

President
Dr Peter Trewby

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Proceedings of the Association of North of England Physicians



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... The interest in the "Are you registrar ready?" course from both trainees and consultants has been very positive....

... We identified severe physical disability as the main risk factor for both mortality and cognitive impairment in the Hai District of northern Tanzania...Hypertension was not associated with mortality despite cardiovascular disease accounting for nearly three-quarters of the deaths recorded.....

... The group with alcohol dependence had mental health disorders and a family history of alcohol excess but no evidence of childhood abuse nor chronic illness to predispose them to dependency. Loss of employment, loneliness and pain perception were also associated with alcohol dependency.....

Abstracts of the meeting held on Saturday 5th November 2016 at Wansbeck Hospital

ATRIAL FIBRILLATION RELATED ISCHEMIC STROKES

Khin Nyo, Helen Skinner, Ijaz Anwar, Binu Nair, Monica University Hospital of North Tees

Strokes in people with AF are more severe and have worse outcomes than in those without AF. 70% of people with AF die because of stroke and AF almost doubles the death rate from stroke. NICE recommends anti-coagulation in patients with AF if their CHA₂DS₂VASC is 1 or above in males and 2 or above in females. Data were collected from 37 patients with ischemic stroke who were diagnosed as having new or known AF on admission from January to June 2015. 43% were male. 73% were age 70-89 years, 19% 90-99 and 8% 60-69. 73% suffered from either total or partial anterior circulation stroke. 30% died during the admission. Modified Rankin Scale (MRS) on discharge was either 4 or 5 in 27%. 81% were known to have AF and in 19%, it was undiagnosed. In those with known AF, only 67% were on anticoagulation and in 45% of those, INR was sub-therapeutic. 53% of known AF patients were neither anti-coagulated nor had therapeutic INR if anti-coagulated. 23% in this group died and the pre-admission MRS were either 0 or 1 in 43% of those deaths.

Conclusion: Our data highlights the lack of appropriate and effective anticoagulation in patients with AF.

AN UNOFFICIAL GUIDE TO THE e-PORTFOLIO

Gilchrist C, Harley J
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50% of F1s rated their knowledge of the ePortfolio prior to F1 as very poor, a further 25% as poor and 83% felt that they did not have a good understanding of the terms used in the ePortfolio.

58% rated their preparedness for the ePortfolio following induction week as average and 42% as poor. 83% and 100% respectively of F1s felt a structured session on ePortfolio accompanied by a handbook would be helpful. We put together a teaching session 1 month into the first rotation of F1s aiming to cover the basics of the site and its navigation and address terminology used within it. We accompanied this with an 'Unofficial Guide to the ePortfolio'. The teaching session resulted in a 92% improvement in knowledge, a 79% improvement in understanding terminology and 84% improvement in site navigation. A further 79% of attendees felt more confident creating Supervised learning events (SLE). We expect this to translate into an improvement in ARCP outcomes for the 2016/2017 F1 year.

Conclusion: Initial understanding of the e-portfolio system is poor. A teaching session and creation of a structured guide improved understanding and confidence.

NCEPOD AND ALCOHOL RELATED LIVER DISEASE: WHAT ARE THE VIEWS OF THOSE WHO DELIVER THE SERVICE?

HC Mitchison, S Saksena, M Hudson
Sunderland Royal Hospital, University Hospital North Durham, Freeman Hospital, Newcastle Upon Tyne

NCEPOD ('Measuring the units' 2013) identified significant concerns for patients with Alcohol Related Liver Disease (ARLD) admitted to hospitals. 700 consultants and trainees were surveyed to seek organisational or attitudinal deficits to confirm/explain NCEPOD findings. Over 200 replied (50:50 split consultants and trainees). 30%, particularly those in ITU and anaesthetics were not aware of the Regional Liver unit service. There was a perception that ARLD patients do not have equal access to HDU with various reasons given including lack of resource, therapeutic nihilism and a feeling that prejudicial judgements occur that would not be made of other patient groups. Access to HDU beds was better for ARLD patients at the hospital hosting the tertiary liver centre than in DGHs.

Conclusions: More training in hepatology for gastroenterologists and more outreach by the Regional Liver unit are indicated. There is a need to explore the attitudes that exist amongst healthcare professionals in relation to ARLD patients. There is a lack of 24-hour access to gastroenterologist's advice: those on endoscopy rotas do not, or are not seen to, offer this.

IS THERE ENOUGH EVALUATION FOR PATIENTS AT RISK OF SUDDEN CARDIAC DEATH?

Tsoi VKW, Lord SW.
Newcastle University, Freeman Hospital

Sudden cardiac death (SCD) is often caused by inherited dysrhythmias. SCD in a first-degree relative is associated with a two-fold increase in risk of SCD in offspring. We aimed to assess adherence to the Heart Rhythm Society (HRS), the European Heart Rhythm Association (EHRA) and the Asia Pacific Heart Rhythm Society (APHRs) Expert Consensus Statement on performing initial investigations to evaluate inherited SCD risk for patients surviving Out of hospital cardiac arrest (OOHCA) and their relatives. We assessed 37

patients admitted over five years from 2010 to 2015 to a tertiary cardiac referral centre for implantable cardioverter defibrillator (ICD) following OOHCA. Initial investigations were generally underperformed (except in 3 cases). History, examination and ECG were performed on all 37 proband cases, followed by echocardiogram (22 times) and pedigree chart (9 times). Exercise ECG was least common (4 times). Of the 37 proband cases, 12 families and 42 first degree relatives were screened.

Conclusions: Initial investigations were frequently underperformed. A standardised request form and simplified referral process could increase adherence.

ARE YOU REGISTRAR READY?

Kate Armitage, Sophie Wilcox
University Hospital of North Tees

Being “the med reg” is deemed an unpopular career choice amongst core medical trainees (CMTs) who believe their training does not prepare them for the role. This contributes to poor recruitment, poor morale, and concerns over the ability of the registrar to provide safe patient care. There is currently an unmet need for formal training in the “generic skills” listed within the Medical Specialty Training Curriculum, despite advances in other specialties. A questionnaire and interview of local CMTs identified the following areas of concern regarding transitioning to the registrar role: heavy workload, prioritisation, procedural skills and complexity of patients. The key challenges trainees identified were: procedures, leadership, decision making, managing others, delegation, organisation and prioritisation. Using the A+E “registrar ready” course as a template, we designed a course based on a simulated night shift to address these non-technical skills. The course has been run as a pilot and has received positive feedback from both faculty and learners. We intend to run the course again for the current cohort of CMTs.

Conclusions: The interest in this course from both trainees and consultants has been very positive. We wish to share our work with others with a view to broadening the availability of the course.

DO GUIDELINES IMPROVE PRACTICE? A RE-AUDIT OF THYROID NODULE ULTRASOUND REPORTING FOLLOWING 2014 BRITISH THYROID ASSOCIATION THYROID CANCER GUIDELINES

A Aldibbiat, SA Tee, A Madathil
Northumbria Healthcare NHS Foundation Trust

British Thyroid Association (BTA) 2014 guidelines outlined the need for risk stratification (U-grading) to be included in thyroid ultrasound (USS) reports. All classified U3 and above would require fine needle aspirate cytology (FNAC) for further evaluation. We evaluated the quality of thyroid-USS reporting using BTA guidelines as the gold standard. All thyroid/neck scans between 01/11/2015 to 31/12/2015 were retrieved from radiology records at NHCT. Outcome was compared to pre-guidelines audit (2013). Nodules were identified in 104 (77%) out of the 134 scans included. Nodule size, U-grading and lymph nodes status were reported in 89%, 67% and 72% respectively. Quality of reporting varied widely between the 23 sonographers who performed the scans. Most nodules were graded U3 (50%) or U2 (43%). FNAC in those with U3-grading yielded 38% Thy1, 21% Thy2, 11% Thy3, 3% Thy4, 3% Thy5; while 24% (n=9) had no FNA done at the time of audit. With regard to risk stratification, reporting quality improved significantly when compared to the pre-guideline risk stratification (70% vs 37%) and cervical lymph node evaluation (93% vs 27%).

Conclusion: The BTA guidelines led to improvement in reporting quality and informed diagnostic provisions. The majority, but not all, U3-graded nodules were benign on FNAC. Further training to sonographers to the BTA reporting standards is key to improving reporting outcomes.

DETERMINANTS OF MORBIDITY AND MORTALITY IN PEOPLE AGED 70 AND OVER IN THE HAI DISTRICT OF NORTHERN TANZANIA

R Jones, H Putnam, WK Gray, J Kissima & R Walker
Newcastle University & Northumbria Healthcare Trust

The number of older people living in sub-Saharan Africa (SSA) and developing countries is increasing. There are no previous long-term studies of an elderly cohort in SSA. We investigated 6-year mortality rates and predictors of mortality together with the rates and risk factors for major cognitive impairment in a community-based elderly cohort in rural Tanzania. Data were gathered at baseline in 2010 and at follow up in 2013 and 2016 through interview and assessment of 663 participants aged ≥ 70 years with a close relative. The 6-year mortality rate was 36.5%; a three-fold increase from rates in 2013. Having a severe physical disability at baseline was the greatest independent predictor of mortality (OR 4.40), followed by age, I will One-quarter of survivors had major cognitive impairment, which is a much higher rate than earlier research in SSA. The strongest

independent risk factor for this was severe physical disability (OR 4.12), along with increased age, impaired grip strength and lack of education, consistent with former studies. Hypertension was not associated with mortality despite cardiovascular disease accounting for nearly three-quarters of the deaths recorded.

Conclusion: We identified severe physical disability as the main risk factor for both mortality and cognitive impairment in the Hai District of northern Tanzania.

HIV: ARE WE TESTING APPROPRIATELY?

J Hulley K Nurse

Queen Elizabeth Hospital, Gateshead.

More than 110,000 people are living in the UK with HIV; 1 in 4 are undiagnosed. An audit by the British HIV Association (BHIVA) in 2006 found over half of deaths were a direct consequence of late diagnosis, with many presenting to healthcare services prior to diagnosis. In 2008, BHIVA created UK National Guidelines for HIV testing. An audit was conducted in December 2014 and a re-audit in August 2015. HIV testing in accordance with BHIVA guidelines was poor. 52% of patients according to guidelines should have had an HIV test, yet only 15% were offered testing. Following education sessions and posters to increase awareness, a further 50 sets of notes were analysed. Results failed to improve, with 20% of patients requiring an HIV test, yet only 10% were tested. A survey to explore the reasons for poor testing found that 28% of respondents remained unsure in which conditions to test. 40% felt there was a stigma amongst medical professionals regarding testing for HIV and 36% said fear of causing upset caused them not to test.

Conclusion: Despite education, doctors failed to test for HIV in appropriate conditions. Underlying issues surrounding testing need to be addressed, before improvements in testing can be made.

WHICH FACTORS ASSOCIATE WITH ALCOHOL DEPENDENCE?

Tighe I, Moss G, Thrasher M and Kelly C
Queen Elizabeth Hospital, Gateshead

This study aims to investigate which biological, psychological and social factors might predispose individuals to alcohol dependence and what might predict continued alcohol dependence. We identified 50 patients admitted to Queen Elizabeth Hospital with alcohol excess and resulting dependency (defined as increased tolerance to alcohol and the development of withdrawal symptoms) over one month. We compared with 50 inpatient case controls without alcohol

dependency. We designed a survey looking at biological health, social background and mental health, including validated screening tools such as the CAGE score and Hospital Anxiety Depression (HAD) scale. We obtained results by structured interviews with both index cases and case controls. The mean age was 53.9 years, with 36 men. 46 had a CAGE score >2. Their mean alcohol consumption was 173 (46 to 560) units/week. 36 had previous alcohol related admissions and 29 had been involved with the police. On average, individuals had been drinking heavily for 18.9 years. Fourteen patients cited their health as responsible for their alcohol dependence, but the group exhibited no more chronic health problems than did controls. Despite this, the group rated their health worse (5.43 vs 3.92), and pain more severe (6.08 vs 3.5) than controls [$p=0.01$]. Unemployment was commoner in the study group (33 vs 19), as was isolation and loneliness (5.2 vs 2.1) [$p=0.02$]. 29 lived alone, and 41 felt that their dependence had interfered with their family life, despite 40 stating they felt supported by their family. 24 reported at least one other family member with alcohol dependence. Reported abuse in childhood was no greater in members of the study group (6 vs 8). Established mental health disorders were more prevalent in the study group (42 vs 16) with anxiety (mean HAD 10.1) and depression (mean HAD 7.5) predominant. Over half (26) reported thoughts of self-harm, and 15 had made suicide attempts. Most (45) reported a happy childhood, although 19 recorded difficult events such as bereavement, family breakdown and bullying.

Conclusion: This group had mental health disorders and a family history of alcohol excess but no evidence of childhood abuse nor chronic illness to predispose them to dependency. Loss of employment, loneliness and pain perception were also associated with alcohol dependency. It is hard to separate cause from effect but identification of at-risk individuals might prevent future dependency.

DO WE IDENTIFY AND TREAT BONE DISEASE IN PATIENTS ADMITTED WITH ALCOHOL-RELATED HARM?

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Gateshead NE9 6SX

Fragility fracture is one complication of alcohol excess. There is little evidence to guide therapeutic intervention in such patients who often fail to appreciate their increased risk of fracture. We felt that the risk might also be underestimated by medical

staff. We identified 50 inpatients with alcohol related harm over 5 weeks. Of these, 29 required medical intervention to reduce fracture risk according to FRAX scores and the National Osteoporosis Guideline Group. DXA scans were recommended by NOGG in 22 patients, while 7 warranted immediate treatment without DXA. Half of the patient group had experienced a previous fragility fracture but only 4% had had a previous DEXA scan and while 28% were prescribed bone active treatment, half were non-compliant.

Conclusion: Patients who misuse alcohol have a high incidence of fragility fractures. We found that they were under investigated and under treated.

UTILITY OF SCREENING TOOLS FOR DETECTION OF HIV-ASSOCIATED NEUROCOGNITIVE DISORDER IN OLDER HIV POSITIVE ADULTS IN NORTHERN TANZANIA

Johanna Kate Kellett Wright, Richard Walker, Catherine Dotchin
Newcastle University, Mawenzi Regional Hospital, Northern Tanzania

People with HIV are living longer due to successful antiretroviral therapy. HIV-related disability is prevalent in sub-Saharan Africa (SSA) and includes HIV-associated Neurocognitive Disorders (HAND). HAND is increasing and affects approximately 8.1 million in SSA. The International HIV Dementia Scale (IHDS) is commonly used for screening but is not validated in older adults. The 'Identification and Intervention for Dementia in Elderly Africans' (IDEA) six item screen was previously validated to screen for dementia in Tanzania. Frontal reflexes (snout and palmomental) were noted in early case control studies of HAND. We aimed to validate the IHDS in older adults against the gold standard assessment American Academy of Neurology (AAN) criteria, and compare the IHDS against the IDEA screen and frontal reflexes. 227 HIV positive cases aged 50 and over were screened followed by an AAN diagnostic assessment. This included a locally validated neuropsychological test battery, functional assessment and clinical assessment with a research doctor. Doctors were blinded to the screening results. The area under the receiver operating characteristic (AUROC) curve (95% CI) was 0.685 (0.613 to 0.756) for the IHDS. For the IDEA, AUROC was 0.701, (0.632 to 0.770). The palmomental reflex was 2.2% sensitive and 100% specific. The snout reflex was 41.3% sensitive and

62.1% specific.

Conclusions: HAND is prevalent in mild forms. The IHDS is not an effective screen in older adults. The IDEA was the most predictive tool. Sensitivity could be optimised by raising the cut-off score. Frontal reflexes were less prevalent than early studies and not sufficiently predictive to be used alone.

HIGH ORIGINATING RADIAL ARTERY: AN ANATOMICAL STUDY

H. HILAL, D. EBOT, J. COEY and S. SULAIMAN
Department of Anatomy, St. George's International School of Medicine; Northumbria University.

Knowledge of variations in blood supply is paramount to safely performing medical and surgical procedures. The radial artery usually arises as a branch from the brachial artery at the level of the neck of the radius in the distal antecubital fossa. Data describing the origin of the radial artery has historically been obtained from cadaveric and angiographic studies demonstrating a wide variability in the prevalence of high originating radial artery (HORA) from 0.3-14.3%. The literature also shows inconsistent nomenclature when describing the arterial system in cases of HORA. This study aims to investigate the incidence of a HORA in vivo using ultrasound. The prevalence of variations was measured using GE LOGIQ e and Sonosite MicroMaxx ultrasound in 120 upper limbs from 60 individuals age 20-75. The radial artery was initially identified and followed proximally to its origin and then distally to the wrist noting its course and relationships to other anatomical structures. Atypical origin of the radial artery was found in nine upper limbs (7.5%).

Conclusion: The presence of a HORA has both clinical and surgical significance in arterial grafting and cardiac catheterization. Ultrasonography is a quick non-invasive means of increasing the fidelity of prevalence data for anatomical variations.

Association Business

Date of next meeting:

**Saturday 11th March 2017 at Royal Victoria infirmary: 10:00 am
to include refreshments and buffet lunch provided free.**

Approved for 3 hours CME.

Abstracts for poster or oral presentations from consultants, trainees and medical students are all welcome. Presentations should reflect the full range of clinical medical practice including original research, clinical series, audit and case reports. Please submit by email (around 250 words with a short conclusion) **before 6th February** to the secretary clive.kelly@ghnt.nhs.uk.

The **Margaret Dewar prize** will be awarded for the best junior doctor or medical student's oral presentation of the year (£150), runner-up (£100) and best poster (£50). Please e-mail the names of any new consultant colleagues or your own name if you are not already on the mailing list to the secretary and please consider presenting your research for the Hewan Dewar prize awarded annually for the best research paper submitted by a junior doctor or medical student.

Do look at **the web site of the Association on <http://anep.co.uk/>** which contains details of future meetings plus back numbers of the Proceedings over the past 11 years and other issues relating to the Association.

Important news

Please see attached letter from Clive Kelly. The morning meeting on March 11th will be the traditional Saturday morning meeting format but from July we are trialling a change in timing of the Association meetings to increase engagement with junior doctors. The meetings will still be the normal mix of oral and poster presentations but will follow on after the afternoon RCP teaching sessions at the Freeman Hospital. Refreshments and a buffet supper will be served (free of charge). The 2017 dates for these meetings will be 5th July and 8th November. Please put the dates in your diary! Likely start time (to be confirmed) 5:30 PM with refreshments

We welcome feedback on this change which received backing at both the last Association meeting and at the RCP teaching session. Please email any thoughts about this revised format to clive.kelly@ghnt.nhs.uk.

But in the meantime –

**we look forward to seeing you at the normal Saturday morning meeting on 11th March 2017 at
the Royal Victoria Infirmary, Newcastle**
