President
Dr Peter Trewby

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Proceedings of the Association of North of England Physicians

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Abstracts of the meeting held on Thursday, 7 July 2016 at Sunderland Royal Hospital

AUDIT OF THE EFFECTIVENESS OF COMMUNITY GERIATRIC INPUT AND EMERGENCY HEALTH CARE PLANNING IN ACHIEVING THE PREFERRED PLACE OF CARE (PPC) FOR FRAIL ELDERLY PATIENTS

J Dunbar, H Filler, M Rudd, D Mayne, M Bateman
Sunderland Royal Hospital, City Hospitals Sunderland NHS Foundation Trust

An Emergency Health Care Plan (EHCP) has been described as a "means of communicating agreed responses to anticipated emergencies" and is part of the NHS NE Strategic Clinical Network 'Deciding Right' Initiative. More elderly people are living with multiple complex medical problems; some patients choose a community setting as their preferred place of care (PPC) and may wish to avoid further hospital admissions. 138 patients with a community geriatric team instigated EHCP were identified. 60.1% patients had an inpatient admission in the six months prior to EHCP implementation and 15.9% afterwards, 7/22 admissions were not in accordance with parameters established in the EHCP. 87/138 patients with EHCP had died by April 2016, death in their PPC was achieved in 94.2%, median time to death after EHCP instigation was 50.5 days. Total length of stay was 1808 days in the six months prior to admission and 167 days in the following six months.
Conclusion: Patients with EHCPs are less likely to be admitted in the six months after instigation than the six months beforehand. This reflects regression to the mean and high rates of death as well as any impact of the EHCP. There are few admissions not in accordance with the EHCP and few deaths in places other than the identified preferred place.

AN UNUSUAL CAUSE OF CARDIAC ARREST

R Fowkes, RJ Graham, AJ Turley
Friarage Hospital, Northallerton, South Tees Hospitals NHS Foundation Trust

A 21-year old woman was admitted under the general surgical team with abdominal pain, vomiting and palpitations. She presented after a binge of alcohol, cocaine and amphetamines with a working diagnosis of pancreatitis. She had a complex rheumatological background including psoriatic arthritis, Scheuermann's disease, lupus/systemic sclerosis overlap and depression. Her regular medications included citalopram, hydroxychloroquine, paracetamol and tramadol. Before clerking she suffered seizure-like activity and a cardiac arrest with polymorphic ventricular tachycardia (torsade de pointes). There was a return of spontaneous circulation after one cycle of CPR. Her 12-lead ECG showed a QTc interval of 550ms and her blood tests revealed a potassium of 2.8mmol/L (normal 3.5–5.0). With IV potassium replacement and cessation of her regular medication her QT interval normalised and she recovered with no long term complications.
Conclusion: Long QT needs to be considered in patients admitted with a history of illicit drug use, especially in those with concomitant metabolic derangements or medication known to prolong the QT interval.

A DAY IN THE LIFE OF UNIVERSITY HOSPITAL OF NORTH TEES

Khin Nyo, Graham Miller, Nick Roper, Christopher Jones, Omer Elneima
University Hospital of North Tees

As part of the Society of Acute Medicine Benchmarking Audit (SAMBA), we looked at three quality indicators for 55 patients admitted over 24 hour period on the 25th June 2015. The indicators were (1) early warning score recording within 30 minutes of arrival, (2) assessment by medical staff within 4 hours and (3) assessment by consultant staff within 14 hours. 61.8% were admitted via GPs, 32% A&E and 3.2% other sources. Around 50% were admitted out of hours and one third between 1700 and midnight. 35% were found to have Clinical Frailty Score of 5 to 9 and 16.9% had some cognitive impairment on admission. 87% had EWS recorded within 30 min of arrival, 91% was seen by medical staff in 4 hours and 78% by consultants in 14 hours. After 72 hours, 98% were discharged out of AMU with 49% being discharged home and another 49% transferred to other wards or another hospital. The median discharge time was 11.1 hours but was longer (17.7 hours) for frail patients.
Conclusion: 55% of our admissions were aged over 65 and 1/3 had a degree of frailty. 91% were seen by medical staff in four hours but only 78%

by consultants in 14 hours. However, our performance on all scores was better than national average figures.

THE GREAT IMITATOR. AN UNUSUAL CASE OF SYPHILIS?

R. Viney, M. Chauhan
Newcastle upon Tyne Hospitals NHS Foundation Trust

Sir William Osler described syphilis as "the great imitator" due to its myriad of clinical manifestations. We describe a 34-year-old homosexual man who presented with symptomatic haemorrhoids and anal canal bleeding. Whilst undergoing haemorrhoidectomy the mucosa over the haemorrhoids was noted to be ulcerated. A biopsy showed treponema pallidum on immunohistological staining indicating syphilis. However, surprisingly his syphilis serology was negative at the time of diagnosis and has remained negative since. He gave no history of past syphilis or having received any antibiotics prior to the diagnosis. Further investigations performed also revealed that he had co-infection with HIV and rectal lymphogranuloma venerum (LGV). He was treated with benzathine penicillin (for syphilis), doxycycline (for LGV) and commenced on anti-retroviral treatment as his CD4 count was 262.
Conclusion: This case highlights an unusual presentation of syphilis with negative serology. It demonstrates the close relation between epidemics of infectious syphilis and LGV and highlights the fact that HIV co-infection is common in those diagnosed with LGV (74%) and syphilis (27%).

POST VIRAL MYOCARDITIS WITH LV THROMBUS AND NEPHROTIC SYNDROME

Rajeev Sharma, Tanjit Singh
Queen Elizabeth Hospital Gateshead

A 30 year old previously well patient was admitted with 6 weeks history of increasing shortness of breath associated with cough, rhinitis, sweating and sore throat. For 72 hrs he had noticed leg swelling extending up to scrotum. Heart rate was 127 /min, chest auscultation revealed bibasal crackles and urine dipstick showed 3+ protein and 2 +blood. Echocardiogram showed global impairment with ejection fraction of 25% and a mass lesion in left ventricular originating in left apical segment. He was treated with B-blockers, ACE-i, diuretics and anticoagulation. His heart rate settled, his urine cleared and repeat ECHO revealed dissolution of the mass.
Conclusion: We believe this to be a case of co-existing post infective viral myocarditis with thrombus formation and nephrotic syndrome secondary to viral infection. We are not aware of any previous cases having been reported.

ELECTIVE MRI SCANNING IN PATIENTS WITH AN MRI CONDITIONAL PERMANENT PACEMAKER

Dewi E Thomas, Robin Taylor, John Ainsworth, Nicholas J Linker, Andrew J Turley
James Cook University Hospital, Middlesbrough

The importance of MRI as a diagnostic tool, and the limitations imposed by conventional pacemakers has led to the recent development of MRI-conditional (safe) pacemakers. We established a protocol in 2013 for scanning patients with MRI-conditional devices. This required liaison between the radiology and cardiac physiology departments, and the involvement of a cardiac physiologist on the day of the scan to perform lead integrity checks and device programming changes before and after MRI. Between June 2014 and July 2015, 10 patients with MRI-conditional pacemakers underwent a total of 12 MRI scans. 5 were performed for orthopaedic indication, 4 were cardiac and 3 were cranial scans. All devices were re-programmed according to manufacturer specific guidelines, no adverse events were recorded and there were no changes in lead integrity parameters following MRI.
Conclusions: Our limited early experience demonstrates that scanning patients with these devices can be done safely providing a strict protocol is adhered to, and we plan to expand this to include ICD and CRT devices.

RISE IN HIV DIAGNOSES IN A NORTH EAST SEXUAL HEALTH CLINIC IN 2015.

B Howe, J Richards, N Jeffrey, M Chauhan.
New Croft Sexual Health, Newcastle upon Tyne.

In the North East there has been a gradual decline in New HIV diagnosis until 2013. However, 2014 and 2015 have seen an increase in newly diagnosed HIV. Some areas of the North East now have a prevalence of 2/1000. At this prevalence universal testing of new patients registering or attending GP or acute medical admissions is recommended. In order to better understand why incidence is increasing we conducted a retrospective analysis of all newly diagnosed cases of HIV between 1st January – 31st December 2015. 27 patients were newly diagnosed (21 in 2014, 17 in 2013) All were male, with an average age 31 (18-56). 78% of the men were men who have sex with men (MSM) and 74% were UK nationals. 7 had never had an HIV test before and 44% had concomitant STI. 32% had likely acquired infection within past 4 months. Increase in diagnosis may partly relate to increased testing, with outreach initiatives, home sampling and raising awareness with events such as National HIV testing week. **Conclusion:** There is evidence that a large proportion of our recently diagnosed patients had newly acquired infection. The majority of new diagnoses are within the MSM UK nationals. We are increasing surveillance of new diagnoses to better understand how transmission occurs in order to direct prevention campaigns.

WHAT CONTRIBUTION DO PSYCHOLOGICAL FACTORS MAKE TO SYMPTOMS IN RHEUMATIC DISEASE?

Rebecca Gibson, Sean Porritt and Clive Kelly
Universities of Sunderland and Newcastle upon Tyne and Queen Elizabeth Hospital, Gateshead

Most symptoms relating to inflammatory or connective tissue disease can now be treated, but a significant minority of patients either present with, or are left with, symptoms that relate to co-existing psychological factors. We assessed 100 consecutive new patients referred to a secondary care rheumatology clinic to estimate the extent to which psychological or social factors influenced their symptoms. We administered the Hospital Anxiety and Depression Scale (HADS) questionnaire to 100 consecutive patients with established inflammatory arthritis (IA) and matched controls. We found that 24 new patients had significant psychological comorbidity and that this was the major factor driving symptoms in 9 patients. A further 18 had social circumstances which influenced their symptoms and expectations of outcome. Among those patients with a IA, significant anxiety and/or depression was present in 33 (controls 4%) with anxiety predominant. This was a major factor in the patient's self-assessment of their response to treatment. Therapeutic strategies were adjusted in 76 (38%) patients to allow for the coexistence of psychological factors in symptom presentation. **Conclusion:** The burden of psychological factors in rheumatic disease is significant and plays a major role in symptom presentation. The potential benefits of psychological input are apparent.

THE ROLE OF SEQUENTIAL MONOTHERAPY IN PREVENTING FRACTURES IN HIGH RISK PATIENTS

Stephen Tuck, La'ali Gutierrez and Clive Kelly
James Cook Hospital, University of Newcastle upon Tyne and Queen Elizabeth Hospital

Oral monotherapy, usually bisphosphonates, has been adopted as the 'gold standard' for treating osteoporosis to prevent fractures. But how to manage patients who continue to fracture on single agent therapy? Trials of oral bisphosphonates with anabolic agents have shown no benefit, but studies have reported favourable results from combining parenteral bisphosphonates with an anabolic agent. We report our experience with sequential monotherapy using an anabolic agent followed by parenteral bisphosphonates. We identified 8 patients (4 male, mean age 66 years) sustaining a mean of 3.4 fractures while on prior monotherapy. Treatment with anabolic therapy was given for 2 years followed by 3 years of IV bisphosphonates in all patients. Bone density and bone turnover markers were measured at baseline, 2 and 5 years. We calculated changes in these and the number of new fractures occurring over the five year treatment period. Mean spinal bone density increased significantly from 0.78 (baseline) to 0.94 (2 years) and 0.99 (5 years), p=0.02. Similar but less dramatic changes were seen in the hip. Bone turnover was increased during the first two years and suppressed thereafter in all patients. No patient sustained a fractures during the 5 year treatment period..

Conclusion: Our results suggest that the use of sequential anabolic therapy followed by annual bisphosphonate infusions is safe and effective in treating patients with recalcitrant osteoporosis who have continued to fracture on oral monotherapy.

IMPLANTABLE CARDIOVERTER DEFIBRILLATOR DEACTIVATION: WE COULD DO BETTER

E Gray, RJ Graham, AJ Turley.
The Friarage Hospital, South Tees NHS Foundation Trust

As heart failure progresses there comes a time when an active defibrillator is no longer appropriate and healthcare professionals have a duty of care to consider deactivation of the device to reduce unwanted shocks and distress at the end of life. 100 questionnaires were sent over a 2-month period to four professional groups: GPs, Heart Failure Specialist Nurses (HFSN), Community Matrons & Cardiac Rhythm Management (CRM) teams. 36 questionnaires were returned. 15 GPs, 4,HFSNs, 8 Community matrons, 9 CRM Teams. 55.9 % participants had received education sessions on caring for heart failure patients with devices. 74.3 % participants had discussed DNACPR with their HF patients, 51.4% participants had discussed deactivation of device therapy. 36.4% did not feel it was their role to discuss deactivation of device.
Conclusion: There is a need for further education and collaboration to promote timely discussions regarding device deactivation in patients nearing the end of their life.

NOVEL EXPERIENCE OF LASER ASSISTED "INSIDE-OUT" CENTRAL VENOUS ACCESS FOR PACEMAKER IMPLANTATION

Aye T, Phan T, Muir DF, Linker NJ, Hartley R, Turley AJ.
The James Cook University Hospital, South Tees Hospitals NHS Foundation Trust

A pacemaker dependent 49-year-old male with bilateral subclavian vein occlusions and a failing epicardial system, who was felt unsuitable for transiliac approach, successfully underwent transvenous pacemaker implantation using a laser-facilitated 'inside-out' approach. Pre-procedure CT venography confirmed long occlusions of both subclavian veins with bilateral tortuous collaterals. Under general anesthesia venous access was gained via the left axillary vein through an infraclavicular incision, and the right femoral vein (RFV). A 7F multipurpose catheter was advanced to the proximal edge of the occluded segment via the RFV. Stiff penetrative angioplasty wires with micro-catheter support were used to tunnel into the body of the occlusion. A 1.4mm Excimer Laser was then delivered over a Pilot 200 wire and progress made toward the distal edge of the occlusion. After serial balloon inflations, the wire was tracked into the sub-intimal plane and advanced toward the left clavicle using a 'knuckle-wire' technique. Next the guide wire was externalised with blunt dissection and secured via the infraclavicular pocket. Amplatz superstiff wire was used to form a rail and after serial balloon dilatations from clavicular end, it ultimately allowed the successful passage of active fixation atrial and ventricular pacing leads.
Conclusion: Pacemaker implantation via the subclavian route is not always feasible, and in such circumstances epicardial or trans iliac approaches are often used. However, both these techniques are associated with high complication and device failure rates. This hybrid inside-out technique permitted transvenous pacemaker lead implantation in our patient. To our knowledge this is the first reported use of a laser in this context.

ENDOSCOPIC NON-ABLATIVE RADIO FREQUENCY ENERGY TREATMENT (STRETTA®) FOR GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)

S. Punnoose, R. Sathasivam, O. Reece-Bolton, P. Thambi, A. Dhar, Y. Viswanath.
Darlington Memorial Hospital, James Cook University Hospital

Stretta is a minimally-invasive endoscopic treatment that delivers non-ablative radiofrequency (NARF) energy to improve and restore the function of the lower oesophageal sphincter muscle, thereby improving symptoms of GORD. We present the early results from the first UK single centre to have adopted this therapeutic technique for treatment of GORD.

Over 12 months, 26 patients with confirmed GORD, unresponsive to medical management with standard or double dose PPI underwent the Stretta procedure. Patients with an associated hiatus hernia of ≤2cm on their index endoscopy were included. Patients needed to be symptomatic for at least 3 months on medication. Patients were administered a Health Related Quality of Life (GERD-HRQL) questionnaire pre and post-Stretta procedure. The mean follow-up period was 3.8 months (range 10.5). There were no procedural complications. Median heartburn (pre-18: post-2.5), regurgitation (pre-19: post-0) and total scores of GERD-HRQL (pre-44: post-6) improved post procedure. The overall patient satisfaction was 78%. 3 patients in the cohort who underwent previous anti-reflux surgery showed complete resolution of symptoms.
Conclusion: In this first UK report of Stretta, we demonstrate therapeutic benefit in medically non-responsive GORD, improving patient's heartburn, regurgitation and overall satisfaction scores with low procedural risks. A larger UK study is needed before Stretta is incorporated into the therapeutic pathway for GORD.

THE CLINICAL AND SERVICE IMPACT OF THE NATIONAL OESOPHAGO-GASTRIC CANCER AWARENESS CAMPAIGN

S Koo, B. Awadelkarim, S. Choudhary, A. Dhar
Darlington Memorial Hospital

Public Health England's 'Be clear on cancer (BCOC)' campaigns aim to improve public awareness of symptoms of cancer. This study assessed the impact of this campaign on diagnosis and the service impact on endoscopy, 2 week wait and routine referrals. We reviewed referrals from general practitioners 4 weeks and again 4 months after the campaign. Referrals during the campaign period (284 cases: 2WW-149, urgent-66, routine-69) was 2.2 times greater than the non-campaign period (123 cases: 2ww-79, urgent-9, routine-35). During the campaign period, there was no significant increase in OG cancer diagnosis. Only 2 were diagnosed compared to 1 during the non-campaign period. Waiting times increased during the campaign period from 29-42 days to 43-56 days.
Conclusion: The campaign did not yield an increase in OG cancer diagnosis but did increase waiting times. Other strategies need to be considered to improve earlier diagnosis.

Association Business

Date of next meeting:

Saturday 5th November at Wansbeck General Hospital: 10am – 1:00pm to include coffee and lunch.

Three hours CME approved. 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 including a short conclusion) **before 30th September** to the secretary clive.kelly@ghnt.nhs.uk.

The Margaret Dewar prize for the best junior doctor or medical student's presentation will be awarded for the best oral presentation of the year (£150), runner-up (£100) and best poster (£50).

Had you considered joining the committee? Our meetings with refreshments take place 3 times a year. We are particularly seeking enthusiastic representatives from James Cook, Northumbria and Carlisle. If interested, please contact Clive Kelly clive.kelly@ghnt.nhs.uk.

Also 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 consider presenting your research for the Hewan Dewar prize awarded annually for the best research paper submitted by a junior doctor or medical student.

Lastly, 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 10 years and other issues relating to the Association.

We look forward to seeing you at Wansbeck on Saturday 5th November

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