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ANAESTHESIA POINTS WEST

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Editorial

Anaesthesia Points West (APW) Vol 41. No.2 will be my last as Editor and this edition has been notable because a few weeks ago the publishing house that APW use (Iles Colour Print Ltd) went bankrupt. The credit crunch hit Bristol’s publishing sector. This did cause a fair amount of panic. As they had produced the journal for as many years as anyone can remember, had the format off to a tee and would do the art work in a predictable way, the Editor’s job was made considerably easier. Suddenly this all went, including all the previous files and documents, as the company’s computers were taken into receivership. Fortunately, a new publisher has been found and we have managed to get this edition to you on time.

It has been an honour and a pleasure to be Editor and I have learned plenty along the way. I have tried to keep the standard up to the level set by the previous editors, a hard act to follow, and you can only do your best. APW is a unique publication and an invaluable forum for unifying people across the large geographical region of the southwest of England. There are very few, if any, equivalent national publications. The journal provides a great opportunity for trainees to publish articles, familiarise themselves with writing scientific papers, data analysis and the like. Some papers are the early versions of work that goes on to be published in more prestigious journals, others have been turned down by other editorial boards only to be snapped up by the astute APW editors. I hope they all have interest to the Society’s membership.

I always enjoy the ‘News of the West’ and more recently the ‘News of the Free’ sections. Having trained in the southwest region it is a great way of finding out how contemporaries, trainees or mentors are doing. With more and more Anaesthetists appointed to the Peninsular and Bristol regions, many of them having been trained in other parts of the country, it provides an invaluable source of information, even gossip! A big thank you to the link people who spend their time creating their missives for each edition.

This edition has an item on the very topical issue of ‘Consent for General and Regional Anaesthesia in Adult Patients’. It looks as if we need to improve what we collectively do to meet current recommendations. Do 37% of anaesthetists really routinely tell their patients of the risk of death under general anaesthesia? I wonder if this is necessary and helpful when the risk is so low. There is a report of a pilot study on ‘Epidural associated hypotension after colo-rectal resection’. This addresses a genuine concern that epidurals may cause serious drops in blood pressure resulting in harm to patients. Although in this particular study the comparator group who received PCA morphine is too small to draw any clear conclusions, it nonetheless brings an important issue to our attention. Has the era of epidurals begun to decline? The evolving use of rectus sheath catheters and transverse abdominus plane blocks for laparotomies offer genuine safer alternatives.

Lastly, I must warmly welcome Fiona Donald to the position of Editor and wish her every success. I am sure she will put her individual style on the journal and hope she continues to enjoy the same support from the regular contributors as I have had. Good luck!

James Pitman
Future Meetings of the Society

Spring 2009
Cheltenham / Gloucester  Thurs 21st and Fri 22nd May, 2009

Autumn 2009
Exeter  Thurs 19th and Friday 20th Nov, 2009

Spring 2010
Rome
Peter John Firth Baskett

Peter Baskett, Past President of the Society of Anaesthetists of the South Western Region (SASWR) and one of the world’s leading figures in cardiopulmonary resuscitation, died on 18th April 2008. In the early 1970s, he developed advanced training for the ambulance personnel who were amongst the first paramedics in Europe. Peter was also responsible for introducing Entonox into the ambulance service in the United Kingdom (UK).

Peter Baskett was born in Northern Ireland on the 26th July 1934. Peter won a scholarship to Queens’ College Cambridge where he spent 3 years doing his preclinical studies in-between playing some rugby and cricket, and rowing. His initial postgraduate training, including his first post in anaesthesia, was at the Royal Victoria Hospital, Belfast. In 1962, Peter moved to Bristol where he completed his anaesthetic training at United Bristol Hospitals and Frenchay Hospital. He acquired the fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) in 1963 and was appointed as a Consultant Anaesthetist to United Bristol Hospitals and Frenchay Hospital in 1966, a position he held until retirement from clinical practice in 1999. Along with his good friend and colleague, John Zorab, Peter established the intensive care unit at Frenchay Hospital – it was opened on 1st May 1967, just one year after his appointment.

Early in his career, Peter was concerned that ambulance personnel had no effective means of relieving pain, so he persuaded the then Gloucestershire service to train crews in the use of Entonox, previously used principally for childbirth. By 1970, the success of this initiative spurred him into providing additional extended training for effective manning by ambulance crews of a Mobile Resuscitation Unit (MRU) that carried not only Entonox but also defibrillators and equipment to record but also — years ahead of its time — to transmit electrocardiograms from ambulance to hospital. This concept, together with schemes in a few centres in the United States and an additional centre in Brighton, led to the development of paramedics.

Meanwhile, general practitioners were founding GP-based-schemes which led to the foundation of the British Association for Immediate Care Schemes (BASICS). Peter was a founder member and later, Chairman (1981-85), of this organisation. He was also a founder member of a committee that

Legend
Peter J.F. Baskett 1934 - 2008

“I am certainly not one of those who need to be prodded. In fact, if anything, I am the prod” – Winston Churchill
in 1981 evolved from BASICS – the Community Resuscitation Advisory Committee (CRAC). In 1984, this committee became the Resuscitation Council (UK) – the first Resuscitation Council in Europe. Five years later, Peter was one of the founding members of the European Resuscitation Council (ERC) and was elected chairman (1989-94). Over 100 publications attest to his knowledge of CPR and airway management. In 2005, in recognition of Peter’s international contributions to CPR, the International Liaison Committee on Resuscitation (ILCOR) named him as a ‘Resuscitation Giant’. He was Editor-in-Chief of the journal *Resuscitation* from 1997 until his death. Few people realised how hard he worked in this role – as well as overseeing the reviewing process, he would personally sub-edit every accepted paper. During his ‘retirement’, Peter personally introduced the European Advanced Life Support (ALS) course into 22 countries. This involved directing about two ALS courses a month for several years and was accompanied by an exhausting travelling schedule. This sustained commitment to frontline ‘hands-on’ teaching was unique for a man of Peter’s experience and stature and because of this he was admired by healthcare professionals throughout Europe. He remained close friends with many ALS instructors and course directors right up until his death.

Peter was dedicated to the speciality of anaesthesia and to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and SASWR in particular. Given the importance that Peter placed on social occasions, it is not surprising that he was strong supporter and contributor to SASWR from 1964, when he first became a member, right up until just before his death. Peter was Honorary Secretary from 1970 to 1972 and was editor of the journal from 1970 to 1973; he was President (“Officer-in-Charge”) in 1997 and 1998. In 2003, I had the honour of delivering the citation supporting Peter’s award of Honorary Life Membership of the Society.

He was elected to the AAGBI Council in 1976 and held several positions until eventually becoming President in 1990. His contributions were recognised in 1998 when he was awarded the John Snow Medal. He spent 12 years on the Council of the (now) Royal College of Anaesthetists: as the College’s representative on the Board of the Faculty of Accident and Emergency Medicine, Peter was the key person at the interface between anaesthesia and emergency medicine as the latter evolved into an independent speciality. In 1999, he was awarded an honorary fellowship (FFAEM) in recognition of this achievement. In the same year, he was elected FRCP by the Royal College of Physicians, having been elected MRCP in 1995.

Peter’s ability to work hard for sustained periods, along with prolific social, administrative and leadership skills meant that he lead almost every organisation he was involved with. He was President of the United Services Section of the Royal Society of Medicine (1997-99), the World Association for Emergency and Disaster Medicine (1989-93), the International Trauma Anaesthesia and Critical Care Society (1995-98), and the Triservice Society of Anaesthetists (1994-95). He was made an honorary life member of the AAGBI, BASICS, the ERC, the Resuscitation Council (UK), the Australian Society of Anaesthetists, the Society of Naval Anaesthetists, the Ugandan Society of Anaesthetists, the Romanian Society of Emergency Medicine, the Slovenian Society of Emergency Medicine and the Polish Resuscitation Council, as well as the SASWR.

I first met Peter in 1986, when he gave a tutorial on the Bristol Part 1 FFA exam course. Peter entered the tutorial room with one leg in a plaster cast and a lit cigarette in his hand. He proceeded to deliver the most entertaining and compelling tutorial I had ever attended – probably because of the sharp sense of humour liberally interspersed with a variety of ‘fruity’ adjectives – I learnt subsequently that this was characteristic of a P. Baskett lecture. The subject, of course, was cardiopulmonary resuscitation – not something I had been particularly interested in
It was this introduction to the subject that stimulated much of my involvement over later years. Peter was an extraordinary lecturer and it was a privilege to watch him inspire audiences around the world. He loved to challenge conventional practice, and frequently did so with a delivery that excited the open minded and with vocabulary that created new levels of political incorrectness! He was the only one who had the charm to get away with it. Following Peter on the podium ranked as one of the most difficult tasks for any lecturer.

Peter had a long-standing and passionate affair with motor sport; as a man who lived life in the fast lane, this was entirely appropriate. In the 1950’s, Peter raced minis, but he eventually realised that he might live marginally longer if he placed himself on the outside of the track as a ‘doc on the corner’. Peter was appointed as Chief Medical Officer to Castle Combe circuit in 1968. He continued to attend motor sport events as a doctor until he became ill in 2007. Over all these years his enthusiasm and charisma attracted many doctors to volunteer their services and join the Castle Combe medical team. They will now work from the recently named ‘Peter Baskett Medical Centre’.

In 1983, Peter noticed that he had an occasional weekend to spare. This oversight was promptly corrected by joining the Medical Section of the Territorial Army (RAMC). Consistent with his successful career in the National Health Service, in 1987 he was promoted to the rank of Lt. Colonel and in 1992 was made Colonel and Commanding Officer of 219 Wessex Field Hospital. Many anaesthetists in the south west region have a great deal to thank Peter for – throughout his career he would go out of his way and, with the help of his international connections, set up training opportunities for numerous trainees from Bristol and elsewhere in the UK. Peter was influential in the development of trauma services in the UK: he set up a strong alliance with the R Adams Cowley Shock Trauma Center in Baltimore, USA, which gave many British anaesthetists, several of whom were military doctors, the opportunity to enhance their skills and knowledge in trauma resuscitation. As always, Peter led from the front – in 1988, he was among the first group of doctors in the UK to be trained as an Advanced Trauma Life Support (ATLS) course instructor. He was one of the leaders of this course in the south west and encouraged many doctors to join the ATLS faculty at the infamous Batch Farm Hotel, near Weston Super Mare. Being an ATLS faculty member with Peter was the ultimate test of one’s stamina. The ‘work hard, play hard’ philosophy seemed less than ideal when, having left the bar only a few hours before, we would then be ‘on parade’ early to prepare frozen, smelly sheep larynxes for the next teaching session.

Peter always loved to play the host; his drinks parties were legendary and he was the life and soul at any social event. But, drinks at ‘the Baskett’s’ came with a health warning: the ‘gin and tonic’ had rarely been in contact with tonic. Alongside every great man is a great lady. Vital to Peter’s success was the tremendous and unfaltering support that he received from his wife Fiona. The strength of her support, along with that of Peter’s son Simon and daughters Lucy, Olivia and Beatrice, was most evident during his final and prolonged illness.

Peter’s Memorial Service was held in Bristol Cathedral on 20th September 2008. The Cathedral has a capacity for 800 - there were very few empty seats.

Acknowledgement
This obituary has been adapted from versions published previously in the British Medical Journal (Nolan J, Chamberlain D. Peter John Firth Baskett BMJ 2008; 336: 1254) and Anaesthesia (Nolan J. Peter John Firth Baskett. Anaesthesia 2008; 63: 796-7).
Steve Forster mentioned in the previous issue of this publication, that that was to be his final contribution, and it has since fallen to me to write the Barnstaple report.

My first task therefore is to record Steve’s retirement after nearly 3 decades of service to the North Devon District Hospital. He worked as a Consultant here from 1979 until April this year. He was the Director of the ICU for 20 years, playing a huge role in its development clinically as well as being an ambassador for what was in effect a new service, promoting awareness and raising funds for essential equipment. Initially this all had to be fitted around routine work for the simple reason that it was some time before there were any sessions allocated to ICU work. He even went as far as to experience ICU life as a patient when he was admitted with Guillain-Barré some years ago, although it is true that he contrived to escape being ventilated.

In addition to his ICU work, Steve did two stints as lead clinician, and one as Medical Director. North Devon is a porphyria “hot-spot” and Steve took it upon himself to become the local expert. Once this was more widely known he was not infrequently consulted from all over the country. He did much to establish the formal teaching of trainees and was always supportive of them. In his younger, more driven years, he had a reputation for having a somewhat short fuse and could suddenly go into orbit with a whoosh, which led the ODPs to nickname him “Rocket”.

Steve has always been a staunch and involved supporter of the SASWR. Outside work he has been active in cricket, walking, cycling and skiing and is well known as a foodie and bon viveur, ably supported by Christine in everything, but the cricket tours!

He and Chris have sold their house in Ashford and are planning to relocate to France in the very near future, the fulfilment of a long-held ambition. We wish them well with their move, and a long and happy retirement.

We continue to struggle with the consequences of MTAS/MMC and all that that involves, but then so does everyone else, so no point in banging on about it here. What it does mean though is that at this time of year we have a larger than usual batch of comings and goings.

We say farewell and good luck to: Hanlie Craven (back to South Africa), Michelle Chopra and Murali Vallabhaneni (to Plymouth), Nicky Campbell (to Exeter), Madhavi Keskar (to Glamorgan), Anne-Marie Bougeard (to Yeovil) and

News of the West

This is where you are kept up-to-date on all the news and gossip from each department in the South Western Region. The name of the correspondent appears at the end of each contribution and he/she is also the SASWR LINKPERSON for that department. Anyone wishing to find out more about the SASWR or wishing to join should search out the local linkperson who will readily supply details and an application form. In addition to other benefits, members receive the twice yearly editions of APW- FREE!
Juzar Adamjee (still around but now in medicine).

We welcome our new trainees and hope you have an enjoyable and fruitful time here in North Devon: Norfaizan Ahmad, Michael Forster, Andrew Hadfield, Laura Hamilton, Eoin Harty, Maytinee Liaonitkul and Venu Mehta.

Congratulations to those who have passed various exams, or parts of them: Hanlie (FCSA Part 1) Michelle (FRCA Part 1), Madhavi and Murali (Part 1 MCQs). Congratulations too to Anne-Marie who arrived single but left betrothed, with all our good wishes. No reproductive news to announce except that your new scribe has become a grandfather for the first time.

We wouldn’t survive the first three months after the yearly changeover without the help of numerous locums to tide us over, so thank you to all those who have helped out.

All our old machines have finally been pensioned off (picture = the passing out parade) and replaced throughout by brand new Datex/GEC machines and monitors which are a delight to use. Thank you to Laurie Marks, Rod Lindenbaum, Pete Grant and everyone else involved in the transformation.

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**Bath**

We laugh in the face of adversity. Playing through bursts of torrential rain as hurricane Gustav clipped the city limits, the Anaesthetists vs. Theatres baseball match went ahead on the A&E cricket pitch. Had any of us known it would turn out to be such a blood bath, many may have bulked at turning up. To date the casualty list includes a fractured finger and fractured ribs as Mike Coupe, on a home run, was brutally body checked by Snr ODP Mike Townsend. Rajesh Srivastava had no idea that manning 4th base could be so dangerous, until he nearly had his head taken off by a baseball bat flying towards him – allegedly the grip was wet. The rules continued to evolve throughout with Darwinian authority, the sole purpose being to counteract any possible appeal for being given out. At the end of much mathematical skulduggery, the Match was declared a tie and the Golden Laryngoscope Trophy retained for next year’s titanic battle. The happy, valiant contestants retired to the sanctuary of the pub, leaving a muddy circular trench in the outfield (sorry Lansdown CC).

The international sports scene appears to have had more impact on staff, with Tom Simpson achieving the Bath triathlon in record time, Vaughan Martin completing his 18th (in 25 years) 100 mile bicycle ride raising funds for Action Medical Research in one of his best times and Monica Baird being awarded her pilot’s wings. Mike Coupe came 23rd in the country in the British Paragliding Championships (a sport only marginally safer than baseball). Malcolm Thornton again completed part of the Tour de France course despite falling off the road after only 100 yards - he was adjusting his seat (or something) at the time.

Sixty years of the NHS is certainly worth celebrating, and like much of the country we did. A marvellous exhibition charting the dramatic changes in the specialities over years was housed in a startlingly revamped hospital social club. The whole event was orchestrated by Brigid Devlin (alias Cook) with the star attraction being a recreation of a 1948 ward including an ‘Iron Lung’ transported...
down from St Thomas’ (always was a backward teaching hospital). A young lad helping set out an original Boyles Machine along side one of our latest Datex-Ohemeda’s observed that, when it came down to it, there wasn’t really much difference between the two. I hastily dispatched him to go and help with the cardiologist’s stand. In the end it was the people that made the occasion so special. From across the region arrived student nurses now in their 80’s, paediatric patients approaching retirement themselves, all bringing their own memorabilia and priceless accounts. Some of these children had been in-patients of the Bath & Wessex Orthopaedic Wing for many many months at a time. Their accounts were both remarkable and humbling; post war rationing, draconian night sisters, the letters written home to parents etc.

Congratulations and celebrations have provided rays of light in an otherwise sunless summer, with the marriages of Associate Specialist Dr Hassan Abuzaid, SpR Catherina Mattheus, and ST2 Adrian Clarke; maternity for consultant Viv Thomas on the birth of her second daughter, sons for Snr SpR Andrea Binks and ACCS Nicky Jones; paternity with another round of sons for SpRs Pete Brennan, Gareth Gibbons, Clinical Fellow Pavan Battu and F2 Nigel Lane.

We were particularly pleased to congratulate Drs Asif, Awan, Hunt, Keeley, Laver and Lim who have all become Associate Specialists, an accolade resisted by the RUH for far too long. We were also pleased to welcome Drs Kamran Banan and Pete Forster from the trainee body to join the permanent staff. Carol Peden was awarded a year’s sabbatical in Boston from July at the Institute of Health Improvement; hopefully they will provide her with all the answers for us.

There have been the usual upheavals as our trainee body moved onwards and upwards. Dr Matt Thomas moved to a very well deserved consultant post at the BRI (another superb colleague we let get away) and clinical fellow Dr Ewa Zasada to a locum consultant post in Manchester; Matt ‘The Younger’ Thomas has nipped down to Australia whilst Aussie Pete Brennan returned home (thankfully before the next Ashes series); we briefly welcomed back Alex d’Agapeyeff as Snr ITU trainee to be replaced by Mark Haslam. Our excellent group of trainees Adrian Clarke, Natasha Joshi, Rebecca Leslie, Henry Murdoch, Nigel Lane and Deepak Subramani, all achieved their next posting whilst Helen Winslow is acting as doctor to several expeditions and running an art exhibition in the Lake District. Beccy Lesley, whilst managing her huge charitable undertakings, has also developed podcasts for the Primary FRCA. I personally have no financial interest, so I can comment that this professional and innovative concept is well worth a trial listen (you may certainly recognise one of the voices).

We welcomed locum Consultant Hesham Ismail, trainee Srdan Bartulic and clinical fellow Manjula Yadagiri. Also Richard Beringer and Philippa Seal, both back from the Antipodes with excellent paediatric skills, and Will English and Hugo Wellesley. Drs Nicky Bosley, Lorna Burrows, Paddy Morgan, Reston Smith and Katie Welch all arrive as fledged anaesthetists with exams heavily on their mind, whilst Drs Kate Crewdson and Tom Mitchell are novice anaesthetists on the critical care rotation.

Bob Marjot

Cheltenham
How fitting that at the party to celebrate Sue Smith’s 17 years as ICU director the lady in question should be presented with a long black leather whip – the old one was very worn and was becoming a serious risk to the health and safety of the ICU trainees. So persuasive are her teaching methods that last year she was voted the best clinical teacher in the whole of the trust. This year’s award went to another Cheltenham anaesthetist in the form of Jon Francis (the lady only managed runner-up). I’ve been too scared to enquire of Jon what the secrets of his success are – he has probably taken a leaf out of Sue’s book and has a locked cabinet in the pain office full of grisly torture devices which he uses.
to impress (or even compress) the trainees. Some questions are best not asked. Rob Orme has now taken on the ICU head honcho role from Sue, but beware if you are planning to catch him up to no good in the dead of night: turn on the lights and rather than some cruel and unusual activity you are more likely to find him practising his putting in the dark.

Into this cesspit of immorality we have welcomed SpRs Anna Davies (now married – hurrah!), Charlotte Steeds (again) and Ashraf Soliman and SHOs (of sorts) Gemma Nickols, Zehrin Nassa, Hamish Breach (another boomerang), Helen Cain, Dave Windsor, Mohammed Farooq (on loan from A&E), Jana Lappyova, Emily Mathews and Wang Tan. Back with no illusions comes Mirela Krotki from adoption leave – better the devil you know (than follow your husband to Hereford). Congratulations to Zeenat Bhalla who beat off all the competition to become a substantive staff grade.

An important part of training is learning to make life and death decisions. Pig feed is not getting any cheaper and Dave Windsor has been more vexed with when to cut his losses and send his five no-longer-so-little truffle-hunting porkers to the slaughterhouse than he has about his upcoming exam. The rest of us are more interested in the potential for a freebie autumn departmental spit roast, but learning how to manage your resources on a tight budget is another lesson to be learnt so we are likely to be disappointed.

July’s leavers, including those on call, were treated to an evening rounders match in the park adjacent to the hospital. The sun shone (can you believe it?), but a close contest it wasn’t and PODP Forryan’s theatre team were roundly thumped by a vaguely anaesthetic crew. It was over so quickly that in the spirit of sportsmanship, decency and fair play the anaesthetists offered their opponents an on-the-spot re-match. Another resounding thrashing was followed by a much more evenly matched session in the pub.

Everyone has an anecdote to tell about Tony Burlingham but for reasons of propriety I haven’t come across a single one that would be appropriate to relate in this column. Tony and Annie have now retired to their tropical paradise on Australia’s east coast (‘where everyone builds their own boat’) via the States where Tony is taking several weeks’ terminal study leave. As a retirement present Tony was delighted to be presented with a framed print by a local artist of the annexe of the hospital in which he has spent more of his career than any other, the Montpellier Wine Bar.

Regular Thursday evening tutorials followed by occasional trips to the Beehive have long been a part of our department’s tradition and continue mostly as before. However in an attempt to involve the wider anaesthetic department including theatre, recovery and critical care staff every last Thursday of the month is now promoted as a ‘whole department’ meeting. Boyle, Nernst, Laplace, Häagen-Dazs and their various equations and laws are off limits. New developments, contentious issues, debates are now the order and several of us have discovered things about our close colleagues’ interests that we never knew before. If this sounds intriguing then all the more reason to sign up to the society’s spring meeting in Gloucestershire to find out more.

When Sue Smith’s turn came to give a ‘last Thursday’ talk she couldn’t resist using this fresh opportunity to express her predilection for large quadrupeds, naked flesh and leather. Personally I couldn’t see the point of the gratuitous picture of the jockey in the buff carrying only a very small racing saddle (hung like a horse, she said, but I couldn’t see how it was possible given the size of the leather postage stamp he was carrying). Now if any readers are under the impression from this and other stories that Dr Smith is any way some sort of domestic (rather than strictly professional) user of kinky S&M gear and suchlike, rumours that could bring to a premature end the careers of less robust and highly respected members of the medical community, I can definitely categorically reassure them that this is almost certainly not the case.

Ted Rees
Autumn is upon us, without summer arriving. How unfair is that? Luckily the sun always shines in the RDE department of anaesthesia. There have been rather a lot of staff changes recently. Paul Moor, Zoe Brown and Juliette Hull have all rotated to Plymouth (are you missing Exeter yet?), Claire Hamer has headed south to Truro, and David Portch has gone to Taunton. Hamzeh Hussein has moved to Frenchay, whilst Nicky Ross has moved way ‘Up North’ to Bradford, and Peter Ricketts has gone even further to Durham. We’ve said goodbye to James Gagg and Rob Horsley, and also to Anand Jayaraman, who is somewhere being lovely right now.

We have had so many new arrivals that I can’t even begin to list them. Suffice to say that we have 12 ST1s (or whatever they are currently known as), and a couple of more experienced trainees. Yes, that’s right – 12. We were handpicked as the only hospital able to cope with such a task, and coping we are. We have a rigorous training programme in place, thanks to Kath Davies, and a firm structure to training which will produce a fine set of trainees, I hope. We welcome new consultants Darryl Johnston and Alistair Martin, as well as two new pain consultants, Rupert Broomby and Mark Jackson.

Congratulations to Ben Ivory on the birth of Matilda, Al Helliswell on the birth of Tom, and Vanessa and Jon on the birth of Ella – a wee bit early, but doing well. Congrats also to Matt Hill, who has recently tied the knot and been appointed as a consultant in Derriford, and to Hayley who married Stuart in August. My final congrats are for Claire Todd, Ben Ivory and Susie Baldwin for passing the Primary. Susie deserves a special mention for somehow managing to not spontaneously combust during the run up to the vivas, and Claire and Ben (and many members of our department) deserve medals for putting up with her. Don’t do the final just yet, Susie.

The summer BBQ was again held at the Turf Locks. Nobody suffered hypothermia this year, as all wore full Arctic clothing. No bare flesh was visible at anytime, as the wind howled through our party. However, after a few glasses of wine, everybody warmed up. Matt Grayling was in trouble for buying the trainees a bottle of the cheapest wine, but they drank it anyway. By the end of the evening all the trainees were huddled around Myn, hanging on his every word. Nobody got lost or sank in the estuary on the way home, nobody fell off their bikes into the canal. All in all it was pretty dull.

Kath Davies had a party to celebrate a big birthday. A good time was had by all, except for me, as I was on call. Lauren declined my husband’s offer to sleep with him (fully clothed, apparently, but in a 2 man tent. I think I would also have declined), and thought she could cycle home after a glass or so of wine – with a mad dog in tow. Wrong. She is still digging the grit out of her knee.

Jo MacIntyre has left for New Zealand. Obviously we are missing him madly. Mark Daugherty organised a fab leaving party, which was well attended by well wishers, all sorry to see him go. You know I love you really, Jo.

The department has been struck with an urge to suffer great torture and unpleasantness (and I’m not talking about covering extra lists). Greer did a skydive, in the name of charity. Steve Straughan went to Vancouver to compete in the world age group triathlon championships. I thought it was Beijing, but apparently not. Sadly due to bad weather the swim was cancelled, so he competed in a biathlon, but had a good time anyway. Lauren Barker has realised that what her life is lacking is gruelling exercise, and has taken to sea swimming regularly, and mad cap competitions. Lauren entered the Exmoor Half Iron Man, completing the whole course with no worse injury than a leaking energy drink in her shoe (which she did initially mistake for blood). Emma Hartsilver ran the London Marathon, disappointingly 10 minutes slower than 6 years ago, prechildren (get a grip, woman). She’s planning the next. The boys took part in the Force Charity cycle race, I mean cycle ride – it’s not a competition, but with so many lycra clad, testosterone filled specimens, what can we expect? No injuries this year, surprisingly.
Well I think that’s all from me. It just remains for me to pass on the lesson of the week from this morning’s audit talk (by my dear husband) “feel it, move it, love it”. That’s the treatment, I’ll leave it to you to guess the disease. Until next time.

Pippa Dix

Frenchay

‘Twas the night before Christmas, when all through the house, not a creature was moving nor even a mouse,’ except for the one in our anaesthetic department, lured, no doubt, by the exotic biscuit collection kept there. Rather lower down the food-chain, Management Consultants have once again been stalking the hospital, despite the fact that we already have plenty of Consultants and more management than we know what to do with. At least they make for a plentiful supply of jokes:

A man is flying in a hot air balloon and realizes he is lost. He reduces height and spots a man down below. He lowers the balloon further and shouts, “Excuse me. Can you help me? I promised my friend I would meet him half an hour ago, but I don’t know where I am.”

The man below says, “Yes, you are in a hot air balloon hovering approximately 40 feet above this hospital. You are between 51 & 52 degrees N latitude and between 2 & 3 degrees W. longitude.”

“You must be an anaesthetist,” says the balloonist. “I am,” replies the man. “How did you know?”

“Well,” says the balloonist, “everything you have told me is technically correct but I have no idea what to make of your information and the fact is I am still lost.”

The man below says, “You must be a Management Consultant”

“I am,” replies the balloonist, “but how did you know?”

“Well,” says the man below, “you don’t know where you are or where you are going. You have made a promise which you have no idea how to keep and you expect me to solve your problem. The fact is you are in exactly the same position you were in before we met but now it is somehow my fault.”

The department’s television screened the Olympics all summer, with much satisfaction being gained by the GB team beating the Australians in the medals table. This result finally gave the lie to visiting Ozzie’s claims that they were somehow genetically predisposed to being better sportsmen. An ability to run fast in their ancestors would surely have meant that they would have evaded arrest and consequent deportation in the first place.

The Consultant ranks have swelled once more, with the addition of Ian ‘Chuffer’ Thomas (thanks Ben) and Guy Jordan, both going to work in ITU. Also we welcome three new locum Consultants in the form of Sarah Love-Jones, Jason Butcher and Masha Golikov. Masha comes from Australia, has a name reminiscent of a Russian assault rifle and laughs at about the same volume. Sarah is the most recent recipient of the Wilton award, which was well-deserved. New offspring of members of the department include Lucy to David and Kate Lockey, William to Rupert and Steph Harris, Freddy to Rhys and Sarah Davies, and Daniel to Kathryn Jackson and partner. John Carter became a grandfather for the second time, with the birth of Emily Harriet. John can tell you to the nearest minute how long he has to go until his retirement, and back to his true vocation of driving a JCB, I mean yacht.

James Nickells bravely organised a departmental walking expedition to the Brecons, including an overnight stay in some sort of hostel. Mountains, or perhaps balance, aren’t really his forte, as he has only just learnt to ride a bike and claims to have been forcibly ejected from ski school for being hopeless and a danger to himself and others. Sue Plastow also displayed extreme bravery, by persevering with a theatre list despite wailing, ‘How can I get through the day… my iPods broken!’

Plans for the new hospital at Southmead were presented by the two bidders to the Consultant body. The neurosurgeons were upset that they weren’t going to get their own tower, presumably hewn from the purest ivory, and have threatened
to leave en masse. Quite frankly, who would want them, and, this tower fixation. Do you think they’re compensating for something? The anaesthetists, naturally, cycled ten miles to the presentation, arrived late, ate all the biscuits and then left before the end, in order to cycle another sixteen miles to a pub. Ben Walton caused a minor pile-up by attempting to cycle headfirst into a small red car, which certainly would have done for the car. Both the architectural presentations resembled the new shopping centre at Cabot’s Circus, albeit on a smaller scale and with less car parking, because you obviously need to drive if you’re going shopping, but if you need to travel to hospital, a bus is just fine.

Congratulations to Jane Olday who came second in her age group in the Bath Sprint Triathalon. Jane, Ruth Spencer, Samantha Shinde and Sarah Martindale attended the recent Association of Anaesthetists meeting in Torquay (see picture). On their return trip, due to an overcrowded train, they found themselves inexplicably in the ‘quiet carriage’, an environment possibly not best suited to such a loquacious group. Inevitably, an announcement went out over the PA system explaining the concept of the quiet carriage. Medical science will one day prove that the ability to ‘receive’ resides on the Y chromosome and ‘transmit’ on the X chromosome.

To finish, best wishes to those of our colleagues who are currently on sick leave. Come back soon.

Richard Dell

Gloucester
A year after the great floods and things are still pretty wet following a monsoon-like August, but we have not let this prevent us from meeting the new Government targets. The waiting list money certainly helps pay a few bills!

Robin Cooper is doing a fantastic job as College Tutor organising the trainees and maintaining the on-call rotas so the spectre of resident Consultant on-call has been averted for the time being.

We have been lucky to have appointed two new Consultants - Claire Gleeson and Sarah “trouble” Muddle. Claire is well known to everyone in Bristol having spent her formative years as a flexible trainee there. Claire knows everything and everyone so would be an ideal successor to take over writing the ‘News from Gloucester’ column for this journal. Sarah is the department’s answer to Jennifer Aniston – rich, young and single (for the time being!)

The department baby boom has continued with congratulations to Tom Perris and Sock for baby Andrew, Sarah Harper for her baby girl, Dan and Chloe Evans for Lili, Judith Stedeford and Rupert for Alexander and Rachel Prout for Matthew. Registrar Matt Drake’s wife also gave birth to twins so we wish them all well.

At the beginning of August it was all change for the trainees. Ian Thomas has now taken up his consultant post in ICU at Frenchay. Chris Bourdeaux has gone to paediatrics in Bristol. Jo Corns has gone to Australia. Matt Drake and Juan “Stroud Salsa DJ” Graterol have moved to rotations in Bristol and Helen Cain has moved to Cheltenham. For reasons I don’t understand James Sidney has stayed with us and is continuing his research on the oesophagectomy patients. We have also managed to hold onto Simon Webster a little longer, although he does seem to spend a lot of time in exotic locations promoting something called the ‘Glostavent’. Louise Sherman, our flexible SpR, has joined us after two years in New Zealand. Louise has caught a few surgeons on the hop as she bears
a striking resemblance to Consultant Kay Chidley. Amelia Pickard is another senior SpR we’re pleased to have join us. Tess Bailey will shortly be leaving to start her maternity leave. Abby Lind is new to the rotation, having exchanged her Swindon number for one in Bristol to be closer to her surgical partner. Tim Bowles has returned to anaesthetics after a busy time in acute medicine. Janine Talbot and Sonja Payne are more junior trainees who should be with us for the next year. Clinton Lobo and Helen Crispin, who were our brand new SHO’s, are both making excellent progress.

I have been liaising closely with my colleague Ted Rees, who is organising next May’s Southwest Society meeting which is being hosted by Gloucester and Cheltenham. Ted and I had fun researching venues but decided on the Cotswold Three Pillars Water Park Hotel after a tour of its spa and bedrooms. We will have an interesting academic meeting combined with some fun social activities and team building events so we look forward to seeing you all there.

Continuing on the social side, we haven’t had a Summer BBQ again due to the bad weather. Dan Evans, Louis Khor and Dave Gabbott spent some time at the Cheltenham Cricket Festival in July but I gather a lot of time was spent at the bar. The female Consultants have continued in their relentless task of testing all the spas in the Cotswolds – well we do need to keep our stress levels low.

Inspired by the success at the Olympics, a big group of Consultants – Pete Sanderson, Charles Rodriguez, Alastair McCririck, Robin Cooper and Louis Khor are taking part in “The Beast”, an epic cycle race in the Brecon Beacons this weekend. The heady mix of Testosterone, lycra and mud doesn’t bear thinking about, but good luck to them.

Talking of Pete Sanderson, he is approaching the end of his three years as Clinical Director. They have taken their toll but he’s still smiling, I wonder who’s taking over?

**Belinda Pryle**

**Plymouth**

The Derriford team once again has had a great summer. Sailing, splicing, producing, passing, augmenting, organizing, deploying and of course departing… Oh, and we also did quite a bit of work! Sophia Wrigley has been working hard at the helm trying to keep everything on an even keel as we sailed into new uncharted waters with revised theatre schedules, the long awaited additional theatres in Freedom (how much did they really cost?) and a host of new responsibilities and targets.

Meanwhile in order to escape the mundane work matters some of us got together to sail to the SASWR meeting in Guernsey and what was originally a few words of bravado over a beer, eventually turned into reality when a Bavaria 44, skippered by Colin Berry left Plymouth on a beautiful evening and headed out across the Channel – eventually linking up with a second boat from Truro skippered by Jonathan Paddle. A great time was had by all, although Paul Young may not quite agree after feeding the fish to the nth degree and heading straight for the FLYBE desk on arrival in Guernsey in order to avoid a return passage! A part crew change in Guernsey meant more variety for the journey home. Consultants, partners and trainees made it all a fun time and some positive team building and adventure training opportunities were snapped up. No doubt this will not be the last such outing.
On the splicing front, Andy Porter managed to break away from the pool management to marry Sarah in June, whilst Gemma Crossingham married Ben in July. Meanwhile the production team not to be outdone, proved as fruitful as ever and proud parents included Geoff Smith (baby Louise), Paul Warman (baby Harry), Mel Knight (Baby George) and Sophia Bratanow (Baby Audrey). ..and as for grandparents! .. well Jonathan and Pat Coghill finally got that title!

On the exam front we also had a bumper crop and the results are shown elsewhere in this journal.

Educational support in the form of the first DAFT course was held in June. Organised by Gary Minto, Tom Gale and Kate Holmes for trainees, it was a great success and the next is already being planned for December this year.

It seemed that all the new consultant offices were straining within weeks of coming on line, but not withstanding this we took on a whole new batch of people, fresh off the top. Andy Hutton as neuro consultant took one look at the first neuro list and disappeared to the US for a year and starts in April, Elizabeth Drake started in August in obstetrics, closely followed by Daryl Thorpe-Jones and Lorraine Alderson in September as general consultants. Matt Hill is about to start in October and Gavin Werrett joins in November – both as general consultants. All are very welcome. All of these will make up for the string of Service anaesthetists who are once again dusting off the desert kit for another jaunt in the sands as the likes of 3 Cdo Bde head off on another tour.

No report would be complete without talk of beach games and fierce competition and once again the department mustered one eve on Bigbury Beach for the “Dept superteams” event! In a highly charged event of international flavour… the “Depleted South Africans” (Tom Gale, Karen Grimsehl and Ian Christie) won the coveted Ross Davis Cup. The grudge return match in the form of the Volleyball tournament organized in the good weather of July… was unfortunately rained off however!

Finally the ones that got away… As this is written we are about to dine out three major players from the department who have made major contributions in their time here. Liz Rawlings, Paul Harvey and Graham Brownlie. Liz has having got “second wind” a few years ago has been unstoppable until now, taking on extra teaching and fiberoptic training in addition to her major input to advancing daycase work in Plymouth. She has even found time to disappear with ORBIS to far-flung areas of the world. Graham and Paul have both been big players in the obstetric world of course and Graham’s other major input to the department has been the development of pre-operative assessment. Paul can sigh with relief at handing over all those critical incident handling tasks and his allergic testing service that has gone from strength to strength. All of them will be sorely missed but I would guess that we have not seen the last of them. We wish them all well.
Leavers - Aug 08  

New comers - Aug 08  
Eleanor Carter, David Connor, Jane Thake, Louise Schonborn, Philippa Squires, Naga Vallabhneni, Clare Blandford, Anthony Bradley, Zoe Brown, Michelle Chopra, Gemma Crossingham, Mark Davidson, Susie Davies, Rob Horsley, Alex Mills, James Brown, Paul Herbert, Juliet Hull, Will Key, Julie Lewis, Will Starkie

Andy Burgess

Southmead

It is a truth universally acknowledged that Mutley is the most decorated dog in cartoon history (oh yes, I may not be able to reference sport, cars or highbrow culture but there isn’t much I don’t know about children’s television of the 1970s) but retired Southmead anaesthetists are coming up on the inside lane. Ed Walsh received the Lord Mayor’s medal in recognition of his contribution to the major incident service in the city. For 20 years Ed was continuously on call for death and destruction on a grand scale in the Avon area and his only thanks was a labelled parking slot at Southmead. He now has a shiny medal and a piece in the Evening Post to add to that. He was apparently “completely bowled over” to receive the medal but I can’t help wishing that he’d said he was “gobsmacked as a parrot” or that disaster management was “a game of 2 halves”. Fiona McVey tells me that the canapés at the reception were very much above average so now we know where our Council Tax goes. Meanwhile, Neville Goodman was undoubtedly “happy as” to receive the College medal in recognition of work for the Royal College of Anaesthetists, which in his case involved many years of examining and many more years of teaching. We are very proud of both of them.

Speaking of retirees, I promised news of the retirement party for Colin Hall and can now bring you that, along with a bonus report on the one held for Ed Walsh. Colin’s do was held at Goldbrick House, which made us all feel very young and trendy – quite a feat at a retirement party. It was a fantastic evening with champagne on the terrace to begin and a splendid 3 course meal to follow. The trio of rhubarb sweets were particularly delicious and I’m told the ox cheek main course was outstanding although I’m afraid the image conjured by the name put me off. Ed Walsh gave a fine speech summarising Colin’s achievements and Colin gave a typically Colinesque response i.e. short yet apposite. Having had such a good time the first time around we decided on the same venue for Ed’s party and we were not disappointed. Tony Madden was the speaker on this occasion, aided and abetted by Barry Pentlow who swears that the incident he recounted really did happen. Unfortunately, under the laws of common decency, I cannot share it with you but suffice to say it was colourful – from Barry’s blue period I’d say. Colin chose a garden bench as his present and this is now installed in a sunny spot at the bottom of his garden mainly for the benefit of the deer and rabbits it seems. Ed chose a camera but on the night appeared to waver over his choice. Fortunately, Jo was there to guide him back to the correct path so it all ended happily.

We’ve had arrivals as well as departures. Karine Zander and Medha Vanarese have joined us as new consultants and Khaled Moaz and Ronelle Mouton have slipped seamlessly from locums to substantive appointments. Welcome to all of you. Claire Fouque gave birth to Sophie earlier this year so congratulations to her and to James. There have been reports in the press that excessive mobile phone use during pregnancy can lead to hyperactivity in the offspring. When n equalled 1 in the Fouque-Pickering household this hypothesis seemed to have been borne out. Let’s hope, for the
sanity of the parents, that now that n equals 2 it has
been thrown it into doubt.

The summer barbecue was held at Chris
and Jill Johnson’s house this year. We were able
and willing to admire their enlarged and newly
landscaped garden as well as their beautifully
restored summer house. Thankfully we managed to
find a relatively rain free evening and were able to
stay outside until quite late. Many people appeared
to be aided in this by the insulating properties of
Jill’s rum cocktails. Steve Robinson and Simon
Lewis kept all the children occupied by kicking
rugby balls at them and I am firmly of the opinion
that the entertainment afforded by this outweighed
the minor damage inflicted to people and property.

We have recently said goodbye to Ndollo
Eboumbou and Zoly Kudela who came to us from
France and Hungary respectively. They both
worked incredibly hard and helped us to keep our
heads above water so thank you to both of them.
We’ve also seen some of our trainees move on,
Andrew Jacques, Ali Johnstone and Amit Goswami
have gone to the BRI, Nico Jelocin to Swindon and
Angela Bell to general practice (via her wedding).
Jin Joseph moved on to Gloucester (but not before
becoming a father) and Niranjan Jayasheela has
gone to the cardiac unit in the BRI. Ali Johnstone
and Angela Bell passed the Primary FRCA earlier
this year and Sentil Vijayan passed the Final so
congratulations to all of them. Simon Thornton, our
F1 trainee has gone to do something very clever and
academic so he was obviously inspired by his time
in ITU and anaesthetics. In their places we have
Marc Vilaseca (Spanish Marc), Jonathan Lightfoot,
Mark Turner (not Spanish Mark) and Raj Malhotra
who are all keeping us entertained and will hopefully
do something gossipworthy over the next 6 months.
Congratulations must go to Malinka Vrabtcheva,
Izzy Iqbal, Usha Devadoss and Pia Lieber who have
all been appointed to permanent staff grade posts.

Kathryn Holder has passed the baton of
department lead on to Nik Koehli who was the only
person not to say that he definitely didn’t want to do
it – schoolboy error. His first task has been to cover
2nd on call at the weekend just to get a taste of what
the trainees go through. How selfless can one man
be in the pursuit of empathy? I think I speak for
the whole department in saying that Kathryn will
be a hard act to follow but that Nik is probably the
best person to give it a go. At least he’ll be able
to look Dave Holland in the eye without need of
a step ladder! Simon Lewis and Mark Pyke have
also taken on new roles in the department. We now
receive regular letters from them outlining the truly
atrocious state of health of our forthcoming patients
but reassuring us that they have full confidence in
our ability to keep them alive for the duration of
their extensive and highly invasive surgery. The
joys of the pre-op assessment clinic – are they
having a laugh? Yes, I suspect they are.

Jill, our department secretary, nearly
disappeared under a pile of confidential waste bags
this week. The departure of Ed Walsh means that
all the paperwork relating to the pain clinic has to
be destroyed so Jill, who interpreted Ed’s tapes and
typed up most of his letters, is now the prime mover
in the annihilation of her life’s work (well nearly).
Turkeys and Christmas if you ask me.

Finally, in these days when we are being
asked to “blue sky think outside the box” I would
like to propose the immediate disablement of the
reply to all button on NHS computers. This would
have several advantages: it would prevent the IT
non-savvy from revealing salacious details about
their lives to the whole Trust, it would prevent a
lot of pointless bickering, it would save time and
it would bring John Leigh’s blood pressure down,
all of which would save time and money. The only
disadvantage would be the loss of the moral high
ground afforded when one is a spectator to the
aforesaid pointless bickering. Genius.

Fiona Donald

Swindon
The Great Western Hospital comes bouncing back
into News of The West. And what a year we have
had. Yes, I bring you a special bumper catch-up
edition.
The anaesthetic department has gone quiet recently. Our departmental secretary, Hilary Millett MBE, retired, not so much kicking and screaming, but more like bluberring and speechless. The occasion was marked by a farewell lunch do on her last day and then a “soiree” with Jackboot providing the entertainment with his jazz band. There was, needless to say, a terrific turnout of gas-folk both old and new. We all miss her humour and kindness.

Mark “Jackboot” Jackson

Once again there is an awful lot of lovin’ going on around the place. Ruth Murphy has just got hitched, Charlotte Allan will follow suit in November and Rachel Perry has got plans for next year. Wall to wall meringues. Simon and Tanya Davies have had another hatchling, Finn. Kate Donovan has gone off on maternity leave and Marcus Fletcher is waiting to be a dad for the third time.

Anisa Sabrine came back from maternity leave a little while ago and more recently David Penney has rejoined the team. Ben Maxwell returned from his tour with the British Army in Afghanistan. It is good to have him back safely. Anthony Carey completed a sponsored bike ride from Land’s End to John O’Groats and we heard that old SpR Paul Trumplemann succeeded in his attempt on the summit of Everest.

Simon Davies organised a superb party in May. Champagne flowed, the disco throbbed and Tony Pickworth (led astray by Aneeta Sinha, I hasten to add) danced on the tables.

Well done to our exam victors: primary FRCA to Sarah Sanders and Anthony Carey and final FRCA for Ruth Murphy, Tracey Christmas and Manoj Parikh. Our two APs (or PA(A)s) Rachel Perry and Beth Lavender completed their training and are now permanent members of the department.

Recent movers have been Aneeta Sinha back to Wessex, Madhu Shankaregowda to Southampton, and Parveen Dhillon to Cambridge. Back to Bristol have gone Sarah Saunders, Kate Sharpe and Anthony Carey. Three of our ACCS foursome (Sarah Warwick, Amy Hughes and Neil Kellie) have moved on and Alex Middleditch is staying with us for another year. Our new August intake comprising the likes of Astin, Davies, Jelacin, Kaushik, Turnham and Upex are now settling in and preparing themselves for either going solo and sitting exams. Our SpR links with Oxford and Wessex will soon be coming to an end so that in future all STs and SpRs will come through Severn.

Sean O’Kelly has become an Associate Medical Director for Women’s and Children’s Services within the trust and Mike O’Connor is now an Associate Dean in the Severn Deanery. Congratulations to Petr Tobias who has secured a consultant post in Masterton, New Zealand. Good luck to Petr and his family.

Mat Ickeringill

Taunton

The last year has been a bit of a whirlwind here in the department, so a few bits to mention since the last Taunton round-up. Firstly Tim Zilkha has taken over the helm from Ian Gauntlett as CD and has continued where Ian left off by managing a significant further CBBE (consultant body bolus exercise), finishing just last week. Following the
appointment of myself and Steve Harris in April 2007, the boardroom has barely gone a few months without Consultant anaesthetist interviews. We therefore warmly welcome Rachel Brown and Helen Hopwood to the general rota and more recently Richard Gibbs and Helene Lindsay to the ITU rota. Following their appointments we also welcome Matt Ward, Andrew Donovan (aka ‘Boris’ to those in the SW) and Mitesh Khakhar to the general rota. These ‘catch up’ new posts will hopefully fill the chasms in the rota and avoid the need for last minute locum cover which during some weeks could have as meant as many as half a dozen new names on the rota. If it were not for Tim, Jo and Sam in the office scouring the country (and wider afield - South Africa included!) for locums, I believe we would have ground to a halt somewhere in May.

What else? - well we have a temporary theatre in the car park allegedly for orthopaedic catch up work / 18 week (or better) target maintenance – although I have personal experience of non-orthopaedic work there which also seemed fairly smooth – so long as one sent for the patient up to 1 hour ahead!

We are 1 year down from MMC implementation and have just about survived on the trainee numbers front. We said goodbyes recently to Suzanne Carty, Julie (Is that my Diamond Platinum engagement ring under the decking at the pub) Lewis, Craig Pope, Jamie Biddulph, Anthony Bradley, Claire Blandford, Dermot Gardiner, Rob Dawes and Katerina Tober. We said goodbye and, 6 months later, hello again to James Griffin (congrats on finally tying the knot!) and new hellos to David Portch, Kajan Kamalanathan and Richard Allan (SpR’s in old money) and Chris Oscier, Graham Simpson, Tom Clarke, Rebecca Brooks, Smita Bapat, Adam Revill, Gemma Matthews and Mark Pauling (ACCS’s and STR 1-3’s ) I hope all that is correct.....

Congratulations to Primary FRCA positive Jamie, Anthony, Rob, Katerina and Claire and final FRCA positive Nigel Hollister. Stu (iron man) Collins continues as a Primary FRCA examiner.

Very best wishes to Daryl T-Jones who moves back to Plymouth to take up his Consultant post. Jane Bellamy and Eleanor Zaremba continue as locum consultants and Will Fox and Nigel Hollister stay on with James Griffin as our senior tier of SpR’s. Tim Wilson stays on to continue his general anaesthetic training.

We are continuing the initiatives of the ‘Safer Patient’ program which has seen a genuine improvement in patient care. We have achieved Foundation Status, so now wait to see what comes of the proposed redevelopment of the surgical buildings.

The blight of the department ‘dodgy knee’ continues this time with Bradley Browne shortly to be back post (long awaited) TKR (rumour is he dictated his own op note having advised the surgeon on the best approach). Mike Walburn has seized the opportunity of his dodgy knee to expand his toys with a lovely new carbon fibre road bike – of course this is the best form of exercise with such an ailment and I am shortly to use this exact excuse to my wife when I purchase my ‘Gucci’ bike.

Dave Creasey has taken over the mammoth that is the department rota – many thanks to him – hopefully the new appointments will allow us to staff the ever growing number of lists....EVARs, yet more spines, 2nd (with rumours of 3rd) bariatric surgeon lists, MRI this and that, paed oncology and the orthopaedic Tardis to name but a few.

The department shared office is now creaking at the seams with consultant desk occupancy running greater than 100 % at times, as up to 3 of us share each others’ desks and junk mail – if we were in Japan I think we would all be in bunk desks or micro office suites by now. Still at least we are visible during our SPA time even if virtually sitting on each others’ laps is not quite official policy!

Until next time from a wet and windy Taunton.

Jo Silsby
Torbay
After a dismal summer in South Devon it was of
some consolation that the weather perked up for the
Association of Anaesthetists meeting last week here
in Torquay. Along with Paignton and Brixham, the
whole of the Bay area around here has been known
for years as the ‘English Riviera’. The local Tourist
Board has adopted the Torbay palm (also known as
the New Zealand cabbage plant) as part of its logo
although is not a cabbage or a palm but in reality is
the Cordyline Australis, a member of the lily family!
I hope that those who came to the meeting were able
to see something of Devon in the sunshine and at
least capture the flavour of the Riviera!

After three years in the Department, John
Speirs, consultant in Pain Management, has left
us to return to his native New Zealand. We give
John our thanks for his service and wish him well
for the future. To replace John we look forwards
to welcoming Dr. Andrew Gunatilleke in the near
future. We are also delighted to learn that Matt
Ward has recently secured a Consultant position in
Taunton. Congratulations to Matt.

The Orthopaedic Department continues to
expand with the recent appointment of a further two
consultants bringing their numbers up to eleven.
The plan is that trauma lists will soon be up and
running seven days a week. Jonathan Ingham, our
Clinical Director, is currently wrestling with the
options that need to be considered to cover this
extra commitment.

Kerri Houghton remains active on all
fronts inside and outside the Department. A recent
achievement is her appointment as Clinical Adviser
to the Department of Health to assist with the 18
week programme. Kerri is also planning to be
part of a medical team going to rural Kenya for
a week in January. The trip is the brainchild of
Lucy Obolensky (SpR orthopaedics) who worked
in Torbay Hospital until quite recently. The team
will also include Andrey Varvinskiy, Gary Minto
(Plymouth), two of our orthopaedic consultants
and theatre nurses. At the moment there are all
sorts of raffles and auctions going on to help raise
sponsorship money. Good luck team! Back from
globetrotting is Douglas Natusch who has been in
the USA lecturing on innovation in chronic pain
programmes.

Yet again the Departmental summer
barbeque was hosted in the sun by Tony Matthews
and Mary Stocker at their home in Torquay. At work,
Mary continues to steer the Day Surgery Unit from
strength to strength. When Mary speaks we listen!
But the trains run on time. Well done, Dr. Stocker!

Jeremy Ackers remains active in his
outdoor pursuits. Back in the summer he took part
in the London Triathlon coming in the top third for
age group. And more recently, just for fun, a group
including Andrey Varvinskiy, David Pappin and
Teresa Hinds paddled on the Exe from the Quay
down to the Double Locks.

It was with sadness that we learned of the
death of retired colleague Dr. Brian Whittard. Brian
was well liked and respected in the Department, and
we send our condolences to his wife, Shirley, who
herself was an anaesthetist at Torbay Hospital.

Ian Norley

Truro
Summer has arrived at last, in September! Now all
roads are slowed by armies of harvest-laden tractors.
I have not found a category for agricultural factors
when reporting the reasons for the late start of a
list. We have survived August with a lot of acting
down. The trust is holding its own and the banking
problems make ours pale into insignificance.
Roll on Aug 09 and the working time crunch set
against reduced waiting times. Our new trustwide
management structure is up and running with only
a few divisional manager posts left to appoint.
Ray Sinclair and Paul Upton are both Assistant
Medical Directors. Ann Dingwall chairs the senior
staff committee. Jonathan Paddle is our Divisional
Director supported by his business committee of
Clinical Leads. There is a buzz of change and
activity, which is exciting. What we need now is
for top management to let the delegated authority
work and not to attempt to micromanage it from
above. So far the signs are good. Our Maternity service merry-go-round is almost complete and we are moving back into the original wards. No more asbestos tiles and a nice paint job on the old ruin, but no improvement in facilities, which is a bit depressing really. I had dared to hope that I might see a new build before I retired. Never mind!

The response to this impending stress has stimulated a wave of fertility within the department. Duncan and Kim Sim have been blessed with twins. Andy Lee has fathered Sam. Georgia Brooker has produced Florence. Will Harris has fathered Monty. Helen King has brought Archie into the world. Saeda Verghese has had a baby girl. Gina Matthews has also had a baby but I have not heard whether she had a boy or a girl. Congratulations to all of you. Congratulations also to David Ashton-Cleary on his wedding. James Simpson has also signed up to wedded bliss.

We currently have a large team of locums helping us hold the service together. Drs Shamallack, Ezzat and Al Saffar are holding our Obstetric on call together, along with our SAS team of Sarah Taylor and Chander Ayathon. Our South African Colleagues from ‘Rapid Sequence’ are rotating through to clear the extra service demand. The new intake of trainees include Drs Teare, Tober, Hamer, Piggot, Roberts, Cromarty, Thorpe, Pietroni, Boulton, Plotnikova, Griffiths. As yet most of them are still names only to me, but by the spring we should have some colour and spice to add to their reputations. Mike Freeman has retired from Anaesthesia although not from climbing! He was the last of the five Consultants originally recruited to staff the West Cornwall Hospital in Penzance. The future of the emergency services at that hospital remain undecided and we are currently staffing it from Truro. Mike was a hard and uncomplaining worker and a passionate defender of the value of the West Cornwall service. We shall miss him and wish him well in his retirement.

Lastly on a sad note, we were deeply shocked to here of the accident, which befell Jo Rugen, whilst walking in Cumbria. We offer her all our best wishes during her convalescence. If any of you are visiting Derriford, drop in and keep in touch.

Bill Harvey

Weston

Apart from the burning down of the Grand Pier, what news from Weston?

The biggest change to affect us recently has been the decision of our Associate Specialist, Magdi Latif, to retire. Magdi has been with us since 1993 and has been a stalwart of the department. Always dependable and cheerful he has been greatly missed in recent months by us all, especially the theatre staff. We wish Magdi and Helen the very best for their future.

We have also lost Hameed Chaudhry who has returned to the Middle East after spending a year with us as a locum consultant. The workload is ever increasing so it is a relief to see the cavalry on the horizon in the form of two new consultant appointments who will take up their posts in the coming months.

Our trainees have been coming and going more frequently than in the past as some only stay for just three or six months following the changes with MMC. I shall only mention those who were with us for twelve months or more, namely Jonathan Lightfoot and Mark Turner. Mark was appointed as an SHO in December 2006 (I think) and therefore qualifies for the award of the trainee who has spent more time with us than any other in living memory. Mark was also responsible for organizing a farewell party in August for his colleagues at a nightspot in Weston. Suffice to say that it was well attended by staff from different departments and an appropriate send off for our trainees.

John Dixon
University Hospitals Bristol

So UBHT finally achieved foundation status and became University Hospitals Bristol – to the bemusement of the other two university hospitals in the city. The conspiracy theorists amongst us are convinced this new name is all part of a cunning plan to finally merge us with North Bristol. Management meetings are now dominated by trust strategy and target markets but efforts to improve trauma theatre efficiency had to be abandoned during the Olympics – have you ever tried to get an orthopaedic team out of the coffee room during the women’s beach volleyball?

The new cardiac centre looks like it will open on time and there are plans for a new ward block, so we can finally move the patients out of the old buildings. More specialties seem to be planning to move there than there is space for so I am looking forward to an “It’s a Knockout” style cross hospital bed race to claim newwards. It’s unclear what will happen to the old buildings but if the underpass becomes redundant the current vote is for its diversion to Cabot Circus with a direct link to Raymond Blanc’s and Harvey Nic’s – but I guess that might be stretching the College definition of on site supervision a little too far…

On the appointments front we have had a host of new consultants to replace last year’s retirements/emigrations. Welcome to Nick Wharton, Nilesh Chauhan and Hannah Blanshard on the general rota, Richard Bateman (cardiac), Matt Carey-Thomas (ICU) and Gail Tovey (Paeds). Congratulations to Matt Carey-Thomas last week on the birth of Olivia, although Matt Coleman-Thomas was a little surprised to receive a lovely bouquet of flowers from the department – one of them is really going to have to change his name. We also now have two fully qualified physicians assistants anaesthesia – Claire Haywood and Alison Shaw who are rapidly making themselves indispensable. Congratulations to Sue Underwood who has been appointed as Head of the School of Anaesthesia for the Severn Deanery; be warned Sue some of our colleagues are already getting quite excited at the thought of getting sent to the headmistress’s office. Congratulations also to John Hadfield on his engagement, we haven’t met her yet but Fran assures me she does exist.

We’ve had a great bunch of registrars over the last year, thanks for all your hard work and good luck in your next hospitals. I am assuming Toby really has gone to Frenchay and is not back touring with the Ministry of Sound cage dancers (any photos to Rachael.craven@uhbristol.nhs.uk). Congratulations to Steve Tolchard, Toby Everett, Dominic Janssen, Claire Hommers, Andy Georgiou, Lucy Kirkham and Kathy Hoya on passing final FRCA, to Charlotte Steeds and Sarah Love-Jones for winning the GAT 1st prize, Tom Martin for winning GAT 2nd prize and Andy Georgiou for winning the ACTA presentation prize. We seem to be equally lucky with our new registrars this year who are all settling in quickly and seem to have multiple projects on the go – good luck to all those taking FRCA this time round.

Rachael Craven
# Examination Successes

**Bristol School of Anaesthesia**

<table>
<thead>
<tr>
<th>Primary FRCA</th>
<th>Bath</th>
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<tbody>
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<tr>
<td>Rebecca Leslie</td>
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<td>Deepak Subramani</td>
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<td>Lucy Kirkham</td>
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<td>Kathy Hoya</td>
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South West School of Anaesthesia

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<td>Claire Todd</td>
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<td>Jamie Biddulph</td>
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<td>Anthony Bradley</td>
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<td>Raj Thangarai</td>
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<tr>
<td>Sofia Bratanow</td>
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<td>Richard Allan</td>
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<td>Truro</td>
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<td>Dave Beard</td>
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<td>Theresa Hinde</td>
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<td>David Pappin</td>
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<td>Richard Kaye</td>
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<td>Juliet Barker</td>
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<td>Clare Moser</td>
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<tr>
<td>David Beard</td>
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I am sorry if anyone from the region has not been included in this list that should have had an examination success or any other honour acknowledged. I can only publish the names sent to me by each departments SASWR linkman or College Tutor.
SASWR Spring Meeting Report
Guernsey June 5th – 7th 2008
Dr Ed Morris, Honorary Secretary

My wife tells me that I go away too much. It was therefore with some trepidation that I revealed that the ‘home’ spring meeting of SASWR was in fact to be ‘overseas’ this year, in Guernsey, under the joint auspices of the Plymouth and Guernsey Departments. Her mood improved appreciably when I showed her the brochures and publicity which Martin Wolfe of Guernsey had liberally distributed to members during the previous November’s meeting; after I had invited her to accompany me all was forgiven.

It seems that many members had had the same idea, and the presence of almost as many guests as delegates made for a meeting which was enormously successful both from a scientific and social perspective. Huge thanks must go to Martin Wolfe and his team of assistants from Guernsey who worked immensely hard to choose venues, plan activities, and show off their beautiful island. The Plymouth Department provided many of the speakers and also the crews for a sponsored sailing challenge of Olympic proportions – of which more later.

Martin had chosen the Old Government House Hotel in St Peter Port as the venue for the meeting. Formerly the residence of the Lord Lieutenant of Guernsey, it was a splendidly appointed building with views over the harbour and an excellent level of service. For many members this was their first trip to the Channel Islands, and with truly excellent weather the island – for me reminiscent of an earlier, more innocent age of mainland British life – was at its best.

On the first evening the Government of Guernsey (yes really) had organised a ‘Vin d’Honneur’ for our delegates and their guests. Guernsey has seen a decline in the ‘Bucket & Spade’ tourism which supported it

The View from the Hon Sec’s bedroom was unusually disappointing.

Presidents past and future.

The local organisers.
Why are they holding two glasses
during the latter part of the last century, and is keen to portray itself as a conference venue. The minister of Tourism, Carla McNulty-Bower, welcomed us to Guernsey during the reception in the Candie Gardens museum. Afterwards members split into groups and explored St Peter Port’s variety of excellent restaurants and (allegedly) its two nightclubs.

The Scientific meeting opened with a welcome from the president, Sir Peter Simpson, who thanked the organisers for their hard work. The 50 members present stood in remembrance of several members who had died in recent months, including Andy Dewar, Claire Ackroyd, Cecil Gray and Peter Baskett.

Martin Coates of Plymouth chaired the first session, entitled ‘Strategies to cope with....’ Three speakers with very different areas of expertise explained how they dealt with challenges with which many of us will be familiar. Simon Courtman of Plymouth described his management of the ‘pre-cooperative child’, calling on his experience of anaesthetising children for dental and other lists. Beautifully illustrated with both videos and anecdotes, his talk covered both psychological and pharmacological strategies for anaesthetising disturbed or distressed children with the minimum of fuss. Tony Davies, also of Plymouth, followed by describing his approach to the management of perioperative pain in opioid-dependent patients, giving some useful information about the cost and equivalent doses of street opioids and those used for medical purposes, and examples from his own practice of how attention to detail and close liaison with outside agencies can smooth hospital stays for this group of patients.

The session finished with Richard Telford of Exeter addressing the complex and topical issue of ‘the patient on clopidogrel’. The increased use of drug-eluting stents and the risks of stopping clopidogrel had to be balanced against the risk of bleeding: Richard concluded that (neuraxial blockade aside) it might be sometimes be safer to manage the increase in surgical bleeding than to stop clopidogrel, depending on the nature and site of the surgery. Much food for thought.

After much food at lunchtime delegates settled down for an entertaining afternoon session hosted by our colleagues in Guernsey and entitled ‘Clinical Practice in Guernsey – all a bit different’. For those of us with no experience of the Guernsey healthcare system three speakers gave a fascinating insight into the benefits and challenges of working for a system distinct from the NHS.

Gary Yarwood, a consultant anaesthetist on the island, took us through a potted history of both the States of Guernsey and its medical provision. He explained how the different medical specialties were formed into ‘groups’ who then sold their services to the health authorities. From 15 doctors on the island in 1947 there were now 38 consultants and a similar number of GPs, who between them delivered all of the health care on the island and arranged transfer of specialist cases to the mainland. This theme was expanded by Jim Chandler, the newest anaesthetist on the island, whose talk ‘Nice work if you can get it’ gave examples of a typical working day. The rather long working week, and the challenges of keeping up to date with CME, often taken away from Guernsey, was stressed but the overall impression was of a group of colleagues with a splendid quality of life and a very satisfying medical practice. Several enquiries about vacancies were apparently made by members later on that evening......
Another fascinating talk was given by John Beausire, the Chief Ambulance and Rescue Officer of Guernsey, who talked about Patient Transfer by Sea. He explained the need for a marine-based ambulance service in a group of islands where planes cannot always be landed and some areas have only basic roads and often no motorised transport. After whetting our appetite with photos of his crafts and the rather splendid access they gave to isolated parts of Guernsey and its surrounding islands, John invited members to join him for a trip on the sea ambulance the following day – an offer which was taken up enthusiastically by a dozen or more delegates.

The Society Dinner was held in the dining room of the Old Government House Hotel, with a splendid menu based on local ingredients, impressive service, and an inspiring view of the English Channel through a picture window. It was the English Channel which had been the setting for the Intersurgical Prize for the most elegant sail from the mainland to Guernsey, and Mark Ellis of Intersurgical was on hand to award a cheque for £100 to the successful crew of ‘Bertie’, which was collected by Colin Berry and Andy Burgess. Their immediate response was to ask that the prize be donated to a charity in memory of ex-president Peter Baskett: an offer which was warmly received by other diners.

Sir Peter Simpson spoke after dinner, again thanking the Guernsey and Plymouth departments for their role in the planning and organisation of the meeting, as well as entertaining us with several anecdotes gleaned from his journeys through the corridors of power. Martin Wolfe of Guernsey responded on behalf of the hosts with a toned-down version of the joke he had initially suggested telling – but wisely run past the Hon Sec first – I am sure he will be happy to relate the uncensored version to members if contacted directly.

Saturday morning saw a Tri-Service presentation in keeping with the military heritage and expertise of our co-hosts from Plymouth. All three talks were received by the non-military members present with respect and appreciation of what our colleagues are doing on our behalf overseas.

David Birt, RN, talked of competencies for the military anaesthetist and explained how training of such officers was changing to take into account the significant amount of time that military doctors currently spend away on active service. The understanding and support of civilian training schemes was important in this area. Robin Berry of the RAF spoke about the care and transfer of injured military personnel and gave moving examples of the challenges and success stories that he had encountered during his time in Afghanistan. Finally Major Paul Moor, an SpR in the South West School, spoke of the innovations in trauma management which were arising with experience of modern warfare, including the concept of ‘C-ABC’ – in
which arrest of major haemorrhage may initially take priority over airway management in the injured soldier - and novel methods of haemostasis. His talk was illustrated with a film of battlefield medicine in practice, and was well received.

After coffee many members were joined by their partners for the Guest Lecture, given this year by Mr Ben Remfrey, MBE, a former Royal Engineer who had founded the Mines Awareness Trust in 1999 in response to a massive need for mine clearing expertise and education in Kosovo. Based in Guernsey, the charity has now grown to be one of the largest in its field and has undertaken work in several other parts of the world, including Rwanda and Sudan. It was a fitting choice of guest lecture for a meeting with such a military theme.

The charity supports both training of mine clearing personnel, and the education of local people about the dangers of mines. Members were incredibly moved by the stories, photographs, and videos that Ben Remfrey told and showed: the success of his organisation in clearing enormous tracts of land and returning them to safe agricultural use was inspiring and much respected. It was no surprise that as well as a gift from the Society in thanks for his time, a retiring collection by members present amounted to several hundred pounds. Further details can be found at www.minesawareness.org

Another meeting over, the vast majority of delegates took the chance to extend their stay in Guernsey and explore more of the St Peter Port and the surrounding area. John Beausire’s ambulance craft was kept busy by members taking up his offer of a trip around the coast of Guernsey in it – Tricia McAteer is even rumoured to have taken the wheel at one stage – and the restaurants of the port did a roaring trade from members on the Saturday night. After the meeting in Bristol in November, the spring meeting will take place at the Cotswold Water Park 4 Pillars Hotel in Gloucestershire, under the auspices of the Cheltenham and Gloucester departments, on 21st and 22nd May 2009, and I do hope to see many of you there.
At the end of the fascinating talk at the Spring Meeting of the Society on the Guernsey Marine Ambulance by Mr Jon Beausire, the Chief Officer of the Guernsey Ambulance and Rescue Service, members of the Society were invited to visit the Flying Christine III at her berth in the harbour at St Peter Port on Saturday afternoon. So it was then, that after a relaxed lunch, a small, select group of us with interests in transporting critically ill patients, sailing or both, turned up at the harbour quay and were shown around the vessel by the paramedics and crew. We were also joined by two of the local Guernsey anaesthetists and their families. The Flying Christine III is a 45 foot ambulance and rescue launch, built in 1994, and is the only craft in the world designed specifically for high speed provision of medical and life saving aid at sea. She is available 24 hours a day, is supported entirely by donations and bequests, and equipped with full paramedic facilities including two stretchers which are interchangeable with those in the road ambulances of the St John’s Ambulance service. For those technically minded, she is driven by twin V8 turbo charged inboard engines, each of which can generate 435 horsepower to reach a top speed of 25 knots.

The Flying Christine III is used by the ambulance service to attend and transport the sick and injured from nearby islands, in particular Herm and Sark, and also from passing ships. To our delight, the crew offered to take us on a trip which we presumed would be around the harbour, or perhaps out to the cruise ships moored in the Little Russell channel between Guernsey and Herm. We soon left the cruise ships behind as we thundered towards Herm and then onto Sark at 25 knots, careering through rock-strewn channels between Herm and Jethou and then Sark and Brecqhou. Brecqhou is owned by the identical twin newspaper owners, the reclusive Barclay brothers, and we had a fine view of the fortress-like mansion they have constructed there. We then followed the route of powerboating events and a James Bond movie as we entered the very narrow sound between Brecqhou and Sark, expertly navigated by a heavily tanned helmsman who did not seemed at all fazed by the 9 metre tidal range around these islands. The paramedics on board told us of the sort of cases they have to deal with. The medical facilities on Herm and Sark are very limited, so most patients are transported to Guernsey. Patients requiring an even higher level of expertise, such as head injuries or those requiring cardiac stenting, may be flown onto London. There are quite a number of cliff-fall casualties - not surprising when one of the
neighbouring islands was referred to by one of the paramedics as “2000 alcoholics clinging to a rock!” Many of these casualties are easier to recover from the bottom of the cliff using a ‘rib’ to transport the patient to the marine ambulance, rather than taking them back up the cliff.

Approaching the harbour on Sark, the crew recounted times when they had collected casualties in gale force winds when helicopters could not have flown, and the seas threatened to dash them against the harbour wall. That apparently was the fate of the previous boat used for transfers, The Flying Christine II. (We never did hear what happened to number I). As we left Sark harbour, heading back towards St Peter Port, we passed some beautiful beaches and attractive inlets with yachts of all descriptions at anchor. Our helmsman then handed the wheel over to Tricia McAteer who had been longing to drive the boat as soon as we had embarked, and she whisked us back through rocky channels at top speed. As we approached the harbour with boats of all sizes entering and leaving, the helmsman commented on how confident Tricia seemed at helming, to which she replied “well that’s because you’re standing right beside me!”

Steady as she goes: The President takes the helm
Consent for General and Regional Anaesthesia in Adult Patients: A Survey of Consultant Anaesthetists in the South West of England

K O'Connor,1 PY Kuo2 and K Jenkins3

1 Specialist Registrar in Anaesthesia, Bristol Royal Infirmary
2 Specialist Registrar in Anaesthesia, Lister Hospital
3 Consultant Anaesthetist, Southmead Hospital,

* This paper has been presented in part at the combined meeting of the Society of Anaesthetists of the South West Region (SASWR) and the Central Hungarian Society of Anaesthetists, Budapest, May 2007.

Summary
The Association of Anaesthetists and the Royal College of Anaesthetists have published guidance for the provision of patient information and discussion of risks before anaesthesia [1 -3]. We undertook a postal survey of 402 consultant anaesthetists in the South West of England to determine current practice in obtaining consent for anaesthesia from adult patients, and compared this with published recommendations. The response rate was 67%. There was enormous variation in practice between anaesthetists. Our study has demonstrated that the process of consent by consultant anaesthetists in the South West does not always meet best practice standards. Consensus should be attained on what anaesthetic risk information is necessary, both to inform patients before general and regional anaesthesia and to satisfy legal requirements.

Introduction
The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Royal College of Anaesthetists (RCA) have published guidance to anaesthetists for the provision of patient information and discussion of risks associated with anaesthesia before surgery [1-3]. The Association’s 2006 revised edition of Consent for Anaesthesia recommends that all patients undergoing elective surgery should be provided with information leaflets about anaesthesia prior to meeting their anaesthetists [1]. The Association and the College have published patient-friendly information leaflets on different types of anaesthesia to ensure a national basic standard of information. This information should include disclosure of risks, ranging from common side effects to rare, yet serious, complications.

Preoperative visits by anaesthetists should include discussion of the proposed procedure. The amount of information disclosed should be determined on an individual basis, i.e. “what would this patient regard as relevant when coming to a decision about which of the available options to accept?” [1]. Patients should have the opportunity to ask questions having read the information leaflets. Details of the discussion, including explanations of risks, benefits and alternatives, should be recorded in the notes.

The objective of this survey was to compare the current practice of consultant anaesthetists in the South West of England regarding provision of information and disclosure of risks to adult patients before regional anaesthesia and general anaesthesia with these published recommendations.
Methods
With approval from the local research ethics committee, a survey on patient consent was sent to all consultant anaesthetists practising in the South West of England between September and November 2006. This region includes 15 anaesthetic departments. Confidentiality and anonymity of respondents were maintained, but each questionnaire was number coded to identify non-responders. Stamped addressed envelopes were included with each survey. The agreed cut-off point for re-mailing of the questionnaires was a response rate of less than 50%.

The survey consisted of two sections. In the first, data were collected on respondents’ gender and years of anaesthetic experience. We asked for details of each anaesthetist’s practice, including regional anaesthesia, and participation in obstetric anaesthesia and anaesthetic pre-assessment clinics. In addition, the survey asked about individual and hospital provision of information leaflets and the local policy on specific written consent for anaesthesia.

In the second section, potential complications and side effects of general anaesthesia, regional anaesthesia and central neuraxial blockade were listed. This list was derived from the AAGBI and RCA joint publication Anaesthesia Explained, which provides information for patients and their relatives [2]. Respondents were asked to indicate which of these issues they routinely discussed with their patients and, if applicable, what risk incidence they quoted. We examined the effects of gender, years of anaesthetic experience, and whether respondents regularly practise obstetric anaesthesia on respondents’ usual practice of consent. Data were entered and analysed using SurveyMonkey.com® (Portland, Oregon, USA), a web-based survey software application.

Results
Of 402 surveys sent, 270 (66% male; 34% female; n=16 not specified) were returned (67% response rate). Table 1 summarises the distribution of respondents’ experience in anaesthesia. Obstetric anaesthesia was part of the regular practice of 19.3% of respondents (n=52), and 70% (n=190) participated in pre-operative assessment clinics. The provision of written information by the hospital on risks associated with anaesthesia was routine practice for 47% (n=127) of respondents, but 13.4% (n=36) were not aware of their hospital’s policies. Nine percent (n=21) of respondents provided their own written information. Only 3% (n=9) of respondents said their hospitals required specific consent for anaesthesia.

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<td>&gt;20</td>
<td>35</td>
<td>13.3</td>
<td>3.4</td>
<td>96.6</td>
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<td>Total</td>
<td>263</td>
<td>100</td>
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Table 1.
Years of experience as a consultant anaesthetist. For n=7 respondents’ years of experience unknown.
Table 2 shows the specific risks discussed by anaesthetists grouped by gender, whether they practised obstetric anaesthesia, and years of experience. There was wide variability in practice. For general anaesthesia, postoperative pain (91%), postoperative nausea and vomiting (87%) and sore throat (60%) were most commonly discussed; for regional anaesthesia, including neuraxial blocks, the most commonly discussed risks were nerve damage (89%), post-dural puncture headache (89%) and hypotension (64%). Many respondents commented that rather than having a blanket policy on disclosure of risks to patients, the extent of their discussion depended on both the patient and the proposed procedure.

### Table 2: Disclosure of anaesthetic risks to patients

<table>
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<tr>
<th>Side effects / complications discussed</th>
<th>Percentage of group that answered 'yes' to specific risk discussed</th>
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**Key:**
- PONV: Postoperative nausea and vomiting
- PDPH: Post dural puncture headache
Although most respondents mentioned the possibility of complications associated with anaesthesia, fewer than 10% routinely quoted the incidence of specific risks. The quoted incidences of the more frequently discussed risks were largely consistent with established risk incidences, but quoted risk incidences of less frequently discussed risks tended to differ from accepted published incidences[4].

We did not make formal statistical comparisons between groups, but females were more likely to discuss specific risks than males: for 25 of the 33 side effects or complications in Table 2, the female percentage is higher. The percentages were markedly higher for paraplegia and nausea and vomiting after neuraxial block. Male anaesthetists were more likely than females not to discuss any regional anaesthesia risks with their patients (5% vs. 0%).

Analysis of practice by years of experience did not reveal clear trends. Anaesthetists with more than 15 years’ experience were more likely to discuss awareness and adverse drug reactions but were also more likely not to discuss any risks. Anaesthetists with more than 15 years’ experience were less likely to discuss the risks of neuraxial blockade than anaesthetists with 0 -15 years’ experience.

Obstetric anaesthetists were more likely to discuss risks of neuraxial blockade, especially hypotension and nausea and vomiting. They were also more likely to discuss headache and itching after general anaesthesia.

**Discussion**

There is large variation in what is discussed before anaesthesia. Current practice falls far short of recommended practice as expressed by the Association and the Royal College. We have examined some aspects of this issue to try to explain the disparity between recommended and actual practice, including differences between sub-groups of anaesthetists.

O’Neill [5] suggests that “Informed consent has become the ‘modern clinical ritual of trust’. As often with rituals, there is disagreement both about its real meaning and its proper performance.” The very essence of the traditional doctor-patient relationship involves trust and informed consent cannot replace this. However, the premise that our patients are neither deceived nor coerced in the decisions they make is integral to the code of beneficence to which we work. The idea of informed consent provides some reassurance that this is fulfilled. It has been established that the law requires us to disclose all material or significant risks to the patient and we should accept this responsibility. Material risk is defined as one that the patient would regard as significant to them, the inference being that this will vary between individuals. As for significant risk the courts have been “startling in their lack of clarity” [6] as this may be interpreted as “any risk of a serious consequence, a common occurrence of a serious consequence, or a common occurrence of any risk” [7].

The paternalistic times in which the courts based their decisions over claims of negligence on the Bolam principle, when a doctor was not found guilty of negligence if he had acted in accordance with a responsible body of medical opinion, may now be past [8]. Recently, the ‘prudent doctor’ approach to consent has been replaced by the ‘prudent patient’ [6]. The House of Lords’ judged, in the case of Chester vs. Afshar [9], that claimants are no longer required to demonstrate causation after poor outcome, only that their intrinsic right to all the relevant information in making their decision was not met. With little assistance from the courts on how to interpret or implement this position, our professional bodies have formally updated their recommendations to align themselves with the current legal standpoint on the issue of consent.

The Association has recommended that the process of consent should begin before the patient and the anaesthetist meet [1]. Aitkenhead emphasises that “it is neither desirable nor practical for all information to be presented to patients at the preoperative visit” [7]. Information leaflets, describing the proposed anaesthetic technique and its associated risks, should be provided for all patients at an appropriate time before elective
admission [1, 7]. This would place some onus on individual patients to satisfy their requirement for disclosure when undertaking treatment that could result in harm. Reading this literature would also make anaesthetists’ preoperative visits on the day of surgery more constructive by enabling patients to ask relevant questions, to which anaesthetists could give up to date, evidence-based information. Leaflets have been produced to facilitate this [2-3]. Our study shows that this is an under-used resource. Fewer than half the hospitals in the South West routinely provide this for patients awaiting surgery. At present the preoperative anaesthetic visit, often on the morning of surgery, may be the first time this information is presented to patients.

Preoperative evaluation clinics allow important pre-operative advice, discussions on anaesthetic and peri-operative management (including issues of consent) to be dealt with efficiently by anaesthetic specialists. These anaesthetic-led clinics decrease the number of referrals to other disciplines in the work up of patients for surgery [10]. Preoperative evaluation clinics reduce costs and improve outcome [11]. Our study showed that only 70% of hospitals in the South West provide this service.

Four percent of anaesthetists in the SW discuss no risks at all when obtaining consent for general anaesthesia, and 3% do not discuss any risks for regional anaesthesia. These anaesthetists might argue that the information we are required to present to our patients is not helpful because of the anxiety the process creates [12]. Klafta et al. [13] concluded that, in fact, preoperative instruction decreases anxiety, postoperative pain and length of stay in hospital. Lee & Gin [14] suggested that information requested by patients varies considerably before surgery and, rather than just providing what doctors think is appropriate, patients should be asked what information they want. Despite information provision and patient education on anaesthesia there is no demonstrable increase in satisfaction among patients, but patient satisfaction levels remain uniformly high. Thus, the argument that it is in the patients’ best interests to avoid providing detailed preoperative information is not supported by the literature. Our study showed that less experienced anaesthetists were more likely to discuss risks, which may be evolution away from a culture of medical paternalism. The practice of the more recently qualified may have been influenced by the changing legal standpoint in the last two decades.

Our obstetric anaesthetists were more likely to discuss most of the risks of neuraxial blockade than their non-obstetric colleagues. We suggest this is explained in part by the patient group involved. First, neuraxial anaesthesia and surgery in parturients are performed in conscious patients and may often be associated with symptomatic hypotension, largely due to the effects of aortocaval compression [15]. Nausea and vomiting associated with hypotension are less common in non-obstetric patients so may not be routinely discussed. Second, the women giving their consent are a motivated group with carer responsibilities so that complications of any procedure are potentially devastating. In addition, obstetrics and its related anaesthetic interventions have been the focus of highly publicised court cases, which has raised the public profile of consent issues in this field of medicine [16]. The idea that labouring women are less able to participate in informed consent than they would be before labour has been disregarded. Pattee et al. [17] showed that anxiety, pain and narcotic analgesics did not affect patient satisfaction with the consent process. Labouring women expected to be informed of all possible complications associated with epidural anaesthesia. Non-disclosure of serious risks was not considered to be acceptable by parturients. Recall of information about the risks associated with epidural analgesia was significantly better in patients who had attended antenatal education classes [18], which reinforces the idea that the process of informed consent should begin before the procedure is required. Most labouring women do not require the risk incidences to be quoted in the context of a consent discussion for epidural analgesia [19]. However, citing these statistics was unlikely to dissuade them from undertaking the procedure at the time.

This raises an important point. The appreciation of information containing statistical descriptors of risk
is variably understood and interpreted. There are many ways of presenting risk information, but the evidence is likely to be influenced by the individual’s perceptions and prejudices. The information is useless if it is meaningless but if it is misunderstood it could be either falsely reassuring or cause unnecessary anxiety. Adams and Smith [20] discuss presentation of risk information to patients and how we can avoid pitfalls in our discussions about risk.

In conclusion, our study showed that the process of consent by consultant anaesthetists in the South West of England does not always meet best practice standards. Consensus should be attained about exactly what anaesthetic risk information is needed to comply with the law. A national standard could then be established. The documented provision of information leaflets to each patient using anaesthetic services is achievable within the current framework of antenatal and surgical clinics. Anaesthetic pre-assessment clinics are one way of improving the consent process for anaesthesia.

The law has been vague on the intricacies of consent and our professional bodies have responded with inclusive recommendations that are hard to implement consistently and meaningfully [1,2,21]. At the moment, we are vulnerable as individuals and at risk of potential prosecution in the course of our working lives. Further action is required to ensure that the law protects both our patients and our profession.

Acknowledgements
We would like to thank Dr Neville Goodman for his advice on preparation of this manuscript.

References
7 Aitkenhead AR. Informing and consenting for anaesthesia. Best Practice and Research Clinical Anaesthesiology 2006; 20:507-524
8 Bolam vs. Friern Hospital Management Committee [1957] 1 WLR 583
9 Chester vs. Afshar [2004] UKFL 41
13 Klafta JM, Roizen MF. Current Understanding of Patients’ Attitudes Toward Preparation for Anaesthesia: A Review. Anesthesia Analgesia 1996; 83:1314-1321
16 Ferriman A. Disabled woman gets £414,000 damages. The Times (London). 1981; 61114(December 22): 1
A Pilot Audit of Epidural Associated Hypotension after Colo-rectal Resection

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Introduction

Epidurals are very commonly used for post-operative analgesia following major abdominal surgery with parenteral opioid therapy often used only as a second best alternative. This is despite the results of the MASTER randomized-controlled trial (a comparison between the use of epidural and standard parenteral opioid therapy) showing no difference in mortality although there was a reduction in respiratory complications\(^1\). However, the sympathetic blockade induced by epidurals results in vasodilatation and may cause a reduction in systemic arterial pressure. Gould et al showed that colonic blood flow in patients with a thoracic epidural was dependent on arterial pressure rather than intra-vascular volume status or cardiac output.\(^2\) They also found that arterial pressure in patients with thoracic epidurals only increased with vasopressor administration after fluid loading rather than fluid therapy alone. Whilst vasopressors are generally only administered in a high dependency setting, many patients are managed on a general ward following colo-rectal resection. We have no means of knowing which patients will tolerate hypotension and which may come to harm either from cardiovascular morbidity or due to splanchnic hypoperfusion and failure of anastomotic healing\(^3\).

The aim of this retrospective audit was to determine the incidence of hypotension after colonic resection comparing the occurrence of hypotension between a high dependency unit (HDU) setting and a general ward setting and between epidural and patient controlled analgesia (PCA) with intravenous morphine. Secondary objectives were to compare the pain scores in patients receiving either an epidural or PCA and to record the incidence of respiratory and anastomotic complications.

Methods

All patients having an open colo-rectal resection performed in the period of August-October 2007 who post-operatively had either an epidural or intravenous morphine PCA were included in this study. Data collected were patient demographics, incidence of systolic hypotension, pain scores, occurrence of complications and post-operative use of vasoconstrictors.

Data were collected by retrospective case note and observation chart review. Degrees of low systolic blood pressure (SBP) were recorded as mild (91 – 110 mmHg), moderate (70 – 90 mmHg) or severe (<70 mmHg). The duration of hypotension was taken as the time between the recording of a low blood pressure and the time of the next documented blood pressure in a different range. This was then expressed as a percentage of the number of hours in that day (in the case of day 1, from the arrival in recovery post-operatively until 0800 the next day when day 2 began). Pain scores were collected and grouped into the percentage of time per day with a score on movement of 0 - 1 (no pain to mild pain). The measurement of pain control was graded as good (pain score 0 - 1 for 75-100% of the day), intermediate (50-74% of the day), and poor (<49% of the day).
BP assessment

BP assessed from observation charts and analysed as a percentage of the time spent on HDU or ward in the arbitrarily chosen ranges:

**Systolic Hypotension**
- Mild: 91 – 110 mmHg
- Moderate: 70 – 90 mmHg
- Severe: <70 mmHg

Pain scores

Pain scores collected and grouped into the percentage of time per day with a score on movement of 0 -1 (no pain to mild pain)

**Analgesia**
- Good: 75 – 100% of the day
- Intermediate: 50 – 74% of the day
- Poor: <49% of the day

Results

29 patients were included in the audit. Five patients were excluded as we were unable to locate the case notes. 20 patients had an epidural, 4 had a PCA. After the operation 19 patients went to HDU and 5 patients were sent to the general ward.

Patient Demographics

- Average age of the study population 69 years
- 12 males & 12 females

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Mild hypotension was recorded for 36%, 48% and 19.6% of each day, on days 1, 2 & 3 respectively with an epidural. This compared to only 5%, 17% & 2% respectively with a PCA (figure 1).

![Figure 1. Incidence of mild systolic hypotension (systolic BP 91-110 mmHg) on Day 1 to Day 3 in patients receiving epidurals compared to patients receiving a PCA.](image)

Moderate hypotension was observed for 6% of the time on day 1, 5% on day 2 and 2% on day 3 with an epidural (Figure 2). No patient with a PCA developed moderate hypotension.

![Figure 2. Incidence of moderate systolic hypotension (systolic BP 70 - 90 mmHg) on Day 1 to Day 3 in patients receiving epidurals compared to patients receiving a PCA.](image)

There were no instances of severe hypotension in either group.
Comparing the HDU & ward settings, the percentage of time with mild hypotension was 28.5%, 45.4% and 0% on days 1, 2 & 3 respectively in HDU whilst on the general ward it was 6%, 15% & 20% (Figure 3).

There were no recorded occurrences of moderate hypotension in the HDU compared to 5.5% of the day on day 1, 5% (day 2) and 2% (day 3) on the ward (Figure 4).

Pain scores showed good analgesia in the epidural group in 78%, 60% & 40% of patients on days 1, 2 & 3 respectively. In the PCA group, good analgesia occurred in 100%, 80% & 50%. This is illustrated in Figure 5, Figure 6, and Figure 7.
Four patients received vasopressor support in the HDU setting compared to none of the patients in the wards. One patient died. The mode of death and type of post-op analgesia is unknown (as the notes could not be traced). One patient in the epidural group developed a significant post-operative complication (pneumonia). There were no anastomotic complications.

Discussion
Clearly our audit suffers from the limitations of retrospective studies involving small numbers of patients. It does however allow some interesting observations to be made and is certainly hypothesis generating in a number of areas. Hypotension was more common with an epidural than a PCA and often persisted until at least day 3. Mild hypotension was seen more commonly in HDU on days 1 & 2 than on the ward. This may reflect the fact that hypotensive patients would be unlikely to be discharged to the ward from recovery or the HDU. Even in HDU, vasopressors were used infrequently in the management of this mild hypotension. This may reflect a view that this degree of hypotension may be clinically irrelevant as the arbitrarily chosen range was a systolic pressure of 91 – 110 mmHg. It is possible that some of the patients’ normal blood pressures would have fallen in this range. We did not compare pre-operative BP with the post-operative values as we felt that in a retrospective study it would be difficult to reliably determine from the notes an accurate resting, unstressed BP in many of these patients. If a future prospective study is carried out, it would be advisable to reference hypotension to the individual’s normal BP.

Moderate hypotension was only seen in ward patients. Vasopressors were not given in these cases. This degree of hypotension (SBP 70 – 90 mmHg) is highly unlikely to be “normal” for any of the patients in our audit and could quite conceivably result in colonic hypoperfusion or cardiovascular complications. Due to the retrospective nature of our audit, we assumed that the degree of hypotension persisted from one documented blood pressure to the next. The blood pressure in ward patients during the interval between recordings may have been higher or indeed lower than that recorded. This would have impacted less on HDU patients as the observations were recorded much more frequently. Pain control was good on days 1 & 2 but poor on day 3 with both epidural analgesia and PCA. We did not find improved analgesia with an epidural compared to a PCA in this audit however the numbers of Patients using a PCA were very small. When considering the serious risks associated with epidural analgesia, those frequently highlighted are those most easy to measure ie epidural space abscess or haematoma, permanent neurological injury etc. The aetiology of peri-operative cardiovascular morbidity or colonic anastomotic breakdown is multifactorial, involving patient, surgical and anaesthetic factors, consequently it is difficult to determine. It is conceivable that a period of relative hypotension due to epidural analgesia is potentially harmful to our patients. As the evidence for a clinically meaningful outcome benefit of epidural analgesia is weak at best, we would argue that we have a duty to manage these patients in an environment where their blood pressure can be frequently measured and hypotension promptly corrected. As always, the choice of mode of analgesia should be made on an individual patient basis, balancing risks and benefits. Future developments may involve other forms of regional analgesia that do not cause sympathetic blockade such as the Transversus Abdominis Plane (TAP) block which may have a role to play as part of a multi-modal analgesia strategy.

Conclusions
We found that a degree of hypotension occurs frequently in our patients following elective open colo-rectal resection which may be attributable in part to the use of epidural analgesia. This may result in harm to our patients who should be managed in an environment with appropriate staffing to detect and treat hypotension.
References


A number of patients suffering from eating disorders will present with the consequences of life threatening malnutrition. We briefly describe the case of a patient admitted to our hospital with very severe anorexia nervosa (AN) and describe her challenging treatment and management on the Intensive Care Unit. This article reviews the recent literature regarding the management of patients with AN in the intensive care setting. Bulimia nervosa (BN) will be included as it leads to similar and additional patho-physiological problems.

Case:
A 23 year-old lady, with a 12-year history of AN was admitted to our Intensive Care Unit. She was severely malnourished with a BMI of 9 and had become acutely ill with respiratory failure. A CXR confirmed she had pneumonia. She responded poorly to antibiotics and non-invasive ventilation. A CT scan of her lungs confirmed the pneumonia and also showed early emphysematous changes that have been previously described in severely malnourished patients. The patient developed sepsis and multi-organ failure. The management of this was complicated by her pre-existing hypoalbuminaemia, poor myocardial function due to myocardial hypertrophy caused by her malnutrition and her presumed immunodeficiency. She had a limited response to intravenous fluid resuscitation and inotropic therapy. Fluid administration resulted in her becoming very oedematous and her skin broke down over her pressure areas. Enteral nutritional support caused diarrhoea and aspects of a Refeeding Syndrome: parenteral nutrition was commenced. Endocrinologists suggested starting an insulin/glucose infusion to encourage cellular uptake of nutrients and a possible conversion from a catabolic to anabolic cellular metabolism. Despite supportive therapy she died on the Intensive Care Unit of multiple organ failure.

What is Anorexia Nervosa?
Anorexia nervosa is a chronic illness characterised by severe weight loss due to an extreme aversion to food. Patients with BN combine binge eating with post-prandial purging, often using diuretics or laxatives. The bulimic form can often be more damaging to the body as it puts additional stress on an undernourished system.

Eighty to ninety percent of patients with AN are female, commonly seen between 12 and 21 years old, but it can start or carry on into adulthood. The prevalence is 0.3% in young women. Eating disorders can often be accompanied by other psychiatric illnesses including major depression, suicidal ideation and substance misuse. Studies have shown that patients with AN have up to a 20% higher risk of premature death compared to the normal population. The complications of AN relate to malnutrition, fluid and electrolyte abnormalities.

We will discuss the complications of this disease by dividing the body into physiological systems. Medical staff should be aware of the psychological aspects of the illness but this review will not cover these areas.

Gastrointestinal complications
Salivary and parotid gland enlargement is a common finding, partly due to lack of protein, and seen more markedly in patients who vomit. Resolution of gland hypertrophy is usual following refeeding and weight gain, but this can take months. Irrigation of the mouth with saline or lemon can help the parotid gland to normalise. Dental problems are also common with long-term vomiting and malnutrition. Good mouth care is important in these patients. Repeated vomiting can lead to the development of oesophageal strictures or Barrett’s oesophagus due
to acid reflux. Mallory-Weiss tears and oesophageal rupture (Boerhave’s syndrome) can occur with vomiting. Any patient with an eating disorder should be presumed to have a full stomach at induction of anaesthesia as delayed gastric emptying is frequently seen. This is often a manifestation of autonomic dysfunction. Acute gastric dilatation and gastric rupture have been reported with repeated vomiting or in cases of refeeding. This is managed conservatively by the early passage of a nasogastric tube to deflate the stomach.

Slow or abnormal peristalsis can occur in the bowel, particularly if stimulant laxatives have been abused. Patients can suffer from constipation, diarrhoea and gastrointestinal bleeds from chronic laxative use. The abdominal bloating and excessive fullness felt after eating improves with regular eating and possibly the use of prokinetics. Hepatic steatosis or fatty infiltration of the liver is seen with severe malnutrition. The ability of the liver to function is not affected.

Cardiovascular complications
Eighty-seven percent of patients with AN have cardiac problems and a third of adult deaths in patients with AN are cardiac related. All cardiac complications seem to resolve as weight is gained. Malnutrition causes a reduction in cardiac muscle mass with decreased chamber size and impaired contractility. This leads to a reduction in cardiac output and a low blood pressure, with systolic pressures often less than 100mmHg. There is usually an associated bradycardia that is thought to be due to an increase in vagal tone and a reduction in metabolic rate. The loss of left ventricular mass eventually causes mitral valve prolapse due to the proportionally larger and redundant valve.

Wandering atrial pacemakers, supraventricular and ventricular tachycardias have all been described in patients with eating disorders, as well as T wave flattening or inversion and ST depression. Many of these abnormalities are due to electrolyte deficiencies. Prolongation of the QT interval is often seen as a marker of severity of the eating disorder.

Other cardiac complications include orthostatic hypotension due to a loss of peripheral muscle mass causing a reduction in venous return. Silent pericardial effusions have been reported on echocardiogram, which resolve as albumin levels normalise. Emetine, the active ingredient of some stimulant laxatives can have direct cardiomyotoxic effects and cause cardiomyopathy. Hypoalbuminaemia results in peripheral oedema and difficulties with fluid resuscitation.

Continuous cardiac monitoring during the initial phases of refeeding is recommended to detect arrhythmias that may arise.

Respiratory Complications
Controversy exists over whether the lungs are affected by malnutrition. There is loss of elasticity leading to a lower lung compliance and respiratory muscle weakness. Several papers report emphysematous changes in AN and with other causes of malnutrition. Others claim that no adverse effects to lung function occur. Repeated vomiting can cause aspiration pneumonia and spontaneous pneumomediastinum. Respiratory compensation for a metabolic alkalosis due to vomiting can cause bradypnoea. Vasoconstriction in response to hypovolaemia and heat conservation leads to peripheral cyanosis.

Endocrine Complications
Interruption of hypothalamic control of the anterior pituitary secondary to malnutrition can in the extreme, produce a picture of panhypopituitarism. Plasma levels of the stress hormones cortisol and growth hormone can be raised and the dexamethasone suppression test is often abnormal. Diurnal variation in cortisol release is often not seen. There may be some reduction in the production of antidiuretic hormone resulting in partial diabetes insipidus. The thyroid hormones adapt to malnutrition with normal levels of thyroid stimulating hormone, reduced levels of the active hormones T3 and T4, and an increase in reverse T3, the inactive hormone. This is not true hypothyroidism and so should not be treated as such. Hypothermia is common, with central temperatures less than 36.3°C seen, there is a lack of
shivering response. Insulin therapy has been tried to change the patients from a catabolic to an anabolic state but needs very careful glucose monitoring.

**Electrolyte abnormalities**
Electrolyte abnormalities are often caused by vomiting and purging rather than malnutrition alone. Persistent vomiting leads to hypokalaemia and metabolic alkalosis. Hypovolaemia secondary to dehydration causes activation of the renin-angiotensin-aldosterone system with further loss of potassium due to the action of aldosterone in the kidneys. The metabolic alkalosis can result in bicarbonate levels rising up to 44mmol/L. Hypocalcaemia is often asymptomatic due to hypokalaemia, until potassium levels are restored. Total body phosphate is low which has consequences during refeeding.

Electrolyte deficiencies can affect the action of some drugs, in particular neuromuscular blockers, their action is prolonged. Hypoalbuminaemia can lead to a higher percentage of a drug being in the unbound active state, requiring dose reduction.

**Renal complications**
Glomerular filtration rate is reduced secondary to dehydration. 70% of patients with AN have renal complications, including proteinuria in up to 64%. Chronic ingestion of magnesium hydroxide laxatives causes renal calculi.

**Haematological Complications**
Anaemia can be secondary to deficiencies in the diet of iron and vitamin B12 or due to the anaemia of chronic disease. A reduction in white blood cell count and function is seen when weight loss reaches 50% of expected body weight. Platelets are also reduced. The bone marrow is often hypocellular with a reduced fat content, not often correlating with the amount of weight loss.

**Musculoskeletal Complications**
Changes in bone density occur very early in AN, with osteoporosis secondary to low calcium intake and low oestrogen production. The changes are not reversed by increasing weight, but bisphosphonates have been shown to help. Generalised myalgia occurs due to electrolyte abnormalities. It is also seen with the use of Ipecac, a laxative.

**Neurological Complications**
Peripheral nerve palsies are seen secondary to nerve compression due to lack of cushioning. Non-specific EEG changes and global cortical atrophy are associated with long term malnutrition. Seizures could be seen secondary to electrolyte abnormalities.

**Eye and skin manifestations**
Skin manifestations of anorexia nervosa are extensive: they include Xerosis (dry scaly skin), Lanugo-like body hair, Telogen Effuvium, Acne, Carotenoderma (yellowing from carotenoid-rich fruit), Acrocyanosis, Pruritis, Thrombocytopaenic Purpura, Stomatitis, Nail Dystrophy, Russell’s Sign (scar over dorsum of hand from stimulating gag reflex) and poor wound healing. Subconjunctival haemorrhages can be seen secondary to vomiting. Vitamin A deficiency can lead to corneal disease and blindness.

**Refeeding Syndrome**
Increasing nutrition in anyone who has previously had a low enteral intake needs careful monitoring. Refeeding Syndrome is the consequence of the insulin released following initiation of feeding in a starved state, and manifests as various metabolic abnormalities.

During starvation, glucagon is secreted from the pancreas which stimulates the liver to release glucose from its stores of glycogen. Depletion of glycogen will occur with long-term starvation and so when insulin is produced during refeeding, hypoglycaemia results. Insulin also acts on the Na+/K+/ATPase cellular pump which moves K⁺ into the cells and Na⁺ out. Insulin also stimulates phosphate uptake into cells and increased urinary magnesium excretion. Consequently, patients become hypophosphataemic, hypokalaemic and hypomagnesaemic. Low phosphate in particular can cause heart failure, arrhythmias, muscle weakness, immune dysfunction and death.
Conclusions
Eating disorders affect all organs of the body. When a patient is admitted to the intensive care unit, these complex changes need to be recognised as they generate novel challenges to the usual supportive management of patients.

Case Report
Is Remifentanil safe in Porphyria?

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Summary
A case is presented of the use of a remifentanil infusion for intra-operative analgesia in a patient with known variegate porphyria. Pre-operative and post-operative screening for urinary porphobilinogen and red blood cell porphyrin excluded an acute exacerbation of porphyria. A marginal increase of urinary porphyrin (mainly coproporphyrins) was noticed post-operatively with no clinical symptoms.

Key words
Analgesics, Remifentanil, Complications, Porphyria

The Porphyrias are a group of diseases in which there is an enzyme defect in the synthesis of the haem moiety leading to accumulation of precursors that are oxidised into porphyrins¹. Acute hepatic porphyrias included acute intermittent porphyria (AIP), variegate porphyria (VP), hereditary coproporphyria (HCP) and plumbo-porphyria (PP). With the exception of PP, which has a recessive inheritance, all the others are inherited in a non-sex linked autosomal dominant form with variable expression.

An attack of acute porphyria is characterised by severe abdominal pain, autonomic instability, neuropsychiatric manifestations and electrolyte disturbance. A markedly increased concentration of δ-aminolaevulinic acid (ALA) and porphobilinogen (PBG) is usually present in the urine. Acute exacerbation of the condition can be precipitated by various anaesthetic drugs as well as fasting, menstruation, stress and infections. Most of the opioid analgesics are considered to be safe with the exception of pentazocine and tilidine ². There is limited experience with the use of remifentanil in porphyric patients. It has been used safely in a case of AIP³. This correspondence is the first in which remifentanil has been used safely in a patient with variegate porphyria.

Case history
A 72 year-old, caucasian female was admitted to our hospital for bi – frontal craniotomy and excision of a frontal meningioma. She had a history of several weeks of increasing tiredness, confusion and disorientation. A CT scan confirmed a 5-cm frontal lobe mass, reported as possibly a glioblastoma. Her previous medical history included well-controlled hypertension. She was otherwise reasonably fit for her age. She had been diagnosed with variegate porphyria 30 years previously when she had a near fatal reaction to barbiturates given during an anaesthetic. She had also suffered from skin fragility, blistering and photo-sensitivity for years. Her acute attacks were precipitated by menstruation or alcohol. She had had no attacks for years despite having had an anaesthetic whilst abroad. No records of these anaesthetics were available. Full clinical examination of the patient did not show any signs of an acute attack. Her Glasgow coma score was 15/15. Her blood results for haematology and biochemistry were within normal limits apart from raised liver enzymes (ALP, ALT). She had a normal plasma bilirubin.
Anaesthesia for her procedure was induced and maintained with a propofol infusion (TCI) with the maintenance plasma level kept at 3-4 mcg/ml. A remifentanil infusion (0.2-0.5 mcg/kg/min) was used for analgesia and the patient was ventilated with an air/oxygen mix (FiO₂ 0.5), using vecuronium for paralysis. The patient was cardiovascularly stable and there was minimal blood loss. The patient was ventilated and sedated for a few hours postoperatively before being extubated uneventfully with a Glasgow Coma Score of 15/15. She did not show any signs or symptoms of porphyria in the weeks following the operation.

Table 1 shows the results of screening for porphyrins in our patient. The normal levels of red blood cell porphyrins and no porphobilinogen in the urine, both pre- and post-operatively, excluded an acute attack of porphyria. This was supported by the absence of clinical signs and symptoms of porphyria. The marginal increase in urinary porphyrin/creatinine level postoperatively was mainly due to coproporphyrins of non-specific cause.

<table>
<thead>
<tr>
<th>Screening</th>
<th>Preoperative</th>
<th>Postoperative</th>
<th>Reference</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine porphobilinogen</td>
<td>Negative</td>
<td>Negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porphyrin/creatinine</td>
<td>32</td>
<td>57</td>
<td>&lt; 35</td>
<td>nmol/nmol</td>
</tr>
<tr>
<td>Red blood cell porphyrins</td>
<td>1.2</td>
<td>1.2</td>
<td>&lt; 1.5</td>
<td>Umol/l</td>
</tr>
</tbody>
</table>

Discussion

The key factor in the anaesthetic management of a porphyric patient is to prevent an acute porphric attack by avoiding precipitating agents. It is essential to take a good history, particularly identifying potential previous exposure to porphyrinogenic drugs. In this case we used anaesthetic drugs with known safety profiles, such as propofol as an induction agent. Although propofol infusions have been considered porphyrinogenic by some authors, we felt that the benefits of using it in neurosurgical anaesthesia, outweighed the risk of precipitating an acute attack of porphyria in this case.

Remifentanil is a synthetic Mu agonist opioid with unique pharmacokinetic characteristics related to its metabolism to an inactive metabolite by non-specific tissue and plasma esterases. Its context sensitive half time is independent of the duration of the infusion and unchanged by renal and hepatic failure. The low potential for enzyme induction and a very rapid clearance makes remifentanil an ideal analgesic agent for use in patients with porphyria. Remifentanil has been used safely in a case of AIP and we felt it would be suitable and beneficial in this case of variegate porphyria.

After discussion with the neurosurgeons we decided to electively sedate and ventilate the patient for a few hours postoperatively in case she developed signs of an acute porphric attack. We tested the plasma and urine for porphyrins postoperatively and watched for clinical signs of porphyria. Results of urinary porphobilinogen and plasma porphyrins pre and postoperatively excluded any exacerbation of porphyria. The marginal postoperative increase in urinary porphyrins (mainly coproporphyrins) was most probably related to non-specific causes.
such as stress, infection or liver disease. This patient had elevated liver enzymes pre-and post-operatively (ALP, ALT), which could have been due to infection or chronic alcoholic intake. It is possible that the enzyme induction was caused by the loading and maintenance dose of phenytoin and /or propofol 6.

In conclusion we have shown that remifentanil did not cause an acute exacerbation in a patient with variegate porphyria. Whilst this is not proof of its absolute safety in the condition we hope it will support further research in this area.

Acknowledgments

We thank the department of biochemistry of the Royal Perth Hospital for their help and advice.

References


7) Stoelting R Pharmacology and Physiology in Anaesthetic Practice Third Edition Lippincott Williams & Wilkins 2000; 100 - 2
Christmas Day 2007 will remain fixed in my memory, as a result of two very distinct events. First, my wife and 2 young children singing ‘Merry Christmas’ down the telephone and secondly because of a critically ill young soldier who had just lost multiple limbs in a mine blast. The contrasting emotions that accompanied these memories were just one part of an incredible ten week deployment to Afghanistan. During the first 10 days alone I had witnessed a range of traumatic, blast and gun shot wounds unlike anything I had seen within the NHS. It soon became apparent that these injuries were not uncommon, and that they brought with them a wealth of clinical and management experience.

Pre-deployment

As a trainee anaesthetist in the military with my hard earned FRCA behind me, I had finally become a deployable anaesthetic asset. Deployment had always been likely within the final three years of my anaesthetic training, as a result of the current operational commitments of HM forces. Having always enjoyed the challenges that come with military operations, I elected to volunteer for operations in Afghanistan over the Christmas and New Year period. In this way I achieved my aim of completing a module of military anaesthesia whilst also ensuring that I returned home in time for the birth of our third child!

Freshly armed with information from the Ministry of Defence and Foreign and Commonwealth Office websites, I set about developing my knowledge base of south central Asia and the ISAF (International Security Assistance Force) mission in Afghanistan. Pre-deployment training involved a number of weeks away fulfilling basic military combat, fitness tests, weapons training, the law of armed conflict and other basic competencies. Such skills and competencies are necessary for all service personnel irrelevant of one’s unit or rank. A further week was spent learning the specifics of the Afghanistan theatre of operations, cultural training, ordnance awareness and further familiarisation exercises. This provided helpful and specific knowledge of Afghanistan, enabling specific technical roles to be deployed swiftly on arrival.

My job in Afghanistan was to provide anaesthesia, peri-operative medicine and critical care under the supervision of a team of consultants. In addition to these familiar skillsets, I was also the first anaesthetic trainee to become part of the Medical Emergency Response Team (MERT), which had the role of retrieval and Prehospital Critical Care. This involved mobilising with a paramedic, flight nurse and combat medic, to retrieve casualties from the point of wounding. This occurs in the arduous and challenging environment of the rear of a Chinook Helicopter. In preparation for this role I visited the Helicopter Emergency Services (HEMS) in London and RAF Odiham to familiarise myself with HEMS work and Chinook air frames respectively.

The journey

The journey from the UK was long and on landing the true nature of the Afghan theatre of operations hit home when we descend into our final airfield. Everyone on the aircraft had to don helmets and body armour as Standard Procedure because of the potential threat of surface to air missiles. My journey’s end was my arrival at the tented field hospital within the arid surroundings of the Helmand Desert. The field hospital had 25 beds with an
ability to surge to higher numbers if required. The staff included Orthopaedic and General Surgeons, 5 Anaesthetists, a Physician, ED Consultant and all of the required nursing and paramedical staff. We were billeted (housed in tents) close by. Clinical personnel were joined by the essential management staff who had the immense task of orchestrating the running of the hospital and patient flux with the precision a finite number of beds demands.

The job

Work was varied and unpredictable and one day would involve dealing with a grade IV hypovolaemic shock casualty pre-hospital, in the back of a fast moving helicopter, and the next, a child with airway burns with limited paediatric Intensive Care capability. Experiences like these allowed a beautiful ‘dove tailing’ and developments of the Anaesthesia and Military Skill sets.

Whilst in Helmand, I spent two days out of four with the MERT, one on call for anaesthesia and one for ICU, involving lots of ‘front of house’ critical care and anaesthesia. The job could often be unrelenting but it was made easier working with like minded people who were equally committed to care for the wounded service personnel. Working and living with medical colleagues 24 hours a day, seven days a week, in such close proximity forges strong bonds and excellent working relationships. This was never more apparent than when the MERT team would be in the ED handing over a trauma patient to the amassed trauma team prior to the all-too-often move to theatre. At all times the members of staff provided slick, well drilled trauma care. In my opinion this facility surpassed the recommendations published in the recent CEPOD trauma review. Not bad for a field hospital in a war zone! It was a true pleasure to be part of such an establishment and to provide and learn in such a unique environment, as an anaesthetic trainee.

Work with the MERT entailed the provision of managerial input into the critical decision making process around the deployment of a ‘high value’ asset, to retrieve the sick and injured front line troops from the four corners of Helmand. As such, this involved a quick refinement of one’s Anaesthetic and non technical skills in the back of a Chinook helicopter, whilst travelling at over a hundred knots. The environmental and tactical challenges that this work involved provided an extraordinary experience.

The bulk of our work was dealing with blast and ballistic trauma. We attempted to mitigate the effects of coagulopathy of trauma right from the point of wounding, via theatre and the subsequent transfer to Selly Oak, the Royal Centre of Defence Medicine in the UK. Damage Control Resuscitation (DCS), Haemostatic Resuscitation with ‘reconstituted blood’ as part of our Massive Transfusion protocol and the Anticipatory Treatment of Trauma Coagulopathy (ATTaC), provided a great learning experience unavailable within the UK. This coupled with the use of novel haemostatic agents, intra osseous (IO) devices and activated factor seven allowed acquisition of skills with potential application back in NHS Practice.

Happy new year

The New Year came and went with predictable humour, goodwill and spirit despite the lack of the liquid latter! The British public were phenomenal with their gratitude and kindness, providing an abundance of what were termed ‘Welfare Parcels’. These were full of treats, bathroom smellies and best wishes for the troops on the front line. Morale was raised by small gestures such as pepper sauce – something which added a bit of difference to the unchanging evening meal. Seeing this sort of support together with drawings and ‘get well’ cards from children in the UK was incredibly humbling.

During my time in Helmand, we moved from the hot and dusty tented hospital to a purpose built, air conditioned facility. This improved the level of care that we, as anaesthetists, could provide. Catheter techniques could now be utilized without fear of contamination from desert dust, which had been fairly ubiquitous. We were now metres away from
our CT scanner instead of having to wheel and transfer patients the short but significant distance, for what was often a total body CT. Whilst functionally things were much the same, the level of hygiene and comfort for the patients was vastly improved with this new facility.

Training

Educationally, I learnt a great deal both medically and militarily. I had an Educational Supervisor who mentored me. They oversaw my completion of many generic and Trauma and Accidents competencies, in addition to the equally important Non Technical Skills involved in our work over there. The managerial and high risk asset management skills involved within the mobilisation of the MERT in a hostile environment and advising military commanders on the appropriateness of MERT team composition was excellent. The ANTS (Anaesthetics Non Technical Skills) and CRM (Crisis Resource Management) within the field hospital and on board a fast moving, noisy, cold, dark helicopter in hostile conditions were legion.

Spare time, when available, was spent on numerous appraisal and Curriculum Vitae ‘buffing’ projects. Audit, medical publishing, presentations and team appraisal have provided ongoing challenges since returning home. Hopefully projects like these will come in useful when applying for the ever closer consultant job!

I’m sure it will come as no surprise that I found this deployment an incredibly beneficial experience. It provided a hugely rewarding opportunity to utilise, refine and extend the competencies I had treating fellow service personnel, under the guidance of senior colleagues. This may sound a bit dramatic and emotive, but there is nothing more humbling than seeing British Service personnel who have been exposed to horrific injuries, who just want to get back to their team and continue operations. Or traumatic amputees nervously jesting about where they may have misplaced their legs. Such professionalism and cheerfulness in such adversity, is typical of military personnel and it made me immensely proud to contribute as a team member in a small, but hopefully significant way.

REFERENCES

1 www.fco.gov.uk

2 www.mod.uk/DefenceInternet/DefenceNews/InDepth/OperationsInAfghanistan.htm


4 NCEPOD. Trauma- Who Cares? 2007

The Wine Column
Viognier: A Grape for Lovers!

Dr. Tom Perris

My heart aches, and a drowsy numbness pains
My sense, as though of hemlock I had drunk,
Or emptied some dull opiate to the drains
One minute past, and Lethe-wards had sunk:

Ode to a Nightingale. John Keats 1819

Actually, it was my head doing the aching and it
was cider that I had drunk to the drains but the
drowsy numbness is spot on. You see, the Editor,
in his wisdom, suggested that since it has been a
bumper year for the apple crop and that if I was
short of inspiration, I might try writing about
Cider. Well, always up for a challenge, I did a little
field research and my findings are;

1. I don’t like it, and
2. It gives you a hangover.

Please feel free to disagree etc….but there’s a
reason why tramps drink it!

Frankly, I was hoping for something special
that night but the French can be annoyingly
inconsistent in many aspects of their affairs, and
Viognier is no exception. At its spiritual homeland
on the Granite Slopes of the Northern Rhone
lies the appellation of Condrieu. A tiny, 200 acre
plot of low yielding vines, the majority owned
by Chateau Grillet. It’s rare and expensive, but
so what on a romantic occasion? She’s worth it!
Sadly St Paul’s Café didn’t run to Condrieu so I
improvised.

Tasting Ch. Grillet as a younger man was an
almost transcendental event. Describing wine is
a tricky business and always prone to pretension
but here goes. It was like listening to the song of
a nightingale whilst smelling spring flowers. Like
being dunked in a bath a crushed apricots and
peaches. Like being dropped into the Garden of
Eden at blossom time or transported to the tropical
house at Kew. Like stepping into a painting by
Gauguin; a vivid and mind distorting experience. I
liked it a lot.

Like all wonderful things in life, if it was easy,
we’d all be doing it and it wouldn’t seem quite
so special. Viognier cultivation has grown
exponentially in recent years but I haven’t yet had
one to match that first taste of Condrieu. I’m still
looking though.

Viognier, Viognier, Viognier; the name itself rolls
off the tongue in a pleasing and sinuous fashion
rather in the manner of Dennis Potter’s famous Singing Detective who eulogised over the joys of saying “Elbow”. Elongated and sensuous, like the wine itself, you’ll know if it’s a good one. So, next time you’re with your special friend, remember the name and slowly raise your glass.

Recommended Suppliers.

Majestic do a variety of Old and New World Viogniers ranging from £5 to £50. Anything by Guigal is good but I particularly liked Viognier Collection 2007 Gérard Bertrand, Vin de Pays d’Oc which is on special now at £4.99. Drink young and cool but not cold.

Waitrose do several good ones too but Majestic is cheaper!
Situational awareness is a very important non-clinical skill in anaesthesia.

Conference of Regional Anaesthesia

I'm really worried that one day one of my patients will be unaware during an operation.

Yeah, there's a new Hollywood blockbuster out - it's called "Asleep!"

Kelly Jeaner, Exeter
Champs Geroux

I remember this place from another life, grass, lush as a fulfilled longing, cows up to their knees; lying down they all but disappear. An old barn, two goats, ancient wisdom in their eyes yet unsure of their fate as we are.

A cockrell crows, proclaiming his wire netted kingdom. He drops to a hen’s back; a brief flurry of feathers with no grand passion, then back to pecking, pecking....... A solitary goose honks like a Paris taxi.

And trees, trees everywhere, a backdrop edging in amongst us, giving us breath, the softness of women. And I remember that boarding school a sea away, us like orphans; the morning run, cold bath.....Sundays we built camps in the woods And I dreamed of escaping for ever.

But even the trees like mothers couldn’t spare us the beatings, nor death in those other fields where our fathers had gone- those bright your men in their uniforms now so still in the mud of the Somme.

Robin Forward
Crossword
Brian Perriss

CLUES ACROSS

1. Bloke, cold, needs garment often ripped. (6)
4. Soften worker with laxative. (8)
10. Fire up a right issue. (5)
11. Swimming pool that is Michael’s local. (9)
12. Frame current gramophone record. (7)
13. Caught nasty disease on the coast. (7)
14. Music for the bedroom? (7,7)
17. Vice-Presidents no good at prognostications. (14)
21. Yell for Indian in school. (7)
23. Refrain from awarding returning graduate a bad mark. (6)
24. Transitory fungus. (9)
25. Hesitate after finding 51st bone. (5)
26. Dread not to bat badly whilst tuniced. (9)
27. A leaving issue. (6)

CLUES DOWN

1. One accountant after money gives it to the Greens (8)
2. Daughter on the mend then goes into rack and ruin (9)
3. A discussion against fighting the fat (7)
5. One way of looking up a friend? (14)
6. Medieval old hat. (7)
7. Story of book in first class condition. (5)
8. Some of these students produce papers. (6)
9. Get a shock receiving utility bill. (8,6)
15. Shape ceramic tile into a mirror image. (7)
16. Noted for making waves. (8)
18. Be romantic about German drill. (7)
19. Proceeding in French, and indicting we hear. (7)
20. A fragrance that is on the up? (6)
22. Shortened form of convalescence. (5)

Solution to Crossword in
Spring 2008 Anaesthesia Points West
Prizes and Bursaries

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

The SASWR Intersurgical Trainee Prize

This prize of £1000 is awarded annually at the November Scientific Meeting of the society. Entries / abstracts of up to 2000 words maximum in the form of an essay or short paper on any topic related to anaesthesia and intensive care should be submitted electronically to the Honorary Secretary of the Society (honsec@saswr.org.uk) by 30th September each year. This may be original research, a review article, results of a particularly useful audit, or the unveiling of a new anaesthetic technique or piece of equipment – all sorts of entries have won in the past. We are very grateful to Intersurgical for their sponsorship of the prize for 2008 and 2009.

The best three entries, as chosen by a panel of judges, will be presented at the SASWR meeting in November, and the prize awarded at that meeting. Any entrants who do not make the shortlist will be invited to display a poster of their work at the same meeting.

The Ross Davis Adventure Bursary

This annual award of £1000 is presented in memory of Dr Ross Davis by his family and friends to trainees of ST3 or above from the Wessex, Peninsula or Bristol deaneries to support ‘exciting endeavours in anaesthesia’. Further information including application forms and rules can be found at www.rosswindsurf.co.uk and applications should be directed to the Honorary Secretary of SASWR (honsec@saswr.org.uk) by 1st May each year. The successful applicant will be invited to accept their award at the following November meeting of the society, although the award may be released before then!

The Feneley Travelling Fellowship

This prize (usually £500) is awarded annually to trainees or consultants to support a ‘mission abroad’. Applications are welcomed throughout the year by the Honorary Secretary of SASWR. (honsec@saswr.org.uk)
The Ross Davis Adventure Bursary
Available for exciting endeavours in anaesthesia!
Up to £1000 to be awarded annually to anaesthetic trainees
ST 3 and above
Open to applicants from Peninsula, Severn and Wessex
Deaneries
For OOPEs, meetings and other educational and
adventurous pursuits

Applications to be made to the Society of Anaesthetists
of the South Western Region (SASWR) by May 1st 2009

Well-rounded CVs essential!
Further information available from:
www.rosswindsurf.co.uk
www.saswr.org.uk
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Please type all articles, including news items, obituaries and reviews on white A4 paper with margins of at least 2.5 cm and throughout use double spacing of lines. One copy should be retained. **Articles should also be submitted by E-mail attachment to the Secretary to Editor (see below).** Scientific articles should be prepared in accordance with uniform requirements for manuscripts submitted to biomedical journals (*British Medical Journal* 1994; 308: 39-42) i.e. as used by Anaesthesia. **They must be accompanied by a letter requesting publication and signed by all authors.** Please ensure that references are complete and correctly punctuated in the required style. The approved abbreviations will be used for journal titles. Attention to these details will save the Editor much unnecessary work. Photographs are best reproduced from transparencies or E-mail digital photographs.

The deadline is usually ten weeks before each meeting of the Society. Submission of articles to Anaesthesia Points West implies transfer of copyright to the Society of Anaesthetists of the South Western Region.

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