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## ANAESTHESIA POINTS WEST

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It is always a relief to get an edition of Anaesthesia Points West to press. As a point of note for other Editors, don’t go away to Nepal for the week of proof reading. It does make life a little stressful!

This issue of Anaesthesia Points West contains the usual wide array of interesting articles. In particular, this edition provides us with an opportunity to celebrate the impressive lives of several colleagues who have sadly passed away in the last six months. Their obituaries speak for themselves and I am sure that all members of our society will join me in commiserating with their respective family and friends. On a happier note it is a great honour for our speciality to have a Knight to lead us in difficult times. Congratulations to Sir Peter Simpson. A just reward for the huge amount of work he has undertaken for our speciality in the last decade.

The future remains uncertain for anyone who works in the National Health Service, especially for trainee anaesthetists. Although unclear what was actually wrong with the ‘old’ system, Modernising Medical Careers (MMC) is now upon us. A more streamlined and structured training will be an improvement, particularly for the ‘lost tribe’ of Senior House Officers, if they can be found! However, the preparation prior to introducing MMC is considerable and there are many loose ends yet to tie up. Regional Advisors, Training Programme Directors and College Tutors are trying to make MMC work but it is not without difficulties. Running a national application and selection process is going to be a challenge and while it works for eighteen year-old school leavers, is less suitable for qualified professionals, often with families and significant responsibilities. Whatever happens, by the next issue of Anaesthesia Points West selection will have occurred and for some the waters will be clearing. I am sure the situation will work itself out, but this time it maybe to the advantage of the Australasian Health Care System which is gladly recruiting excellent disillusioned UK medics.

There are two reports in this issue from South-West Anaesthetists who recently worked in the developing world. We are lucky to be in a speciality that travels well and can really make a difference in so many countries. The opportunities seem to grow and grow and the rewards for taking up the challenge are considerable.

I must again thank the regular contributors for their time and stimulating articles and apologise to Janine Mendham and Steve Coniam for an error that appeared in the book review section of the Spring 2006 edition. After putting so much time and effort into a book it is understandably very disappointing when one of the Authors names is omitted. Finally, this is Nicky Williams last edition as Assistant Editor of Anaesthesia Points West. She has been a great help to me and dedicated considerable time and effort to the Society over the last six years. In her place I warmly welcome Fiona Donald to the editorial team and we will strive to keep the standards up!

James Pittman
Exeter
Future Meetings of the Society

Spring 2007
Budapest 9th-12th May

Autumn 2007
Diamond Jubilee, Bristol 21st-23rd November

Spring 2008
Plymouth/Guernsey

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Society of Anaesthetists of the South West Region – Abbott Prize

REGISTRAR PRIZE: £1,000

Entries in the form of an essay of about 2000 words on any topic related to Anaesthesia and Intensive Care to be submitted to the Hon. Secretary, Dr P. McAteer, Bath (by the end July 2007). The Winning entry will be presented at the next meeting of the Society.

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Society of Anaesthetists of the South West Region

ODA/NURSE PRIZE: £500

Entries in the form of an essay of about 2000 words on any topic related to Anaesthesia and Intensive Care to be submitted to the Hon. Secretary, Dr P. McAteer, Bath by end July 2007. Winning entry to be published in the next edition of Anaesthesia Points West
Obituary of John Stanley Mornington Zorab

John Zorab was born on 16th January 1929 into a strong medical family, all of his five brothers going into medicine or dentistry. John was the youngest and the last survivor of his generation. He was educated at Cheltenham College, and then read medicine at Guys, qualifying MRCS LRCP in 1957.

By all accounts he had moments of considerable non-conformity at medical school. In cahoots with his mother, he made some printed note paper purporting to come from the Countess Schleswig-Holstein announcing that the Countess would be attending the final of the Hospitals Rugby Cup and would be pleased to be looked after in suitable fashion. There was much fussing about in the higher echelons and the Dean, the Vice Chancellor and the Lord Mayor all turned out. The Countess (alias John’s mother) turned up looking very regal in a Rolls Royce hired by John and was danced attendance upon by the sycophants. He never really had the heart to tell them.

He married Shirley in 1953 and their marriage was to prove a great and lasting success for them both for over 50 years. He trained in anaesthesia at Guys, Westminster and Southampton, under Sir Geoffrey Organe and Cyril Scurr from the Westminster, Phillip Helliwell from Guys and Patrick Shackleton from Southampton, obtaining his FFARCS (now FRCA) in 1962.

John was appointed to his consultant post at Frenchay in mid 1966 where he met Peter Baskett who became a lifelong friend and colleague. Working together and with Tom Wilton, they created an anaesthetic department with a national and international reputation for innovation and clinical excellence, but above all friendliness. Numerous anaesthetists both in the UK and around the world bear testimony to this.

John was a clear thinker, a diplomat and a formidable achiever. Together with Peter Baskett he set up the ICU at Frenchay, obtained a one-man hyperbaric chamber for treating coal gas poisoning and wrote a book on Immediate Care.

He was also responsible for setting up the courses for the anaesthetic Fellowship across Bristol and stimulating the building of the hospital’s Postgraduate Medical Centre, which became a model across the UK. He helped to found the European Academy of Anaesthesia and the European Diploma in Anaesthesiology and Intensive Care, a truly multilingual exam which has been running for 22 years and attracts over 1000 candidates annually.

He went to Vietnam for 6 months to help clear up the aftermath of the ravages of war and set up, with Roger Eltringham, a programme for helping anaesthesiologists in developing countries.

John soon found himself on the Council of the Association of Anaesthetists and on the Board of the Faculty of Anaesthetists of the Royal College of Surgeons. He became Honorary Secretary of the Association and set about organising their annual meetings professionally, the blueprint of which remains to this day. By this time John was also developing an interest in anaesthesia both in Europe and worldwide. In 1982 he was the Secretary General of the European Congress held in London. He and Shirley were soon spotted as being a great talent and team and he rapidly rose to be President of the European Section and later President of the World Federation of Societies of Anaesthesiology. Together they attended every meeting until 2002.
He was President of the Society of Anaesthetists of the South West Region in 1990-91 and had Honorary Membership conferred just after his retirement.

In his latter years he became involved in hospital management at Frenchay, alongside Anne Lloyd, the Chief Executive. He was so effective in his initial appointment as Clinical Director for Anaesthesia and Intensive Care that the surgeons, who could not decide which of their number to choose, all agreed to ask John to become their Clinical Director and represent them too, being someone whom they could trust with their interests. So did the Emergency Department.

It was only natural that he should become Medical Director and he stayed on for two years after his retirement at 65 to fulfil this. Although he was his own man and never taken over by the system, Anne Lloyd respected this, and together with John Bradshaw, their management team was arguably the best Frenchay could have had.

After retirement he plunged himself into studying the history of medicine, and at 76 he took and passed the History of Medicine Diploma of the Society of Apothecaries (DHMSA). He also wrote numerous letters to the medical press deploring the standard of dress amongst some of the profession. He would exhort all doctors to smarten up a bit and wear a tie and a jacket when they saw a patient. He also said that being a doctor was a privilege and you worked until the job was done. The European Working Time Directive would never have concerned him and he always practiced what he preached.

Polite, always well dressed – with an old school or college tie and a handkerchief in his top pocket, he was very, very English. Very genial. He would say “I like to meet people, because with a name like mine they might think I was a foreigner”.

He was both tolerant and intolerant. Tolerant and helpful to the under dog. The friend of the timid SHO or nurse who had got into trouble. Tolerant and helpful to the overseas doctor from anywhere in the world, who needed access to a journal, a job opportunity, or some equipment.

Intolerant of arrogance, bullying and unfairness. Intolerant of the suppression of the young and the worthy. Intolerant of a lowering of professional standards. He was not very good at taking orders if he did not think it was a good idea. He never liked the practice of wearing a disposable hat in the operating theatre, preferring a bright red sun hat with “Acapulco” written on it.

Poor John had much more than his fair share of illness and pain. He bore everything with remarkable courage and fortitude and seemed to defy the laws of medicine on many occasions. He was also a deeply religious man, but never discussed this in depth, believing it was essentially a private matter.

John’s was devoted to his wife Shirley, to his family of four children and, latterly, his grandchildren. He and Shirley clearly had a deep love for each other – both thought constantly of how to help and please the other. They were a great couple together and are remembered fondly to this day in virtually every country in the world.

John Zorab made a major contribution to anaesthesia and intensive care both in the UK, in Europe and worldwide. Numerous friends and colleagues have been truly saddened by the news of his death, but he and the principles and standards he stood for will certainly not be forgotten. Many have reason to be grateful for John Zorab’s influence and wise advice at some stage of their career and we rejoice that we had the privilege to know him.

Peter Baskett
Peter Simpson
John Carter
Obituary of Ross Martin Davis
MBChB, MRCS, FRCA

On June 13th 2006, all of us were shocked and saddened to learn of the sudden, tragic accident that claimed the life of Ross Davis. Many of you knew Ross personally, having met him or worked with him at some point in the South West. He had been based in Plymouth for the last 18 months and was living with his long-term partner Kate Holmes, a fellow anaesthetist. For those of you who did not have the privilege of knowing him, he was well known for his dedication, generosity of spirit, great sense of humor and above all his fantastic zest for life.

I’ve known Ross since we first met over 15 years ago at Bristol Medical School and I have the honor of calling him my best friend. At university he was always known for his cheeky grin, fun-loving attitude and general out-going nature. Ross thoroughly enjoyed his time at university and graduated near the top of the year. He excelled at all aspects of university life, throwing himself into the academic, social and sporting sides of life with his trademark unbridled enthusiasm. Ross had many fine moments at university but his proudest was being voted “Torso of the Year”.

After graduating in 1996, with the exception of the year that he and Kate spent in Perth, Australia, Ross has always lived and worked in the South West. He dabbled in a number of specialties including surgery, ENT, and A&E before discovering his true calling in anaesthetics. Ross was an excellent anaesthetist and displayed his vitality and commitment in all areas of his job. He enjoyed the variety and responsibility anaesthetics gave him and displayed his dedication by passing both his primary and final FRCA first time. He was well known for his enthusiasm in teaching junior doctors and took great pride in his role in their apprenticeship. He willingly shared his knowledge and experience to encourage and inspire the next generation of doctors. He was often known to have come to work early or stayed behind late to give the SHOs an impromptu teaching or viva session. He was universally liked and respected wherever he worked and is remembered fondly by trainees and consultants alike. He brought energy, compassion, integrity and a very necessary sense of humor to a physically and emotionally taxing job. In anaesthetics, he had finally found a specialty that allowed him to display his many talents as well as allowing him the freedom to pursue his outdoor exploits and I know he absolutely loved his work.

Another great love of his was sport. He was a keen sportsman and played cricket and hockey for his school, as well as playing water polo for a national team and at university. In recent years he had developed a deep passion for the outdoor life. Windsurfing, mountain biking, surfing, skiing, climbing, snowboarding; he loved all these sports and many more and he attacked each and every one with great enthusiasm and gusto. His competitive spirit made him excel at everything as he always put 100% effort into whatever he had turned his mind to. He delighted in spending time in the outdoors; be it a quick afternoon sail before an evening shift or a weeklong skiing odyssey with the boys. His love for
the outdoors was infectious, with everyone around him swept away by his zeal and happiness. He could often be found chatting merrily in a coffee room discussing the wind, weather and waves, with his mischievous grin and boyish charm. For Ross, growing old was inevitable but growing up was optional.

Ross’s greatest love was, of course, his family and Kate. He was very close to his parents, Peter and Min, as well as his younger sister, Angie. He called them several times a week to fill them in on his latest exploits, get advice or simply just to chat. They are all extremely proud of his many achievements and the man he had become. Ross was thrilled to have made a home in Plymouth for himself and Kate and there was always a warm welcome to all who visited. Ross’s love for Kate was evident to all who knew them and he delighted in looking after her. He was always loving and generous and it was the little things he did that made him so special to her. Ross was proud of Kate for so many reasons, most recently for getting her number, which meant they could finally work closer together. Ross and Kate completely adored each other and had made many plans for their future life together.

Ross was the most kind, gentle and genuinely happy person you could ever know. Despite his many successes, he remained grounded, modest and ego-less throughout. His overwhelming positive outlook on life and ‘carpe diem’ attitude was an inspiration. Ross would always encourage others to realize their greater potential and to push themselves beyond their limits, be it at sports or at work. He made friends effortlessly, with his easygoing nature, charisma and great sense of humour. He was generous and thoughtful and could always raise your spirits when you were worried or anxious, making the dull moments sparkle with his energy and vigor.

For Ross, every single day was an adventure, a day to be savoured. Over the last few months, we have been truly touched by the love and support given to Kate and his family. The genuine feeling of loss and the sentiments expressed by family, friends and colleagues have been overwhelming. The world is a poorer place without him.

Ross was a loyal, honest and true friend. He was a unique and extraordinary individual and even though he is gone, the burning passion he had for life will never be extinguished from our hearts and our minds.

Vikram Vijayan
www.rosswindsurf.co.uk
Knighthood – Sir Peter Simpson

Sir Peter Simpson received a knighthood in Her Majesty The Queen’s 80th Birthday Honours, as President of the Royal College of Anaesthetists, in recognition of his services to the NHS.

This well-deserved honour is the culmination of a brilliant career in which, in addition to a full-time NHS consultant appointment, he has held numerous other posts including Medical Director of Frenchay Hospital, Chairman of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), Deputy Chairman Postgraduate Medical Education and Training Board (PMETB), Vice-Chairman of the Specialist Training Authority (STA), Chairman of the Examinations Committee of the European Society of Anaesthesiology and is the current President of the European Society of Anaesthesiology. During his time as President of the Royal College of Anaesthetists the College purchased and developed the new premises in Churchill House, taking our specialty firmly into the 21st Century.

Peter’s natural diplomacy and leadership skills are legendary, and he has tackled and resolved many major issues that others have chosen to sidestep or ignore. Always respected and popular in equal measure, now despite his elevated status and busy workload he remains totally approachable by all staff and will always take time to offer advice and to teach trainees.

In his truly modest fashion, Peter describes his knighthood as an honour for the specialty of Anaesthesia. Whilst it is satisfying for our specialty and our Society to bask in this reflected glory, one should not take for granted the incredible amount of work and time that Peter has given to medicine.

The Society congratulates Sir Peter on this most well-deserved honour.
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 (and from our member in ‘exile’ in New Zealand). The name of the correspondent appears at the end of each contribution and he/she is also the SASWR LINKMAN for that department. Anyone wishing to find out more about SASWR or wishing to join should search out the local linkman who will readily supply details and an application form. In addition to other benefits, members receive the twice yearly editions of APW – FREE!

Bath
The last few months at the RUH have been busy, as everywhere I expect. We have been trying very hard indeed to save the money that we have overspent from a budget that was pretty much made up in the first place. This has involved belt tightening which for a few has meant the loss of jobs; in the Department of Anaesthesia it has at least not gone that far. However, consultant hours have been reduced. This was intended to accompany a reduction in theatre workload, but that commitment went out of the window the second week when the hospital remembered waiting time limits. We all wait with interest to see how events play out. Maybe we will be back on full hours very soon.

The department is meanwhile building an airway teaching lab to house medical students and SHOs when they cause trouble in theatres. After an incredibly nail-biting wait, during which nobody knew if it really would happen or not, it is almost ready. Unfortunately we are no longer allowed to use the medical students themselves as the teaching material, so we have also had to buy a lot of expensive kit to go in the room with them.

We have also undergone reorganisation of a different sort – the trainees are finally being wrenched onto 1A rotas, by hook or by crook. This has not been as harmonious as the naïve reader might imagine, since working patterns are being altered like it or not, and since less money will follow. Of course trainees are flying off at all angles at the moment desperate to ensure they get a training number so the instant we think we have a compliant rota we also get a resignation and the crisis of adverts, interviews, and appointments in time to plug the rota gaps. Still, it is at least interesting times again.

We have had an excellent group of trainees over the last few months. Sarah Love-Jones and Charlotte Steeds/Yeli Horswill as joint Pain Fellows caused confusion by the sheer weight of names alone, but provided excellent support to our Clinics and are already sorely missed. We were lucky enough to have RAF officer Curtis Whittle as senior SpR and hope he will return to us after a year of flying planes around Australia. Kathryn Jackson provided a superb job in trying to sort out the compliant rota issue before handing over and heading back to Bristol. Rachel Alexander and Nirosha de Zoysa were much appreciated and hopefully are settling well into their next role in the BRI and as mother at home respectively. We were really sorry to see Clinical Fellow Michael Clarke, and SHOs Chris Green, Dom Janssen, John McGrath, and Ruth Murphy head off to pastures newer and greener. Our new intake of SpRs James Armstrong, Neil Muchatuta, Mark Knights, Ben Gibbison, Clinical Fellows Saad Anis, Rajesh Srivastava, and SHOs Mel Bloor, Kate Brunton, Abi Eyre Brook and Nicky Jones are already doing sterling work, and by this time next year we will look back on these times as full of wonderful resources and easy rota drafting.

Finally, our organising abilities succeeded at last in holding a retirement for Alan Avery, six months after he left. Obviously we just needed to be sure he really meant it, and I have to say that I fear he did. He looked and sounded in excellent form, which was hugely encouraging as an example for those who fear the advance of retirement and wondered what they would do with all that time with no work to add structure and enhanced value to their life.

Monica Baird

Barnstaple
Amazingly it is nearly all good news from the wild and woolly shores of North Devon.

On the 30th June we officially moved into the new anaesthetic department. We had an opening ceremony and lunch attended by Basil Muir’s widow Mickie, and three generations of the Muir family, retired consultants and ODAs, several of our surgical colleagues and the “great and the good” (?)
from the Trust. Basil’s grand-daughter, Jane, did the official naming of the department, and unveiled a portrait of her grandfather – she is studying medicine and thus maintaining the family tradition. So from now on all correspondence should be addressed to the “Basil Muir Department of Anaesthesia.”

It is now possible for all members of the department to assemble at the same time without inappropriate physical intimacy and there are an adequate number of computers as well as space for tutorials, business meetings etc. It’s been a long and rocky road and our thanks go to Martin Coates for his robust support as R.E.A.

There has been a bit of action on the births and marriages front (not necessarily in that order). Rod and Lottie Lindenbaum and Juan and Tamsin Graterol have produced sons, Pip and Esteben respectively, and by the time you read this Tim Bowles will have married Louise. Our congratulations to all of them.

Two new consultants are starting this autumn, Charlie Collins, who needs no introduction to readers of this journal, and Laurie Marks, a born and bred Zimbabwean, who has finally given up on Robert Mugabe’s “utopia”. One of them is a replacement (at last) for Nick O’Donovan, the other is a new post – no one seems to know which is which.

New to the S.H.O. ranks are:- Carlen Read-Poysden, Hanlie Craven from S. Africa, (the answer for rugger-buggers is: yes, she’s his grand-daughter); Beth Sillince and Anthony Bradley. They are presumably the last SHOs we’ll appoint ourselves. Does anyone believe the new system is going to work?

It’s not all good news however, Linsey Low an invaluable member of the departmental secretariat has left and her replacement has been blocked because of the Trusts parlous financial position; thus putting extra work and stress onto Pat and Linda. Then at the start of September the secretariat were kicked out of their accommodation (“temporarily for three months” – watch this space), to house the directorate management team. All this against the background of uncertainty over the future of the hospital. The expensive “consultants” hired by the Trust to tell them how to get out of the financial mire, have suggested closing the hospital, selling the site and building a “Health Mall” on the far side of town! Happy days.

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**Cheltenham**

History is repeating itself. It’s the year 1912. The Titanic has been successfully launched with plenty of lifeboats should the survivors of other (smaller) sinking ships need rescuing and Captain Scott has made it to the South Pole proving that ponies *can* help you get part of the way there. Only looking back will we realise that, notable achievements though these were, perhaps things could have been done a bit better and that it wasn’t just bad luck that brought these ventures to a sticky end.

Perhaps the health service near you is about to encounter a similar run of ‘bad luck’ what with cutbacks, closures, efficiency drives, redundancies, rationalisation, independent sector treatment thingamajigs and Muckin’up Medical Careers? You could be right, but what the hell would I know about all that?

No, this is the year that a carefully selected team of Cheltenham theatre staff including Messrs Johnson, Rees, Stankus, Rooney, Hulatt and a Filipino back four with a sense of defensive nous unparalleled in the history of football took on a Gloucester theatres side containing both skill and anaesthetists in equal, but separate, measures. The result? Cheltenham conceded five, like Scott, and were left to perish short of One Ton Depot, while Gloucester let in four, who all made it, like Amundsen, safely back to base camp and glory. The prize for heroic failure went to our goalkeeper Simon ‘Birdie Bowers’ Forryan, who man-hauled his considerable frame into the path of countless shots from point bank range. If only we had laid a few large strategic depots across the back and had a few more big hairy dogs in our team (anyone know any that work in theatres?) things would have worked out differently.

These lessons of team selection should have been learnt a few weeks later when our ‘Titanic’ golf team set off from Cheltenham in search of victory against our Bristol anaesthetic rivals. Much fun was had by Drs Williams, Ritchie, Visser, Rees, Padoa (ex-Cheltenham SHO, now Birmingham SpR) & Westlake (Truro eye surgeon, aka Mr Sam Banks), but too many encounters with bunkers, hedges, water hazards and icebergs left us realising too late that leaving our lifeboats back home in the form of Drs Orme, Copp, Mather & McSwiney was a mistake (most were at the Association annual golf meeting up in Aberdeen at the time). We were sunk without trace.

Not that these setbacks have in any way dampened spirits in the department, which have
remained remarkably upbeat despite the losses of Caroline Price (to the Oxford SpR rotation), Rob Wise (back to South Africa), Richard Pierson (rotating on to Bath) and Sally Taylor (making the logical progression from surgical SHO to ICU SHO to drug rep.), as well as our popular and garrulous acute pain sister Debbie Elrick (to run a fruit ‘n’ veg shop). Laurence Hulatt passing the primary would have been even more of a boost but for the fact that we all knew he would do it – well done to him, and to Hannah Minor for successfully getting married – we all knew you would do it too. Bursts of morale have accompanied the arrival of acute pain sister Sophie Moran, staff grades Martina Nedjlova (from Prague via the highly-acclaimed Ravenscourt ISTC in London), Raj Shivanna and Naren Padhiyar (both from the north-west), SpRs Lucy Miller, Ann Young, Jonathan Anns and Kieron Rooney from Bristle, SHOs Claire Kaloo (from Southampton), Zeenat Bhalla (from Bromley) and David Hamilton (from Scotlund).

So alluring is the feel-good factor that after sustaining a rib fracture in the morning and spending the afternoon in casualty, Jill Dale (‘It only hurts when I breathe’) chose the healing powers of working a night shift on ITU rather than returning home in considerable pain that most would consider normal behaviour. Or maybe it was the proximity to controlled drugs.

No talk of enthusiasm would be complete without mentioning Mandy Rees (‘I’ve got a posh accent, not a Welsh accent’), who continues to organise more fun-filled consultant nights out, or Tony Burlingham, who was looking rather chirpy before he left for Queensland’s Sunshine Coast on his six month winter break.

So 1912 was a funny one, but what happens in the next year or two? Oh yes, Archduke Ferdinand gets it in the neck. That’ll be medical unemployment.

Ted Rees

Exeter
The main news from Exeter in the past few months must be the shocking reports of the untimely demise of Steve Irwin. Thanks to a careless moment in HMV a few years ago, Steve was like a family member to me – a regular in our front room, and oft quoted by the children (“Crickey, Mum”).

In comparison, all other news seems mundane. Colin has seamlessly taken over the role of CD from Teabag, and now realises that Teabag wasn’t just paranoid. It’s a thankless task, but currently there are opportunities for change in so many areas. There’s a hope and belief that we can improve CEPOD organisation, ultimately with a view to drastically reducing operating in the wee hours, and reducing the number of trainees who need to be resident over night. There will still be paper cuts that risk the viability of somebody’s dominant index finger at 3am, but we must unite to educate our surgical colleagues, and put in place the mechanisms to repair afore mentioned cuts in the daylight hours. We can do it.

In addition we are facing the uncertainty of the run through training, and the implications for staffing the department, coupled with the increasing number of post CCST trainees with no hope of finding a consultant post soon. Hmmm. Also, two of our best trainees are seriously considering a career in GP land, and 2 more are heading down under.

People are coming and going in the department, as always. Richard Seigne has returned to New Zealand, after a year here. Jo Macintyre has also left for New Zealand for a year (peace at last), with Alice Mann doing his locum. Kieran Rooney has become an Spr in Bristol, while Simon Hebard has a number in Wessex, and Paul Margetts has a LAT. Steve Fordham has returned to Casualty.

We welcome new SHOs Nickie Bosley, Ben Ivory and Chris Oscier, LAT James Ling, and PRHO Remnique Srai, and welcome back to Susie Baldwin. We also have Sally Nash, Pete Ford and Vanessa Hellwell as locum consultants. Emma Hartsilver should return from maternity leave sometime soon, and of course, Lauren is back from New Zealand.

Our trainees are clearly not busy enough, as David Pappin has managed to pass the primary, have his teeth whitened and get married within a week, and Nick Preston has similarly passed the MCQ and got married a week later (he denies whitening his teeth, so maybe it was a sunbed session). David Lacquiere has also tied the knot recently.

Babies are appearing everywhere. Congrats to Sheena Hubble, who’s old enough to know better, on the birth of Honey Rose (she knows it’s a crazy name). Congrats also to Omar, Richard Hughes and Kim Chisti on their safe arrivals, and good luck to Rachel Brown and Vanessa Hellwell for the rest of their pregnancies.

Hayley and Dave, our anaesthetic practitioners have reached the end of their training, and have only the exam standing between them and a substantive post. Well done to both of them, and good luck with the exam.
Other news – Mark Daugherty has finally moved back into his house after months of building work. Sadly, the house calendar is still in storage, so his daughters are doomed to forget about school trips for ever. I have reached a certain age (where did my twenties go?), and following a clear and vivid dream, feel the need to go running. The only difference it seems to have made to me is a sore knee and a sore ankle, but I’m sure it must be doing some good.

And finally, I send my thoughts and hugs to Kate Holmes, who’s partner Ross tragically died recently. 

Pippa Dix

Frenchay

The big news from Frenchay is that Peter Simpson, our prodigal President, has achieved the recognition he so richly deserves for his contribution to anaesthesia. Yes, in the June edition of Woman’s Weekly, between ‘Bonnie Langford; I was never a brat’ (actually, you were) and ‘It’s fun to stay at the YHA’ (no, it’s not), Peter has an entire article explaining what to expect from a general anaesthetic. OK, OK, and he received a knighthood in the Honour’s List as well. We are just a little awestruck by this achievement, but it hasn’t changed Peter at all, although having to address him as ‘Sir Peter’ takes a little getting used to. I was hoping he would be able to select a title, such as ‘Sir Peter Simpson of Bart’ (he trained at Bart’s), but apparently that is a different type of honour. He returned to Frenchay very good-naturedly, not even minding that his office had become infested with locum Consultants in his absence. We seem to have acquired a tier of de facto junior Consultant posts, although we refer to them as long-term locums. Emma Bendell has joined the paediatric team as (another) locum Consultant. It’s been so long since we appointed to a substantive Consultant post, nobody can remember who was last in. Meanwhile we continue to export good people, this time Michelle White leaving to continue her paediatric career at the Hospital for Sick Children, in Toronto. We also celebrated a significant birthday for Lynne, our longstanding office manager/secretary/confidante, by all going out to the Glassboat restaurant. Many of the blasts from the past turned up, including Peter Baskett, David Cochrane, Frank Walters and Tony Bennett. Alarmingly, they all looked rather well, suggesting that leaving the NHS is rather better for your health than working in it.

John Carter has become the only grandfather in the department, following the birth of William to his daughter Lucy. John had become rather distracted by the gestation of his new yacht, and when being asked whether ‘it’, meaning the baby, had arrived yet, would reply, ‘No, it’s not due until next summer.’ The baby, John, not the boat. Continuing the theme, James Rogers and Venetia are celebrating the safe arrival of Francesca, their second daughter. James has recently moved into a larger house, but wouldn’t divulge the cost of it, apparently due to his refined, and costly, education. He would refer obliquely to the house costing ‘x’ potatoes, with ‘y’ potatoes needing to be spent on its refurbishment. Quite frankly, I suspect that ‘z’ potatoes was wasted on his education. Not that he has a chip about the size of his garden, but on being introduced to Google Earth, James immediately discovered a cursor function which lets you measure distances, in particular the size of other people’s gardens. Oh dear.

Steve Sale makes a welcome return from Australia to take up his Consultant post, joining the happy throng of paediatric anaesthetists. Steve Coniam is due to be the next Departmental Chairman, and has relinquished the rotameister role to Jane Olday, my roomie and owner of several very expensive bikes. Frenchay always seems to attract triathletes, or worse. Matt Thomas and Will English, both registrars, recently competed in an Iron Man contest consisting of a 2.4 mile swim, 112-mile bike ride followed by a 26 mile run (i.e. a marathon). What is wrong with these people? My other roomie, David Lockey, has been busy with various medical journals, leading to a severe case of publication bias. That is, we feel biased towards him because he gets published so much. David also found time to go to Kenya with the army in July, and was exasperated to find that he’d managed to put on weight, something most inhabitants of the African interior find difficult to achieve. Samantha Shinde is taking over as College Tutor from Maggie Gregory, but has also become our social secretary. Two of Maggie’s children, Sophie and Guy, won the Prince Phillip Cup at the 2006 Horse of the Year Show. They were representing Banwell Pony Club in the finals of the “Farmers Guardian Pony Club Mounted Games”, and won on the final event! Apparently everybody was yelling encouragement so much that they’ve all lost their voices, although Guy, on being presented with his medal by the Duke of Edinburgh, had enough voice left to ask Prince Phillip if he was the Duke of Normandy. Maggie and Steve recently
celebrated their 25th wedding anniversary, and had a combined party with their daughter Sarah, celebrating her 18th birthday. Ruth Spencer is back at work (hurrah!) and quickly re-established her reputation for bizarre phenomena by inducing an SVT in one of the trainees, presumably by standing too close to her, during an anaesthetic induction. This resulted in two unconscious people in the anaesthetic room. She’s not called the ‘Lightning Conductor’ for nothing. Ruth was only disappointed that this didn’t coincide with the flood of biblical proportions that appeared by her theatre one day, as she liked the image of her having to carry an unconscious registrar out of theatre through rising flood waters. James Nickells is still living in a caravan while his house is being enlarged to accommodate his simply enormous stereo system. So far he has endured artic chills, followed by the heatwave of early summer.

The Trust management are currently obsessed with our ability to compete with the independent sector, given the impending build of an Independent Sector Treatment Centre nearby. This may explain the publication of several lengthy, and generally unworkable protocols covering venous cannulation (10 pages) and central venous access (22 pages). Some light-hearted e-correspondence, questioning the lack of input from key stakeholders, i.e. anaesthetists, and the over-representation of nurses on these committees followed, but Wim Blanke unfortunately fell foul of pressing the ‘reply to all’ button, and managed to upset some members of the nursing staff. Bizarrely, he then received a form of ASBO from the Trust, although he had indirectly highlighted the immense waste of time in having lengthy policies formulated by people who aren’t at the pointy end (sic) of healthcare. Perhaps we could compete more easily with the Independent Sector if we sent them our middle management? That should slow them down a bit.

There are only two marriages to report; Katie Welham to Daniel, who is a Trauma surgeon working in Dusseldorf, and Chris Thompson to Kate. Chris went on his stag weekend to the ‘badlands’ of Perranporth in Cornwall. Surfing localism is rife here, and on an early morning walk to the beach, a local paraglider collapsed his parachute and fell 100 feet, breaking his pelvis but luckily missing Chris. Continuing on a surfing theme, Simon Webster managed to fracture the spinous processes of two cervical vertebrae surfing in Croyde at low tide. Thankfully he is fine and is recovering well. Dominic Janssen, one of the SHOs, is an international frisbee player, and recently competed in the National Frisbee Championships. We welcome back some old faces, including Ian Thomas, Sarah Love-Jones, Dave Healy, Nicky Weale, Richard Beringer, Alex D’Agapeyeff, Kay Spooner and Chris Langrish. And a few new ones, including Katy Leuchars, David Barnes, Mark Porter, Nick Parry, Ping-Yi Kuo, Neil Rasburn, Simon Webster, Jo Connell and Yeli Horswill, who recently gave birth to Lola.

Richard Dell

Gloucester
Our fantastic Summer is long gone. The Theatre Ball in June was a great success with the anaesthetic band, ‘Dural Tap’, re-forming to give an exclusive performance. Unfortunately, Simon Cowell couldn’t make it so they won’t be appearing on ‘X Factor’ anytime soon! (Sorry boys; don’t give up the day job.)

The excesses of the Ball were evidently not enough to satisfy some of the younger members of the department. Registrar Mike Eales escorted our secretary, Chris Finch, and SHO’s, Ed Bick and Gemma Nickols, to Subtones, a Cheltenham night club. Apparently they narrowly escaped being arrested for drunk and disorderly behaviour – no surprises there!

I caused a few raised eyebrows when, after an eye list at Cheltenham, I went to the Lido for a swim with Registrar Richard Beringer. In my defence it was a very hot day and the experience of “Swimming with Registrars” is akin to “Swimming with Dolphins” (well he is a very good swimmer). Dr. Berringer did in fact leave very shortly after this and is no doubt working somewhere in a department near you! Other departures include Karine Zander and Anne Young, our flexible SpRs; Hugo Wellesley, Katie Leuchars and Catherina Mattheus, who may well now be with you. SHOs Brad Sartori and Paul Rowe have left for Australia and New Zealand and Jeremy Pallot has returned to A&E. SHO Nick Shepherd took up a LAS post in Truro while waiting for an elusive number to come up.

Newcomers include novice SHOs Rob Glasson and Gemma Nickols and experienced SHOs Suman Biswas, Shariq Khan and Hamish Breach. Incoming SpR’s include Claire Gleeson, Jill Homewood, Will English, Mark Haslam, Jamie Peyton and Rob Price. The transition has been slightly easier as we knew
some of these already. For the record, Jamie Peyton’s extracurricular activities include being ex-county squash player and being given the Freedom of the City of Swansea for services to the female population!!

The Gloucester Anaesthetic Department Football Team have been celebrating their recent win over local rivals Cheltenham, further details appear in Ted’s report.

On the baby front we have two new births to report. Sue and Charles Garcia Rodriguez are proud parents of a second baby daughter; Chloe and Dan Evans have a strapping baby boy and Alice Braga and Rob Johnson are awaiting the imminent arrival of their second child. I think they must all have been at the same party! Not far behind these three couples is Sarah Wigmore. Also new Chronic Pain Consultant, Sarah Harper, will start in February following her maternity leave.

With the change in the Law to prevent age discrimination, Dr. Eltringham is staying indefinetly! Although since his ‘library’ cover (AKA the pub) has been blown, work may not be so appealing. Mike Durkin’s meteoric rise continues with his new job as head honcho for the South West Region. Richard Vanner has managed to fit a little bit of anaesthetics in between racing his yacht, another successful year for him – winning Cowes week and the National Championships. Richard and SHO, Ed Bick, have just returned from presenting at the Difficult Airway Society in Dublin. No gossip just drinking their own weight in Guiness. Finally, my thoughts on the chaos being caused by MMC. I used to share a desk with Malcolm Savidge and this is courtesy of him.

We trained hard but it seemed
that every time we were beginning
to form up in teams
we would be reorganised.

I was to learn later in life
that we tend to meet any new situation
by reorganising, and a wonderful
method it can be for creating the
illusion of progress, while producing
confusion, inefficiency and demoralisation.

By Caisu Petronius  AD66

Sound familiar!!

Belinda Pryle

Plymouth

Has the time come again to write anew
– a Derriford chronicle of all that we do? . . .
I know that you think that it’s all play and no work
– but the results show that our trainees don’t shirk
First take the Primary - one we’ve all feared. . .
Well, success came to Drs Campbell & Beard,
Fehrmann, Wells, Hooper and Kaye,
Edgar and Pope – all mastered the day!
Another keen group prepared for a test
Nicholson-Roberts, Gillen, Read and Guest.
They obviously worked hard enough on the day
As they’re now the proud owners of the FRCA!

But what of other characters that in our midst are found
There are plenty of travellers, and surfers do abound!
Talking of the latter, young Courtman did fly
With Orbis to Vietnam to heal the odd injured eye,
Liz Rawlings she did similar in Ethiopa we hear
Whilst Uganda had Chris Seavell for part of the year.
To Gemma Crossingham though, special thanks are due
For organising a flotilla – full of anaesthetic crew
The wind blew, the sea rose up but nothing stopped the fun
Up and down the Sound they went until the day was done.
Other travels though are not all to sea and sun
But who said military consultants should always have such fun? –
We’ve done the Iraq visit - we came back with a tan
Now Matthews, Birt, Bree, Berry and I are off to Afghanistan!

The world population continues to expand
And Plymouth always does its bit to lend a tender hand
We’ve had babies galore to add to the cheer
any excuse for champagne and more beer!
And who were the culprits in the department for this?
Well, many claimed leave for their moment of bliss:
Simon Courtman, Rachel Blackshaw, Lynn Margetts and Geoff Smith
. . . along with Rachel Johns – to name but a fifth
Gary Minto, Matt Oldman and also Paul Moor
Surely you are thinking – there can’t be any more!
But wait for it now, Steve Boumphrey had one too
Fiona Martin and Kath Gardner – but then again –
I suppose you knew!
Good luck to one and all of you we hope it all
goes well
better thank your partners too – they’ll all have
tales to tell!

We’re getting to the end of this little Plymouth rhyme
And I haven’t mentioned wedding bells
or appointments in the time
So in the closing moments I’ll just let you know the score
And apologise to those we missed – and those who found this a bore
... Well, Teresa Hinde got married to a gasman in the west –
George Pappin at Exeter – we wish them all the best!
Then there’s Peter of the Davies kind
who’s windsurfing as a rule
But has become Programme Director of the SW Anaesthetic School
Sophia known as Wrigley has become associate CD
Replacing Jeremy Langton - now wrapped up with MMC!
The department rumbles on it seems through changes far and wide
And takes the hits the Trust throws forth from each and every side
The hatches are all battened down, the silver cleared away
Despite another job-plan round ... we’ll survive another day!!

Andy Burgess

Addendum: I couldn’t put the tragic death of Ross (covered elsewhere in this journal) into such a light-hearted dit. Suffice to say that all in the department were devastated by such an event, and this was reflected by the big turn out to his funeral, the contributions to his charity and the amazing send-off that many of us gave him on a sunny evening at Bigbury Bay. Our thoughts remain with his family, Kate and close friends.

Southmead
What a great summer it’s been. We had the department barbecue at John and Linda Leigh’s house this year and thus had a chance to admire their beautiful garden. This was swiftly followed by a chance for hordes of children and Mark Pyke to lay it to waste by playing football all over it. Linda was very stoical and was still smiling when we left – I think. As usual there was far too much food but the Pyke family helped out here as well. Polly Pyke (age 3) confidently informed Colin Hall that she had eaten 10 sausages. Still, at least she didn’t get locked in the loo this year.

Our other social event was a welcome dinner for Kristina Birch at Deasons Restaurant. Having been welcomed she is now off with the RAF keeping the peace somewhere. The lengths some people will go to to avoid on-call.

Juliet Learner is back in the fold after a year in Melbourne. Apparently the theatre staff in the AOC greeted her with “We haven’t seen you for a while, have you been on holiday?”. It’s great to be missed.

Change is afoot in sunny Southmead. Ed Walsh has given up anaesthetics and now works as a full time pain doctor. He is keeping his actual retirement date under wraps but having survived a series of 162 rapids in the Grand Canyon earlier this year, could obviously cope with several more decades of pain. He had a bit of a clear out of his desk space in celebration of his new status and found Steve Bolsin’s theatre clogs lurking in a corner. Don’t ask me the significance of that.

Neville Goodman is preparing for retirement by giving up organising our morning meetings. He has been the organiser for 20 years and has seen meetings go from Monday morning to Friday afternoon and finally to a rolling early morning programme. I don’t wish to cast any aspersions but we did notice he was late for the first meeting he didn’t organise – he surely can’t have forgotten which day it was on could he?

David Pilditch has been working as a locum in our department for a while now. He’s a quiet unassuming sort of bloke but you get the feeling there might be hidden depths. So it was no surprise to find that he had done a sponsored cycle ride the other day from Temple Meads to Chobham in Surrey! It took him about 9 hours despite having at least 5 punctures on the way. He ran out of spare inner tubes so had to resort to patching and repatching. At one point he tells me he developed an aneurysm of his outer tube – I’m no cyclist but that sounds bad to me. In terms of endurance I’m not sure whether that would be worse than Mark Pyke’s experience of running/walking across Wales in the rain with 2 voluble vascular surgeons. A close call I’d say.

Now that the trainees are writing their own “News of the West” I don’t really need to say anything about them. However, I couldn’t really not mention that Dominic Hurford has got engaged to surgeon
Sarah. Congratulations to them. Judith Ochola and Ping-Yi Kuo both passed the Primary FRCA at the first attempt. Judith’s prize is that she gets thrown out of the country but the upside is that she’s got a job on the Gold Coast! The confusion over visas also means that Vivek Kakar has left us to go to a LAT in Newcastle. It’s very sad to see great trainees leaving the Region but we wish them well in their new posts.

Finally, Claire Fouque and James Pickering have had a baby boy, the only member of the Fouque/Pickering household who has ever knowingly arrived early. Mother, Father and baby Joshua are doing well. Congratulations to them all.

Fiona Donald

Swindon
Well here it is. The first contribution from Swindon to News of the West.

Swindon has traditionally had links with both Wessex and Oxford and currently trains senior SpRs from both schools. For a number of years we have been training novice SHOs who rotate to BRI and Southmead. From August 2007 with the commencement of MMC, our “STs” will rotate through Bristol only. Thus it seems an opportune time to affiliate with the SASWR. Many of our consultants have at some time worked in hospitals in the South West and hopefully our professional and social links with the South West will be rekindled.

Enough preamble. What about the gossip. Nick Jones left in August to join Basingstoke. Nick was a consultant at TGWH for a couple of years but made a huge contribution to training with a particular interest in airway management. He has left us with a fantastic training room featuring a fine selection of manekins, training aids and IT kit. Richard Hodgson, Steve Tolchard, Andy Georgiou, Yvette Coldicott and Angela Bell left to continue their SHO training in Bristol. From August 2007 with the commencement of MMC, our “STs” will rotate through Bristol only. Thus it seems an opportune time to affiliate with the SASWR. Many of our consultants have at some time worked in hospitals in the South West and hopefully our professional and social links with the South West will be rekindled.

The local stork is always busy around these parts and delivered a baby boy (Benjamin) to Simon Davies. There are a number of fine sportsmen and women in the department and of note Doug Smith ran a splendid Cape Town Marathon.

A hearty congratulations go out to Hilary Millet our departmental secretary who was recently awarded an MBE for services to the NHS – and jolly lucky we are to have her as a colleague.

Finally, continuing the patriotic theme, Gary Baigel (South Africa) and Susannah Zambrano (Cuba) have become British citizens. Obviously both will have immediately gone out and bought Union Jack underwear.

Matt Ickeringill

Taumarunui
No news from the Southern hemisphere appeared in the last edition of Anaesthesia Points West, and this was not through any intention of mine to be uncommunicative – I did pen a bulletin, and thought I had e-mailed it correctly, but it never materialised in your editor’s inbox. So this time I am relying on more old-fashioned methods.

The ‘Surgical Bus’ has recently visited us again. This is 39 tonne, 20 metre long pantechnicon which provides a fully equipped operating theatre on wheels; when parked and deployed the sides of the unit cantilever out to a width of almost five metres, so one does not feel cramped within. It can turn in its own length, and negotiate even the challenging rural Kiwi roads. For the most part it provides day surgery procedures in a wide range of subspecialties – orthopaedics, ENT, Urology, dental and gynae to name but a few. Here in Taumarunui it has been used for general surgery and endoscopy. There is a dedicated travelling team of theatre nurses, anaesthetic technician and driver/engineer, but these are supplemented by the local theatre staff, surgeon or endoscopist and anaesthetist. It cost, apparently, over $5,000,000 to set up, and is supported by another $5,000,000 annually from the Minister of Health.

I was intrigued by the invitation to work on the bus, although I had, and still have, reservations as to whether it is cost-effective in our situation, given that we have a perfectly good operating theatre in Taumaurunui Hospital. But I must acknowledge that the bus theatre is well designed and thoughtfully equipped, with anaesthetic machine and monitoring that would be the envy of many hospitals. (Particularly ours – we’re still struggling to get our hands on an anaesthetic machine that doesn’t belong in a museum).

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I’ve now done 12 all-day lists on the bus and can truthfully say I’ve enjoyed the experience. The travelling team are congenial colleagues and the working atmosphere is always good. However,
we’ve had some excitements. I was barely home after our first list when I was summoned back urgently. I found the last patient, a tiny Filipino lady who’d had a haemorrhoidectomy, making a spirited attempt at bleeding to death. She was successfully resuscitated and haemostasis achieved. Then on the next visit, some weeks later, a middle-aged lady of wholly unremarkable medical history threw a second degree type II heart block on induction with a ventricular rate of 39/minute. She went to Waikato Hospital – 100 miles away – to have a pacemaker inserted. Since then (and I’m touching wood as I write) the bus lists have all been fairly tranquil.

On another recent list in Tokoroa Hospital we were reminded of the general hardiness of rural New Zealanders. The fourth child on our paediatric dental list, a little lad of five years, had been retrieved by Search and Rescue from the bush at only 1:30am that morning! He’d been on a hunting trip with his father when they’d become disorientated in deteriorating weather. Despite everything, the family had fronted up for the child’s dental treatment, less than 12 hours later; Dad seemed a bit subdued, but the little boy was fine.

I have just ordered, and look forward to enjoying, the book of Steve Yentis’ cartoons, “A View from Head End”. As it was reviewed in the December 2005 Anaesthesia I fear it reveals how rapidly I get to read journals these days . . . it will be interesting to see how long it takes to secure a copy here in the central North Island.

We had depressing news last month. Our lovely manager, Karen Akhtar, has resigned. The hospital is awash with gloom as to what kind of replacement will be foisted upon us by the juggernaut of the Waikato D.H.B. personnel department. Karen has managed Taumarunui Hospital with imagination, flair and affection for almost five years, and, selfish that we are, we all hoped that she would stay forever (– or at least until yours truly reached retirement). We can’t hope to get another Karen, but please keep your fingers crossed for us.

I have run out of time and space to give an account of our very successful Trumarunui Hospital Reunion, held late last year. Or to relate the stresses of covering the ward and emergency room, not as anaesthetist but as general medic, and having to cope with a plump and inebriated young lady who’d had an unfortunate interaction with a glass ashtray.

All good wishes for Christmas and the New Year.

P. Heather Cosh

Taunton

There are tins of chocolates appearing on the shelves of Sainsbury’s, which means Christmas is on its way and summer must be over. Where has the year gone! Now with all the holidays out of the way, Geer can relax a bit more and the rota can get back into its normal swing again – wishful thinking! His next challenge (along with our CD Ian Gauntlett) is trying to plan ‘life after SHO’s’. Who knows how we consultants will be working in the aftermath of MMC – I thought life was supposed to get more comfortable as one progressed through the ranks.

The refurbished ITU opened in the spring with great relief as having ITU/HDU patients on split sites was not ideal. Mind you, the HDU staff may beg to differ – having the whole of ward 11 for 4 beds was extremely luxurious – it’s amazing what you can get used to.

The summer brought both a wedding and a new baby to the intensivists of the department – no not a shot gun wedding – Andy and Lorraine Daykin who were married early in the summer, and then a little later another ‘Baby Innes’ arrived into the world – how many is that now Richard? At this rate, he might have to trade his car in for a minibus – congrats to all. Our 1940’s maternity theatre has at last been replaced with a new “off the shelf” portacabin theatre. This boasts enhanced temperature controls to keep conditions optimal for the newborn baby – fantastic. Unfortunately it experienced a few teething problems with this years scorching high summer temperatures outside – one Saturday morning Harry was met with such extreme tropical humidity as he opened theatre doors he thought he was in the steam room at Esporta Leisure centre! After a quick mop up job and re-tuning of the air-conditioning unit, its now back in full swing again. As for the rest of the hospital’s new build – everything is still on ‘hold’. What a surprise. Oh no – sorry – we do have progress – the new car park is due to open in the autumn. Let’s keep the visitors happy eh!

We have decided to let one of the trainees do ‘trainee corner’ this year – so Nic, over to you. Thanks Jane – here goes. Much change has occurred on the trainee front in Taunton in the past few months. The high point has undoubtedly been the recent society wedding of Dr Melanie Knight, who proved convincingly that the meringue is back. Look out for the full page spread in Hello magazine soon. Mel also won the GAT poster prize for...
teaching our non anaesthetic colleagues how to put in central lines without the aid of an anaesthetist.

TA Major Harry Pugh has left us for the cut and thrust world of PICU but its ok because we got surf dude Richard Gibbs back as part exchange. Other recent SpR departures include the very clever Chris Gowers, who has gone to show them how it’s done in Ireland and Fran Smith who has returned yet again to her alternative reality of motherhood. We hope that she will return to planet earth soon as we miss her random comments and smiling face. In the meantime congratulations to Fran on the birth of baby Ella and also for passing the FRCA. We welcome our new SpRs – Tracey Prior, Jane Bellamy and Vijaya Ramaiah, who haven’t been around long enough to cause too much trouble but time will tell. We also congratulate Juliette Lee on the birth of her second child earlier in the year and for getting a locum consultant job in Salisbury. We are still enjoying the company of our Australian SpR Roger Wong, who recently amused us with horror stories of the perils of transferring patients across the outback by light aircraft. Makes a trip to Bristol look like a walk in the park. Nij Niranj and Mike Spivey are getting ready to think about sitting the Final, that’s if Mike can find his books once he’s moved house. Our influx of new, keen, enthusiastic and sporty SHOs led to the unlikely sight of 14 of us marching over the Quantock hills one summer evening, led by the dynamic Nicky Campbell. What started out as a gentle ramble ended up with us rambling in the pub until closing time. We’ve managed to employ some new trainees with the same surname so it’s all had to go rather informal to prevent total confusion (as compared to the background basal level of confusion that permeates Taunton). We welcome Dr Lewis (Anna), Dr Lewis (Julie) and Dr Biddulph (Jamie) and thank our lucky stars that Drs Helen Cain and Alex Day made it past the three month post so that we’ve got enough people for the rota. All good things, however, must come to an end and so we have said a sad goodbye to Francois Roodt (who went to PICU in London), slightly less sad goodbyes to Miguel García (because he’s only gone across the corridor to ITU) and Caroline Collins (who has gone to Paeds) and we are getting ready to send Will Key into the big wide world as a LAT in Exeter.

There has been much hype in the media recently about the suggestion that we all work a day for free in order to shore up the trust. However, this hasn’t been necessary as they have forgotten to pay Will, Jane and myself this month. I’m glad that we’ve helped by providing our services for free!

Teaching continues at its usual excellent standard here in Taunton, although Ian Gauntlett’s plan to introduce compulsory 3-month blocks in gossiping and whinging appear to have stalled due to everyone sitting around whinging and gossiping. Our SHOs Nicky Campbell, Ed Searth and Zoe Brown are getting ready to join Julie Lewis in Red Lion Square to sit the Quiz in December. I managed to pass it in May (which was nice) so I end with some sage advice from someone who has been there. Don’t sit in the Red Lion Square gardens and eat a sandwich in between vivas – those pigeons are vicious.

Jane Thurlow & Nic Crutchley

Torbay

In line with changes up and down the country there is a lot happening here in Torbay with regard to the hospital and health care provision in general. As from this November we are becoming a Foundation Trust with a governing body including 17 elected public representatives to ensure local accountability. By 2012 we are to have a new (100 fewer beds) hospital at a cost of £160 million. Our neighbouring primary care trusts are about to disappear into one big Devon-wide trust, although Torbay itself is making history by becoming one of the first Trusts to run both health and social services.

Despite all of this, anatomy, physiology and patients seem relatively unchanged, and in general terms we turn up for work to do some anaesthesia! To help with this we are delighted that Matt Halkes has joined the department as a consultant colleague. Matt has had a long association with Torbay as a trainee and more recently as a locum.

Our congratulations also go to Sarah Rees who has secured a consultant position in Cardiff. Sarah has recently been an SpR with us in Torbay, and we are not surprised that she got a job so readily.

Kerri Houghton continues as the Torbay Medical Director of CITEC (Centre of Innovation and Training in Elective Care). Our League of Friends have given the project a big boost by funding £1.5 million towards the provision of a new building on the Torbay campus which will be the hub of the new clinical skills centre. Darren Woodall, who used to be one of our more lively ODPs, is now well established in the project as its Clinical Skills Coordinator.

Jonathan Ingham is looking at the possibility of day case coblation tonsillectomy in children using...
the ubiquitous laryngeal mask, and initial trials suggest that this is going well. Coblation is a non-heat driven technology using radio frequency to create a focussed plasma, and causes less pain than conventional methods. A comprehensive package of analgesics enhances significantly the wellbeing of the children in the hours following surgery.

Nuala Campbell remains Clinical Tutor and Associate Dean. With her understated serenity Nuala is adored by the trainees as a font of wisdom and stability in their topsy-turvy world of modernisation in medical training. The story is that recruitment agencies have got wind of career uncertainties in the trainees mess and have visited at least one hospital pushing careers in accountancy and the like.

As I write, we are not at all jealous that SODIT (South Devon Intensivists) under their team leader, Mick Mercer, are living it up at meeting in the Island Hotel on Tresco. Mick is our meetings guru, and takes on the onerous task of checking out the venues. Someone has to do it. I wonder if it is anything like these holiday rep. programmes or “Get Me Out of Here” we see on TV?

Our summer barbeque was hosted by Kerri and Paul Houghton at their charming farmhouse at Ogwell. There was a fantastic spread and ale in abundance. The back lawn looked like a theme park and the youngsters had a whale of a time. John Thorn helped with the cooking in hot conditions and by mid afternoon his face resembled a well-done hamburger.

Jeremy Ackers organised a canoe outing on the river Dart back in July, ending up at the Maltsters’ Arms in Tuckenhay. A good time was had by all, and another example of a departmental function that finished in alcoholic hospitality. Talking of which, our Christmas party this year is being held at Torquay’s ‘Living Coasts’, our coastal zoo with puffins, fur seals and penguins (hope it’s not black tie).

Ian Norley

Truro

A fine summer draws to a close. The tail of Hurricane Gordon last week combined with an offshore wind to produce the best surf of the season. Good weather also favoured the annual boat race with the customary barbeque hosted by Anna Weiss and family. All of which has helped to take our minds off the gloom at work. We have progressively lost most of the Board. We have had no Chief Executive for four months. Expenditure still exceeds revenue. We have paid Price Waterhouse Cooper to tell us what we already knew. Clinicians have been largely excluded from the turnaround planning and predictably many of the ideas are demonstrably unworkable. Financial expenditure has been discouraged and all projects put on hold, including the replacement of the maternity building, which is held together by scaffolding! These scenarios are depressingly familiar to many of you, but you all still seem to be in business, which gives us hope. Perhaps the Maternity block will be terminally damaged in a winter gale, and we will get a smart set of portacabins on the car-park in which to deliver Cornish babies. They would probably last for 10 years, but we would have to park out of town and walk the last couple of miles.

Happy events: Congratulations to Gail Gillespie on her marriage to Cameron. Congratulations to the Andersons on the birth of their son. Congratulations to Toby Everett for collecting the gold medal in the Part 1 Fellowship exam.

Three of our Registrars have moved on. Steve Harris has left us for Torbay. David Adams and Subhasis Duttagupta have returned to Plymouth. Kevin Patrick and Andy Tillyard have joined us in their stead. Rachel Broadley has a training number in Leeds. Coralee Carle has a training number in Manchester (her homemade cakes are sorely missed at Thursday teaching!). Colin Bigham rejoined us briefly but has moved to a training number in London. At SHO level we have been joined by Anne Whitehouse, David Sainsbury, Nick Sheppard and Steven Seale. Alex Harrison and David Ashton-Cleary have returned from their rotations to medicine. They are the last of that generation and later recruits to rotational posts are waiting in limbo for MMC to determine their fate. Tom Martin, Hannah Gill and Rob Jackson also passed the part 1 exam; good luck to those facing the examiners in the next fortnight.

Our permanent SAS grades: John Gowenlock, Alex Smith, Sarah Taylor and Siva Manyan are being very tolerant and flexible as we cope with rapidly changing service commitments. We hope that SAS grades have an opportunity to sign a national contract before MMC redefines their status and futures. In spite of our uncertain future we remain a large and busy department, servicing a large emergency service. There may be no money but the patients are still coming in.

Thank you all of you who came down and supported our May meeting, in Cornwall. I hope you
enjoyed it as much as we did, and will find an excuse to return in the future. By next year the new road to solve the Bodmin Bottleneck should be open!

Best wishes from the far west.

Bill Harvey

UBHT

To paraphrase an old curse we are living in interesting times at the UBHT. The jobs freeze continues, we await news of whether we will be allowed to apply for foundation status and what specialties we will have after the strategic plan for Bristol have finished meeting (although I believe we’ve been waiting for that for 10 years). In addition we are soon to be surrounded by 6 DTC’s or ISTC’s or whatever they’re called this month. This is great news as apparently it will allow “greater patient choice in an environment of open competition between healthcare providers on a level playing field”. I can’t wait as presumably this means the BRI will also have a guaranteed volume of work, paid above tariff, some nice new wards and finally planning permission for a large carpark . . .

There have been the usual large number of comings and goings. Firstly we welcome our new professor, Kai Zacharowski and his wife Paula. Kai has arrived from Germany along with his research assistant Alex. He has got off to a flying start by inviting the whole department to an all expenses paid dinner and dance, including free bar (bit worried he may not understand what that means). He has many ideas, including hopefully a rolling programme of research projects that will be easier for our registrars to be involved in. Attendance at Friday morning meetings amongst the female members of the department also seems to have increased, can’t think why . . .

Frances Forrest is now our new Chairman, a tricky job now that she has to coordinate 52 consultants working in three different divisions. Amongst the trainees we welcome (back in some cases) Tim Murphy, James Sidney, Katrien Mathheus, Chris Bordeaux, Ben Howes, Chris Thompson, Rachel Alexander, Cathi Hoyer, Lucy Miller, Phillipa Seal and new SHO’s Amit Goswami and Kaj Kalamanathan. We also have some F1 and F2s; not spotted them yet but apparently we have to be extra nice as this will be their only exposure to anaesthesia before making a decision to sign on for a 7 year run through training programme. Congratulations also to Bev Guard on the birth of William.

On the minus side, Simon Massey and Gill Lauder have hung up their matching bum bags and departed for Vancouver (hopefully just for one year). We also say goodbye and thank you to a great bunch of registrars and SHO’s – Graham Knottenbelt, Simon Ford, John Anns, Alex D’Agapeyeff, Mark Porter, Dave Barnes, Neil Muchatuta, Aidan Marsh, Joe Silsby, Claire Gleeson, Gill Homewood and Ben Gibbison. Sorry if I’ve missed anyone.

It’s been a good year for exams: congratulations to John Gatwood, Neil Muchatuta, Gareth Gibbon and Mark Porter on passing final FRCA, to Claire Haywood and Duncan Toon our anaesthetic practitioners on flying through their first year exams and good luck to Alla Belhaj and Andy Georgiou for their primary vivas.

The countdown to the Bristol Half Marathon was marked by an increasing frequency of dodgy lycra being spotted in the department. Mark Scrutton got the fastest time, 1hr 23 and has been heard muttering how next year he has to apply for an elite number – I think that’s veterans elite Mark (he would also like to refute the scandalous suggestion made by Dr Dell in the last News from the West that he snores), close behind was Mike Taylor who insists that he was just treating it as a training run for the New York Marathon. Mike’s success in the half marathon however was soon overshadowed by his success at the Bristol Crammer course (Q. comment on this lecturer, A.”nice eye candy”), rumour is this evaluation form now has pride of place in his CPD portfolio. Pete Brook, normally our fastest, was unable to run due to a mysterious mountain bike injury. Fran O’Higgins and Chris Monk were separated by seconds and ever since have been devising a complex handicap system based on age, BMI and leg length to try and prove which of them actually did the better time – this cutting edge research is likely to be published in the Xmas BMJ or at the very least count for an SPA at the upcoming job planning. John Gatwood and Aidan Marsh were also spotted but no news on times yet.

Socially it’s been quiet over the summer, the real ale appreciation evening (pub crawl) was a great
success; it seems dancing on tables in pubs is still frowned on. Sadly John Gatwood had trouble lasting the pace and was discovered fast asleep in someone’s car boot (why did you have a pillow with you John?) and I still don’t know where those wigs came from – all photos can be bought back for the usual fee.

Finally many thanks to Rebecca Aspinall for writing this column for the last few years, she has now moved on to command the MMC empire at UBHT – good luck!

Rachael Craven

Weston
Despite our Trust being named as one of the 20 hospitals in the UK most at threat because of an inability to balance the books, there has been no recent change upon the workload demands for the department. We continue to share somewhat limited office space but we are least centrally situated next to the theatre suite and ICU. Other groups of clinicians have just moved their offices away from the main hospital to a large portable building which is rumoured to have been acquired by the Trust on e-bay. It’s amazing what you can get on e-bay, isn’t it?

There are of course many changes that are being introduced to the NHS but the one challenge which is presenting us most problems is the advent of MMC. The carefully worked out scheme of appointing new SHOs every three months, which has been mutually beneficial for SHOs, the department and colleagues in Bristol, will soon be history. There is understandable apprehension amongst our SHOs about their job prospects next August and we wish that we could give them more definite answers, but, of course, like others, we cannot. There have been three SHOs moving on to Bristol in the past six months: Kaj, Jonathan Baird and Nick Parry.

It is rare that we report engagements, marriages or births. One of our SHOs, Gill Austin, has recently become engaged to Adrian, a radiographer. It will be a pity to lose Adrian who has been working with us for more years than I can remember. Gill is threatening to take him back with her across the border to Scotland in due course, and we wish them both well.

The departmental summer gathering was again organized by Alison Smith at the same venue, the Walled Garden at Wrington, as in the previous year. This is a perfect spot for such an event, the weather was suitably warm and everyone was on their best behaviour.

The Trust has recently “gone live” with the Cerner Millenium patient record system. We have all been trained in how to use the basic system but, judging by the comments of colleagues, we have been fortunate that we do not need to use it for our clinical work either in theatre or on the wards. Hopefully, by the time that we do need to use it, the system will have been appropriately improved to suit our needs. We don’t ask for much.

John Dixon

Yeovil
Firstly many apologies, it has been a long time since you have heard from YDH. Life has been very hectic here, what with Foundation Trust status (yawn!) and counting all our clinical excellence awards, barely a minute to stun a patient.

We have had one or maybe two Consultant appointments since I last put pen to paper. Jon Howes has come to us from deepest darkest Wales, taking charge of the ITU and catching the Chief Exec’s eye – definite Medical Director potential there. Jeremy Reid has recently been appointed – another intensivist from Southampton. We are very lucky to have him, with Jon and Jeremy the ITU is in good hands. The rest of us are ISQ – Roger shooting, Rob beating, Wootters missing, Graham part-time, Jo part-time and it seems like me part-time as well, Chris windsurfing and Matthew and Stephen still with their fingers in the dyke holding back the chronically pained.

We are looking forward to MMC with unrestrained glee, we prefer that approach at YDH, very much a Æ full department. Unfortunately we cannot seem to engender the same enthusiasm in our juniors for the forthcoming changes. I do feel for them.

Our middle grades continue to prop up the department, a couple of them are waiting on the deliberations of PMETB – I hope they are not holding their breath.

Well time to go and check on the Boyles bottle. Any time anybody wants to witness cutting edge anaesthesia in a sleepy market town, you’d be most welcome.

Tim Scull
## Examination Successes and Honours

### Bristol School of Anaesthesia

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### Southwest School of Anaesthesia

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<td>Rob Jackson</td>
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I am sorry if anyone from the region has not been included in this list that should have had an examination success or any other honour acknowledged. I can only publish the names sent to me by each department’s SASWR linkman and college tutor.

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**CORRECTION**

We would like to apologise to Janine Mendham and Steve Coniam for the error that appeared in the book review section of the Spring 2006 edition. The details of the book should have read:

*Principles of Pain Management for Anaesthetists*

Authors: S. Coniam and J. Mendham

Publisher: Hodder Arnold  Price: £34.99  ISBN: 0 340 81648 1
They are still at it, the happily retired, though they must be busier than ever because, not only have I been offered slightly fewer reports on what they are up to, but the reports are a little shorter too.

**Popular Pursuits**

Gardens, grandchildren, golf, travel and wine often get mentioned by your correspondents. While not unusual, they provide a great basis for those years of leisure. To include 3, 4 or even all 5 can leave little spare time! So thank you Finola Roche, Ed Charlton, Ralph Vaughan and Alistair Fuge. And to Peter Young for telling of the satisfaction he and Anne get in reaching unlikely places with her wheelchair. He knows he has done something right when asked, ‘How on earth did you get there?’

**Professional Activities**

As is only to be expected, withdrawal from work after 30 or so years does leave a few dabbling in the medical world. Habits die hard. Alistair Fuge has just retired again, this time from sitting as a medical chairman of a War Pensions Tribunal. Sheila Willatts relaxes at the GMC, involved with both long and short cases. Ralph Vaughan reduced his clinical work gradually, before hanging up his laryngoscope, but has continued as Hon. Treasurer of the Mushin Trust Fund. Frank Walters, busy with renovations, has still been to teach in Malawi, and wants to do more. John Balance has taken over from Peter Baskett as International Co-ordinator for ALS and Instructor Courses for the European Resuscitation Council, of which he has been made a full member. This has necessitated a week in Perth, Australia!

Guy and Jane Routh spend most of their time in their house on a Greek island. He gives a lot of medical advice, using “informed common sense”, mostly orthopaedic or gynaecological, and is glad he chatted with his surgeons over the years. He adds, “Time is spent on a large number of pets and the house and land. I am learning some veterinary skills as there is no vet on the island. I am OK with cat castration and working on spaying females, and have repaired one feline umbilical hernia. A vet visits the island 2 or 3 times a year and he is training me up. Should the GMC know?” What Guy omitted to tell me was which island he is on! Very wise.

Robin Weller (in the third person) has continued to drink wine, and is recently back from yet another visit to Bordeaux. This was followed by a 3 day wedding in Kilkenny. What price his LFTs? He is also awaiting his call-up by the U.S. Military. With only an hour and 15 minutes to change planes in Chicago, he realised the queues in Immigration would make it completely impossible. However a desk marked ‘Military’ seemed to have nobody queueing for it, bar a couple of wheel-chair passengers. The nice man let him through, but at the (standard) cost of being finger-printed and photographed.

**Continuing Development.**

This paragraph relates to property. Too late for much else.

Frank Walters sent a picture of his house in North Wales, being not so much developed as demolished. The view of cliffs and the sea in the background will obviously make the end result worthwhile. He is making more progress than Jenny Eaton who, having sold her house, is renting while still battling for planning permission for the dilapidated house she and Roger have bought in the middle of Box.

Deep down in North Devon, Sheila Willatts and Mike continue to improve their estate at Heale. “And a tile fell off the shower wall. No problem said He, I’ll fit another. But the colours didn’t match, and they were metric not imperial, and more fell off, and the wall was damp and uneven. Don’t worry She said, the shower is no use anyway, it’s too small to shave legs in (for visitors of course). Redo the whole room!! Make it a wet room, She said and while you’re at it fit a decent shower. But the toilet roll will get wet and we don’t have a hot water tank said He weakly and feeling defeat. Well you can put the tank where the boiler is . . . and put the toilet roll on the
window sill. So the floor was stripped and the concrete dug up, the drains laid, the room was waterproofed, and the floor sloped to the drain. The shower was fitted, and safety extractor fans, humidistat and lighting installed. Then came the boiler and tank, in a different place than planned, and it was all turned on. But the boiler wouldn’t pump the oil and the rain went down the flue and drowned the flames and the many heating engineers had many on-site conferences and called in reinforcements. They raised the oil tank and fitted new pumps and pipes and other bits. The boiler still doesn’t work all the time, but we have a Mecca for leg shavers.”

The Arts
Derek Cadle has, he wrote, “seemed to have developed a second career as a sculptor”.

“I have always had an active interest in three dimensional art. But hospital medicine and ITU work in particular does not leave much scope for such a time consuming activity. I was invited to join the South West Sculptors Association several years ago. Last year I exhibited in Devon, London and France, and had two pieces of work featured in House and Garden. I have also sold a number of bronze pieces of my work.

My work is mainly figurative, human or animal, depicting either mood or motion. Sculptures are mostly cast in bronze from clay, but also include wood carvings and mixed media. Work also includes child portraiture. Some works are presented as pairs.” (see below).

Derek is a difficult act to follow, but I never despair if Roger Eltringham is around! I cannot do anything but pass on to you, in full, his recent Near Miss.

“In these times when near misses have to be reported, I feel compelled to alert readers of this column to a narrow escape which could have had unforeseen consequences of a grievous nature.

My last appearance on stage was at a hospital review many years ago in which I was cast as a villain, a role for which I felt completely unsuited. Every entry was greeted with boos and catcalls which so upset my 7 year old daughter, Billie, that she asked on the way home “ Daddy, why does everyone hate you so much?” This is a question I have never been able to explain satisfactorily, but I am sure readers will not be slow to come forward with suggestions. I couldn’t have been very convincing on stage because no further parts were offered for several decades. All this, however, suddenly changed at the beginning of August when, out of the blue, I was asked to fly to Budapest and play the role of a Communist Party leader in a fleeting appearance in a feature film being made by Warner Brothers. Actually, it was not QUITE out of the blue because Billie is now a film director and they were suddenly a man short. As roles had been so hard to come by I accepted without hesitation, even though it entailed growing a moustache and acquiring accessory facial hair, which I felt would be hard, and speaking 10 words of German, which I felt would be harder. However, I stopped shaving for a while and started watching old war films until guttural sounds and teutonic gestures began to occur naturally. I also did some research and was a bit disappointed to discover that the character I had been chosen to impersonate was an ugly, vulgar, obscene Party boss with a piercing stare and disagreeable countenance. To be honest I had hoped for a more glamorous role for myself and, in a feeble attempt to back-track, even put forward the name of a former academician of my acquaintance who was, I felt, more suited to the role and would not even have to do any acting! However, when parts are so hard to come by, I felt that if I had to wait another 30 years I may only have been able to accept the less demanding role of a corpse. With that in mind I decided to plough on, and for a few days I harboured visions of sitting in an Awards Ceremony in Hollywood while the Master of Ceremonies ripped open an envelope bearing my name inside, and announcing amid

“Ravens” by D. Cadle.
acclamation “and the winner for Best Supporting Actor goes to . . .”

At this moment the phone rang and Billie’s voice, now much happier, said “It’s alright, Dad. We don’t need you now; you can get your hair cut”

Haven’t we all lost out on this? I do wonder which hair Roger needed cutting. I also remember a speech somewhere in a foreign tongue, given by a certain Dr Eltringham.

**A Major Project**

A couple of years ago, Ed Galizia mentioned that he had embarked on an attempt to move a public footpath which crossed his property. Four years later the end is in sight; the path is moving, and his solicitor is rich enough to retire. Ed has written a fascinating account about it; I could not begin to shorten it. It needs to appear in a legal journal, or a Ramblers Association publication. But thanks, Ed, anyway.

Thanks, too, to those who told me they had no news, and to those who said they would write next time. (Promises, promises.) Boating, ballooning, and organ restoration will appear or reappear in the future.

Finally, and very sadly, I miss, and will always miss, the descriptions of what the forever active John Zorab was up to. He was a unique, stimulating and marvellous man to have had as a friend and a colleague.

Robin Weller
The spring meeting of the Society was held at the Bedruthan Steps Hotel, Morgan Porth in mid-May. Nearly eighty members convened at this sprawling hotel complex in a glorious setting overlooking the spectacular north Cornish coast above an award winning beach with golden sand and rock pools. We arrived as an atmospheric sea-mist developed into a downpour of rain, something we have, of late, got used to at our spring meetings! However, during the afternoon the rain stopped and the rest of the weekend proved a good opportunity to explore the surrounding cliffs, beaches and facilities when not attending the excellent lectures and social programme so very well organised by Bill Harvey and the rest of the Truro organising committee.

One of the features of the hotel was that it was family-friendly and this certainly encouraged a number of our members with young families to attend. Many stayed on to enjoy a weekend family break. The hotel thoughtfully also provided adult-only areas for those guests whose attitude to children was more akin to that of Oscar Wilde – while liking children, really couldn’t manage a whole one! Despite this, it was good to see the Dell-boys and other “juniors” enjoying themselves so much. An interesting feature of such hotels is the baby-listening service in each room. Unfortunately John and I did not realise this was switched on until we had been in the room for some time when, out of the wall, a disembodied voice with a hint of panic in it, advised us to switch it off. John would like to apologise now for anything that might have been overheard, and I am sure that the hotel will be able to regain it’s family friendly reputation eventually!

Lunch
The meeting commenced with lunch in the hotel restaurant with the sun appearing, to reveal stupendous views of the golden sands and pounding surf. Lunchtime also provided an opportunity to visit the Trade stands which had been set up in the conference centre adjoining the hotel. The ever-popular ‘Stand and Deliver’, in which delegates receive a bottle of wine having visited a number of the sponsors stands, ensured a steady flow of visitors to all the stands, and the Society is very grateful for the continued support of all the Trade exhibitors. This sponsorship is an important factor in keeping the cost to members attending these meetings reasonably low by comparison with other conferences.

Scientific Programme
Session One
Dr Neville Goodman, President of the Society, welcomed the delegates warmly at the start of the meeting in the hotel conference room, and took pleasure in introducing the chairman of the first session, Dr Thys de Beer, Consultant Anaesthetist...
from Truro. This session was devoted to aspects of Critical Care, and started with Dr Gill Saville who reported on the work of the ICU Follow-up clinic in Truro, a topic very close to my heart as I have also been running such a clinic. My clinic in Bath has been shut down to save money so I was intrigued that Gill receives so much financial support from the Truro trust. They are very enlightened in the deepest southwest! The second speaker was Dr James Boyden, another Truro Consultant Anaesthetist who answered the self-posed question – ‘Which patients should be admitted to ICU?’ One of the pitfalls in such a decision he stated was assessing for others what might be an acceptable quality of life. The third speaker of this session was also a local Consultant Anaesthetist, Dr Jonathon Paddle. His talk, on Intensive Insulin Replacement Therapy, described the Truro experience of tight insulin control on ICU and drew on the Bath ICU experience. This session was followed by some lively questions before adjourning to the Trade stands and sunny terrace for afternoon tea.

Session Two
Following this break for tea, the second session, ‘Team Training and Resource Management’, was ably chaired by Dr Paul Rich, from the Truro department. The first speaker of this session was Kate Mules, Risk and Safety Manager at St George’s Hospital, London. She described a course she runs aiming to improve patient safety, and made some interesting comparisons with the aviation industry. She explained that medical adverse incidents, such as removal of the wrong kidney, had similar root causes as the well known aviation example where the wrong engine was switched off causing the catastrophic plane crash at Kegworth. The second speaker of this session was Dr Toby Everett, an Anaesthetic SHO currently at Truro. He related the Truro experience of setting up, and the outcome of, training scenarios designed to prepare staff dealing with patient evacuation from operating theatres in the event of fire. On a chilling note he warned that, in some circumstances, it would be impossible to successfully evacuate all patients, and that some may have to be abandoned. Naturally this had caused considerable distress amongst the staff undertaking the training. The contemplation of such a dreadful decision is truly shocking to doctors, and the disquiet felt by the Truro staff was shared by all of us in the audience.

Guest Lecture
The final session on Friday was the Society’s guest lecture which was introduced by the President, Dr Neville Goodman. The guest speaker was Professor Peter Hutton from Birmingham, a previous speaker and guest of our Society on many occasions. His topic was ‘Individual Success but Team Failure’, a rather depressing view on how the whole of the NHS is less than the sum of its parts. As a consolation for highlighting such a depressing view of modern medicine, he reassured us that prospects for the political scene were even worse, and concluded by encouraging us to have hope for the future, as patient-centred care is what doctors are good at and what patients still appreciate.

Social Programme
Meanwhile, partners of members of the Society had
a special social programme arranged for them by the local organisers. Following lunch with the members, partners were taken by coach to Lanhydrock, a magnificent late Victorian country house surrounded by beautiful gardens in a wooded estate at nearby Bodmin. The house was used as film locations for the Three Musketeers and Twelfth Night, and has been described as the ultimate 19th Century ‘Upstairs-Downstairs’. Following a tour of the house and gardens the partners enjoyed a traditional Cornish cream tea.

On Saturday morning a visit to the Camel Valley Wine Farm was planned for partners. This English (or should I say Cornish!) winery had produced the only sparkling wine from outside the Champagne region of France to win a gold medal at the International Wine Challenge in 2005. This visit was an opportunity to taste and purchase local wines and Cornish cheeses and proved popular with those who made the outing.

Society Dinner
The Society’s Dinner commenced with a President’s reception in the hotel ballroom hosted by Dr Neville Goodman and his wife Sally. The dinner itself was held in the conference centre and entertainment was provided by a local harpist who, from a corner of the room, played beautifully yet unobtrusively throughout the meal. As usual the occasion provided a great opportunity to renew old friendships and acquaintances, as well as making several new friends.

In all, 106 members and their guests attended the dinner, and following the usual toasts to the guests and to the Society, we all retired to the hotel cocktail bar and ballroom where further socialising and dancing ensued.
Saturday Science

Despite the attractions of the nearby award-winning beach and the fine weather, a large audience attended the morning scientific session. The first session entitled ‘Home and Abroad’ was chaired very ably by Dr Bill Harvey. He is a Cornishman by birth, a Consultant Anaesthetist at Truro and the local organiser of the meeting. The opening talk of this session was by Dr Subhasis Duttagupta a Fellow in Pain Studies at Truro who gave a very thorough account of the use of intrathecal drugs for palliative care in the community. He described how, although only 2% of patients with cancer need intrathecal therapy, the dramatic reduction of side effects or toxicity of other drugs made this a very worthwhile addition to other forms of pain therapy. The second speaker of this session was David Wilkinson, one of the first Anaesthetic Practitioner trainees from Exeter. He presented a talk based on an essay for which he was awarded the Society’s ODP prize. A meta-analysis of epidural complications suggested to him that the only benefit of neuroaxial block as part of anaesthesia for general surgery is a reduction in the pain score. He deduced that there are no apparent differences found in morbidity, mortality or length of stay. Enthusiasts of neuroaxial blockade who are sceptical of meta-analyses (and to my mind the manipulation of data from a large number of small, insignificant, unrelated studies into one big highly significant study, often does not bear close examination. But I am no statistician!) may not yet change their practice. The third speaker was an ‘old girl’ from Truro, Dr Lyn Wells, currently working in North Carolina as an Attending Anesthesiologist at the University of Durham. She gave an interesting account of the differences in postoperative pain relief between the US and the UK. US anesthesiologists, unlike anaesthetists in the UK, do not have responsibility for post-operative pain control, and there is a greater reliance on drugs such as methadone analgesia. She pointed out that the pharmacological profile of methadone meant that a large dose given at the start of an operation produced a high initial plasma concentration and long decay time, resulting in prolonged postoperative analgesia. The final speaker of this session was another Truro Consultant Anaesthetist, Dr Patrick Hopton, who gave a moving account of his work with the Tropical Health Education Trust in Ghana, during several visits as part of a team who educate health workers and perform operations using the locally available equipment and facilities. These are very limited by our UK standards. It is a sobering thought to be reminded of the great inequalities of healthcare between us and the developing world. It makes instances of postcode lottery in healthcare in the UK seem very petty!
The Society Lecture

After coffee, the members were joined by guests and partners for a fascinating talk from Jonathon Ball, one of the co-founders of the Eden Project. I think most of the audience expected an account of the development of the Eden Project accompanied by a slideshow, instead of which we were entertained with what he described as ‘Rambling thoughts from Cornwall’. It is said that those who can lecture, lecture, whilst those who cannot, bring slides. Jonathon belongs firmly in the first category, and recounted his life as a Cornishman determined to set up an architect’s office in Cornwall. It has the charming address ‘Beach Hut 31, Bude’. His talk was full of gems. We learned, for example, that his father-in-law was Dr Anthony Blood, the GP who starred in the 1950’s programme ‘Your Life in their Hands’. Jonathon’s theme for the talk was the value that he attached to living in, and being part of, a community. He expanded on the importance of the human touch to mention a friend of his who had organised the Sydney Olympics, and who, 48hrs before the opening ceremony, had banned communication by email, recognising the importance of direct verbal communication. This was close to my heart – surely a telephone call or face to face discussion beats a letter or an email hands down? He kept the audience spellbound for over 45 minutes, and afterwards, over lunch, disclosed a wealth of local knowledge which proved most useful for those of us staying on for the rest of the weekend.

Finally the President, Dr Neville Goodman thanked all the speakers and the local organisers for such an excellent meeting, and hoped to see all the members and guests at subsequent meetings, in particular the forthcoming Autumn meeting to be held at the Assembly Rooms in Bath in November.
Are Day Surgery Outcomes After General Anaesthesia Affected By Increasing Age?*

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Key Words: Elderly, Day Surgery, General anaesthesia, Unplanned admission

Summary
The use of day surgery under general anaesthesia in the elderly is likely to increase. There is a need to determine whether or not quality of care in this setting is affected by increasing patient age. We present a retrospective review of outcomes for 2124 patients aged 70 and above, undergoing day-case surgery under general anaesthesia, over a five-year period. Rates of unplanned post-operative hospital admission, while marginally higher than those normally recommended for day surgery, did not increase with increasing age, and were favourable when compared with those reported elsewhere. Post-operative complications were rare, as was the need for contact with primary care services, and satisfaction scores were excellent. We conclude that age should not be considered a barrier to the anticipated increase in provision of day-case general anaesthesia for the elderly.

Introduction
It is well known that day case surgery is cost effective, efficient, and convenient for patients¹. The Department of Health recognises this, and through its NHS Plan² has set a target of 75% of elective surgery in the United Kingdom to be carried out as day cases, by 2010. Currently 67% of operations are performed as day cases³ – clearly the desired increase cannot be achieved without a substantial increase in the proportion of elderly people undergoing day surgery, many of whom will require general anaesthesia. Can this be offered safely, regardless of age⁴?

In 1992 the Royal College of Surgeons produced selection criteria for day surgery⁴, stating that the upper age limit for patients should be 65-70 years. This has been superseded by advice from the NHS Modernisation Agency⁵, which suggests that there should be no upper age limit. The Association of Anaesthetists of Great Britain advises that ‘Patients should be selected according to their physiological status not their age⁶.’

There is some evidence that patients over the age of 70 are at no increased risk of complications after day surgery, compared to their younger counterparts⁷,⁸. Whether the risks following day case general anaesthesia increase with increasing age in the over-70 age group, is unknown. The aim of this study was to examine outcomes within this group. The specific primary objective was to determine whether increasing age results in a greater likelihood of patients being admitted rather than discharged home after surgery – unplanned hospital admission rates are widely regarded as being a good indicator of quality of care provided by day surgery units⁹,¹⁰. Secondary outcomes were morbidity occurring in the first 24 hours after day surgery, whether patients sought post-operative help from community-based services, and patient satisfaction with the service.

Methods
After obtaining ethical approval we carried out a retrospective review of all patients aged 70 and over,
who had received general anaesthesia in our day surgery unit (attached to a district general hospital in Devon, England) between January 2000 and December 2004. The data was anonymised and held on the audit module of the computerised patient information system in the day surgery unit (Daynamics and Epiaudit, Calcius Systems Ltd.).

In our unit Total Intravenous Anaesthesia (TIVA) is frequently administered, patients often breathe spontaneously via a Hudson mask, and intravenous fluids (1 litre) are usually infused. The use of local anaesthesia to supplement general anaesthesia is encouraged during surgery. Post-operative nausea and vomiting prophylaxis is at the discretion of each anaesthetist. Anti-emetics used include cyclizine, granisetron and dexamethasone. The unit uses a stepped protocol for ‘To Take Away’ (TTA) analgesia which includes paracetamol (1g) six-hourly or co-codamol (60mg/1g) six-hourly, and ibuprofen (600mg) six-hourly (see Appendix).

All patients were preassessed by nursing staff prior to admission, with input from a consultant anaesthetist when required. A nurse also conducted post-operative telephone follow-up of all patients the day after surgery. Data was thus collected regarding the age and sex of the patients, ASA status, unplanned admission rates, post-operative complications (pain, bleeding, nausea, vomiting and drowsiness), whether or not post-operative contact with the GP or community nurses was needed, and satisfaction with the service provided by the day surgery unit (satisfied, very satisfied, or not satisfied).

Table 1
Basic demographics of the sample. Values are numbers (percentages)

<table>
<thead>
<tr>
<th>Age in years</th>
<th>70-79</th>
<th>80-89</th>
<th>90+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>1695 (79.8)</td>
<td>407 (19.2)</td>
<td>22 (1.0)</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td>1101 (65.0)</td>
<td>268 (62.5)</td>
<td></td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>594 (34.9)</td>
<td>139 (37.5)</td>
<td></td>
</tr>
<tr>
<td><strong>ASA 1†</strong></td>
<td>364 (21.5)</td>
<td>62 (14.5)</td>
<td></td>
</tr>
<tr>
<td><strong>ASA 2‡</strong></td>
<td>1124 (66.3)</td>
<td>294 (68.5)</td>
<td></td>
</tr>
<tr>
<td><strong>ASA 3‡</strong></td>
<td>194 (11.4)</td>
<td>70 (16.3)</td>
<td></td>
</tr>
</tbody>
</table>

*The sex of two patients was not recorded
†The ASA status of 16 patients (13 aged 70-79, three aged 80+) was not recorded

Table 2
Case mix. Values are numbers (percentages)

<table>
<thead>
<tr>
<th>Cases</th>
<th>Age in years</th>
<th>70-79</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rigid cystoscopy + intervention*</td>
<td>577 (34.0)</td>
<td>151 (35.2)</td>
<td></td>
</tr>
<tr>
<td>Rigid check cystoscopy</td>
<td>304 (17.9)</td>
<td>87 (20.3)</td>
<td></td>
</tr>
<tr>
<td>Repair of inguinal hernia</td>
<td>145 (8.6)</td>
<td>28 (6.5)</td>
<td></td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>69 (4.1)</td>
<td>9 (2.1)</td>
<td></td>
</tr>
<tr>
<td>Cataract extraction and intraocular lens implant</td>
<td>66 (3.9)</td>
<td>30 (7.0)</td>
<td></td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td>55 (3.2)</td>
<td>16 (3.7)</td>
<td></td>
</tr>
<tr>
<td>Grommet insertion</td>
<td>33 (1.9)</td>
<td>13 (3.0)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>446 (26.3)</td>
<td>95 (22.1)</td>
<td></td>
</tr>
</tbody>
</table>

*For example biopsy or resection of bladder lesion.

Table 3
Reasons for admission to hospital. Values are numbers.

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>Age in years</th>
<th>70-79</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post operative bleeding</td>
<td>11</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Lengthy surgery</td>
<td>11</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Feeling faint, drowsy or dizzy</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Unable to mobilise</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Change of procedure</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Pain</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Aspiration</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

Results
Over the five years 2124 patients aged 70 years and over received day case surgery under general anaesthesia (mean age 76, range 70-96). The basic demographics of the group are shown in Table 1, and the case mix in Table 2. As there were only 22 patients aged 90 and over, these patients were grouped with those aged 80-89. Comparisons have been made between the 70-79 age group and the 80+ age group. There was no statistical difference in the sex ratio of the groups ($\chi^2 = 0.32$).
A total of 83 (3.9%) patients were unable to be discharged post-operatively and therefore admitted. Admission was for a variety of surgical, anaesthetic/medical and social reasons (see Table 3). The unplanned hospital admission rates for both age groups are shown in Table 4. There was no statistical difference in the admission rates between the two groups.

The incidences of post-operative complications and comparisons with the appropriate local targets (based on data obtained from our unit across all age groups) are shown in Table 5. There was no significant difference between the groups in the reported rates of these complications.

Table 4
Unplanned hospital admission rates. Values are numbers (percentages)

<table>
<thead>
<tr>
<th>Age in years</th>
<th>70-79</th>
<th>80+</th>
<th>( \chi^2 ) value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions</td>
<td>64 (3.8)</td>
<td>19 (4.4)</td>
<td>0.53</td>
</tr>
<tr>
<td>Surgical reasons</td>
<td>38 (2.2)</td>
<td>13 (3.0)</td>
<td>0.35</td>
</tr>
<tr>
<td>Anaesthetic/medical reasons (for ASA 1 or 2 patients)</td>
<td>24 (1.6)</td>
<td>5 (1.4)</td>
<td>0.78</td>
</tr>
<tr>
<td>Anaesthetic/medical reasons (for ASA 3 patients)</td>
<td>2 (1.0)</td>
<td>1 (1.4)</td>
<td>0.79</td>
</tr>
</tbody>
</table>

Table 5
Post-operative complication rates, the need for post-operative help, and comparisons with local standards. Values are numbers (percentages) unless stated otherwise

<table>
<thead>
<tr>
<th>Age in years</th>
<th>( \chi^2 ) value</th>
<th>Local standard (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain (moderate/severe)</td>
<td>66 (3.9)</td>
<td>11 (2.6)</td>
</tr>
<tr>
<td>Bleeding</td>
<td>168 (9.9)</td>
<td>56 (13.1)</td>
</tr>
<tr>
<td>Nausea</td>
<td>29 (1.7)</td>
<td>8 (1.9)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>14 (0.8)</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>32 (1.9)</td>
<td>8 (1.9)</td>
</tr>
<tr>
<td>Sought help*</td>
<td>12 (0.7)</td>
<td>2 (0.5)</td>
</tr>
</tbody>
</table>

*Sought help = patient sought help post-operatively from GP or community nurse

Of the 70-79 yr olds who answered the question of satisfaction with the service, 1332 (99.7%) were satisfied or very satisfied. From the 80+ group the figure was 337 (100%).

Discussion
The most important observation is that there was no significant difference between the admission rates for the 70-79 age group and the 80+ age group. However the rates for both age groups were above the Royal College of Anaesthetists’ suggested maximum of 2% for surgical reasons and 1% for anaesthetic/medical reasons (ASA 1 & 2)\(^\text{10}\). The probable reason for the higher than standard admission rates is that our sample only contained individuals who had received general anaesthesia, whereas the standards quoted are for a mixed case load, where the general anaesthetic rate may be in the region of 55\%. Patients who undergo operations under local rather than general anaesthesia would be expected to suffer less frequent and less severe post-operative complications, and thus have a lower admission rate. Indeed our figures compare well with those reported elsewhere, for day-case general anaesthesia\(^\text{7,11}\).

Admission rates for ASA 3 patients for anaesthetic/medical reasons were well within the Royal College of Anaesthetists’ proposed standard of 5\%\(^\text{10}\), for both age groups. This finding is consistent with recent work which shows a favourable outcome in this group after day surgery\(^\text{12}\). It is possible that ASA 3 patients might be selected for relatively non-invasive surgery because of fears about the combined effects of their age and co-morbidities, and hence they may experience less post-operative pain and bleeding than their ASA 1 and 2 counterparts.

Post-operative complication rates did not increase with age, and for both groups were below the locally agreed targets. The Royal College of Anaesthetists’ audit book suggests a target of reported rate of severe pain of <5\%\(^\text{13}\). Our figures compare well; this may be due to our unit’s frequent use of intraoperative local anaesthetic and the stepped protocol for TTA analgesia.

The post-operative bleeding rates may seem high, however they refer to any bleeding reported by the patient at telephone interview while at home the day after surgery. The bleeding was unlikely to have been significant for most patients, given the fact that few needed help from their GP or community nurse.

There are no widely accepted standards for rates of nausea and vomiting, though the Royal College of Anaesthetists suggests 5\% and 1\% respectively for inguinal hernia repair\(^\text{14}\). That our rates are
significantly lower than these may be due to our frequent use of TIVA, spontaneous ventilation, intravenous fluids and anti-emetics.

In conclusion, unexpected admission rates among our elderly patients are not affected by increasing age. Rates of post-operative complications are low in the over-70 age group, and do not significantly rise with increasing age. The need for post-operative help from the GP or community nurse does not increase and patients appear to remain satisfied with the service. Thus it seems that old age itself is not an impediment to safe day case surgery under general anaesthesia.

Acknowledgements
We would like to thank Dr Peter Selley for critical review of the manuscript.

Appendix
Stepped protocol for TTA analgesia

<table>
<thead>
<tr>
<th>Anticipated degree of pain</th>
<th>Analgesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Paracetamol 1g six-hourly</td>
</tr>
<tr>
<td>Medium</td>
<td>Paracetamol 1g six-hourly + ibuprofen 600mg six-hourly</td>
</tr>
<tr>
<td>High</td>
<td>Co-codamol 60mg/1g six-hourly, and ibuprofen 600mg six-hourly</td>
</tr>
</tbody>
</table>

References
In January 2006 I spent two weeks in Liberia anaesthetising adults and children aboard MV Anastasis, the world’s largest hospital ship (Figure 1). The Anastasis has three fully equipped operating theatres and is the flag ship vessel for Mercy Ships, a charity founded in 1978. Mercy Ships specialize in maxillo-facial surgery and have developed the second largest program in Africa for the repair of vesico-vaginal fistula (VVF). They aim to bring ‘hope and healing to the poor, mobilizing people and resources worldwide’.

The Anastasis is based in West Africa and visits countries in the bottom third of the United Nations Health Development Index and only at the specific invitation of the government. Typically eight to twelve months are spent docked in the port of the host country before returning to Europe for fund-raising and recruiting.

My time in Liberia exposed me to third world pathology but with the luxury of first world technology. The anaesthetic machine I used is shown in Figure 2. Three fibreoptic bronchoscopes (including a paediatric one) were available and the same range of drugs as one would expect in the NHS with the exception of Remifentanil. Difficult airways requiring fibreoptic intubation were encountered most days. The most interesting case I anaesthetized was a 35 year old man (Figure 3 and 4 [see over]) with a tumour weighing over 3.5kg. A Swiss anaesthetist and I performed an awake fibreoptic intubation, and anaesthesia was maintained with isoflurane in air enriched with 30% oxygen. A portable Istat gas machine was available for intraoperative blood gas, haemoglobin and electrolyte analysis. At the end of the case we inserted a Cook Airway exchange catheter prior to extubation. The Cook catheter was left insitu for 6 hours and then removed.

The three theatres are staffed by three volunteer anaesthetists one of whom is of consultant level experience. The Anastasis has one full time plastics / maxillo-facial surgeon, Dr Gary Parker, with the remaining surgeons being volunteers of various specialities (VVF, orthopaedics or general surgery) who come on a rotational basis and there is also usually an eye surgeon present. The three anaesthetists share the workload, one for plastics/
maxillofacial, one for the second theatre (general, orthopaedics or VVF) and the third person acting as a ‘float’. The ‘float’ assists with difficult intubations, provides lunch relief, and anaesthetises extra cases or performs eye blocks to aid the eye surgeons. The theatre was run in North American style, i.e., no ODPs but rather a nurse (of variable skill) to assist with induction, meaning you had to be
self sufficient and therefore making the ‘floating anaesthetist’ a particularly valuable asset for difficult cases.

The paediatric difficult airways required asleep fibreoptic intubation and the ones I saw were most commonly for release of ankylosis or following surgery utilizing an Eastlander flap (Figure 5 [previous]). Noma (Cancrum oris), otherwise known as ‘the face of poverty’ is a gangrenous condition which starts as a benign oral lesion which if left untreated progresses to destroy both hard and soft tissues causing facial disfigurement (Figure 6 [previous page]). Various plastic surgical procedures can be performed depending on the disfigurement, one of which is the Eastlander flap. This is a two stage procedure and leaves the child unable to open their mouth after the first stage (Figure 5 [previous page]).

Mercy Ships have an approach to health care that involves not only the practical and physical but also the spiritual and emotional. I found this a refreshing approach and it was inspiring to feel I was making a difference to so many peoples lives. In West Africa facial disfigurement results in the individual and their family being ostracized from the community so further embedding them in the cycle of poverty. Another condition which causes a similar effect is VVF.

VVF results from obstructed labour. The absence of obstetric care means the obstruction persists for several days until fetal death and a shrinking of the fetal skull allows the baby to pass out of the vaginal canal. During this time the fetal head causes a pressure necrosis on the anterior vaginal wall eventually creating a vesico-vaginal fistula and incontinence. This usually occurs in the first pregnancy leaving a young girl not only with a dead baby but a husband and community who subsequently disown her because of the smell of stale urine. VVF surgery restores urinary continence, thereby restoring a sense of dignity to these women who are then willingly accepted back into their communities. I was privileged to anaesthetise for a VVF surgeon called Professor Goh who has developed the Goh Scale used to grade the severity of fistulas. Most of the operations are performed under spinal anaesthesia with 0.5% bupivacaine. Some procedures lasted over two hours and I found morphine was a useful addition to the spinal bupivacaine but unfortunately this caused unacceptable levels of postoperative nausea and vomiting. So after complaints by the nursing staff I omitted the morphine and used intravenous ketamine +/- midazolam if the spinal began to wear off. This was much more acceptable to both the patients and the nurses.

I found my time with Mercy Ships challenging, rewarding and enjoyable. We did not work at weekends and there was time to explore some of Liberia. The Anastasis is currently in Ghana and is short of anaesthetists. Later this year the Anastasis will be replaced by the Africa Mercy, a bigger vessel housing six operating theatres. I intend to return as a volunteer next year and would recommend the experience. Further details about Mercy Ships can be found at www.mercyships.org
Acupuncture and Dry Needling for Myofascial Pain
Dr Nilesh Chauhan MBChB, FRCA
SpR/Pain Fellow, Frenchay Hospital

Acupuncture (from the Latin acus, ‘needle’ and pungere, ‘prick’) is an ancient Chinese medical art form, widely considered to be one of the oldest and most commonly used medical procedures in the world. It is a therapeutic technique intended to restore health and well being. The practice of acupuncture can be traced as far back as the 1st millennium BC in China, from archaeological evidence. Yin and Yang are the basic root intuitions of China. Yin is associated with cold, darkness and tranquillity. Yang is associated with heat, light and stimulation. These complementary opposites are successively intertwined. Qi, (chi), is a fundamental concept of everyday Chinese culture, interpreted as ‘life force’ or ‘spiritual energy’ that is part of everything that exists. Theories of traditional Chinese medicine assert that the body has natural patterns of Qi associated with it that circulate in channels called meridians. Symptoms of various illnesses are often seen as the product of disrupted or unbalanced Qi movement through these meridians. Traditional Chinese medicine seeks to harmonise the imbalances in the Yin and Yang and it’s connecting Qi using a variety of therapeutic techniques. There are recognised to be about 365 acupuncture points, located on 14 main channels or meridians, which link through the body. Needling of particular points or combination of points along these meridians on these so-called acupuncture points is the art of acupuncture. It is thought that needling these points release the Qi and harmonises the imbalance, which in turn cures ailments. ‘Western Medical Acupuncture’ differs from traditional ‘Chinese Acupuncture’ in that the approach emphasises using acupuncture points based on western understanding of myofascial trigger points, the nervous system and scientific discoveries about the likely mechanisms of how acupuncture works. Acupuncture is thought to produce its effects at a number of different levels throughout the body:

- Peripheral effects: include local pain relief through release of neuropeptides and endorphins
- Spinal effects: include the gate control theory, spinal inhibition and the balance between long term depression and long term potentiation
- Supra-spinal effects: through the descending pain inhibitory systems
- Cortical effects: through the psychology of counselling, reassurance and anxiety reduction.

Dry needling is the act of using an acupuncture needle or any other dry needle for that matter to needle trigger points. A myofascial trigger point (MTrP) is a highly localised and hyperirritable spot in a palpable taut band of skeletal muscle fibre. Dry needling differs from ‘wet’ needling in that no local anaesthetic or other drug is used.

As doctors, throughout our training we are not taught to examine muscles. Muscles make up a large part of the body and muscular spasm or myofascial pain accounts for a large part of chronic ongoing pain for many patients throughout the world. Examination of muscle for trigger points involves knowledge of muscle groups and the orientation of fibre strands of the individual muscle groups. Examination involves palpation with the pulp of the fingers moving perpendicular to the muscle fibres, a bit like kneading dough but with the fingers! Eliciting pain on a particular point during examination together with feeling a knot or taut band under the skin determines a trigger point. The palpable taut band is a semi-hard strand of muscle that feels like a cord or cable. It can sometimes be similar to plucking a guitar string.

Common clinical characteristics of MTrP include:

- Compression causes local pain or referred pain in the area where the patient normally gets pain
● Rapid compression across the muscle fibres may elicit a ‘local twitch response’ which is a brisk contraction of the muscle fibres in or around the taut band
● Restricted range of stretch, which may cause tightness of the involved muscle
● The muscle may be weak but without significant atrophy
● There may be associated autonomic phenomena.

There are common recurring areas for MTrP but they can occur anywhere in any of the muscle groups. They may also be associated with characteristic referred pain patterns. MTrPs tend to correlate with the position of some acupuncture points, suggesting that the underlying neural mechanisms are the same5.

MTrPs commonly occur due to chronic overloading of muscles. Other causes include direct impact from trauma. They can also occur due to iatrogenic causes such as surgery or injections.

There are various practices for the act of needling. They include quick insertion and withdrawal of the needle, variations in the length of time the needle is left in, twisting or flicking the needle, and repeated insertion/withdrawal techniques. Whichever method, the aim is to apply the tip of the needle to the taut band, thereby releasing the muscle spasm. Whether this is done by dry needling or by injection of a drug, the act of needling the MTrP appears to be an effective treatment6, 7.

My practice includes identification of trigger points from the history and examination. I use a combination of dry needling and needling of acupuncture points. Educating the patient regarding awareness of their trigger points and teaching to self-massage and stretch these areas is key to self-management of the patients own pain8.

Dry needling or acupuncture can be a very useful tool for relieving myofascial pain however quite commonly this can only be a short-term measure. It is important therefore to determine the reasons for the return of the pain. In many cases the reason is due to a range of ‘perpetuating factors’ that cause the trigger points or muscle spasm to return. These can be structural or mechanical causes such as scoliosis and joint laxity or can be metabolic causes such as anaemia, hypothyroidism or vitamin D deficiency9. More commonly it is due to bad postural habits that the patient consciously or subconsciously has learnt over the years10. Patient awareness of these habits is the key to making corrections to avoid them. Such habits include poor posture. Incorrect movements whilst turning, bending, reading, sleeping, working at a desk etc can overload particular muscle groups which can all contribute to the perpetuating factors. It is important to dissect down these perpetuating factors, correct them and thereby prevent the return of the MTrPs.

Needling can have its drawbacks. It can be associated with post injection soreness and autonomic effects such as nausea, vomiting, sweating and vasovagal collapse. Some patients are sensitive responders causing drowsiness and lethargy and so it is prudent to start with fewer points in the first treatment. Other adverse effects associated with injection therapy are uncommon and although life-threatening complication have been described they are rare. Acupuncture and dry needling are safe techniques if used in a safe and controlled manner.

Many people suffer from chronic myofascial pain. Acupuncture and dry needling are a useful adjunct to conventional therapy. It is also important for the patients to recognise the perpetuating factors, which need to be resolved to prevent reoccurrence of the MTrPs. Awareness of this and education together with self-massage techniques enable patients to self manage their pain.

References
Atrial Fibrillation for Anaesthetists

Dr A. Theron, SHO Royal Devon and Exeter NHS Hospital
Dr K. Davies, SpR Royal Devon and Exeter NHS Hospital

Atrial fibrillation (AF) is a common arrhythmia with significant healthcare issues worldwide. The prevalence of AF increases with age resulting in an increased risk of death; commonly from thromboembolic events. The signs and symptoms include dizziness, palpitations, fatigue, dyspnoea, angina and congestive cardiac failure.

The risk of a stroke is significantly increased in patients with AF in association with increased age, diabetes, hypertension and previous history of stroke. Those patients with rheumatic heart disease and AF have a 17 fold increased risk of stroke. Anticoagulation has been clearly demonstrated to reduce the risk of stroke by 50-80%.

Classification
The recent guidelines from the American Heart Association and European Society of Cardiology have recommended classifying atrial fibrillation into 3 patterns, irrespective of symptoms or duration. The 3 recognised patterns are:

Reversible causes of atrial fibrillation are excluded from this classification such as thyrotoxicosis, ethanol intoxication and electrolyte imbalance. Conditions associated with AF such as acute myocardial infarction (AMI), pulmonary embolism, pericarditis, cardiac surgery are also considered separately from this classification due to a significantly reduced risk of recurrence once the condition is treated.

Pathophysiology
The rhythm of AF is a result of multiple re-entrant waveforms arising in the atria and bombarding the atrioventricular node (AV node), which becomes refractive to conduction and an irregularly irregular ventricular rhythm occurs. The rhythm is usually rapid and irregular. The causes of the multiple re-entrant waveforms may be grouped into 3 distinct clinical circumstances:

- A primary arrhythmia in the absence of any identifiable structural cardiac abnormality
- A secondary arrhythmia in the absence of any cardiac abnormality but in the presence of a systemic abnormality which predisposes to AF, ie electrolyte imbalance
- A secondary arrhythmia in the presence of identifiable structural cardiac abnormality that affects the atria

The rapid irregular and chaotic depolarisation of the atria and loss of effective atrial contraction reduces the filling capacity and the stroke volume. The resulting rapid irregular ventricular rhythm reduces the ventricular diastolic filling causing haemodynamic instability. This is of importance in patients with hypertension, mitral valve stenosis, and hypertrophic and restrictive cardiomyopathy.

The main objective of treatment of AF is to revert back to sinus rhythm either by treating the cause or through cardioversion; this may be by either chemical or electrical means. Failing this, rate control and anticoagulation reduce the risk of thromboembolic events and death.

Assessment
The anaesthetist will encounter the patient with AF through a variety of routes.

- The patient with recurrent or persistent AF for cardioversion
The patient with AF for surgery; cardiac or otherwise

- The patient who develops AF in the perioperative period
- The patient admitted to high dependency unit (HDU) or intensive care unit (ICU) due to haemodynamic instability secondary to AF due to another cause ie. AMI, cardiac surgery, pericarditis.

The initial assessment of the patient must include the onset of the arrhythmia, duration of current treatment, previous treatments and potential causes of the AF. If the cause for the AF is reversible then the treatment of this condition must be considered before any elective surgery or elective cardioversion.

Reversible causes of AF are:

- Ethanol intoxication
- Excess caffeine intake
- Thyrotoxicosis
- Drugs ie. amphetamines
- Electrolyte imbalance

Other associated conditions to be considered:

- AMI
- Pericarditis
- Post cardiac surgery
- Cardiomyopathy
- Pulmonary embolism
- Sick sinus syndrome

A full history and examination is mandatory including any medical or family cardiac history. The use of illicit drug use must be noted.

The basic investigations must include a 12-lead ECG, full blood count, electrolytes and renal function test and thyroid function test. Consider drug levels such as digoxin and ethanol.

The ECG of AF shows a loss of the p waves and an irregular ventricular rhythm. There may be evidence of left ventricular hypertrophy, pre-excitation bundle branch block (Wolf-Parkinson-White syndrome), myocardial ischaemia or other cardiac arrhythmias.

A chest X-ray will be of benefit in patients with suspected ventricular dilatation and cardiac failure. A transoesophageal echocardiogram (TOE) will identify the presence or absence of an intracardial thrombus 6,7.

### Drug therapy

The treatment of patients with AF may be divided into two groups.

The **rhythm controlled** group: the aim is to maintain sinus rhythm using a variety of drugs (Vaughan Williams classification) 5.

<table>
<thead>
<tr>
<th>Class</th>
<th>Action</th>
<th>Drugs</th>
</tr>
</thead>
</table>
| Ia    | Membrane-stabilising | Procainamide  
|       | Blocking the fast Na channels  
|       | Slowing of the conduction through the myocardium  
|       | Prolong the myocardial refractoriness  
|       | Extend the repolarisation time |
| Ic    | Membrane-stabilising | Flecaainide  
|       | Block the Na channels  
|       | Prolong conduction |
| II    | β-adrenoceptor blockers | Esmolol  
|       | Reduce the ventricular rate |
| III   | Block the K channels | Amiodarone  
|       | Prolong the action potential  
|       | Prolong repolarisation  
|       | Lengthen the QT interval |
| IV    | Calcium channel antagonist | Verapamil  
|       | Block inward movement of calcium  
|       | Reduce automaticity  
|       | Increase the refractory period  
|       | Slow conduction at AV node |
| Others | Cardiac Glycosides | Digoxin  
|       | Inhibit Na/K dependent ATPase |

The **rate-controlled** group relies on drugs to control the ventricular rate at both rest and during exercise. These drugs include beta-blockers, calcium channel blockers and digoxin. A combination of these drugs is often needed for control of the ventricular rate through depression of conduction through the AV node, which may lead to bradycardia or heart block.
**Anticoagulation** plays a major role in the treatment of patients in AF. The evidence is that there is no significant difference in the risk of stroke between the patients with transient, persistent and permanent AF. All patients with AF should be anticoagulated during the arrhythmia. The risk of stroke increases in patients with AF in conjunction with increasing age, diabetes mellitus, previous thromboembolic events, coronary artery disease, hypertension and thyrotoxicosis.

Oral anticoagulation is effective in reducing the risk of stroke by 60% in patients with AF compared to placebo. The maximum benefit is achieved with an INR between 2 and 3. The risk of bleeding is significant and the risk-benefit ratio must be assessed. Aspirin offers only a moderate reduction in risk of disabling stroke.

The recommended antithrombotic therapy for AF is:

<table>
<thead>
<tr>
<th>No risk factors</th>
<th>Aspirin 325mg once daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 moderate risk factor</td>
<td>Aspirin 325mg od or warfarin (INR target 2.5)</td>
</tr>
<tr>
<td>High risk factors or &gt;1 moderate risk factor</td>
<td>warfarin (INR target 2.5)</td>
</tr>
</tbody>
</table>

The risk factors are:

<table>
<thead>
<tr>
<th>Low risk factors</th>
<th>Moderate risk factors</th>
<th>High risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female 64-75 yrs</td>
<td>≥75 yrs</td>
<td>Previous stroke, TIA, embolism</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>Hypertension, Heart failure</td>
<td>Mitral stenosis</td>
</tr>
<tr>
<td>Throtoxicosis</td>
<td>LV ejection fraction &lt;35%</td>
<td>Prosthetic heart valve</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Aspirin may be used in patients when warfain is contraindicated.

Oral anticoagulation may be stopped in a patient with AF, with no mechanical valve, for up to 1 week without the need for additional anticoagulation. If the oral anticoagulation needs to be stopped for a period greater than 1-week then un-fractionated heparin or low-molecular-weight heparin should be used.

**Perioperative care**

**Stable patient in sustained AF presenting for elective DC cardioversion**

This is a day case procedure with patients undergoing a procedure under general anaesthetic. Ensure that all reversible causes have been excluded and that patient has been adequately anticoagulated. Routine monitoring, oxygen throughout the procedure and adequate recovery care is mandatory for the perioperative period.

**Unstable patient for DC cardioversion**

This must be treated as an emergency procedure. A rapid sequence induction is mandatory with endotracheal intubation.

The risks following DC cardioversion include:

- Ventricular and supraventricular premature beats
- Bradycardia
- Sinus arrest
- Ventricular tachycardia and ventricular fibrillation
- Embolic event

All patients undergoing DC cardioversion need to be anticoagulated for 3-4 weeks both before and after the procedure. If the patient is unstable and requires an emergency DC cardioversion then the patient should receive a heparin bolus prior to the procedure and then anticoagulated for 3-4 weeks. Alternatively, a transoesophageal echocardiogram will detect any thrombus; the presence of a thrombus requires anticoagulation prior to DC cardioversion whereas the absence requires a bolus of heparin prior to the procedure.

**Stable patient in sustained AF for non-cardiac surgery**

The main aim in the management of patients with sustained or permanent AF undergoing non-cardiac surgery is to maintain a satisfactory ventricular rate.

The optimum rate for patients in AF is **90bpm**. The rate may be inherently low without drug therapy, particularly in the elderly. However, most patients in chronic AF will need long-term oral therapy for rate control.

Patients who experience an increase in heart rate in the perioperative period may require a rapid control of the ventricular rate. Esmolol and verapamil are very useful in the acute phase. The
short elimination half-life of esmolol allows easy manipulation of this drug thereby minimising the negative ionotropic effect.

Amiodarone may also be used in the acute phase and may also chemically convert the arrhythmia to a sinus rhythm.

**Stable patient in sinus rhythm with recurrent AF for non-cardiac surgery**

The aim is to maintain sinus rhythm and prevent recurrences of AF.

Therefore a carefully administered, appropriate anaesthetic avoiding precipitating factors such as myocardial ischaemia, hypotension and electrolyte imbalance will reduce the risk of intraoperative AF. Prophylactic treatment to prevent the recurrence of AF may be considered and is effective in maintaining sinus rhythm in 50-70% of cases. The initiation of drugs to maintain sinus rhythm must only follow consultation with the cardiologist. The drugs used are Class Ia, Ic and III.

**Stable/unstable patient that develops acute-onset AF in the perioperative period**

The immediate management of the unstable patient with acute-onset AF is usually DC cardioversion to sinus rhythm, particularly if the patient is already anaesthetised. The precipitating factors must first be identified and treated as this may result in reverting to sinus rhythm, such as myocardial ischaemia, electrolyte imbalance and surgical manipulation within the mediastinum or thorax.

Indications for DC cardioversion are haemodynamic instability, aortic stenosis, mitral stenosis or hypertrophic cardiomyopathy. Digoxin toxicity and sick sinus syndrome are contraindications to DC cardioversion.

Chemical cardioversion may be appropriate for the stable patients with acute onset AF perioperatively. The most useful drugs in this setting are amiodarone and digoxin due to speed of onset and intravenous administration.

Amiodarone is effective in slowing the ventricular rate and may chemically convert the arrhythmia. Digoxin also slows the ventricular rate and has a mild inotropic effect, which is beneficial in the presence of heart failure.

These drugs must be continued in the postoperative period even if the patient converts to sinus rhythm and an urgent cardiology consultation should be sought.

**Conclusion**

Patients with atrial fibrillation potentially present a significant burden to the healthcare service particularly when associated with co-morbidities. The risk and consequence of a thromboembolic event have focused the long-term treatment to reducing this risk through rhythm and rate control and adequate anticoagulation. The role of the anaesthetist in the care of these patients is to maintain either the current rhythm or rate and to effectively treat any perioperative arrhythmias while taking into account precipitating and potentially reversible factors, current medication and associated conditions.

**References**

Volunteer for Third World Anaesthesia?

(Blatant recruitment article)

Adam Skinner, Locum Consultant Anaesthetist, Bristol Children’s Hospital
Rowan Hardy, Consultant Anaesthetist, RUH Bath

Interplast is a non-government charity organisation based in Mountain View, California. The stated aim is to provide free plastic reconstructive and burns surgery to children of developing countries. Below is an account of two separate experiences of surgical trips. We will attempt to address some of the ethical and logistic aspects of the organisation, and also to answer the many historical criticisms of ‘safari surgery’. We would like you to make up your own mind as to whether it is something you feel you would like to do. At the same time however, we will not try to hide the fact that the subtext of this article is to unashamedly recruit experienced (peri-CCT or above) anaesthetists as volunteers.

Interplast was established by Dr Donald Laub, a plastic surgeon from Stanford University in 1969. It started when he met a 13-year-old called Antonio from Mexico. Antonio had a cleft lip and palate, was ostracised from most of his community and had never attended school. The team operated on his lip and palate and Antonio returned home, started attending school and was integrated back into the community. Dr Laub coordinated surgical teams to visit other areas in Central America, and in time established surgical trips to many parts of the rest of the World. Now surgical teams are sent to approximately 25 sites worldwide; in total over 3000 operations are performed on children each year.

Over time, other Interplast organisations have been set up in Australia and Germany, although these are in not linked to the original USA Interplast in terms of authority, accountability or responsibility.

If you listen to any speaker on the subject of third world medicine, certain themes seem to arise: Firstly, if you are going to go, you need to have some experience before you volunteer. Quite rightly, gone are the days of ‘jollies in the sunshine’ to improve logbook numbers and provide ‘practice for the lads’. Most organisations such as Interplast will not consider volunteers until they are ‘independent practitioners’. In practical terms, in the UK this generally refers to being post CCT.

Secondly, most speakers will say that for a trip to have value, it is important to leave something behind. This has traditionally been an area of criticism; teams from various organisations have been reported to swoop into a region, exclude the local medical community, fix a few patients and feel jolly good about themselves before flying home. Interplast are very careful to portray a different image; the goal is clearly stated as “to establish, develop and maintain host country medical care”. During our accounts we will give our opinion as to whether this slogan is translated into practice.

Myanmar (Burma) February 2006
Adam Skinner

After an informal chat to a couple of previous volunteers, a perusal of the website (www.interplast.org), a CV and a couple of bits of

Figure 1: Sites visited by Interplast (USA).
paperwork, I soon found myself presented with a choice of Vietnam or a craniofacial trip to Myanmar. Being possibly the most politically naïve person in the world, my choice was forced more by availability of annual leave than by deep exploration of my personal ethics and worldly knowledge. We all realise that Myanmar is not known for its exemplary record on human rights (a subject I would rather avoid in this forum); however I felt I had no quarrel with the population, so I blindly gave it a go. I was a little concerned to have to sign legal papers to say I would not take action against Interplast if I was kidnapped, imprisoned, killed etc., however based on the ‘It will probably be OK’ principle, I signed the papers and arranged for the MDU to provide cover for the trip. Interplast asked us to pay US$385 each towards the trip; this was our only contribution for bed and breakfast accommodation, transfers, economy return airfare and taxes.

Pre-trip organisation was excellent. Visas arrived on time, booklets were provided on ‘anaesthesia in developing countries’ and clear lists of what medical and non-medical equipment to bring were provided in good time. To this day however, I am unclear as to why we were all required to bring two packets of ‘moist wipes’.

All members of the team met for the first time in Singapore airport ready for our onward trip. The team comprised two senior Californian plastic surgeons (one was the team leader), three ‘anesthesiologists’, one nurse educator, two recovery nurses, a ‘pediatrician’, two scrub nurses and two translators. Unlike some other organisations, teams tend to be small and this trip did not include sponsors or fundraisers.

Our transit through customs in Yangon (city formerly known as Rangoon) in Myanmar (country formerly known as Burma) was surprisingly stress-free considering our medical load of 33 medical boxes, 19 suitcases and 17 pieces of hand luggage. This was quite a relief to some return volunteers, who remembered customs impounding all equipment on one trip to Peru for the first 10 days of a 2-week mission.

I will not pretend we lived in squalid accommodation; we paired ourselves up and shared rooms in a polished 4 star hotel. I chose to share a room with a surgeon called Steve; he chuckled enthusiastically at my copy of Viz, so I knew we would get on well.

The evening meal on day 1 was used as a team-building exercise and to explain our itinerary. The chief surgeon made it very clear that on these trips the “anesthesiologists have the hardest job, so we won’t do anything too difficult”. This seemed to be an encouraging opening statement; of course, it would have been even better had it been accurate.

Day 2 (Monday) was clinic day. The aim was for surgeons, the paediatrician and anaesthetists to see all prospective patients. We had a list of 78 names, approximate ages, weight and haemoglobin measured by our haemocue. I was concerned that being in Myanmar for only two weeks we would be pressurised into operating on patients who were not necessarily medically fit. This could not be further from the truth. The Interplast rules were refreshingly conservative; anyone from the team can suggest a cancellation, anyone with an upper respiratory tract infection should be cancelled and anyone with a haemoglobin below 8g/dl for a palate repair (or 12g/dl at altitude) should be given iron and postponed until the next Interplast trip. Most children had a Hb concentration between 8 and 10g/dl. No syndromic children were undertaken, particularly if suspected of having a cardiac anomaly. It is estimated that 25% of the population is below the poverty line. Many patients are therefore malnourished and have poor healthcare. Unlike the UK or USA, in Myanmar the paediatric weight estimation (Age+4) x 2 is almost always an overestimation. Pathology of course presents late and TB, Malaria and Dengue fever are common.

Interplast are invited to Yangon by the Myanmar government 3-4 times per year, so re-booking patients is only marginally slower than in some sectors of the NHS.
In total, 15 were postponed due to reasons above or cancelled for being inappropriate for surgery. This left us with 63 to do with some room for late bookings if required. We had a total of 7 operating days. The caseload was 70% paediatric, of which the great majority was cleft lip and palate surgery. The youngest cleft lip was 3 months of age. The rest of the work involved Burns, trauma and facial tumours. One child was cancelled due to a new diagnosis of Tuberculosis.

Day 3-6 (Tuesday-Friday) were theatre days. The anaesthetic setup was surprisingly good. We had wall oxygen (which we later discovered was switched off at night) and a basic Boyle’s machine. The rest of the equipment including plenum vaporisers, co-axial circle systems, monitors, absorbers, drugs, syringes, giving sets etc. were provided by Interplast. We all provided our own scrubs, gloves, masks and hats, and each anaesthetist provided their own non-depolariser of choice and special airway equipment. I am very grateful to Frenchay for providing bougies, intubating LMA’s and Aintree catheters. The chief anaesthetist provided an adult fibre-optic scope.

There were two theatres to run two simultaneous lists (often on Interplast trips one theatre houses two operating tables). Therefore with three anaesthetists, we had one per theatre and one floater to help with induction, emergence and recovery and to clean laryngoscopes and endotracheal tubes with Cidex for repeat use. ODPs or anaesthetic nurses are not part of the American anaesthetic set-up as we all know.

The day started in accordance with Interplast rules with a group meeting and to verbally discuss emergency drills such as cardiac arrest, power failure and oxygen supply failure. Figures 7-14 provide examples of the cases undertaken.
In an attempt to promote healthcare in the host country, one of Interplast’s projects is to educate parents and local healthcare providers to be able to provide basic speech therapy. Approximately 50% of cleft palate repairs in the UK require speech therapy. There are no ‘speech pathologists’ in the whole of Myanmar. These ‘therapeutic follow up programs’ have been successfully set up in other countries but it is yet to be established in Myanmar.

**Burns - Acid**

Although this was apparently accidental, acid attacks are common in some parts of the world. Interplast have partnered with many organisations to help treat, prevent and re-integrate acid burn survivors back into their community. One such organisation is the ‘Acid Survivors Foundation’ in Bangladesh.

**Burns – Bomb blast**

Although not widely publicised, Reuters and other new agencies have reported 3-4 bomb attacks in the cities of Myanmar in the last 12 months.
Burns – Domestic Accidents

According to figures from Interplast, 1 in 2000 children in the developed world suffer burns which are usually promptly treated with reduction in scar and contractures. In the developing world the figure is 1 in 200, many of which have disabling injury with severe social, economic and psychological consequences. The child below presented an obvious difficult airway. Apart from the neck flexion due to severe contractures, the facial scars limited the mandibular growth. As well as the micrognathia, contractures around the mouth further limited mouth opening. The plan was to do a gas induction followed by a fibre-optic oral intubation. Unfortunately the light source broke after a few seconds of testing. In the absence of a spare or parts to fix it, we were forced into plan B, which involved a gas induction followed by surgical release of scars with diathermy to allow laryngoscopy and intubation with the aid of a bougie.

Tumours

Figure 11: Bomb blast victim required contracture release.

Figure 12a and 12b: A 5 year old girl suffered facial, neck and shoulder burns 2 years ago due to an accident at home with an open fire used for cooking.

Figures 13 and 14: Patients presented with Neurofibromatosis. One was relatively mild (above) and the other was severe (overleaf).
This 78 year old man had multiple neurofibromas. The large tumour above his lip was mobile enough to allow us to intubate orally with direct laryngoscopy. Only mild sedation and topical lignocaine was required. The irregular mass at the lower margin of his mandible is a large aberrant branch of the facial artery. This precluded us from removing all the tumours.

Days were long. We left the hotel at 0715 and operated often until 1900. We then went to eat stunning food at various places around Yangon before returning to the hospital for an evening ward round. One surgeon, a nurse and an anaesthetist would be on call for emergencies. Two children needed to return to theatre for bleeding. There was no mortality.

We had the middle weekend off to explore some of the country. We took a plane to Bagan, a fascinating ancient city filled with over 2000 stunning pagodas between 700 and 900 years old. Transport for most was by horse and cart. Steve said that it would be one of the most romantic places he had ever seen. He continued “What a pity I am sharing a room with someone I do not find remotely attractive.” I was strangely comforted by these words.

Days 9-11 were in theatre, which left the Thursday for the team to pack up our equipment while I lectured to the local trainee anaesthetists for a couple of hours. We left some anaesthesia and resuscitation books behind for the trainees.

My Tho, Vietnam March 2005
Rowan Hardy
My experience of Interplast in action in Vietnam was in many ways remarkably similar to Adam’s in Myanmar. I too browsed through the list of interesting destinations, ranging from the exotic to the frankly unappealing and plumped for the former. My Tho is a town in Southern Vietnam, on the Mekhong delta in an area important for its paddy fields and fishing. The district hospital is of good quality, but cannot provide a specialist paediatric plastic surgery service, despite great need. Interplast has been operating here annually for the past 6 years and is involved in the long-term training of local surgeons and anaesthetists.
The application process was simple and slick, including a conference call for all the team a week or so before departure (at a very convenient time of day in California, less so in Wiltshire). Clearly, these people had thought through (and experienced) every eventuality – not surprising after operating on 60 000 patients – and I was full of admiration for their organisation and planning.

The rest of the team were American and we joined together in Hong Kong for the final flight up to Ho Chi Minh City (formerly Saigon). I have never seen so many pieces of luggage tumbling onto the carousel: expensive medical equipment is of course returned, but large quantities of supplies (eg. drugs, drapes, airway devices) are left with the hosts. The trips are self-sufficient, with some items such as drugs and fluids being purchased locally where possible.

Our team had a very appropriate mix of professionals and apart from being the only non-US member I was also the only Interplast-novice. Our two Vietnamese American translators were full of enthusiasm and excitement at being ‘home’ and guided us through our various experiences with relish (and amusement). They gave great reassurance and comfort to the children, whilst teasing us relentlessly! Our two plastic surgeons were senior US surgeons of the highest calibre. We also had a paediatric specialist, three anaesthetists as well as theatre and recovery nurses. I would reiterate Adam’s point that the quality of staff involved could not have been higher – it was a delight to work with these people.

On our first day, we ran our clinic to select patients from a huge and enthusiastic crowd of families. Publicity about the Interplast trip had been sent out weeks before, around the region on posters, radio messages and by word of mouth. Many people had travelled for hours on bikes, motorcycles and buses. Each patient was triaged through each specialty to ensure their suitability. About half were rejected – and I was most reassured by the very sensible and strict criteria we applied. These standards are the same as Adam’s trip as these are universal to Interplast. Our commonest reasons for rejection were suspicion of chest infection or asthma: both very common due to the prevalence of open cooking fires in the home.

This for me was the worst part of the trip and was immensely humbling. For many of these children, our trip represented the only chance of surgery – their families put great faith in our ability to help.

To face rejection at this stage was cruel and very sad: however, all those I saw took the news calmly and with great dignity; most thanked us very sincerely before they set off on their journey home. Of course, many of these children can re-attend next year when Interplast return to My Tho – a great advantage of their long-term commitment.

We unpacked our boxes to create a very acceptably equipped theatre. As in Myanmar, we had new Datex monitors, circle breathing systems, Iso & Sevoflurane (!), scavenging (well, a pipe trailing out of the window) and a large selection of paediatric airway equipment. Our drug choices were somewhat limited, yet cleverly chosen since we never seemed to be lacking. For example, although our only antiemetic was dexamethasone, just 2/80 patients vomited.
We had a single theatre, but being a large room we ran two tables simultaneously: a system that worked rather well (Patricia Hewitt’s ears are pricking up). Cases were timed to ensure that there were always two anaesthetists involved with each induction and emergence. I was amazed by the resilience of the children: even young children would happily (well, rather meekly sometimes) walk in past another operation, climb aboard the operating table and await their induction: no parents in tow here! We had a similar patient and case mix as Adam’s group in Myanmar and carried out 70 operations in 9 days. I am happy to report that we had no critical incidents and just one patient had to return to theatre (due to failed ptosis correction).

We had 1-2 cleft lip/palate operations each day, often in older children than we would expect in the UK, but also including several infants. Clearly for these children, the implications for development, speech, feeding & general well being are enormous. In the UK, these cases are immensely rewarding— in Vietnam, where expectations are so low, the emotions run even higher. In recovery, to witness the reunion of mother and baby was a privilege.

Burns are also common in Vietnam and the long-term sequelae are severe and disabling contractures. Some children require serial operations, over the years – something Interplast is able to achieve.

The man in figure 18 was burned as a child and despite severe contracture is able to work as a farmer, supporting a wife and family. Our initial plan was to release the contracture under LA, enough to consider induction of GA. However, he proved to be so stoical (he chatted to us throughout and showed absolutely no change in heart rate / blood pressure) the entire procedure was performed without need of our services!

Ptosis is a common condition in Vietnam. Our surgeon used a technique of implanting a length of Palmaris longus tendon into the upper lid, to great effect.

Our days were also long, but in the evenings we too experienced some wonderful local cuisine whilst relaxing on the shores of the Mekhong. Our hotel was fine and the backdrop was the colourful and noisy procession of riverboats chugging past at all hours, carrying anything from wood & cement to bananas and rice. The only danger we faced was crossing the road – our translators showed us that walking fearlessly out into the tide of bikes and trucks was the only approach - and sure enough, the waves parted and we all survived. Our middle weekend was spent in Ho Chi Minh, including a visit to the moving museum on the ‘American War’.

Overall, both trips were an outstanding experience. We felt we provided the best service we could under the conditions. It was culturally illuminating. We would like to address some commonly cited criticisms of these surgical trips. Some of these are debatable, others we feel are a little unfair today. Please decide for yourselves . . .

1. “Surely you are providing a sub-standard surgical service?”

This often comes from experience or anecdotes from a few years ago. Most Interplast surgeons are from
the USA and are all board certified plastic surgeons with extensive experience in cleft palate and lip repair. Over-ambitious surgery was not undertaken and there was a low threshold for cancellation or postponing cases if deemed inappropriate.

2. “I would not be comfortable with unfamiliar 3rd world anaesthetic equipment.”

Unlike many accounts of overseas work, the equipment is familiar and generally of good standard. There were inevitable equipment issues due to ‘wear and tear’ such as small vaporiser leaks, however most of the equipment would not be out of place in an anaesthetic room in the UK. It is true to say that certain aspects of care were not absolutely ideal; we needed to sterilize and re-use endotracheal tubes unless heavily soiled, clean laryngoscopes between cases and needles were re-used if only used for injection into a proximal port of the fluid giving sets. There was no ventilator, so techniques needed to be adapted to use spontaneously breathing techniques in situations where many of us would use neuromuscular blockers in the UK.

3. “Is the after-care adequate?”

There are 3-4 trips to Myanmar and 6 to Vietnam per year. Follow-ups can be seen on subsequent missions if required. Twice daily multidisciplinary ward-rounds identify the immediate post op problems. Pain relief can be a problem as the availability and safety aspects of opiate delivery on the wards prevented us from providing a gold-standard service.

4. “What was the point of us being there?”

In Myanmar, this is a question I wrestled with for the first week of the trip. A reasonably well-staffed craniofacial hospital with capacity to perform cleft palate surgery is a strange site for repeated humanitarian trips by overseas medical staff. I reconciled this apparent paradox in a number of ways:

Firstly, (in both locations) the doctors and nurses require ongoing educational contact with the outside world; they do not have the opportunity to visit international meetings due to cost and perhaps political restraints. There is severely limited availability of the internet which is very expensive and highly censored. Books and journals are in short supply.

Secondly, in Myanmar, the patients could not afford the treatment themselves. Although medical staff care is free, patients still need to pay for analgesia, drugs, fluids, drip sets, cannulae etc. For a laparotomy for instance, this would come to US$300. This is out of range for many patients (even the head anaesthetist earned only £17 per month!). Some surgery was beyond the scope of local surgeons. I was informed there would be no absolute guarantee that a financial contribution would reach the intended destination. It is more reliable to supply the medical team itself. I cannot say whether this is true.

Thirdly, one of the team mentioned to me that the mission goes some way to improving relations between the two countries. The US is still imposing sanctions on Myanmar. Vietnamese – US relations are improving dramatically and it is certain that such contacts can accelerate this progress.

5. What do you leave behind?

Interplast intends to educate and empower local medical communities to be independent. Since 1997, many surgeons in Myanmar have been trained by Interplast to perform procedures such as cleft palate and lip surgery. The US surgeons tell us the local surgeons have become very skilled. Nursing lectures were held throughout the week in Myanmar, despite the fact that the local government apparently disallowed US lectures to take place in certain public buildings. In-theatre teaching by the surgeons occurred on a daily basis and Adam lectured to the anaesthetists at the University hospital. Rowan was involved in daily teaching of anaesthetists and anaesthetic nurses in theatre. Occasionally, the US offers a scholarship for a third world doctor to go to the USA for a year to train in a surgical speciality.

6. Surely if you want to do some good you should go for a few months with M.S.F. or the Red Cross?

One previous Interplast volunteer said “To be honest, you are doing it for yourself, if you want to do some good then go with MSF or Red Cross for a few months”. One can argue this statement ad infinitum; however people balance their own motivation against their individual domestic
practicalities. Two weeks is easy to take as annual leave – some consultant contracts in the UK include provision for 2 weeks every 3 years for humanitarian work. We did not put ourselves through hardship, nor did we have to cope with personal danger or the helplessness of inadequate medical supplies. We do not believe, however, that this detracts from a hugely rewarding experience. We also probably did a bit of good along the way.

Further information can be found on the website www.interplast.org. Alternatively if you have a query you can e-mail Beverly Kent at beverly@interplast.org.

We are very grateful to ODPs at the RUH, Bath, Frenchay and BMI Bath Clinic for collecting ‘expired’ and unwanted medical equipment and also to Glaxo Smith Kline (UK) for providing supplies of mivacurium.

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**FENELEY TRAVELLING FELLOWSHIP**

A variable sum of money awarded annually to support a “mission abroad”. Applications to Dr P. McAteer, Hon. Sec., Bath.
There is such a thing as society
Neville Goodman, Consultant Anaesthetist, Southmead

A poster caught my eye. The inaugural meeting of the South West Regional Anaesthesia Group.
Is it really necessary?

Next year, SASWR celebrates its Diamond Jubilee: 60 years of anaesthetic practice, science and social activity. In common with other general societies it is worried about the future. The Anaesthetic Research Society (ARS), for so many years the scourge of maturing senior registrars, is having trouble filling its meetings. At one time, a presentation at the ARS was one of the tick boxes on the CV, but no longer. The meetings are just as valuable for anyone interested in general research – but there is the problem. There are so many sub-specialist societies now that the audience for the ARS has been seduced away. Obstetrics, paediatrics, pain, intensive care, intravenous anaesthesia, difficult airways, regional anaesthesia, the elderly, orthopaedic surgery, eyes – the list goes on of an ever-increasing number of groups who seem only to want or need to know about their own sub-specialty. Although, of course, there may be other motives. Each society will have committee members, a president, an hon. sec. – all grist to the clinical excellence awards mill.

It is difficult not to be facetious. To wonder why there is no inhalational anaesthesia society. To wonder what is so special about intravenous anaesthesia, seeing as all of us do it, if only at induction. To wonder who will have the nerve to be the founding members of the “20s to 40s Laparoscopic Cholecystectomy Society”. Few anaesthetists are so specialised that they need to be so naval gazing during their study leave and, though I don’t do private practice, I have heard it said that specialists in the NHS are nonetheless generalists in the private hospitals.

General journals have the same worry. Journals are even more sub-specialised than societies. Look wider than anaesthesia, at some of the basic science journals, and the specialisation brings to mind angels dancing on pinheads: there is a journal title Codon, devoted solely to those sections of the genetic code. But there is more point to specialist journals than to specialist societies. The journals can be read whenever convenient, dipped into, and ignored; but societies have something that journals do not have: society. While it is true that the most valuable parts of a specialist society meeting are the informal chats about practice and research that take place over coffee, dinners are much more enjoyable at general societies such as SASWR than at specialist ones. Who would want to take one’s spouse to the ARS? The conviviality of SASWR goes beyond a sharing of work to a sharing of life. Sub-specialisation has advantages both for doctors and for patients, but something that is refreshingly becoming more and more mentioned, even in official documents, is ‘work-life balance’. Sir William Osler (1849-1919) said some sensible things. ‘The greater the ignorance the greater the dogmatism.’ ‘One of the first duties of the physician is to educate the masses not to take medicine.’ ‘The value of experience is not in seeing much, but in seeing wisely.’ These sentiments are as true now as when he said them a century or more ago. But ‘What about the wife and babies if you have them? Leave them! Heavy are the responsibilities to yourself, to the profession and to the public’ is not a modern sentiment, and now it is better to bring your wife – or indeed your husband - and babies with you.

So I don’t think the South West Regional Anaesthesia Group is necessary. Not like SASWR. SASWR keeps anaesthetists’ bodies and souls together.
There is a school of thought that people, given time, come to resemble their pets. I don’t know if this is in fact the case or, if shaggy, unkempt people buy sheepdogs and silly, yappy actresses own silly, yappy dogs. It is more likely that aloof, selfish individuals were like that before they bought a cat. (Just joking, don’t write in!).

I have begun to wonder however, if something similar occurs with wine. Does the character of a Nation’s wine come to resemble the character of its citizens? At the risk of perpetuating the most general of generalisations, take French wine. For any grape you care to mention (and they do grow an astonishing variety in France), the French expression of it usually will be elegant and delicate with quality obvious to see. But it will also be somehow difficult to love immediately – just like the French. There are formalities to observe with a French wine. You need to cellar it, uncork and decant it, have a proper glass and sip it with thought. It’s like meeting your partner’s parents for the first time. A nice occasion probably, but a little stiff.

Not so with your Aussie Shiraz. This is a great friendly puppy of a wine. A purple coloured monster that bounds up to you, sticks its fruit covered nose in your face and hugs you in a warm, wonderful alcoholic embrace; An instant pal that will put you up, lend you money or get you drunk – whichever is called for. That’s why I love it. Aussie Shiraz has no pretension, no delusions of grandeur. It is simply the most fruit-driven, ripe, gluggable delicious mouthful of cherries, brambles, coffee, chocolate and pepper that ever was put in a bottle.

That’s not to say it’s not a quality product. Some of the best rank with the world’s top wines. No longer is Australian wine derided as having “A kick like a mule and a bouquet like an aborigine’s armpit” and Shiraz is the quintessential Aussie Red Grape. Obviously the French had it first but they call it Syrah and it’s a very different animal over there – all dusty and spicy. Very delicious but less joyful somehow. Actually the Persians had the name first calling their capital “Shiraz” but they only grew white grapes apparently, so there you go.

Since the Aussies now outstrip the French in UK wine sales, I doubt if any of you have not yet tried a Shiraz but since a great deal of the imports are mass produced, pretty dilute and non-distinguished (stand up Jacobs Creek etc), I urge you to seek out a good one.

Three of the favourites in the Perris household are: -

1. Tim Adams Shiraz. Possibly the best value red in the world since Tesco routinely discount it to around £6.50. Wonderful fruit and liquorish flavour with excellent concentration. My Friday night bottle of choice unless we are really pushing the boat out. Try also Tim’s Aberfeldy Shiraz if you can find it. It’s unbelievable!

2 St Hallet Old Block Barossa Shiraz. Classic Barossa power and fruit. Totally delicious. Tescos used to do it on line. Australian Wine Bureau will tell you who stocks it now. About £15 usually. This was my favourite ever wine until I discovered . . .

3. D’Arenberg Dead Arm Shiraz. Chester D’Arenberg makes huge, concentrated, quirky wines from very old vines. This is quite simply the most delicious mouthful I can write about without being arrested. It tastes like black cherries soaked in coffee and mixed with chocolate gateau. Or better than that sounds anyway. Perfection.
That Laugh

At the literary dinner
you laughed at the sudden realisation
of what you’d said . . .

and you laughed and laughed,
eyes streaming like an engine driver
on a runaway train, smoke in his eyes,
barely breathing, downhill now
into a valley of incoherence.
Men crossed battle lines,
laid down their guns in slow motion.
Even the stone saints, with their stern faces
smiled suddenly in the cathedral.

Unusual for the dark city, eyes met eyes.
Emperor moths flew through woods.
Waterfalls grew rainbows.

In gardens we took to the air like sparrows.
High on our swings, out in the warm rain,
we were children again.

Robin Forward
Crossword

Dr B. W. Perriss

Clues Across

7. They must be met by writers of obituaries. (9)
8. Decayed molar teaches one a lesson. (5)
10. SS + R = a bold headline. (8)
11. French opening for official emissary. (6)
12. In West Yemen I caught an eye problem. (4)
13. Sent in a plant when aggrieved. (8)
15. He could be called on to bridge the gap. (7)
17. To study the journey get a line on the map. (7)
20. A dumb bird? (4, 4)
22. Anthony visits an ancient garden. (4)
25 & 27. Go mad after lifting lid of boiling kettle . . . (3, 3, 5)
26. Start a war in the living room? (4, 4)
27. See 25 across.
28. Fight to the last then finish your round with a beer. (6, 3)

Solution to Crossword in
SPRING 2006 Anaesthesia Points West

Clues Down

1. Trials for International matches. (5)
2. Coming for the first part of the adventure (6)
3. Scene creation after the celluloid hardens. (4, 4)
4. Jordon city railway targeted by stone hurler. (7)
5. Silly ring of cake. (8)
6. Political form of transport around election time. (9)
9. A positive sign. (4)
14. French Foreign Legionnaire with a nice action (4, 5)
16. No alcohol allowed during Isle of Man races. (8)
18. Noted drama on a small scale. (8)
19. One is charged when initially in charge but negatively. (7)
21. Get a whiff of a new aftershave. (4)
23. Attempt to overturn an iron stronghold. (6)
24. Smile died when told to work hard. (4)
Notice to Contributors

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

The deadline is usually ten weeks before each meeting of the Society.

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Society of Anaesthetists of the South West Region

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Society Ties – £10.00
Society Brooches – £15.00

Available from Hon. Sec. and at all home meetings