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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 Wednesday 11th July 2018 at Freeman Hospital Newcastle

CORE MEDICAL TRAINEES' PERCEPTIONS OF AN EDUCATIONAL STRUCTURED WARD ROUND.

J Catlow, R Thomas
University Hospital of North Tees

We implemented a registrar-led educational ward round where core medical trainees (CMTs) were allocated five patients to review with structured feedback given after the ward round. Complex patients were reviewed together. During subsequent qualitative interviews all trainees commented on the benefits of feedback. Five focussed on previous lack of opportunity, and five on the high quality of specific feedback to their training. All commented on improved autonomy and decision-making experience. They accepted the structure had a small burden on work load making such a round on a daily basis unmanageable.
Conclusion: This is a small study of trainees' experiences, but the interview data were a rich source for exploring their educational experience. The ward round structure was beneficial to trainees, improving feedback and autonomy with little impact on service.

A CASE OF GIANT CELL ARTERITIS

B Mekkayil, K Khan A Paul
James Cook university hospital

An 89-year-old previously independent lady was admitted general unwell with loss of appetite, weight loss and constipation over 2 weeks. Investigations showed a CRP of 158 mg/L. There was no evidence of infection and CT scans of chest, abdomen and pelvis were normal. On the 7th day of admission she woke with complete blindness. Giant Cell Arteritis (GCA) was diagnosed. Fundoscopy showed right optic disc swelling and left sided disc atrophy. Further history established a history of 10 days of left temporal headache with jaw claudication which was the cause of her loss of appetite and loss of weight. Temporal artery ultrasound scan confirmed temporal arteritis. She was commenced on intravenous methylprednisolone according to protocol followed by oral prednisolone.
Conclusion: GCA is the commonest vasculitis. As in our patient, headache, scalp tenderness, jaw and tongue claudication, and constitutional symptoms, should be investigated promptly for GCA as early recognition and treatment can prevent blindness.

A TRIAL TO EVALUATE AN EXTENDED REHABILITATION SERVICE FOR STROKE PATIENTS (EXTRAS).

Rodgers H, Shaw L, Bhattarai N, Cant R, Drummond A, Ford GA, Forster A, Francis R, Hills K, Howel D, Laverty AM, McKevitt C, McMeekin P, Price C, Stamp E, Stevens E, Vale L.
Newcastle University, Northumbria Healthcare Trust; Newcastle upon Tyne Hospitals, University of Nottingham, Oxford University, University of Leeds, King's College London, Northumbria University.

Development of long-term stroke rehabilitation services is limited by lack of evidence for specific interventions. In this multicentre randomised controlled trial 573 patients from 19 sites were randomized to receive an extended stroke rehabilitation service provided for 18 months following completion of early supported discharge (ESD). The service involved regular contact (usually by telephone) with a senior ESD team member who coordinated further rehabilitation. The control group received "usual care". At 24 months there was no significant difference between the groups for the primary outcome of the Nottingham Extended Activities of Daily (NEADL) score nor in the secondary outcomes of health status or mood. However, at 24 months the patients in the intervention group were more satisfied with the services they received (97.7% vs 87.5%, difference 10.2%;. 95% CI 5.3 – 15.0).
Conclusion: The extended stroke rehabilitation service did not improve stroke survivors' extended activities of daily living, mood or health status. However, at 24 months patients in the intervention group reported higher levels of satisfaction with services.

BETA BLOCKERS IN END-STAGE RENAL DISEASE (ESRD)

C. Greenstreet, W.Hinchliffe
City Hospitals Sunderland

Evidence suggests that beta-blockers are effective antihypertensives in the dialysis population, and that their use can reduce the risk of cardiovascular events during dialysis. When choosing a beta-blocker in a patient with ESRD, the degree of renal excretion is an important consideration, as is its hydro/lipophilicity as more lipid soluble agents are less likely to be removed during dialysis. We performed a case-note review of all patients in Durham satellite dialysis centre. Of the

40 patients, 88% (35) were prescribed antihypertensives, with 63% (25) prescribed beta-blockers. The majority were on bisoprolol, with 1 patient on atenolol and 1 propranolol. We have advised GPs to switch antihypertensives to beta-blockers and will monitor uptake and the effect on blood pressure control in the dialysis unit.
Conclusion: This study has prompted targeted blood pressure reviews of patients not prescribed antihypertensives and a switch in betablocker to those not on bisoprolol.

DIETARY NITRATE AND FOLATE SUPPLEMENTATION IN TANZANIANS WITH HYPERTENSION

Meghna Prabhakar, Richard Walker, Mario Siervo
Boman'gombe Hospital, Tanzania (associated with North Tyneside General Hospital)

Tanzania is undergoing demographic and economic shifts leading to rapid changes in lifestyle habits and a rise of non-communicable diseases (NCDs). We aim to conduct a pilot 3-arm parallel randomised clinical trial in 48 pre-hypertensive and hypertensive Tanzanian adults testing the efficacy of a combined nutritional intervention in low income settings evaluating the effect of BP changes derived from combined dietary nitrate and folate supplementation. The aim of the study is to establish the efficacy of nitrate supplementation on hypertension using changes in 24-hr blood pressure over 30 days. We hope that this trial will provide data on the efficacy of dietary nitrate in an African population.
Conclusion: The trail is underway and results will be presented at a future meeting.

IMPLEMENTATION OF GROUP CLINICS INTO UK CLINICAL PRACTICE

Fraser Birrell
Northumbria Healthcare NHS Foundation Trust

We introduced group clinics with a mean number of 18 patients, maximum 32, to manage patients with mixed early/chronic inflammatory arthritis, osteoporosis (pharmacy led), early arthritis and mixed early/chronic inflammatory arthritis. There was consistently high patient satisfaction and satisfactory outcomes with regard to disease activity. Clinics were implemented without additional resources beyond on-the-job training.
Conclusions: Group clinics are sustainable, clinically effective and efficient for UK chronic disease care and can be led by different clinicians after brief training.

MALIGNANT ASCITES MANAGEMENT IN NORTHUMBRIA

L Armstrong, F Werrett, K Frew, S Robinson, A Aujayeb
Northumbria HealthCare NHS Foundation Trust

From 2016-2018, 11 patients with median aged 67 have had an intra-peritoneal catheter (IPC) inserted for the treatment of malignant ascites. Diagnoses were pancreatic cancer (3), mesothelioma (2), breast cancer (2), colorectal cancer (1), gastric cancer (1) and oesophageal cancer (1). 4 were having chemotherapy with palliative intent and 1 hormone therapy. A pleural physician inserted 6 and a surgical consultant 5. Median procedures before IPC was 3 and time from development of clinical ascites was 46 days. Median time to death was 58 days. 1 complication arose with migration of a drain precluding drainage. Procedures were done in the operating theatre under strict asepsis. The practitioners have ultrasound training. Local guidelines are being implemented , focussing on when and where (e.g. theatre or ambulatory care treatment rooms) to insert an IPC.
Conclusions: We have an established a service for intraperitoneal catheterisation for recurrent ascites. IPCs are supported by NICE, have a low complication rate and have an estimated cost saving of £1051 per patient.

PRUCALOPRIDE USE IN CHRONIC CONSTIPATION

Beaton D
North Tees University Hospital

Prucalopride is licenced for use in managing chronic constipation in women who are refractory to standard laxative treatment. Given its price (£59.52/month for 2mg dose) NICE have set criteria for its use that Trusts must follow: i) it is recommended only in women for whom treatment with at least two laxatives from different classes at the highest tolerated recommended doses for at least 6 months has failed to provide adequate relief and invasive treatment for constipation is being considered; ii) if treatment with prucalopride is not effective after 4 weeks, the benefit of continuing treatment must be reconsidered; iii) it should only be prescribed by a clinician with experience of treating chronic constipation, who has carefully reviewed the woman's previous courses of laxative treatments specified. We reviewed the 17 patients prescribed Prucalopride in North Tees

Hospital between April 2016 and April 2017. In 4/17 appropriate laxatives had not been used prior to starting prucalopride. 12/17 were not reviewed at four weeks. All patients were seen by a consultant surgeon or gastroenterologist.
Conclusions: Patients' medication is not being reviewed at 4 weeks. To counter this pharmacy will send an email to the colorectal specialist nurse to assess by telephone the patients' response at 4 weeks to determine whether or not to continue medication.

RENAL BIOPSY COMPLICATIONS – A SINGLE CENTRE REVIEW

Taha R, Ahmed S
Sunderland Royal Hospital

This is a retrospective single centre study, looking at all patients who had a renal biopsy between August 2016 and August 2017.Complications were divided to major complications (large haemorrhage requiring intervention) and minor complications (minor haemorrhage causing haematuria or perinephric haematoma, biopsy of other surrounding organs, pain and failure of first attempts).107 renal biopsies were done during the audited period, 95(88.7%) were from native kidneys, 12(11.2%) from transplanted kidneys. 55(51.4%) of the procedures were performed by nephrology registrars, 46(42.9%) by nephrology consultants and 6 (5.6%) were radiologically guided. 94 patients (87.8%) had no complications, two patients (1.86%) had post biopsy haemorrhage requiring renal artery coiling (one biopsy was radiologically guided and the other performed by a senior nephrology registrar). One patient developed haemorrhage, acute kidney injury and a clot in the renal pelvis requiring cystoscopy and stent insertion. That procedure was performed by a nephrology consultant. Two biopsies (1.86%), both performed by nephrology consultants, showed non-renal tissues (spleen and large bowel respectively). Two patients (1.86%) had to have their procedure repeated due to a failed first attempt, four (3.73%) developed post biopsy haematuria, two of these four required catheterization and irrigation. One patient developed a perinephric haematoma, one had significant pain. Seven (6.5%) of samples (4 by consultant, 2 by registrars and 1 radiologically guided) contained inadequate numbers of glomeruli to establish a diagnosis.
Conclusions: There was an adequate tissue for diagnosis in 93.4% of cases. Our rate of major complications was 2.80% which is higher compared to the quoted 0.066% in the generic consent form yet achieving a standard of < 5%. Minor complications were observed in 10 patients (9.34%). 1.5 WTE Nephrology registrars performed 36 procedures while our 4.5 WTE nephrology consultants performed 10 procedures on average balancing the need to maintain skills vs supervising registrars. This audit raises the questions of the minimum number of renal biopsies required to maintain skills and supervise trainees.

AMBULATORY PNEUMOTHORAX MANAGEMENT

L Standing, K Conroy, S Parker, S Ellis, A Aujayeb
Northumbria HealthCare NHS Foundation Trust

A 2013 systematic review recognised the main benefit of ambulatory valves as a saving of approximately 12,000 UK bed days per year. Rocket® pleural vent™ is one such drain and one way valve. It is licensed for insertion into the 2nd intercostal space, mid clavicular line for primary, secondary and iatrogenic pneumothoraces. It enables management of well selected patients in an outpatient setting. A randomised controlled trial is ongoing. A local retrospective review (January 2016 to December 2016) found that 41 pneumothoraces could have been managed with a vent, with a potential saving of over 100 patient bed days and an estimated £73,100. Local guidelines have been produced. Three patients have been managed with a pleural vent so far with a consequent saving of 17 bed days. The local 14 respiratory, 24 accident and emergency and 7 acute medicine consultants have received training. Northumbria HealthCare NHS Foundation Trust has adopted this as a cost Improvement programme.
Conclusion: Increased use of ambulatory valves for the management of pneumothorax will save money and bed-days.

Association Business

Date of next meeting: Wednesday 7th November 2018 6.00 pm Freeman Hospital.

Many thanks to all those who attended the July meeting which we thought it wise to start early because of a clash with the World Cup.

The November meeting will be at the normal time of 6.00 pm with refreshments from 5:30 following the GIM teaching.

The meeting is **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 research, clinical series, audit and case reports. Please submit by email (around 250 words including a short conclusion) to the secretary Colin Doig (colin.doig@northumbria-healthcare.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, both consultants and junior doctors from James Cook, Northumbria and Carlisle. If interested, please contact Colin Doig (colin.doig@northumbria-healthcare.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.

Have you considered presenting your research for the Hewan Dewar prize (£500) awarded annually for the best research paper submitted by a junior doctor or medical student. Details available from the secretary.

We look forward to seeing you at the Freeman Postgraduate Centre on Wednesday 7th November