## Strategy 432448/8

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1. Frequency of biologic/small molecule monotherapy for rheumatoid arthritis in the EU: Real-world evidence from a patient audit study

**Authors**: Pouliot P.; Price L.

**Source**: Annals of the Rheumatic Diseases; Jun 2019; vol. 78; p. 1660

**Publication Date**: Jun 2019

**Publication Type(s)**: Conference Abstract

**Database**: EMBASE

**Abstract**: Background: Biologic/small molecule therapy has been the standard of care for adult patients diagnosed with rheumatoid arthritis (RA) who have failed conventional DMARD therapy, resulting in familiarity, comfort, and satisfaction among physicians. Prior recommendations of combining biologics/small molecules with a DMARD like methotrexate (MTX) have recently been challenged by clinical data demonstrating the effectiveness of IL-6 and JAK inhibitors as monotherapy.

Objective(s): This research sought to evaluate the frequency of biologic/small molecule monotherapy regimens among European RA patients who were recently switched from one biologic/small molecule to another.

Method(s): An independent market analytics firm collaborated with rheumatologists in France (n=62), Germany (n=66), Italy (n=61), Spain (n=68) and the UK (63) to conduct an online retrospective chart review of RA patients who had switched treatment from one biologic/small molecule to another in the prior twelve weeks. Rheumatologists were able to submit up to seven RA patient charts. A total of 1,312 patient charts were collected via a market-specific compliant audit form in September 2018 and included patient and physician demographics, patient treatment history, and clinical/non-clinical patient parameters.

Result(s): Overall, the analysis of patient chart audits revealed that 22% of all recently switched patients were switched to a biologic/small molecule monotherapy regimen. The frequency of monotherapy was highest in Germany (32%) and lowest in the UK (13%). Monotherapy was more frequent for patients switched to infliximab (39%) and tofacitinib (39%) and lowest for those switched to tocilizumab IV (12%) and rituximab (11%). When combined into classes of agents, frequency of monotherapy among recently switched patients was 25% for TNFs, 24% for JAK inhibitors, 23% for IL-6 inhibitors, and 16% for non-JAK/IL-6 AMOs (abatacept or rituximab). On a country-specific level, rates of TNF monotherapy were highest in Germany (38%) and lowest in the UK (16%). IL-6 monotherapy was also more common in Germany (27%) but least common in France (17%). JAK monotherapy was highest in France (34%) and lowest in the UK (7%), while monotherapy for abatacept/rituximab was highest in Germany (32%) and again lowest in the UK (13%).

Conclusion(s): The popularity of biologic/small molecule monotherapy varies by EU5 country and while rates are highest for TNF inhibitors, use of biologic/small molecule monotherapy for patients recently switched to a JAK or IL-6 inhibitor are comparable.

2. Adaptation of the WHO Essential Medicines List for national antibiotic stewardship policy in England: being AWaRe

**Authors**: Budd E.; Wilcox M.; Muller-Pebody B.; Hopkins S.; Cramp E.; Howard P.; Sharland M.; Hand K.; Wilson P.

**Source**: The Journal of antimicrobial chemotherapy; Jul 2019

**Publication Date**: Jul 2019

**Publication Type(s)**: Article

**PubMedID**: 31361000

**Database**: EMBASE

**Abstract**: Background: The popularity of biologic/small molecule monotherapy varies by EU5 country and while rates are highest for TNF inhibitors, use of biologic/small molecule monotherapy for patients recently switched to a JAK or IL-6 inhibitor are comparable.
OBJECTIVES: Appropriate use of and access to antimicrobials are key priorities of global strategies to combat antimicrobial resistance (AMR). The WHO recently classified key antibiotics into three categories (AWaRe) to improve access (Access), monitor important antibiotics (Watch) and preserve effectiveness of ‘last resort’ antibiotics (Reserve). This classification was assessed for antibiotic stewardship and quality improvement in English hospitals.

METHOD(S): Using an expert elicitation exercise, antibiotics used in England but not included in the WHO AWaRe index were added to an appropriate category following a workshop consensus exercise with national experts. The methodology was tested using national antibiotic prescribing data and presented by primary and secondary care.

RESULT(S): In 2016, 46/108 antibiotics included within the WHO AWaRe index were routinely used in England and an additional 25 antibiotics also commonly used in England were not included in the WHO AWaRe index. WHO AWaRe-excluded and -included antibiotics were reviewed and reclassified according to the England-adapted AWaRe index with the justification by experts for each addition or alteration. Applying the England-adapted AWaRe index, Access antibiotics accounted for the majority (60.9%) of prescribing, followed by Watch (37.9%) and Reserve (0.8%); 0.4% of antibiotics remained unclassified. There was unexplained 2-fold variation in prescribing between hospitals within each AWaRe category, highlighting the potential for quality improvement.

CONCLUSION(S): We have adapted the WHO AWaRe index to create a specific index for England. The AWaRe index provides high-level understanding of antibiotic prescribing. Subsequent to this process the England AWaRe index is now embedded into national antibiotic stewardship policy and incentivized quality improvement schemes.

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3. An Intracerebral Hemorrhage Care Bundle Is Associated with Lower Case Fatality

Authors Parry-Jones A.R.; Rowland J.; Paroutoglou K.; Birleson E.; Lee S.; Cecchini L.; Massyn M.; Patel H.; Sammut-Powell C.; Emsley R.; Bray B.

Source Annals of Neurology; 2019

Publication Date 2019

Publication Type(s) Article

PubMedID 31291031

Database EMBASE

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Available at Annals of Neurology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.

Abstract Objective: Anticoagulation reversal, intensive blood pressure lowering, neurosurgery, and access to critical care might all be beneficial in acute intracerebral hemorrhage (ICH). We combined and implemented these as the “ABC” hyperacute care bundle and sought to determine whether the implementation was associated with lower case fatality.

Method(s): The ABC bundle was implemented from June 1, 2015 to May 31, 2016. Key process targets were set, and a registry captured consecutive patients. We compared 30-day case fatality before, during, and after bundle implementation with multivariate logistic regression and used mediation analysis to determine which care process measures mediated any association. Difference-in-difference analysis compared 30-day case fatality with 32,295 patients with ICH from 214 other hospitals in England and Wales using Sentinel Stroke National Audit Programme data.

Result(s): A total of 973 ICH patients were admitted in the study period. Compared to before implementation, the adjusted odds of death by 30 days were lower in the implementation period (odds ratio [OR] = 0.62, 95% confidence interval [CI] = 0.38-0.97, p = 0.03), and this was sustained after implementation (OR = 0.40, 95% CI = 0.24-0.61, p < 0.0001). Implementation of the bundle was associated with a 10.8 percentage point (95% CI = -17.9 to -3.7, p = 0.003) reduction in 30-day case fatality in difference-in-difference analysis. The total effect of the care bundle was mediated by a reduction in do-not-resuscitate orders within 24 hours (52.8%) and increased admission to critical care (11.1%).

Interpretation(s): Implementation of the ABC care bundle was significantly associated with lower 30-day case fatality after ICH. ANN NEUROL 2019.


4. A review of compliance with pain assessments within a UK ICU

Authors Melia R.; Morrell-Scott N.; Maine N.

Source British journal of nursing (Mark Allen Publishing); Mar 2019; vol. 28 (no. 6); p. 382-386
5. Complementary and alternative medicine use during chemotherapy for neuroendocrine tumours

**Authors** Whyand T.; de Lima Y.C.; Davies P.

**Source** British journal of nursing (Mark Allen Publishing); Mar 2019; vol. 28 (no. 6); p. 387-393

**Publication Date** Mar 2019

**Publication Type(s)** Article

**PubMedID** 30925244

**Database** EMBASE

Available at [British journal of nursing (Mark Allen Publishing)] from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Available at [British journal of nursing (Mark Allen Publishing)] from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

**Abstract**

**BACKGROUND:** clinical audits highlight areas where care may not be of the desired quality; they are essential to ensure care is safe and effective. Effective assessment and management of pain have been shown to improve patient wellbeing and clinical outcomes. **AIM:** this audit aimed to identify compliance with pain assessment tools and documentation within intensive care and make recommendations to improve practice. **DISCUSSION:** compliance with documenting pain assessments was poor, a finding that is consistent with the literature. Although a wealth of evidence has shown pain assessments are not being completed effectively, this continues to be a problem. Intensive care has significant areas for improvement in this area, which would improve patients' experiences and outcomes. Nurses should be educated in the use of pain assessment tools and compliance.

**CONCLUSION(S):** providing patients in intensive care with appropriate analgesia benefits their physical and psychological health. Areas for improvement identified in this audit include that pain assessments need to be carried out and documented regularly. The audit has implications for practice in that it shows a need for reinforced education for staff, better communication and updates to promote pain assessment and the implementation of guidelines.

6. Failure demand: a concept evaluation in UK primary care

**Authors** Walley P.; Found P.; Williams S.

**Source** International journal of health care quality assurance; Feb 2019; vol. 32 (no. 1); p. 21-33

**Publication Date** Feb 2019

**Publication Type(s)** Review

**PubMedID** 30859878

**Database** EMBASE

Available at [International journal of health care quality assurance] from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

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Available at [International journal of health care quality assurance] from Unpaywall
Abstract

PURPOSE: The purpose of this paper is to assess failure demand as a lean concept that assists in waste analysis during quality improvement activity. The authors assess whether the concept's limited use is a missed opportunity to help us understand improvement priorities, given that a UK Government requirement for public service managers to report failure demand has been removed. DESIGN/METHODOLOGY/APPROACH: The authors look at the literature across the public sector and then apply the failure demand concept to the UK's primary healthcare system. The UK National Health Service (NHS) demand data are analysed and the impact on patient care is elicited from patient interviews. FINDINGS: The study highlighted the concept's value, showing how primary care systems often generate failure demand partly owing to existing demand and capacity management practices. This demand is deflected to other systems, such as the accident and emergency department, with a considerable detrimental impact on patient experience. RESEARCH LIMITATIONS/IMPLICATIONS: More research is needed to fully understand how best to exploit the failure demand concept within wider healthcare as there are many potential barriers to its appropriate and successful application. PRACTICAL IMPLICATIONS: The authors highlight three practical barriers to using failure demand: first, demand within the healthcare system is poorly understood; second, systems improvement understanding is limited; and third, need to apply the concept for improvement and not just for reporting purposes. ORIGINALITY/VALUE: The authors provide an objective and independent insight into failure demand that has not previously been seen in the academic literature, specifically in relation to primary healthcare.

7. Assessing the potential for integrating routine data collection on complementary feeding to child health visits: A mixed-methods study

Authors
Tully L.; Garcia A.L.; Wright C.M.; McCormick D.

Source
International Journal of Environmental Research and Public Health; May 2019; vol. 16 (no. 10)

Publication Date
May 2019

Publication Type(s)
Article

PubMedID
31100804

Abstract

There is no routine data collection in the UK on infant dietary diversity during the transition to solid foods, and health visitors (HVs) (nurses or midwives with specialist training in children and family health) have the potential to play a key role in nutrition surveillance. We aimed to assess items for inclusion in routine data collection, their suitability for collecting informative data, and acceptability among HVs. A mixed-methods study was undertaken using: (i) an online survey testing potential questionnaire items among parents/caregivers, (ii) questionnaire redevelopment in collaboration with community staff, and (iii) a survey pilot by HVs followed by qualitative data collection. Preliminary online questionnaires (n = 122) were collected to identify useful items on dietary diversity. Items on repeated exposure to foods, aversive feeding behaviors, flavor categories, and sugar intake were selected to correspond to nutrition recommendations, and be compatible with electronic records via tablet. HVs surveyed 187 parents of infants aged 12 months. Semi-structured interviews indicated that HVs found the questionnaire comparable with standard nutrition conversations, which prompted helpful discussions, but questions on eating behavior did not prompt such useful discussions and, in some cases, caused confusion about what was ‘normal.’ Lack of time among HVs, internet connectivity issues, and fear of losing rapport with parents were barriers to completing electronic questionnaires, with 91% submitted by paper. Routine nutrition data collection via child health records seems feasible and could inform quality improvement projects.

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8. Statistics on mortality following acute myocardial infarction in 842,897 Europeans

Authors
Alabas O.A.; Jernberg T.; Pujades-Rodriguez M.; West R.M.; Rutherford M.J.; Hall M.; Gale C.P.; Timmis A.; Lindahl B.; Fox K.A.A.; Hemingway H.

Source
Cardiovascular research; Jul 2019

Publication Date
Jul 2019

Publication Type(s)
Article

PubMedID
31350550

Abstract

There is no routine data collection in the UK on infant dietary diversity during the transition to solid foods, and health visitors (HVs) (nurses or midwives with specialist training in children and family health) have the potential to play a key role in nutrition surveillance. We aimed to assess items for inclusion in routine data collection, their suitability for collecting informative data, and acceptability among HVs. A mixed-methods study was undertaken using: (i) an online survey testing potential questionnaire items among parents/caregivers, (ii) questionnaire redevelopment in collaboration with community staff, and (iii) a survey pilot by HVs followed by qualitative data collection. Preliminary online questionnaires (n = 122) were collected to identify useful items on dietary diversity. Items on repeated exposure to foods, aversive feeding behaviors, flavor categories, and sugar intake were selected to correspond to nutrition recommendations, and be compatible with electronic records via tablet. HVs surveyed 187 parents of infants aged 12 months. Semi-structured interviews indicated that HVs found the questionnaire comparable with standard nutrition conversations, which prompted helpful discussions, but questions on eating behavior did not prompt such useful discussions and, in some cases, caused confusion about what was ‘normal.’ Lack of time among HVs, internet connectivity issues, and fear of losing rapport with parents were barriers to completing electronic questionnaires, with 91% submitted by paper. Routine nutrition data collection via child health records seems feasible and could inform quality improvement projects.

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### 9. Incidence and risk factors for important early morbidities associated with pediatric cardiac surgery in a UK population

**Authors**
Brown K.L.; Wray J.; Tsang V.T.; Ridout D.; Pagel C.; Utley M.; Anderson D.; Tibby S.; Barron D.J.; Cassidy J.; Davis P.J.; Stoica S.; Rodrigues W.

**Source**
The Journal of thoracic and cardiovascular surgery; Jun 2019

**Publication Date**
Jun 2019

**Publication Type(s)**
Article

**PubMedID**
31353100

**Database**
EMBASE

Available at The Journal of thoracic and cardiovascular surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

**Abstract**
OBJECTIVE: Given excellent 30-day survival for pediatric cardiac surgery, other outcome measures are important. We aimed to study important early postoperative morbidities selected by stakeholders following a rigorous and evidenced-based process, with a view to identifying potential risk factors. METHOD(S): The incidence of selected morbidities was prospectively measured for 3090 consecutive pediatric cardiac surgical admissions in 5 UK centers between October 2015 and June 2017. The relationship between the candidate risk factors and the incidence of morbidities was explored using multiple regressions. Patient survival, a secondary outcome, was checked at 6 months.

RESULT(S): A total of 675 (21.8%) procedure episodes led to at least 1 of the following: acute neurologic event, unplanned reoperation, feeding problems, renal replacement therapy, major adverse events, extracorporeal life support, necrotizing enterocolitis, surgical infection, or prolonged pleural effusion. The highest adjusted odds ratio of morbidity was in neonates compared with children, 5.26 (95% confidence interval, 3.90-7.06), and complex heart diseases (eg, hypoplastic left heart), 2.14 (95% confidence interval, 1.41-3.24) compared with low complexity (eg, atrial septal defect, P < .001 for all). Patients with any selected morbidity had a 6-month survival of 88.2% (95% confidence interval, 85.4-90.6) compared with 99.3% (95% confidence interval, 98.9-99.6) with no defined morbidity (P < .001). CONCLUSION(S): Short-term mortality following STEMI and NSTEMI was higher in the UK compared with Sweden. Mid- and longer-term mortality remained higher in the UK for NSTEMI, but was similar for STEMI. Differences in mortality may be due to differential use of guideline-indicated treatments. For permissions please email: journals.permissions@oup.com.

### 10. Updating the evidence on the effectiveness of the alcohol reduction app, drink less: Using bayes factors to analyse trial datasets supplemented with extended recruitment [version 2; peer review: 2 approved]

**Authors**
Garnett C.; West R.; Brown J.; Michie S.

**Source**
F1000Research; 2019; vol. 8

**Publication Date**
2019

**Publication Type(s)**
Article

**PubMedID**
31354942

**Database**
EMBASE

Available at Cardiovascular research from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

**Abstract**
AIMS: To compare ST-segment elevation myocardial infarction (STEMI) and non-STEMI (NSTEMI) mortality between Sweden and the UK, adjusting for background population rates of expected death, case mix and treatments. METHODS AND RESULTS: National data were collected from hospitals in Sweden (n=73 hospitals, 180,368 patients, Swedish Web-system for Enhancement and Development of Evidence-based care in Heart disease Evaluated According to Recommended Therapies [SWEDEHEART]) and the UK (n=247, 662,529 patients, Myocardial Ischaemia National Audit Project [MINAP]) between 2003 and 2013. There were lower rates of revascularisation [STEMI (43.8% vs. 74.9%); NSTEMI (27.5% vs 43.6%)] and pharmacotherapies at time of hospital discharge including [aspirin (82.9% vs. 90.2%) and (79.9% vs. 88.0%), beta-blockers (73.4% vs. 86.4%) and (65.3% vs. 85.1%)] in the UK compared with Sweden, respectively. Standardised net probability of death (NPD) between admission and 1 month was higher in the UK for STEMI (8.0 [95% confidence interval 7.4-8.5] vs. 6.7 [6.5-6.9]) and NSTEMI (6.8 [6.4-7.2] vs. 4.9 [4.7-5.0]). Between 6 months and 1 year and more than 1 year, NPD remained higher in the UK for NSTEMI (2.9 [2.5-3.3] vs. 2.3 [2.2-2.5]) and (21.4 [20.0-22.8] vs. 18.3 [17.6-19.0]), but was similar for STEMI (0.7 [0.4-1.0] vs. 0.9 [0.7-1.0]) and (8.4 [6.7-10.1] vs. 8.3 [7.5-9.1]). CONCLUSION(S): Short-term mortality following STEMI and NSTEMI was higher in the UK compared with Sweden. Mid- and longer-term mortality remained higher in the UK for NSTEMI, but was similar for STEMI. Differences in mortality may be due to differential use of guideline-indicated treatments. For permissions please email: journals.permissions@oup.com.

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Abstract

Background: A factorial experiment evaluating the Drink Less app found no clear evidence for main effects of enhanced versus minimal versions of five components but some evidence for an interaction effect. Bayes factors (BFs) showed the data to be insensitive. This study examined the use of BFs to update the evidence with further recruitment.

Method(s): A between-subject factorial experiment evaluated the main and two-way interaction effects of enhanced versus minimal versions of five Drink Less. Participants were excessive drinkers, aged 18+, and living in the UK. After the required sample size was reached (n=672), additional data were collected for five months. Outcome measures were change in past week alcohol consumption and Alcohol Use Disorders Identification Test (AUDIT) score at one-month follow-up, amongst responders only (those who completed the questionnaire). BFs (with a half-normal distribution) were calculated (BF<0.33 indicate evidence for null hypothesis; 0.33Result(s): Of the sample of 2586, 342 (13.2%) responded to follow-up. Data were mainly insensitive but tended to support there being no large main effects of the enhanced version of components on consumption (0.22Conclusion(s): Data from extended recruitment in a factorial experiment evaluating components of Drink Less remained insensitive but tended towards individual and pairs of components not having a large effect. In an exploratory analysis, there was weak, anecdotal evidence for a synergistic effect of four components. In the event of uncertain results, calculating BFs can be used to update the strength of evidence of a dataset supplemented with extended recruitment.

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13. Validating a risk stratification tool for audit of early outcome after operations for squamous cell carcinoma of the head and neck

**Authors**  
Tighe D.; Hills A.; Quadros R.; Thomas A.J.

**Source**  
British Journal of Oral and Maxillofacial Surgery; 2019

**Publication Date**  
2019

**Publication Type(s)**  
Article

**PubMedID**  
31353090

**Database**  
EMBASE

The aim of this study was to validate a case-mix adjustment tool (neural network) for the audit of postoperative outcomes. We tested its calibration and discrimination on two unseen groups of patients being treated for squamous cell carcinoma (SCC) of the head and neck and compared observed complication rates with predicted rates. A total of 196 patients who were treated at two UK NHS institutions between 2016 and 2018 were audited. Preoperative data pertaining to risk (T classification, complexity of operation, and “high-risk” status) were collected, together with data on postoperative complications. Diagnostic test statistics and receiver operating curves (ROC) were used to test the performance of the tool. The score was well calibrated (predicted and observed complication rates both 43%), but discrimination suggested only fair accuracy (ROC 0.66 - 0.68). Adjustment of case mix for the audit of postoperative complications is difficult, although our model suggests that departmental audit is possible, and its accuracy is equivalent to that of other national audits. Further work may elucidate key variables that have not yet been assessed.

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14. Risk of post-colonoscopy colorectal cancer in Denmark: Time trends and comparison with Sweden and the English National Health Service

**Authors**  
Pedersen L.; Bernstein I.; Valori R.; Lindorff-Larsen K.; Green C.; Torp-Pedersen C.

**Source**  
Endoscopy; 2019; vol. 51 (no. 8); p. 733-741

**Publication Date**  
2019

**Publication Type(s)**  
Article

**PubMedID**  
31174223

**Database**  
EMBASE

The aim of this study was to validate a case-mix adjustment tool (neural network) for the audit of postoperative outcomes. We tested its calibration and discrimination on two unseen groups of patients being treated for squamous cell carcinoma (SCC) of the head and neck and compared observed complication rates with predicted rates. A total of 196 patients who were treated at two UK NHS institutions between 2016 and 2018 were audited. Preoperative data pertaining to risk (T classification, complexity of operation, and “high-risk” status) were collected, together with data on postoperative complications. Diagnostic test statistics and receiver operating curves (ROC) were used to test the performance of the tool. The score was well calibrated (predicted and observed complication rates both 43%), but discrimination suggested only fair accuracy (ROC 0.66 - 0.68). Adjustment of case mix for the audit of postoperative complications is difficult, although our model suggests that departmental audit is possible, and its accuracy is equivalent to that of other national audits. Further work may elucidate key variables that have not yet been assessed.

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Abstract
Background: The post-colonoscopy colorectal cancer (PCCRC) rate is a key quality indicator for colonoscopy. Previously published PCCRC rates have been difficult to compare owing to differences in methodology. The primary aim of this study was to compare Danish PCCRC rates internationally and to calculate Danish PCCRC rates using the World Endoscopy Organization (WEO) consensus method for future comparison. The secondary aim was to identify factors associated with PCCRC.

Methods: National registries were used to examine the risk of PCCRC. The Danish 3-year rate of PCCRC (PCCRC-3yr) was calculated using previously published methods from England, Sweden, and the WEO. Poisson regression analysis was performed to identify factors associated with PCCRC. Results: The Danish PCCRC-3yr was significantly higher than the rate in the English NHS (relative risk [RR] 1.12, 95% confidence interval [CI] 1.05-1.19) and Sweden (RR 1.15, 95%CI 1.06-1.24). The Danish PCCRC-3yr based on the WEO consensus method fell from 22.5% in 2001 to 7.9% in 2012. The multivariable Poisson regression model found PCCRC to be significantly associated with diverticulitis (RR 3.25, 95%CI 2.88-3.66), ulcerative colitis (RR 3.44, 95%CI 2.79-4.23), hereditary cancer (age < 60 years: RR 7.39, 95%CI 5.77-9.47; age >= 60 years: RR 3.81, 95%CI 2.74-5.31), and location in the transverse (RR 1.57, 95%CI 1.28-1.94) and ascending colon (RR 1.85, 95%CI 1.64-2.08). Conclusions: The PCCRC-3yr was higher in Denmark than in comparable countries. Differences in colonoscopist training, background, and certification are possible contributing factors. A review of colonoscopist training and certification in Denmark, and continuous audit and feedback of colonoscopist performance may reduce PCCRC-3yr.

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15. The Cleft Multidisciplinary Collaborative: Establishing a Network to Support Cleft Lip and Palate Research in the United Kingdom
Authors: Sainsbury D.C.G.; Davies A.; Wren Y.; Southby L.; Chadha A.; Slator R.; Stock N.M.
Source: Cleft Palate-Craniofacial Journal; Apr 2019; vol. 56 (no. 4); p. 502-507

Publication Date: Apr 2019
Publication Type(s): Article
PubMedID: 30068232
Database: EMBASE

Available at Cleft Palate-Craniofacial Journal from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).
Available at Cleft Palate-Craniofacial Journal from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Available at Cleft Palate-Craniofacial Journal from Unpaywall

Abstract
Background: As a growing paradigm of health research, trainee collaboratives can influence clinical practice through the generation of cost-effective multicenter audit and research projects. The aims of the present article are to outline and discuss the establishment of a multidisciplinary collaborative in the context of cleft lip and/or palate (CL/P).

Method(s): The Cleft Multidisciplinary Collaborative (CMC) was formed in April 2016 under the overarching supervision of the National Institute for Health Research. Membership of the CMC is open to all members of the CL/P multidisciplinary team, who are encouraged to submit ideas for new research projects that will benefit clinical practice.

Result(s): To date, 48 clinical participants are involved in the CMC. These participants represent all 17 cleft teams from the United Kingdom and encompass a wide range of disciplines. The CMC has undertaken 2 major projects so far. The first involved collection of phenotype data to support a national cohort study. The second, still in progress, is a systematic review investigating factors associated with outcomes for velopharyngeal competence following cleft palate repair.

Conclusion(s): The concept of a multidisciplinary collaborative in CL/P has been demonstrated through the generation of a United Kingdom-wide network of committed clinicians and researchers and the effective undertaking of 2 large research projects. As the CMC gathers momentum, it hopes to attract funding to support its activities, to promote more involvement from the allied health and nursing professions, to encourage a more ingrained research culture within the CL/P community, and to promote the wider ambition of a global collaborative.

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16. The Victorian Comprehensive Cancer Centre lung cancer clinical audit: collecting the UK National Lung Cancer Audit data from hospitals in Australia
Authors: Mileshkin L.; Dunn C.; Duffy M.; Shaw M.; Antippa P.; Akhurst T.; Cross H.; Mitchell P.; Conron M.; Moore M.; Philip J.; Bartlett J.; Emery J.; Zambello B.
Source: Internal Medicine Journal; 2019; vol. 49 (no. 8); p. 1001-1006

Publication Date: 2019
Publication Type(s): Article
Database: EMBASE
Purpose or Objective: Non-small cell lung cancer (NSCLC) patients with stage 3 N2 disease are a heterogeneous group of patients who are offered surgery or chemo-radiotherapy. ESMO lung cancer guideline recommends consideration of surgery for early stage NSCLC - cT1-3 NO-cN2 M0. And inoperable, locally advanced patients are treated with radical chemoradiation (CRT) if permissible. This study investigated the outcomes of stage 3 N2 patients either diagnosed after surgery or before CRT in order to compare their survival outcomes.

Material(s) and Method(s): Patients with stage cN2 NSCLC diagnosed from January 2013 to January 2016, and treated with chemo-radiation or patients who underwent lung resection and had a diagnosis of pN2 in the West of Scotland were identified. A retrospective audit of patients was performed. Eight hundred and forty-five patients were diagnosed across the sites in 2013. Most were aged 65-80 (55%) and were male (62%). Most had non-small-cell lung cancer (81%) with 9% diagnosed with small cell lung cancer and 2% with mesothelioma. Data completeness varied significantly between fields. For those with higher levels of completeness, headline indicators of clinical care were comparable with EMLCA data. The Victorian population seem to lack access to specialist lung cancer nurse services.

Conclusion(s): Lung cancer care at participating hospitals appeared to be comparable with the UK in 2013. In future, prospective data collection should be harmonised across sites and correlated with survival outcomes.

One area of concern was a lack of documented access to specialist nursing services.

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17. Analysing stage III cN2 NSCLC treated with surgery or concurrent chemo-radiation

Authors Lyons P.; Gan H.W.G.; Chan C.W.E.; McCully E.; Ansel S.; Philip M.; Mohammed N.

Source Radiotherapy and Oncology; Apr 2019; vol. 133

Publication Date Apr 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract Background: Clinical audit may improve practice in cancer service provision. The UK National Lung Cancer Audit (NLCA) collects data for all new cases of thoracic cancers.

Aim(s): To collect similar data for our Victorian patients from six hospitals within the Victorian Comprehensive Cancer Centre and associated Western and Central Melbourne Integrated Cancer Service.

Method(s): We conducted a retrospective audit of all newly diagnosed patients with lung cancer and mesothelioma in 2013 across the six Victorian Comprehensive Cancer Centre/Western and Central Melbourne Integrated Cancer Service hospitals. The objectives were to adapt the NLCA data set for use in the Australian context, to analyse the findings using descriptive statistics and to determine feasibility of implementing a routine, ongoing audit similar to that in the UK. Individual data items were adapted from the NLCA by an expert steering committee. Data were collated from the Victorian Cancer Registry, Victorian Admitted Episodes Dataset and individual hospital databases. Individual medical records were audited for missing data.

Result(s): Eight hundred and forty-five patients were diagnosed across the sites in 2013. Most were aged 65-80 (55%) and were male (62%). Most had non-small-cell lung cancer (81%) with 9% diagnosed with small cell lung cancer and 2% with mesothelioma. Data completeness varied significantly between fields. For those with higher levels of completeness, headline indicators of clinical care were comparable with NLCA data. The Victorian population seem to lack access to specialist lung cancer nurse services.

Conclusion(s): Lung cancer care at participating hospitals appeared to be comparable with the UK in 2013. In future, prospective data collection should be harmonised across sites and correlated with survival outcomes.

One area of concern was a lack of documented access to specialist nursing services.

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18. Caring for Patients with Dementia Undergoing Radiation Therapy - A National Audit

Authors: O'Donovan A.; Flood J.
Source: Radiotherapy and Oncology; Apr 2019; vol. 133
Publication Date: Apr 2019
Publication Type(s): Conference Abstract
Database: EMBASE

Abstract

Purpose or Objective: The number of people with dementia is increasing in conjunction with the rapid growth of the older aged population in many countries worldwide. More people with dementia will also be diagnosed with cancer and may require radiotherapy at some stage of their disease trajectory. It is therefore necessary that care is taken to ensure that the Radiation Therapy (RT) department practice environment meets criteria for good practice in dealing with patients with dementia, in order to limit distress whenever practically possible. The primary aim of this national audit was to investigate Irish radiation therapy departments, with regard to dementia care in the areas of the department environment, clinical practice and staff training.

Material(s) and Method(s): The audit was conducted according to recommendations for best practice and universal design, particularly those of the Society and College of Radiographers (UK), the dementia friendly environment/dwelling guidelines and the King's Fund. The audit took place between September and November 2017. The environmental assessment consisted of six standards encompassing orientation, mobility, security, continence, wellbeing, and meaningful interaction. Clinical practice consisted of four standards encompassed by patient rights, informed consent, holistic care, and patient autonomy. Staff education and training was divided into the standards of training and support.

Result(s): Nine RT departments were assessed during the course of this audit, representing a 75% response rate. The national mean level of compliance with current best practice was 67%, with overall compliance to the recommendations for environmental layout (65%), clinical practice (67%) and staff training (75%). Only the latter achieved the target level of compliance.

Conclusion(s): Improvement of areas such as environmental layouts, dementia-focused protocols and education, as well as establishing links with other healthcare professionals and departments, will enable centres to meet all current standards of best practice in the future.

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19. Has the introduction of a primary care gout guideline resulted in serum uric acid (SUA) targets being achieved?

Authors: Farid R.; Gray L.; John D.; Ottewell L.; Holehouse D.
Source: Annals of the Rheumatic Diseases; Jun 2019; vol. 78; p. 1298-1299
Publication Date: Jun 2019
Publication Type(s): Conference Abstract
Database: EMBASE

Abstract

Purpose or Objective: The number of people with dementia is increasing in conjunction with the rapid growth of the older aged population in many countries worldwide. More people with dementia will also be diagnosed with cancer and may require radiotherapy at some stage of their disease trajectory. It is therefore necessary that care is taken to ensure that the Radiation Therapy (RT) department practice environment meets criteria for good practice in dealing with patients with dementia, in order to limit distress whenever practically possible. The primary aim of this national audit was to investigate Irish radiation therapy departments, with regard to dementia care in the areas of the department environment, clinical practice and staff training.

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Result(s): Nine RT departments were assessed during the course of this audit, representing a 75% response rate. The national mean level of compliance with current best practice was 67%, with overall compliance to the recommendations for environmental layout (65%), clinical practice (67%) and staff training (75%). Only the latter achieved the target level of compliance.

Conclusion(s): Improvement of areas such as environmental layouts, dementia-focused protocols and education, as well as establishing links with other healthcare professionals and departments, will enable centres to meet all current standards of best practice in the future.

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Background: Gout is the most common inflammatory arthritis thought to affect 2.4% of the UK population. A local primary care audit in 2012 suggested suboptimal gout management. In an attempt to improve gout management we introduced a local guideline which was supported by an increase in gout education to our local primary care physicians.

Objective(s): To assess the impact of a local primary care gout guideline (introduced in 2015) by comparing pre-guideline audit data (2012) to post guidelines audit data (2019). To identify if the introduction of this guideline translated into a reduction in secondary care referrals for advice on gout management.

Method(s): Retrospective analysis of primary care data covering all patients with active diagnosis of gout since 2015 in a large primary care medical group (list size of 30,000 patients). This data was then compared to the results of a previous audit carried out prior to introduction of guideline (2012). As well as assessing primary care data, we carried out a secondary care audit pre and post guideline introduction.

Result(s): Out of a population list of 30,000 patients, 650 (2.1%) cases were coded as gout. 521 (80%) were male and 129(20%) were female. 429(66%) were on ULT. 407 (94.8%) were on Allopurinol. 214(48%) were on Febuxostat and only 1 patient on sulfinpyrazone. Of those on Allopurinol, 24 (5.9%) had no documented monitoring of sUA levels. Out of the remaining 383 (94.1%), 179 (46.7%) achieved target sUA of <360, compared to 16.7% in the previous audit. 204 (53.3%) had not achieved the target SUA levels. 178 (46.4%) patients had had their SUA levels checked in the last year compared to 23.5% in the previous audit. 107 (28%) had SUA levels checked in last 3 years compared to 40% in the previous audit. SUA levels were not checked in the last 3 years in 98(25.6%) compared to 36.4% in the past. Of those on febuxostat, 14 (67%) achieved target SUA levels. 7 (33%) did not achieve target SUA levels. 10 (47%) patients had their SUA levels checked in the last year. 7(33%) had their SUA levels checked within the last 3 years and 4 (20%) had not had their SUA levels checked within the last 3 years. No patient was prescribed more than 300mg allopurinol daily by their primary care physician despite the recommended dose being up to 900mg daily. We found a 70% reduction in the number of referrals to secondary care for gout management over the same period of time.

Conclusion(s): The introduction of a local primary care gout guideline and associated education appears to have improved the number of patients achieving target serum uric acid levels as well as leading to a reduction in secondary care referrals for gout.
22. The anesthetic drug treatment of refractory and super-refractory status epilepticus around the world: Results from a global audit

Authors
Ferlisi M.; Hocker S.; Trinka E.; Shorvon S.

Source
Epilepsy and Behavior; 2019

Abstract
Multinational and multicenter registries collecting cases of refractory and super-refractory status epilepticus help to understand what the current practice in the treatment of such conditions is and can improve the rational therapy. We prospectively collected 776 cases of refractory status epilepticus requiring continuous intravenous anesthetic drugs in an intensive care unit setting, through online questionnaires compiled by the treating physicians in 50 countries. Initiation of an intravenous anaesthetic drug was relatively delayed in middle-income compared with high-income countries. There were marked regional differences in the choice of initial intravenous anaesthetic drug. Generally, midazolam was the most commonly used initial anesthetic drug (56%), followed by propofol (35%), in Europe, propofol was preferred over midazolam. In addition to anaesthesia, 26% of cases received some form of immunosuppression (with corticosteroids and/or intravenous immunoglobulin).

In this observational study, outcome was not affected by choice or sequence of anesthetic drugs, and nor was the use of barbiturate anesthetics associated with poorer outcome. The proportion of patients responding to cycles of different anaesthetic drugs was high even after failure of the earlier anesthetics, but the neurological outcome progressively worsened the longer anaesthetic drugs were needed and the longer the status epilepticus continued. However, even in the 158 patients who required three or more different anaesthetic drugs, 49% had seizure control on tapering the third anesthetic, and 20% had a good neurological outcome anywhere. For these reasons we believe that it is important to persist with therapy in patients who are intractable initially, especially as etiology, not the number of duration of anesthesia, is the primary determinant of prognosis. This article is part of the Special Issue “Proceedings of the 7th London-Innsbruck Colloquium on Status Epilepticus and Acute Seizures”

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23. Time to NIV and mortality in AECOPD hospital admissions: An observational study into real world insights from National COPD Audits
24. Outcomes of delivering a fertility preservation service for women with cancer over a 12-year period at a UK assisted conception unit

Authors: McDougall S.; Wilkinson A.; Vogt K.S.; Jones G.L.; Skull J.
Source: Journal of Obstetrics and Gynaecology; 2019
Publication Date: 2019
Publication Type(s): Article
Database: EMBASE

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Available at Journal of Obstetrics and Gynaecology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Abstract

This service evaluation aimed to appraise the delivery of a fertility preservation service for women with cancer which was established in 2005 as part of an Assisted Conception Unit. First, the ACU-database was interrogated between 08/2005 and 01/2017; revealing 174 women received referrals over the 12-year period with a steady referral increase each year. Demographic analyses revealed factors, such as being partnered, to be strong indicators of whether women would seek FP or not. To improve service provision, women who had consented to be contacted for audit, administrative and research purposes, received questionnaires to ascertain their perspectives on the FP decision-making process, their outcomes and ACU after-care. The majority perceived their experience as excellent due to the care they received from ACU staff, speed and efficiency in service delivery. The increasing number of referrals since 2005 is reassuring. However, this audit also highlighted shortcomings of the service, such as limited awareness of the fertility counselling service and lack of after-care. IMPACT STATEMENT

What is already known on this subject? There has been an increase in women diagnosed with cancer undergoing fertility preservation (FP) before starting potential gonadotoxic treatment. Offering FP to these women is essential as the ability to have future children is often perceived as equally as important as survivorship, and a source of hope for the future.

What do the results of this study add? This study presents a service evaluation, across a 12-year period, of delivering FP services to women with cancer in one UK Assisted Conception Unit (ACU). Women’s experiences of the service were evaluated to enhance service delivery and make recommendations for clinical practice. What are the implications of these findings for clinical practice and/or future research? The current service evaluation demonstrated increased rates of FP referral over a 12-year period for women with cancer. While this increasing number is reassuring and reflecting increased awareness among professionals and patients; shortcomings in the care pathway were also found: women reported limited opportunity to see fertility counsellors and desired better after care. This information may also be of benefit to other ACUs seeking to enhance and improve service provision in the care of women with cancer, contemplating fertility preservation.

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25. Association between anaesthetic technique and unplanned admission to intensive care after thoracic lung resection surgery: the second Association of Cardiothoracic Anaesthesia and Critical Care (ACTACC) National Audit

Authors


Source

Anaesthesia; 2019; vol. 74 (no. 9); p. 1121-1129

Publication Date

2019

Publication Type(s)

Article

PubMedID

30963555

Database

EMBASE

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Abstract

Unplanned intensive care admission is a devastating complication of lung resection and is associated with significantly increased mortality. We carried out a two-year retrospective national multicentre cohort study to investigate the influence of anaesthetic and analgesic technique on the need for unplanned postoperative intensive care admission. All patients undergoing lung resection surgery in 16 thoracic surgical centres in the UK in the calendar years 2013 and 2014 were included. We defined critical care admission as the unplanned need for either tracheal intubation and mechanical ventilation or renal replacement therapy, and sought an association between mode of anaesthesia (total intravenous anaesthesia vs. volatile) and need for intensive care admission. A total of 253 out of 11,208 patients undergoing lung resection surgery in 16 thoracic surgical centres in the UK in the calendar years 2013 and 2014 were included. We defined critical care admission as the unplanned need for either tracheal intubation and mechanical ventilation or renal replacement therapy, and sought an association between mode of anaesthesia (total intravenous anaesthesia vs. volatile) and need for intensive care admission. A total of 253 out of 11,208 patients undergoing lung resection surgery in the study period had an unplanned admission to intensive care in the postoperative period, giving an incidence of intensive care unit admission of 2.3% (95% CI 2.0-2.6%). Patients who had an unplanned admission to intensive care unit had a higher mortality (29.00% vs. 0.03%, p < 0.001), and hospital length of stay was increased (26 vs. 6 days, p < 0.001). Across univariate, complete case and multiple imputation (multivariate) models, there was a strong and significant effect of both anaesthetic and analgesic technique on the need for intensive care admission. Patients receiving total intravenous anaesthesia (OR 0.50 (95% CI 0.34-0.70)), and patients receiving epidural analgesia (OR 0.56 (95% CI 0.41-0.78)) were less likely to have an unplanned admission to intensive care after thoracic surgery. This large retrospective study suggests a significant effect of both anaesthetic and analgesic technique on outcome in patients undergoing lung resection. We must emphasise that the observed association does not directly imply causation, and suggest that well-conducted, large-scale randomised controlled trials are required to address these fundamental questions.

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26. Increasing the incidence of drain-free day-case mastectomies with the use of a fibrin tissue sealant; data from a single surgical center in the United Kingdom

Authors: Harrison C.; Remoundos D.D.; Harvey K.L.; Stoker G.V.; MacLean G.; Adwani A.; Roy P.G.
Source: Breast Journal; 2019
Publication Date: 2019
Publication Type(s): Article
PubMedID: 31338929
Database: EMBASE

Abstract
Day-case mastectomy surgery provides benefits to both patients and hospitals. Key barriers are the use of a drain and the risk of postoperative seroma formation. We introduced the use of a tissue sealant (Artiss) into the surgical site (post-mastectomy without immediate reconstruction and postaxillary clearance) and evaluated its effect on our practice, particularly day-case rates. A prospective audit of 177 patients who underwent a simple mastectomy with or without axillary surgery, or axillary node clearance with or without breast-conserving surgery was conducted at a single surgical center in the UK between November 2015 and November 2016. Artiss was used in all operations and, where appropriate, the drain was omitted to facilitate day-case surgery. The clinical outcomes were compared between patients undergoing different operations and duration of hospital stay. There was no statistically significant difference between day-case patients and inpatients in seroma aspiration rates (24.5% and 21.7%, respectively; P = 0.381) or other complications (22.4% and 16.1%, respectively; P = 0.106). The day-case mastectomy rate increased from 3.9% in the first quarter to 45.5% in the final quarter, which was a significant increase reaching well beyond the national target. The use of Artiss enabled us to increase the drain-free day-case surgery rates over a 1-year period, exceeding the 30% target recommended by the British Association of Day Surgery. We did not observe any increase in patient morbidity, and the change was cost-effective. We have now implemented the routine use of Artiss in women undergoing simple mastectomy with or without axillary surgery and stand-alone axillary node clearances as part of enhanced recovery clinical pathways.

27. Are energy and protein requirements met in hospital?

Authors: Pullen K.; Collins R.; Stone T.; Carter H.; Sadler H.; Collinson A.
Source: Journal of human nutrition and dietetics: the official journal of the British Dietetic Association; Apr 2018; vol. 31 (no. 2); p. 178-187
Publication Date: Apr 2018
Publication Type(s): Article
PubMedID: 28586107
Database: EMBASE

Abstract

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Available at Journal of human nutrition and dietetics: the official journal of the British Dietetic Association from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
BACKGROUND: Malnutrition is a problem within hospitals, which impacts upon clinical outcomes. The present audit assesses whether a hospital menu meets the energy and protein standards recommended by the British Dietetic Association's (BDA) Nutrition and Hydration Digest and determines the contribution of oral nutrition supplements (ONS) and additional snacks.

METHOD(S): Patients in a UK South West hospital were categorised as 'nutritionally well' or 'nutritionally vulnerable' in accordance with their Malnutrition Universal Screening Tool score. Energy and protein content of food selected from the menu ('menu choice'), menu food consumed ('hospital intake') and total food consumed including snacks ('overall intake') were calculated and compared with the standards.

RESULT(S): In total, 93 patients were included. For 'nutritionally well' patients (n = 81), energy and protein standards were met by 11.1% and 33.3% ('menu choice'); 7.4% and 22.2% ('hospital intake'); and 14.8% and 28.4% ('overall intake'). For 'nutritionally vulnerable' patients (n = 12), energy and protein standards were met by 0% and 8.3% ('menu choice'); 0% and 8.3% ('hospital intake'); and 8.3% and 16.7% ('overall intake'). Ten percent of patients consumed ONS. Patients who consumed hospital snacks (34%) were more likely to meet the nutrient standards (P <= 0.001).

CONCLUSION(S): The present audit demonstrated that most patients are not meeting the nutrient standards recommended by the BDA Nutrition and Hydration Digest. Recommendations include the provision of energy/protein-dense snacks, as well as menu, offering ONS where clinically indicated, in addition to training for staff. A food services dietitian is ideally placed to lead this, forming a vital link between patients, caterers and clinical teams.

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28. Carbotaxol definitive chemoradiotherapy for inoperable oesophageal cancer: UK multicentre study

Authors
Owens R.; Mukherjee S.; Cox C.; Hurt C.; Gomberg S.; Prince S.; Bird T.; Dorey N.; MacGregor U.; Al-Chamali H.

Source
Radiotherapy and Oncology; Apr 2019; vol. 133

Publication Date
Apr 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

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Available at Radiotherapy and Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Abstract
Purpose or Objective: The CROSS trial established weekly carbotaxol (CP) based CRT as standard of care for pre-operative treatment of oesophageal cancer. Given the promising outcome and low toxicity profile, this regimen is being increasingly used internationally as a component of definitive CRT (dCRT) for inoperable oesophageal cancer, although no large studies demonstrate benefit or equivalence over standard cisplatin fluoropyrimidine (CF) based dCRT. In the UK, a national questionnaire demonstrated that although CF-dCRT remained treatment of choice, CP-dCRT was being offered to elderly patients, less fit patients and in those whom CF-dCRT was contra-indicated. We present the outcomes of CP-dCRT from a UK-wide national audit in this selective patient group.

Material(s) and Method(s): Appropriate UK centres were identified through a national questionnaire. All patients were treated with weekly carboplatin (AUC2) and paclitaxel (50mg/m2) dCRT with curative intent between 2011-2018. Patient and tumour demographics, indication for CP-dCRT, toxicity, response rates (as per endoscopy and imaging), recurrence and overall survival were collected.

Result(s): 143 patients from 7 centres were included. Patient and tumour demographics are shown in Table 1. [Table Presented] Median age was 73 years (range 42-91; 60.8%>70yrs; 17.5% >80 yrs). Indications for CP-dCRT included co-morbidities (48.3%), clinician choice (32.9%), poor tolerance/progression on induction chemo (18.9%), 43.4% received induction chemotherapy (commonly CF). 71.3% received IMRT, and 75.5% received 50Gy/25 fractions (dose range 41.4/23-64/32#). 96.5% completed RT and 85.3% completed >=4 weekly infusions of CP. 36% of patients experienced at least one grade 3+ toxicity (haematological-12%, non-hematological-34%). The most common grade 3 non-haematological toxicities were nausea and vomiting (8%). There were 2 recorded deaths during treatment (oesophageal hemorrhage, duodenal perforation). At the post-treatment response assessment, 91 patients had an endoscopy, 121 had imaging, and 12 patients died prior to this point. 69.2% had complete response (CR) on endoscopy, 86.0% had CR/Partial response (PR)/Stable disease (SD) on imaging and 70.3% had combined CR on endoscopy with CR/PR/SD on imaging. In all patients, median follow-up was 17.2 months (95% CI 14.7-20.5), median OS was 24.3 months (95% CI 20.0-33.5), median overall/local/distant relapse free survival were 16.8 (95% CI 14.2-24.3)/20.3 (95% CI 16.8-28.8)/24.3 (95% CI 16.8-33.1) months respectively, and 31% of patients had relapsed. [Figure Presented] In patients that had a post-treatment endoscopy (n=91), treatment response (CR on endoscopy with CR/PR/SD on imaging) was associated with superior survival on multivariate cox regression (HR 4.79 (95% CI 1.83-12.55, p=0.001)).

Conclusion(s): CP-dCRT is safe and deliverable in elderly and "poor performance" patients who would have otherwise received palliative treatment. The outcomes are comparable to CF based dCRT, and should be considered as the preferred treatment option in this patient group.

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29. A 2018 IPEM audit of MRI in external beam radiotherapy treatment planning in the UK

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Source Radiotherapy and Oncology; Apr 2019; vol. 133
Publication Date Apr 2019
Publication Type(s) Conference Abstract
Database EMBASE

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Available at Radiotherapy and Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Abstract

Purpose or Objective: Interest in MRI for external beam radiotherapy (EBRT) planning is growing, as is the need for consensus guidelines for its use in the UK. In response to this, IPEM will report guidelines on MRI use for EBRT planning. As a first step, an audit has been performed to assess the current UK landscape of MRI in EBRT and the results are presented here.

Material(s) and Method(s): IPEM has supported a multidisciplinary working group, who developed a survey to assess the current landscape and needs of institutions regarding MRI in EBRT. The survey was split into six sections covering: institution details and MRI access; MRI use at the institution; MRI to CT registration; commissioning, QA and safety of MRI scanners; workflow, staffing and training; and, future applications of MRI. The survey was sent to 71 UK departments (63 NHS and 8 private groups) in June 2018 and closed after 8 weeks.

Result(s): Responses were obtained from 62/71 centres (87%) with good engagement from both NHS centres (89%) and private groups (75%). Of the responders, 94% use MRI for radiotherapy treatment planning taken from PACs, potentially acquired at another institution or not optimised for radiotherapy purposes. 69% of responders have some access to an MRI scanner for EBRT, i.e., in some format where they have control over the MRI acquisition, see figure. It was reported that there are only two dedicated MRI-simulators in the UK. [Figure Present] All centres using MRI in EBRT use rigid MRI to CT registration and two centres are currently using deformable image registration in addition. Commissioning and QA of image registration and MRI for EBRT showed large inter-centre heterogeneity caused by a lack of guidance. Physics support for setting up a new MRI for EBRT service is varied across the UK with links with radiology being very important and 23% of centres reporting no support from physics staff with specialist MRI knowledge. The largest reported barrier to utilising MRI further is a lack of MRI access (87% of centres) but a large proportion of all concerns are financially driven with a lack of tariff meaning centres do not get reimbursed for an MRI scan, see figure. [Figure Presented] Looking forward, within the next five years, 37% of centres intend to use functional MRI, 38% of centres are planning for an MRI-simulator, 16% of centres are planning to utilise MRI-only radiotherapy and 10% are planning for an MRI-linac (on top of the 3% that currently have access).

Conclusion(s): The current use of MRI for EBRT in the UK was audited. More than 2 in 3 of centres have some form of MRI access, but there are only 2 MRI-simulators at present. Collaboration with radiology departments is vital for both MRI access and staff support. The main barriers to fully integrate MRI are financially driven and a lack of tariff resulting in limited access. Knowledge gaps have been identified such as the lack of standardised QA guidance that will be addressed in the IPEM guidelines.

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In the UK we are aiming for adaptive radiotherapy (ART) to be the standard of care with IGRT as a core, essential component. These national recommendations define a roadmap to modern 4D-ART within a multi-professional team (MPT) environment with each profession bringing different perspectives to the development and implementation process. ART can be reactive, proactive, scheduled and real-time. Each have workflow considerations which should be carefully considered including roles and responsibilities of the MPT. Standardisation of clinical practice is essential for the delivery of safe, accurate radiotherapy treatments. New protocols and processes for ART should be developed which can be at both local and national levels. These can be established using existing evidence, through clinical trial participation and driven by technology. Examples of these approaches, from a radiation therapist (RTT) perspective, will be discussed. Clinical trials enable new technologies to be evaluated with regard to outcome, in a controlled environment. There have been a number of ART clinical trials in the UK which use a proactive plan of the day technique for bladder treatments. This assisted the centres involved to develop ART standards within their departments within a quality assured clinical trial. One such standard was the competency of RTT’s to select the plan of the day. Clearly defined guidelines within the protocol and the advice and support of the QA team enabled successful implementation throughout the UK. It is important to consider the role of QA together with audit programmes both during the implementation phase and also on a routine basis following the implementation of the new evidence based standards. This should include process mapping and resource assessments for each step in the ART process.

RTTs are a key component of this process within the MPT. The advent of real-time ART techniques, particularly utilising the MR-linac technology, presents an opportunity to improve outcomes for a number of disease sites and for RTTs to further extend their role within the patient pathway. However, this also presents challenges from a training perspective for RTTs to ensure correct interpretation of on-line image guidance, now with both CBCT and MR modalities.

Conclusion(s): Utilisation of national recommendations or clinical trial processes ensure that ART can be developed and implemented safely and accurately within a multi-professional team environment. Advanced ART techniques provide an opportunity for RTTs to extend their roles and scope of practice. This can be achieved by developing an educational framework which includes ART. References 1 National Radiotherapy Implementation Group Report. Image Guided Radiotherapy. Guidelines for Implementation and use. Copyright © 2019 Elsevier Ireland Ltd
National Institute for Health and Care Excellence guidelines recommend measuring vitamin D levels at diagnosis of melanoma and giving advice on supplementation in line with local guidelines on vitamin D. We sought to examine practice among healthcare practitioners (HCPs) across the region (six National Health Service trusts) about their management of vitamin D in patients with melanoma via an online questionnaire. The questionnaire (constructed in Google Surveys) was launched in November 2018, and to date 36 responses have been obtained (25 dermatologists, three plastic surgeons, five nurse specialists, two oncologists and one cancer care coordinator). Patients diagnosed with melanoma were reviewed in a designated melanoma clinic (25%), a designated skin cancer clinic (both melanoma and nonmelanoma; 28%), a general clinic (14%) and a mixture of the above clinics (33%). Two-thirds (67%) of responders confirmed there is a local policy on vitamin D monitoring specifically for patients with melanoma within their trust; however, 22% were not sure, 6% said there was only a general vitamin D deficiency guideline and 6% said there was no vitamin D guideline. Interestingly, less than half (46%) of responders were ‘very likely’ to know how to access their local guideline. In total 22% felt ‘neither confident nor unconfident’; or ‘unconfident’ in managing vitamin D in patients with melanoma, and 92% of HCPs would find standardized regional guidance helpful in managing vitamin D in patients with melanoma. There is variation in practice in measuring vitamin D levels; the majority (53%) would check levels at diagnosis and at 6 months, 11% at diagnosis only and 8% at diagnosis and at 3 months, while 8% would not routinely check vitamin D levels. The remainder would check at diagnosis and then vary frequency of monitoring depending on the time of year, or whether the patient was on supplements. Most HCPs (89%) vary the dose of the vitamin D supplement they recommend according to the blood level. However, the way in which this is done is varied. When asked ‘at what blood level of vitamin D would you consider stopping supplements for a period?’ 25% said > 85 nmol L\(^{-1}\), 25% > 100 nmol L\(^{-1}\), 19% > 90 nmol L\(^{-1}\) and 17% > 80 nmol L\(^{-1}\), while 6% would never stop vitamin D supplements. Preliminary observations from this small sample suggest lack of cohesion in how HCPs manage vitamin D monitoring in patients with melanoma. These results show the need to drive quality improvement to produce clear, easily accessible and standardized guidance across our region and also nationally.

32. Mohs micrographic surgery specimen processing and tumour-free margin interpretation: U.K. trends

Authors
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Source
British Journal of Dermatology; Jul 2019; vol. 181 ; p. 112

Abstract
In 2018, a survey was sent out to all U.K. Mohs micrographic surgery (MMS) centres with the aim of clarifying practices of specimen processing and tumour-free margin interpretation. Responses were received from 14 MMS centres. In total 88% of respondents were consultant level, and 47% of respondents required histological proof of tumour type prior to performing MMS (i.e. prior biopsy or frozen section biopsy). There was considerable variation in section thickness, with several respondents varying thickness depending on tissue type. The most frequently stated thickness of each section was 8 mum (range 5-200 mum). The distance between each section varied from 7 mum up to 200 mum. Just over three-quarters (77%) of centres lay their first section on the slide before the full epidermis is visible, with one-quarter (24%) waiting until the full epidermis is visible. The mode for the number of sections prepared for each tissue block was tied equally between six and nine sections. Exactly half (50%) of respondents continue to cut into the tissue block until tumour becomes visible. One section free of tumour was the most commonly accepted end point. However, some centres required up to eight sections to be clear of tumour before considering the Mohs margins to be free of tumour. Overall, 53% of centres used both haematoxylin and eosin and toluidine blue to stain their specimens, whereas 47% of centres used haematoxylin and eosin as their only stain. Mohs slides in half (50%) of U.K. MMS centres are reviewed by a histopathologist in addition to the Mohs surgeon. Other centres audit a proportion of their Mohs slides cases with histopathology for quality assurance. This survey, which has sampled a representative number of Mohs surgery units throughout the U.K., has shown significant variation in the technical preparation of Mohs tissue slides. It may be that different protocols for the preparation of Mohs tissue slides produce equal outcomes. However, we recommend that further study is undertaken, with the input of Mohs technicians, to identify best practice and optimize outcomes.

33. Audit of narrowband ultraviolet B in the treatment of eczema
Abstract

Photonet, the National Managed Clinical Network for phototherapy units in Scotland, has set standards for phototherapy units to achieve clearance or near clearance (minimal residual activity) in at least 70% of completed narrowband ultraviolet B (NB-UVB) courses in patients with whole-body psoriasis, with a median number of treatments per successful course of 30 or less. A similar outcome standard is also recommended in the National Institute for Health and Care Excellence accredited guidance and standards for phototherapy units. Patients with whole-body eczema form another significant patient group treated NB-UVB phototherapy in the U.K., and response of eczema to this treatment varies in the published literature [Garristen FM, Brouwer, Limpens J et al. Photo(chemo)therapy in the management of atopic eczema: an updated systematic review with implications for practice and research Br J Dermatol 2014; 170: 50113]. These patients generally respond less predictably than those with psoriasis and require a longer course of treatment. As part of our ongoing quality assurance programme, we carried out an audit of all patients with generalized eczema who completed a course of whole-body NB-UVB in 2018. The treatment protocol consisted of a starting dose of 70% of the minimal erythema dose, with incremental increases of 20% at each visit according to the erythema response. Treatment was given three times per week up to a maximum of 40 exposures. In total, 131 patients (89 men and 42 women) with generalized eczema who had failed to respond to topical therapy completed a course of treatment. Their median age was 32 years (interquartile range 23-58) and 76% had skin type I or II. Two-thirds (66%) achieved clearance or minimal residual activity within 40 exposures. The median exposure for these patients was 30 exposures (interquartile range 25-35). In addition, 24% of patients obtained moderate improvement. This audit has established a baseline for response of our patients with eczema, which compares favourably with outcomes in published clinical trials. A regional audit is now planned to establish outcomes in the other units in our regional network, which should provide valuable information for phototherapy governance.

34. Meeting the challenges of dermatology service redesign: Sharing our experience

Abstract

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British Journal of Dermatology; Jul 2019; vol. 181; p. 78
Our dermatology department was given the opportunity for comprehensive service redesign in an off-site location driven by the need to release space for acute specialties in our hospital. The prospect of moving off-site was initially daunting; we were concerned we would struggle to provide inpatient care, or that we would provide it by compromising our outpatient waiting list or by increasing agency staff expenditure. We feared isolation from other specialties and limiting the exposure of our trainees to acute dermatology. Our National Health Service trust secured the budget for new premises to house a modern, expanding dermatology department. We took a hands-on approach in the planning and design of the new space, and simultaneously developed solutions for the smooth running of our service, both inpatient and outpatient, to overcome the challenges of the off-site location. Systematic and careful planning led to a seamless off-site move. We put together a strong team of dedicated dermatology nurses to support the existing dermatology clinicians. We adopted innovative ways of working and piloted a digital platform conforming to all the requirements of the British Association of Dermatologists' teledermatology standards, which enabled intermediate teledermatology for inpatients as well as 2-week wait referrals. During the 4-month pilot period, we continuously improved the digital platform to suit our needs. Not only did we meet our targets, but we started exceeding them. By changing just two face-to-face one-stop lesion clinics per week to teledermatology assessments, our locum agency expenditure reduced by 40,000. We had zero skin cancer breaches and 50% discharge from lesion clinics after initial assessment. We provided timely inpatient dermatology care, with a consultant opinion being available within an average of 5.6 h via teledermatology without unnecessary travel between sites. We continued to provide very good exposure to acute dermatology for our trainees. This was all achieved within existing consultant job plans. The self-auditing digital platform enabled us to adjust the efficiency of our service more robustly, for example by triaging to the correct skin biopsy waiting lists, and allowed education and feedback to referring hospital teams, general practitioners and patients. We have proven that with careful planning, digital innovation and the implementation of modern workflow patterns, a hospital dermatology department with limited resources, struggling to cope with demand, can be transformed into a thriving community-based service.

35. Closed-loop audit of skin cancer conversion rate

Authors
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Source
British Journal of Dermatology; Jul 2019; vol. 181; p. 174

Abstract
The British Skin Foundation reports skin cancer as the most common type of cancer in the U.K., with an incidence rate of over 100,000 cases annually. Furthermore, skin cancer is responsible for more than 2500 cases of mortality every year. The skin cancer conversion rate is defined as the proportion of the patients referred by primary care due to suspected skin cancer diagnosis who receive a positive clinical and/or histological diagnosis of skin cancer. In 2013-14, Public Health England reported the skin cancer conversion rate as 10.5%. This audit aims to assess the effectiveness of teledermatology intervention by gathering data on the skin cancer conversion rate before and after the introduction of the mentioned intervention in a trust. A closed-loop audit of skin cancer conversion rate was conducted at a healthcare trust in the U.K. before a teledermatology intervention was conducted. Demographic data (sex and age), referral pathway information and clinical diagnosis data were recorded using patient files. No patient-identifiable information was recorded, and no ethical issues were encountered. No data were taken from patients without a referral. Two patients were excluded from this study due to missing information about their referral pathways. Biopsy results were obtained using electronic patient records. In total, 207 patients attended the skin cancer screening clinic. Overall, 20% (n = 41) of the patients attending the skin cancer screening clinic were clinically suspected by the secondary care dermatology team to have cancer. In total, 10% of the patients (n = 21) received a confirmed cancer diagnosis either clinically or histologically, 6% received a negative biopsy result (n = 12) and 4% (n = 8) are still awaiting biopsy. The skin cancer conversion rate before the introduction of teledermatology was 1014%, which is close to the national standard. A second audit of patients attending the same skin cancer screening clinic is in process and will be finished in spring 2019. The results will be presented at the Annual Meeting of the British Association of Dermatologists.

36. Teledermatology effectiveness in the welsh national melanoma audit
Melanoma is the fifth most common cancer in the U.K. and is rapidly increasing in incidence. Clinical practice varies throughout the U.K., especially with regard to the use of dermoscopy, sentinel lymph node biopsy (SLNB), vitamin D measurement and follow-up policies. Our aims were to record practice in Wales against the National Institute for Health and Care Excellence (NICE) melanoma guidelines and to review the pattern of melanoma referral from primary care. Data were collected retrospectively on new patients diagnosed with invasive melanoma between September and December 2017 (4 months). All seven health boards in Wales contributed, with a total of 112 patients. The lesion distribution was similar to published data: trunk (39%), arms (26%), head and neck (17%) and legs (15.2%). In total, 46% of lesions were AJCC 7th edition stage IA, with the remainder including stage IB (21%) and stage II (23%). Dermoscopy was documented at diagnosis in 68%, full skin examination in 81% and lymph node examination in 87%. Vitamin D was measured in 57% of patients, and 39% of these had low levels requiring supplementation. SLNB was offered to 83% of AJCC stage IBIIC patients. Staging investigations were discussed with 100% of patients with stage 2C and above; however, the NICE option grid was used in only 53%. BRAF testing was requested in 63% of patients. Only 79% of patients reached the 62-day cancer treatment target. Reasons for not meeting the target included melanomas referred as routine (n = 10), incisional biopsy performed initially (n = 4) and referral to other specialist (n = 4). Surprisingly, nearly one in four melanomas were referred through the routine pathway in Wales by the general practitioners (GPs). Further analysis of Cardiff and Vale University health board referral data was carried out, where all referrals from primary care are screened using teledermatology. This is unique to our trust in Wales, where only in 2017 we received 17 312 referrals through teledermatology. We noted that 15 of 30 melanomas were referred as routine rather than urgent or urgent suspected cancer, and 12 of these 15 were upgraded by a consultant dermatologist. This national audit revealed an alarmingly low level of suspicion among GPs in identifying features of melanoma, highlighting the urgent need for further education and training. This demonstrates the utility of teledermatology in prioritizations and also the unreliability of GPs in priority selection of referrals. We are currently investigating melanoma features that lead to lack of suspicion among GPs.
Abstract

Nondermatology doctors find diagnosis and management of cutaneous disease challenging due to lack of undergraduate training, and there remains an underestimated demand for dermatology on-call. Our tertiary referral dermatology service provides 24/7 on-call cover to one of the largest U.K. hospital trusts. An acute dermatology trainee responds to referrals Monday to Friday 09.00-17.00 h, over a 6-month rotation, in addition to providing advice to regional general practitioners, daily urgent clinics and inpatient dermatology ward cover. A 1:10 on-call rota provides out-of-hours and weekend cover. Named 24/7 consultant cover is available. Adult and paediatric inpatient referrals are received from three hospital sites, all of which were previously received via telephone contact through the trust switchboard. This traditional way of working posed numerous problems, which included no auditable trail of received referrals, disruption to the working day due to a high volume of calls, and less effective triage due to poor descriptions from referring teams with lack of medical illustration support. As part of a quality-improvement project, we created a group nhs.net e-mail account accessible to regional dermatology trainees on the on-call rota to accommodate transmission of a new e-referral form. A new dermatology trust intranet page accommodates information relating to use of the e-referral pathway and a link to medical illustration services introducing teletriage. Our proposed standard was that all requests for dermatology advice from trust inpatient wards complete an e-referral form, with only urgent requests having an accompanying phone call. Referral data were collected over two, 3-week periods, before and 2 months after implementation of the system. The data revealed a comparable total workload (119 vs. 123 events) and referral source breakdown in both periods. Postimplementation data revealed (i) 60% (37 of 62) of referrals completed the e-referral form, with 30% appropriately unaccompanied by a phone call; (ii) 35% of e-referrals had an unprompted accompanying medical illustration, compared with 0% previously; (iii) improved e-triage resulted in a 90% reduction in handover of cases to out-of-hours cover. A qualitative feedback survey undertaken by all regional trainees on the on-call rota was unanimously positive. The inpatient dermatology e-referral service was reaudited only 2 months after digitalization; however, our data already documented, supporting a paper-light service, and there is improved teletriage through medical illustration leading to safer, more efficient patient service.

38. Identifying varicella-naive patients before immunosuppression

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Source
British Journal of Dermatology; Jul 2019; vol. 181; p. 139

Publication Date
Jul 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

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Varicella is a common infection, affecting over 90% of children by age 15 years; however, a small proportion reach adulthood without acquiring it. In patients not previously exposed, immunosuppressive medications increase the risk of severe, disseminated varicella infection. The British Association of Dermatologists' guidelines on biological therapy in psoriasis, azathioprine (AZT) and methotrexate (MTX) recommend checking varicella antibodies in patients without a clear history of chickenpox. We audited appropriate documentation and investigation of previous varicella infection in dermatology patients prior to immunosuppression. The audit was performed across two district general hospitals in the U.K. Patients started on biological therapy for psoriasis, AZT or MTX between October 2016 and October 2018 were identified from pharmacy records, and notes were reviewed. In total, 96 patients were included: 49 starting biological therapy for psoriasis, 10 on AZT and 37 on MTX. The age range was 18-87 years (mean 48) and the male-to-female ratio was 1:1. Of patients starting biological therapy, 35 of 49 (71%) had documented enquiry about previous varicella, of whom 26 of 35 (74%) gave a clear chickenpox history. Of the patients who reported previous varicella, 12 of 26 (46%) still had varicella antibodies checked. Seven of 14 (50%) of those without documented enquiry regarding previous varicella had serology checked. One patient who had serology did not have varicella antibodies and the vaccine was given 4 weeks prior to starting biological therapy. In comparison, only 10 of 47 patients (21%) starting MTX or AZT had documented enquiry about previous varicella. Of these, one patient gave no clear history and had serology checked. No patients who gave a clear history of chickenpox had unnecessary serology. Seven of 37 patients (19%) without documented enquiry about previous varicella had serological testing. All serologies were positive for varicella antibodies. These results show a lack of documented questioning about previous varicella, particularly in the patients starting MTX or AZT. This could indicate a lack of enquiry or of documentation. In the biologics group more patients were asked about varicella, but a significant proportion also had serology checked unnecessarily. This could suggest that clinicians are more cautious when starting biological therapies, perhaps because they are newer drugs, or because biologics are more likely to be prescribed in nurse-led clinics where blood tests are requested from a checklist. The most significant audit finding was that some patients did not have documented enquiry about previous varicella or serology, and may be at risk of severe varicella infection while on medication.

39. Ethylenediamine allergy: A historical problem?

Authors
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Source
British Journal of Dermatology; Jul 2019; vol. 181; p. 159-160

Publication Date
Jul 2019

Publication Type(s)
Conference Abstract

Database
EMBASE
Abstract

Ethylendiamines are a structural class of antihistamines developed in the 1940s, which have other useful functions. Ethylendiamine dihydrochloride (EDA) is currently a constituent of parenteral aminophylline, insecticides, lubricants, herbicides, metal polishes, detergents, floor polish removers, waxes, rubbers, dyes, freezing/cooling solutions, epoxy curing agents and bleach accelerators (Dittmar D, Politiek KM, Coenaards P-J et al. Contact Dermatitis 2017; 76: 310-12). EDA is no longer present in any prescribed cream in the U.K. The first case report of cutaneous allergy to EDA was in 1958 (Tas J, Weissberg D. Allergy to aminophylline. Acta Allergol 1958; 12: 39-42). From 1968, routine patch testing to EDA in baseline series was recommended, owing to the high frequency of sensitization. In recent years, allergy to EDA has declined, and it was removed from the European Baseline Series in 1995. Tri-Adcortyl cream (containing EDA as a preservative, emulsifier and stabilizer), the most common source of allergy to EDA in the U.K., was discontinued in 2009. The resulting decrease in the frequency of positive patch tests led EDA to be removed from the British Society for Cutaneous Allergy baseline series in March 2018. We wished to assess the current prevalence of sensitization to EDA and its relevance. We performed a retrospective audit using data from 12 patch test centres in the U.K., examining the rate of sensitization to EDA in consecutively tested patients between 2013 and 2018 and the relevance of any positive patch tests, where known. In total, 20,456 consecutive patients were tested and 127 (0.62%) had a positive patch test to EDA. Demographics were available for 112 of these patients; two-thirds (70%) were female (n = 78) and the mean age was 59.4 years (median 60 years). Of the 127 patients sensitized to EDA, 41 (32%) had positive tests deemed to be of current (19) or past (22) relevance. Tri-adcortyl was the source of sensitization in 16 (39%) of these 41 cases. Other sources of exposure included rubber, aminophylline and topical nystatin. In some cases, sensitization was thought to reflect exposure to crossreacting oral antihistamines, including hydroxyzine. Only one case was thought to be occupational. EDA is now a rare sensitizer, and relevance cannot be determined in most patients with positive patch tests. In the past decade, reported cases have largely been due to occupational exposure. We suggest that EDA be reserved for occasional testing in selected patients with a history of relevant occupational exposure, or in those with severe dermatitis after exposure to intravenous aminophylline.

40. Paediatric 2-week-wait skin cancer audit

Authors

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Source

British Journal of Dermatology; Jul 2019; vol. 181 ; p. 150

Publication Date

Jul 2019

Publication Type(s)

Conference Abstract

Database

EMBASE

Available at British Journal of Dermatology from Wiley Online Library Medicine and Nursing Collection 2019 - NHS

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Abstract

The incidence of skin cancers is rising, and dedicated 2-weekwait skin cancer clinics have been set up throughout the U.K. However, skin cancer in paediatric patients is relatively rare, with a reported incidence in the U.S.A. of 1.1 per million in 1 4 year olds, and 10.4 per million in 1519 year olds (Saiyed FK, Hamilton EC, Austin MT. Pediatric melanoma: incidence, treatment and prognosis. Pediatric Health Med Ther 2017; 8: 39 45). In 2015, the National Institute for Health and Care Excellence provided updated guidelines on skin cancer recognition and referral; While the incidence of skin cancer is higher in the adult population, these guidelines cover all age groups, and provide advice on when the primary care physician should refer a suspected skin cancer, advice on the 2-week time frame when patients should be reviewed in secondary care, and advice on the 62-day target for first treatment. We conducted a retrospective audit of all patients who were referred under the 2-weekwait skin cancer pathway over a 1-year period. In our institution, patients are reviewed in either a dermatology or plastic surgery clinic. The primary aim of our study was to determine whether patients were reviewed within the recommended 2-week time frame, and whether the 62-day treatment target was achieved. The secondary aims were to determine how many patients were being referred under the 2-week-wait pathway over a 1-year period, to determine whether any skin cancers were suspected in secondary care, and to determine whether any skin cancers were diagnosed on histopathology review. Electronic case records were analysed from August 2017 to August 2018 and a pro forma was completed. In total, 81 patients were referred from primary care for evaluation of a suspected skin cancer; with 53% female, 47% male and a mean age of 11 years (range 117). Overall, 99% of patients were reviewed within 2 weeks of referral, and 100% of patients had first treatment completed within the 62-day target. Two patients from dermatology and five patients from plastic surgery underwent urgent excision of a skin lesion where a skin malignancy could not be completely refuted. No patients were diagnosed with a skin cancer after histopathology review. In conclusion, 81 patients were referred over a 1-year period as potentially having skin cancer. Patients of different ages were reviewed and no skin cancers were detected.
41. What’s in? What’s out? Giving the British Society of Cutaneous Allergy facial series a lift

Authors: Rolls S.; Hughes T.; Stone N.; Owen E.; Bertram C.; Bourke J.; Buckley D.; Chowdhury M.M.U.; Cooper S.; Ghaffar S.A.; Green C.; Johnston G.; Reckling C.; Thompson D.A.; Wakelin S.; Wilkinson M.

Source: British Journal of Dermatology; Jul 2019; vol. 181; p. 156

Publication Date: Jul 2019

Publication Type(s): Conference Abstract

Abstract: Facial dermatitis is an important diagnosis, with allergic contact dermatitis to cosmetics widely reported as a leading cause. The current British Society of Cutaneous Allergy (BSCA) facial series recommends 26 allergens and was last modified in 2012. A recent survey revealed a wide discrepancy in the number of allergens currently tested in facial/cosmetic series among 12 large U.K. patch test centres, with battery size varying between 24 and 66 allergens (mean 43). Testing with a large number of allergens is time-consuming and costly, and can increase risk of sensitization, while testing with too few or outdated allergens could lead to missed diagnoses. We aimed to update the recommended BSCA facial series by reviewing results from these 12 patch test centres, compiling the outcomes, and highlighting low-yield allergens to be removed from the series and new high-yield relevant allergens that should be added. We retrospectively reviewed the facial series results from the 12 centres over a 2-year period between 1 January 2016 and 31 December 2017. We recorded the allergens used in each centre, the numbers tested to the facial series and the number of positives for each allergen. Results were calculated to identify currently recommended allergens with positive pick-up rates < 0.3% and those not currently in the BSCA facial series with a positive pick-up rate of > 0.3%. In total, 4224 patients were patch tested to the facial series. Thirteen allergens in the BSCA series had positive pick-up rates of > 0.3%, while 14 allergens not currently in the BSCA facial series had positive pick-up rates of > 0.3%. Half of the allergens currently recommended had low positive pick-up rates, whereas a significant number currently not on the list had high pick-up rates and were felt to be relevant. The BSCA committee reviewed the data for each allergen and recommended standardizing the facial series to include 23 allergens. Fifteen current allergens remain in the facial series, while 11 were removed (five of which are on other recommended series) and eight new allergens with a pick-up rate of > 0.3% were added. This audit highlights the need to review recommended series on a regular basis to reflect clinical practice and keep updated with current literature and changing allergen exposure in the population. We hope that this new ‘lift’ to the facial series will allow an increased yield of relevant allergens for this important patient group.

42. Incidental radiation to the spleen after treating gastric lymphoma with radical radiotherapy-should we recommend prophylactic immunisation and an oar dose constraint?

Authors: Yuille F.; Kyle M.J.; Bedi C.; Urquhart W.

Source: Hematological Oncology; Jun 2019; vol. 37; p. 452

Publication Date: Jun 2019

Publication Type(s): Conference Abstract

Abstract: Facial dermatitis is an important diagnosis, with allergic contact dermatitis to cosmetics widely reported as a leading cause. The current British Society of Cutaneous Allergy (BSCA) facial series recommends 26 allergens and was last modified in 2012. A recent survey revealed a wide discrepancy in the number of allergens currently tested in facial/cosmetic series among 12 large U.K. patch test centres, with battery size varying between 24 and 66 allergens (mean 43). Testing with a large number of allergens is time-consuming and costly, and can increase risk of sensitization, while testing with too few or outdated allergens could lead to missed diagnoses. We aimed to update the recommended BSCA facial series by reviewing results from these 12 patch test centres, compiling the outcomes, and highlighting low-yield allergens to be removed from the series and new high-yield relevant allergens that should be added. We retrospectively reviewed the facial series results from the 12 centres over a 2-year period between 1 January 2016 and 31 December 2017. We recorded the allergens used in each centre, the numbers tested to the facial series and the number of positives for each allergen. Results were calculated to identify currently recommended allergens with positive pick-up rates < 0.3% and those not currently in the BSCA facial series with a positive pick-up rate of > 0.3%. In total, 4224 patients were patch tested to the facial series. Thirteen allergens in the BSCA series had positive pick-up rates of > 0.3%, while 14 allergens not currently in the BSCA facial series had positive pick-up rates of > 0.3%. Half of the allergens currently recommended had low positive pick-up rates, whereas a significant number currently not on the list had high pick-up rates and were felt to be relevant. The BSCA committee reviewed the data for each allergen and recommended standardizing the facial series to include 23 allergens. Fifteen current allergens remain in the facial series, while 11 were removed (five of which are on other recommended series) and eight new allergens with a pick-up rate of > 0.3% were added. This audit highlights the need to review recommended series on a regular basis to reflect clinical practice and keep updated with current literature and changing allergen exposure in the population. We hope that this new ‘lift’ to the facial series will allow an increased yield of relevant allergens for this important patient group.
Abstract

Introduction: Fibreoptic intubation in airway management: A review article

Method(s): A retrospective analysis was performed of 15 patients (pts) with gastric MALT and 1 with DLBCL who received radical RT from 2012 to 2018 at our centre. Doses to the spleen were analysed to evaluate the effect of radiation dose in relation to lymphocyte count and infection rates. Splenic Dose Volume Histogram (DVH) parameters were reported as mean splenic dose (MSD), maximum splenic dose (MxSD) and V5, V20 and V30 for the spleen. Lymphopenia was defined as absolute lymphocyte count (ALC) < 1.5 and infection was defined as any infection noted within hospital records.

Result(s): 14 pts received 30Gy in 20 fractions and 2 pts received 24Gy in 12 fractions. Median MSD 19Gy (range 14-27) and Median MxSD 32Gy (26-34). Median V5 91.5% (63.6-100), Median V20 52.3% (30.6-94) and Median V30 23.6% (6.1-59.2). All pts regardless of lymphocyte count before RT were found to be lymphopenic in the first 2 years (yrs) following treatment. Beyond 2 yrs, return to normal lymphocyte count was variable. However, between yrs 2 and 4 post RT, 50% had lymphopenia, then from yr 5 onwards all lymphocyte counts were normal.

Conclusion(s): There appears to be no direct correlation between MSD, MxSD, V5, V20, V30 and rates of lymphopenia but all patients became lymphopenic for the first 2 years following RT. Therefore, minimising dose to the spleen should be achievable to limit long term reduced function of this important organ, and prophylactic immunisations should be considered to protect these pts against potentially life-threatening infections.

Discussion(s): RT can reduce the function of the spleen after gastric irradiation for lymphoma (and for solid tumours). Routinely, the spleen has not been considered an important OAR. However, our data shows that lymphopenia occurs in all patients for the first 2 yrs following RT, and can continue for several more yrs, leaving pts at risk of infection. To prevent infection, in the UK, we would recommend immunisation for at least 2 yrs after receiving RT with the following vaccines: seasonal Influenza, Pneumococcal, Haemophilus influenza type B, Meningococcal C, Meningococcal ACWYW conjugate and Meningococcal B. Introducing a formal OAR dose constraint would be useful for clinicians treating upper abdominal organs with RT. As we were able to achieve a MSD of 14Gy, we would suggest 15Gy as a starting point. This could then be used to gather further data and relate to levels of lymphopenia and infection with a prospective audit.

43. Study protocol for the groin wound infection after vascular exposure (GIVE) audit and multicentre cohort study

Authors
Gwilym B.L.; Bosanquet D.C.; Saratzis A.; Benson R.; Forsythe R.; Dowell G.; Dattani N.; Lane T.; Shalhoub J.; Preece R.

Source
International Journal of Surgery Protocols; 2019; vol. 16; p. 9-13

Abstract
Introduction: Surgical site infections (SSIs) following groin incision for arterial exposure are commonplace and a significant cause of morbidity and mortality following major arterial surgery. Published incidence varies considerably. The primary aim of GIVE will be to compare individual units’ practice with established guidelines from The National Institute for Health and Care Excellence (NICE). Secondary aims will be to describe the contemporary rate of SSI in patients undergoing groin incision for arterial exposure, to identify risk factors for groin wound infection, to examine the value of published tools in the prediction of SSI, to identify areas of equipoise which could be examined in future efficacy/effectiveness trials and to compare UK SSI rates with international centres. Methods and analysis: This international, multicentre, prospective observational study will be delivered via the Vascular and Endovascular Research Network (VERN). Participating centres will identify all patients undergoing clean emergency or elective groin incision(s) for arterial intervention during a consecutive 3-month period. Follow up data will be captured at 90 days after surgery. SSIs will be defined as any infection noted within hospital records.

Discussion(s): RT can reduce the function of the spleen after gastric irradiation for lymphoma (and for solid tumours). Routinely, the spleen has not been considered an important OAR. However, our data shows that lymphopenia occurs in all patients for the first 2 yrs following RT, and can continue for several more yrs, leaving pts at risk of infection. To prevent infection, in the UK, we would recommend immunisation for at least 2 yrs after receiving RT with the following vaccines: seasonal Influenza, Pneumococcal, Haemophilus influenza type B, Meningococcal C, Meningococcal ACWYW conjugate and Meningococcal B. Introducing a formal OAR dose constraint would be useful for clinicians treating upper abdominal organs with RT. As we were able to achieve a MSD of 14Gy, we would suggest 15Gy as a starting point. This could then be used to gather further data and relate to levels of lymphopenia and infection with a prospective audit.

44. Fibreoptic intubation in airway management: A review article

Authors
Wong J.; Lee J.S.E.; Wong T.G.L.; Wong P.; Iqbal R.

Source
Singapore Medical Journal; Mar 2019; vol. 60 (no. 3); p. 110-118

Abstract
Introduction: Radiotherapy (RT) is an effective treatment for gastric lymphoma, the majority of which is low grade Mucosa-Associated Lymphoid Tumour (MALT) subtype. In view of its close proximity to the stomach, the spleen receives a significant dose of radiation which can affect its subsequent function. This leads to the potential for increased risk of infection, which could be lifethreatening. We therefore reviewed doses to the spleen, and aim to calculate a RT dose constraint for the spleen as an organ at risk (OAR).

Method(s): A retrospective analysis was performed of 15 patients (pts) with gastric MALT and 1 with DLBCL who received radical RT from 2012 to 2018 at our centre. Doses to the spleen were analysed to evaluate the effect of radiation dose in relation to lymphocyte count and infection rates. Splenic Dose Volume Histogram (DVH) parameters were reported as mean splenic dose (MSD), maximum splenic dose (MxSD) and V5, V20 and V30 for the spleen. Lymphopenia was defined as absolute lymphocyte count (ALC) < 1.5 and infection was defined as any infection noted within hospital records.

Result(s): 14 pts received 30Gy in 20 fractions and 2 pts received 24Gy in 12 fractions. Median MSD 19Gy (range 14-27) and Median MxSD 32Gy (26-34). Median V5 91.5% (63.6-100), Median V20 52.3% (30.6-94) and Median V30 23.6% (6.1-59.2). All pts regardless of lymphocyte count before RT were found to be lymphopenic in the first 2 years (yrs) following treatment. Beyond 2 yrs, return to normal lymphocyte count was variable. However, between yrs 2 and 4 post RT, 50% had lymphopenia, then from yr 5 onwards all lymphocyte counts were normal.

Conclusion(s): There appears to be no direct correlation between MSD, MxSD, V5, V20, V30 and rates of lymphopenia but all patients became lymphopenic for the first 2 years following RT. Therefore, minimising dose to the spleen should be achievable to limit long term reduced function of this important organ, and prophylactic immunisations should be considered to protect these pts against potentially life-threatening infections.

Discussion(s): RT can reduce the function of the spleen after gastric irradiation for lymphoma (and for solid tumours). Routinely, the spleen has not been considered an important OAR. However, our data shows that lymphopenia occurs in all patients for the first 2 yrs following RT, and can continue for several more yrs, leaving pts at risk of infection. To prevent infection, in the UK, we would recommend immunisation for at least 2 yrs after receiving RT with the following vaccines: seasonal Influenza, Pneumococcal, Haemophilus influenza type B, Meningococcal C, Meningococcal ACWYW conjugate and Meningococcal B. Introducing a formal OAR dose constraint would be useful for clinicians treating upper abdominal organs with RT. As we were able to achieve a MSD of 14Gy, we would suggest 15Gy as a starting point. This could then be used to gather further data and relate to levels of lymphopenia and infection with a prospective audit.

43. Study protocol for the groin wound infection after vascular exposure (GIVE) audit and multicentre cohort study

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Source
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Introduction: Surgical site infections (SSIs) following groin incision for arterial exposure are commonplace and a significant cause of morbidity and mortality following major arterial surgery. Published incidence varies considerably. The primary aim of GIVE will be to compare individual units’ practice with established guidelines from The National Institute for Health and Care Excellence (NICE). Secondary aims will be to describe the contemporary rate of SSI in patients undergoing groin incision for arterial exposure, to identify risk factors for groin wound infection, to examine the value of published tools in the prediction of SSI, to identify areas of equipoise which could be examined in future efficacy/effectiveness trials and to compare UK SSI rates with international centres. Methods and analysis: This international, multicentre, prospective observational study will be delivered via the Vascular and Endovascular Research Network (VERN). Participating centres will identify all patients undergoing clean emergency or elective groin incision(s) for arterial intervention during a consecutive 3-month period. Follow up data will be captured at 90 days after surgery. SSIs will be defined as any infection noted within hospital records.

Discussion(s): RT can reduce the function of the spleen after gastric irradiation for lymphoma (and for solid tumours). Routinely, the spleen has not been considered an important OAR. However, our data shows that lymphopenia occurs in all patients for the first 2 yrs following RT, and can continue for several more yrs, leaving pts at risk of infection. To prevent infection, in the UK, we would recommend immunisation for at least 2 yrs after receiving RT with the following vaccines: seasonal Influenza, Pneumococcal, Haemophilus influenza type B, Meningococcal C, Meningococcal ACWYW conjugate and Meningococcal B. Introducing a formal OAR dose constraint would be useful for clinicians treating upper abdominal organs with RT. As we were able to achieve a MSD of 14Gy, we would suggest 15Gy as a starting point. This could then be used to gather further data and relate to levels of lymphopenia and infection with a prospective audit.

44. Fibreoptic intubation in airway management: A review article

Authors
Wong J.; Lee J.S.E.; Wong T.G.L.; Wong P.; Iqbal R.

Source
Singapore Medical Journal; Mar 2019; vol. 60 (no. 3); p. 110-118
45. Radiotherapy Quality Assurance for the CHHiP Trial: Conventional Versus Hypofractionated High-Dose Intensity-Modulated Radiotherapy in Prostate Cancer

Authors: Naismith O.; Bidmead M.; Khoo V.; Roberts K.; Dearmaley D.; Mayles H.; Clark C.H.; South C.; Gulliford S.; Hassan S.; Hall E.

Source: Clinical Oncology; Sep 2019; vol. 31 (no. 9); p. 611-620

Abstract: Aims: The CHHiP trial investigated the use of moderate hypofractionation for the treatment of localised prostate cancer using intensity-modulated radiotherapy (IMRT). A radiotherapy quality assurance programme was developed to assess compliance with treatment protocol and to audit treatment planning and dosimetry of IMRT. This paper considers the outcome and effectiveness of the programme.

Material(s) and Method(s): Quality assurance exercises included a pre-trial process document and planning benchmark cases, prospective case reviews and a dosimetry site visit on-trial and a post-trial feedback questionnaire.

Result(s): In total, 41 centres completed the quality assurance programme (37 UK, four international) between 2005 and 2010. Centres used either forward-planned (field-in-field single phase) or inverse-planned IMRT (25 versus 17). For pre-trial quality assurance exercises, 7/41 (17%) centres had minor deviations in their radiotherapy processes; 45/82 (55%) benchmark plans had minor variations and 17/82 (21%) had major variations. One hundred prospective case reviews were completed for 38 centres. Seventy-one per cent required changes to clinical outlining pre-treatment (primarily prostate apex and base, seminal vesicles and penile bulb). Errors in treatment planning were reduced relative to pre-trial quality assurance results (49% minor and 6% major variations). Dosimetry audits were conducted for 32 centres. Ion chamber dose point measurements were within +/-2.5% in the planning target volume and +/-8% in the rectum. 28/36 films for combined fields passed gamma criterion 3%/3 mm and 11/15 of IMRT fluence film sets passed gamma criterion 4%/4 mm using a 98% tolerance. Post-trial feedback showed that trial participation was beneficial in evolving clinical practice and that the quality assurance programme helped some centres to implement and audit prostate IMRT.

Conclusion(s): Overall, quality assurance results were satisfactory and the CHHiP radiotherapy quality assurance programme contributed to the success of the trial by auditing radiotherapy treatment planning and protocol compliance. Quality assurance supported the introduction of IMRT in UK centres, giving additional confidence and external review of IMRT where it was a newly adopted technique.

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## 47. The first UK survey of dose indices from radiotherapy treatment planning CT scans for adult patients

**Authors**
Williams M.; Wood T.; Davis A.; Palmer A.; Earley J.; Nesbit A.; Plaistow R.; Lindsay R.; Edyvean S.; Findlay U.

**Source**
Radiotherapy and Oncology; Apr 2019; vol. 133

**Abstract**
The management of oesophageal SCC is a fully multidisciplinary process. There are options for treatment and the selection for an individual patient requires careful discussion in the context of each individual’s health, stage of disease and personal wishes. The availability of options stimulates significant differences in opinion amongst all oncology disciplines, not only reflecting available evidence but also the pattern of disease epidemiologically. Across Europe there are significant variations with surgery, usually with neoadjuvant treatments, in some centres and definitive chemoradiotherapy in others. In the UK there is an apparent 50:50 split between surgery and chemoradiotherapy. National audit data show similar results stage for stage. Furthermore many UK patients have significant co-morbidity precluding radical surgery. Despite the sensitivity of oesophageal SCC to combination chemoradiotherapy, the rates of recurrence vary. This can occur as residual disease at the end of treatment or recurrent disease some time after treatment. Past series have indicated that salvage surgery was hazardous with limited survival. However more recent series have shown that although complication rates are greater than primary surgery, in experienced centres these rates are manageable. Furthermore 5 year survival rates show similar outcomes for planned surgery after neoadjuvant treatment and for salvage surgery. As a result the option of more selective surgery needs further investigation with not only the evaluation of surveillance programmes but also to address patient preferences based on careful discussion of all evidence. There is therefore still a definite place of surgery in the treatment of oesophageal SCC.

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### 47. The first UK survey of dose indices from radiotherapy treatment planning CT scans for adult patients

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48. Head and neck radiotherapy consent: a national survey

**Authors**
Thomas P.; Ferguson C.

**Source**
British Journal of Anaesthesia; Sep 2019; vol. 123 (no. 3)

**Publication Date**
Sep 2019

**Publication Type(s)**
Conference Abstract

**Database**
EMBASE

Abstract
The Fourth National Audit Project showed that 39% of major airway complications involved head and neck patients. Many of these patients will receive radiotherapy as part of their treatment. Radiotherapy to the head and neck can cause contractures, rigidity, and distortion of oropharyngeal tissue, interfering with facemask ventilation and laryngoscopy. These risks are highlighted in the UK Multidisciplinary Guidelines for head and neck anaesthesia and the Difficult Airway Society extubation guidelines. Radiotherapy delivery is overseen by clinical oncologists, and we wanted to assess their current understanding of how radiotherapy side-effects can challenge anaesthetists and whether patients are consented for these potential risks. A survey was sent to all centres within the UK that provide head and neck radiotherapy. Distribution was to centres on the Royal College of Radiologists Clinical Oncology Workforce List and also placed on their Head & Neck Clinical Oncology Online Forum. We asked what patients are currently consented for and whether they are specifically told to inform future anaesthetists about their radiotherapy. We asked whether the oncologists were aware that radiotherapy can cause specific anaesthetic challenges and whether they would consider consenting patients for these risks and also if they would consider issuing a difficult airway card. More than half (n = 31) of UK centres responded. Patients were consented for difficulty in opening their mouths (83%), difficulty extending their necks (33%), oral ulceration (96%), reduced tongue mobility (53%), loss of teeth (87%), and skin tethering on anterior neck (74%). Only 3% of responding centres ask their patients to inform future anaesthetists about their radiotherapy. Half of respondents were unaware that radiotherapy to the head and neck is one of the most significant risk factors for difficult airway management. Moreover, 83% of respondents would be willing to issue difficult airway cards to head and neck radiotherapy patients. This survey demonstrates that although patients are consented for many potential radiotherapy side-effects, they are not warned that it may cause anaesthetists challenges. This raises a potential issue of consent in that they are not being made aware of some important potential side-effects. Importantly, more than half of oncologists were not aware that radiotherapy can cause anaesthetic challenges. Encouragingly, a majority of centres were receptive to being part of a system that could alert anaesthetists to potential danger (i.e. patient’s difficult airway alert card). It may therefore be time to update oncology consent forms and to raise awareness of radiotherapy-induced anaesthetic challenges throughout the oncology field. Patients could also play a role by carrying alert cards or wearing medic alert bracelets.


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49. Airway trolley shadow board incorporating intubation checklist for critically ill adults

**Authors**
Leigh A.; Salih T.; Same M.; Hoogenboom E.

**Source**
British Journal of Anaesthesia; Sep 2019; vol. 123 (no. 3)

**Publication Date**
Sep 2019

**Publication Type(s)**
Conference Abstract

**Database**
EMBASE

Abstract
Many of these patients will receive radiotherapy as part of their treatment. Radiotherapy to the head and neck can cause contractures, rigidity, and distortion of oropharyngeal tissue, interfering with facemask ventilation and laryngoscopy. These risks are highlighted in the UK Multidisciplinary Guidelines for head and neck anaesthesia and the Difficult Airway Society extubation guidelines. Radiotherapy delivery is overseen by clinical oncologists, and we wanted to assess their current understanding of how radiotherapy side-effects can challenge anaesthetists and whether patients are consented for these potential risks. A survey was sent to all centres within the UK that provide head and neck radiotherapy. Distribution was to centres on the Royal College of Radiologists Clinical Oncology Workforce List and also placed on their Head & Neck Clinical Oncology Online Forum. We asked what patients are currently consented for and whether they are specifically told to inform future anaesthetists about their radiotherapy. We asked whether the oncologists were aware that radiotherapy can cause specific anaesthetic challenges and whether they would consider consenting patients for these risks and also if they would consider issuing a difficult airway card. More than half (n = 31) of UK centres responded. Patients were consented for difficulty in opening their mouths (83%), difficulty extending their necks (33%), oral ulceration (96%), reduced tongue mobility (53%), loss of teeth (87%), and skin tethering on anterior neck (74%). Only 3% of responding centres ask their patients to inform future anaesthetists about their radiotherapy. Half of respondents were unaware that radiotherapy to the head and neck is one of the most significant risk factors for difficult airway management. Moreover, 83% of respondents would be willing to issue difficult airway cards to head and neck radiotherapy patients. This survey demonstrates that although patients are consented for many potential radiotherapy side-effects, they are not warned that it may cause anaesthetists challenges. This raises a potential issue of consent in that they are not being made aware of some important potential side-effects. Importantly, more than half of oncologists were not aware that radiotherapy can cause anaesthetic challenges. Encouragingly, a majority of centres were receptive to being part of a system that could alert anaesthetists to potential danger (i.e. patient’s difficult airway alert card). It may therefore be time to update oncology consent forms and to raise awareness of radiotherapy-induced anaesthetic challenges throughout the oncology field. Patients could also play a role by carrying alert cards or wearing medic alert bracelets. References: 1. Cook TM, Woodall N, Harper J, Benger J; Fourth National Audit Project. Br J Anaesthesia 2011; 106: 617-42. 2. Charters P, Ahmad I, Patel A, Russell S. J Laryngol Otol 2016; 130: S23-7. 3. Popat M, Mitchell V, Dravid R, Patel A, Swampillai C, Higgs A. Anaesthesia 2012; 67: 318-40
50. Preoperative ultrasound measurement of depth to the airway at the level of the cricothyroid membrane correlates with patient weight

Authors: Athanassoglou V.; Hughes-Jones H.; Hadjipavlou G.; Teoh W.H.; Kristensen M.S.; Vanner R.

Source: British Journal of Anaesthesia; Sep 2019; vol. 123 (no. 3)

Abstract: Of 80 cases of emergency cricothyroidotomy reported in 1 yr in the UK, 25 were obese. Our aim for this study was to determine the depth to the airway at the level of the cricothyroid membrane (DACM) by ultrasound (US) in a large group of adult patients over a wide weight and BMI range in a two-centre study. This procedure was a routine part of V. Athanassoglou's airway assessment. Written informed consent was obtained from all participants. The following data were collected for each patient: age, weight, height, gender, and DACM in milimetres by US examination while they lay supine with a pillow under the shoulders and with their neck extended. Oxford used the S-nerve (Sonosite) and Gloucester the GE Healthcare Venue 40 US machines. The transducer was applied with just enough light pressure to ensure contact between transducer and skin with care taken not to deform or compress underlying tissues. The cricothyroid membrane was identified as described by Kristensen and Teoh. DACM was measured to the leading edge (the edge nearest to the transducer) of the bright air-tissue interface. A total of 352 patients were studied: 252 in Oxford and 100 in Gloucester. Using the independent sample t-test, we found no differences between the two centres in terms of DACM, weight, and BMI. Combining the data from both centres, we found that DACM strongly correlated with weight (r=0.855, P<0.001) and, to a lesser extent, BMI (r=0.781, P<0.001) but not gender. We went on to conduct a stepwise linear regression, which excluded BMI, institution, and gender as being non-contributory to DACM. The linear model output from the regression analysis of weight vs DACM produced the following equation: DACM = 14.16 + 0.00264 x weight

51. Optimising emergency front of neck airway training in obese patients: randomised controlled trial comparing a novel synthetic ‘obese neck’ manikin with ‘slim neck’ and ‘meat-modified’ manikins

Authors: Gough C.; Le Fevre P.; Hearne B.J.; Corbett L.; Seller C.; Kelly F.E.; Cook T.M.
The Fourth National Audit Project (NAP4) reported that emergency airway rescue techniques were more likely to fail in obese patients, and that emergency front of neck airway (eFONA) took longer and with lower success rates than those reported during simulation training using conventional manikins. Such manikins are designed to mimic slim patients, with easily palpable landmarks, and do not train operators to deal with a blood-filled field. Previous work simulating eFONA in obese patients, using pork belly to modify standard training manikins, reported lower success rates and longer time-to-ventilation when using such 'obese neck' manikins, and with results that were consistent with those reported in NAP4. Using pork belly in this way has a number of practical limitations, including food hygiene issues, preparation time, and cost. We liaised with a medical manikin manufacturer (Limbs and Things, Bristol, UK) to design and manufacture a novel section of synthetic 'obese skin' which could be used with the existing TruCricTM training manikin (Trucorp, Belfast, UK). We designed and completed a study to compare the following: (i) 'slim neck' standard manikin with 3 mm thick silicon synthetic skin; (ii) 'obese neck' meat-modified manikin with a layer of pork belly (~2.5 mm depth) overlying the trachea; and (iii) 'obese neck' synthetic manikin using a section of synthetic skin and subcutaneous soft tissue overlying the trachea, and with 30 ml red dye solution injected into the model to simulate blood. The study was discussed with our research and development department, and formal ethics approval was not deemed necessary. Each participant gave written informed consent before the study. A power analysis study was undertaken. Each participant was asked to perform a scalpel cricothyroidotomy eFONA on all three types of manikin, freshly prepared for each participant and presented in random order, using the technique described in the 2015 Difficult Airway Society (DAS) guidelines. Each attempt was timed and filmed and the manikin subsequently analysed. A questionnaire was completed by all participants after taking part in the study. Thirty-three participants completed the study: 27 consultants, six senior anaesthetic/ICU doctors. All had received eFONA training within the past 3 yr. Time-to-ventilation for both the obese synthetic model and obese meat-modified model was longer than for the slim synthetic model (median 159 vs 58 s, P<0.001; median 105 vs 58 s, P<0.001). Both obese models had longer incision lengths than the slim model (obese synthetic: median, 83.5 vs 16 mm [P<0.001]; obese meat: median, 45 vs 16 mm [P< 0.001]), but there was no significant difference in airway puncture count. Both obese models had much poorer puncture accuracy (distance from midpoint of farthest incision to centre of cricothyroid membrane) than the slim neck model (obese synthetic: median, 8.3 vs 3.4 mm [P<0.001]; obese meat: median, 9.4 vs 3.4 mm [P<0.001]). Participants reported that the obese meat-modified manikin simulated human skin/tissue planes more realistically, but that the obese synthetic manikin was equivocally realistic, in that the landmarks were equally difficult to palpate and because it simulated bleeding. Our study demonstrates that this novel 'obese neck' synthetic model reproduces many of the difficulties encountered when performing an eFONA in an obese patient: it performed in a similar fashion to an obese meat-modified model and was more challenging than a traditional 'slim neck' manikin, while avoiding the practical hygiene issues associated with using pork belly to modify manikins. Such synthetic manikins may be useful tools for improving eFONA training in the future.


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Abstract

Background: Our department provides a service for inpatient Rheumatology reviews Monday to Friday, 9am to 4pm, with a guaranteed review timeframe of 48-72 hours. We work predominantly on the QEUH site, which comprises 1677 acute inpatient beds. We launched an electronic referral system for inpatient Rheumatology reviews in February 2018. Interspeciality referrals are an essential part of most inpatient stays. In a time of increasing service demand within the NHS it is important that we have an effective system to manage our time and resources. Electronic referrals allow us to audit our workload, our efficiency at reviewing patients and allow for accountability of both the referrer and reviewer, therefore improving patient safety. Using a set proforma allows us to improve communication, the quality of the referral and triage effectively.

Objective(s): We performed a baseline review of the new system.

Method(s): We reviewed all electronic referrals between 8.2.18 and 13.8.18. We collected data on demographics, timing, reasons for referral and outcomes.

Result(s): There were 346 referrals (58.4% female, mean age 64 years). Most (78%) were made from medical wards; the mean number of referrals per month was 49.4. Referrals were most frequently made on Fridays (23%). Most were in-hours (81%). The most common reason for referral was: a request for review (212; 61.3%); phone advice (70; 20.2%); procedural requests (50; 14.5%). 207 referrals (59.8%) were made for new patients, 91 (26.3%) for patients known to Rheumatology prior to admission, and 48 (13.9%) for patients already seen during the current admission. 50% of procedures were performed on knees and 50% on other joints. 82% of patients were seen within 72 hours. Acute hot swollen joint was the commonest reason for referral of new patients (38%), followed by vasculitis (6%). Questions regarding pre-existing disease management (59%) or DMARD questions (24%) predominated amongst referrals for patients known to Rheumatology prior to this admission.

Conclusion(s): The use of the electronic referrals system has made it simple to review the workload of our Rheumatology on-call service. We have used the data on ‘reason for referral’ to guide the topics for our educational meetings to improve patient management. We actively contribute to the procedural teaching on knee joint aspiration both in junior doctor’s formal training sessions, and opportunistically on wards following referral. This is a core procedure required for training completion for medical trainees in the UK and should help reduce referrals and manage patients in a more time efficient and cost-effective manner. We have also improved documentation by recording the time, date and name of the reviewer in our electronic entry.

We intend to collect data in the same period this year, to assess changes in referral pattern in the 12 months since the system was initiated and the impact of our interventions.

53. Can we improve inpatient referrals to Rheumatology in a teaching hospital in the UK?

Authors
Vivekanantham A.; Mateen Z.S.; Wheatley R.; Myers R.; Watson P.; Little J.

Source
Annals of the Rheumatic Diseases; Jun 2019; vol. 78 ; p. 605-606

Publication Date
Jun 2019

Publication Type(s)
Conference Abstract

Database
EMBASE
Abstract

Background: Inpatient referrals to Rheumatology vary nationally from paper/electronic methods to phone conversations with the Rheumatology registrar. In our Trust, which includes two large teaching hospitals in the UK, Rheumatology referrals were hand written, faxed to secretaries and then given to the Rheumatology registrar. This method was time consuming and referrals often lacked vital information. The referrer would also not know when the registrar had received the referral. A quality improvement project (QIP) in another UK hospital has shown an electronic referral system to be more efficient and safer for patients [1].

Objective(s): This QIP aimed to evaluate the current system for inpatient referrals to two Rheumatology departments within one large UK NHS trust and to identify aspects for improvement.

Method(s): Two hundred and ten inpatient Rheumatology referrals received between January 2018-January 2019 were analysed retrospectively for inclusion of important information such as, patient location and referrer’s contact details.

Result(s): The review of current referrals identified several areas for improvement. The results are summarised in Table 1. The reasons for referrals ranged from swollen, painful joints to new rashes and medication reviews. A process mapping session was undertaken to identify how the referral system could be improved. An electronic referral system, via the local electronic patient record (EPR), was created. As well as ensuring that there is an audit trail and referrals are received in a timely manner, referrers are provided with a proforma to direct them to supply the relevant information. There is also functionality for the Rheumatology team to reply to the referral with advice, which creates a new permanent document in the patient’s EPR. The Orthopaedic team, who are the first point of call for hot joints in our Trust, were consulted to ensure that there were not any unintended consequences as a result of this change. The form included the following sentence to avoid delays in patient care for septic arthritis: ‘patients with suspected septic arthritis should be referred to Orthopaedics by ringing the on-call registrar’.

Conclusion(s): The current method of paper Rheumatology referrals was inefficient and referrals often lacked vital information. The new electronic system will ensure relevant items are included in the referral and that there is a clear audit trail of the referral process. Referrals will be reevaluated again in three months to assess the impact of this change on outcomes including time to Rheumatology review and inpatient bed stay. In the second round of this project we plan to include an education component onto the Rheumatology referral form. For example, if gout is suspected, the referrer will be linked to guidelines and patient information sheets to assist best management whilst awaiting review. We would encourage others to consider their referral systems—could you improve yours?

54. The safe disposal of controlled drugs: A prospective audit of procedures and practices

Authors: Lee H.; Sattar F.
Source: Anaesthesia; Jul 2019; vol. 74 ; p. 36
Publication Date: Jul 2019
Publication Type(s): Conference Abstract
Database: EMBASE

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Abstract

Controlled drugs (CDs) are widely used in anaesthesia, and it is a responsibility of an authorised staff member to dispose of CD safely. Unused CDs are commonly encountered in clinical practice, and there are wide variations in disposing of CDs as shown in previous publications. This audit was performed to assess the procedures adopted and in use at Tameside and Glossop Integrated Care NHS Trust for the disposal of CDs. We also investigated whether anaesthetists and their assistants who are involved in the preparation and disposal of CDs are aware of recommended practices. Methods Questionnaires were given to the anaesthetists including consultants, specialty and associate specialists (SAS), anaesthetic trainees and nurses who were present in the anaesthetic department in April 2018. Results Fifty-five participants completed and returned the questionnaire, which included 48% of consultants, 69.2% of SAS/CT trainees and 72% of nurses. Regarding disposal method, some respondents had variation in their practice to empty or leave the remaining amount of CD: 64% will leave the remaining amount in the syringe/ampoule. Out of those 64%, 35 respondents will discard the unemptied syringes/ampoules into a sharps bin and four respondents will use the yellow bin for disposal. Some respondents answered to discard to both the sharps and yellow bins. All respondents empty the remaining amount in syringe/ampoule, and of those, 65% will use a sharps bin and 16% will use absorbing material for this purpose, 9% will use the yellow bin and 9% will empty into a sink/wash basin. One person reported that they would discard the remaining amount in a white/green bin. Regarding checking with a colleague, 64% will check with colleagues when disposing CDs. Sixty-nine per cent of respondents were aware of guidelines and their needs. Discussion The results demonstrated that our practice in disposal of CDs is not meeting the local hospital, Association of Anaesthetists and RCoA guidelines. Sixty-five per cent of respondents were following the correct practice by emptying the remaining content in the yellow bin; however, those respondents could have assumed the presence of an absorbing material, such as gel vac, at the bottom of the sharps bin, which is not always present. A wide variation exists among medical and nursing staff regarding their awareness and practices of disposing of CDs. There should be clear and easily accessible protocols for disposal of CDs and an improved awareness of the guideline is crucial for safe practice. (Figure Presented).

55. Are we using throat packs too often?

Authors Mincher N.
Source Anaesthesia; Jul 2019; vol. 74 ; p. 86
Publication Date Jul 2019
Publication Type(s) Conference Abstract
Database EMBASE

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Abstract

Retained throat packs are a ‘never event’, which occurred 21 times from 2013 to 2016 in England. The risk of airway obstruction is the most serious. There has been no proven benefit of using throat packs. I wished to establish whether recently published guidelines on throat pack use were being adhered to in a large university teaching hospital. If they were not, the aim was to improve the quality of patient care by changing this practice. Methods A short online survey was sent out to anaesthetists of all grades in the University Hospital of Wales. Results Eighty-eight surveys were returned (63% response). Fifty-nine per cent of respondents were consultants. Eight per cent of respondents would use a throat pack when using an endotracheal tube if there was likely to be pharyngeal soiling; with an laryngeal mask (LM) 18%. Six per cent use packs to stabilise airway devices, 2% if using nasal vasoconstrictors and 15% only in specific cases. Two per cent would never use one. Forty-four per cent of respondents were aware of national guidelines, but only 18% were aware of local policy. Forty-six per cent of respondents thought the anaesthetist should insert the pack, 9% thought surgeons should and 44% felt it depended on the circumstances. Thirty-one per cent thought the pack should be removed by the surgeon and 36% by the person who inserted it. A wide range of methods for identifying throat packs in theatre were shown, the commonest being: sticker on the patient (89%), record on white board (89%) and leave pack protruding from the mouth (65%). Only 40% included it in the swab count. Discussion The results showed that the department was not adhering to the latest advice as published in Anaesthesia. The main recommendations of this systematic review, consensus statement and accompanying editorial were (1) there should be a team decision to insert a pack in specific cases only; (2) the surgeon should generally insert the pack unless inappropriate; (3) it should be included in the swab count; (4) packs should be removed by the surgeon to be included in the final count; and (5) the anaesthetist is responsible for checking a clear airway before extubation. The National Patient Safety Agency (NPSA) 2009 recommendation of having ‘one visual and one documented piece of evidence’ appears to have been followed. As a result of this survey, local guidelines were updated in line with the consensus statement. These guidelines and the survey results were then presented at the hospital audit meeting. The updated guideline was emailed to each member of the department. The planned follow-up is to resurvey the department and see if practices have changed.
56. A local audit and departmental survey on preoperative antimicrobial prophylaxis following NAP6

Authors
Haughey B.; Cherian-McIvor V.

Source
Anaesthesia; Jul 2019; vol. 74 ; p. 32

Abstract
The 6th National Audit Project identified antibiotics as the most common trigger for anaphylaxis (47%) with teicoplanin 17 times more likely to cause anaphylaxis compared to alternatives [1]. In response to NAP6, a departmental survey and audit were carried out, within departmental guidelines, to identify current practices and areas for potential improvement. Methods A survey was disseminated to ascertain current practice regarding antibiotic choice, as well as timing of administration and use of test doses. A prospective audit, carried out over 2 weeks, reviewed 245 anaesthetic charts with data collected on the operation, antibiotics administered, adherence to guidelines and antibiotics received in cases of penicillin allergy. Results The survey was completed by 16 anaesthetists. Seven stated that they often gave a test dose of antibiotic (43.8%). Six routinely administer antibiotics pre-induction (37.5%). The audit revealed relevant guidelines were available in 151/245 cases (61.6%). Two specialties had no formal guidelines. In cases with available guidelines, they were followed in 115/151 cases (76.2%). In patients with documented penicillin allergies, alternative antibiotics followed guidelines in 7/11 cases (63.6%). Discussion This local survey and audit identified clear areas for improvement, although results are in keeping with those contained within NAP6 (e.g. a third of UK anaesthetists routinely administer test doses [2]). Findings were discussed at the departmental audit meeting where education was provided on the role antibiotics play in peri-operative anaphylaxis. Recommendations within NAP6 were highlighted and reiterated including having readily available guidelines that should be strictly adhered to, the avoidance of test doses and early administration of antibiotics. These findings were discussed with the lead antimicrobial pharmacist within the Trust and presented to the Trust governance meeting. New guidelines are currently being developed in specialties without guidelines and being updated in others. Ongoing discussions are taking place reviewing the role of teicoplanin in penicillin allergy. This audit loop will be completed following publication of new Trust guidelines this spring.

57. An audit of peri-operative anaesthetic practice for the care of patients undergoing emergency neck of femur surgery at large district general hospital

Authors
Garland A.; Debenham J.; Whittaker B.; Jewell W.; Bevir T.

Abstract
The 6th National Audit Project identified antibiotics as the most common trigger for anaphylaxis (47%) with teicoplanin 17 times more likely to cause anaphylaxis compared to alternatives [1]. In response to NAP6, a departmental survey and audit were carried out, within departmental guidelines, to identify current practices and areas for potential improvement. Methods A survey was disseminated to ascertain current practice regarding antibiotic choice, as well as timing of administration and use of test doses. A prospective audit, carried out over 2 weeks, reviewed 245 anaesthetic charts with data collected on the operation, antibiotics administered, adherence to guidelines and antibiotics received in cases of penicillin allergy. Results The survey was completed by 16 anaesthetists. Seven stated that they often gave a test dose of antibiotic (43.8%). Six routinely administer antibiotics pre-induction (37.5%). The audit revealed relevant guidelines were available in 151/245 cases (61.6%). Two specialties had no formal guidelines. In cases with available guidelines, they were followed in 115/151 cases (76.2%). In patients with documented penicillin allergies, alternative antibiotics followed guidelines in 7/11 cases (63.6%). Discussion This local survey and audit identified clear areas for improvement, although results are in keeping with those contained within NAP6 (e.g. a third of UK anaesthetists routinely administer test doses [2]). Findings were discussed at the departmental audit meeting where education was provided on the role antibiotics play in peri-operative anaphylaxis. Recommendations within NAP6 were highlighted and reiterated including having readily available guidelines that should be strictly adhered to, the avoidance of test doses and early administration of antibiotics. These findings were discussed with the lead antimicrobial pharmacist within the Trust and presented to the Trust governance meeting. New guidelines are currently being developed in specialties without guidelines and being updated in others. Ongoing discussions are taking place reviewing the role of teicoplanin in penicillin allergy. This audit loop will be completed following publication of new Trust guidelines this spring.
58. Assessing the impact of operation cancellations on anaesthetic training

**Authors**
Hammerbeck H.; Kambli A.

**Source**
Anaesthesia; Jul 2019; vol. 74 ; p. 56

**Abstract**
Case numbers can be used to quantify experience acquired during anaesthetic training and logbooks are assessed at each stage of training to ensure adequate experience has been gained. A recent major national audit [1], showed that 13.9% of inpatient cases are cancelled on the planned day of surgery, most commonly due to lack of beds. The impact of cancellations on training should be considered, especially as services within the NHS remain under pressure. Methods We audited cancellations at a large district general hospital (DGH) over the preceding 12 months and evaluated the impact on training by surveying current and recent trainees on their experiences in the department. The project was approved by the audit department. Results From October 2017 to September 2018, 20,943 elective cases were booked, of which 1812 were cancelled on the day, giving an overall cancellation rate of 8.6%. For those cases planned for an overnight stay, the cancellation rate was 11%. A total of 18 trainees (eight CT1-2 and 10 ST3-7) completed the survey. The range of cases per year was 150-600 (median 400). More than 50% reported that cases were cancelled at least once a week. The most common activities when cases were cancelled were non-clinical activities (55%) and emergency cases (27%). Forty-five per cent reported no impact of cancellations on their training; however, 27% felt there had been a moderate or major impact. No trainees reported keeping a record of missed training opportunities. Freetext responses indicated various reasons for cancellation: principally lack of beds, equipment and time. Discussion Cancellation rates and reasons are similar to a recent national audit. There is a broad range of trainee experience, both in terms of cases numbers and the experience of lost training cases. Many trainees do not feel cancellations affect their training; however, some perceive a marked effect. We recommend that trainees record such missed training opportunities in addition to their usual case logbook. Similar analyses should be considered in all departments involved in training.

59. An audit of the use and effectiveness of fascia iliaca compartment blocks in hip fractures

**Authors**
Carson M.; Cowan-Rawcliffe S.; Camilleri G.; Barker H.

**Source**
Anaesthesia; Jul 2019; vol. 74 ; p. 25

**Abstract**
In the UK, hip fracture is the most common reason for an elderly frail person to require an anaesthetic. Patients have associated comorbidity that presents a high risk of postoperative mortality [1]. Pain and loss experienced by patients creates a physiological challenge that must be overcome in the peri-operative period. Outcomes following hip fractures are a marker of hospital quality. Despite this, there is still controversy over optimal anaesthetic technique. Our aim was to audit current practice in the anaesthetic management of hip fracture patients. Methods A retrospective case note review was performed on all patients undergoing emergency neck of femur surgery from 1 November 2017 to 31 December 2018. The data collected represented the National Hip Fracture Database Anaesthesia Sprint Audit of Practice recommendations [1]. Results Table 1 presents an audit summary. Eighty-two patients had their case notes reviewed. The median age was 84 years. Forty patients underwent hemiarthroplasty. Forty-one patients underwent a general anaesthetic and nerve block. The median mean arterial pressure (MAP) at baseline was 92 mmHg. The median drop in MAP was 43% of baseline. Cardiovascular support was required in 75.6% of patients. Sixty-eight per cent received metaraminol boluses. Thirty-day mortality was 9.7%. Discussion Hip fractures are a serious injury in the elderly, resulting in significant morbidity and mortality. Despite recent developments in the standard of care to be obtained when managing patients with hip fractures, large variation in anaesthetic delivery is still present. The audit results have contributed to the creation of a neck of femur anaesthesia guideline to align peri-operative care. The data will be re-audited in December 2019. (Table Presented).
60. Promoting risk scoring for patients undergoing emergency laparotomy at the busy district general hospital in London

**Authors**
Shah R.; Bemand T.; Pittaway H.; Blackburn T.

**Source**
Anaesthesia; Jul 2019; vol. 74 ; p. 24

**Publication Date**
Jul 2019

**Publication Type(s)**
Conference Abstract

**Database**
EMBASE

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**Abstract**
In 2017, the National Emergency Laparotomy Audit (NELA) team launched a risk stratification tool to improve the accuracy of peri-operative risk prediction specifically for patients over the age of 18 undergoing emergency laparotomy. In turn, this improves patient outcomes by increasing awareness of high-risk patients that need early consultant surgical and anaesthetic involvement. In the 2016 NELA cycle, our department was noted to have a pre-operative documentation of risk of 27%, compared with the national average of 71% and a senior pre-operative review of 24% for high-risk patients, compared to the national average of 60% [1]. This quality improvement project aimed to improve awareness of the NELA risk score and improve its documentation of emergency laparotomy patients in line with national guidelines. Methods We performed a retrospective analysis of 20 cases over 3 months to assess use of the NELA risk calculator in the booking of emergency laparotomy. We looked at the surgical clerking, emergency booking and consent form, operation notes and anaesthetic charts. We presented these data at our hospitals joint surgical and anaesthetic meeting, and introduced posters and a new NELA risk calculator to our hospitals emergency surgery booking form. Results Our pre-intervention results demonstrated that formal risk assessment was recorded by anaesthetists in 29% of cases and by surgeons in 45.8% of cases. Following our intervention, overall documentation of peri-operative risk had improved to 80%. Discussion Formal documentation of risk prior to emergency laparotomy may improve patient outcomes by aiding early senior input in high-risk cases. By introducing targeted clinician education and design of a new emergency booking form, we increased awareness of peri-operative risk from emergency surgery. We will continue to re-audit these data prospectively.

61. Formation and application of a ‘peri-operative trauma care bundle’ for proximal femoral fracture patients

**Authors**
Gilani A.; Sivasubramaniam S.
We addressed the need for a comprehensive, interdisciplinary, 7-day consultant-led peri-operative trauma care service for our elderly patients in our district general hospital. As the elderly population of the UK continues to increase, so too do the number of patients presenting with proximal femoral fractures. These patients typically have multiple comorbidities, presenting a variety of challenges to their care peri-operatively. We recognised prior to 2015 our Trust demonstrated worse peri-operative outcomes in reference to national standards in the National Hip Fracture (NHF) Database [1]. We felt we needed to improve our practice significantly, with the culmination of a ‘peri-operative trauma care bundle’. Methods A baseline audit in 2014 identified 374 proximal femoral fracture patients were operated upon; examples showing change was needed included variation in pains scores, increased rates of delirium, spurious cancellations leading to delayed care, high rates of postoperative hypotension, no methods of risk stratification and poor communication. The ‘peri-operative trauma care bundle’ commenced in 2015 to improve peri-operative outcomes. Through discussions in clinical governance meetings with orthogeriatricians, orthopaedic teams, reflecting on audit results and evidence-based practice, and listening to concerns raised from patients and family members, we created a bundle that was revised between 2015-2018. Results Our main objective was standardising practice, creating a 7-day consultant-led service providing individualised peri-operative care for all our elderly proximal femoral fracture patients, with the intention of reducing morbidity and mortality. Using the peri-operative pro-forma (which is filled by the ward-based peri-operative anaesthetist from day 1 until day 7) we can chart our progress and collect data continuously. Contrasting the 374 patients in 2014 with outcome data for 359 patients in 2018, we demonstrated significant improvements in peri-operative care [1]. Discussion Our bundle is now routine practice for all our proximal femoral fracture patients; the continuous auditing cycle and application of the ‘plan-do-study-act’ model allows it to sustain itself and ascertain further problems facing this population. We believe our project shows one continual way to improve care for this growing population. Our approach was cost neutral, extended its remit to other related projects and can be replicated elsewhere.

62. A review of the University Hospital of North Midlands NHS Trust and Midlands Partnership NHS Foundation Trust paediatric dental extraction service

Authors  Price A.; Edmends S.; Nichols A.

Source  Anaesthesia; Jul 2019; vol. 74; p. 23

Publication Date  Jul 2019

Publication Type(s)  Conference Abstract

Database  EMBASE

Available at  Anaesthesia from Wiley Online Library

Available at  Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).
The University Hospital of North Midlands NHS Trust (UHNM) and Midlands Partnership NHS Foundation Trust (MPFT) paediatric dental extraction service has been running for over 20 years. This service provides pre-assessment clinics in the community and day-case procedures carried out under general anaesthesia, using an outpatient model, for approximately 1400 patients per year. We conducted the first review of the service against national guidelines [1].

**Methods**

The audit was registered with the UHNM audit department and permission granted from the MPFT governance committee. An audit questionnaire was produced using recommendations from the national guidelines, and advice from the local dental team. Parents and guardians who attended the service with their child between June and August 2018 were recruited into the audit. Those who provided informed written consent and a contact number were followed up using a telephone questionnaire 1 day after their child’s treatment. The feedback was transcribed anonymously. Results

In total, 36 parents/guardians participated. Ninety-seven per cent of parents agreed that they understood the information provided and were listened to by the dentist at the pre-assessment clinic, as recommended in guidelines 4 and 5 of the national standards. One parent stated that they would have liked more information after speaking to the team about how long the procedure would take and how long their child would spend in the recovery room. Recommendations 7 and 12 specify parents should receive written information at the preassessment clinic. Thirty-four parents answered yes to reading the information provided, which included fasting guidance and advice regarding the effects of the general anaesthetic. Thirty-four parents also knew the out of hours contact details. Finally, 100% of parents were either extremely satisfied or satisfied with the service provided.

Discussion

Overall, results show that the UHNM and MPFT paediatric dental extraction service is meeting national guidelines with > 90% in all areas selected for review. Results and recommendations for service improvement were presented to both the anaesthetic and dental teams. The written information has since been reviewed and updated to include approximate time frames of events and clear guidance on return to school as required in recommendation 12. A second audit cycle is planned after the publishing and distribution of the updated booklet.

### 63. Are psoriatic arthritis outcomes better in early arthritis service? study from a national award winning centre

**Authors**
Nisar M.K.

**Source**
Annals of the Rheumatic Diseases; Jun 2019; vol. 78; p. 617

**Publication Date**
Jun 2019

**Publication Type(s)**
Conference Abstract

**Database**
EMBASE

Background: There is good evidence that dedicated early arthritis clinics (EACs) improve referral lag time and reduce delay in establishing disease-modifying therapy. However, it remains arguable whether such clinics improve outcomes especially for arthritides other than RA. In the UK, only 57% of units have dedicated EACs. Our early arthritis service won national best practice commendation award for achieving high standards. Objective(s): We analysed our psoriatic arthritis (PsA) population data to ascertain whether this cohort benefits from EACs.

Method(s): The department set up an early arthritis service with introduction of six clinics (EACs) every week. An agreed treatment protocol incorporating ultrasound was developed to ensure standardised approach to early initiation of treatment, drug education and timely review. This is a retrospective study of all patients with PsA presenting to the service in the first year. Results: Our catchment area covers a population of 350,000 with 40% ethnic minorities. Of 1884 patients referred, 482 (25.5%) were Waged into EACs based on set criteria. All were reviewed within 3 weeks. 247 (51%) were confirmed to have early inflammatory arthritis (EIA). Mean age was 52.4 years (17-86y). 157 (63.5%) were women. 177 (71.6%) were White, 58 (23.5%) of Asian and twelve of other background. 159 (64.3%) had RA, 55 (22%) with PsA and 33 had other inflammatory arthritides. There was median 26 weeks delay (0.4-1043 weeks) from symptom onset to GP presentation. Median time for GP referral to the department was 4.0 days (0-84 days). All PsA patients had regular PsARC assessment. Mean tender (TJ) and swollen joint (SJ) counts at first visit were 8.2 (1-35) and 3.5 (0-14) respectively (n=55). The patient (PtGA) and physician (PhGA) global assessments mean were 3.0 and 2.9 (1-5). 95% commenced their DMARDs within 3 week of initial review. Other 5% who missed the target was owing to patient factors. Target [TJ & SJ <2] was achieved for 38 patients (69%) and good PsARC response for a further four (7%). Median time to achieve the target or good response was 22 weeks (0-48 weeks). Of 55, only four (7%) patients required escalation to biologic therapy. Final TJ and SJ mean was significantly better at 1.2 (0-4) and 0.3 (0-2) [p <.0001] with similar improvement in PtGA [mean 1.8 (1-4)] and PhGA [mean 1.6 (1-3)]. Only six (11%) patients were true non-responders as the remaining seven declined therapy.

Conclusion(s): Dedicated EACs help achieve good clinical outcomes in majority of PsA patients. Nearly 76% of our cohort attained the target or good PsARC response in less than six months. This was despite a significant delay in patients presenting to their GPs and moderately-high disease activity. 100% of our patients were treated to target facilitated by protocol driven escalation of therapy in these clinics. This is in contrast to the national audit findings whereby only 68% of patients were treated with disease modifying drugs within 6 weeks of referral and 89% had treatment to target. This study shows that the establishment of dedicated EACs improve the prognosis of psoriatic arthritis in terms of primary clinical outcomes compared to patients managed outside of EACs.

64. Updating the humble anaesthetic chart: A study in usability and human factors engineering

Authors
Eden D.

Source
Anaesthesia; Jul 2019; vol. 74 ; p. 74

Publication Date
Jul 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

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Abstract

Dudley Hospitals NHS Foundation Trust Despite the march of automated electronic anaesthetic record systems, the paper chart is still commonly used across many UK NHS Trusts. It is scoured for research data, scrutinised for fiscal information, monitored to ensure compliance with governance and exhibited to resolve medicolegal disputes [1]. It is therefore vital that it reduces cognitive burden and the information recorded is accurate and easy to identify. We recently undertook a redesign of our paper anaesthetic chart using solid usability principles and based on an appreciation of human factors. Methods Usability refers to the ease of use or 'learnability' of any human-made system, or the extent to which users achieve their goals in an effective and efficient manner. A well-designed user interface should help users complete their work efficiently and make them feel competent and satisfied [2]. Usability principles suggest these goals can be achieved with a paper chart that is be simple, consistent and efficient, whilst allowing for an amount of flexibility. Our re-design process was executed with this in mind. As well as 'high-level' elements such as layout, content and size, smaller details such as colour, font and shading were used to optimise our new chart’s usability. Results Every interaction we have during anaesthesia influences our clinical ability and application of knowledge in this setting. An appreciation of this in the design of these interactions can have a direct influence on patient safety and outcome. Reducing cognitive burden was our primary goal, both in the recording of data and in the diagnosis and management of intra-operative events. Feedback from the wider department on our new chart has been positive. Discussion Despite significant investment in the electronic anaesthetic record in recent years, the humble paper anaesthetic chart cannot be ignored. We strongly advocate good chart design based on sound usability principles, which helps reduce cognitive burden and enhance the accuracy and accessibility of data when audited retrospectively.

65. Be PREPPared: pain relief education for prospective parents (PREPP)-a novel obstetric anaesthesia quality improvement project

Authors Shah R.; Depala A.; Nicholas S.
Source Anaesthesia; Jul 2019; vol. 74 ; p. 48
Publication Date Jul 2019
Publication Type(s) Conference Abstract
Database EMBASE

All women should be given evidence-based information on analgesia for labour and anaesthesia for caesarean section [1]. The results from QUAIL (a trainee-led, pan-London audit looking at the quality of anaesthetic information for labour) revealed that at the time of performing the procedure, 61.7% of women recalled receiving complete information about epidural analgesia and 27.6% recalled receiving complete information regarding anaesthesia for caesarean section [2]. Our quality improvement project aims to promote knowledge of anaesthetic and analgesic options available during labour, delivery and in the postnatal period, to prospective parents at an antenatal session led by obstetric anaesthetists within a busy London hospital. Methods We surveyed patient satisfaction regarding the quality of information provided to them about analgesia and anaesthesia for: labour, induction of labour, caesarean section and postoperatively. We used this patient feedback to set up monthly interactive drop-in sessions designed and led by obstetric anaesthetists, delivering high-quality information to prospective parents. Results We surveyed 50 women over a 3-week period in the labour and postnatal wards of our hospital. Regarding analgesia for labour and anaesthesia for caesarean section, we found that 60% of women recalled receiving information antenatally and 40% recalled receiving information at the time of intervention. Of those that received information antenatally, 68% would have liked the opportunity to receive more information antenatally and 72% would have found written information useful. Our patient feedback also revealed that 72% of women would have liked to have attended a face-to-face session with an obstetric anaesthetist during the antenatal period. Discussion Provision of high-quality information in the antenatal period is paramount to providing a positive birth experience and empowering women to make their own decisions regarding their care. We used patient feedback locally to introduce a patient-centred antenatal workshop to help educate prospective parents regarding the anaesthetic and analgesic options available during labour, delivery and in the postnatal period. We will continue to audit knowledge and use feedback to improve the quality of our educational workshop.

66. Improving post-anaesthetic care unit capacity at St Mary's Hospital, London

Authors McLean E.; Illingworth J.
Source Anaesthesia; Jul 2019; vol. 74 ; p. 19
Publication Date Jul 2019
The post-anaesthetic care unit (PACU) is an important part of the journey for a patient through surgery. When the PACU is full, this reduces patient flow and theatre efficiency. Delays in discharge from the PACU to critical care, ward or home can negatively impact on both individual patients and the running of the whole surgical unit [1]. A PACU multidisciplinary team (MDT) was established to improve patient flow in June 2018. The aim of this quality improvement project was to understand which patient groups were experiencing delays in PACU discharge so that the appropriate pathways could be targeted to help reduce unnecessary patient stays in the PACU. Methods Patients attending for an operation in all nine main theatres at St Mary’s Hospital were searched covering two sample weeks in October 2017 and 2018. The PACU documentation on the electronic patient record for each patient was used to identify the time into the PACU, time ready to leave and time discharged from the PACU. In addition, destination after recovery and speciality were noted. Results There were 137 cases in 2018 with an average cycle time through the PACU of 147 min compared to a closely comparable number of 136 cases in 2017 with an average time of 238 min. On average, the cycle time had decreased significantly between the two sample weeks. The longest cycle times were for day-case patients whilst paediatric patients spent only a short time in the PACU (average 43 min in 2018). Analysing data by day of the week demonstrated that there was increased day-case cycle times on Monday and Friday (232 min and 204 min on average respectively) compared to the rest of the week (average 184 min on the Wednesday) in 2018 as well as in 2017. Discussion Using data on the different patient pathways enabled the PACU MDT to target change ideas with the greatest potential for improvement. The PACU data identified that reducing the day-case length of stay could improve PACU capacity. To achieve this, the day-case pathway was re-designed and a step-down area created. Early data have shown an improvement in length of stay. Paediatric patients spent the shortest time in the PACU suggesting that this pathway is efficient and a lower priority for change. We are now creating a PACU dashboard using the electronic patient record to enable real-time monitoring of patient flow through the PACU.

67. Laparoscopic adhesiolysis for small bowel obstruction: The largest UK single-centre series
Authors
Basson S.; Haffenden V.; Giuliani S.; Blackburn S.; Curry J.; De Coppi P.; Cross K.
Source
Journal of Laparoendoscopic and Advanced Surgical Techniques; Jun 2019; vol. 29 (no. 6)
Publication Date
Jun 2019
Publication Type(s)
Conference Abstract
Database
EMBASE
Available at Journal of Laparoendoscopic and Advanced Surgical Techniques from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Journal of Laparoendoscopic and Advanced Surgical Techniques from Unpaywall
68. Capnography in recovery-a multidisciplinary responsibility

**Authors**  
Mohan N.

**Source**  
Anaesthesia; Jul 2019; vol. 74; p. 41

**Publication Date**  
Jul 2019

**Publication Type(s)**  
Conference Abstract

**Database**  
EMBASE

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-Available at [Anesthesia](http://www.anaesthesia-journal.com) from Unpaywall

**Abstract**

The ‘National Audit Project 4’ in 2011 focussed on complications of airway management in the UK, mentioning the use of capnography. Case reviews showed how capnography, with its correct interpretation, could have led to earlier recognition of airway obstruction in several cases. The Association of Anaesthetists standards of monitoring for anaesthesia and recovery in 2015 state capnography to be essential at all times in patients with an endotracheal tube or supraglottic airway device in situ. An audit was completed to assess how frequently there was appropriate use of capnography in a recovery area. Methods An initial audit was performed where appropriate capnography use on patients in the recovery area was checked randomly, three times a day for 7 days over 3 weeks. This included settled patients with a supraglottic airway in situ. Results were recorded and presented to anaesthetists in a departmental meeting. A questionnaire was completed by a range of recovery staff including questions regarding their understanding of the importance and benefits of capnography, along with individual confidence using capnography. A compulsory teaching presentation was created for recovery area staff to complete and sign a register. A follow-up questionnaire was completed. The audit was repeated after 3 months. Results The initial audit found none of the patients with supraglottic airway devices had the capnography monitor attached appropriately. When questioning why, the questionnaire highlighted recovery staff did not know capnography was the reference standard in monitoring ventilation. There was mixed understanding of its indications, importance and benefits, as well as confidence with its use. Following a departmental meeting and teaching presentation, the repeat audit showed an increase to 82% of appropriate patients having capnography monitoring attached. The follow-up questionnaire found in scores ranging from 0 to 10 an increase in confidence in the use of capnography from an average of 4 to 9. There was an average score of 8 and 7, respectively, regarding understanding the importance and benefit of capnography, and 7 with confidence in interpreting a capnography trace Discussion This audit highlights the importance of multidisciplinary teaching (anaesthetists and recovery staff) in order to achieve national standards of monitoring, contributing to increasing patient safety in recovery areas.

69. Obesity in pregnancy: An audit of the care given to pregnant patients with a BMI &gt;= 40

**Authors**  
Williams B.; Baxendale L.
Abstract
Obesity is associated with increased fetal and maternal morbidity, rates of caesarean section and postpartum haemorrhage [1]. MBRRACE-UK 2018 demonstrated that 37% of all women who died were obese [2]. The Royal College of Obstetricians and Gynaecologists have released clear guidelines for the management of these patients. Methods We identified all women with a booking body mass index (BMI) >= 40 who delivered a baby at Queen's Hospital, Burton, during June/July 2018 and collected data retrospectively concerning the following standards: In women with a BMI >= 40.

- 90% should have an antenatal anaesthetic review and a plan in the notes
- 90% should have documentation of a duty anaesthetist being informed of arrival
- 90% of operative deliveries should be attended by anaesthetist of ST6 or greater experience
- 90% should have venous access established in a timely manner prior to delivery

Standards taken from RCoA audit recipe book 2012 [1]. Results
Nineteen patients with a booking BMI >= 40 were identified. Ten patients had normal vaginal deliveries, one instrumental delivery, two elective caesarean sections and six emergency caesarean sections. Eighteen (94.7%) had an antenatal anaesthetic review. There was documented evidence of a duty anaesthetist being informed of arrival in 58.8% of patients. An anaesthetist of ST6 or greater experience attended 87.5% of operative deliveries. Timely cannulation was achieved in 58.8% of patients. Discussion Patients are consistently reviewed antenatally; however, the plan is not always clear for the midwifery team to follow. Arrival of these patients is often only communicated to the duty anaesthetist when an intervention is required. Patients are not being cannulated in a timely manner, with a number of midwives not understanding that this was essential. For a small district general hospital where out of hours anaesthetic cover is provided by junior anaesthetists, a good number of operative deliveries are attended by a senior anaesthetist. The following recommendations have been made: Clinic documentation to be changed to make plan for cannulation essential
- Duty anaesthetist to be informed of arrival of all women with BMI >= 40
- Midwife to document that anaesthetist has been informed
- Anaesthetist should review all BMI > 40 and document this review
- Continue to aim for senior anaesthetist being present at operative delivery for BMI >= 40, whilst appreciating this is not always achievable
- All labourers with BMI >= 40 to be cannulated ASAP when arrives on Delivery suite, if not before.

70. Pre-operative pregnancy testing of young females: A survey of practice in the East of England

Authors
McGuire S.; Ritchie-Mclean S.; Barkshire K.

Source
Anaesthesia; Jul 2019; vol. 74 ; p. 40
**Abstract**

Pre-operative pregnancy testing in adolescent females may be a source of anxiety and confusion for patients, parents and healthcare professionals. National Institute for Health and Care Excellence (NICE) guidance on the subject states that if there is any doubt about the possibility of pregnancy in a woman of childbearing potential, then a test should be advised pre-operatively, and recommends that hospitals should have a documented local protocol that is audited. We feel this guidance lacks clarity, and therefore, investigated policies for pregnancy testing in children's surgery units in our region. Our own policy was updated in 2016 from a seven-step flow-chart, to a simpler regimen whereby all females from the age of 12 years have a urine pregnancy test. This policy was modelled on those of Great Ormond Street and Birmingham Children's Hospitals. Methods A link to an online survey was sent via email to the paediatric anaesthetic leads of every hospital in the East Anglian Children’s Anaesthesia Network with a reminder email sent to non-responders. The survey consisted of five questions. (1) Does your Trust have a specific policy covering this? (2) Do you test all women above a certain age if so what age? Or is this menarche dependent? (3) If not, what procedure do you use? (4) What is your policy if the test is refused? (5) Does a pregnancy test result form part of your pre-operative checklist? Results Of the 15 hospitals in the network, we received 11 responses. Eighty-one per cent reported having a specific policy. Five had policies of testing every patient based on age, but that age varied between 12 and 16 years. Five had a guidance flowchart, including questions on date of last menstrual period and history of sexual activity to determine whether they would be tested. One hospital tested all females post-menarche. All gave similar answers regarding refusal of test, that depending on the surgery, it may be cancelled. Seventy-two per cent stated that it formed part of the pre-operative checklist. Discussion The results of our survey demonstrate significant variation in practice in preoperative pregnancy testing of young female patients in paediatric surgical units across our region. We would expect similar differences nationally. Pregnancy testing in young teenagers is a highly sensitive issue, and our study demonstrates a clear need for specific national guidance both on identifying when children should be tested and what needs to be done in the event of a positive test result.

71. How low can you go? A survey of current practice as the first step towards sustainable anaesthesia in a district general hospital

**Authors**

Lusby E.; Connal S.; Hodgetts A.

**Source**

Anaesthesia; Jul 2019; vol. 74 ; p. 39

**Publication Date**

Jul 2019

**Publication Type(s)**

Conference Abstract

**Database**

EMBASE

Available at Anaesthesia from Wiley Online Library

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**Abstract**

Inhaled anaesthetic agents (IAAs) are known to be potent greenhouse gases. It is estimated that they account for 5% of carbon emissions in the acute hospital setting in England [1]. A joint statement from the Royal College of Anaesthetists and the Association of Anaesthetists in 2017 advocated for environmental sustainability in healthcare [2]. Strategies for reducing the contribution of IAAs to climate change include low-flow techniques, decreasing the use of nitrous oxide (N2O) and desflurane, and increasing the use of total intravenous anaesthesia (TIVA). Methods We evaluated current ‘green’ anaesthetic practice in our hospital in two ways: 1. Snapshot audit of all elective and emergency cases (excluding regional-only cases) over a 1-week period in main theatres. Data were collected on: a) IAA or TIVA b) Type of IAA used c) Fresh gas flow (FGF) at 30 min into case d) 2 Survey of anaesthetists of all grades regarding their current practice and knowledge of the environmental impact of anaesthesia Results Audit data were collected on a total of 48 cases. The proportion of cases using each IAA and TIVA is depicted in Fig. 1. The mean FGF at 30 min was 1.07 l.min⁻¹. Fig 1 Percentage of cases using each mode of anaesthesia over 1 week in our hospital. The survey had 28 respondents. Key findings included: * 57% of anaesthetists report their average FGF to be 500-999 ml.min⁻¹ * 50% correctly identified desflurane as the volatile that has greatest carbon footprint * 36% reported using N2O in the last month (main uses were in obstetrics and paediatric gas induction) * 71% reported using TIVA in the last month (main indication was potential benefit over volatile in oncology cases) Discussion This project has revealed that there is enthusiasm for sustainable anaesthesia within our department. Anaesthetists recognise the global warming effects of IAAs, and the majority are running low gas flows for maintenance of anaesthesia. However, there is still room for improvement. N2O is still used frequently in certain clinical situations, and average FGF rates remain at 1 l.min⁻¹. Most notably, the audit revealed a low frequency of TIVA use, whilst survey respondents indicated that they would use more TIVA if resources (availability of target-controlled infusion pumps) and training allowed. These results have been presented at a local audit meeting to raise awareness and to explore the ways in which we can reduce our anaesthetic carbon footprint. Further work will focus on providing education on TIVA and advocating purchase of additional TCI pumps to facilitate its use. (Figure Presented).
72. Ten-year review of ICU admissions after cardiac arrest at East and North Hertfordshire NHS Trust

Authors: Style L.; Prasad V.
Source: Anaesthesia; Jul 2019; vol. 74; p. 92
Publication Date: Jul 2019
Publication Type(s): Conference Abstract
Database: EMBASE

Abstract:
This review aimed to determine the change in admission numbers, mortality and cost of care for patients admitted to the intensive treatment unit (ITU) after cardiac arrest either in or out of hospital. Methods: A retrospective analysis of 10 years of Intensive Care National Audit and Research Centre (ICNARC) data from East and North Hertfordshire NHS Trust was performed for the period 2008 to 2017. Results: There was a near fourfold increase in admissions to the unit from 2008 to 2017, despite the fact that bed numbers have not changed over this period. The rise in numbers was particularly marked between 2013 and 2014. Mortality rates in the ITU changed little over the observation period. For patients having cardiopulmonary resuscitation (CPR) in hospital mortality was 38-63% (average 53.5%); for patients having out-of-hospital CPR, the rate ranged from 40-69% (average 52.8%) over the 10-year period. There was no evidence of correlation between mortality rates and rise in patient admissions (in-hospital CPR admissions R2 0.0361, out-of-hospital CPR admissions R2 0.0975). Apache scores have remained relatively constant over the observed period, ranging from 17.8 to 21.63 (average 19.37). The length of stay in the unit and hospital has also remained fairly constant, ranging from 4.5 to 6.83 days (average 5.9), hospital stay 10.36-19.61 days (average 13.84). The estimated total annual cost for all patients admitted post-cardiac arrest has increased significantly as a result of the absolute increase in number of admissions. The cost difference between survivors and non-survivors over the whole period shows no significant difference (p = 0.712). Length of stay year-on-year has remained stable (average 5.9, range 4.5-6.83). Discussion: The increase in patient admissions in the absence of an increase in mortality rate demonstrates that the ITU is coping well with a markedly higher workload.

73. Let them eat cake! Optimising peri-operative nutrition for elective caesarean section patients

Authors: Strong E.; Stevenson K.
Source: Anaesthesia; Jul 2019; vol. 74; p. 91
Publication Date: Jul 2019
Publication Type(s): Conference Abstract
Database: EMBASE

Abstract:
This review aimed to determine the change in admission numbers, mortality and cost of care for patients admitted to the intensive treatment unit (ITU) after cardiac arrest either in or out of hospital. Methods: A retrospective analysis of 10 years of Intensive Care National Audit and Research Centre (ICNARC) data from East and North Hertfordshire NHS Trust was performed for the period 2008 to 2017. Results: There was a near fourfold increase in admissions to the unit from 2008 to 2017, despite the fact that bed numbers have not changed over this period. The rise in numbers was particularly marked between 2013 and 2014. Mortality rates in the ITU changed little over the observation period. For patients having cardiopulmonary resuscitation (CPR) in hospital mortality was 38-63% (average 53.5%); for patients having out-of-hospital CPR, the rate ranged from 40-69% (average 52.8%) over the 10-year period. There was no evidence of correlation between mortality rates and rise in patient admissions (in-hospital CPR admissions R2 0.0361, out-of-hospital CPR admissions R2 0.0975). Apache scores have remained relatively constant over the observed period, ranging from 17.8 to 21.63 (average 19.37). The length of stay in the unit and hospital has also remained fairly constant, ranging from 4.5 to 6.83 days (average 5.9), hospital stay 10.36-19.61 days (average 13.84). The estimated total annual cost for all patients admitted post-cardiac arrest has increased significantly as a result of the absolute increase in number of admissions. The cost difference between survivors and non-survivors over the whole period shows no significant difference (p = 0.712). Length of stay year-on-year has remained stable (average 5.9, range 4.5-6.83). Discussion: The increase in patient admissions in the absence of an increase in mortality rate demonstrates that the ITU is coping well with a markedly higher workload.
Abstract

Peri-operative nutrition as part of enhanced recovery after surgery (ERAS) has been shown to improve patient comfort and recovery from caesarean section [1, 2]. As part of our ERAS programme, non-diabetic patients receive two carbohydrate drinks to consume on the morning of surgery. Postoperatively, all patients are encouraged to eat a snack within an hour, as one of the core elements of the national ERAS care bundle in Scotland. We conducted an audit to evaluate our current practice and areas for improvement. Methods Patients were asked directly about peri-operative nutrition within 24 h of their elective caesarean section. No patient identifiable data were required, and verbal consent was obtained prior to interviews. Statistical significance was calculated using chi-square analysis. Results Thirty-six patients, six of whom were diabetic, were interviewed. All non-diabetic patients received pre-operative carbohydrate drinks and 28 (93%) consumed them completely. When rating taste from 1 to 4 (1 being best), the median was 2 (IQR of 1 [range of 3]) and only three rated them as 4. Patients consuming drinks also had an insignificantly lower rate (p = 0.2) of theatre nausea and vomiting (41%) than those who did not (70%). Only 55% of patients received a postoperative snack. This was independent of whether they had experienced nausea and/or vomiting in theatre or not. Let them eat cake! Optimising peri-operative nutrition for elective caesarean section patients E. Strong and K. Stevenson Simpson Centre for Reproductive Health, Edinburgh Royal Infirmary Peri-operative nutrition as part of enhanced recovery after surgery (ERAS) has been shown to improve patient comfort and recovery from caesarean section [1, 2]. As part of our ERAS programme, non-diabetic patients receive two carbohydrate drinks to consume on the morning of surgery. Postoperatively, all patients are encouraged to eat a snack within an hour, as one of the core elements of the national ERAS care bundle in Scotland. We conducted an audit to evaluate our current practice and areas for improvement. Methods Patients were asked directly about peri-operative nutrition within 24 h of their elective caesarean section. No patient identifiable data were required, and verbal consent was obtained prior to interviews. Statistical significance was calculated using chi-square analysis. Results Thirty-six patients, six of whom were diabetic, were interviewed. All non-diabetic patients received pre-operative carbohydrate drinks and 28 (93%) consumed them completely. When rating taste from 1 to 4 (1 being best), the median was 2 (IQR of 1 [range of 3]) and only three rated them as 4. Patients consuming drinks also had an insignificantly lower rate (p = 0.2) of theatre nausea and vomiting (41%) than those who did not (70%). Only 55% of patients received a postoperative snack. This was independent of whether they had experienced nausea and/or vomiting in theatre or not. (Table Presented).

74. Cancelled! Cancelled! An audit on cancellation of paediatric surgical cases on the day of surgery in a district general hospital

Authors
Singh M.; Annadurai S.

Source
Anaesthesia; Jul 2019; vol. 74 ; p. 90

Publication Date
Jul 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

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Abstract
Surgical case cancellation has significant impacts on operating theatre efficiency and the UK loses a substantial amount of money on these cases [1]. A recent prospective study over a 1-week period in an NHS hospital suggested a adult surgical case cancellation rate between 10% and 14% and the majority of these cases were due to non-clinical reasons [2]. It is distressing for the patient and affects outcomes. We undertook an audit regarding cancellation of paediatric surgical cases on the day of surgery at a district general hospital (DGH) to look for various reasons for the cancellations and to evaluate the services. Methods We collected prospective data from the hospital's database regarding cancelled paediatric surgical procedures over a 6-month period from February 2018 to July 2018 in our DGH. Results We found that a total of 70 paediatric surgical cases were cancelled on the day of surgery out of total of 653 paediatric surgical cases, which is an approximately 10% cancellation rate over the 6-month period with a range of cancellations from 7% in May and June to 18% in February. We observed that 76% of the cancellations were of elective cases. We subdivided the reasons for cancellations into organisational, patient, surgical and anaesthetic factors. Among the organisational factors, 23% of cancellations were due to 'unavailable beds'. We observed that 11% of cancellations occurred because patients 'did not attend'; 7% of patients were reported as 'sick' and 3% of patients did not follow preoperative fasting instructions. Surgeons cancelled 15% of cases for the reason 'procedure no longer required'; whereas anaesthetist 'sickness' was the reason for cancellation in 9% of cases. Discussion Cancellations prolong the waiting list and worsens patient experiences and clinical outcomes. In our audit, we found that the main reasons for cancellations were non-clinical. To improve the surgical reasons for cancellation, we suggest timely re-review of the need for surgery. Although staff allocation is looked at regularly, some cases were cancelled due to the unavailability of staff, which can be improved on. We discussed the idea of seasonal planning of cases. We plan to re-audit with the aim of investigating cancellation rates in elective cases over a 1-year period to also review the cancellation rate during the winter months.
75. Non-alcoholic fatty liver disease in patients attending a referral lipid clinic in Scotland: Has it been adequately investigated?

Authors: Kanonidou C.; MacKenzie S.; Blackwell S.

Source: Inflammatory Intestinal Diseases; Jun 2019; vol. 4 (no. 2); p. 2-3

Abstract:
Background: Non-alcoholic fatty liver disease (NAFLD) is among the leading causes of liver disease in the UK. It is usually associated with a hepatic pattern of abnormal liver function tests (LFTs). Dyslipidaemia is prevalent in patients with NAFLD. We assessed our practice against the 2017 British Society of Gastroenterology guidelines for identification and risk stratification of NAFLD.

Method(s): We conducted a retrospective audit of the investigation of transaminasaemia (ALT >55 U/L and/or AST >45 U/L) in patients attending our Lipid Clinic in 2018. Data were collected from electronic medical records.

Result(s): Thirty seven of 361 patients (10.2%) had non-drug induced transaminasaemia (25 males, 12 females, mean age 48.54 years). Further laboratory and/or imaging testing was undertaken in 28 patients (75.7%); only 7 had the full liver screen. Abdominal ultrasound (USS) was performed in 23 cases (62.1%). Of the 19 patients with fatty liver, 6 reported excessive alcohol consumption and 13 were diagnosed with NAFLD (7 males, 6 females, mean age 42.84 years). Eight of them had >=3 risk factors for NAFLD. Retrospective calculation of FIB-4 index showed 8 patients with low and 5 with intermediate scores. None of the latter had further workup for advanced fibrosis/cirrhosis. Six of the 14 patients who did not have USS had >=3 NAFLD risk factors.

Conclusion(s): NAFLD, a common cause of deranged LFTs in dyslipidaemic patients, remains sub-optimally investigated. Clinicians should request adequate testing to confirm the diagnosis and risk stratify patients so as to prevent the development of complications in those at high risk.

76. A prospective audit of a patient cohort prescribed hydroxychloroquine for rheumatoid arthritis and other inflammatory rheumatic diseases in order to prioritise retinopathy screening and estimate the need for drug education appointments

Authors: Yeo B.; Low A.; Chadwick A.; Wills S.

Source: Annals of the Rheumatic Diseases; Jun 2019; vol. 78; p. 759-760

Abstract:
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Abstract

Background: Hydroxychloroquine (HCQ) is prescribed for rheumatoid arthritis (RA), systemic lupus erythematosus (SLE) and inflammatory osteoarthritis (IOA). A potential side effect of HCQ is drug-induced retinopathy, with an increased risk reported for patients taking >5mg/kg/day and those who have renal impairment. In the United Kingdom, the Royal College of Ophthalmologists (RCO) has published new screening guidelines for HCQ, recommending 1) patients receive doses <5mg/kg/day and 2) all patients planning to be on HCQ long term (>5 years) should receive baseline eye examination ideally within 6 months of starting HCQ and definitely within 1 year.

Objective(s): This audit aimed to: 1) audit dose prescription by body weight, 2) estimate the screening burden on ophthalmology services, 3) estimate service needs for additional drug education appointments to counsel patients starting HCQ.

Method(s): A list of all patients who were started on HCQ from January 2017 to February 2018 was obtained from the outpatient pharmacy at Salford Royal Hospital. Demographic and clinical data were extracted from electronic patient records. High-risk patients were defined as those who were prescribed an initial dose of >5mg/kg/day or those with an eGFR <=50 ml/min/1.73m2. Patients were followed until the most recent follow-up visit by July 2018 to determine drug persistence and reasons for HCQ cessation, if any.

Result(s): 177 patients were started on HCQ, with most (62%) diagnosed with rheumatoid arthritis (Table). Most patients were female (76%) and a third (35%) were older than 60 years old. 9 patients (5.1%) had impaired renal function. 83 patients (47%) were prescribed an initial daily dose of HCQ >5mg/kg/day. By July 2018 (follow-up duration 6-19 months), 127 patients (71.8%) remained on HCQ and will need baseline eye screening. The remaining 50 patients (28.2%) stopped HCQ due to inefficacy (7.3%), GI disturbance (3.4%), rash (3.4%).

Conclusion(s): Clinicians need to be cognisant of recent guidelines and adjust HCQ dosing to the recommended 5mg/kg/day. Additional specialist pharmacist input for DED (12-13 extra appointments per month) is required. Almost a third of the patients had stopped HCQ by July 2018, mostly due to side effects and reported inefficacy. However, a large proportion (71%) of HCQ starters remain on the drug by 6-12 months and will need baseline screening. Ophthalmology services can estimate services and capacity required for baseline HCQ screening per annum. (Table Presented).
Abstract

Background: The United Nations Convention on Children's Rights stresses the importance of providing children with information relating to their health and well-being, yet reports suggest children are offered insufficient support in healthcare environments. We audited the information provided to children and families requiring planned surgical admission in comparison to those admitted acutely to medical paediatrics. Additionally, we identified examples of child-specific information resources in national and international hospitals.

Method(s): Three approaches were taken to gain insight into practice locally, nationally and internationally. (1) Information resources provided to paediatric inpatients admitted to the acute receiving unit were audited in comparison to information given to children with planned admissions via process observations. (2) Qualitative feedback was gained from play specialists (n=2), families (n=30) and children (n=9; aged 3-15 years) via interviews. (3) A review, including UK, Australian and US hospitals, was conducted to assess child-specific information resources (n=36 hospitals) and to systematically compare the information available on websites (n=9 hospitals).

Result(s): At the study site, no child-specific information resources were available for acute admissions, whereas planned admissions were offered significant information face-to-face with supplemental resources. Child, parent and play specialist interviews highlighted gaps in information provision regarding hospital practicalities and processes. Twelve external child-specific resources were identified, for 4-14 year olds, explaining key care information: medical procedures, equipment and staff. These resources could positively respond to the topics cited as lacking by the interviewed patients and families at the study site. International hospital websites provided considerably more in-depth information compared with UK hospitals.

Conclusion(s): The hospital experience of children and families can be improved by ensuring they are provided with adequate information relating to their hospital stay. It is essential that suitable high-quality resources are consistently available and that feedback from children informs the process of resource development.

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79. Diagnosis of congenital CMV infection via DBS samples testing and neonatal hearing screening: An observational study in Italy

Authors
Pellegrinelli L.; Galli C.; Primache V.; Pariani E.; Binda S.; Alde M.; Di Berardino F.; Ambrosetti U.; Fagnani E.; Zanetti D.

Source
BMC Infectious Diseases; Jul 2019; vol. 19 (no. 1)

Publication Date
Jul 2019

Publication Type(s)
Article

PubMedID
31331274

Database
EMBASE

Abstract
Background: Congenital Cytomegalovirus (cCMV) is the most common cause of non-genetic hearing loss in childhood. A newborn hearing screening program (NHSP) is currently running in Italy, but no universal cCMV nor statewide hearing-targeted CMV screening programs have been implemented yet. This observational monocentric study was aimed at estimating the rate of cCMV infections identified by CMV-DNA analysis on Dried Blood Spots (DBS) samples in deaf children identified via NHSP in Northern Italy in the period spanning from 2014 to 2018.

Method(s): Children with a confirmed diagnosis of deafness and investigated for CMV-DNA by nucleic acid extraction and in-house polymerase-chain reaction (PCR) on stored newborns screening cards (DBS-test) were included in this study. Deafness was defined by a hearing threshold >= 20 decibel (dB HL) by Auditory Brainstem Responses (ABR); all investigated DBS samples were collected within 3 days of life.

Result(s): Overall, 82 children were included (median age: 3.4 months; lower-upper quartiles: 2-5.3 months; males: 60.9%). Most of them (70.7%) presented bilateral hearing loss with a symmetrical pattern in 79.3% of the cases. ABR thresholds were >= 70 dB HL (severe/profound deafness) in 46.5% of children. Among all tested children, 6.1% resulted positive for cCMV. The rate of severe/profound deafness was statistically higher in children with cCMV infection.

Conclusion(s): The addition of DBS-test to the NHSP allowed the identification, in their first months of life, of a cCMV infection in 6.1% of children who had failed NHS. The introduction of a targeted CMV screening strategy could help clinicians in the differential diagnosis and in the babies' management. DBS samples can be considered a "universal newborns biobank": their storage site and duration should be the subject of political decision-making.

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80. Patient perspectives on a national multidisciplinary team meeting for a rare cancer

Authors
Bate J.; Donkin A.; Taylor R.; Whelan J.; Wingrove J.

Source
European journal of cancer care; Mar 2019; vol. 28 (no. 2)

Publication Date
Mar 2019
Abstract
Multidisciplinary team meetings (MDTM) provide a regular forum for cancer teams to convene and discuss the diagnostic and treatment aspects of patient care. For some rare cancers, MDTMs may also occur at national level to pool expertise and to ensure more consistent decision-making. One such national MDTM exists in the UK for patients with a diagnosis of Ewing’s sarcoma of the bone—the National Ewing’s MDT (NEMDT). This study explored the patient perspective of this rare cancer national MDTM using focus group and survey methodology. Study participants used their experience to provide several recommendations: that their views should always inform the decision-making process, these views should be presented by someone who has met them such as a specialist nurse, MDT recommendations should be provided to them in plain English, and tools to improve patient choice and enhance communication should be implemented. These patient-centred recommendations will be used to improve the NEMDT but may be valid to inform quality improvement processes for other similar national panels.

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81. Association of quality of paediatric epilepsy care with mortality and unplanned hospital admissions among children and young people with epilepsy in England: a national longitudinal data linkage study

Authors

Source
The Lancet Child and Adolescent Health; Sep 2019; vol. 3 (no. 9); p. 627-635

Abstract
Background: Concerns have been raised about variation in care quality and outcomes among children and young people with epilepsies in England. We aimed to investigate the association between quality of paediatric care, hospital admissions, and all-cause deaths among epilepsy patients.

Method(s): In this longitudinal data linkage study of paediatric epilepsy services in England, we linked unit-level data from round 1 (2009-11) and round 2 (2013-14) of the Epilepsy12 national clinical audit, with death registrations from the UK Office for National Statistics and data for unplanned hospital admissions from Hospital Episode Statistics. We investigated the association between unit-level performance in involving a paediatrician with epilepsy expertise, an epilepsy specialist nurse, and a paediatric neurologist (where appropriate) in round 1 and the proportion of adolescents (aged 10-18 years) with epilepsy admitted to each unit who subsequently died during the study period (April 1, 2009, to March 31, 2015). We also investigated whether change in Epilepsy12 performance between the two audit rounds was associated with changes in the standardised ratio of observed-to-expected unplanned epilepsy admissions over the same period.

Finding(s): In 99 units with data for the analyses relating to paediatricians with epilepsy expertise and epilepsy specialist nurses, 134 (7%) of 1795 patients died during the study period, 88 (5%) of whom died after the transition to adult service. In 55 units with data for the analyses relating to paediatric neurologists, 79 (7%) of 1164 patients died, 54 (5%) of whom did so after the transition. In regression models adjusting for population, unit, and hospital activity characteristics, absolute reductions in total mortality risk (6.4 percentage points, 95% CI 0.1-12.7) and mortality risk after transition (5.7 percentage points, 0.6-10.8) were found when comparing units where all versus no eligible patients were seen by a paediatric neurologist. Units where all eligible patients were seen by a paediatric neurologist were estimated to have absolute reductions of 4.6 percentage points (0.3-8.9) in total mortality and of 4.6 percentage points (1.2-8.0) in post-transition mortality, compared with units where no or some eligible patients were seen by a paediatric neurologist. There was no significant association between performance on being seen by an epilepsy specialist nurse or by a paediatrician with epilepsy expertise and mortality. In units where access to an epilepsy specialist nurse decreased, the standardised ratio of epilepsy admissions increased by a mean of 0.21 (0.01-0.42).

Interpretation(s): Among adolescents with epilepsy, greater involvement of tertiary specialists in paediatric care is associated with decreased all-cause mortality in the period after transition to adult services. Reduced access to an epilepsy specialist nurse was associated with an increase in paediatric epilepsy admissions.

Funding(s): The Health Foundation.

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82. Early wound infection identification using the WIRE tool in community health care settings: An audit report

Authors: Siaw-Sakyi V.
Source: British journal of community nursing; Dec 2017; vol. 22
Publication Date: Dec 2017
Publication Type(s): Article
PubMedID: 29189075
Database: EMBASE

Abstract

Wound infection is proving to be a challenge for health care professionals. The associated complications and cost of wound infection is immense and can lead to death in extreme cases. Current management of wound infection is largely subjective and relies on the knowledge of the health care professional to identify and initiate treatment. In response, we have developed an infection prediction and assessment tool. The Wound Infection Risk-Assessment and Evaluation tool (WIRE) and its management strategy is a tool with the aim to bring objectivity to infection prediction, assessment and management. A local audit carried out indicated a high infection prediction rate. More work is being done to improve its effectiveness.

83. Improving care for patients with dementia in the recovery room

Authors: Edis H.
Source: British journal of nursing (Mark Allen Publishing); Nov 2017; vol. 26 (no. 20); p. 1102-1108
Publication Date: Nov 2017
Publication Type(s): Article
PubMedID: 29125364
Database: EMBASE

Abstract

Caring for patients with dementia emerging from general anaesthesia in the recovery room can be very challenging. Sedation is sometimes necessary in order to nurse patients effectively and avoid any negative consequences of poor post-anaesthetic care. No local or national guidelines could be found to suggest best nursing practice in this situation. Three small-scale innovations were introduced into the recovery room in one hospital as part of a quality improvement project to give alternatives to chemical restraint. These were: music and distraction therapy, maximising the use of the 'About Me' document and improved access to staff training. The simple innovations were well received by recovery room staff. Further research is needed to quantify the benefits of these innovations and further work is needed to develop use of the carer's passport in recovery.

84. National BSUG audit of stress urinary incontinence surgery in England

Authors: Jha S.; Hillard T.; Monga A.; Duckett J.
Source: International Urogynecology Journal; Aug 2019; vol. 30 (no. 8); p. 1337-1341
Publication Date: Aug 2019
Publication Type(s): Article
PubMedID: 29995163
Database: EMBASE

Abstract

Available at International Urogynecology Journal from Unpaywall
Abstract

Introduction and hypothesis: The aim of the British Society of Urogynaecology (BSUG) 2013 audit for stress urinary incontinence (SUI) surgery was to conduct a national clinical audit looking at the intra- and postoperative complications and provide outcomes for these procedures. This audit was supported by the Healthcare Quality Improvement Partnership (HQIP) and National Health Service (NHS) England.

Method(s): Data were collected for all continence procedures performed in 2013 through the BSUG database. All clinicians in England performing SUI surgery were invited to submit data to a central database. Outcomes data for the different continence procedures were collected and included intraoperative and postoperative complications and the change in continence scores at postoperative follow-up. Changing trends in stress incontinence surgery were also assessed.

Result(s): We recorded 4993 urinary incontinence procedures from 177 consultants at 110 centres in England: 94.6% were midurethral slings; 86.7% (4331) were submitted by BSUG members with the remaining 13.3% (3676) were very much better/much better postoperatively, and 4806 (96.3%) proceeded with no reported complications. There were 187 cases (3.7%) in which a perioperative complication was recorded. Pain persisting >30 days was reported in 1.9% of all patients.

Conclusion(s): Surgery for SUI has good outcomes in the short term. Midurethral synthetic slings have been shown to be safe and effective as a treatment option, with >90% being very much/much better at their postoperative follow-up.

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85. Inequalities in glycemic control in childhood onset type 2 diabetes in England and Wales-A national population-based longitudinal study

Authors

Source
Pediatric Diabetes; 2019

Publication Date
2019

Publication Type(s)
Article

PubMedID
31329349

Database
EMBASE

Available at Pediatric Diabetes from Wiley Online Library Medicine and Nursing Collection 2019 - NHS Available at Pediatric Diabetes from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection Available at Pediatric Diabetes from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.

Abstract

Background: Not much is known about glycaemic-control trajectories in childhood-onset type 2 diabetes (T2D). We investigated characteristics of children and young people (CYP) with T2D and inequalities in glycemic control.

Method(s): We studied 747 CYP with T2D, <19 years of age in 2009-2016 (from the total population-based National Pediatric Diabetes Audit [>95% diabetes cases in England/Wales]). Linear mixed-effects modeling was used to assess socioeconomic and ethnic differences in longitudinal glycated hemoglobin (HbA1c) trajectories during 4 years post-diagnosis (3326 HbA1c data points, mean 4.5 data points/subject). Self-identified ethnicity was grouped into six categories. Index of Multiple Deprivation (a small geographical area-level deprivation measure) was grouped into SES quintiles for analysis.

Result(s): Fifty-eight percent were non-White, 66% were female, and 41% were in the most disadvantaged SES quintile. Mean age and HbA1c at diagnosis were 13.4 years and 68 mmol/mol, respectively. Following an initial decrease between diagnosis and end of year 1 (-15.2 mmol/mol 95%CI, -19.2, -11.2), HbA1c trajectories increased between years 1 and 3 (10 mmol/mol, 7.6, 12.4), followed by slight gradual decrease subsequently (-1.6 mmol/mol, -2, -1.1). Compared to White CYP, Pakistani children had higher HbA1c at diagnosis (13.2 mmol/mol, 5.6-20.9). During follow-up, mixed-ethnicity and Pakistani CYP had poorer glycemic control. Compared to children in the most disadvantaged quintile, those in the most advantaged had lower HbA1c at diagnosis (-6.3 mmol/mol, -12.6, -0.1). Differences by SES remained during follow-up. Mutual adjustment for SES and ethnicity did not substantially alter the above estimates.

Conclusion(s): About two-thirds of children with childhood-onset T2D were non-White, female adolescents, just under half of whom live in the most disadvantaged areas of England and Wales. Additionally, there are substantial socioeconomic and ethnic inequalities in diabetes control.

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86. Diagnostic delay for superficial and deep endometriosis in the United Kingdom

Authors
Ghai V.; Jan H.; Shakir F.; Haines P.; Kent A.

Source
Journal of Obstetrics and Gynaecology; 2019

Publication Date
2019

Publication Type(s)
Article

PubMedID
31328629

Abstract

Background: The diagnostic delay for superficial and deep endometriosis remains poorly investigated. We report the surgical delay, defined as the time from symptom onset to surgical intervention, in women with superficial and deep endometriosis.

Method(s): Women with superficial and deep endometriosis were selected from the practice of a single gynaecologist (G.V.G.). Follow-up data were collected from hospital records, a gynaecologist’s clinic, and by self-report (online questionnaire).

Result(s): The median time from symptom onset to diagnosis was 3.5 years (interquartile range [IQR] 1.5-8.5 years) for superficial endometriosis and 8 years (IQR 5-12 years) for deep endometriosis. The median follow-up was 4 years (IQR 2-7 years) for superficial endometriosis and 6 years (IQR 3-9 years) for deep endometriosis.

Conclusion(s): The diagnostic delay for superficial and deep endometriosis remains long, highlighting the need for early diagnosis and treatment.

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Abstract

A Cross-sectional study was undertaken at a specialist centre in the United Kingdom investigating duration and causes of delay in the diagnosis of endometriosis. One hundred and one women completed a self-reported questionnaire containing 20 items about their psychosocial, symptoms and experiences. The statistical analysis included a Mann-Whitney U test. A p value of 0.05 was considered statistically significant. The Spearman’s rank correlation was also calculated. Overall, there was a median delay of 8 years (Q1-Q3: 3-14) from the onset of symptoms to a diagnosis of endometriosis. Factors such as menstrual cramps in adolescence, presence of rectovaginal endometriosis, normalisation of pain and the attitudes of health professionals contributed to a delayed diagnosis (p values < 0.05). There was a negative correlation indicating the earlier the onset of symptoms, the greater the delay to diagnosis (Spearman’s Rank Correlation Coefficient -0.63, p<.01). The results of this study highlight a considerable diagnostic delay associated with endometriosis and the need for clinician education and public awareness. Impact statement

What is already known on this subject? The diagnostic delay of 7-9 years with endometriosis has been reported globally. In an effort to standardise surgical treatment, improve outcomes, and shorten delays specialist endometriosis centres were introduced in 2011. There has been no recent quality improvement assessment since the establishment of such centres. What do the results of this study add? This is the most recent evaluation in the United Kingdom since the introduction of specialist endometriosis centres. There is a considerable diagnostic delay associated endometriosis in the United Kingdom with a median of 8 years. The delays seem not to have improved over the last two decades. We have identified medical and psychosocial factors that may contribute to such delays. These include factors such as menstrual cramps in adolescence, presence of rectovaginal endometriosis, normalisation of pain and attitudes of health professionals contribute to a delayed diagnosis. What are the implications of these findings for clinical practice and/or further research? The results of this study, highlight the need for clinician education and public awareness to decrease the long term-morbidity and complications that result from untreated endometriosis. Copyright © 2019, © 2019 Informa UK Limited, trading as Taylor & Francis Group.
Abstract

This session celebrates the life and accomplishments of Peter B. Dunscombe, PhD, FAAPM, whose illustrious 40 yr career in Medical Physics was devoted to mentoring students, residents, and young professionals as well as making radiation therapy safer for patients around the world. He was passionate about improving quality and safety in radiation therapy. In this quest, he served in many capacities in organizations worldwide and advanced the profession of medical physics on many fronts. In AAPM he chaired the Workgroup (WG) on Prevention of Errors for many years. Under his leadership the WG pursued incident learning initiatives which ultimately led to the formation of Radiation Oncology Incident Learning Systems (RO-ILS). He was an active member of AAPM Task Group 100, which provided paradigm shift recommendations for how quality management activities should be performed in radiation therapy. He traveled around the world giving workshops on the TG-100 methodology to educate the medical physics community. Other important safety tools championed by Peter are The Safety Profile Assessment and i.treat safely. These gave cancer professionals around the world tools to evaluate readiness of their centers for the safe treatment of cancer patients. Peter was instrumental in supporting many safety and quality initiatives undertaken by various Divisions within the International Atomic Energy Agency (IAEA). These include writing web-based tools for safety and quality in radiotherapy, making significant contributions to the IAEA project Quality Assurance Team for Radiation Oncology (QUATRO) and advocating for the IAEA/WHO postal audit services. Peter was also very active at the European Society for Radiotherapy and Oncology (ESTRO). He was a member of the Health Economics in Radiation Oncology (HERO) group and advanced the understanding of health economics and challenges faced by resource limited countries. Peter was also a faculty at the ESTRO clinical school on Comprehensive Quality Management in Radiotherapy. In the UK and in Canada, Peter influenced patient safety in radiotherapy practice by challenging the UK endeavors to improve patient safety and enhancing the Canadian Technical Standards (CPQR). Peter impacted the lives of thousands of patients and families and this impact on oncology patient care has stretched across oceans. His dedication, talent, compassion and unwavering commitment to improve patient care inspired both his colleagues and patients. It is not an overstatement to say that because of Peter's personal efforts, thousands of radiotherapy patients around the world are treated today with improved quality management procedures. The worldwide radiotherapy community will miss a tireless champion of quality of care and patient safety, a very generous and compassionate man, a person with a great sense of humor who loved all aspects of life. Learning Objectives: 1. Learn about the contributions Peter made to enhance the safety and quality of care in radiation therapy 2. Learn about the development of TG-100 approaches to quality management in radiation therapy 3. Learn about Peter’s focus on resource-limited practice settings in the context of safety 4. Learn about the origins of incident learning and taxonomy for radiation therapy safety culture and Peter’s contributions in this regard.

88. An audit of the use of the direct oral anticoagulants (DOACS) in clinical practice: 6 years of data

Authors Bond S.; Rhodes S.; Garcia M.
Source Research and Practice in Thrombosis and Haemostasis; Jul 2019; vol. 3 ; p. 811
Publication Date Jul 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Background: Since 1997 the Anticoagulant Service at GWH has provided counselling and dose adjustment of all patients commencing vitamin K antagonists (VKAs), discharge planning and a telephone advice line for patients and healthcare professionals. From June 2012 we adopted the UK NICE- TA for all Direct oral anticoagulants (DOACs) for treatment of non-valvular AF in stroke prevention (SPAF) as they became available. Agreement was made with the local commissioners to continue to counsel and monitor patients commenced on the DOACs. Aims: Patients are reviewed at 3 months then annually with the aim of checking for any adverse events including bleeding, deteriorating renal function or any other minor event. Data is also collated for patients on a DOAC for treatment of venous thromboembolism (VTE). Methods: A decision aid was developed to ensure suitability of any proposed anticoagulant including checking for contra-indications, specialist groups where advice is required before prescribing and risk factors for bleeding (HAS-BLED). At each review the drug is checked for appropriateness, dose and bloods are screened and any adverse events recorded. Results: 2,278 patients currently on a DOAC for SPAF. 58 on dabigatran with 4 major adverse events and 32 minor, 633 rivaroxaban with 25 major adverse events and 194 minor, 1,381 on apixaban with 24 major adverse events and 227 minor and 206 on edoxaban with 4 major adverse events and 31 minor. For VTE the event rate was 17% on rivaroxaban (first line treatment at our institution). Conclusions: In our patients’ experience the DOACs appear to be well tolerated although adverse events are increasing. Serious adverse events ranged from 1.7% - 6.8%. Bleeding events ranged from 8.7% to 29.3% and were slightly more likely in patients over the age of 70. This system allows us to check the concordance with the dose parameters of each drug on an individual patient basis.

89. Audit of the use of the GEKO device on an acute stroke unit (ASU)

Authors Oliver D.; Rhodes S.
Source Research and Practice in Thrombosis and Haemostasis; Jul 2019; vol. 3 ; p. 26
Abstract

Background: Patients with a stroke carry a 6.3% risk of symptomatic venous thromboembolism (VTE) without mechanical intervention. Our current methods of VTE prevention for this group are intermittent pneumatic compression devices (IPC) but the CLOTS 3 audit data suggests that more than 35% of patients are contraindicated or become intolerant to these devices. Whilst the GEKO device would not seek to displace current methods of VTE prevention it covers an unmet need in some patients with an acute stroke who cannot receive traditional methods of VTE prevention. Aims: Since 2015 there have been 5 VTE events on the Acute Stroke Unit (ASU) where no prophylaxis has been used. Whilst this number is small we wanted to explore the use of the GEKO device to meet the needs of this group. Methods: We collected data on 100 consecutive stroke or suspected stroke patients admitted to the ASU. Data collection included when VTE prophylaxis was prescribed, what device was prescribed and when the device was actually initiated and discontinued. Results: 4/100 patients were assigned to receive the GEKO device: 3 patients being contraindicated to receive low molecular weight heparin (LMWH) and 1 patient intolerant of the IPC device. The average age was 75 (37–95) and there were 48 male and 52 female patients. No VTE events were reported and it was very well tolerated. The average duration of use was 12 days. 42/100 did not have any significant reduction in mobility and medical VTE prophylaxis was prescribed in 6/100. Conclusions: NHS reference costs for a VTE event (weighted average cost of DVT and PE) are £2778 and the cost of 12 days (average use) of the GEKO device is £264. Forecast use is 16 patients per year = £4224 against 2 VTE events per year = £5556. Can we afford to deny patients VTE prevention?

90. A nurse led thromboprophylaxis re-assessment tool to improve the safety of patients at risk of developing a hospital acquired thrombosis

Authors
Croft A.

Source
Research and Practice in Thrombosis and Haemostasis; Jul 2019; vol. 3; p. 3-4

Abstract

Background: English Hospital Trusts attach CQUIN payment to Venous Thromboembolism Risk Assessment (RA) to improve uptake of RA on admission. Welsh Health Boards’ have no financial incentives. 2012-Nurse led Thromboprophylaxis (TP) Re-Assessment (Re-A) Tool was implemented on wards in Princess of Wales Hospital (POWH). Before March 2012, focus had been on completing the TP RA during admission, predominantly by Doctors. Doctors continued to complete initial TP RA but now nurses complete TP Re-A for the duration of the patient’s admission. Aims: The Aim of the tool is to increase the number of patients RA on admission to reduce the incidence of Hospital Acquired Thrombosis (HAT). The TP Re-A tool has 2-fold benefit; 1. Nurses prompt clinicians to complete TP RA improving number of patients risk assessed and treated appropriately on admission. 2. Nurses Re-A patients daily or as condition alters. Methods: The Thromboprophylaxis Re-Assessment innovation was piloted POWH from March to July 2012. The Improving Quality Together Model for Improvement was utilised and following the completion of Plan, Do, Study, Act (PDSA) Cycles, the Re-A tool was added to The Welsh Care Metrics Audit tool in 2013 to measure quality of care at ward level. Results: Graph A demonstrates situation in POWH prior to implementation of TP Re-A tool but now nurses complete TP Re-A for the duration of the patient’s admission. Aims: The Aim of the tool is to increase the number of patients RA on admission to reduce the incidence of Hospital Acquired Thrombosis (HAT). The TP Re-A tool has 2-fold benefit: 1. Nurses prompt clinicians to complete TP RA improving number of patients risk assessed and treated appropriately on admission. 2. Nurses Re-A patients daily or as condition alters. Methods: The Thromboprophylaxis Re-Assessment innovation was piloted POWH from March to July 2012. The Improving Quality Together Model for Improvement was utilised and following the completion of Plan, Do, Study, Act (PDSA) Cycles, the Re-A tool was added to The Welsh Care Metrics Audit tool in 2013 to measure quality of care at ward level. Results: Graph A demonstrates situation in POWH prior to implementation of TP Re-A tool, the low inconsistent uptake was common throughout the hospital. Graph B and C demonstrate continuous improvement and sustainment of TP RA & Re-Assessment rate. Graph data taken from Welsh Care Metrics monthly audit results. Graph D demonstrates reduction in HAT’s in POWH 2013-2018. Conclusions: The power of collaborative working between all clinicians is essential to the success of the innovation. The introduction of the TP Re-Assessment tool has resulted in an increase in the Thromboprophylaxis Risk Assessment uptake and a decrease in the number of HAT’s resulting in the provision of a safer service within POWH. (Figure Presented).

91. Nurse-led ranibizumab intravitreal injections in wet age-related macular degeneration: a literature review

Authors
Gregg E.

Source
Nursing standard (Royal College of Nursing (Great Britain) : 1987); Apr 2017; vol. 31 (no. 33); p. 44-52

Abstract

Background: Radiological and endoscopic appearance of the pancreas distinguishes the head, body, and tail. Vascular anomalies of the head include the supraduodenal artery which arises from the gastroduodenal artery and passes into the head of the pancreas. The supraduodenal artery is a feature of the uncinate process and can be identified in 75% of cases. Endoscopic retrograde cholangiopancreatography (ERCP) provides an opportunity to demonstrate tumor vascularity, either from an emerging blood supply or failure of perfusion. This case report describes a patient with a 2 cm insulinoma arising from the uncinate process. The tumor was discovered during routine follow-up and was confirmed to be a functional insulinoma with high levels of insulinemia. The management of this patient included medical therapy with octreotide and surgical excision. A successful surgical outcome was achieved and the patient experienced a dramatic improvement in their insulin levels. Conclusion: The identification of vascular anomalies at ERCP can aid in the management of pancreatic tumors and facilitate surgical resection.
92. Evaluation and its importance for nursing practice

**Authors**
Moule P.; Armoogum J.; Douglass E.; Taylor DJ.

**Source**
Nursing standard (Royal College of Nursing (Great Britain) : 1987); Apr 2017; vol. 31 (no. 35); p. 55-63

**Publication Type(s)**
Article

**PubMedID**
28443444

**Database**
EMBASE

Evaluation of service delivery is an important aspect of nursing practice. Service evaluation is being increasingly used and led by nurses, who are well placed to evaluate service and practice delivery. This article defines evaluation of services and wider care delivery and its relevance in NHS practice and policy. It aims to encourage nurses to think about how evaluation of services or practice differs from research and audit activity and to consider why and how they should use evaluation in their practice. A process for planning and conducting an evaluation and disseminating findings is presented. Evaluation in the healthcare context can be a complicated activity and some of the potential challenges of evaluation are described, alongside possible solutions. Further resources and guidance on evaluation activity to support nurses’ ongoing development are identified.

93. 'Staff want to address cultural issues, but don’t know how'

**Authors**
Cole E.

**Source**
Nursing standard (Royal College of Nursing (Great Britain) : 1987); Jan 2017; vol. 31 (no. 19); p. 18-20

**Publication Type(s)**
Article

**PubMedID**
28094628

**Database**
EMBASE

Katie de Freitas believes a greater awareness of cultures is crucial if clinicians are to meet the needs of patients and families. 'Cultural competency is a matter of quality and safety,' says the quality improvement lead at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH). 'It can help to bridge the gap between those providing care and those accessing services.'
94. New guidance on oxygen use in adults

**Authors** Hackett K.

**Source** Nursing standard (Royal College of Nursing (Great Britain) : 1987); Jul 2017; vol. 31 (no. 48); p. 15

**Publication Date** Jul 2017

**Publication Type(s)** Article

**PubMed ID** 28745151

**Database** EMBASE

Available at Nursing standard (Royal College of Nursing (Great Britain) : 1987) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.

**Abstract** Essential facts The 2015 British Thoracic Society (BTS) emergency oxygen audit report found one in seven of the 55,000 patients in UK hospitals at the time of the audit received oxygen therapy for their condition. Of these, 40% were receiving oxygen without a prescription or written order.

95. Second party audits of human research biobanking organisations from a responsible sourcing perspective

**Authors** Bossow T.; Clark B.

**Source** Biopreservation and Biobanking; Jun 2019; vol. 17 (no. 3)

**Publication Date** Jun 2019

**Publication Type(s)** Conference Abstract

**Database** EMBASE

Available at Biopreservation and Biobanking from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.

**Abstract** Research using human biosamples (HBS) requires legitimacy of use and quality for consistency and reproducibility of results. As there was no international standard for governance and quality of organisations supplying/using HBS in research (“suppliers”), Novo Nordisk evaluates its suppliers to ensure that they meet high standards. The audit standard consists of 64 mandatory requirements, derived from existing laws and regulations, declarations, best practices, guidelines, conventions and quality management standards. The requirements relate to a range of topics: legal and ethical, quality and integrity of HBS, donor recruitment and consent, donor confidentiality, contract management, document control, infrastructure and outsourcing. This study reports the results of audits conducted between November 2015 and the end of December 2017. Forty-nine suppliers from 12 countries were invited. The suppliers were from the public and private sectors and included biobanks, contract research organisations and research collaborators. Thirty-nine accepted the invitation and underwent full audit. There were no significant differences in the types of suppliers that agreed to be audited, and suppliers in all countries equally agreed, with the exception of the UK where suppliers were significantly less likely to agree. Eleven suppliers were in full conformity with all requirements on initial audit.

Twenty-eight suppliers were initially non-compliant, with an average number of non-conformities (N/Cs) of 5.1. Twenty of these suppliers became compliant after correcting N/Cs. The rate of N/Cs did not vary by the types of supplier or the ownership type. Suppliers in the USA had a higher N/C rate in comparison to suppliers in other countries. Most N/Cs were related to biological safety, packing and transportation of HBS, or handling of liquid nitrogen. A lack of standard operating procedures for key processes was common, as was payments to donors or sub-standard consent documents. Novo Nordisk’s approach to responsible sourcing of HBS, by conducting “second party” audits against an internationally applicable standard, benefits Novo Nordisk and also its suppliers by fostering working towards higher international standards. This assists Novo Nordisk to select suppliers from a responsible sourcing perspective. The success of the process predicts that ISO 20387:2018 will benefit both biobanking organisations and their stakeholders, particularly their end-user researchers.

96. Audit of incomplete BCC surgical excisions: How to improve patients’ outcomes and services

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**Source** Journal of the American Academy of Dermatology; Sep 2018; vol. 79 (no. 3)

**Publication Date** Sep 2018

**Publication Type(s)** Conference Abstract

**Database** EMBASE

Available at Journal of the American Academy of Dermatology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Abstract
Incomplete basal cell carcinoma (BCC) excisions can pose a significant burden to patients and health care providers. These include the need for further treatment prolonged follow-up and recurrence of more aggressive tumor. We aimed to review our incomplete BCC excisions to identify ways to improve our patient outcome and services. Out of 665 non-Mohs Micrographic surgical excisions for BCCs from January to October 2016, in one of the U.K. skin centers 75 (11.2%) were incomplete. Procedures included excision with graft repair (38%), direct closure (35%), flap repair (8%) and double curettage (14%). 15 patients had both peripheral and deep margins involved and the majority (97%) had multiple contributing factors. Mean age was 77 years (47-95) with 82% above 70 years old. Men were predominant (65%). All the tumors were on the head and neck with commonest sites being ear and nose (15%) followed by forehead (13%) and inner canthus (13%). Mean duration of lesion was 14 months (2-48) with 63% of lesions present more than 6 months. Mean thickness of lesions was 2.5 mm (0.8-7). Mean tumor diameter was 10.8 mm (1-32) with 3 tumors greater than 20 mm. 12 patients underwent multiple simultaneous procedures during the same session. Other risk factors included comorbidities (hypertension [14], dementia [2], anticoagulants [2], and previous nonmelanoma skin cancer [9], nodular type (96%) of which 34% were infiltrative). One had perineural invasion. 59% did not have biopsy before excision. We highlighted the importance of identifying high risk patients and introducing measures such as avoiding multiple simultaneous procedures, considering Mohs micrographic surgery and preexcision biopsy for this group.

97. Assessing the impact of patient support programs on patient outcomes in adalimumab-treated patients with psoriasis in Europe

Abstract
Objective: AbbVie provides a free-to-patient Patient Support Program (PSP) called AbbVie Care to individuals treated with adalimumab (ADA). Benefits of this PSP have previously been shown in ADA-treated patients with psoriasis (Ps) in the United States. We describe the usage of this PSP among adult ADA-treated patients with Ps in Europe and the associated impact on patient outcomes.
Method(s): Real-world data of patients with Ps and their treating dermatologists were collected from a cross-sectional survey and chart audit in France, Germany, Italy, Spain and the United Kingdom. Data collected included demographics, Physician Global Assessment (PGA), and remission status. Patients currently receiving ADA were asked about PSP participation. Comparisons between patients enrolled in the program vs. those not enrolled were assessed using t tests for continuous variables and chi-square tests for categorical variables unless stated otherwise.
Result(s): Of the 344 patients currently receiving ADA, 61 (17.7%) used at least one PSP component (PSP cohort), 185 (53.8%) did not (non-PSP cohort), and 98 (28.5%) did not know. PSP cohort patients had a mean age of 45.2 years, 57% were male, and 71% were currently employed; mean diagnosis duration was 11.5 years. Non-PSP cohort patients had a mean age of 47.4 years, 61% were male, and 69% were currently employed; mean diagnosis duration was 15.2 years. Mean duration of adalimumab treatment was 1.6 years for both cohorts. The most commonly used PSP components were: education materials on life with Ps (39.3%), ADA home delivery (27.9%), ADA call center (21.3%), ADA injection guide (19.7%), and nursing services for ADA use (19.7%). A greater proportion of patients in the PSP cohort were currently in remission (80.3% vs. 60.5%; P = .008) and had a physician assessment of clear (PGA = 0; 41.0% vs. 21.1%; P = .040). 12 PSP cohort patients (19.7%) reported a flare in the past year, of whom 1 was currently flaring; of the 39 (21.1%) non-PSP cohort patients who reported a flare, 15 were currently flaring (Fisher exact P = .075).
Conclusion(s): ADA-treated patients using the PSP were more likely to have a favorable clinical profile than patients who did not use the PSP. This suggests that PSPs may have a positive effect on the clinical status and lives of patients with Ps.

98. Outcomes following small bowel obstruction due to malignancy in the national audit of small bowel obstruction
Abstract

Introduction: Patients with cancer who develop small bowel obstruction are at high risk of malnutrition and morbidity following compromise of gastrointestinal tract continuity. This study aimed to characterise current management and outcomes following malignant small bowel obstruction.

Method(s): A prospective, multicentre cohort study of patients with small bowel obstruction who presented to UK hospitals between 16th January and 13th March 2017. Patients who presented with small bowel obstruction due to primary tumours of the intestine (excluding left-sided colonic tumours) or disseminated intra-abdominal malignancy were included. Outcomes included 30-day mortality and in-hospital complications. Cox-proportional hazards models were used to generate adjusted effects estimates, which are presented as hazard ratios (HR) alongside the corresponding 95% confidence interval (95% CI). The threshold for statistical significance was set at the level of P ≤ 0.05 a-priori.

Result(s): 205 patients with malignant small bowel obstruction presented to emergency surgery services during the study period. Of these patients, 50 had obstruction due to right sided colon cancer, 143 due to disseminated intraabdominal malignancy, 10 had primary tumours of the small bowel and 2 patients had gastrointestinal stromal tumours. In total 100 out of 205 patients underwent a surgical intervention for obstruction. 30-day inhospital mortality rate was 11.3% for those with primary tumours and 19.6% for those with disseminated malignancy. Severe risk of malnutrition was an independent predictor for poor mortality in this cohort (adjusted HR 16.18, 95% CI 1.86 to 140.84, p = 0.012). Patients with right-sided colon cancer had high rates of morbidity.

Conclusion(s): Mortality rates were high in patients with disseminated malignancy and in those with right sided colon cancer. Further research should identify optimal management strategy to reduce morbidity for these patient groups.

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99. Variations in competencies needed to complete surgical training

Authors

Source
BJS Open; 2019

Publication Date
2019

Publication Type(s)
Article

Database
EMBASE

Available at BJS Open from Unpaywall

Abstract
Background: This study aimed to analyse the degree of relative variation in specialty-specific competencies required for certification of completion of training (CCT) by the UK Joint Committee on Surgical Training.

Method(s): Regulatory body guidance relating to operative and non-operative surgical skill competencies required for CCT were analysed and compared.

Result(s): Wide interspecialty variation was demonstrated in the required minimum number of logbook cases (median 1201 (range 60-2100)), indexed operations (13 (5-55)), procedure-based assessments (18 (7-60)), publications (2 (0-4)), communications to learned associations (0 (0-6)) and audits (4 (1-6)). Mandatory courses across multiple specialties included: Training the Trainers (10 of 10 specialties), Advanced Trauma Life Support (6 of 10), Good Clinical Practice (9 of 10) and Research Methodologies (8 of 10), although no common accord was evident.

Discussion(s): Certification guidelines for completion of surgical training were inconsistent, with metrics related to minimum operative caseload and academic reach having wide variation.

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100. Consensus standards of healthcare for adults and children with inflammatory bowel disease in the UK

Authors

Source
Frontline Gastroenterology; 2019

Publication Date
2019

Publication Type(s)
Article

Database
EMBASE

Available at Frontline Gastroenterology from BMJ Journals - NHS
Available at Frontline Gastroenterology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection
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Objective: Symptoms and clinical course during inflammatory bowel disease (IBD) vary among individuals. Personalised care is therefore essential to effective management, delivered by a strong patient-centred multidisciplinary team, working within a well-designed service. This study aimed to fully rewrite the UK Standards for the healthcare of adults and children with IBD, and to develop an IBD Service Benchmarking Tool to support current and future personalised care models.

Design(s): Led by IBD UK, a national multidisciplinary alliance of patients and nominated representatives from all major stakeholders in IBD care, Standards requirements were defined by survey data collated from 689 patients and 151 healthcare professionals. Standards were drafted and refined over three rounds of modified electronic-Delphi.

Result(s): Consensus was achieved for 59 Standards covering seven clinical domains; (1) design and delivery of the multidisciplinary IBD service; (2) prediagnostic referral pathways, protocols and timeframes; (3) holistic care of the newly diagnosed patient; (4) flare management to support patient empowerment, self-management and access to specialists where required; (5) surgery including appropriate expertise, preoperative information, psychological support and postoperative care; (6) inpatient medical care delivery (7) and ongoing long-term care in the outpatient department and primary care setting including shared care. Using these patient-centred Standards and informed by the IBD Quality Improvement Project (IBDQIP), this paper presents a national benchmarking framework.

Conclusion(s): The Standards and Benchmarking Tool provide a framework for healthcare providers and patients to rate the quality of their service. This will recognise excellent care, and promote quality improvement, audit and service development in IBD.

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