery).

Thanks to SASWR

We would like to say a sincere thank you to the SASWR committee for their continuing support of the south west trainee research networks

(SWARM and STAR). It is very much appreciated. The funds will go a long way to help continue delivering valuable trainee led and delivered projects in the regions.

More Information

Plenty of information can be found on our website (www.ukswarm.com) and you can follow us on Twitter (@ukswarm).





STAR Update

Dr Katie Samuel – Chair

STAR has undergone some exciting changes through the year to date. We have had a change of committee members; I took over as Chair at the end of 2017, and we are delighted to welcome both Sarah Heikal and Ben Hearne as our new Treasurer and Secretary respectively. Massive thanks to Alex Looseley, Marchin Pachucki and Matt Martin for all the dedication and hard work they have delivered to STAR over the years – we wish them the best of luck as they CCT.

Other new developments include our new and improved STAR website; stylish, easy to navigate and packed with up to date news of STAR projects and events (our IT lead Ed Miles has outdone himself). It also includes a new secure 'members' area' for trainees to keep a record of ongoing local projects and opportunities – this will aim to stop both the 'forgotten and incomplete' project when trainees move on, as well as the hunt for a project when starting at a new trust. The address remains unchanged – www.anaesthesiaresearch.org.

Both SASWR and The Bristol School of Anaesthesia have kindly continued to provide bursaries to STAR for 2018. This has given us the ability to work on and improve both our website and STAR events (including a new regional STAR study day for post fellowship trainees), as well as provide new and exiting benefits for our members.

We have a number of both local and national projects ongoing and fast approaching. The RAFT (Research Anaesthetic Federation of Trainees) national project for 2018 is DALES (Drug Allergy Labels in the Elective Surgical population). This aims to determine the true prevalence of drug allergy labels in elective surgical patients, the nature of these allergic reactions, and anaesthetist's attitudes towards drug allergies. STAR have recruited local leads at all 8 sites for this national project, and it is being led regionally by Jon Bower. The data collection window has just opened, and runs from the 21st May until the 2nd of July. Each individual site has chosen 3 days within this window – if you would like to be involved in your trust do get in touch.

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. We are immensely proud of STAR ICM lead Aggie Skorko in continuing to lead and develop this study, along with the rest of the steering committee including Bob Goss from SWARM. The team

have applied for NIAA HSRC funding for the project, and our locally run STAR study day for those involved with ATOMIC-2 was a great success.

Our new STAR research fellow, Dave Cronin, has made an excellent start to the year. As well as introducing a STAR session as part of NBT's new starters induction, he is, in collaboration with the North Bristol Trust team, undertaking an obstetric research study. The observational cohort study's aim is to assess thigh circumference and skin to muscle distances in women at term, with the purpose of assessing whether conventional methods of administering IM injections in this cohort are reliable for drug delivery.

We have an active following on Twitter (**@STARResearch** and **@STAR_Research**), and have recently set up our STAR facebook group. Our Membership base continues to grow, with medical students and foundation doctors also now included – they have fed back that being involved in STAR projects is not only interesting but also a driver towards a career in anaesthetics and ICM.

We are currently looking for our next regionally led project – all those with an idea to pitch are welcome to come forward at our next meeting (date to be confirmed) or to contact STAR on **stargroupresearch@gmail.com**

The Wine Column

Tom Perris

Sunshine and Mountains: The Rise of Malbec

A number of new-world countries have seized upon an old-world grape and made it their own. New Zealand and Sauvignon Blanc, California and Cabernet and / or Zinfandel spring to mind, but Argentina chose Malbec. Which turned out to be a pretty smart choice, as it achieves a riotously rich, plummy gorgeousness that is generally lacking in its homelands of Bordeaux, the Loire and sundry other uncelebrated areas of France. Only in the limestone hills around Cahors does it achieve any distinction. Indeed, the calcium rich, barren soils force the vines to work hard and an intense, slow-developing, tar-scented “black wine” is produced. Here they call the grape “Auxerrois” although God knows why, since Auxerre is in the North of Burgundy. They mostly grow Chardonnay to make Chablis there. Elsewhere they call Malbec “Cot” and add it in as a makeweight to local Reds. Recently the word Malbec is starting to appear on French labels, as even they aren’t averse to capitalising on an emerging market.

In Argentina, however, the unique climate and geography allow it to achieve much more. Malbec is a thinned skinned and sulky sort, not given to resisting disease or ripening nicely unless treated correctly. Which

is to say, lots of sunshine but not too much heat or rain. Since most of Argentina’s vineyards are situated around Mendoza where it only rains about 300mm per year (less than a Manchester weekend!) and not at all in the summer, excess moisture is not a problem. In fact, the flow of snow- melt coming from the High Andes in four large rivers is the only thing preventing the area being a desert. Irrigation is universal. Planting your grapes up the hills sorts out the temperature issue and the poor stony soils and spring floods keep the vine disease phylloxera at bay. So, no need for sulking by the vines and large crops of ripe, healthy fruit are harvested to the delight of the increasingly large numbers of international companies investing in the area and the growing numbers of international quaffers who are lapping it up.

But what does it taste of? Well, it depends on what you do to it. the poor soil and high sunshine can give a concentrated, spicy, ripe wine loaded with plummy fruit. Add irrigation water and you get a higher volume, lower intensity crop typical of the cheaper versions made at a price point. Still ok but not very exciting. Add oak barrels and a star winemaker and you get a complex, age-worthy

wine just begging for a big steak from the cattle ranches on the Pampas. And a price tag to match! The wine world is having to wake up to the fact that perfect growing conditions can produce outstanding wines. Chile, on the other side of the hills, is already making some exceedingly fine wines including Malbec. The twin cooling influences of altitude and cold ocean currents allow the long slow ripening period necessary to extract maximum finesse.

So, what do I drink? Well, every week

there seems to be a new offering in the shops so it's not hard to find new ones to try. From Argentina, I like Norton wines very much (Waitrose carry several of their reds at around ten quid) but I'm currently working my way through a case of Chilean Malbec from Enco (Anakena Reserva) which Mr Tesco obligingly discounted on his website. It really is very delicious but I've had lots of good ones recently from most outlets. Why not try a few and see which one washes your sirloin down the most pleasingly? Enjoy!

THOSE WERE THE DAYS

TODAY, FRIDAY, through
my letterbox, big surprise;
' Bulletin' from Royal College
of Anaesthetists, catches my eye.

I've retired, now missing
the theatre gang at Yeovil,
cherishing their retirement glass decanter
engraved 'Robin, 14th August 1972...

Apparently there is a 'PSO'
which meets to measure standards,
some trained at Melbourne University
for basic sciences like my back yards.

...to 28th January '99...
Oh how the time has gone....

In my fifty poems to celebrate
'the fifty year jubilee'
Page thirty shows, Joanna, our
daughter,
out in Australia,
holding my hand, she aged three

Robin Forward

Ted Rees - Head of School 2013-2018

A poem by Su Underwood

A poem is often quite farcical
Especially the ones which are medical
The good ones I've seen
Are rarely clean
And the clean ones are rarely comical

So I picked up my pen for to write
A verse which is rather polite
To say a big thank you
From all of your crew
To the leader who kept us all right

Ted Rees came to Bristol Infirmary
A trainee he came to see me
He asked for advice
To keep it concise
He wanted to know what to be

He started a long distance course
With no other help or resource
He studied alone
Stayed 'in the zone'
And finished it with tour de force

He had chosen to learn from Dundee
Which came as a surprise to me
The local one's shorter
Perhaps by a quarter
But Ted got a top CME

After training and passing the college
exam
He became a consultant in Cheltenham

He was ed sup and CT
Then following me
He started directing the programme

As Head of our School he was awesome
Ted carried it off with aplomb
He stuck up for us
Never made a fuss
Kept us gently under his thumb

Ted likes to go cycling long distance
I don't know if he takes any substance
But like all the greats
He's surrounded by mates
Who are known for keeping their silence

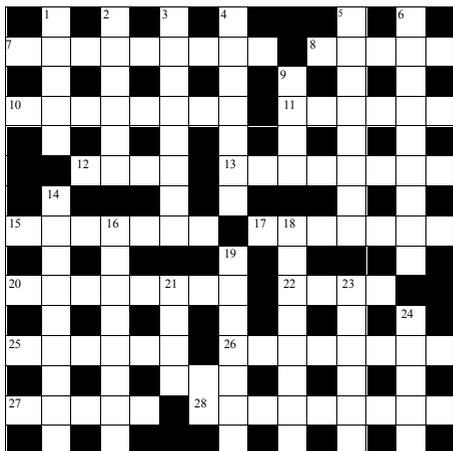
I'm not sure I should tell Ted's secret
But Ted is just a short cut
His real name is longer
Sounds a lot stronger
But I can't let it out of the closet

Today we are gathered together
To celebrate Ted's end of tenure
His term is completed
We are depleted
Now we must cut loose the tether

So thank you to Ted for all he has done
To make sure our school is so well run
He was always ready
He was always steady
But then he was also good fun!

CROSSWORD

Brian Perriss



Clues Across

7. Chairman's breaking no laws. (9)
8. Clip English bird. (5)
10. Providing feline form of reign. (8)
11. Skirting hospital arrive at slum area(6)
12. Sailor from South Africa studies bone(4)
13. Main goal to produce shrub. (8)
15. Ways to overdose in meths. (7)
17. City rebuilds true church at last. (7)
20. Helping worker in middle of leave year. (8)
22. Every penny first goes on fruit. (4)
25. Wise men record vehicle used by painters. (6)
26. Reprimand son, unfriendly in general at first. (8)
27. Type of examination on carbons colour.
28. Married doll Maria played with. (9)

Clues Down

1. What masseurs do when naked. (5)
2. Underwear barristers receive. (6)
3. Country resort for a thin lad. (8)
4. Is love lively in biological union? (7)
5. Insect to run off seeing larger creature. (8)
6. Notice insubstantial illumination. (9)
9. Uber-excited. (4)
14. Controller organised Regal tour. (9)
16. Convenient headgear they say, but still a disadvantage. (8)
18. How many golf pegs on the wagon. (8)
19. Watches foreign money – not a pretty sight. (7)
21. Bond's declaration in game.(1-3)
23. Fellow attached to many clubs. (6)
24. Germanic invader offers perspective. (5)

Solution to Crossword in Spring 2017 Anesthesia Points West

A	B	O	V	E	A	L	L		S	T	R	E	A	M		
S		I		R		E				A		X		A		
C	O	L	L	A	T	E	D		S	K	A	T	E	R		
E		H		S		W		A		E		R		K		
N	I	E	C	E		A	G	G	R	A	V	A	T	E		
T		A				R			O		P			D		
	A	T	T	E	N	D			G	L	A	C	I	A	L	
R		E		X						R		L		Y		
E	R	R	A	T	I	C			R	A	T	T	L	E		
S					R		R		E			A		B		
T	E	E	N	A	G	E	R	S		S	A	T	Y	R		
R		S		C		W		O		H		E		I		
A	S	T	U	T	E			A	L	I	E	N	A	T	E	
I		O		O					V		L		S		F	
N	I	C	E	R	Y				L	E	A	F	L	E	S	S

Prizes and Bursaries

Details of all prizes, rules, and entry deadlines can be found at www.saswr.org

There are several bursaries and prizes available to members of SASWR:

The SASWR Intersurgical Trainee Prizes

Two prizes, of £750 and £250 respectively, are awarded annually at the November Scientific Meeting of the society. Entries of up to 2000 words maximum in the form of an essay or short paper on any topic related to anaesthesia, intensive care or pain medicine should be submitted electronically to the Honorary Secretary of the Society (honsec@saswr.org), by 30th September each year.

The three best entries will be presented orally at the SASWR meeting in November, and the prize awarded at that meeting. Any entrants who do not make the shortlist will be invited to enter the poster prize at the meeting. Please note that you must be registered for the meeting in order to present your work, and you may not enter both this and the poster prize.

SASWR Poster Prize

The Spring and Autumn scientific meetings will have a poster prize of £250 awarded to the best poster presentation. To enter, submit your work as an abstract or poster to the Honorary Secretary (honsec@saswr.org) by 30th September each year for the Autumn meeting and 31st March for the Spring meeting. You will need to be registered for the meeting and be able to present your poster to the judges during coffee.

The SASWR Travelling Fellowship

This cash bursary is awarded to any member of the society to support a 'mission abroad'. Applications, to the Honorary Secretary of SASWR (honsec@saswr.org), are welcomed throughout the year.

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.

Submission of articles to Anaesthesia Points West implies transfer of copyright to the Society of Anaesthetists of the South Western Region. If an article has been previously published elsewhere, permission to use the material should be sought from the editors of that journal before submission to Anaesthesia Points West. Submissions will be acknowledged on receipt and notice of acceptance/rejection/need for corrections will be sent as promptly as possible.

Editor

Dr Ben Ivory
Anaesthetic Dept
Torbay Hospital
Torquay
TQ2 7AA
benjamin.ivory@nhs.net

Assistant editor

Dr Mark Pauling
Royal Devon and Exeter Hospital
Barrack Road
Exeter
EX2 5DW

