**HEARING AID CAN’T TAKE THE HEAT!**

Relentless rehearsing for their performance at the SASWR dinner in Bristol this November caused the hearing aid of one of the singers for the band ‘Bougie Knights’ to blow up. The band’s musical director, Ben Howes, commented; “If that’s not rock’n’roll, I don’t know what is!”. Come and see them play live at the Winter Scientific Meeting in Bristol, 28-29th November.

**WMD SPOTTED IN NORTH KOREA**

Woman of Mass Destruction Dr. Ruth Spencer has been spotted in North Korea, leading to concerns that political tensions in the region may be rising, or at least a major natural disaster will occur. Previous sightings of the WMD have occurred in Madrid at the time of the train bombings, Hemel Hempstead when the oil refinery blew up, Thailand during the military coup, San Francisco during an earthquake, and airports in both India and Glasgow which spontaneously combusted. Rumours of unusual troop movements in the area accompanying the North Korean visit could not be confirmed, and search operations for the two missing guards continue.

**SPATE OF MUGGINGS IN NORTH BRISTOL TRUST**

Doctors in North Bristol Trust have been warned to be on the alert following a series of muggings at both Frenchay and Southmead Hospitals. Victims report being called into a meeting and being asked to hand over their SPA money, despite protestations that they ‘need it for the school fees’. Police are on the lookout for a tall, bearded figure.

In related news, the Spring 2014 edition of Anaesthesia Points West will see the debut of a new ‘Complaints’ section.

**BRISTOL REMAINS IN GRIDLOCK**

Major renovation work to the water supply in Bristol continues to cause disruption to traffic, adding to concerns that merging two hospitals on the Southmead site may exacerbate the problem. A spokesman for Bristol and Wessex Water dismissed the rumour that the enormous pipe was being laid to enable the water supply to the Gloucester area to be converted from fluoride to bromide as “frivolous and unhelpful, during a difficult time for everybody.” In fact, the Gloucester water supply is being augmented to cater for the unusual number of Pampas Grass plants in the area.
THE SOCIETY OF ANAESTHETISTS OF THE SOUTH WESTERN REGION

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Dr Chris Johnson</td>
<td>Southmead</td>
</tr>
<tr>
<td>President – Elect</td>
<td>Dr Chris Monk</td>
<td>UHBristol</td>
</tr>
<tr>
<td>Honorary Secretary</td>
<td>Dr James Pittman</td>
<td>Exeter</td>
</tr>
<tr>
<td>Honorary Treasurer</td>
<td>Dr Ed Morris</td>
<td>Southmead</td>
</tr>
<tr>
<td>Trainee Representatives</td>
<td>Dr Richard Reed</td>
<td>South West School</td>
</tr>
<tr>
<td></td>
<td>Dr Gemma Nickols</td>
<td>Bristol School</td>
</tr>
<tr>
<td>Editorial Committee</td>
<td>Dr Richard Dell</td>
<td>Editor, Frenchay, NBT</td>
</tr>
<tr>
<td>Administrator</td>
<td>Kate Prys-Roberts</td>
<td>UHBristol</td>
</tr>
<tr>
<td>Website Manager</td>
<td>Dr Ben Howes</td>
<td>UHBristol</td>
</tr>
</tbody>
</table>

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# ANAESTHESIA POINTS WEST

## Contents

**Vol 46 No 2**

<table>
<thead>
<tr>
<th>Article</th>
<th>Author(s)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial</td>
<td>Richard Dell</td>
<td>3</td>
</tr>
<tr>
<td>Future meetings of the Society</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>News of the West</td>
<td>Linkmen of the Region</td>
<td>6</td>
</tr>
<tr>
<td>Examination successes and honours</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Spring Scientific Meeting report</td>
<td>James Pittman</td>
<td>22</td>
</tr>
<tr>
<td>A Message from the Treasurer</td>
<td>Ed Morris</td>
<td>28</td>
</tr>
<tr>
<td>So, you want your own website?</td>
<td>Ben Howes</td>
<td>29</td>
</tr>
<tr>
<td>Ross Davis Adventure Bursary Report</td>
<td>Zoe Smith</td>
<td>31</td>
</tr>
<tr>
<td>Tranexamic acid in Major Orthopaedic Surgery</td>
<td>Jonathan Blackman, James Pittman</td>
<td>37</td>
</tr>
<tr>
<td>Awake Fibreoptic Intubation-Improving the Patient Experience</td>
<td>Deborah Sanders, C Matthews, A Moore, Ruth Taylor</td>
<td>42</td>
</tr>
<tr>
<td>The Wine Column - Spanish Stars</td>
<td>Tom Perris</td>
<td>49</td>
</tr>
<tr>
<td>Poem – The Way We Were</td>
<td>Robin Forward</td>
<td>51</td>
</tr>
<tr>
<td>Ross Davis Adventure Bursary</td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>Cartoon- Attending an Emergency</td>
<td>Guy Rousseau</td>
<td>53</td>
</tr>
<tr>
<td>Crossword</td>
<td>Brian Perriss</td>
<td>54</td>
</tr>
<tr>
<td>Prizes and bursaries</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>Notice to Contributors</td>
<td></td>
<td>56</td>
</tr>
</tbody>
</table>
Editorial

Welcome to the new look Anaesthesia Points West, designed not so much to scandalize, as to provoke debate. What does the SASWR represent to you? If you’re a trainee, ‘creeping like snail, unwillingly to school’, maybe it seems a bit stuffy, with its’ serious-sounding committee roles of Honorary Secretary, President-Elect et cetera. Be aware, however, that many of those who are successful in obtaining Consultant posts in the region have raised their profile by presenting posters at the Society’s meetings, or competed for the Registrar prize, or simply just fallen off a table dancing at the annual dinner (although the latter actually lowers one’s profile, technically).

Perhaps you’re a young Consultant, ‘full of strange oaths…jealous in honour, sudden and quick in quarrel, seeking the bubble reputation’, but now you’re busy, maybe with a young family, and those colleagues that became friends who came to your wedding, they’re at the far end of the region, busy themselves, but still the same people.

For you, the Society offers a chance to take some heavily subsidized leave, scoop up some CEPD points to fill the dreaded revalidation Matrix, whilst simultaneously meeting up with old friends, and maybe even falling off a table with them again.

For the senior Consultant, ‘with eyes severe…full of wise saws and modern instances’, the Society needs the benefit of your experience, and your freedom to speak out, unfettered and with the security of a career largely behind you. The medical profession seems to be under a constant state of siege, with the public being told all will be fine if only Consultants would work all seven days of the week (when did we not?). We need your sense of perspective, so as to know where the line in the sand should be drawn.

The Society also caters for retired members, “the sixth age shifts into the lean and slipper’d pantaloon, with spectacles on nose…youthful hose, well saved, a world too wide for shrunk shank’, although it’s very noticeable that the newly retired look ten years younger the instant they stop working. Some of them have second careers now, and are more active then ever. Again, society meetings and dinners give an opportunity for former colleagues to catch up on news and gossip, to watch developments in their previous profession, and also to marvel at the folly and presumption of the young.

This edition has all the old favourites, including News of the West, although it is a shame that there is not a full house of reports from around the region. I’ve temporarily removed the provenance of the trainees listed in Examination Successes as there is a concern that listing the hospital a trainee is at as they pass an exam, especially the primary, overlooks the efforts put in by the hospital that was their initial placement, often as a novice anaesthetist.

The Ross Davis bursary was put to brilliant use by Zoe Smith, who travelled to Africa to work as a lecturer, flying doctor and paediatric anaesthetist. I fear she may find the rest of her career quite dull by comparison. Tom Perris takes us through the veritable minefield (or should that be meritable vinefield) that is Rioja, and there is a cartoon by Guy Rousseau depicting
how to take evasive action when chased by the rozzers.
For those of you who don’t like the front cover, if you turn the journal over and squint a bit, the back cover looks just like the old version of the front cover. The same technique also works well when trying to avoid oneself in the mirror.
I hope to see many of you at the scientific meeting in Bristol in November, and my apologies to Jacques, whose speech I stole.

Richard Dell
Future Meetings of the Society

**Autumn 2013**
Bristol (UHB)
28th-29th November 2013

**Spring 2014**
Truro. Headland Hotel, Newquay
15-16th May

**Autumn 2014**
North Bristol NHS Trust
Dates to be announced
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 about more about 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, each member will receive the twice-yearly edition of APW-free!

Bath

As the leaves fall from the trees and the hospital is already in Black escalation due to the “Winter Pressures”, I look back on a very eventful summer here at the RUH. Can I start with an apology, as in the last update I did not mention the great achievement of Dr Andy Lim, who was awarded the Humphry Davy Medal in recognition of the fantastic service he has given to the RCoA. Andy has been on the College council for many years and has represented the views of Career Grade anaesthetists with strength and vigor as well as providing an insight to our department on the current issues facing the College. We are lucky to still have a spy in the council chamber in the form of Jerry Nolan, who continues to enjoy the endless committee meetings and discussion’s on the minutiae of specialist training and curriculum development.

I was tactically away for the first couple of weeks in August while the new intake arrived to an underwhelming but enthusiastic welcome. The volume level at the induction coffee break augurs well for a very keen bunch. They have lived up to their billing but Dr Thornton has his hands full as we currently have 5 novices in the department. While I am on the subject of new starters, we have a new Chinese anaesthetist who has started with us for three months following on from the success of our last two visitors, Dr’s Wan and Wang or was it perhaps because we had a pleading phone call from the Dean. Annie, as she likes to be called, has immediately been a huge hit after having been overheard saying Prof Cook looks a lot fatter and seems to have aged in real life and also that his male children looked like girls – and they say the art of international diplomacy is dead!

There has also been TV stardom for Dr Peden over the summer. As well as appearing in the local press, she also made it onto the famous red couch of early morning TV as she was interviewed on the Berwick report on BBC1’s breakfast programme. She was talking about the work the RUH is involved in to improve the outcome of our many emergency laparotomy patients.

We had a sunny and auspicious end to the academic year with a summer party at the wonderfully landscaped estate of Dr Thomas (she has the ideas, her husband has the muscle) when Drs Seller and Thornton donned the pinny, and the latest annual awards were presented to Dr Tim Howes (in absentia as he is in Australia), Dr Kieran Oglesby and Dr Skylar Paulich.
Much weeping as usual as a really good and hard working group moved on to pastures new, but we were exceedingly fortunate in retaining Drs Gouldson, Habib, Harris and Williams for a while longer and also welcome Dr Todhunter back, even if she has gone all Aussie on us.

On the ICU front, the Unit was awarded the Pask Certificate by the AAGBI for “distinguished service for gallantry in the performance of their clinical duties … in recognition of your extreme bravery and consideration of patient safety during the gas cylinder incident”. We are all extremely proud of those involved on the day of the fire. Also in good RUH tradition there have been a number of publications and Dr Fifi Kelly has presented the RUH’s experience and also led on the development of national guidance for prevention and management of similar events. It was a terrible event but a lot of good has come from it.

More recently, our Lead Clinician for ITU most generously offered to repatriate a local resident who had been stranded in an overseas ITU with dubious morals and, more importantly, a very slack infection control policy. When cultured he grew some very interesting organisms that even Dr Gupta couldn’t pronounce but did need extreme isolation and a suite being built for their sole use (ongoing after several weeks). Happily the patient did pretty well but once the man had left the unit we had to decant to CCU (it was there or the chief executives offices) for 5 days for total bombing (regrettably of a cleaning nature as we really do need a new building). The bill for this whole process was rumoured to run into 6 figures.

On a more competitive front I would like to report that Dr Handle has completed an Ironman triathlon in Flippers but that would be untrue, in fact we have Dr Marjot to thank for a brilliant idea which has seen the department walls become far more interesting as well as creating a lot of fun. He set up the inaugural (as I feel there are many more to come) RUH Department of Anaesthesia Photography competition. There were over 100 photos submitted from over 20 participants. It was formally judged by the head of Art at the RUH and the Estates Manager. There were six finalists and the winner was Dr Hassan Abuzaid (photo below) with very close runners up Dr Nick Harris and Bob.

Bob then also got all the photos printed some in poster format and they now adorn the walls of the department and look amazing. As I know many in the anaesthetic world are of a competitive nature, how about an interdepartmental one hosted through the auspices of SASWR?

In the spirit of the Great British Bake Off, we had a charity bake for Lightbox, ably organized by Lynn Fenner. With Elspeth’s and Fiona’s support, Lynn not only got everyone baking – even Dr Goodwin- but managed to bake a superb anaesthetist-shaped cake, which by all accounts tasted as good as it looked. However, there was some controversy in the baking world with rumours of bought cakes and, sadly, I
have to report that Dr Thorntons acclaimed Chocolate cake was not produced by his fair south African hands as he repeatedly claimed, but Dr Hommers had been the one with the mixing spoon in her hand. There have been many more achievements that I have surely forgotten about, but well done to Nick Harris for his award winning presentation in Dublin, the two Sarah’s Toddhunter and Gouldson on getting registrar jobs in the Severn Deanery, and Annabel Pearson on her forthcoming marriage. I am sure I have missed many more out and if I have I apologise.

Tom Simpson

Barnstaple
It’s been a fantastic summer here in North Devon, enough to make up for the last five rubbish ones. Not so good for surfers as the ocean looked like a millpond. Lots of arrivals and departures, enough to make the department feel like a train station. On the trainee front we said goodbye to Matt Browning who’s off to join some surgical team in Derriford, Helen Fothergill off to GP land but not quite yet as she is still in Hospital in Torquay and just about to knock off the Medical fellowship. Sarah Morris back to London, love and an ITU job. Wren Holdom has joined the Anaesthetic Team in Exeter, cats “ducky” and all. Layth Tameem is sunning himself somewhere on the Gold Coast in Australia having married his sweetheart in a field in Cornwall (he can be contacted for advice on how to celebrate a marriage on a shoe string- something along the lines of get out an O&S map and canvas local farmers). I don’t think he went as far as another couple of newly wed eco-warriors I heard of who powered their wedding reception disco with exercise bikes! The result of this was an extra variable to the tempo of the music. Johannes Relief has moved to an ST3 job in Cornwall. Matthew Casemore is due to be a father anytime soon, probably around the time of his primary MCQ attempt! Catherine “no problem” Dore is forging ahead and due to attack the OSCE viva in November together with Junayed Ahmed who has plans to study Arabic in Morocco after all is done and dusted. Arrivals in no particular order are Nick Ledlie and James Bickley, frequently confused due to the same military hair cut. David Robertshaw (no, not related to a Paediatric laryngoscope), Anna Wamsley, Rebecca (how do you spell that?) Skrzypczak and Eleanor Quinn. We wish them well as they come to grips with the local version of Anaesthesia and Intensive Care. As a group they are sadly lacking in dart playing skills as they failed to help us retain the annual Anaesthetists vs ODP’s Darts Challenge trophy.

Higher up the food chain, we have said goodbye to Balzas Ittzes who has taken an ITU consultant job in Chester. We wish him all the best, and also to Balzas Bartos who is doing a pain fellowship in Cambridge. You could say that the department has lost its ba….s. Both will be sorely missed. Charlie Collins is winding down rapidly and retiring properly as is David Hurrell. Barrie Loader recently braved local orthopaedic surgery and had his hip replaced. He was looking lean and clean-shaven on the day of surgery, a gesture I am sure Tony Laycock appreciated. Barrie says it was the stress that did it! He is due to retire in May. Ruth Whittle will also be leaving next year some time, and I for one will sorely miss her no nonsense tell it as it is approach to life. Ruth is very popular, not only for her teaching style but also for her legendary dinners,
which several generations of trainees will no doubt look back on nostalgically. Laurie Marks is taking a sabbatical to care for his aging relatives in Zimbabwe. Felix “that’s not how you put a laryngeal mask in” Underwood has joined us and cheerfully reprimands all and sundry. Also new are Szolt Ungvari, Maria Karatzi, Christina Schub and Brigitte Schweitzer, to help fill the gaps left by novice trainees and departing colleagues alike. As you can see we will shortly be embarking on a recruitment drive of note and if you want to sample “the good life” in North Devon please don’t hesitate to get in touch with Kate (animal menagerie) Tipping, Cecily Don or Joerg Kuehne. Joerg has a passion for prehospital medicine and spends much of his free time in a little red helicopter so if one lands in a field near you, just go over and have a chat.

We have our very own version of “pleb gate”! Tony, recently more cheerful since moving from ITU to the General on call rota, was called in to the Maternity unit at 4am to attend a 160 kg woman needing a grade 1 caesarean section. He was followed up the hill by a police car but elected to shoot the lights to save vital minutes. The police gave chase but were thwarted by the nimble Dr Laycock who (they claimed in their letter to the Chief Exec) nonchalantly waved as he disappeared behind Maternity unit security doors calling out “attending an emergency”. Instead of bursting through the doors and clapping him in iron, our hero’s retired to the police station to draft a letter of complaint (cartoon later in journal) Andy Walder had been spotted in Lycra tearing around the Exmoor Beauty and Charlie Collins is so in love with the sport that he cycles through lower back pain with the aid of a Tens machine.

Colin Collville and Jan (Janet!) Hanousek were shown the door on a recent surfing holiday in Morocco. The proprietors evidently thought the hapless pair were a couple and after getting over their initial surprise couldn’t be persuaded that they weren’t.

Guy Rousseau

Exeter

Life in Exeter is very quiet, possibly because everybody is working so hard covering the gaps in the rotas, there is no time to do anything else. We somehow survived the summer holidays, only to find that the rota deficiencies have continued unabated into September. We are due a bit of an influx of new blood into the department, which will be very welcome. We have had the usual trainee turn over, with Old Exeteronians heading off to all points between Australia and Plymouth. In their place Graham Simpson has returned, with Geena Mathew, Wren Holdom, Libby Fontaine and Lizzy Thompson joining us afresh, and at least 6 new CT1s. Best wishes to all our ex-trainees, especially Julie Lewis and James Cole, who have taken up consultant posts in Taunton and Derriford respectively.

Now that we have said our fond farewells to Jon and Vanessa Purday, we have appointed 2 ITU consultants and 3 general consultants. We welcome Rebecca Appleboam and Mark Davidson to ITU, and Kath Meikle, James Lloyd and Tom Martin to the sensible group. They will all be very much welcomed and appreciated. I feel a party coming on.

Love is in the air, with Jo Edwards, Dave Hutchins, Ben Ballisat, Kate Smurthwaite and Jon Blackmore all becoming engaged. Congratulations to Ashleigh Williams who is expecting her first baby, and to Bruce
and Kate McCormick on the birth of their fourth child and first daughter, Winnie Grace. I think that means you can stop now.

We have had a change of personnel in the department. Alex Grice has handed over to John Saddler, although the exact title and remuneration is in dispute, as Clinical Directors have been abolished in the New Order. I have taken over the rota again, now that Vanessa has left us.

This year’s Department Summer party saw a break with tradition, and was held at Emma Hartsilver’s house. Monali spent all day cooking a fab biriani, which was so plentiful we all took a doggy bag home. After Emma’s error of offering to buy nan breads (with biriani, honestly!), she was given the task of making raita. A cursory check by Monali’s lovely husband revealed that this would be a disaster, so he saved Emma from herself, and took over. A great success all round.

And that is about all there is to say, other than well done to Lexi, who not only was a hero on a long haul flight, but managed to present an audit of in flight medical equipment. No matter how dire the situation, there is always a CV opportunity. Until next time…

Pippa Dix

Frenchay

So we are inching ever closer to the end of an era, as the merging of Frenchay and Southmead hospitals approaches. It’s fair to say that there have been a few ups and downs recently but, despite the occasional bout of despair, everyone is remaining relatively cheerful. As there will be no anaesthetic rooms in the brave new world (of huge concern to Jules Brown owing to the lack of dining space for his hourly snack) we have started, on occasion to anaesthetise our patients in theatre. One especially anxious looking patient was asked if they would like some music on to take their mind off the blood and gore that was being removed from the floor and ceiling from the previous case. They thought that was an excellent idea until the unmistakable chorus of “I just died in your arms tonight” by Cutting Crew rang out loud and clear. Memo to new hospital sound system – Classic FM not Jack FM on button number one.

As usual we have been ever such a busy bunch both in and out of work. Maggie Gregory continues to impress as our leader. Nothing seems to phase her despite her office companions learning a few new expletives. Dr Milne is still acting as an admirable interface between the management and clinicians and hasn’t muttered “Et tu Brute” – yet. Dr Shinde led a group to the recent AAGBI conference where she and others played a great game called who could collect the most kisses from select male colleagues. Professor (no one has got use to the title yet) Lockey is still juggling a huge number of roles and responsibilities meaning he has now well and truly taken his eye off the ball at home. The evidence for this being that he only discovered via the Bath planning office that the Family Lockey were building a stable block in the back garden. Revalidation is bearing down on us which seems to justify a CEPD points makes prizes approach which has the rotameisters reaching for the rulebook on professional leave.

There’s been a great deal of departmental sporting triumph recently. Most notable being Sarah Martindale’s donning of a genuine international vest as she represented Queen and Country in the
(cough, cough) GB Veterans Triathlon event in Hyde Park.

Who are you calling a veteran?

The department were impressed to a person, though one dissenting voice did ask if you required a diagnosis of Tourettes as a selection criteria based on a particularly withering Martindale coffee room assessment of one of her surgical colleagues the previous week. Jane Olday, at a recent half iron woman triathlon bravely ran, swam and biked her way through several episodes of sea sickness and, as far as is known, all the cyclists in the dept have stayed upright and climbed many a hill. On a cycling note there is a certain amount of controversy amongst the lycra clad ranks with the first electric bicycle being purchased and ridden by a certain Dr Peter Klepsch. There have been a few cries of foul play and mutterings of “it’s just not right and proper” and no one is looking forward to the day when he forgets to plug it in – honest.

Many at Frenchay are reeling from the news that the last eligible bachelor has finally been caught, wooed and wedded. Dr Matt Thomas is now happily married and ensconced in Thornbury so he can enjoy a longer cycle into work. He has, however, assured his harem of now devastated ITU nurses that he will still be attending the Christmas night out wearing his ‘special’ jumper.

Dr Spencer has finally fulfilled a lifetime’s ambition and entered, played in and then left North Korea. It’s the first time world opinion has been sympathetic towards a despot dictatorship. She brought back lots of photos (!) and a few ideas for the NBT senior executive management team. You’d think her colleagues would have learnt their lesson but she has now dragged Debbie Harris and James Rogers off with her to teach trauma care in Tanzania. We think it’s part of her plan to make the world a safer place (from her).

The trainees are, as usual fantastic to a man / woman. They seem to get on so well that two of them (Ian Kerslake and Clinton Lobo) have taken this a stage further and are now related. Sonja Payne has just been lucky enough to have been blessed with twins which will test her organisational brilliance to the max. An unnamed trainee worked so hard one night (yes it does still occasionally happen) that she fell asleep on her bicycle on the way home. Lucky for her we are the regional trauma centre and even more lucky she didn’t need to return. There’s hopefully the party to end all parties to report on in the next edition so it’s time to sign off.

Ben Walton
Gloucester
Greetings form Gloucestershire. As always when I write the news the county is a hive of activity. This time of year it is not the races but the literature festival, so just as busy but less debauched!
Firstly our congratulations to Helen Makins who has just joined us as a consultant- we are very excited to have her on board. Also congratulations to Henry Murdoch who has a locum consultant post at the BRI. We will be sorry to lose him from Gloucester. He has been doing his best to further our expertise with ultrasound. I for one am very impressed and familiar with his lumbar vertebrae! We welcome Helen Hanman to our secretarial team, some of you will know her from the Deanery.
News from our fab trainees; Liam Scott and Matt Govier passed their primary MCQ paper. Phil Bewley has got an ST3 number which is well deserved. Shailendra Deep arranged a fantastic post fellowship study day on appraisal, revalidation and preparation for consultant jobs. In addition to the excellent programme Mrs Deep provided delicious homemade samosas. The day was so well received that it is going to run again at Cheltenham in January, so if you missed it the first time, book your study leave now! Sarah Warwicker has just returned to work having got married and been on an amazing honeymoon to French Polynesia. Tanya Brookes will be leaving on maternity leave shortly and Amy Dodd will be returning from Maternity leave in November. Obviously being Gloucester there have been some parties; Dave Gabbott had a 75th (well his 50th and his 25th wedding anniversary). It was a great party with our usual band and most of us dancing into the early hours. Another very sociable event and educational of course, was the AAGBI in Dublin. A large Gloucester contingent went and Louis Khor managed to redeem himself by booking some reasonable accommodation this time as opposed to the stag and hen accommodation he booked in Edinburgh! It was great to catch up with lots of Bristol and Bath anaesthetic friends. Fiona Kelly did an amazing talk about the fire on Bath ITU which highlighted the incredible teamwork and bravery of the entire unit that night.
Now to news of Paddy Clarke who, although he no longer works at Gloucester Royal, I thought you may want to know his news! He has had a whirlwind romance and got married at Sudeley Castle, all within a couple of months of meeting. We wish them all the best.
Our anaesthetic department is currently undergoing an extensive refurbishment. We are really excited about our new plasma TV, Nespresso coffee machine and juicer so come and visit.

Claire Gleeson

Plymouth
After another restructuring of the hospital/directorate/service lines structure we are no longer part of the Critical Care, Recovery, Anaesthetics and Pain Directorate, and that there is an air of relief that we may be able to consider using acronyms again. Andy Porter decided that enough people already said AR (pronounced Aaarrrr in a soft warm tone) after his name and that the new name of Anaesthetics and Recovery may have encouraged too much of it. He has handed over the helm to Richard Struthers AR (pronounced with a rising tone and note of discovery). He is busy working out how to get the money that the department is entitled to, and whether this means we can buy an expensive
departmental yacht or possibly consider employing enough consultants to cover the work. We have had four new consultant appointments and a warm welcome to Kate Holmes, Laurence Hulatt and Helen Anderson, who all took up their posts in time to help the August shortages, and Duncan Parkhouse who arrived and then headed off for a short sojourn in the sand. There has also been a change at the top of ICU and Pete MacNaghton has handed over to Sam Waddy who becomes only the second lead of ICU in living memory.

The reinforcements were insufficient to prevent the inevitable gaps in the on-call rotas and under Dave Adams stewardship, the trainee rota has become increasingly moth eaten. He strenuously denies that it is his fault or that he should step in to cover all the gaps himself. The shortage of trainees to cover the on-call rotas has its benefits and increasing numbers of consultants have taken the opportunity to relive those halcyon days of their youth. Apparently time affects the memory and the registrar on call shifts aren’t quite how they were remembered, although I can confirm that the on call room is still hot and noisy, and the bed still incredibly uncomfortable.

Despite the opportunities to relive some of the finest years of our lives, Rebecca Appelboam has decided that the fringe benefits of seeing her children and husband are worth the upheaval of moving to Exeter. Mark Davidson has also been appointed as an intensivist at Exeter and rumours this is part of the outreach service from Plymouth are entirely unfounded. Congratulations also go to Clare Blandford on her job in Torbay. Their success at interview pales slightly when compared to Tom Martin’s efforts on the day of his interview. During his interview in Exeter his wife got a bit bored and when he returned to the car park she was nowhere to be found. A quick phone call found her to be on labour ward...! Soon after the birth of his daughter, John Saddler walked round to offer Tom a job. The emotional response to this was nearly enough to bring a tear to John’s eyes as well. Tom very nearly won the “hats off for holding it together” award but after due consideration the jury decided that the award should go to his wife for her control of the situation.

Other new arrivals with just the normal amount of associated anxiety were May Newmarch (boy) in March, Alex Mills (girl) and Marc Ridgeway (boy) in May, Charly Gibson (girl) and Adam Revill (girl) in August and Helga Rohwer.

This year’s Hospital Star awards were a great success and although there was disappointment for Mel and Sam who were nominated for ‘Non clinical team of the year’ and ‘Unsung hero’, there was success for Gary Minto who won the star award for ‘excellence in innovation and research’. Apparently Gary’s citation said that “Everyone is always pleased to see him when he walks into their office” but did not go on to say how this was demonstrated. Unfortunately some mis-cueing of the music on the night meant that the crowd witnessed Gary walking on to the stage to the theme from James Bond! (They were tears of pride, not laughter from Cath!) His new-found position as a role model left him slightly inhibited, and the crowd were disappointed not to see his full dancing repertoire. Fortunately, other members of the department were more inspired by his success and the occasion, and the like of Tom Gale’s dancing had never been seen before at the Pavilions.

Other tales of physical prowess include
Chris Seavell coming an excellent 29th in the Olympic Distance Age-Group World Championships on the Olympic course in London, and Daryl Thorpe-Jones who was accosted in a parking rage incident. Unfortunately he didn’t realize that the first rule of fight club is that it doesn’t take place in the M&S car park. A head-butt and two punches and he didn’t flinch.

The trainees in the department have been busy and have been rewarded with international presentations of their work. Helen King had a largely uneventful trip to Barcelona and no-one from Plymouth had their pockets picked. The tales of the dangers of foreign cities led Mark Davidson to develop tactics to demonstrate his physical prowess to deter potential muggers. The impromptu demonstration of physical prowess went someway to deter any potential muggers in Brussels and the mussel vest did the rest. He may need to share his training regime with his new consultant colleagues in Exeter.

Rick Hunt’s poster was so well received in Berlin that he attained instance superstar status. Unfortunately in a melee of adoring fans he lost his bodyguard, had his i-phone stolen and only received a Glaswegian kiss in return. His wife did some great work to cover up the black eyes with make up that just left him looking a little tired.

There has been the usual roll call of departing trainees and it is a sad farewell to Debbie Webster, Anthony El-Khier, Rick Hunt, David Connor, Susie Davies, Emily Howells, Abiola Ladele, Becky Marsh, Simon Marshall, Eusebius Nworah, Will Rutherford and Susie Connor. They have been replaced by new and old faces, and it’s a warm welcome to Nick Boyd, Steve Copplestone, Anna Ferguson, Sandeep Kusre, Mark Pauling, Jeremy Preece, Marc Ridgeway, Debbie Sanders, Barnaby Scrace, Tom Teare, Ross Vanstone, Matt Boyd, Sarah Droog, Juleen Gill, Libby Graham, Matt Jenkins, David Radley and Geoffrey Taverner. Now that Steve Boumphrey has demonstrated and innate ability to remember names (sometimes) he has taken over as Foundation Programme Training Director. He thought that with the appointment of Justine Elliot as college tutor he would be able to relinquish this role. Justine’s 5 week holiday to reflect on the opportunities the new role will afford has delayed this slightly.

Finally, Alex Mayor has decided that the allure of registrar on calls is not strong enough and has decided that after several years as the Medical Director he is not going to return to anaesthetics. He has taken up the role of Medical Director at the AHSN and we wish him well in his new job. I’m sure Anna will keep him up to date with the coffee room news of Derriford.

Matt Hill

Southmead
Phew, what a scorcher…a glorious summer has meant that cheery faces abound here all looking suspiciously tanned. However autumn has now arrived and there is lots to do. Preparations for the MOVE hotted up with a merry-go-round for the ODPs as they attempted to work in 5 different places in one day so they could be all be familiar with all areas of work across the trust. Perhaps the less successful outcomes of this “throw it all up in the air and see how it lands” approach might be remembered when we come to planning the anaesthetic job plans! We have a new chief executive and have just appointed 4 new consultants across NBT in the run up to the MOVE (capitalisation is mandatory in all trust communication about MOVE just case
we forget it’s happening – unlikely). Congratulations to Anthony Carey, Nick Preston, Subbu Halder and Lucy Kirkham, great to have you, don’t expect any holiday in May next year…

Some of us have had the chance to tour the new Brunel building which will be the heart of the new hospital which has been named- after a staff vote – Southmead Hospital Bristol. It is impressive and vast, see photos. There are bound to be teething problems and several logistical and manpower issues are yet to be resolved but many things about it will be a major improvement for patients and there are some great design features.

Back in the old Southmead we welcome Andy Bartlett, Ian Davies, Jeremy Brammer, Nicola Stewart, Anna Simpson and Mark Vilaseca, and also Janine Talbot back from maternity leave. Into obstetrics we also welcome Judith Dickson, Sarah Heikal, Jo Collins and Ruth Greer. They have arrived along with the camera crews from Channel 4’s “One Born Every Minute” who are filming at Southmead during September and October. Their fly on the wall presence is most noticeable in the coffee room where there has been an upgrade of the kitchen appliances and microphones dangle discreetly to pick up happy banter amongst the midwives et al above the sound of munching cake. Careless talk costs reputations if not lives and the staff are twitchy. Dr Pyke was challenged as he tried to approach a large woman to insert her epidural by a midwife who correctly identified him as a dodgy media type never normally spotted in CDS. Do watch it when it goes out next year and try to spot your favourite obstetric anaesthetist!

Trainees have excelled themselves this summer. Chris Newell became a reluctant hero after performing an emergency tracheostomy on the ward on a fully anticoagulated patient about to completely obstruct. As this was about a week after the transfer of all head and neck services to UHB there was a slight panic as no one could find any ENT kit to complete the job but all was well in the end.

Well done Pete Steed for getting the primary FRCA. Goodbye and thank you to Kate Reeve, Helen Johnston, Emma Jenkins, Pete Steed and Emma Bellchambers and good luck to Natasha Joshi for her maternity leave. Kate Nickell has started an educational fellowship so
will still be with us one day a week. The very best of luck to Siobhan King who has transferred to East Anglia to complete her training, we wish all her family well after a very difficult year and commend her for her determination in returning to work.

Chris Johnson has retired (shame!) but returned (hooray!) in a part time capacity, to continue to give us the benefit of his wisdom and experience. In an everchanging workplace, his insights are valuable and his thoughtful reflections always relevant. Don’t go Chris!

Next instalment will possibly see us even closer to our happy union with Frenchay – watch this space…

Jill Homewood

Swindon

The NHS transfer window closed on 6th August – no last minute deals, no drama, no countdown special on Sky. Leavers destinations? – Bristol, obviously, but not all . . . Having started here as an ACCS three years ago, Mat Gibbons was almost one of us – we knew him as you would have known your SHOs before Calmanisation and the working time directive made them all part time. Mat departed to Pietermaritzburg for a year to hone his obstetric skills prior to applying for an ST3 post. Alan Radford is now ‘Academic Fellow’ at the Academy here in Swindon – sounds posh, but what it involves is shrouded in mystery – including to Alan. We had a couple of fallers too - Clare Ashley & Mike Lacey switched off their vapourisers & opted for GP land. Our new recruits did the M4 shuffle on the 7th.

As usual, there are a couple of ‘gaps’ in our trainee company. The most interesting factule is that one of the newbies is called Skylar – I haven’t got to the bottom of that one yet.

The last few months also saw two of our senior trainees move on to consultant posts: Matthew Drake to New Zealand (obviously the UK wasn’t wet enough for him), and Anthony Carey to Southmead. Congratulations to both. This means that they have not applied for our recently advertised consultant jobs – I hear a collective game show ‘whoa’ from SASWR members. Read the next instalment for the lowdown on the newest recruits to this esteemed department. Will they be man (or woman) enough to fill Mike Tat and Chris Beeby’s shoes?

Other news: Gary Baigel did his back in & submitted himself to the knife . . . it must have been bad. Jill Dale also went to the carpenters to have her shoulder subacromially decompressed. Your scribe had a tooth out (not many left now). Neil Campbell’s dog died. Julian Stone’s Top Box blew open on the Bodmin by-pass. Pete Dewar has a new medical maxim: a watched drain always fills, a watched catheter never fills. Julie Griffiths lost two hens; one to obstructed delivery of an egg - horrible way to go. Lastly, congrats to Catherine Bryant for cracking the final fellowship.

It was on our annual golf tour that a recently married Bristol cardiac anaesthetist took me to task for overusing the word ‘scribe’. It’s good to know that there is a reader out there; and I trust that my reader has noted that I have cut down on the aforementioned word. Talking of golf, may I recommend the Ugradale hotel, Machrihanish, tip of the Kintyre peninsula – ask for the Duchess suite. The famous golf course is across the road – laid out by ‘Old’ Tom Morris himself. It is a tough examination. After your round, your scribe recommends the haggis nachos as an accompaniment to
Another summer draws to a close. There is an autumnal feel in the air as the evenings draw in. It hasn’t been a bad summer, not that the baseline would make that difficult. The family holiday is a distant memory, ‘O’ and ‘A’ level results are known and the kids are back at school. The NHS lurches on and I count my blessings that I’m not an A & E consultant.

Doug Smith

Torbay
I write this at the start of the August bank holiday, sitting on a train meandering along the beautiful coastline between Newton Abbot and Exeter. The beaches of Teignmouth and Dawlish pass me on the right, the deer of Powderham Castle on my left. The idyllic scenery and gentle movement of the train is threatening to send me to sleep but first I shall sit back and reflect on the events of the past 6 months….

Sipping on my complimentary cup of tea (1st class, dear) I conclude that this has been a truly memorable summer. The British weather delivered (finally!), Andy Murray won Wimbledon, we whipped the Aussies at rugby and cricket, the economy is back on track….could life get any better? Well, perhaps for 8 lucky CT anaesthetic trainees it could: Gillian Barnett, Ella Downey, Sophie Gray, David Hay, Lydia Jones, Christopher Leighton, Aiden Melia and Rory Riddell have all been welcomed with open arms into the supportive, learning rich environment of the Torbay Anaesthetic department. We look forward to getting to know them and nurturing their talents over the coming 2 years. Sadly this has meant we have said goodbye to others and Pete Thomas, Rebecca Thurairatnam, and Tandip Mann have all moved on to pastures new. We wish them well in the future. Of the ST trainees we welcome Suzy Baldwin, James Simpson, Claire Ward, Simon Marshall and we welcome back Nikki Freeman (after the birth of Monty) and Cathi Hoyer.
We have also welcomed four new consultant colleagues since my last column, Will Key has moved smoothly into position as lead for pre-assessment and is already steering a steady ship through those rough waters. Incidentally, Will and I bear a passing resemblance and initially, were often mistaken for each other. However, I was recently informed that if-in-doubt, Will is the younger, better looking one. So there you go.

Then we have Dave Portch, a master educationalist (literally), obstetric enthusiast (yes! they do exist), and part-time spear fisherman from Totnes. We also have Andy Baker- a rarity for our department in that he trained out of region, who we look forward to getting to know over the coming years. And finally, Claire Blandford- as I write this still to start- but eagerly anticipated, especially in the Matthews/Stocker household where she is known for her baking skills as much as her anaesthetic skills.

As a department our fertile streak continues so congratulations to Rachael Blackshaw on the birth of Marcus, Claire Atwood on the birth of Eloise, Zoe Brown on the birth of Christopher, and Hannah Shiels on the birth of Naomi. From what I hear all seem to be doing well and we look forward to perhaps meeting some of them at the department BBQ. More are expected in the not too distant future for Susan Cummins, Dan Quemby’s wife Francis and Dave Portch’s wife Nazma.
There have been no major changes in who does what in the department (at least as far as I know which doesn’t guarantee anything). Nuala Campbell continues her reign as Clinical Director, ably assisted in the Chairman’s seat by Tas Ali. Both are now on the home straight of their 3 year term/sentence and I’m sure will be extremely sad when it finally comes to an end...

Kerri Jones continues to make 6 monthly trips to Kenya with a now fairly regular cohort of theatre staff and surgeons, and earlier in May the trust welcomed back some of the Nanyuki clinicans when they visited Torbay for only the second time. Kerri recently gave a fascinating presentation on the work that has been done over the last few years and I hope that this inspirational work continues to flourish.

We have recently advertised 3 more consultant posts (2 anaesthetics and 1 ICU) and by the time you read this the appointments will probably have been made and we will be planning another welcoming party! This will make 9 appointments in the last 2 years - quite an injection of ‘fresh blood’ into the department. As for myself, having only been appointed 18 months ago, I will soon be 8 up from the bottom-comfortably out of the relegation zone (just like Torquay United).

And so, finally, as my train journey comes to an end I am left to ponder the most important issue of the year: Will the weather hold good for the department BBQ on bank holiday Monday? Indeed, after so many years at Tony and Mary’s will we be able to find our way to the new venue at John Carlisle’s house? Will there be enough food or will we have to resort to eating his chickens?!! So many questions to be answered but you shall have to wait until next time.

Andrew McEwen

University Hospitals Bristol

We begin with the grave news that construction of the staff restaurant in the new ward block has been shelved. We must move on and accept the fact that the only food available in this Trust is newsagent confectionery. On a brighter note, there is a contest going on to design a new facade for the vile Queens building. It seems to be a toss up between glass or grass, with an interesting ‘vertical garden’ that is sure to become weeds in a matter of months.

The new helicopter pad is perched up there on the roof, patiently waiting for something to land on it. So far there has been limited interest from a few pigeons and gulls. Apparently the local Air Ambulance helicopters can land on this type of helipad, but lack the power needed to take off again from a building top. Which is why North Bristol has built theirs on the ground. Perhaps the whirlybirds will disembark patients by winching them down on a wire?

Speaking of high wires, our talented senior trainee Helen Cain recently ran away with the circus. In her debut appearance she performed death defying acrobatics in a hoopla ring suspended high in the air. Fortunately she didn’t end up on the trauma list, and she did return to us to do her on call.
Is it a bird, is it a plane?

In other physical feats, Dr “Mo” Scrutton and a pan Bristol Trusts team managed to run, cycle and kayak from one side of Scotland to the other in about half a day. Fran O’Higgins successfully repeated an Iron Man triathlon, which surely proves without doubt that she is double-hard. Finally the general anaesthetists are limbering up for their annual teambuilding weekend: this time frolicking in the mountains with onesies and compasses.

In the last period we’ve appointed three fine locum consultants in Alistair Johnstone, Sarah Sanders and Kaj Kamalanathan. Welcome to each of you, hope you stick around. We are jealous of North Bristol in their ability to magic four substantive appointments out of thin air. And they’ve poached Lucy Kirkham too - sorry to see you go Lucy.

Ever curious, Dr John Hadfield has been contributing to anaesthesia by self experimentation:

**Hypothesis:** GTN spray on the skin improves the diameter of peripheral veins, thus facilitating cannulation.

**Method:** dorsum of subject/researcher’s hand and forearm sprayed with GTN

**Result:** The subject/researcher felt queer and needed to lie down on the theatre floor. ODP resuscitated with warm beverage. No apparent change in vein diameter.

**Conclusion:** I won’t do that again!

Up the hill at St Michaels, our friendly senior obstetrician Mr Pip Mills recently made an entrance Mr Bond would have been proud of. Whilst getting changed to go to theatre for a Caesarian section, Pip sensibly made use of the WC. At this inopportune moment, the fire alarm started blaring out and, (horror) the toilet door was jammed shut! Action hero Pip climbed onto the cistern and then into the suspended ceiling. He crawled along a joist and moved another tile away to lower himself into theatre 2 in a cloud of dust, much to the surprise of the spinalised parturient! Fortunately, the fire was only a false alarm and everyone lived happily ever after. Best wishes until next time.

**Ben Howes**

**Weston super Mare**

I am not sure where to start. I could see we were missed out in the previous Points West. May be we are not producing enough gossip. Never mind!

It is nearly 5 years since I have left UBHT (as was) and my journey up and down the motorway to Weston appears shorter every year-maybe the motor way is shrinking!

Weston Hospital, as others have been, has been in the NEWS with buzzing words “integration…private sector take over” etc. In reality, up until now we have seen “change over of management and endless meetings”. I hope I will have something really spicy to write in the next newsletter. However the hospital is having an excellent make over..including (free) wifi for the staff and the patients… a bit like at Emerson’s Green.

On the theatre front, the improving efficiency saga goes on…”TPOT” has come back with a couple of new managers
in the team, fortunately not in the tea!

With all these things going on our lead has managed to stabilize and expand the department despite of her odd socks & shoes. Pavol Sukenik, Szabi Rugonflavi and Ammar Naser have joined us as consultants with special interest in expensive care. Dr Dixon is still with us teaching bits of history to our trainees. Para Ray left us to join her husband at Leicester…good luck with her new job.

All our middle grades have created bit of news. Naren Padhiyar is moving as locum consultant up north. Best wishes to Ben Burrows who is curtailing his bachelor life shortly, and Janos Mayer has passed his European Diploma In Anesthesiology & Intensive care. Along with that he has managed to fit in a baby boy. Congratulations to him and his wife Szilvia. Well done and congratulations to all of them.

We have got an interesting bunch of trainees that started in August with us. Jon Bower, ex-Bar manager, Emil Hodzovic, cage fighter, Paul Watson- Chinese medicine doctor, Ed Miles-alchemist (I hope he doesn’t mind) and Alek Kumar is known for his sharp leather necklace! (I am sure our infection control team will have him in their sights. Finally Andy Grant says he plays under water hockey!

Our previous generation of trainees: Carlens, Toby, Natalie, Tanya and Genevieve all did very well. They are not babies any more, and they have moved on to experience the “Real” world (what can I say).

Finally, during the summer some of us travelled all the way to Greece, France, Shetland (yes..yes) and to their respective home towns to seek sunshine. Whilst others basked in unusual sunshine in the UK day after day after day.

_Guru Hosdurga_
## Examination Successes and Honours

**Bristol School of Anaesthesia**

### Primary FRCA
- Rich Hunt
- Rachel Montgomery
- Pete Steed
- Debbie Webster
- Tandip Mann
- Peter Thomas
- Helen Fothergill
- Johannes Relief
- Layth Tameem
- Carlen Reed Poysden

### Final FRCA
- Seb Brown
- Charley Gibson
- Emily Howells
- Kat Ng
- Tim Cominos
- Toby Jacobs
- Thomas Barrett
- Scott Grier
- Catherine Bryant

### Society of Anaesthetists of the South Western Region Prizes

- **Poster Prize:** Helen Marshall
- **Intersurgical Prize:** Louise Cossey

*Please accept the apologies of the editorial team if your success has not been mentioned above. We can only print the names supplied to us by the college tutors and linkmen from around the region.*
Frankfurt, the financial capital of Germany, was the venue for this year’s SASWR overseas meeting in May; and a very good venue it turned out to be. Chris Monk and I had chosen Frankfurt because Professor Kai Zacharowski had given us a very warm invitation to run a joint meeting with his Anaesthetic Department at the Goethe University Hospital. Kai was well known to many in the southwest as he had been the previous Professor of Anaesthesia at the BRI and everyone was keen to remain in contact.

After a preliminary fact finding visit last year a scientific and social programme was put together. Kai’s vision and enthusiasm helped to maximise the learning opportunity of the meeting; in addition to lectures he suggested small group workshops and interactive lecture sessions. We stressed the value of the trainee prize, poster presentations and proposed some of the topical subjects for the lecture sessions. In combination, the programme had a fresh look for a SASWR meeting but I was concerned that this was a potentially ambitious programme to organise from a different country. It is usually meetings organised by the likes of the AAGBI which can pull together the resources needed to run 8 concurrent workshop sessions.

My worries, whilst reasonable, were put to rest by the recruitment of Dr Alex Koch and Kerstain Haschke, Kai’s PA, to the organising team. I must thank them both for all their hard work. The meeting would not have run nearly as smoothly without them. By the end of the meeting they looked exhausted and I am sure they felt they had been served up a genuine hospital pass when the Professor recruited their services.

The meeting was well advertised and circulated throughout the regions trainees and consultants. Uptake was slow, but, by the end we had a reasonable sized group and I hoped for a similar number of delegates from the Frankfurt Department. A Frankfurt flight from Bristol also became available which eased the
travel arrangements of some delegates, unless of course your name is Monk. The outgoing Hon Sec, who had put plenty of thought into the meeting, forgot that the flight he had booked was from Bristol not Birmingham. They were delighted to see him in Birmingham but there was no plane. Some calming and sympathetic words from Charlotte Monk (?) and the use of a credit card meant a later flight from London was purchased with a minimal delay in arrival. The other SASWR delegates arrived throughout Wednesday and people convened in the Hotel Intercontinental to catch up and reunite with their old friends. There was a good mix of generations with a generous number of trainees and a few welcome grandees.

Thursday had a full schedule. Professor Kacharowski had invited the society members on a guided tour of his hospital after breakfast. Work starts early in Germany and he met us at 0830 by which time he had already done a round of the 40 bedded ITU ward. He was waiting for us in a pristine ironed white coat in the huge and elegant hospital lobby. Why did we let our white coats be taken away from us? Patients could identify who the doctors were and we looked professional. Surely this is something that patients want? Kai gave us a very warm welcome and clearly enjoyed reuniting with ex-colleagues from Bristol. The tour was excellent and exposed many of the differences and some similarities between our two health care systems. Those delegates who had not managed the early morning start were picked up by bus from the Hotel and brought over to the hospital for the start of our day excursion to the Rhine Valley.

I had fortunately managed to make contact with a German tour guide prior to the meeting and arranged for her to take us around some of the sites of the area surrounding Frankfurt. We drove for about 45 minutes to our first stop at the medieval monastery, Kloster Erbach. Our guide had an encyclopedic knowledge of the history behind the monastery and the spartan life of the resident Benedictine monks. The monastery is now famous for its wine production and we had an excellent tasting session in the magnificent and atmospheric cellars. The wine is nearly all Riesling which seemed to be acceptable to the palates of the SASWR membership.
We had lunch in the beautiful village of Eltville in a local restaurant called the Glebes Haus. Unfortunately the weather was not ideal but as we ate our local speciality dish of roast beef and green sauce, we had a beautiful view down onto the River Rhine. We had planned to explore the village of Rudesheim after lunch and go by cable car up to the monument of Germania but by now the rain was coming down rather hard and we decided on a boat trip from Assmannshausen down the river. The Rhine is lined by many wonderful old castles, providing a record of the centuries of human history that have been played out along this famous river.

We were back in Frankfurt by early evening for a quick turnaround before the Presidents reception at the hip restaurant Margarete. There was a good turn out, with almost all of the UK delegates in attendance. We were joined by the German Anaesthetists who were running the workstations or giving lectures over the following days. The Society President, Dr Mike Durkin, made an excellent welcoming speech and thanked Kai and his department for their hospitality and engagement in the meeting. The prosecco flowed and a good social evening was had by all.

Dr Mike Durkin and Professor Zacharowski opened the academic meeting on Friday morning in the hospital lecture building. SAWR member’s time keeping needs some attention as it took some time for them to arrive and take their seats! The first session was chaired by Chris Monk and untitled ‘the bleeding patient’ and we had 4 excellent lectures on different aspects of this challenging clinical problem. Dr Weber (Frankfurt) is an expert on point of care coagulation testing and gave a superb lecture on the problems of traditional anticoagulation studies and the advantages of machines such as the Rotem.
which reduce transfusion rates, save money and decrease mortality. Dr Richard Telford (Exeter) skilfully talked us through the growing number of new anticoagulants and the real challenges these present to anaesthetic practice. We really need to be on our guard to spot patients on these drugs, many of which are not familiar to us and have potentially devastating irreversible bleeding consequences. Major Richard Reed (MOD trainee, Derriford) brought us up-to-date on the experience of managing haemorrhage that is coming out of the conflict zones around the world, particularly Afghanistan. Finally, Dr Scheller (Frankfurt) spoke about cutting edge clinical management of coagulopathic patient and the use of tranexamic acid, factor 7, FFP and prothrombin complex. My suggestion is get the on-call consultant haematologist involved early.

The expert panel on coagulopathies

After coffee, we ran the trainee prize section chaired by Dr Ed Morris and Dr Alexander Koch. It had always been clear that the German trainee research would be on a different level to their UK colleagues and so we had 2 prizes. Professor Zacharowski’s laboratory work is internationally acclaimed and leading the world in our understanding of the Toll-like receptor in various clinical situations. The first four presentations were by Franfurt trainees and were all excellent, provided you were not a mouse! Toll-like receptor activity in our furry friends was reported following reperfusion injury, sepsis, and acute renal failure. There are amazing advances that are going on in basic medical science that may be the future direction of travel in clinical management. The winner though was Dr Caral Jennewein who discussed her newly discovered vascular adhesion molecule Ninjurin and its role in inflammation.

Up stepped the UK trainees. At this stage there was a concern that we might be about to see a Sunday Clifton Downs football team taking on the Bundesliga. Dr Louise Cossey (Peninsular trainee) spoke first about her emergency laparotomy project, Dr Helen Marshall (Peninsular trainee) presented her audit of post amputation analgesia and lastly, Dr Peter Thomas (Peninsular trainee) spoke on the creation of SWARM and the results of their survey of post operative pulmonary complications. All 3 talks were great, relevant and the Hon sec could actually understand what was being talked about! Dr Cossey was judged the winner and received the Intersurgical Prize for £500 pounds.

After Lunch we tried something different for a SASWR meeting, home or away. Delegates had the opportunity to take part in eight practical workshops, spending 15 minutes in each station. My thanks to Dr’s Matt Molyneux, Dan Quemby, and James Brown who joined the other faculty from the Goethe Department in running the stations. Point of care testing, airway training, ultrasound scanning, bronchoscopy, double lumen tube insertion and cardiac output monitoring were all
demonstrated. This proved a real success with very positive feedback. As a note to future Hon sec's, this type of session is very labour intensive to organise, needs multiple rooms, lots of equipment, plenty can go wrong and should not be attempted outside of a German academic institution!

The day finished with a couple of excellent lectures given by the two presidents. Dr Mike Durkin spoke first about the NHS in the 21st century, and his Department of Health work looking at patient safety. A real culture change is needed and an overhaul of the way we design, understand, record, respond to and tackle safety issues. We fundamentally have to put the needs of the patient first. We have a lot to do in the acute sector but it was interesting that only 0.4% of all nationally reported patient safety incidents currently come from general practice. I assume their reporting culture is not what we are used to. Professor Zacharowski followed on and used his experiences of both the UK and Germany systems to describe the multiple differences in health care between our two countries. For me the stark difference was the influence and opportunities that doctors in Germany have to influence the way health care is developed and delivered. They have retained the control and power to manage the systems they work in.

The gala dinner was held at the Restaurant Druckwasserwerk in the historic waterworks building. The food and atmosphere were fantastic and by the noise and laughter that emanated from the SASWR tables it was an evening that everyone thoroughly enjoyed.

The gala dinner

The Saturday morning was well attended and started with a session on the acute abdomen. Dr Claire Todd gave a very polished lecture on the Emergency Laparotomy and the pathways that are being used to improve the care we give to this high risk group of patients. Dr Ben Gibbison then brought us right up to date with the latest in the Hypothalamic-Pituitary-Adrenal axis and the role of steroids in the critically ill patient. Dr Matt Thomas then ran an interactive session where delegates were asked to electronically vote on what they individually do when managing the high risk general surgical patient. There is considerable variation. His animated use of Lego had to be seen to be believed!

The scientific programme ended with Dr Kieran Rooney tackling the difficult and relatively unrecognised problem of delirium on the intensive care unit that carries a 3 fold increase in 6 month mortality. What can we do...at least give the patients their glasses, hearing aids and talk to them! Dr Mutlak from Frankfurt finished with a lecture on ECMO which is used extensively on their ITU with improving survival rates. Their practice is certainly far ahead of the UK.
The toll-like receptor meets the Matrix

The final Guest lecture of the meeting was given by Mr Dedbit Chaudhuri. This very entertaining computer hacker turned internet security advisor gave a fabulous lecture looking at the frightening world of IT security. It seems we have probably all had our computers hacked into and big companies and even governments are virtually unaware of who is looking at their business. As medical technology advances and micro chip biosensors are inserted into patients, even our own bodies and identity will potentially become the target of other people. How could someone steal my identity when I have not yet figured out who I am!

The meeting was then closed by the Presidents, and SASWR members left to make their way home to the UK after a very successful joint meeting. I must thank again Dr Alex Koch for all his help in organising this meeting without which it would have been considerably more stressful and I suspect less successful. Finally, a last thank you to Professor Zacharowski for facilitating, supporting and making his staff available to help run this overseas meeting.
A Word from the Treasurer

Are you paying the right subscription to SASWR?

Dear Members,

A few years ago we voted (unanimously as I recall) to increase the annual subscription for consultants, SAS doctors, and newly retired members to £40 per year. At the time we had a big push and a large number of you completed new standing order forms to enable that to happen. The extra income will keep the society in good financial health in the years to come.

I’ve realised on looking through the accounts that some people in the above groups still have standing orders for only £20 in effect (the £20 rate is for trainees, non-permanent career grade doctors and people already retired at the time.) Of those who failed to upgrade their payments some are newly appointed consultants; some I suspect we failed to contact; some may merely have forgotten.

Before I trawl through the lists of names on the bank statements at this stage and approach members individually, could I ask you to kindly check your banking details (it should be easy now so many of us are online) to see what has gone out this year? Subs are normally taken in October.

For reasons of cost we haven’t been able to set up a direct debit scheme – so if you do feel that your annual contribution to running the society should be higher than it is, please contact me and I will arrange to send you a new standing order form. I, the society, and the trainees who benefit from our prizes and awards will be very grateful.

Please would you kindly check your bank statements / online banking and see what you are paying.

edmund.morris@nbt.nhs.uk is my email address and I look forward very much to hearing from you.

Ed Morris
Treasurer
September 2013
I often get asked how to build a website. My advice is based on experience of building five or six sites over the last few years, I do not have any special technical knowledge or expertise. Your basic computing skills should carry you through – you should be happy using websites generally, and be familiar with general filing and office software. Trial and error, searching the net for help and general fiddling are highly recommended.

There are several approaches to this task. I have outlined one that works for me and gives you maximum flexibility for the future, giving you full control of your content. Free blogging sites may be all you need, but remember you will have third-party adverts on your site. Many web hosts offer a basic single page layout for little or no money. Expect to adhere to their preformed structure and advertising. For more flexibility and control, you should buy your own little corner of the internet and use it your way. This is very easy these days. You will need the following:

1. Some content that is worth putting on the internet
2. A web hosting package – a bit of space on a computer that is always on and connected to the internet. This computer is known as a server
3. A domain name – your dot com, for example saswr.org or fluffybunny.co.uk
4. Some software that you install on your server to manage the content of your site
5. Some time on a rainy day to get it working well and looking nice – allow 4-8 hours, it’s amazing how time flies

UK-based hosting packages start at around £40 per year - no need for more than the basic for now. Most hosts offer domain name registration at the same time. It’s easiest to do this as they will link your site with your name automatically. It takes a day or two from registration to get the hosting and domain all working together. Once you have received your email saying all is running, you can log in to your server control panel and install some software. Most control panels have automated installation of a variety of packages including blogging, gallery, e-commerce, forum and poll software. A content management software package (CMS) is an ideal place to start as they provide a flexible template to display your content. Wordpress is my favourite CMS and is the heart of the saswr.org site. It began as a blogging package but grew into a simple but very flexible content manager with thousands of templates and extension modules available. It is open-source and free of charge. Go ahead and install Wordpress on your server via the control panel. Make powerful passwords for any of your website accounts - not your pet’s name. Wordpress sites are potential targets for bored hackers practising their trade. Regular backups and maintaining
latest versions of your software are crucial defence and much more important than on your home computer.
To get started with Wordpress, you need to log in as administrator to the ‘back-end’. This is where you have a control of, and access to all your content. The ‘front-end’ is what the user of the site sees when they visit. The default template is perfectly usable and allows you to slightly adjust the appearance and layout within Wordpres. There are thousands of alternative templates available which are installed from the Wordpress back-end. Now, make a new page and insert your content. It’s very much like using a word processor, except instead of save, you update and your page is saved on the server. Click visit page and view what your work looks like on the internet. Be aware that ‘posts’ are designed for regularly updated blogs whilst ‘pages’ are static. You will probably want to select a static home page from the settings menu. The media manager is a very convenient way to upload and display pictures, documents etc. Just get stuck in and play around with it until you like it. Lots of people want to have their own image at the top of the page. This is a feature of your template, some of which (eg. twenty twelve) have an easy way to add your own image. It helps greatly to use an image editor such as Photoshop or Gimp (freeware) to make your image exactly the same size (eg. 900 by 400 pixels) as the default image from the template. A final tip: when editing you page make sure you uncheck “allow comments” or you’ll find a lot of junk/spam tends to accumulate at the bottom of the pages you wish to keep clear and nice. This can be made default in the general settings for future pages you create.
Now you have done this, you should have something presentable and functional out there on the net. The next step is to keep the content relevant, fresh and up to date. You also need to raise the profile of your site so that people - not just web-trawler robots - visit it. Now you have a server, you can also install other packages such as poll/survey software, you can usually have 5 or more installations. Keep an eye on the design and structure of other websites as you can often get tips on how to present things nicely. Finally, get stuck in and be prepared to experiment!
Ross Davis Adventure Bursary Report 2012

Dr Zoë Smith

Following my CT2 year as a Wessex Anaesthetic Trainee I took the opportunity to spend six months undertaking voluntary work in Africa prior to commencing my next stage of training. The aim was to develop growing interests in developing world anaesthesia, paediatric anaesthesia and aeromedicine whilst combining the experience with a healthy dose of exploration and adventure. I am extremely grateful to the Ross Davis Adventure Bursary for supporting my experience.

Jimma University Specialised Hospital, Ethiopia – Visiting lecturer programme (August – October 2012)

Ethiopia has a population of over 83 million with a life expectancy at birth of 54 years. In 2010 only 12% of the population had access to sanitation. Jimma University Specialised Hospital (JUSH) is a 450-bedded university teaching hospital 350km southwest of Addis Ababa with a catchment population of 15 million. Since 2006 its facilities have included a six-bedded Intensive Care Unit with capacity for three ventilated patients. The Department of Anaesthesia comprises two medically qualified anaesthetists with the remainder of anaesthetic care being provided by “anaesthetists” with anything from three months to four years (BSc) training.

Operation Smile teams have visited Ethiopia for several years and volunteers have recognised a need for further training and education in anaesthesia in Jimma. In 2012 a partnership was established to allow UK “Visiting Lecturers” to work at JUSH as part of a sustainable educational programme. As the first Visiting Lecturer of this kind, I established key objectives in conjunction with the Head of Anaesthesia and spent the following six weeks working with nursing, theatre and medical staff in the hospital and university towards achieving these aims.

WHO safe surgical checklist

This was introduced to the main JUSH theatres through a combination of presentations and practical training involving over 50 staff. Despite initial resistance to its use, it was adopted into routine practice in the three main theatres during daytime hours. A degree of ownership was encouraged by personalising the
checklist for JUSH. The use of inter-theatre competitions and YouTube videos made in Addis Ababa in Amharic (the predominant local language) helped to engage theatre staff in its implementation.

Postgraduate anaesthesia syllabus
I also worked on developing a postgraduate teaching syllabus for qualified doctors wishing to train as Anaesthesiologists. This involved co-ordinating with existing Anaesthetic staff and the University in compiling a syllabus for a three-year training programme in postgraduate Anaesthesia. To date, although the syllabus has been approved there has yet to be a trainee doctor enrolled in the Anaesthesia programme, largely due to poor rates of pay in comparison to surgical colleagues.

Figure 2. JUSH operating theatres. Anaesthesia predominantly comprised of ketamine, suxamethonium given as repeated boluses and halothane. There were no opiates, capnography was rarely available and the majority of “consumables” were re-used.

Jimma University Hospital pain guideline
A recent MSc study revealed that pain has historically been poorly managed at JUSH. Specific guidelines for pain management were designed for JUSH and introduced to all surgical wards, ICU and to the nursing staff, interns and residents running these areas. This was preceded by a number of teaching sessions involving over 150 staff on issues surrounding pain management and its importance. There are currently many barriers to analgesia prescribing which include the culture that it is acceptable for patients to experience pain.

Life support and simulation training
Having shipped a donated Laerdal manikin to Ethiopia, I conducted training in the recognition of the sick patient and life support to healthcare professionals including nursing staff, interns and residents. Practical training of this kind was a relatively new concept but the feedback received was overwhelmingly positive and assessments revealed a positive impact on knowledge.

Lifebox follow-up
During an Operation Smile mission, the Lifebox pulse-oximetry training programme (www.lifebox.org) and oximeters were delivered to 15 anaesthetists. The aim of follow-up 6-months later was to assess the efficacy of the training and sustainability of the donation programme. A telephonic semi-structured interview demonstrated all anaesthetists were able to accurately answer knowledge questions designed to assess their understanding of the initial training. In 100% cases, the donated pulse oximeters were functioning and in regular use, providing evidence for the success of the work by the Operation Smile/Lifebox collaboration.
The ICU has six beds and three ventilators but is otherwise poorly equipped and even more poorly staffed. The overall ICU mortality rate was 50.4% and major causes included trauma, cardiac disease, acute abdominal presentations, septic shock, tetanus and hysterectomy secondary to uterine rupture. Head injury carried a mortality of 52.1%.

The six weeks that I spent in Jimma also involved obstetric anaesthesia and a study revealing ICU mortality rates in excess of 50%. In these two areas in addition to those previously mentioned there are a number of issues still to be addressed. In this respect it is fantastic to report that there have been three further Visiting Lecturers from KSS Deanery to JUSH since my departure. It was both exciting and rewarding to have been involved in a sustainable and mutually beneficial educational project improving patient care in Ethiopia.

**Red Cross War Memorial Hospital, Cape Town (October – December 2012)**

Having spent over a year working as an emergency medical officer in Kwa-Zulu Natal following my Foundation years, I had a longing to return to South Africa not only to take advantage of the fantastic medical experience but also to maintain friendships forged over stressful trauma room resuscitations, and strengthened by Drakensberg hiking trips, kitesurf sessions and sun-soaked braais. The Red Cross Children’s Hospital in Cape Town is well regarded worldwide, so having developed an interest in paediatric anaesthesia, I was excited to receive a reply from Professor Thomas inviting me to work there on a voluntary basis between October and December 2012.

My work at the Red Cross was extremely varied with great exposure to a number of cases and medical conditions uncommonly encountered in the UK. My lists included complex ENT and general surgery, severe burns cases, and paediatric specialities including neurosurgery and cardiac anaesthesia. Whilst this was very daunting at first, I always felt well supported and the working environment was extremely friendly. Notably, the surgeons often assisted with difficult cannulations. Care was provided...
in a first world setting with excellent support at consultant level, and the weekly departmental teaching was excellent. Over all the experience was fantastic and gave me a great deal of confidence in dealing with paediatric cases which has extended into my registrar training. Living in Cape Town, catching up with good friends, and working in theatres with a view of Table Mountain served to make the experience particularly pleasurable.

Figure 5. Sunset from Lion’s Head, Cape Town.

AMREF Flying Doctors Service – Volunteer Physician Programme (December 2012 – January 2013)

Prior to studying medicine, I was a member of an expedition to Kenya involving teaching, climbing Mount Kenya and desert camel trekking. This was not only the start of a longstanding love affair with Africa but also my first encounter with the AMREF Flying Doctor service (www.flydoc.org). It has since been a personal ambition to return and work as a volunteer physician, so it was with great excitement that 13 years later I was in a position to do so.

In 1957, three doctors founded the Flying Doctor Service (FDS) of East Africa. Based from Wilson Airport in Nairobi, the AMREF FDS generates income through paid membership and by providing medical evacuations for insurance companies. This is reinvested in charity retrievals and supporting AMREF’s outreach programmes which provide free healthcare throughout East Africa.

The AMREF FDS relies on physicians worldwide volunteering for periods of 1-3 months. I was on call for 24-hours a day during December 2012 and flew a total of 21,698 miles evacuating 27 patients. I was largely working independently with a very experienced flight nurse whose expertise was invaluable. Often patients were triaged and stabilised on the runway prior to take-off. Flights were extremely varied from medical evacuations from dirt strips in Kenya in a Cessna Caravan to international repatriations on Citation Bravo Jets and I was involved in the management of a number of challenging cases.

Figure 6. One of AMREF’s Cessna Caravans at an airstrip in Northern Kenya awaiting the arrival of five trauma patients from a road traffic accident.
One afternoon involved stabilising and evacuating a young Kenya man from a road traffic accident with multiple injuries including a spinal cord transection and chest trauma. The same evening I repatriated a floridly hallucinating 3-year-old from Dar Es Salaam following a buscopan overdose. I spent Christmas Eve in Johannesburg after transferring a 15-year-old with a blocked ventriculoperitoneal shunt. One of my most difficult flights involved the transfer of an unstable 66-year old with a ruptured abdominal aneurysm. Other memorable cases included a 55-year old Indian lady with extreme bradycardia requiring in-flight transcutaneous pacing, a case of high altitude pulmonary oedema, and severe paediatric falciparum malaria.

My experience with AMREF was immensely diverse and unpredictable but ultimately extremely rewarding. It presented new challenges that demanded tangential thinking, constant attention to detail and meticulous planning for potentially evolving situations. I was constantly thankful for the huge wealth of experience of the AMREF team supporting me.

**Figure 8. Working with the AMREF flying doctor service.**

**Exploration and adventure**

Part of this six-month experience involved exploring the countries in which I worked and lived. Following my work in Ethiopia I travelled extensively in the North of the country journeying through what I discovered to be an extremely beautiful and diverse landscape steeped in history. The rock hewn churches of Lalibela and the Simien Mountains were particular highlights. A beautiful high altitude trek culminated in an ascent of Mount Buahit.
In South Africa, the majority of my time out of hospital was spent kite-surfing with incredible views of Table Mountain, or along the coast at Langebaan. When the Cape Doctor was not blowing, Table Mountain offered some fantastic running and biking and watching the sunset from Lion’s Head was a great way to finish a long day. In Kenya, I lived in Nairobi but had a great opportunity to travel to a number of other countries in East Africa through repatriation flights. At the end of my job, I travelled through Tsavo National Park to the coast where the kite-surfing was some of the best I have experienced. It was a shock to the system to come back to the UK in January to the start of my ST3 post and straight into Final revision…

Acknowledgements

I am extremely grateful to all those who have helped me along the way with these projects, offering their support and encouragement. In particular, thanks go to the Ross Davis Adventure Bursary, the AAGBI International Relations Committee, Operation Smile and the Emirates Foundation, without whose financial assistance this experience would not have been possible.

Dr Zoë Smith
Wessex ST3 Trainee
**Introduction**

Tranexamic Acid (TA) is an anti-fibrinolytic agent that can be used as part of a peri-operative strategy to minimise blood loss and transfusion requirements in elective orthopaedic surgery. Interest in this drug has recently been heightened through the publication of meta-analyses underlining its potential benefits. As a result TA is now given to all knee and hip arthroplasty patients at our hospital. After summarising its mechanism of action, indications and contra-indications, this article aims to review the published evidence for its use and to highlight areas where the evidence for its use remains incomplete.

**Pharmacology**

Tranexamic Acid is a synthetic derivative of the amino acid lysine. It improves clot stabilisation through the competitive blockade of the lysine binding site of plasminogen\(^1\)\(^2\). This prevents plasminogen from binding to the lysine residues present on fibrin and thus the breakdown of clot. Tranexamic Acid injection is currently licenced in the UK for administration as a slow intravenous injection for short term use in the prophylaxis and treatment of bleeding arising from prostatectomy, conisation of the cervix and surgical procedures for patients with haemophilia\(^3\). Its off label use however is now increasingly widespread and it has been tried in multiple surgical specialties to minimise blood loss in medium to high risk procedures. Cautions include patients with massive haematuria, acquired defective colour vision and disseminated intravascular coagulation (DIC). Its use in patients with thromboembolic disease is contra-indicated.

**Evidence of Benefit**

Interest in the use of TA in elective surgery has increased due in part to the 2010 CRASH-2 study\(^4\). This large, high quality, international randomised controlled trial examined the effect of administering TA to trauma patients. Over twenty thousand adult trauma patients who were at risk of or experiencing significant haemorrhage were randomised to either a placebo group or a group receiving a 1g intravenous loading bolus of TA followed by an infusion of 1g over 8 hours. The primary outcome of all cause mortality within 4 weeks was 14.5% in the TA group vs 16.0% in the placebo group [RR 0.91 (0.85-0.97) \(p=0.0035\)]. Death due to bleeding was 4.9% vs 5.7% [RR 0.85 (0.76 – 0.96) \(p=0.0077\)]. Later analysis of the same trial\(^5\) revealed that the timing of TA administration was important. TA appeared more effective in those treated within 3 hours of injury reducing the relative risk of death by 13% [RR 0.87, (0.81 to 0.95)]. In those treated greater than 3 hours post injury the relative risk of mortality through bleeding actually increased [RR 1.44 (1.12 – 1.84)].

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**References**

1. Cras et al. (2010)
2. International Randomised Study of Transfusion in Acute Cerebral Haemorrhage (CRASH-2)
3. Health Technology Assessment Programme (HTAP)
4. CRASH-2: Cochrane Database of Systematic Reviews
5. CRASH-2: International Trials Collaboration
A statistically significant increase in vascular occlusive events (MI, Stroke and PE) was observed. The trial was therefore immensely important in firmly establishing the role of TA in preventing blood loss and improving mortality in trauma patients. This was followed by the publication of robust evidence that the effect of TA in reducing blood loss can be extrapolated to elective surgery. A 2012 meta-analysis published in the BMJ included 129 randomised controlled trials involving 10488 patients comparing placebo groups with TA groups in surgical patients. Outcomes of interest included the number of patients receiving a blood transfusion, thromboembolic events and mortality. Of the 129 studies, 126 were in elective surgery, 95 supplied data regarding blood transfusion and of this subset, 36 were in orthopaedic surgery. TA reduced the risk of receiving a blood transfusion by 32% [RR 0.68 (0.62-0.74) p<0.001]. No evidence was found to suggest that the relative effect of TA on blood transfusion varied according to type of surgery. When restricted to orthopaedic surgery, transfusion risk was reduced by 45% [RR 0.55 (0.49-0.61) p<0.001]. Mortality was reduced in the TA groups by 39% [RR 0.61 (0.38-0.98) p=0.04] although when restricted to trials with adequate blinding this effect was uncertain [RR 0.67 (0.33-1.34) p=0.25]. The effect of TA on pulmonary embolism, deep vein thrombosis, stroke and myocardial infarction was ambiguous with no statistically significant results. The overall conclusion of the meta-analysis was that TA reduces blood transfusion requirements in surgery but that further trials are required to resolve uncertainty regarding its potential adverse effects.

In addition to this general meta-analysis of the use of TA in surgery, more specific meta-analyses have been published regarding TA use in Total Hip Replacement (THR) and Total Knee Replacement (TKR). A systematic review and meta-analysis of the use of TA in THR published in 2010 included 7 clinical trials comprising 350 patients, all of which compared blood loss outcomes in primary THR. Tranexamic Acid reduced intra-operative blood loss by a mean of 104ml [95% Confidence Interval (CI) (44ml – 164ml) p=0.0006], post-operative blood loss by a mean of 172ml [CI (138ml - 263ml) p=0.0002] and total blood loss by a mean of 289ml [CI (138ml - 440ml) p=0.0002]. The proportion of patients requiring blood transfusion was also significantly reduced with a risk difference of -0.20 [CI (-0.29 - -0.11) P<0.00001]. No statistically significant differences in rates of deep vein thrombosis and pulmonary embolism between the two groups were found.

Similarly positive findings arose from a systematic review and meta-analysis into the use of TA in TKR. This analysed 19 trials involving over 800 patients, 18 of the trials studied intravenous administration. Reduction of blood loss was greater than in total hip surgery, with an average of 591mls [95% Confidence Interval (CI) (536ml – 647ml) p<0.001, 9 trials, 763 patients]. The proportion of patients requiring blood transfusion in the TA treatment arm was also significantly reduced [RR 2.56 (2.1-3.1) p<0.001, 14 trials, 824 patients]. The authors did comment that interpretation of these results was limited due to the substantial heterogeneity in trial design. No statistical difference in rates of deep vein thrombosis (13 trials, 801 patients) or pulmonary embolism (18 trials, 971 patients) was observed. A more
recent meta-analysis published in 20139 regarding TA use in primary unilateral knee replacement including 19 RCTs and 1114 patients revealed very similar results with statistically significant reductions in total blood loss, proportion of patients requiring blood transfusion and volume of transfusion per patient. Again no statistically significant differences were found in rates of venous thromboembolism.

**Safety**

The evidence for the efficacy of TA in reducing blood loss in trauma, elective surgery and orthopaedic surgery settings appears compelling. Its safety, however, continues to be under investigation. There are no published meta-analyses suggesting that TA significantly increases the risk of venous thromboembolism although non-significant increases have been reported in some trials10. One trial11, testing efficacy of TA in THR versus placebo in reducing blood loss, recorded a DVT rate of approximately 17% in the TA group versus 0% in the placebo group. These numbers were too small to be statistically significant. However in view of these types of result, TA use in spinal surgery remains controversial due to the frequent difficulty in commencing post-operative pharmacological venous thromboprophylaxis12. A specific trial designed to quantify the risk of thromboembolic complications post TA administration in primary THR and TKR was published in 201313. This demonstrated a low risk of thromboembolic complications with rates of symptomatic DVT in three groups of patients given TA co-administered with aspirin, warfarin and dalteparin found to be 0.35%, 0.15% and 0.52% respectively. Results for non-fatal PE were similar (0.17%, 0.43% and 0.26% respectively). Rates of deep vein thrombosis from the 2012 BMJ meta-analysis of TA in elective surgical patients even revealed a non-significant reduction [RR 0.86 (0.53-1.59) p=0.54]. Despite this it remains difficult to draw robust conclusions due to the low frequency of observed clinically significant venous thromboembolism reported in the trials and lack of systematic investigation and for this reason the same study strongly recommends further research in this area. There is no firm evidence to suggest that TA increases the risk of intra-arterial thrombosis. Although there are isolated case reports of TA causing ischaemic stroke in patients with specific genetic karyotypes14, the majority of the evidence seems to suggest that TA is safe in this context. Rates of stroke in the CRASH-2 trial were no more common in the treatment arm. Indeed rates of myocardial infarction were in fact lower (p=0.0035). Non-significant differences in intra-arterial thrombosis were reported from the 2012 BMJ meta-analysis, specifically stroke [RR 1.14 (0.65-2.00) p=0.65] and myocardial infarction [RR 0.68 (0.43-1.09) p=0.11]. Further useful data regarding the risk profile of TA is expected from the ATACAS trial evaluating the use of TA following coronary artery surgery. This is an ongoing, large, multicentre trial with rates of myocardial infarction, pulmonary embolism and stroke studied as primary end-points. Currently it remains difficult to draw robust conclusions regarding the safety of TA in orthopaedic surgery due to the low frequency of these clinically significant events.

**Dosage and Timing of Administration**

One of the major difficulties in drawing
cogent conclusions from the multitude of trials that have used TA stems from their heterogeneity, particularly the differences in dosage and timing of administration. Pfizer Product Information Documentation\textsuperscript{15} recommends doses of 15mg/kg prior to skin incision and a further dose of 15mg/kg, 8 hours later for primary THR. For TKR, a dose of 15mg/kg prior to tourniquet release followed by two 15mg/kg doses at 8 hourly intervals is advocated. Practice varies across the UK. A 2001 study examined regimes for TA administration in TKR\textsuperscript{16}. A total of 99 patients were split into four groups comprising a control group, a group given 20mg/kg TA 10 minutes prior to surgery, a group given 20mg/kg ten minutes before tourniquet deflation and a final group given both doses of TA. All groups receiving TA were observed to have significant reductions in blood loss and transfusion requirements compared to the control group. The group given pre-operative and intra-operative TA performed best with a statistically significant reductions in blood loss compared to other regimes. There were no differences in adverse events recorded between the groups. A further 2012 study compared four different intravenous treatment regimens of TA against a control group in primary TKR\textsuperscript{17}. Each treatment arm comprised 40 patients. Regimes included a single intra-operative dose, a pre-operative and an intra-operative dose, an intra-operative and post-operative dose and all three together. This found that single dose 10mg/kg TA was ineffective, failing to produce a statistically significant reduction in blood loss compared to control. A three dose regime of 10mg/kg boluses given pre-operatively, before tourniquet deflation and post-operatively produced the largest reduction in total blood loss. The minimum dose required for statistically significant blood loss reduction comprised a 10mg/kg pre-operative dose followed by a further 10mg/kg intraoperative dose. Rates of complications were not compared between groups.

In summary, the optimum dosing regimen remains uncertain together with the safety profile of some of the higher dosage schedules. The discussion regarding dosage and timing is not trivial, CRASH-2 clearly demonstrated an increase in mortality when the drug was delivered greater than 3 hours post injury.

**Conclusion**

Rigorous research has shown that TA reduces blood loss in elective surgery. Although its uptake has been relatively slow despite a wealth of evidence, its more routine use can be expected. The potential reduced blood transfusion rate is of clear benefit and may also obviate the need for routine group and save samples prior to major joint replacement surgery. There is no robust evidence that TA is associated with adverse effects in the scenario of elective joint replacement however more research is required for confirmation. In addition, precise, optimal dosing regimens remain elusive. This uncertainty should of course be weighed against the increased risk of receiving a blood transfusion and/or anaemia without TA.


3 NICE Evidence Summary: unlicenced or off label medicine. ESUOM1: Significant haemorrhage following trauma: Tranexamic acid. 16/10/2012


10 Ralley F et.al. One Intraoperative Dose of Tranexamic Acid for Patients Having Primary Hip or Knee Arthroplasty. Clinical Orthopaedics and Related Research. 2010; 468:7:1905-1911


Awake Fibreoptic Intubation – Improving the Patient Experience

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Summary

Awake fibreoptic intubation (AFOI) is an established technique for the management of a difficult or potentially difficult airway but may cause patient discomfort. In appropriate cases this can be attenuated by use of sedation [1-4]. This is a retrospective analysis of consecutive patients undergoing AFOI between 1st March 2011 and 1st May 2012 at the Royal Cornwall Hospital. Patients were identified via the online hospital record system (Galaxy). Standardized data extraction tables were used to record demographic and AFOI technical data obtained from the patient notes. This was followed by a postoperative interview or postal questionnaire using a specifically designed feedback form to elicit a detailed account of the patient’s experience. The online hospital record system identified 16 procedures over a period of fourteen months. All of the awake fibreoptic intubations were successful with a 6% (1/16) complication rate. 100% (16/16) patients received remifentanil sedation and 86% (14/16) received topicalisation. Despite this 50% (7/14) described the experience as unpleasant and 14% (2/14) would not be prepared to undergo an AFOI again.

Introduction

Awake fibreoptic intubation (AFOI) is an established technique for the management of a difficult or potentially difficult airway but may cause patient discomfort. In appropriate cases this can be attenuated by use of sedation [1-4]. Remifentanil sedation has been described in several small studies to provide good intubating conditions and high levels of patient satisfaction when used in conjunction with topical anaesthesia [1,2] Successful AFOI using remifentanil without topical anesthesia has also been described but levels of patient satisfaction were not assessed and patient numbers were small [3] This article describes a single centre retrospective analysis of patient satisfaction following elective and emergency AFOI.

Methods

This is a retrospective analysis of consecutive patients undergoing AFOI between 1st March 2011 and 1st May 2012 at the Royal Cornwall Hospital. Patients were identified via the online hospital record system...
Standardized data extraction tables were used to record demographic and AFOI technical data obtained from the patient notes. This was followed by a postoperative interview or postal questionnaire using a specifically designed feedback form to elicit a detailed account of the patient’s experience (see figure 1).

Data was presented as absolute numbers and percentage rates. For demographic data, median and ranges were used where appropriate. Any missing data or loss to follow up was recorded and presented with the results. Since the study represented retrospective follow up of a single intervention no specific statistical tests were applied.

Results

Demographics

Sixteen patients had an AFOI during the analysed period. 81% (13/16) were elective and 19% (3/16) emergency cases. Two patients did not return the questionnaire. All patients were included in the analysis of technical data but only the 14 patients who returned their questionnaires were included in the analysis of patient satisfaction. The median age of the patients was 61 years (34-75) Further demographic data is shown in table 1.

<table>
<thead>
<tr>
<th>Table 1 Characteristics of patients undergoing awake fibreoptic intubation</th>
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<td>Demographic</td>
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Values are median (range) or number (percentage)

Sedation

100% (16/16) of patients received remifentanil sedation. 38% (6/16) of patients also received midazolam. The airway was topically anaesthetized in 88% (14/16) of patients. The topical agents used included 4% lignocaine, cophenylcaine, instillagel, cocaine and 1/200,000 adrenaline/lignocaine mix.

Route

75% (12/16) of the intubations were nasal and 19% (3/16) were oral. In 6% (1/16) the route was not recorded. No cricothyroid punctures were performed.

Outcome

There was a 100% success rate in tracheal intubation. The only complication
recorded was bleeding from oedematous friable tissue in a patient who had received radiotherapy to his neck.

**Patient Preparation**

93% (13/14) of patients received verbal information about the procedure and 7% (1/14) received written information. 71% (10/14) felt the information given had prepared them adequately for the procedure. 29% (4/14) felt extra information would have been helpful. Of these four patients, 75% (3/4) would have liked to know about the unpleasant taste of the lignocaine topicalisation. Only 86% (12/14) of patients understood why the procedure was necessary.

**Patient Experience**

50% (7/14) of the patients found the awake fibreoptic intubation unpleasant, citing the taste of the lignocaine spray, a choking sensation, nasal pain and shortness of breath as reasons. 14% (2/14) felt the procedure would not be acceptable to them again.

**Discussion**

Awake fibreoptic intubation is an unusual procedure at the Royal Cornwall Hospital. The online hospital record system identified only 16 procedures over a period of fourteen months. All of the awake fibreoptic intubations were successful with a low complication rate (6%). To try and attenuate patient discomfort 100% (16/16) patients received remifentanil sedation and 86% (14/16) received topicalisation. Despite this, 50% (7/14) described the experience as unpleasant and 14% (2/14) would not be prepared to undergo an AFOI again.

The small case numbers of patients undergoing AFOI is surprising. It is possible that some awake fibreoptic intubations were missed due to a failure of accurate inputting of data into the record system by anaesthetic staff.

In the 16 cases identified, detailed information on the method of topicalisation, dose of sedation used and level of sedation achieved were not routinely and clearly recorded in the patient notes. Limited documentation of the procedure hindered data collection meaning we were unable to relate patient satisfaction levels with remifentanil dosage, level of sedation and mode of topicalisation.

The pre procedural preparation of the patient was diverse and only 7% (1/14) received formal written information. The content of verbal information was not assessed but 36% (5/14) thought pre operative written information would be helpful and 14% (2/14) thought an informative video about the procedure would be helpful. In particular patients wanted to be warned about the unpleasant bitterness of topical anaesthetic agents. It is possible that improved pre operative patient preparation could improve overall patient satisfaction with the procedure.

Adequate sedation and effective topicalisation are required to ensure a comfortable awake fibreoptic intubation. Complaints of nasal pain may suggest inadequate topicalisation whilst complaints of choking and shortness of breath may suggest an inadequate level of sedation. Given the small numbers of awake fibreoptic intubations performed a clinical guideline may supplement
individual clinician expertise in optimizing topicalisation and ensuring an appropriate sedation level.

There are several limitations to this study. This was an observational study with limited number of subjects and incomplete data collection. A non validated patient satisfaction questionnaire was used.

Following the survey the Royal Cornwall Hospital has taken measures to try and improve the patient experience of an awake fibreoptic intubation. A patient information leaflet has been developed to improve pre-operative patient understanding of the procedure (Appendix 1). A departmentally agreed recommendation for topicalisation of the airway and sedation has been attached to all difficult airway trolleys in the trust (Appendix 2) and a tick box sticker designed to allow rapid detailed documentation of the procedure including topicalisation, sedation, approach and complications has been introduced.

It is hoped that the introduction of these simple measures will improve patient satisfaction and clinician confidence with the procedure of awake fibreoptic intubation.

Acknowledgments
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Competing Interests
No external funding and no competing interests declared

References


What is awake fibreoptic intubation?
An awake fibreoptic intubation means having a breathing tube passed whilst you are still awake. A flexible telescope is used to look down your nose, through your throat and into your windpipe.

What are the benefits?
An awake fibreoptic intubation is done only when absolutely required to ensure your safety whilst enabling general anaesthesia. It may not be possible to have the operation safely without an awake fibreoptic intubation.

Are there any risks?
All procedures carry some risk. For awake fibreoptic intubation, possible risks include:
- discomfort during the procedure including the bitter taste of the local anaesthetic, coughing and a panicky feeling as the tube is passed
- nose bleed
- sore throat
- damage to your teeth and vocal cords – this is uncommon.

Are there any alternatives?
Sometimes it is possible to avoid general anaesthetic and have an operation awake, using local anaesthetic to numb the site being operated on. This is more feasible for minor surgery and surgery to the lower part of your body.

What happens afterwards?
The tube is removed at the end of the operation when you are still sleepy. You may remember this happening. No follow up appointment is required with the anaesthetist.

Who needs an awake fibreoptic intubation?
If the anaesthetist is concerned that a breathing tube may be hard to pass they may recommend an awake fibreoptic intubation. A breathing tube may be difficult to pass if you:
- have had radiotherapy to the head or neck
- are unable to open your mouth or move your neck due to arthritis, cervical spine fractures or jaw fractures.
- have swelling to the tissues of the mouth and throat.
- have anatomical variations which may make passing a tube difficult.

What does the procedure involve?
1. An anaesthetist will come and see you before your operation and ask you questions about your general health. They will give you a medication to take which makes your mouth dry. This makes it easier to see with the telescope.
2. In the anaesthetic room a nurse will put on a blood pressure cuff, a heart tracing and a peg on your finger, which monitors your oxygen level. The anaesthetist will then put a drip in the back of your hand. The anaesthetist will then numb your mouth and throat to make the procedure more comfortable. This is achieved by spraying local anaesthetic up your nose and into your mouth. The local anaesthetic is very bitter and tastes unpleasant.
3. When the anaesthetist is happy they may be able to give you a sedative agent through the drip. This will make you feel calm, relaxed and sleepy. It is not possible for all patients to have sedation and your anaesthetist will explain what they are planning to do and why.
4. When you are comfortable the anaesthetist passes a narrow flexible telescope through your nose into your windpipe. More local anaesthetic will be sprayed down the telescope onto your voicebox. This may make you cough slightly.
5. Next the breathing tube is passed over the telescope into your windpipe. As the breathing tube passes through your nose, you may experience discomfort and you may cough as it passes into your windpipe.
6. Whilst the anaesthetist is confirming the tube is in your windpipe you may find it hard to breathe and some people feel panicky. This lasts only a few seconds before the anaesthetist drifts you off to sleep.

Further information
The anaesthetist who is looking after you will be able to answer any questions on the day of the operation.

Appendix 1 Patient Information Leaflet
Suggested Technique of Airway Topicalisation and Sedation for Awake Fibreoptic Intubation

This is not intended to replace your personal practice but merely to act as a suggestion/aide memoire for people who perform AFOI infrequently

Topicalisation

**Step 1**
Gargle with a 5mls of Instillagel

**Step 2**
Using MAD device apply 4mls of Xylocaine (2% lignocaine with 1/200,000 adrenaline) to the nose and nasopharynx

Using MAD device apply further 2mls Xylocaine (2% lignocaine with 1/200,000 adrenaline) to oropharynx

**Step 3**
Apply a further 2mls of 4% lignocaine to the vocal cords through the fibreoptic scope either via epidural catheter or suction port.

This equates to a total of 200mg of lignocaine, which is a safe dose for a 70kg patient.

Sedation

- Remifentanil should be used as a single agent using a target controlled infusion on the Minto model aiming for an effect site concentration of 3-6ng/ml.
- Aim of sedation is to have a patient who is relaxed and calm but still able to obey commands.
- Give supplemental oxygen 4l/min via the other nasal passage.

Alison Moore
Deborah Sanders
May 2013

Appendix 2  Laminated recipe for topicalisation and sedation present on all difficult airway trolleys
**Figure 1** Postal Questionnaire

**Patient Survey Following Awake Fibre-optic Intubation**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>What reason was given for you needing this procedure?</td>
<td>Patient safety, Staff training, Other</td>
</tr>
<tr>
<td>Did you understand why this was necessary?</td>
<td>Yes, No, Not sure</td>
</tr>
<tr>
<td>Did the information given before prepare you for the procedure?</td>
<td>Yes, No, Not sure</td>
</tr>
<tr>
<td>What information were you given?</td>
<td>Information leaflet, Verbal information, None</td>
</tr>
<tr>
<td>Is there anything you wished you had known before?</td>
<td>Yes, No, Not sure</td>
</tr>
<tr>
<td>If so what would you have wanted to know?</td>
<td></td>
</tr>
<tr>
<td>Was there anything you found unpleasant or concerning?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Local anaesthetic spray, Coughing, The telescope</td>
<td>Difficulty breathing, passing the tube, Other....</td>
</tr>
<tr>
<td>What words best describe how you felt during the procedure?</td>
<td>Calm, Out of control, Short of breath, Distressed, Anxious, Uncomfortable, Pain, Panic, Relaxed, Sore, Comfortable, Other......</td>
</tr>
<tr>
<td>Was everything explained to you to your satisfaction during the procedure?</td>
<td>Yes, No, Not sure</td>
</tr>
<tr>
<td>If no what would you have liked to know?</td>
<td></td>
</tr>
<tr>
<td>Would an awake fibreoptic intubation be acceptable to you next time?</td>
<td>Yes, No, Not sure</td>
</tr>
<tr>
<td>If not why not?</td>
<td></td>
</tr>
<tr>
<td>Is there anything you think should be emphasized to patients having an awake fibreoptic intubation?</td>
<td></td>
</tr>
<tr>
<td>Would written information on the day be helpful?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Would a short video on the day of surgery be helpful?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Any other comments?</td>
<td></td>
</tr>
</tbody>
</table>
The Wine Column

Tom Perris

Sometimes, in fact more often than not, I have to scratch around for a subject with which to regale my readers. This time, it has dropped serendipitously into my brain from a combination of an invite to a recent Spanish tasting, and a Paella and Rioja fuelled carbo-loading session around last weeks’ Cheltenham half marathon. No I wasn’t running, obviously given the amount of Rioja I was consuming, but I was there supporting my neighbours who were.

Anyway, the wines of Spain (amongst the world’s largest producers) aren’t exactly unknown but knowledge of them is limited by many to Sherry alone. I’m not proposing to discuss Sherry today as, with the exception of the super-sweet and monumentally delicious Pedro Ximenez, I don’t much care for it. Deeply unfashionable to admit, I realise, but I know my own tastes by now.

So what else is there? Well, quite a lot as it happens. Spain is a pretty big place with an extraordinary variety of climate and geography from the cool, mountainous region of Galicia on the North Atlantic coast which receives more rain than Scotland to the arid slopes of Toro and Ribera del Duero where daytime temperatures exceed 45 Celsius in summer and it’s dryer than a teetotaller’s tea party.

The most famous regions for red wines and justifiably so are Rioja and Ribera del Duero. Rioja has been making wine for centuries but benefitted in the mid-19th century from an influx of French wine merchants who, stricken by the vine disease Phylloxera in their own vineyards, brought investment, expertise and an export market. Their influence persists even now, as they were the ones to introduce the use of oak barrels (French, naturally) for wine aging. The classic flavour of Rioja is still heavily overlaid with oak but these days, the barrels are more likely to come from California or Russia and the more modern style of lighter, fruitier wines is gaining more influence. Could this be because barrels are rather expensive and Spain is somewhat short on cash? Certainly, many wineries that opened after the removal of restrictions following the death of General Franco in1975 are now closing through lack of funds.

You can choose the level of oak flavour which best suits your palate with a little knowledge of the rules concerning aging. Crianza (meaning “aged”) has to spend a year in a barrel and a year in a bottle before it’s sold to you. Long enough to develop some of those silky, vanilla flavours. A Reserva has also had a year’s barrel age but 2 in bottle and should be more complex, fuller and often some of Spain’s best wine. The top category of “Gran Reserva” is usually made in the best vintages and has enough fruit to benefit from 2 years in a barrel and 3 in bottle prior to release. Of course, they don’t have to use new barrels (which saves expense) and an old one will impart hardly any flavour so you’ll need to get to know which particular Bodega produces the style you
like. 2005 and 2008 vintages of the better wines are appearing now and are textbook examples for your enjoyment.

Ribera del Duero, sited South West of Rioja on the upper reaches of the Duero river on its way to Portugal is the rising star of Spanish wine producing dark, fresh, intense wines of power and concentration (usually 14.5% alcohol) from the indigenous Tinto Fino grape (known as Tempranillo elsewhere in Spain). It is the home of probably Spain’s greatest red wine, Vega Sicilia (nothing to do with Sicily, it comes from the name of the farm where it’s grown). It’s mixed with a fair lump of Cabernet Sauvignon these days and no longer spends 10 years in oak developing flavour – merely 6 or 7 but remains and extraordinary, complex powerful wine and is not to everybody’s taste which is probably just as well. They only make a few thousand cases a year and it retails for upwards of £200 a bottle. Even the king of Spain only gets a few cases a year! I’ve tried it, I liked it, I’m not expecting to get the chance again in this lifetime. Happily, there are many other lip-smacking examples around on the shelves of your local supplier at far more reasonable prices. As in Rioja, there is a quality classification based on a similar aging system and prices reflect that. However, for my money they are generally better value than the Riojas. Neither is so costly as to discourage experimentation though! If price is a consideration, however, the neighbouring regions of Navarre and Toro make similarly satisfying, fruity wines at distinctly lower prices.

The white wines of Spain are another story, all of their own. There has been an explosion of planting of international varieties (some not bad Sauvignon and very decent Chardonnay) but the real excitement lies in the indigenous grape varieties. There are lots of these, but the ones who’ve impressed my taste buds the most are Albarino and Verdejo. The latter is usually, a crisp fruity wine that partners seafood well and is refreshing on a hot summer’s day. Albarino, however, is altogether much classier, resembling a burlier version of Viognier with a baked apple flavour and creaminess in the mouth that I find very appealing. It also ages to a more complex, golden wine with a petrol character reminiscent of Riesling.

**Perris’s Picks**


*An robust, rustic style with chunky fruit flavours. Discounted currently at my local store, it would go well with barbequed lamb. Shame I’ve just put the Barbie away for the winter.*

Rioja Reserva 2008 Lagunilla. Majestic and elsewhere. £8-10

*Classic stuff.*

Pazo Senorans Albarino, Rias Baixas 2011. Wine Society. £11.95

*Gorgeous peachy flavours with a little flinty minerality to keep it honest. Not cheap, but worth every penny, I believe.*
The Way We Were
Yeovil 1980’s

Up on the top floor
of the women’s hospital was where
I gave the first GA
in the brand new Gynae theatre.

It was Zakki’s Monday list.
as far as I know
the only anaesthetic room
with a round window.

He liked to have
some soothing music on.
That theme from the Titanic
with Celine Dion…

Thursdays, Nick, ENT surgeon
came up from Dorchester first light.
Kids in their mothers’ arms;
ODA Mo always got the tube size right.

Lunchtime, list done
Nick and I, for recuperation
would head off to the buffet
in the local railway station.

Thursdays, general surgery with David.
Incisions precise, sutures neatly in line.
I remember him once saying
‘skin is beautiful  tattoos a crime’.

Fridays, wards and ICU.
Weekend you couldn’t stray too far.
Surgeons, gods, and mobile phones
know where you are.

Except those wild ATLS weekends
the other side of somewhere,
organised by Peter,
premedication Irish beer.

Robin Forward
The Ross Davis Adventure Bursary

Available for exciting endeavours in anaesthesia!

Up to £1000 to be awarded annually
Open to trainees in anaesthesia 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 2014

Well-rounded CVs essential!

Further information available from:
www.rosswindsurf.co.uk
www.saswr.org.uk
Cartoon

Evading the Rozzers

Guy Rousseau- Barnstaple
CROSSWORD
Brian Perriss

CLUES ACROSS
1. Instrument for picking up the beat (11)
9. Lemon rent to bits needs joining up. (9)
10. Bill free from pungent smell. (5)
11. Stick the poster in this spot. (6)
12. Lecturer gives talk of no practical importance. (8)
13. Operation on toy becomes shapeless lump. (6)
15. Anonymous but strangely less mean. (8)
18. Arthur is to attempt some painting. (8)
19. Add a rider, minus nine. (6)
21. Ride a horse without a shirt on. (8)
23. Starts as a girl, ends as a girl, a girl all over. (6)
26. Moon over thing in bronze box. (5)
27. The home of Eric Steel, apparently. (9)
28. The French nob’s side goes ballistic. (3,3,5)

CLUES DOWN
1. Race official in agitated state on a road. (7)
2. On Thursday, listen before going to ground. (5)
3. Amusing to greet French lady with debts. (9)
4. In distress over a dish. (4)
5. He can see you through the week. (8)
6. Antelope from Spain? (5)
7. At home, chop up the lists. (7)
8. Prime minister makes a point on initial showing. (8)
14. Arty types from sunlit era timidly reappear. (8)
16. Cook and drake for instance, for the scouts. (9)
17. Two allowed to have trinket. (8)
18. Judge a different rare bit. (7)
20. Plan to help back in Greece, at a push. (7)
22. Forbid gangster. How trivial! (5)
24. Inert explosive. (5)
25. Barney’s disagreement. (4)

Solution to Crossword in Winter 2012 APW

MYOPIA
ARTESIANS
ARCH
HEL

WHEELCHAIR
S T O N

C O N C E R T O
T Y P I S T

R D L T
T

MINI
ILLINOIS
N D C E O C

I D L E N E S S
F A S T

O C T T
R

ANGORA
EMINENCE
EN T E

ISIS
TROUBADOR
IE I O N

BATTERED
TOMATO

54
Prizes and Bursaries

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

The SASWR Intersurgical Trainee Prize
This prize of £1000 is awarded annually at the November Scientific Meeting of the society. Entries of up to 2000 words maximum in the form of an essay or short paper on any topic related to anaesthesia, intensive care or pain medicine should be submitted electronically to the Honorary Secretary of the Society (honsec@saswr.org), by 30th September each year. The three best entries will be presented orally 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 enter the poster prize at the meeting. Please note that you must be registered for the meeting in order to present your work, and you may not enter both this and the poster prize.

SASWR Poster Prize
The Spring and Autumn scientific meetings will have a poster prize of £250 awarded to the best poster presentation. To enter, submit your work as an abstract or poster to the Honorary Secretary (honsec@saswr.org) by 30th September each year for the Autumn meeting and 31st March for the Spring meeting. You will need to be registered for the meeting and be able to present your poster to the judges during coffee.

The Ross Davis Adventure Bursary
Annual awards totaling £1000 in memory of Dr Ross Davis, are presented 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 can be found at www.rosswindsurf.co.uk and applications should be directed to the Honorary Secretary of SASWR (honsec@saswr.org) 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 cash bursary is awarded to any member of the society to support a ‘mission abroad’. Applications, to the Honorary Secretary of SASWR (honsec@saswr.org), are welcomed throughout the year.
Notice to Contributors

All articles should be sent by email to the editor (see below for address). 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. Please ensure that references are complete and correctly punctuated in the required style. The approved abbreviations will be used for journal titles. Photographs should be sent as separate attachments.

The deadline for submissions is usually 10 weeks before the next 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. If an article has been previously published elsewhere, permission to use the material should be sought from the editors of that journal before submission to Anaesthesia Points West. Submissions will be acknowledged on receipt and notice of acceptance/rejection/need for corrections will be sent as promptly as possible.

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**Assistant editor**
Post currently unfilled. The assistant editor holds the role for usually two years, before stepping up to the position of Editor. If interested, please contact the current editor.