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## ANAESTHESIA POINTS WEST

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It is budget day and it seems as if everything is going to cost more. Spring is here and Brown seems to be turning green. The sport utility vehicles in the Consultant’s car park seem to be shining less brightly and the swagger of those who cycle to work has just got bigger. At least the subscription fee for membership of the Society of Anaesthetists of the South Western Region (SASWR) remains affordable.

It has been an interesting six months. As a College Tutor, Modernising Medical Careers (MMC) has tended to dominate my field of vision. Many of you will have followed the process with some interest. The shortcomings of the application and selection process have been well publicised and hopefully the latest modifications will ensure that the correct trainees are matched to the right jobs. Many people have worked extremely hard to make MMC work and the Regional Advisors and Training Programme Directors all deserve a sabbatical. When MMC is resolved we will look forward to getting on with training anaesthetists and addressing related concerns such as those reported by Drs Brown and Carr in their article. We do not have long though before the demands of the next European Working Time Directive provide another hurdle to negotiate.

One of the consequences of the selection process for MMC has been the focus on personnel portfolios, particularly the publication section. This has resulted in a flurry of articles arriving in the Editors Inbox. I hope the enthusiasm to write interesting and informative items continues in the future. The SASWR Registrar’s Prize always produces quality articles for publication. In this edition are two examples: Dr Tolchard’s prize winning research into the inhibition of the hypothermic response by α₂-adrenoceptor agonists and Dr Beringer’s paper looking at the effectiveness of different sticky tapes. Dr Cowlishaw’s article clarifies the risks of taking herbal medicines with Anaesthesia and there is also a good review of Paracetamol and the advantages of the newly available intravenous preparation. There is much more, including the usual excellent items from the regular contributors. I hope you enjoy Edition No.40.

Congratulations to the organising committee for arranging the Spring Meeting in Budapest. It is sure to be a memorable event for the sixty or so members who are going and will be reported in full upon our return. Finally, I must remind you that the SASWR Autumn Meeting 2007 is a Diamond Jubilee event. It will be a full two day meeting held over Thursday 22nd and Friday 23rd of November and will have an excellent academic and social programme. Book it up now!

James Pittman
Exeter
Future Meetings of the Society

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

**Spring 2008**
Plymouth/Guernsey, final dates to be arranged

**Autumn 2008**
North Bristol, final dates to be arranged

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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 E. Morris, Southmead, Bristol (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 E. Morris, Southmead, Bristol by end July 2007. The winning entry to be published in the next edition of Anaesthesia Points West.
Honours and Awards

Evelyn Baker Medal – Dr Martin Coates

Dr Martin Coates was awarded the Evelyn Baker medal at the Winter Scientific Meeting of the Association of Anaesthetists of Great Britain and Ireland. This medal is awarded in recognition of outstanding clinical competence, including the ability to train and enthuse junior colleagues, above and beyond formal teaching and presentations. Throughout his career, Martin has been involved in organising and running training programmes in developing countries, for GP anaesthetists, trainees, medical students and school children. He has been Regional Advisor to a region which has since split the RA post into two (it was so busy!). He invented the ubiquitous needle through needle combined epidural/spinal technique, and at an age when most people would be thinking of hanging up their clogs, he has taken on the chairmanship of his department and the post of Associate Dean of the Peninsular Medical School as well as maintaining his heavy clinical workload.

The Society is proud and delighted that the hard work and dedication of one of our eminent members, and a past president, has been so honoured.

John Carter
undergraduate training was not without financial implications, and so, on the advice of his bank manager, he joined the RAMC as a medical student, with a commitment to a 5 year short service commission following house jobs, solving his insolvency problem at a stroke. Later, as Programme Director of the SW Anaesthetic Training Scheme, this early career stumble led him to take an avid interest in supporting those whose had also run an unconventional course.

Following house jobs at Cuckfield Hospital, Sussex (now closed) he entered the Army as Regimental Medical Officer to the 1st Battalion, The Light Infantry. The battalion was about to serve in Belize for 6 months before being posted to Hong Kong. There was no truth in the rumour that he had misheard his posting instructions, and was looking forward to joining the 1st Italian Delight Infantry! Unfortunately the situation in Northern Ireland was deteriorating, and John was loaned to the Royal Regiment of Fusiliers and stayed with them for the next two years as their RMO, on two tours in South Armagh, for exercises in Germany, and the wilds of Essex.

John started his anaesthetic training in the British Military Hospital, Tidworth, (now closed) and at the Joint Services Hospital, RAF Wroughton, (now closed), where he stayed for the next three years, apart from a tour of duty at the Military Wing, Musgrave Park Hospital, Belfast, miraculously, still open. On leaving the army, he continued his anaesthetic training in Bristol, as a registrar and then on the SR scheme, in Plymouth, Bristol and Bath, with a year in Adelaide. Here he gained a mixture of experience including paediatric craniofacial surgery, chronic pain, adult and paediatric ITU, barbecues, windsurfing, sailing and the exploration of wineries . . . although not necessarily in that order!

In 1986, he was appointed to what he considered his ideal consultant post at Frenchay Hospital, (despite rumours to the contrary, still open), with an interest in neuro and thoracic anaesthesia, and ITU. The added bonus was that the plastic surgery commitment was private! In his first year, he set up
a very successful course on Anaesthesia for Difficult Locations and Developing Countries. This has now helped train over 600 anaesthetists. Following a brief foray into management as Director of Intensive Care, he concentrated on postgraduate education, and was programme director of the SW Registrar Training Scheme during the difficult period of introducing Calman training, as well as the development of 2 schools of anaesthesia in the South West. He was also a Postgraduate Dean’s representative, and RCA Deputy Regional Advisor.

In 2001, he was elected to the Council of the AAGBI, soon becoming chairman of the Safety Committee. For the past 2 years he has been Vice-President, contributing to such fields as safety, research, independent practice, and in relationships with various NHS agencies, for example the National Patient Safety Agency, and with ‘Industry’. His fairly prolific contributions to medical literature include chapters, papers and reviews, though his favourites are his tongue-in-cheek articles written under a pseudonym. One of his strengths is organising meetings; these have included both GAT and the Neuroanaesthesia Society in Bristol, as well as the SASWR when he was Hon Secretary.

Despite all these responsibilities, which clearly show a man with an orderly mind, his desk at Frenchay remained in a permanent mess. For filing, read piling. As the person who shared his office for the last few years, I was grateful the piles were seldom on the floor, but it remained a mystery to me that he could ever find anything.

John has been an enthusiastic member of the SASWR since winning the Registrars prize in 1979. He was heard to observe the value of the said prize has increased by 2000% since he won it. He was Hon Sec from 1997 to 2000. Who can forget his overseas meeting in Malta? He has been constantly supported and encouraged by his wife Tricia, throughout his career, and later this year they will be celebrating 20 years of marriage (to each other). In addition, they share a passion for skiing, partying and yachting. Later this year they are taking delivery of a new 38 foot yacht, currently under construction in Sweden.

His two children, Lucy and David declared at an early age that they had no intention of following their father into medicine or table football, and are both teachers in the Bristol/Gloucester area. He is very proud of them, and pleased to see them happy and successful. John is currently coping with the fact that he is now a grandfather. I am told the role of doting grandfather suits him almost too well!

There is also no doubt whatsoever that John will enjoy the role of President of the Society of Anaesthetists of the South West Region, and that enjoyment, thoroughly deserved, will show in the enthusiasm he brings to it, and the success that will inevitably follow. We are all lucky, and will all benefit from having John Carter as our President this year.

Robin Weller
Obituary of Tessa Whitton

Many of you will have fond memories of Tessa Whitton who sadly died in February after a long battle with stomach cancer. Tessa remained very much herself right to the end.

Tessa was good at making friends, at the age of fourteen she went on a school trip to Moscow and persuaded her group to attend a party hosted by the local Mafia. This was just the start of her love of travel and parties.

She studied medicine at Southampton and took her elective in China in order to see some acupuncture and other ‘alternative treatments’. Her entry in the medical school yearbook stated the following.

Tessa “Flasher” Whitton, the immortal hippy, has just acknowledged that Woodstock is over, only recently exchanging her fringed, flowered dungarees for the latest designer numbers.

She makes the feeding of the five thousand look like a mid-morning snack: so long as it’s food- hot, cold, old, new, hers, someone else’s, Tessa is there! Saturday afternoons are spent buying out the Mark’s and Spencer’s food department, to last till Saturday evening, when she is forced to create one of her three specialities: “thingy” tagliatelli, spaghetti carbonara and stuffed aubergines.

Sitting in her car is a white knuckle ride. Past performances include a collision with a JCB, a first attempt at a right hand turn on The Avenue/Burgess Road junction and narrowly missing a roundabout on the way back from the Glastonbury festival (her spiritual home).

Ambitions:
1. To make it to the hospital before midday
2. To open a fast food restaurant and eat the profits’

It has been said that Tessa never really changed from those student years, though she did get better at appearing to conform.

Tessa did her house jobs in Bath and Portsmouth. She returned to Bath for posts in Paediatrics and A&E, and started her Anaesthetic career. Between various posts Tessa would disappear to Central America, mostly Mexico. She spoke (and sang) fluent Spanish and enjoyed the relaxed approach to time keeping in those parts. She supported various land reform groups or Zapatistas and did some volunteer medical work. On her return from Mexico Tessa continued her anaesthetic training in Treliske Hospital. She loved Cornwall and they still talk warmly about her nude Pilates demonstration on the cliff tops (sounds chilly). After another six months in Mexico, Tess returned to work in Torbay, Southmead and Plymouth. She made a further visit to China, this time with the ORBIS project and returned as a Specialist Registrar on the Bristol rotation. Tess spent six months in Bath, before taking a year out to work in Seattle, with its famed Pain Clinic. Once she had finished her training and despite other career opportunities, Tess stayed on as a locum consultant in Anaesthetics and Chronic Pain Management at Frenchay Hospital. She had a good number of publications about Pain and
Neuroanaesthesia to her credit, including one in ‘The Knee’, which sounds fascinating.

Tessa was a fearless individual (except when flying) and would confront clinical problems head on. She had the ability to engage with and understand patients, some of whom had been the victims of torture or similar suffering. She achieved this with her disarming warmth, honesty and straightforward nature.

When presented with her diagnosis Tessa showed great determination to seek all possible therapies. She eventually had her gastrectomy and intraperitoneal chemotherapy in Lyon, France, having won over Professor Gilly, with her usual charm. Tess managed to leave hospital on day 10, the average length of stay is 17 days. This was in part due to the lack of air-conditioning and that the hospital charged by the day! After a week in a motel room being looked after by her family and friends she returned by Eurostar, to avoid flying. After a period of convalescence and some more chemotherapy in Bristol, she managed a short holiday in Cuba, giving her a chance to air her Spanish and get a little sun. She even managed a day on horseback, singing Spanish songs with a Cuban gaucho.

Tessa spent her last days at home supported by her family and friends. The palliative care team and community nurses did an excellent job of pain and symptom management, though she could be a difficult and demanding patient (junior doctors always attended her in pairs). She was always grateful for the help and support she received.

Tessa stands out as a strong and challenging individual- an inspiration to us all. She will be missed by all who knew her and remembered with a smile.

Steve Hill
piped music throughout the site. ‘One Wheel on my Wagon’ is now beginning to grate. We’ve created an Anaesthetic Department ‘Room 101’ into which we’ve persuaded Paul Merton to tip MMC along with the current agonies being endured by our trainees applying for ST posts. The custodians of our profession can only hang their heads in shame at the debacle being bestowed onto the next generation.

How did we let it go so badly wrong? In addition we have thrown in the apparent Bath phenomenon of the ‘visiting Chief Exec’. Yes, we’ve lost yet another one. The consultant body clubbed together and sent a card saying ‘thanks for popping in’. It’s a pity really. By all accounts he was doing a good job and unlike Rotherham General, most seemed to know what he looked like (well, the consultants anyway).

It was grudgingly fascinating to watch Gerry Robinson on BBC2 hold his head in despair at the machinations of Rotherham General Hospital, a supposedly Foundation Trust. It was striking that ‘lack of beds’ never featured as a problem, because here in Bath it seems fundamental to the many frustrations we face. The extreme dislocation between management and the medical fraternity was embarrassingly exposed for all to see (mercifully we’re not quite so dysfunctional here). Of course the straight up no nonsense solutions proposed by the front line nursing staff were by far the most sensible and practical. But these disempowered voices of reason are all too often lost amongst the ‘bigger picture’ ideas that continually hit us from every direction. Anyway, England is winning the rugby again and training up the road at the University. Thankfully, we’ve also finally beaten the Aussies at cricket (I couldn’t take the look of abject pity on Damien Wood’s face any longer). How can we persuade a bankrupt Trust to install Sky TV into the anaesthetic department in time for the World Cup?

Time is rampaging as ever. Viv Thomas has had a lovely baby girl. The last list she did before going on
maternity was the section list, and she was back before the sun rose to have Rose Anne. Perfect timing Viv, but I wouldn’t have bothered going home. Meanwhile, Tom Simpson has taken over as College Tutor on 1st January and Jeff Handel has gone on to become the Post Grad Deputy ‘Dog’ Dean. These two have been the ‘dream ticket’ in terms of running the training and education here in Bath. They, together with Jerry Nolan, Kim Gupta, Rowan Hardy and Lesley Jordan are, as we speak, killing the MMC website short-listing. Rumour has it Jeff is still on ‘dial up’, so no wonder it keeps crashing.

We seem to have survived the ebb and flow of staffing numbers once again, largely thanks to the endeavours of our ever flexible trainees and staff anaesthetists. Kay Spooner left in October to finish her training at the BRI before being offered a consultancy at the Royal Glamorgan in Llantrisant, which she already loves; she was all too briefly replaced by Aidan Marsh followed by Jon Gatward. SpR Dan Freshwater-Turner arrived and has reduced the font size on the rota whilst Clinical Fellows Mark Campbell and Juliet Drew arrived at a particularly crucial time mid December (with Christmas on calls approaching), but we also sadly “lost” Emma Blair and Saad Anis to training numbers and Abi Eyre-Brook off on maternity, SHO Juliet Hull has moved to Exeter, and Joy Sanders returned to Cheltenham to be replaced by Richard Pierson. We were particularly delighted to welcome Clare Hommers back as an on-and-off locum during the autumn after she survived a year in the even more challenging parts of the world with Medcins Sans Frontieres. February has seen only modest changes as we said farewell to SpR Ruxandra Mihai who moved to Frenchay and is looking forward to potentially a quieter life without the responsibility of the trainee rota, and welcomed back Matt Thomas, SHO Katherine Stenlake returned to Yeovil who duly sent us Charlie Heldrech and Henry Murdoch. We were very pleased to extend Becky Brooks, Kate Brunton, Raj Srivastava, Rajesh Srivastava (no family connection), and Ben Gibbison’s appointments to the edge of known world (31st July), Vashek Vanek for a year, and to welcome Andreas Zafiropoulos from the ITU to the general rotation as a novice anaesthetist. That’s Bath “over and out!”

Bob Marjot

Cheltenham
The sea may have been flowing the wrong way round the Pacific plughole this year, causing spring to arrive in December and spoiling many an alpine skiing holiday, but El Niño has also sent our department into a spin. Audit projects, presentations to learned societies, computer driving licence tests and even passing exams have become highly fashionable activities in the last few months. For two weeks in late January/early February there was an outbreak of collective madness as all the SHOs were glued to their typewriters in a form-filling frenzy. Then to cap it all they suddenly started resigning in droves, 'Must go and get some medical experience', 'Do you think six months paeds would look good on my CV?', 'I think a spell on MAU would be really good for ITU'. Cynics have been heard to comment that these extraordinary efforts at self-improvement are something to do with the scramble for 'run-through training' posts, but our college tutor has been stoutly defending the trainees against such libellous suggestions: 'Can you really imagine any of our fine, upstanding SHOs, the crème de la crème of all the SHOs in the world desperate enough to want to work in our department, stooping so low and being so superficial and blatantly career-minded as to put their own selfish interests above those of their patients, their social lives (blah blah blah ...)?' No one has been taking him seriously since then (did they ever?), but El Niño has been making people behave very oddly indeed.

Now some of you may want to hear the sensible news, so enough silly stuff ... Congratulations to Zeenat Bhalla (SHO, Bromley & Bombay) for the birth of her second child and to Ben Huntley (Dursley), Atul Gaur (Delhi), Owen Bodycombe (Worcester) and Joy Sanders (Bath) for all passing their primary. Zeenat will be back from maternity leave soon, whilst Laurence Hulatt (Surrey) has left for an SpR post in Oxford, Atul has left for an ICM/anaesthetic post in Leicester and Ben has taken leave of both his senses and a job on the acute admissions unit in Gloucester. Hannah Minor (SHO, Chippenham) has moved on to paeds in Bath before heading for GP-land, Jill Dale slipped off to Oxford for a regional anaesthesia fellowship year, Ann Young is lighting up dark corners in the pain clinic as a fellow in her final months as an SpR, Neil Rasburn has come from Bristol with a yet-to-be-tested reputation as a footballer, Mike Clarke has arrived and will shortly be leaving for a proper numbered SpR post on the South Birmingham rotation and Jaz Ahmed (from medicine) has made regal progress through his ICU block and is now
doing the same in anaesthesia (before returning to a medical ST post in due course). New faces include Mark Gilmore and John Horsnell, ICU medic and surgeon respectively, and SHOs Siddhi Padhiyar (North Tyneside & Karamsad) and Biju Peringathara (from Fife en route to Gloucester), whilst remarkably Kate O’Connor returns from six months on the medical wards with a face that looks only six months older than when she left.

And for those less interested in the sensible stuff... Cheltenham may be a town renowned for its multiculturalism, but trying to win a game of football with a team of Mauritians, Indians, Filipinos & Welshmen is like using a laryngoscope to cannulate a vein. We tried. It doesn't work. Thus Cheltenham Theatres lost again to our Gloucester counterparts by a single goal. (No more football reports please {Ed}. OK, Ed, but what if we win?)

Our traditional Christmas party at Vanilla restaurant was capped by a performance of 'Cheltenham Royale' written anonymously by Claire Kaloo (with some other SHOs to blame as well). Fortunately it involved no hairy chested consultants emerging from the waves, but a talent contest for aspiring Sean Connery's, egged on by Sue 'Pussy Galore' Smith, judged by Miss Wendy-, Betty- and Jenny-penny and won by Bond, Ted Bond (much to the annoyance of Bond, Peter Bond). After last year's unforgettable performance as 'the only gay in the department', Bond, David Bond should have been wearing his shocking pink peaked cap and become the first openly homosexual 007 - but someone missed a trick there. The low point was surely the spectre of Mrs Copp nibbling enthusiastically at an edible G-string being worn by her husband Bond, Mike Bond during his moment in the spotlight. Whether this PDA (no, not a handheld computer) was anything to do with the diet of raw vegetables she has had him on recently I cannot say.

But if anything could make all our lives, the Pacific Ocean, The World and The Universe go into a spin, it is Wendy, our departmental administrator, going on holiday to New Zealand for a month. She did. They did. Glad you had a good time, but please don't do it again in a hurry.

Ted Rees

STOP PRESS: We won, at last, 10-6, from 0-4 down! (Oh, shut up! {Ed})

Exeter

Well, its good news from Exeter. Following some quick thinking by hospital management, and some covert beachcombing, we have managed to kit out the entire new Woman and Child Health Centre, from the contents of the Napoli. We have nappies, motorbikes to ease the inevitable parking crisis, good quality china, homely bedding, . . .

In fact there has been a flurry of building activity at the RD&E. The aforementioned W&CHC is due to open in June, bringing the gynae, maternity and neonatal services onto the main hospital site. The endoscopy unit is undergoing an expansion, taking over the daycase recovery area, and the ITU expansion is almost finished. The heart of the Anaesthetic Department has returned to its base next to main theatres, allowing the Pain Team to relocate into the offices vacated by the Anaesthetic Department secretaries, thus liberating more space for the ITU expansion. It’s all so clever. The new CEPOD system is up and running, with a dedicated theatre, and theatre staff, and a will to make it work. So far so good.

Our trainees have had great exam success; Nick Preston, Abrey Theron, Alia Darweish, Ben Gupta, Fin O’Sullivan and Max Hodges have all passed the Primary in the past few months. However, it was a sobering experience when we went out to celebrate, and instead of basking in their collective glory, the main conversation was about MTAS, and whether they would be unemployed in a few months time. The baby boom continues – with a clutch of sons. Congratulations to Vanessa and Jon Purday on the birth of Finn, and to Phil Cowlishaw, Rachel Brown, Pete Ford and Sally Nash. Congratulations also to Kris our department secretary who is expecting her first baby.

We have recently appointed what will possibly be our final consultants for a while. Vanessa Helliwell was appointed just before Christmas, and Kath Davies was appointed a few weeks ago. Kath will be replacing Paul Marshall, who retires from his post in Anaesthesia and Pain Management soon. Paul will be sadly missed, especially his booming laugh and smiling face. However, I know he will be back, helping out with locums in the future. We also welcome Tara Bolton as a Locum Consultant.

The Christmas party was held at the Clarence again, in accordance with tradition. A good time was had by all. This year I was assisted in my quest to dance with all the SHOs by Emma Hartsilver, who was clearly making up for being boringly pregnant last year. Colin Berry also made a sterling effort, with some energetic dancing. Nick Preston, who was awarded the trainee of the year prize,
proved his point by being on call.

This year’s ski trip was not without incident. A larger than average contingent went from the department, leaving the few remaining workers to do their best. Bruce McCormick erased a whole evening from his memory and woke with a sore head. Apparently he managed to knock himself out while snow boarding – what goes on tour stays on tour, as they say.

And finally, we’ve had the usual change over of trainees. Pip Hawkins and Anna Negus have both emigrated ‘Down Under’, with no plans to return. Danny Murphy and Sally Woods have departed for GP land. James Limb managed to sneak into one of the final SpR posts and Kim Chisti has rotated back to Plymouth. We welcome all their replacements, most of whom I have yet to meet.

And so, until next time…

Pippa Dix

Frenchay

As I write this, the local radio has just announced the Department of Health’s go-ahead for the ‘new £374m state-of-the-art acute and integrated community hospital on the Southmead site’. Hoorah! ‘Today’s announcement enables us to start advertising for a partner to fund, build and maintain the new hospital.’ Uh-oh. Given a choice between using PFI money or borrowing from the Mafia, who would offer the best deal? Well, Tony Soprano would be the edgier option, but at least the Mafia lend money at a reasonable rate of interest. In an interesting departure from sane thinking, it’s been decided that the roads and infrastructure around Southmead, generally regarded as truly woeful, will be able to accommodate the majority of the Frenchay site being decanted into it. Apparently GPs are going to manage patients in the community for longer, thereby obviating the need for hospital referrals, until presumably bits start falling off them. And we’re all going to share lifts, cycle or walk (through Southmead, as if). Noble sentiments, but barking all the same.

The Anaesthetic Department continues to contract with three of our Consultants leaving. Steve Wimbush, whom we all wanted to stay, sensibly decided that a job in the hand was worth two in the bush (blimey, and I really was trying hard to keep it clean this time) and successfully applied for a substantive Consultant post in Winchester. In a post increasingly resembling that of Professor For Teaching Defence Against The Dark Arts (see Harry Potter, volumes 1-6), the turnover of Paediatric Anaesthetists continues apace, with locum Consultant Emma Bendell leaving for the Children’s Hospital, to be replaced by Rupert Harris. In a new departure for us, Steve Sale, one of our substantive Paediatric Anaesthetists, is also leaving for the Children’s Hospital. He was due to go there in a few years anyway, when paediatric services are centralised at BCH, but seemingly couldn’t wait that long. We’re supposed to be advertising four Consultant posts, but we need an as yet undetermined number of staff grades (soon to be known as Specialists), to join various leftovers from the MMC process to staff rotas, and it’s all looking a bit iffy. Peter Klepsch, our German locum Consultant, maintains that working under a contract which is reviewed bi-monthly still beats working in the German system, so his Maß is definitely half-full still. That we’re living in different times was reinforced by the retirement of Lynne Scott, our long-standing secretary. A farewell party in the office turned into a surprisingly tearful affair.

James Rogers, aggrieved by his recent treatment in this column, became positively suicidal and agreed to take Ruth Spencer (aka the Lightning Conductor) flying in a light aircraft. Recent research demonstrating that women talk three times as much as men (Daily Mail, 28th November, 2006) was vividly demonstrated as soon as Ruth plugged her headphones into the instrument panel, instantly causing a freakish electrical fault which broadcast James and Ruth’s conversation to Air Traffic Control and all the planes circling Bristol Airport. Eventually the intervention of a ground mechanic, despatched from the control tower to bang on the plane’s window, put a stop to it, but the plane and

Ruth Spencer (aka the Lightning Conductor).
our intrepid duo were grounded. The plane was subsequently pulled to bits in an effort to find the fault. Undaunted, they eventually got airborne a few weeks later (see scary photo of Ruth piloting a light aircraft).

Gareth Wrathall emerged relatively unscathed from an encounter with his lawnmower, when he ran over his own foot. On inspecting his bloodied and bruised foot for damage, Gareth was congratulating himself on a lucky escape when it dawned on him that he’d been wearing shoes when he’d started mowing, but now one was missing! David Lockey scared us all by becoming jaundiced, but eventually found the cause with positive Epstein-Barr serology (aka infectious mononucleosis, glandular fever, kissing disease). He can’t drink alcohol for six months, but claims at least his wine is having a chance to mature.

The Trust has been reviewing its contingency plans for bird flu, in case of an outbreak. That’s fine, but the trouble with these headline grabbing diseases is that they detract attention from the real killers in our midst, notably Man flu, which is particularly nasty. Jane Olday took her family off skiing to Fernie, in Canada, and bumped into our very own Nuala Dunne in a bar...of all the gin-joints in all the world etc. Keya Quader gave birth to Aubrey Joseph, and I misreported last time the name of Yeli Horswill’s baby. Sorry for that, and still no idea. Ashraf Awad, an Associate Specialist from Yeovil, has joined us to gain some specialist experience in order to jemmy himself through the Article 14 process. It doesn’t sound like a pleasant process, so disgruntled trainees should think twice before jumping ship from the specialist training programme. Maybe the light at the end of the tunnel has gone, but at least they still have the tunnel! Our present SHOs all seem to be coping with the MTAS process, although at times it seemed to resemble a course in creative writing skills. The Registrars just looked generally relieved they weren’t having to go through it, unlike the poor Consultants who had to pore over interminable numbers of their trainees answers. Samantha Shinde had 220 applications to assess, and had to get up at 4 am to get through them in time. Chris Langrish will be leaving to take up his Consultant post in ITU at St. Thomas’, London, so congratulations to him, and David Healy is leaving for the States to return to Ann Arbour, and a very big house by a lake.

I’m sure many people in the South-West region will have known Tess Whitton, who died on Saturday 24th February, following a long illness. Tess packed more into her time than most people could ever dream of, and fought her disease with the same strength and spirit that characterised her life. I’m sure more will be written about her elsewhere, but my lasting memory is of Tess at her 40th birthday, just surrounded by friends and family, and looking at them, it occurred to me that they were all such warm and interesting people, and that that was a reflection of Tess’s own nature.

Richard Dell

Gloucester

We are recovering from the recent extreme weather conditions. The Forest of Dean was apparently completely impassable for 24 hours after the heavy snowfall. Now we are just back to the wind and rain. Various members of the department have been skiing with no injuries so far which must be a record. I attended the Bel-Plagne Ski Conference with Colin Green, Chris Roberts and some of my Cheltenham colleagues Mike Copp, Chris Mather and Sheila West. The academic content of the meeting was actually very good. I think we all had a bit more sleep and less alcohol than at previous meetings, although Colin playing Welsh music (Katherine Jenkins) early in the morning was obviously very disturbing. His ipod was so loud on the coach home we all thought it was the radio!

We have all been battling with MMC applications, particularly College Tutor Robin Cooper, who I fear could go prematurely grey after spending a whole week going through all the SHO’s forms. In a few years it will all be routine and we will have perfected the best answers.

Tom Perris organised our Christmas party last year and decided we should put on a play, so it was a revised version of the Nativity. With no type-casting Tom made himself the Angel Gabriel, SHO Ed Bick was the voice of God and Malcolm Savidge the narrator. Paddy Clarke played the suave gynaecologist from Yorkshire! Assisted by Madwife Sarah Bakewell and I was the almost Virgin Mary. Clinical Director, Peter Sanderson, and Intensivist Tracy Clayton were the two Wise Men. Following our award winning performances, SHO Biswas, sang some of his own compositions which were fantastic, so if MMC doesn’t come up with a match the Westend may be the answer. The anaesthetic band “Dural Tap” are re-forming for one night only (they said that the last time) to perform at Theatre Nurse, Thea Cox’s, retirement...
party. Personally I blame Sting for re-forming the Police.

As usual our trainees keep changing. Ed Bick moved to Frenchay to fill a LAT post. Registrar Mike Eales has gone to New Zealand for a year. Jamie Peyton to the BRI. Rachel Prout has gone to Bath to do ICU. Hannah Wilson and John Anns, SpRs, have replaced the above and Hamish Breach joined us as an SHO from Yeovil. Apologies to those I have left out.

I’ve just seen Roger Eltringham, who has some wonderful pictures from his most recent trip to Africa. He has been made a Fellow of the West African College of Surgeons. I hope they don’t expect him to perform any surgery but actually knowing Roger he probably could have a stab at it! New Consultant, Sarah Harper, has started this week - a very welcome addition to the Pain Clinic. Congratulations to SpR Mark Haslam whose wife had their first baby this week.

Belinda Pryle

Southmead

What to say about Southmead in these turbulent times? Well, we’re having another little shuffle round of services in April or thereabouts. I believe the thinking is that regular shuffling prevents bedsores or something like that. We’re also getting 3 session days in the AOC which have been a great success so far. The anaesthetic department excelled itself by producing 3 anaesthetists for 2 lists on the first day and if Kathryn Holder thinks that Nik Koehli is ever going to let her forget just how early he had to get up for his non existent list she’s got another think coming.

We all seem to have spent quite a lot of time recently advising trainees how to get jobs in a system we know nothing about and can have no experience of. Also, can anyone advise me on the ethics of the people doing the shortlisting and the interviewing checking people’s application forms or conversely the ethics of not checking them. Either way, I’m uncomfortable. I think Alice would have felt at home in this Wonderland. I’m very admiring of the way our trainees have handled the whole thing and wish them all luck. August is going to be an interesting month but March to July is not going to be a picnic either.

On to less weighty matters. The Christmas party was held at my house this year. In my humble opinion it was a great success although in gossip column terms there is not much to report. The most traumatic part for me was the pre-party shopping. Waitrose with a slightly hyperactive Steve Robinson was something I will not forget in a hurry. The Christmas quiz was won jointly by Colin Hall and John Leigh whilst the “still standing after several hours in the Post Office Tavern” award was won by Jo Connell.

Kristina Birch has emerged from what seems to have been a fairly gruelling time in Afghanistan and is back with us. The blinding flashes of light coming from the enormous rock on her left hand suggest that she has become engaged in the interim. Congratulations to her and Martin. She says the main difference about working here and working in Afghanistan is that you don’t deal with fat people over there. I think that says a lot about something but I haven’t quite worked out what.

Geoff Morris has taken a 3 month sabbatical to brush up his skiing techniques. His only complaints so far are that his little toes are suffering from being crammed into ski boots every day and that, having bought one pair of skis, he now realises he needs another pair. Oh to be so weighted down with worry. His sartorial elegance has been challenged by the fact that his teaching duties require him to wear a yellow jacket and trousers (described in French as the colour of “kaka” which I’m sure needs no explanation but does raise questions about the French diet) but he has complemented the look by dying his hair blue so that’s alright. Goodness knows what the nurses in the Cotswold Suite will make of that.

I’ve noticed that all the other correspondents to Points West seem to have complete recall of exactly which trainees have come and gone in the department since their last missive. Either I have a memory like a sieve or our trainees move faster than everyone else’s' because frankly it’s all a blur to me. However, in the interests of fairness I’ll give it a go but please don’t make me tell you who went to Frenchay then came back but only for one month because they broke their arm/leg/clavicle (delete as appropriate) and anyway there was an r in the month so they had to go back to the hospital they first thought of. Most recent moves are Dom Hurford to Nottingham to do PICU, Tamas Veto to the BRI, Janine Talbot, Jill Austin and Ruth Mathes to us from Weston, Yvette Coldicott to us from Swindon and Rachel Perry back to us from maternity leave and working on the flexible doctors scheme. We’ve also gained Clare Hommers, Nilesh Chauan, and Lucy Kirkham and are about to lose Jo Silsby and
Matt Molyneux to the good old US of A. Bon voyage!

Jas and Jackie Soar are expecting a baby later this year – good job they’ve got the house finished in time for it to be trashed once the baby gets mobile. The trainees have also been busy. Nick Parry has got engaged to Emma and Jay Van der Westhuizen is expecting the stork to fly all the way to Oz – twice. Izzie Iqbal and Dave Gillat are expecting their second and Pia Lieber and Alex Brederode their third. Para Ray and Gavin had a baby boy, Charlie and Simon Lewis and Nicky have added Rosie to their collection of daughters. Congratulations to all of them. Chris Langrish will be leaving us soon to take up his consultant post in London and Stephen Sniders, who has already left, will take up his post in Buckinghamshire. Dom Hurford passed the Primary FRCA and is particularly delighted as this means he can now take a more active role in preparations for his wedding. Never mind the Bohr equation – what colour should the bridesmaids wear?

Finally a mention for Sally, our secretary of 10 years, who has retired to a life of Scottish dancing and gardening. Presumably not both at the same time although that would make great reality TV. We had a small Trust based party last week but will be having the proper do in April so any shenanigans from that will make it to the next report. Our best wishes and thanks go to Sally and Mike.

Fiona Donald

Swindon
I’m not sure what’s in those water dispensers that sit in our coffee room. I have a total of three births to announce. Anisa Dale became a mother to Sam – belated congratulations to her and Neal, Dave Pritchard a father to Jack, and wait for it, Tilak became a grandfather for the first time. I’m gonna stick to the Coke machine from now on.

MMC, MTAS etc etc etc. All of our SHOs have been shortlisted for ST posts - so fingers crossed for their success. Sam Hilyard and Dave Pritchard (busy boy) both just beat the deadline and secured SpR posts in South Eastern and Newcastle schools respectively. Other news from the departure lounge: SpRs Nick Craw has moved on to Oxford and Dom Melville to Bournemouth and Poole; SHOs Siobhan Dwyer and Ellie Carter survived their first year with us and are now somewhere in Bristol. In the arrivals hall we welcome Fourie de Kock as Staff Grade and a couple of SHO old boys returning from Bristol in the way of Andy Georgiou and Alla Belhaj. Our only examination candidate was brain-box James Dinsmore who passed the Final FRCA.

And finally, Ben Maxwell has joined the TA and we wish him well with this new facet to his career. I hear also from a reliable source that Richard Craig is training as a lifeguard – our answer to David Hasselhoff. Can Richard sing too? Didn’t stop the Hoff.

Matt Ickeringill

Taunton
The mornings are getting lighter and buds are on the trees – yes, spring is here and we have survived another winter. So what lies ahead. Good news – the Cancer Centre has at last been signed off with work starting on site…….spring 2007. Well at least they have surveyed the site! Cedar Park, the new multi-storey car park with its ‘multi-story multi-coloured light sculpture’ is now open. It’s all very modern and futuristic – not quite in keeping with the normal mellow tones of sleepy ol’ Somerset – no excuses that you can’t find it! And as for the new surgical re-build……..still waiting.

It’s musical chairs with our wards at the moment. They close ward 11 and amalgamate it onto Blake ward. ITU is closed for refurbishment. ITU moves to HDU, HDU moves to ward 11……..work finished, ITU moves back, HDU moves back and ward 11 is re-modelled into the new surgical admission lounge – SAL for short. Phew! Glad that’s over. Now let’s close ward 1 (to save money of course)……..and refurbish the childrens wards. So ward 16 and ward 18 move down the corridor to ward 1 for……..just for a few weeks, then presumably will move back again. Have you kept up? Well even if you have, just to make it a little more confusing, they decided to keep all the original ward names in the move. No wonder the lists don’t start on time – we can’t find the patients – “send for the first patient” - “little jonny is on ward 16, or is it ward 1, no its 16” “is that the old ward 16, or the new ward 16”. Is that left or right down the corridor? You might then ask “what will then become of ward 1 – management offices perhaps. Who knows?”

On to more serious matters, who’s coming and going in the department. We say farewell and good luck to some of our more senior SHO’s. Francois Roodt to London as a ‘senior SHO’ before hopefully securing a registrar place back home in South Africa. Miguel Garcia to Bristol as a clinical fellow
(congratulations to Miguel on the safe arrival of his daughter Maria Antonia in February), and to Nic Crutchley to Plymouth as a Cardiothoracic Anaesthetic SHO. Congratulations to Nicky Campbell and Julie Lewis on passing the Primary – well deserved. Meanwhile, the rest of crew, Zoe Browne, Helen Cain, Ed Searth, Alex Day, Jamie Biddulph and Anna Lewis are busy getting their applications up-to-scratch for the mammoth MTA. Good luck to all.

There has been quite a change around in the registrars. Nij Niranjan, having passed his fellowship (well done), moved back to Plymouth. Mike Spivey having just moved house, also moved jobs and returned to Plymouth. We welcome back Suzanne Carty, Dominique Mumby and Simran Minhas - nice to have the gals back! Welcome to Andy McEwan, who has just secured the last SpR number in the SW. We say a temporary goodbye to Tracey Prior who is about to go on maternity leave. Meanwhile Jane Bellamy, Vijayah Ramaiah and Roger Wong continue to prop up the workforce. Last but not least, we say goodbye and good luck to Melanie Knight – having started anaesthetics here as a novice SHO 3 years ago and then progressing into an SpR a year ago she is finally leaving the nest. Mel, you will be sorely missed.

Congratulations to Dr Sreekumar on attaining a Consultant post in Newport - she has been invaluable over the last few months acting as locum consultant. We also say a very sad goodbye to Laila Mohammed. Having been here in Taunton for the last 6 years, initially as locum consultant and then associate specialist, Laila has decided to return home to Africa. We wish her a safe return and good luck.

Jane Thurlow

Torbay

Our local newspaper, The Herald Express, has recently published an open letter from Tony Blair in which Torbay Hospital is highly praised, especially its initiatives such as the new Bowel Cancer Screening Centre and the proposed £160 million redevelopment of the hospital. It is also reported that the hospital is on track to meet the eighteen week target for treatment from the time of GP referral; this is well ahead of most other Trusts in the country. Very well done, everybody. However, the letter goes on to conclude: “And an NHS which makes the most of medical advances and knowledge must also involve painful decisions.” The source of this pain is not identified in the letter, although I would imagine it would not be too difficult to make a few informed guesses!

The buzz around the Department at present is largely concerning the way that trainees now have to sort out their jobs. Of course, all hospitals are affected. For those readers currently not in hospital practice it is known as the Medical Training Appointment System (MTAS), and initial steps involve e-mail submissions. Those successful in this first stage are invited to interviews which in our Peninsula School will consist of four stations; a clinical scenario, a presentation, a conventional interview and a portfolio check. Despite glitches with the national e-mail networking, candidates being offered simultaneous interviews in different parts of the country, and general uncertainties about the whole system, our trainees remain optimistic and astonishingly resilient. We wish them well in trying to organise their careers in these new territories.

Torbay Hospital’s Medical Centre has, sadly, been closed. This is to make way for the construction of the new Centre for Innovative Training in Elective Care, substantially under the leadership of Kerri Houghton. The Medical Centre was not much of a building, but was the HQ for the Torquay and District Medical Society, founded more than 160 years ago as a support network for local practitioners. Of late its dining room had been used less and less due to changing working practices, but the older school will have fond memories of the lunchtime fellowship it promoted, and of the sumptuous fish, chips and mushrooms on Fridays.

The Department remains active. Now that the “Hospital at Night” concept is well established, Jonathan Ingham is looking towards the “Hospital at Day.” Physician and Torbay’s Director of Education, Dr. John Lowes, has obtained funding for skills training and induction processes to help establish this scheme including the training grades. Essentially it will have an effect on the acute admissions protocols and potentially impact on the Critical Care Unit. Very early days.

We are delighted that Roger Tackley is in receipt of a Bronze Award in recognition for his work in IT within the NHS. He is our longstanding computer buff, albeit in spirit to some extent now that his work draws him increasingly to other centres!

The Department continues to expand the Difficult Airway Management Course. Under the direction of Dr. Sudheer Medakkar, and ODPs Stewart Cook and
Martin Copeman a regular one day course for ODPs, nurses and Paramedics has been created. The next date for this is on a Saturday in July. Further details are available from Nicola on 01803 654311. It is expected that the course will be eligible for CPD points and registration is very reasonably priced.

On a more personal level we are very pleased to announce that Sarah Goodwin (SHO) and husband Steve now have a son, Elliot. Also we welcome back to work Kate Prince who has been on extended maternity leave. John Thorn organised yet another successful Departmental Christmas party. As usual the girls from the office made the most noise and won the quiz, sowing seeds of suspicion that it was an inside job. And Torquay is to get a casino. Will the government impose revenue targets on it to help pay for our new hospital? You bet it will. And if it rains much more we will be part of the Scilly Isles down here with a government and flag of our own.

Looking forward to an enjoyable meeting in Hungary in May.

Ian Norley.

Truro
It’s a new year and almost a new Trust. We have a new Chief Executive, a revamped Board and some new ideas. There is a new unitary Primary Healthcare Trust and of course a rejuvenated Strategic Healthcare Authority. There is still a mountain to climb, but things are more optimistic. Our next challenge as a department is the impact of MMC. We expect that we will have trouble maintaining our emergency cover in its present form. I foresee a major job-plan review later in the year. The maternity unit saga continues. There are now plans to move it into temporary accommodation, while the old building is made safe enough for another couple of years, to allow time for a new build. No details yet as we learnt this from the local newspaper.

Tasneem Ali joined us as a consultant last autumn after a year in New Zealand. There has been the usual turnover among the junior staff. Andy Lee is now a locum consultant. Kevin Patrick and Tania Pommereit have rotated out. In their place we welcome doctors Beard, Herbert, Miekle, Brooker and Burrows. Among the SHOs, Hannah Gill has moved to a training post in London. Toby Everett has moved to a training post in Bristol. Steve Seale has moved to A & E. Helen Fellows and Thilo Marquardt have moved to the ITU. In their place we welcome doctors Dunn and Middleditch. We welcome back Ryan Jackson from Paediatrics and Alex Harrison from medicine. Our senior tranche of SHOs: Tom Martin, Will Harris, Rob Jackson, Nick Erdal and Alistair Lockwood have spent the last three weeks glued to the computers tackling the new applications system. I think we will have to give them study leave for this in future and award them CME points! David Sainsbury, Anne Whitehouse, Simon Scott-Hayward, George Bostock and David Ashton-Cleary are providing continuity and waiting their turn.

Congratulations to Alex Harrison and Toby Everett who both became fathers last month. New job, new city, new baby; Toby you have our sympathies. Congratulations to Will Harris, Alistair Lockwood and Jijin Joseph for passing the part 1 FRCA.

John Gowenlock, Alex Smith, Chander Ayathon and Sarah Taylor, our SAS team are all doing more obstetric anaesthetics to keep our rotas going. It looks as though the NHS exec is going to escape agreeing a new SAS contract before redefining their jobs.

Have fun in Budapest and have a good summer in this brave new NHS!

Bill Harvey

UBHT
The last few months have seen UBHT battling with the twin challenges of MMC and the holy grail of foundation status. College tutors and educational supervisors have been spotted puzzling with SHOs over exactly how to fill in an ST3 application form and still stand out from the crowd. Sue Underwood was last seen fast disappearing behind a wall of chocolate biscuits and coffee cups whilst wading through several thousand applications. The quest for that elusive financial balance for foundation status has also stepped up a notch. Any member of staff wishing to use a pen, paper clip or staple is kindly requested to bring one in from home – all stationery orders are on hold till after April 1st, however there still seems enough printer paper for the chief execs motivational letter to be distribute...

On the sporting and social front things have been pretty quiet since November. John Hadfield invented the new sport of ventilator racing at
SICCO – apparently all you need is a sloping driveway, a couple of willing registrars and some reps to leave a few ventilators unattended overnight. Kai Zacharowski wins the stamina award for remaining in the bar till 6am and still managing to get up to give his 9am lecture. Large numbers of the department already seem to be in training for this year’s half marathon – or could it be the need to get in shape to look good in their wetsuits for the inaugural BRI surf weekend in June?

Exam congratulations to Kaj Kalamanathan and Amit Goswami for Primary FRCA. Job congratulations to Tim Murphy (Freeman, Newcastle) and Steve Snyders (Stoke Mandeville). The stork has also been busy, congratulations to Alex Koch, Mike Clarke, Gareth Gibbon and Judith Nolan on the births of Henry, Amelia, Hannah and George respectively.

On the shop floor we have had the usual large number of staff changes. Thank you and goodbye for now to Phillipa Seal, Ronelle Mouton, Guy Bailey Nilesh Chauhan, Ben Walton, John Gatwood, Rachel Prout, Mike Clarke and Andrea Binks. Welcome to Simon Webster, James Peyton, Hugo Wellesley, Katie Leuchars, Dave Healey, Aidan Marsh, Murli Krishna, Tamas Veto, Siobhan Dwyer and Angela Ball. Apologies as ever to anyone I’ve managed to miss. We look forward to welcoming Michelle White and Steve Sale to their consultant posts at the Children’s Hospital.

This year we also have a large number of escapees to the land of the free. Bob Johnson retired in November and will shortly be joined by Les Shutt, David Hughes and Paul Thomas. We wish them all happiness in their retirement – party to be held at the Orangery in May. Many of you may also remember Dina Plowes, anaesthetic sister in theatre 4 who has also retired after more than 20 years at the BRI.

**Rachael Craven**

**Weston super Mare**

Although in many ways it has been a relatively quiet past six months at Weston, the turmoil caused by MMC is now hitting us. As all our trainees are at SHO level the changes to be introduced in August will wipe out our existing junior staff altogether. Well, not exactly! Alison Smith and colleagues have devised a grand scheme combining trainees at different levels of experience to rotate through the department. Although I don’t pretend to understand the finer details of this latest plan (but then I suppose that’s true of MMC generally) I have been reassured that it “sort of makes sense”. Anyway, there’s plenty of water to flow under the bridge before August even arrives. SHO departures in the past six months include: Janine Talbot, Justin Marshall, Jill Austin and Ruth Mathes.

Developments within the Hospital itself include the recent appointment of three paediatricians and the construction of a children’s day ward / assessment unit which will be open during daytime hours Monday to Friday. Although this has had no impact yet on our working practice we are working on plans to develop a limited service for the older child who may benefit from day surgery. In my experience the names of new wards have been chosen by asking members of staff for suggestions; this one has been called the Seashore Centre.

On the consultant front, Dr Subramani (Subbu) has decided to return this summer to rejoin his family in India. We shall be very sorry to see him go, not just because he is a universally well liked colleague, but also because we have all gained from his expertise in Intensive Care. We are busy seeking a replacement and also determining just how large a department we need to ensure that we can fulfill future contracts. Oh, for some stability in the system!

**John Dixon**
## Examination Successes and Honours

### Bristol School of Anaesthesia

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### Southwest School of Anaesthesia

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<td>Nij Niranjan</td>
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### Society of Anaesthetists of the South West Region Prizes

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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.
Meeting Report

The Society of Anaesthetists of the South West Region
Autumn Scientific Meeting Report
Assembly Rooms, Bath 24th and 25th 2006

Dr Patricia M'Atteer, Hon. Secretary

The autumn meeting of the Society was organised and hosted by members of the Department of Anaesthesia at the Royal United Hospital, Bath. The meeting attracted a very large number of registrants drawn by the excellent social and scientific programmes arranged by the local consultants, in particular Dr Jenny Tuckey and Dr Tim Cook.

The scientific part of the meeting was held in the beautiful Georgian splendour of the Assembly Rooms, Bath, and consisted of the usual format of lectures and discussions on the Friday afternoon and Saturday morning. Topics included trauma, resuscitation, management of the airway and mountaineering, and lectures were given by an array of speakers, the majority of whom were of national or international repute. It was highly regarded by delegates as being of first class quality. As ever, in spite of extra expense and much promise the acoustics were challenging for all.

Annual General Meeting

The meeting commenced, on the Friday morning, with the annual general meeting of the Society, chaired by the outgoing President, Dr Neville Goodman. The President has the privilege of awarding a prize, The President’s Prize, to someone he feels has contributed to the Society during his term in office. Dr Goodman was delighted to be able to present the prize this year to Dr Robin Forward from Yeovil, who has produced poems for each edition of the Society’s journal for as long as the President could recall. Robin was presented with a suitably engraved Bristol Blue glass bowl, and some copies of the booklet with a collection of his poems which were published to coincide with the Society’s 50th Anniversary in 1997. Other copies of this publication were available at the registration desk. Never one for saying several words when one will do, Dr Goodman got through the agenda in record time, much to the chagrin of the Hon. Treasurer, Dr Andy Burgess, who was still struggling through the notorious Bath traffic. Having abandoned his wife and car, and run the final mile, Andy arrived just in time to reassure the members that although the Society’s finances had taken a sizeable hit with the increased cost of running meetings and publishing the journal, they were still on a good footing. It was however, proposed from the floor and unanimously agreed, that a significant rise in subscriptions would be appropriate and acceptable to our members. A full report of the minutes of the AGM are available to members. At the end of the AGM, the outgoing President, Dr Neville Goodman welcomed the incoming President, Dr John Carter, and transferred the Presidential medal to Dr Carter. Dr Carter thanked the Society for conferring the honour of being its President on him, and then...
presented Dr Goodman with a set of coasters engraved with the Society’s crest, the now traditional present for the outgoing president.

Lunch and the Trade
A buffet lunch was available in the adjoining historic Card room, and there were a record number of Trade stands set up in the Octagon room and the nearby Ballroom. As in previous years registrants were encouraged to support the Trade and visit the stands by the inducement of a bottle of wine for visiting a minimum of five stands. The financial support provided by the Trade helps to keep the cost of these meetings to a reasonable level, especially when such city centre venues are becoming increasingly expensive. Bath is, notoriously, a venue which cannot be visited on a low budget – unless the actual meeting is held somewhere other than Bath!

Scientific Meeting
The President, Dr John Carter opened the meeting by welcoming all members and guests, and first introduced Dr Ed Morris, the Hon Secretary-elect, who gave a brief but enthusiastic exposition on the forthcoming overseas meeting of the Society in Budapest in May 2007. He then introduced Dr Peter Baskett, the chairman for the first session entitled Terrorism, Trauma and Resuscitation. This excellent session commenced with Dr David Lockey, Consultant Anaesthetist at Frenchay and with HEMS, relating the lessons that were learnt from the evacuation and immediate treatment of the casualties from the recent London suicide bombings. He had attended three of the sites during the evacuation phases and gave a graphic account of the appalling scenes of carnage and the need for rapid evacuation, and his role in these activities. It was a completely absorbing talk.

The next speaker was Dr Jerry Nolan, Consultant Anaesthetist from Bath. He gave (as always) a very polished update on the management of patients following resuscitation. This was a “state of the art” talk from a world leader in this field. Another Consultant Anaesthetist from Bath, Dr Kim Gupta, then presented his thoughts on the challenging clinical dilemma of deciding when treatment is futile, illustrated very tellingly by the recent experience at Bath in the difficult management of an ITU patient – and his family. There was little time for formal discussion but this session generated much interest and debate over afternoon tea and throughout the rest of the meeting.

Session II – SASWR/Abbott Prize Session
This session consisted of presentations by trainees of three short-listed entries for the SASWR/Abbott Prize. The prize is worth £1000, and the pharmaceutical company Abbott have kindly agreed to continue to sponsor this prize for a further two years. The winning entry is also published in Anaesthesia Points West. There were twelve entries this year, and the final three had been shortlisted by the judges, Professor Andy Wolf (Bristol) and Dr Jeremy Langton (Plymouth). The first presentation was by Dr Richard Beringer who related how an accidental extubation in the prone position had inspired him to set up a project to investigate alternate means of fixing endotracheal tubes. The second was by Dr Chris Thompson who had investigated the difficulty in establishing effective trans-cricothyroid ventilation as part of the can’t intubate/can’t ventilate scenario, using both available equipment in anaesthetic rooms, and specific emergency equipment. The final presentation was by Dr Stephen Tolchard who discussed a project he had set up looking at alpha agonists and the thermal response to infection.

The standard of all three presentations was extremely high, and I would not have liked the responsibility of picking the best! However in this life there are winners and losers, and the judges’ decision is final. The winning presentation was Dr Stephen Tolchard, and the President was delighted to present him with a cheque for £1000.

Session III – The Sir Humphry Davy Lecture
The Sir Humphry Davy Lecturer was the world renowned inventor of the laryngeal mask airway, and recently retired Consultant Anaesthetist from Reading, Dr Archie Brain. He treated us to an enthralling, entertaining, and at times amusing, account of his trials and tribulations in developing, introducing and producing his invention which has taken the world of anaesthesia and airway management by storm. His obvious dedication and determination, coupled with his affable, charming manner made this a lecture to remember, and a fitting end to an excellent afternoon. At the end of his lecture, amid much enthusiastic applause, the President, Dr John Carter, presented him with a ship’s
Social Programme
One of the great attractions of Bath are the hot spa waters, famous since Roman times. In addition, the centre of Bath forms a very compact area, with all the main attractions within walking distance. While the lectures were going on in the Assembly Rooms, partners were taken on a guided walk from the Assembly Rooms, taking in many of the attractive local sites, to the wonderful new Thermae Bath Spa which has been so long in preparation, but has been well worth the wait, although the local council tax payers may choose to differ!

On the Saturday morning, partners were left to their own devices, and with the plethora of interesting shops so close by and Christmas shopping in mind, many partners found this a “must do” in Bath.

The Society Dinner
The evening festivities commenced with the President’s reception held in the stunningly atmospheric surroundings of the Roman Baths. Members, partners and guests enjoyed a glass of mulled wine beside the pillars and ancient stonework of the King’s Bath, lit by flaming torches
A new career for the Hon Sec?

Archie Brain and Brigid Cook on the dance floor.

Dancing in the Pump Rooms.

Rod Casserley, the guest speaker, and Jenny Tuckey, the local organiser.

Dancing to the Beatles.

Best friends!
as steam rose from the water’s surface into the cold November night air. Following this the dinner itself was held in the Pump Room, with 109 members and guests. At the end of the dinner the President proposed the health of the Society’s guests, and one of the principal guests, Dr David Whitaker, President of the Association of Anaesthetists of Great Britain and Ireland, proposed the continuing health of the Society. The evening continued with some enthusiastic dancing to a Beatles tribute band, although there was a marked reluctance from the trainee contingent to leave the bar. No doubt they thought they would be shown up by the dancing skills of the consultant members of the Society!

The evening, or to be more precise the night, finished back in the bar of the Bath Hilton with the usual suspects reflecting with pleasure on the joys of another SASWR meeting.

Saturday Science
Despite the previous night’s revelry there was an excellent attendance early on the Saturday morning to hear Dr Tom Simpson, a local Bath consultant anaesthetist, introduce and chair the first session entitled ‘Airway Bonanza!’

This session started with Dr Anil Patel, Consultant Anaesthetist at the Royal National Throat, Nose and Ear Hospital who gave a fascinating talk on anaesthesia for laryngeal lesions. I meant to ask him why his hospital was not called the Ear, Nose and Throat Hospital, but his intriguing talk left all thoughts of such mundane questions behind! Next on was Professor Martin Burchall, a Bath ENT surgeon who had previously worked at Southmead Hospital and spoke on laryngeal replacement surgery. He pointed out that half the hospitals doing this procedure do less than 5 cases a year, and questioned whether the expertise should be more concentrated. Somehow or other he managed to include the girl-band Pussy Cat Dolls in his lecture and that seemed to be a popular move with some members of the audience. The final speaker of this session was Dr Tim Cook, another Consultant Anaesthetist from Bath whose lecture entitled ‘Mea culpa’ took the form of a confession regarding the management of a particularly difficult airway, and left the audience wondering how they would cope in the same situation. They probably all felt “not so well!” A lively discussion ensued before breaking for morning coffee.

Society Lecture
Following coffee, the members were joined by their partners to hear the Society lecture, given by Dr Rob Casserley, a surgical SHO at Bath and veteran of no less than three climbs of Everest. His talk, entitled ‘Summit, tragedy, close calls and fewer brain cells’ recounted his various assaults on the highest mountain, including one on which a close friend died, and the subsequent one to attempt to retrieve his body. This was an extremely moving talk, made more dramatic and very personal by the inclusion of video footage of himself and his doomed friend clearly suffering from both the hypoxic effects of altitude, and acute mountain sickness. The superb photography, and his moving delivery really made the audience feel that they had been through this ordeal with him; and the appreciative applause at the end of his talk reflected the strong affection Rob had stirred up.

The President, Dr John Carter, thanked Rob warmly for such an excellent talk, and then closed the meeting, thanking all speakers, the organisers, Trade representatives, and indeed members and their guests for continued support, and looked forward to welcoming as many of them as possible at the Spring meeting in Budapest in May.
Hypothermic Responses To Infection Are Inhibited by \(\alpha_2\)-adrenoceptor Agonists: Possible Implications for PICU Patients

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MRC Centre for Synaptic Plasticity\(^3\) and Psychopharmacology Unit\(^4\), University of Bristol

Introduction
Agonists of the \(\alpha_2\)-adrenoceptor such as clonidine and dexmedetomidine have proven very useful as primary sedative agents and in the management of sedative withdrawal in the paediatric intensive care unit (PICU) patient\(^1\). Convalescent PICU patients often have multiple indwelling cannulae and are at significant risk of sepsis. Clinical surveillance of such patients relies, in part, upon patients being able to mount an appropriate response to infection, in particular changes in core temperature. Such changes may comprise a febrile response, spiking temperatures or hypothermic responses to infecting organisms\(^4\-\(^6\). Current evidence suggests that thermoregulatory responses to infection involve central noradrenergic circuits\(^4\-\(^7\). Thus if central noradrenergic neurotransmission is affected by sedative doses of \(\alpha_2\)-agonists this may interfere with the ability of these patients to mount an effective thermal response to invading organisms.

Bacterial infection triggers an interaction between the immune and central nervous systems (immune-CNS) comprising thermoregulatory, endocrine and behavioural responses. Clinically this interaction is important and its components are recognized as thermal changes, raised plasma cortisol and glucose, and behavioural malaise in affected patients. The study of the immune-CNS interaction to infection has been most extensively studied in the laboratory rat\(^6\). Febrile and hypothermic responses, accompanied by activation of the hypothalamo-pituitary-adrenal (HPA) axis and consequent rise in plasma corticosterone have been demonstrated following infection in this, and other species, including humans\(^4\-\(^6\). The direction of the thermoregulatory response to infection seems to be dependent upon the dose of inoculum\(^7\) and the ambient temperature\(^4\). Hence in experimental models of infection using bacterial lipopolysaccharide (LPS - a cell wall constituent of E. coli) to activate the immune system, low dose LPS evokes monophasic febrile responses whereas high dose LPS is associated with the evolution of an initial hypothermic response to infection, both of which are highly reproducible\(^5\-\(^7\).

Regardless of the direction of the thermal response to infection, the responses are macrophage dependent and believed to be mediated by the pro-inflammatory cytokines interleukin IL-1, IL-6 and tumour necrosis factor-\(\alpha\)\(^4\-\(^7\). In addition, hypothermic and febrile responses involve activation of the same regions of the brain\(^7\) and specifically involve activation of central noradrenergic neurons\(^7\). The involvement of central noradrenergic neurons in thermoregulatory responses to infection raises the possibility that ligands which have affinity for adrenoceptors may affect core temperature in the presence or absence of infection.

To date, no one has investigated whether adrenoceptor ligands are capable of modulating hypothermic responses to infection. In the present study the effect of \(\alpha_2\)-adrenoceptor agonists upon LPS-induced hypothermia were studied using doses of \(\alpha_2\)-agonist comparable to those used in PICU patients.
Methods

Temperature Measurement and Plasma Corticosterone

Barrier-reared juvenile male Wistar rats (n = 48; 10-12 weeks old) were housed in a 14:10 h light: dark-cycle at 21°C. All procedures were carried out in accordance with the UK Animals (Scientific Procedures) Act 1986. Four days prior to experimentation each rat was implanted with a peritoneal temperature-sensing device and an indwelling venous (jugular) catheter under a combination of anaesthesia of pentobarbitone (30 mg kg-1 Sagatal, RMB Animal Health Ltd., UK) and xylazine (8 mg kg-1 Rompun, Bayer UK Ltd.), as described previously. Over the ensuing 5 days leading up to the experiments each rat was familiarised with handling by connection to the temperature-sensing module (Digitron 3754-PT100, RS Components, UK) and flushing the venous cannula to ensure patency.

At the beginning of the experiment each rat was connected to the temperature-monitoring device and to the venous infusion system. Prior to the commencement of the infusion, the core temperature of each rat was recorded in order to ascertain whether there were any effects of the infusion itself on this parameter. The infusion delivered either sterile saline (0.9%) or an α2-adrenoceptor ligand at a rate of 9 µl min⁻¹ (for different experimental groups see Table 1). During the experiment, core temperature was continually monitored and recorded at 5 min intervals. After a control period of 30 min the infusion was momentarily stopped in order to administer an intravenous bolus injection of either sterile saline (0.9 %, 0.1 ml) or 3.5 µg LPS (E.coli, serotype 0127:B8 in 0.1 ml saline, Sigma), followed by a flush of the respective infusion medium (0.05 ml: the volume of the jugular cannulae employed). The infusion was then restarted and continued for the duration of the experiment. The investigator recording temperatures in the experimental groups was blinded to the specific treatments.

Table 1: The intravenous infusion of α2-adrenoceptor ligand or saline in the different experimental groups of rats receiving a single bolus intravenous injection of either LPS or sterile saline vehicle.

<table>
<thead>
<tr>
<th>Group</th>
<th>i.v. infusion (9 µl min⁻¹)</th>
<th>i.v. injection (0.1 ml)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Sterile saline (0.9%)</td>
<td>Sterile saline</td>
<td>8</td>
</tr>
<tr>
<td>II</td>
<td>Sterile saline (0.9%)</td>
<td>LPS (3.5µg in saline vehicle)</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>Mivazerol (4.8µg kg⁻¹ h⁻¹)</td>
<td>Sterile saline</td>
<td>5</td>
</tr>
<tr>
<td>IV</td>
<td>Mivazerol (4.8µg kg⁻¹ h⁻¹)</td>
<td>LPS (3.5µg in saline vehicle)</td>
<td>6</td>
</tr>
<tr>
<td>V</td>
<td>UK14304-18 (6µg kg⁻¹ h⁻¹)</td>
<td>Sterile saline</td>
<td>4</td>
</tr>
<tr>
<td>VI</td>
<td>UK14304-18 (6µg kg⁻¹ h⁻¹)</td>
<td>LPS (3.5µg in saline vehicle)</td>
<td>5</td>
</tr>
<tr>
<td>VII</td>
<td>RX811059A (7µg kg⁻¹ h⁻¹)</td>
<td>Sterile saline</td>
<td>3</td>
</tr>
<tr>
<td>VIII</td>
<td>RX811059A (7µg kg⁻¹ h⁻¹)</td>
<td>LPS (3.5µg in saline vehicle)</td>
<td>4</td>
</tr>
<tr>
<td>IX</td>
<td>RX811059A (7µg kg⁻¹ h⁻¹)  and mivazerol (4.8µg kg⁻¹ h⁻¹)</td>
<td>LPS (3.5µg in saline vehicle)</td>
<td>6</td>
</tr>
</tbody>
</table>

Data Analysis

The hypothermic response to LPS begins at 20 min and terminates at 95 min following LPS administration. In order to statistically compare the effects of each treatment on LPS-induced hypothermia the temperature of each successive 5 min epoch between 20 and 95 min post LPS-injection was subtracted from the individual mean baseline temperature prior to LPS administration. This effectively gave the area under the curve for the individual responses to each of the treatments. Group data were then compared using a two-way analysis of variance (tANOVA).

Core temperature before and 20 min following the commencement of the infusion of α2-ligand or saline were compared using a paired-t-test.

Adrenoceptor Ligands

The selective α2-adrenoceptor agonist mivazerol was donated by UCB Pharma, Belgium. The selective α2-agonist, UK14304-18 and the α2-antagonist, RX811059A were gifts from Reckitt and Coleman Pharmaceuticals. The doses of the agonists used were chosen based on two criteria: doses were of the same magnitude as those currently used for sedation and sedative withdrawal in PICU

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patients (1-10µg/kg) and the doses used had previously been demonstrated to affect central noradrenergic release in microdialysis studies of rat brain.

Results

Effect of infusion of α2-ligand(s) on core temperature

The infusions of saline or the respective α2-ligand occurred prior to the injection of LPS, therefore, in the comparison of the effects of the various infusions on core temperature, it was possible to pool data from control and respective LPS-treated groups. A comparison of core temperature immediately prior to and 20 min after onset of the infusion of either saline or α2-ligand showed that none of the α2 ligands employed had independent effects on core temperature. These data are shown in table 2.

Table 2: The core temperature prior to and 20 min after the onset of the intravenous infusion of saline (Sal; 0.9%), mivazerol (Miv; 4.8 µg kg⁻¹ h⁻¹), UK14304-18 (UK; 6 µg kg⁻¹ h⁻¹), RX811059A (RX; 7 µg kg⁻¹ h⁻¹) or Rx811059A and mivazerol (Rx/Miv; 4.8 µg kg⁻¹ h⁻¹ & 7 µg kg⁻¹ h⁻¹, respectively).

<table>
<thead>
<tr>
<th>Infusion (n)</th>
<th>Temp. (°C) before infusion (±SEM)</th>
<th>Temp. (°C) 20 min after onset of infusion (±SEM)</th>
<th>P value</th>
<th>T value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sal (n=15)</td>
<td>37.0 ±0.1</td>
<td>37.1 ±0.1</td>
<td>0.178</td>
<td>-1.41</td>
</tr>
<tr>
<td>Miv (n=11)</td>
<td>37.0 ±0.1</td>
<td>37.2 ±0.1</td>
<td>0.170</td>
<td>-1.48</td>
</tr>
<tr>
<td>UK (n=9)</td>
<td>37.0 ±0.1</td>
<td>37.1 ±0.1</td>
<td>0.108</td>
<td>-1.81</td>
</tr>
<tr>
<td>RX (n=7)</td>
<td>37.0 ±0.2</td>
<td>36.9 ±0.1</td>
<td>0.172</td>
<td>-1.55</td>
</tr>
<tr>
<td>RX/Miv (n=6)</td>
<td>37.0 ±0.2</td>
<td>37.1 ±0.2</td>
<td>0.403</td>
<td>-0.91</td>
</tr>
</tbody>
</table>

Effect of α2-ligands on LPS-induced hypothermia

In the group receiving a saline infusion, a single bolus i.v. injection of saline had no significant effect upon core temperature whereas a similar injection containing 3.5 µg LPS caused a marked hypothermia (P < 0.005, tANOVA) commencing 20 min after the injection and lasting for 75 min before core temperature returned to pre-injection values (Figure 1a). In the group infused with mivazerol a similar

![Figure 1](image-url)
pattern was observed, with LPS causing a marked hypothermia compared to saline treated controls (P < 0.005, tANOVA). However, when comparing the magnitude of the LPS-induced hypothermic responses, it was found to be significantly smaller in the group that received a mivazerol infusion (P < 0.005, tANOVA), suggesting that mivazerol inhibited the hypothermic action of LPS (Figure 1b). Figure 1C shows that the inhibition of LPS-induced hypothermia was mimicked by infusion of the highly selective α2-agonist, UK14304-18 (P < 0.005, tANOVA).

Having mimicked the inhibitory action of mivazerol on LPS-induced hypothermia using UK14304-18, the selective α2-antagonist RX811059A was employed to see if the thermo-inhibitory action of mivazerol could be reversed. In the group that received an infusion of RX811059A, LPS induced a significant hypothermia compared to saline treated controls (P < 0.005). Infusion of RX811059A had no significant effect upon the response induced by LPS (Figure 2a), however, infusion of RX811059A simultaneously with mivazerol reversed the inhibitory effect of mivazerol on LPS-induced hypothermia (Figure 2b). Thus there was no difference between the magnitudes of LPS-induced hypothermia in the group that received an infusion of saline compared to that which received RX811059A and mivazerol (P > 0.19, tANOVA) (Figure 2b). Furthermore, the magnitude of the LPS-induced hypothermia in this latter group was significantly greater than that induced in the group that received only a mivazerol infusion (P < 0.005, tANOVA) (cf. Figures 1b & 2b).

**Discussion**

This is the first study to investigate the effects of α2-ligands on LPS induced hypothermic responses. Furthermore, it is the first study to show such effects of α2-agonists at clinically effective doses. The results show that LPS-induced hypothermia can be inhibited by the selective α2-agonist mivazerol, which has no effect on core temperature when infused alone. This action would appear to be mediated by the α2-adrenoceptor since it was mimicked by the selective α2-agonist, UK14304-18, and antagonized by the selective α2-antagonist, RX811059A. The inhibition of LPS-induced hypothermia by α2-agonists has implications for PICU patients receiving α2-agonists for sedative, or withdrawal therapy, since these PICU patients are at high risk of infection and may have an impaired ability to mount a thermal response to an infecting organism.

A number of studies have addressed the role of α2-receptors in LPS-induced fever. Evidence suggests that the febrile response to LPS is due to an increase in metabolic rate and peripheral vasoconstriction leading to an increase in core temperature, and this is associated with increase
hypothalamic noradrenaline turnover and release in the medial preoptic area. Administration of α2-agonists such as UK14304 and medetomine inhibit LPS-induced fever by reversing the metabolic actions of LPS and causing peripheral vasodilatation. Similarly, prazosin, the α1-adrenoceptor antagonist, is also antipyretic. This effect is thought to be post-synaptic, reversing the vasoconstrictor effects of LPS and having a profound inhibitory effect on metabolic rate. The effects of α2-agonists on fever have, however, only been shown at doses 100-1000 times greater than those used in the present study. The conflicting reports of the effects of α2-agonists on fever might indeed be accounted for by cross-reactivity of α2-ligands at such high doses. Thus, whether LPS-induced febrile responses are inhibited by microgram doses of clonidine has yet to be demonstrated. Although it would seem likely in view of the current results.

Acknowledgments
This work was funded by UCB Pharma, Belgium. The research was performed in laboratories of The MRC Centre for Synaptic Plasticity, University of Bristol, UK.

References
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Introduction and Background
Adhesive tapes are routinely used during anaesthesia. We rely upon them for a multitude of purposes, such as securing tracheal tubes and cannulae. Occasionally, the performance of these tapes is critical, as demonstrated by the following case:

Case Report
A 76 year old lady with advanced rheumatoid arthritis presented for occipito-cervical fusion following acute collapse of the third cervical vertebra. She was otherwise well apart from severe aortic stenosis with a peak gradient of 124 mmHg.

The rheumatoid arthritis had resulted in a fixed neck and limited mouth opening, so she underwent awake fibreoptic nasal intubation. The tracheal tube was secured using the standard fixation method of 2 strips of Elastoplast covered with a sheet of Mefix. She was positioned for surgery in the prone position with the head held in pins.

After 10 hours on the table, the bellows of the ventilator were noted to be falling and an investigation commenced for leaks. The bellows then rapidly emptied. Inspection under the drapes showed the tracheal tube to be hanging loosely from the nose, soaked in saliva and blood. LMA insertion in the prone position was unsuccessful and by the time she had been freed from the head pins and turned supine, she had suffered a hypoxic cardiac arrest. Intubation was not possible following standard laryngoscopy, but by passing an Aintree catheter mounted on a fibreoptic bronchoscope through a Proseal LMA, a tracheal tube was successfully railroaded into place. After four minutes of CPR and two doses of adrenaline she regained a spontaneous circulation.

Following 12 hours of elective sedation and mechanical ventilation, she was allowed to wake and went on to make a full recovery.

Inspired by this case, a postal survey of British Neuroanaesthetists revealed that there are four tapes in widespread use for securing tracheal tubes during prone neurosurgery: Elastoplast, Mefix, Sleek and zinc oxide. Some correspondents felt that the prior application of Friars’ Balsam (Benzoin Tincture compound) improved tape performance.

The preference of which tape to use seems to be dependent on individual experience, as there is little published literature on which to base an informed choice. Various studies in North America and Australia have assessed the performance of a selection of tapes using a variety of methods, but did not investigate those commonly used in the UK. No study has assessed the effects of the tape getting wet, or whether there is an advantage to using Friars’ Balsam.

This study has been designed to compare the adhesiveness to skin of four commonly used tapes under three different sets of conditions: dry, wet and with the prior application of Friars’ Balsam.

Methods
Ethical approval was deemed unnecessary by the Trust Research and Development department, as the author was the sole subject.

The four tapes assessed were: Sleek (BSN medical, Brierfield, UK), pink Elastoplast (BSN medical, Brierfield, UK), Mefix (Möllycke Health Care, Göteborg, Sweden) and Leukoplast pink zinc oxide (BSN medical, Brierfield, UK). All tapes were unused and stored as recommended by the manufacturer. The same batch of each tape was used throughout the study.

All measurements were made by the author using the skin on his medial forearm. A pilot study determined the optimal size of tape (1cm by 2.5cm) and the necessary duration of adhesion before measurements were taken (15 minutes). The measurements were made over 12 days under constant conditions, with the ambient temperature between 24 and 26°C. The skin was prepared by wiping with an isopropyl alcohol Steret (Seton...
Healthcare, Oldham, UK) and allowed to dry. Five pieces of each tape were tested on each day. The same area of skin was not used twice in one day.

The tape was applied transversely across the medial forearm. A 10 Newton strain gauge (Salter Brecknell, Smethwick, UK) was attached to the tape using a metal equilateral triangle placed under the tape at its halfway point (Figure 1). A two point calibration was performed on each study day. The force required to pull the tape free from the arm was assessed by holding the gauge perpendicularly and increasing the tension by one Newton every three seconds until the tape pulled free. This was repeated 20 times for each tape under each of the three different conditions:

**Dry:** The tape was applied to the skin and left for 15 minutes before tension was applied.

**Wet:** The tape was applied to dry skin, left for 15 minutes and then submerged in 0.9% saline for one minute. Measurements were taken after a further 5 minutes.

**Friars’ Balsam (FB):** A small quantity of FB (Thornton Ross, Huddersfield, UK) was applied to the arm to achieve a consistent yellow discolouration of the skin. After allowing to dry for one minute, the tape was applied and measurements taken after a further 15 minutes.

**Statistical analyses**
The data was analysed using ANOVA analysis of variance (two way). The Scheffe post hoc test was used to determine where differences lay and to identify homogenous subsets.

**Results**
Two hundred and forty tests were carried out in total, including 60 for each tape and 80 for each different condition. The raw data is shown in Table 1. A histogram confirmed that the results fall within a normal distribution. ANOVA analysis confirmed significant differences between the four tapes and between the three different testing conditions (p<0.001). Figure 2 illustrates the means and 95 percent confidence intervals for each of the 12 groups of data (i.e. four tapes, each tested under three different conditions: dry, wet and after FB).

Overall comparison of the four tapes demonstrates clear differences in performance: Leukoplast was significantly more adhesive than any of the other tapes (p<0.001); Sleek was more adhesive then Mefix and Elastoplast (p<0.001); and Mefix more adhesive than Elastoplast (p=0.018).

Subgroup analyses of the results for each testing condition are described.

\[Figure 1.\] 10N Strain gauge attached to tape

\[Figure 2.\] Mean tension required to detach each tape when dry, wet and following application of Friars’ Balsam (FB). (95% confidence intervals shown).
Dry
Of the four tapes, Leukoplast required the most force to remove and Elastoplast the least. The mean force required to detach Sleek was the same as for Mefix. The difference between Leukoplast and Elastoplast was statistically significant (p<0.001), whereas the difference between Leukoplast and Sleek/ Mefix was not significant (p=0.215 for both). Mefix and Sleek were both more adhesive than Elastoplast, but this was also not statistically significant (p=0.817).

Wet
Under wet conditions, both Elastoplast and Mefix were removed by significantly less force than when dry (p<0.001). Leukoplast and Sleek both required a slightly greater force compared to when dry, but this was not statistically significant (p=0.958 and p=0.652 respectively).

Leukoplast and Sleek both required significantly more force to remove than Elastoplast and Mefix (p<0.001). Leukoplast required the greatest force overall, but not significantly more than Sleek (p=0.11).

Friars’ Balsam (FB)
The prior application of FB significantly improved the adhesiveness of Elastoplast (p=0.02) and Sleek (p=0.019). Mefix required more force to remove after FB, but this was not significant (p=0.652). FB did not affect the performance of Leukoplast (p=1.0). The use of FB with Elastoplast, Sleek and Mefix improved performance such that it was statistically indistinguishable from that of Leukoplast (p=1.0 for all).

Discussion
This study has assessed the adhesiveness of four tapes to the arm of a single subject under narrowly defined and therefore artificial conditions. This may reduce the value of these results when extrapolating them to clinical practice, such as the taping of tracheal tubes. Limitations include the use of a single skin type, on an area which may have different properties to that found on the face. Only new tape from a single batch was studied, therefore not allowing for variations related to age or manufacture.

Nevertheless, the study was designed to be as clinically relevant as possible and statistical analysis has demonstrated convincing results. Leukoplast zinc oxide tape was the most strongly adhesive overall. The difference was less marked when the tapes were dry, when all tapes performed reasonably well and may be considered reasonable to use under these conditions.

However, the most striking results were for the tapes soaked in saline. Both Elastoplast and Mefix performed very poorly in this situation, whereas Sleek and Leukoplast were relatively unaffected. These results suggest that Elastoplast and Mefix are not an appropriate choice for areas which may become wet, such as in the case history described above.

Friars’ Balsam improved the performance of Sleek, Elastoplast and Mefix such that they were indistinguishable from Leukoplast in dry conditions. This is likely to be clinically significant and would support the use of FB with these tapes unless contraindicated. However, disadvantages of FB include occasional local allergic reaction and skin discoloration, best removed with alcohol. This may discourage clinicians from its use, except when it is crucial that tape stays stuck. Further study of the effect of FB under wet conditions would be beneficial.

For the purposes of the discussion, it is assumed that increased adhesiveness confers improved clinical performance. This overlooks the possibility that tape which is too sticky may have adverse effects. Skin damage was not assessed during this study, but was minor and reversible.

Conclusions
The choice of adhesive tape for a particular clinical

Table 1. Mean tension required to detach each tape when dry, wet and following application of Friars’ Balsam (FB). (95% confidence intervals shown).
situation should depend upon where it is being used, the likelihood of it being soaked in fluid and the consequences if it were to come unstuck. This study has investigated the performance of four tapes on a single subject and has compellingly demonstrated that: for all conditions, Leukoplast performed best; under dry conditions Leukoplast was equal to the other tapes used with FB; and under wet conditions Elastoplast and Mefix perform poorly.

Future investigation is required to confirm these findings for different skin types and different parts of the body.

References
Rates of anaesthesia-related death have fallen steadily since the Confidential Enquiries into Maternal and Child Health (CEMACH) began in the UK in the 1950s (Figure 1). Along with failure to oxygenate after failed intubation, acid aspiration was historically an important cause of maternal death at Caesarean section.

Despite the historical decline in maternal death rates from anaesthesia, the most recent reports of CEMACH have actually shown a rise in deaths from anaesthesia. Although it is too early to say whether this trend will reach statistical significance, the CEMACH authors expressed concern over the lack of experience and confidence attained by some anaesthetists in the conduct of general anaesthesia for obstetric procedures. This lack of experience is due to a combination of factors; including greater use of regional anaesthesia in obstetrics, use of a variety of supraglottic airway devices during general anaesthesia in the non-obstetric population, reduction in weekly hours of duty (due to the European Working Time Directive) and reduction in duration of training. These factors are unlikely to change.

The National Institute for Clinical Excellence (NICE) has issued specific guidelines for the use of acid aspiration chemoprophylaxis in elective Caesarean section (LSCS): ‘to reduce risk of aspiration pneumonitis, women should be offered antacids and either Histamine-2 (H₂) receptor antagonists or Proton Pump Inhibitors (PPIs) to reduce gastric volume and acidity before LSCS’. A problem in fulfilling these guidelines may arise when a labouring patient, planning a non-instrumental vaginal delivery, develops an indication for urgent operative delivery. H₂ receptor antagonists and PPIs take at least one to two hours to achieve reduction in gastric volume and acidity, so waiting to administer chemoprophylaxis until an indication for urgent delivery arises will miss the opportunity to lower aspiration risk. Ideally these agents should be given during labour to women at risk of operative-delivery; particularly the use of capnography and pulse oximetry, have led to a decline in death from other airway complications.

Two factors have led to the decline in maternal death from acid aspiration. Firstly, the recognition since the 1980s that regional anaesthesia for caesarean section is a safe alternative that avoids the potential for airway problems associated with general anaesthesia. The second is the improvement in measures taken to prevent acid aspiration under general anaesthesia, including:

- tracheal intubation by rapid-sequence induction with cricoid pressure
- acid aspiration chemoprophylaxis prior to anaesthesia.

Alongside these factors leading to the decline in acid aspiration, improved techniques and monitoring,
however no clear guidelines are given by NICE as to which women should be considered at-risk.

The Royal College of Obstetricians has published guidelines for continuous Cardiotocographic (CTG) monitoring in Labour (Table 1). Electronic foetal monitoring is considered advisable in moderate- to high-risk labours, which may be due to maternal, foetal or intra-partum factors. As a consequence, it is this group of parturients who are more likely to require urgent operative delivery, and should be therefore be given acid aspiration prophylaxis in labour.

<table>
<thead>
<tr>
<th>Maternal Factors</th>
<th>Intrapartum Factors</th>
<th>Foetal Factors</th>
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<tr>
<td>Previous CS</td>
<td>Oxytocin augmentation</td>
<td>IUGR</td>
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<td>Epidural analgesia</td>
<td>Prematurity</td>
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<tr>
<td>Post term (≥42 wks)</td>
<td>Vaginal bleeding in labour</td>
<td>Oligohydramnios</td>
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<td>Prolonged ROM</td>
<td>Maternal pyrexia</td>
<td>Abnormal doppler velocimetry</td>
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<tr>
<td>Induced labour</td>
<td>Meconium-stained liquor</td>
<td>Multiple pregnancy</td>
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<tr>
<td>Diabetes</td>
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<td>Breech presentation</td>
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<tr>
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<td></td>
<td>Foetal abnormality</td>
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<tr>
<td>Other maternal medical disease</td>
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Table 1. Indications for Continuous CTG (RCOG)

Locally, in addition to these indications for acid aspiration prophylaxis, we have two additional indicators. Our central Delivery Suite regularly accepts maternal transfers in labour from the 6 community midwife-led units in our catchment area. These mothers are generally transferred because labour is not progressing as planned, because there are concerns regarding maternal or foetal well-being, or for provision of epidural analgesia. Therefore these women are also given acid aspiration prophylaxis prior to transfer. Secondly, as pethidine reduces gastric emptying, another local protocol requires that mothers receiving intra-muscular pethidine in labour receive ranitidine 6-hourly.

The gold standard is that all mothers at risk of an operative delivery should receive acid aspiration prophylaxis in labour. We decided to conduct an audit to investigate whether we were meeting this standard locally.

The prophylactic agent used in our unit is oral ranitidine 150mg 6-hourly. This is cheap (around 3p per dose), has a favourable side effect profile, a long history of use in obstetrics and can be administered by midwives without the need for prescription by a doctor. Discussion of the ideal chemoprophylactic agent is beyond the scope of this audit.

Inclusion Criteria
All deliveries at our obstetric unit.

Methods
The audit took the form of a retrospective review of notes of all deliveries occurring in a 3-week period in September 2005. The notes were examined between delivery and discharge from hospital. The notes had to be reviewed prior to discharge because mothers take the notes home with them to assist community midwife follow-up. Daily review by the auditors unfortunately missed some patients who were discharged on the “4-hour discharge” programme for uncomplicated deliveries, but would have been likely to capture almost all of the pregnancies that had an indication for ranitidine. Of the 178 deliveries that took place in the audit period, 123 sets of notes were reviewed and all these were included in the audit (69%).

Results
Of the 123 deliveries included in the audit, 102 had an indication for acid aspiration prophylaxis. Of these 61 were given ranitidine, whilst 41 were not (shown as dot pattern on figure 2). Of the 41 not given ranitidine, 8 went on to have operative delivery, thereby breaching the NICE guidelines. Significantly, none of the 21 deliveries with no indication for ranitidine went on to operative delivery.

If we remove from the cohort those patients having elective Caesarean section, leaving only those who went into labour (figure 3), the figures change: 99 women went into labour in the audit period; 79 had an indication for ranitidine, but slightly fewer than half of these were given prophylaxis (figure 3). Of those not given ranitidine (40, shown as dot pattern in figure 3), 7 ultimately required operative delivery.
Subgroup analysis was undertaken to attempt to ascertain which indications were associated with a high degree of compliance with the protocol (figure 4). Almost all patients undergoing elective Caesarean section were given prophylaxis, whilst those having induction of labour were only rarely given ranitidine. This graph also highlights the relative frequency of the commonest indications. Note that many mothers had multiple indications for ranitidine.

Figure 4. Compliance by Indication.

One subgroup of particular interest to the auditors was the mothers who opted for epidural analgesia in labour, as these mothers had been in contact with a member of the anaesthetic team. Epidurals have been shown to increase the risk of instrumental delivery, although not the risk of Caesarean section\(^7\,8\). Forty women had an epidural inserted in labour (33%). This is higher than the national average of 1 in 5 (20%) in England and Wales\(^9\), but this is to be expected due to the local arrangement of many midwife-led normal vaginal deliveries in the area taking place at six community midwifery units, hence their notes were not available to the reviewing team. Of the 40 parturients with epidural anaesthesia in this audit, 28 were compliant with protocol (70%) and received ranitidine. Eighteen women with epidurals (45%) went on to operative delivery.

Also of particular interest are the women who went on to unplanned operative delivery. Twenty-one women in labour went on to have urgent operative delivery (17%). Of these, 14 had correctly followed the acid aspiration chemoprophylaxis protocol. Of the seven mothers not compliant with the protocol, six had not been given ranitidine at any time prior to transfer to the operating theatre. For the remaining patient, more than twelve hours had elapsed since ranitidine administration when she was transferred to theatre, which exceeds the recommended 6-hourly administration regimen for acid aspiration chemoprophylaxis in labour\(^6\).

Figure 5 shows the indications for ranitidine in those seven mothers who underwent urgent operative delivery without being given prophylaxis. It shows that all seven mothers had multiple indications according to our protocol.

Figure 5. Unplanned Operative Delivery.

**Discussion**

Although patients having elective Caesarean section are routinely offered aspiration chemoprophylaxis, many labouring mothers who are at increased risk of urgent operative delivery are not being given ranitidine and hence are in breach of the NICE guidelines on Caesarean Section (2004).

Following the presentation of this audit to anaesthetists, obstetricians, hospital and community midwives, a change of practice has been agreed unanimously. As well as mothers undergoing elective Caesarean Section, all mothers with an indication for...
continuous cardiotocograph (Royal College of Obstetricians & Gynaecologists) will be given ranitidine 6-hourly in labour. This last group includes mothers with moderate- to high-risk labours and hence includes those at greatest risk of operative delivery. ‘Reminder’ signs have been laminated and attached conspicuously to all CTG machines as well as to the controlled drug cupboard where epidural solutions are kept as an aide memoire to staff to administer ranitidine 6-hourly in labour. We plan to re audit the use of ranitidine 12 months after the introduction of these reminder signs.

Acknowledgements
1. The idea for the audit came from an audit presented at Wessex Obstetric Anaesthetists Meeting 2004
2. The audit was conducted by D Janssen (SHO) and J McGrath (SHO) under the guidance of J Tuckey (Consultant)

References
A Survey and Review of Herbal Medicine and Anaesthesia

Dr P J Cowlishaw, SpR Southwest Peninsular Region

Introduction
Recent literature has highlighted the potential risks of combining herbal therapy, anaesthesia and surgery. McKenzie et al.1 conducted a survey in 2005 involving 5% of practising members of the Association of Anaesthetists of Great Britain. He found that 90% of members do not elicit a herbal drug history despite being aware of their potential hazards. 80% admitted to an inadequate knowledge of herbal medicine. It has been shown that patients are reluctant to disclose their use of complementary medicine2 and clinicians must question them directly.

Popularity and usage of herbal medicines in the UK is rapidly rising. Studies in the US found that 20-30% of pre-surgical patients take herbal remedies2,3. Skinner et al. found that rates were lower in the UK at around 5%. The BBC conducted a poll of 1200 people and discovered that 20% had used a form of complementary medicine in the preceding year. The UK herbal medicine market is estimated to be worth between £55-70 million and is increasing by over 10% each year.

For these reasons I decided to survey anaesthetists in the south west region to ascertain their attitudes, practices and knowledge of herbal medicines.

Methods
An email questionnaire was sent to the anaesthetists working at three of the main hospitals in the south west (Royal Devon and Exeter Hospital, Derriford Hospital and Royal Cornwall Hospital). Three questions were asked (see appendix 1). Replies were received by email. Although the replies were kept confidential they were not anonymous. Of the 196 emails sent, 94 replies were received, a response rate of 48%.

Results
89% of respondents stated that they do not routinely ask their patients if they take herbal medicines and 85% felt they could not advise patients of the risks of using herbal remedies with anaesthesia and surgery (figure 1). Despite this, 33% were aware of published guidelines or recommendations with regard to administration of herbal medicines during the perioperative period (figure 1). Consultant anaesthetists were better informed compared with juniors (see figure 2).

Conclusions
Anaesthetists are inadequately informed and unable to counsel patients with regard to the risks of herbal therapies. Further audit and education is required to address this. An additional survey is planned at the Royal Devon and Exeter Hospital to assess the prevalence of herbal drug usage in surgical patients. A review of the literature now follows which I hope will promote discussion, awareness and knowledge in the field of herbal medicine.
Regulation of Herbs
In UK law herbal drugs are considered to be dietary supplements and not medicines. This is due to an exemption clause in the Medicines Act (1968). They do not require a drug licence and there is no necessity to demonstrate safety, quality and efficacy. The burden of regulation is shifted from the Medicines & Healthcare Regulatory Agency (MHRA) to the Food Standards Agency (FSA). Herbal medicines must comply with the Food Safety Act (1990) which states that ‘all foods sold must not be injurious to health’. Herbal products can be purchased freely from health food shops and supermarkets without instruction or guidance. They are marketed as natural and perceived by clinicians and patients to be safe and free from side effects. New European legislation has introduced a Traditional Herbal Medicines Registration Scheme (THMRS). All unlicensed medicinal herbal products will be required to meet specific standards in order to register under the THMRS. Mandatory registration is required by 2011.

Despite the regulatory exemption the MHRA encourages Yellow Card reporting of adverse events due to unlicensed herbal medicines. 529 adverse events were reported between 2000 & 2005, 10 of which were fatal. Between 1993 & 1998 2621 adverse events including 101 deaths were reported by the US Food and Drug Administration (FDA).

Safety of Herbal Medicines
Knowledge of efficacy and safety remains poor due to a lack of well-constructed trials. Herbal medicines cannot be patented which removes financial incentives to perform research. Logistical difficulties arise because products marketed under the same name contain mixtures of compounds in varying concentrations. For example, Ginseng is the global name given for several species of herb (Panax, American, Korean red and Siberian). The active ingredient in ginseng is thought to be ginsenoside which is a group of steroidal compounds (the main ones being Rg1, Rc, Rd, Rb1, Rb2, and Rb0). Even within the specific extracts, standardisation of the ginsenoside content varies between manufacturers. Each ginsenoside subtype has unique pharmacodynamic and pharmacokinetic properties, some of which are opposing.

Side effects and toxicity can be directly due to the herbal ingredient or due to contamination. The former may be a result of inappropriate dosing regimens or overdose. Herbal products imported from Asian countries often contain contaminants. These are either heavy metals (such as arsenic, lead, mercury) or conventional Western medications (NSAIDs, corticosteroids, diuretics, hypoglycaemics). Adverse events may occur as a result of drug interactions.

Popular Herbal Medicines
Commonly used herbal remedies in surgical patients in the UK are Garlic, Ginseng, Ginkgo, St Johns Wort, Echinacea, Evening Primrose Oil, Valerian, Ephedra and Kava.

Garlic
Garlic (*Allium sativum*), a popular cooking ingredient, is consumed regularly in food. It is sold in a capsule formulation containing crushed raw garlic, aged garlic extract, or garlic essential oils. It has been extensively researched and is used to improve immunity, treat hypertension and atherosclerosis, and reduce cholesterol. These effects are attributed to the allicin and ajoene compounds found within garlic. In vitro studies have shown that these constituents act as antiplatelet agents by altering thromboxane and arachidonic acid metabolism. In vivo studies are less conclusive. Garlic has been implicated in excessive haemorrhage after transurethral resection of prostate and a spontaneous epidural haematoma occurred in a man taking 2g garlic daily for an unknown period. Placebo-controlled trials repeatedly show reductions in cholesterol and triglycerides at 4-12 weeks but the response is unsustained. In humans the antihypertensive effect of garlic is marginal. Garlic appears to induce cytochrome p450 3A4 enhancing the metabolism of some drugs (cyclosporine and saquinavir). Common side effects include nausea and indigestion. It is recommended to discontinue Garlic therapy 7 days prior to surgery especially if the patient is on concurrent antiplatelet agents.

Ginseng
There are several types of Ginseng but American Ginseng (*Panax quinquefolius*) and Oriental Ginseng (*Panax ginseng*) are the most common. Purported benefits include immunomodulation, mood enhancement, energy restoration, and hyperglycaemic control. It can be taken as a tablet, powder or tea. The active ingredients (ginsenosides) vary depending on the species. Ginsenoside Rb-1 blocks sodium channels and appears to regulate...
GABA transmission in the brain resulting in prolongation of hexobarbital sleeping time in mice\textsuperscript{16}. Rg1 improves humoral and cell-mediated immunity in mice and may have a role in anticancer therapy\textsuperscript{17}. Panax ginseng (Ginsenoside Rb-2) has been shown to reduce postprandial blood glucose and may precipitate hypoglycaemia in fasted patients or patients on hypoglycaemic therapy\textsuperscript{18}. Reported side effects include insomnia, headache, hypertension and vomiting. In vitro Ginseng reduces platelet adhesiveness\textsuperscript{19}, but clinically it may be a procoagulant. It has been found to reduce the INR in patients on warfarin therapy\textsuperscript{20}. Due to its possible irreversibility, therapy should be discontinued one week prior to surgery.

**Ginkgo**

Ginkgo has been used as a medicinal plant (Ginkgo biloba) for centuries in China and Japan. It is commonly used in Europe to improve cognitive function and reduce dementia. It contains various flavonoids and terpenoids. Gingko was found to be superior to placebo in improving cognitive function\textsuperscript{21}. Ginkgo has been reported to reduce seizure threshold and should be avoided in epileptics\textsuperscript{22}. Laboratory studies suggest an antiplatelet effect. Multiple case reports including intracranial bleeding\textsuperscript{23} and postoperative bleeding\textsuperscript{24} support this although small clinical trials have been inconclusive. Based on the pharmacokinetic data, Ginkgo should be stopped at least 36 hours prior to surgery.

**St John’s Wort**

St John’s Wort (Hypericum perforatum) is used as a herbal remedy to treat depression and anxiety. A meta-analysis involving 1757 patients concluded that 300-1000 mg/day of extract was superior to placebo\textsuperscript{25}. St John’s Wort induces hepatic cytochromes (mainly P450 3A4) and reduced therapeutic efficacy has been reported with digoxin, warfarin, oral contraceptives, theophylline and cyclosporine\textsuperscript{26}. In a series of organ transplantation St John’s Wort was associated with a mean decrease of 49\% in blood cyclosporine levels\textsuperscript{27}. The compounds hypericin and hyperforin found in St John’s Wort are serotonin & noradrenaline reuptake inhibitors. The commercial preparations have a standardised 0.3\% content of hypericin. Patients taking St John’s Wort are at risk of serotoninergic syndrome, when combined with SSRI, high tyramine diet, sympathimemetics, or MAOIs. The syndrome results in autonomic dysfunction, muscle rigidity and psychological disturbance and can prove to be fatal. For these reasons this herbal medication should be discontinued 2 weeks prior to surgery.

**Echinacea**

Three species of Echinacea are used for the treatment and prophylaxis of infections (Echinacea angustifolia, Ech. pallida & Ech. purpurea). The pharmacodynamic effects are attributed to the lipophilic compounds. Multiple in vitro studies have shown immunostimulatory effects\textsuperscript{28}, but clinical trials are less conclusive. Echinacea may reduce severity and duration of upper respiratory tract infections. It is contraindicated in patients with autoimmune conditions and patients on immunosuppressant therapy. Long term use (greater than 8 weeks) may actually have a paradoxical immunosuppressive effect, resulting in poor wound healing and nosocomial infection\textsuperscript{29}. Allergy and anaphylaxis has been reported. Concerns have been raised over liver toxicity and Echinacea should be avoided in patients with hepatic dysfunction.

**Evening Primrose Oil (EPO)**

EPO is extracted from the night willow herb (Oenothera biennis). It is used for treatment of rheumatoid arthritis, premenstrual syndrome, mastalgia, eczema and diabetic neuropathy. It contains the oil gammalinolenic acid (GLA) which is converted to the prostaglandin precursor dihomool- GLA. Trials are inconsistent with regard to the clinical efficacy with the exception of one; this showed that GLA was an effective adjunctive therapy for breast cancer\textsuperscript{7}. EPO is contraindicated in pregnancy\textsuperscript{8} and may lower the seizure threshold and precipitate seizures in patients taking phenothiazines\textsuperscript{9}.

**Valerian**

Valerian officinalis is used as a sedative and for insomnia. Valerian contains a cocktail of compounds but sesquiterpenes are thought to be the main active ingredient. In animal experiments valerian increased barbiturate sleep time\textsuperscript{30}. It may produce dose-dependent sedation and hypnosis via modulation of GABA neurotransmission\textsuperscript{30}. A case of valerian withdrawal has been reported, with characteristics similar to that found with barbiturates or benzodiazepines\textsuperscript{20}. Therefore, the dosage should be reduced gradually over several weeks prior to
surgery or continued throughout the perioperative period.

**Ephedra**

Ephedra is used to relieve asthma, headache, fever and colds. The active alkaloids are mainly ephedrine and pseudoephedrine. It is therefore a bronchodilator and nasal decongestant. Due to its stimulatory effect it is currently being marketed as a slimming aid. Common side effects include palpitations and hypertension. Seizures, cerebral vascular events, myocardial infarction, and fatal arrhythmias have all been reported. In the US, the FDA banned all sales of ephedra-containing products in April 2004. It should be discontinued at least 24 hours prior to surgery.

**Kava**

Kava is derived from the root of the pepper plant *Piper methysticum*. It is used as an anxiolytic and sedative. Clinical trials have shown therapeutic benefit, which has been attributed to an active ingredient, the kavalactones. They appear to have antiepileptic, neuroprotective and local anaesthetic effects and may act by potentiating GABA inhibitory neurotransmission. Dependence and withdrawal have not been reported. The MHRA prohibited sales of Kava in December 2002, due to a number of reported cases of fatal hepatotoxicity. Other rare adverse effects include thrombocytopenia, dermopathy and leukopenia.

**Conclusion**

The field of herbal medicine remains challenging due to limited availability of evidence-based data, poor education, unregulated practices and patient misconceptions. It is encouraging to see that changes are being implemented to combat these problems. For example, the MHRA has improved surveillance and awareness through the yellow card scheme and pharmacovigilance publications. Implementation of the THMRS will make the sale of unregistered herbal medicines illegal by 2011.

Anaesthetists should be familiar with the hazards of herbal remedies and must take a herbal drug history from all patients. Although adverse events from the day-to-day use of herbal medicines are rare, the risks are substantially increased in relation to surgery, due to polypharmacy and the physiological stresses of anaesthesia and surgery. Anaesthetists are responsible for advising and educating patients of the potential risks of continuing or ceasing herbal treatments over the perioperative period.

**References**


**Appendix 1**

1. In your preoperative assessment do you routinely ask if the patient is taking herbal medicines? YES / NO

2. Do you feel adequately informed with regard to advising patients of the risks and hazards of using herbal remedies during the surgical period? YES / NO

3. Are you aware of any recommended guidelines with regard to administration of herbal medicines in the perioperative period? YES / NO
Perceptions Of The Effects Of Hours Reduction On The Training Of Specialist Registrars In Anaesthesia

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Summary
Concerns have arisen that training in anaesthesia is becoming inadequate following the implementation of the European Working Time Directive1. We conducted a postal survey of Specialist Registrars in the South West School of Anaesthesia to determine how they perceive their training has been affected. The return rate was 47/65 (72%). The majority of trainees (81%) believe they anaesthetise fewer patients since the reduction in hours. Under one third of trainees consider that their training modules provide adequate numbers, variety and complexity of cases in terms of their competence, confidence and progression at Record of In Training Assessment. Fifty-eight percent of trainees feel that under the current system, 5 years training provides adequate preparation for consultancy. Although competency-based and modular training may partially compensate for the decrease in hours, many trainees lack confidence that training as it is currently delivered provides adequate clinical experience.

Introduction
Since December 2000, the average number of hours worked per week by junior doctors has significantly decreased as a result of the New Deal. Junior doctors’ hours will be further reduced with the implementation of the European Working Time Directive. With the Jaeger and siMAP rulings that all time spent in the hospital whilst on call will count as work2,3, along with the requirement that resident doctors must have 11 hours rest in any 24 hour period, a full shift pattern of working will become inevitable for anaesthesia trainees. In order to meet these requirements, hospitals have utilised changes in shift patterns, rationalisation of night time work, and delegation of duties to non-medical personnel.

Training in anaesthesia in the United Kingdom has been modified over the last decade to compensate for the inevitable reduction in trainees’ hours. Competency-based and modular subspecialty training have been developed to provide a more structured framework essential for gaining a well rounded experience and preventing unnecessary repetition4. In addition the introduction of the Record of In Training Assessment (RITA) process and regular appraisal may allow earlier recognition of problems in trainees’ progress. These systems may only be successful if employed in conjunction with adequate clinical experience.

In light of the hours reduction, it has been suggested that five years of specialist registrar training in anaesthesia may no longer provide adequate experience. Concerns have arisen already amongst junior doctors and their trainers on the impact of the current hours reduction on training. Several authors have quantified the impact of hours reduction on training lists and total hours worked before and after the New Deal5,6, and the Royal College of Anaesthetists has recently conducted an on-line survey of logbook numbers7. To date no study has looked specifically at how trainees perceive their training has been affected.

This paper determines how specialist registrars (SpRs) in the South West School of Anaesthesia...
consider their training has been influenced by the implementation of a reduction in doctors’ hours.

Methods
Approval was obtained from the ethics committee to conduct this postal survey. A six part anonymous questionnaire was sent to all SpRs in the South West School of Anaesthesia. These trainees rotate to the following hospitals: Derriford Hospital, Plymouth; Royal Devon and Exeter Hospital, Exeter; Royal Cornwall Hospital, Truro; Torbay Hospital, Torquay and Musgrove Park Hospital, Taunton.

Demographic data was collected including age, sex, year of training, flexible training, and current pay band. Respondents were then asked a series of questions on how they perceived that the reduction in hours has affected their training. The answers to questions were in the form of a five point Likert Scale and were divided into the following headings:

1. Adequacy of anaesthetic lists and numbers of patients anaesthetised;
2. Modular training;
3. Preparation for consultancy;
4. Comparison of similar modules completed prior to and after the reduction in hours.

In addition, respondents were asked for free text comments and suggestions for improving their training.

Results
The overall response rate was 47/65 (72%). The characteristics of the trainees are summarised in Table 1.

1. Adequacy of lists
Figure 1 illustrates the perceptions of trainees on the impact of the reduction in hours on the adequacy of lists, including numbers of cases and proportion of training lists. The majority of trainees (81%) felt they anaesthetise fewer patients since the reduction in hours.

Only a small proportion of trainees felt that they had more training lists per week (17%). Although many trainees felt a larger proportion of their lists were teaching lists (42%), a similar number disagreed that this was the case (36%).

Opinions were divided on whether a greater proportion of patients were anaesthetised out of hours. Many of those who did not report a shift towards a greater proportion of out of hours cases commented that this might be due to anaesthetising only small numbers of patients out of hours as a result of on call commitments in the Intensive Care Unit and Labour Ward rather than the operating theatre.

| Age; years | 25-29 | 3 (6%) |
| 30-34 | 30 (65%) |
| 35-39 | 11 (23%) |
| 40-45 | 3 (6%) |

| Sex | M:F | 1.63:1 |

| Year of training | 1-2 | 28 (60%) |
| 3-5 | 19 (40%) |
| Flexible trainee | 7 (15%) |

1. Adequacy of lists

**Table 1**

**Figure 1. Since the reduction in hours:**

- I have more training lists per week.
- I anaesthetise less patients.
2. Modular training

The perceived impact of the New Deal on modular training is shown in Figure 2. Less than one third of trainees felt that the numbers, complexity, and variety of cases anaesthetised during their modules had been adequate in terms of competence/confidence and progression at their Record of In Training Assessment (RITA) (25-30%). The remainder of respondents either expressed no opinion (14-25%), or, more commonly, did not feel the modules provided an adequate case load (45%), variety (59%), or complexity (56%). Overall, less than one third of trainees rated their modular experience as adequate (32%).
3. Overall training
Figure 3 describes how trainees feel their overall training has been affected by the hours reduction. Around half the trainees felt that training had become more structured since the reduction in hours (47%).

Most trainees reported having a clear understanding of what they need to achieve by the end of SpR training (73%) but only 55% of trainees agreed that under the current system, five years of training is sufficient to prepare them adequately as consultants. A small proportion would like to see an increase to a six or seven year training period (15%). Many trainees believed that they would not be prepared as adequately as those who completed training prior to the reduction in hours (51%).
4. Comparison of modules pre and post hours reduction
Six trainees had completed similar modules before and after the reduction in hours. Of these, opinions were divided as to whether the number, variety and complexity of cases were noticeably less in the most recent module, and only one trainee believed their recent module was more comprehensive than previously.

5. Free text section
Comments by trainees were organised into three broad categories: the organisation of their training, service delivery, and trainee responsibilities (Table 2).

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<th>Table 2. Free-text (frequency of comments)</th>
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</thead>
<tbody>
<tr>
<td>1. Organisation of training</td>
</tr>
<tr>
<td>● Align modules according to career needs. (1)</td>
</tr>
<tr>
<td>● Up to date timetables of interesting lists and flexibility to seek out good cases. (1)</td>
</tr>
<tr>
<td>● Greater adherence to appropriate lists within modules. (6)</td>
</tr>
<tr>
<td>● Assessment/testing after each module. (4)</td>
</tr>
<tr>
<td>● More time for the trainees to plan modules and assess trainees. (1)</td>
</tr>
<tr>
<td>● Less training lists in SpR years 4 and 5 to promote clinical decision making, autonomy and opportunities for training less experienced trainees. (3)</td>
</tr>
<tr>
<td>● Dropping non-clinical commitments including research and audit. (1)</td>
</tr>
<tr>
<td>2. Organisation of service delivery</td>
</tr>
<tr>
<td>● Less emphasis on Intensive Care and Obstetric service commitment. (10)</td>
</tr>
<tr>
<td>● Week of nights followed by period of proper modular training. (1)</td>
</tr>
<tr>
<td>● Service lists on days when no relevant lists occurring, or module of service lists. (1)</td>
</tr>
<tr>
<td>4. Trainee responsibilities</td>
</tr>
<tr>
<td>● Trainees to use their initiative, admitting to gaps in their knowledge and seeking to fill them. (2)</td>
</tr>
<tr>
<td>● Senior trainees need to be able to “cherry pick” the more complex cases, rather than adhere to the true modular structure. (1)</td>
</tr>
</tbody>
</table>

Discussion
The results of our questionnaire illustrate that most of the SpRs in our region feel they anaesthetise fewer patients and participate in fewer training lists than prior to the New Deal. These perceptions correlate well with quantitative data from other authors comparing the differences between higher specialist training prior to and following the reduction in hours. A publication from the largest hospital in our School describes a decrease of 18% in the number of cases anaesthetised by trainees and 11% in the number of training lists per week when compared immediately before and after hours reduction. Similar results are seen in a departmental audit comparing the number of theatre sessions achieved in a thirteen-week period by Senior Registrars in 1991 and third year SpRs in 2004. The author suggests that the number of hours worked by the SpRs in 2004 equate to 73% of the hours worked by Senior Registrars in the same department in 1991.

A Group of Anaesthetists in Training (GAT) postal survey of Senior House Officers and SpRs in 2003 showed that the RCA recommendation of 3 in theatre training sessions per week was not achieved in 69% of respondents over a four week period. Many of our year 1 and 2 SpRs felt they had excessive commitments in the Intensive Care and Obstetric units at the expense of theatre training sessions. Although providing valuable experience, the out of hours commitments in these areas further add to the difficulties of attaining compliant rotas. The more senior SpRs in our School expressed a need for increased autonomy as consultancy approached, with an active role in teaching others. A redistribution of training lists to SpRs in their earlier years of training may be more appropriate.

In terms of competency-based training, many of the respondents felt that they lacked adequate exposure to subspecialty cases within modules. As suggested in our study up to date timetables of appropriate lists should be provided by trainers and the allocation of trainees to lists should incorporate a degree of flexibility enabling trainees to “cherry pick” cases which will be most beneficial to their current module. Trainees should also take responsibility for optimising their modular experience and continuously monitor the number and complexity of their cases, alerting their trainers should the module not be providing adequate exposure.

It is clear from our questionnaire and from published audits that the numbers of cases and theatre sessions have decreased since the reduction in
hours, but how does this relate to the confidence of SpRs within the current system in their training and preparation for consultancy? In our questionnaire 58% of trainees perceived the current five year period of registrar training to be an adequate time scale, and similarly, a recent GAT questionnaire reported that 49% of trainees felt that they would be sufficiently trained for consultancy within the current system.10 This leaves a significant number of trainees who clearly lack confidence in their training in anaesthesia, however most of our respondents did not feel that simply extending the length of SpR training would provide a satisfactory alternative.

The findings of our study suggest SpRs in the South West School of Anaesthesia feel they have less clinical experience than before the reduction in doctors hours. In addition, many trainees are not confident that the new working pattern will allow for adequate training for consultancy in the current timescale. Modernising Medical Careers may further impact upon training due to fewer trainees available to cover out of hours work. Our study provides useful information on the effects of a reduction in junior doctors’ hours’ on the training of SpRs and action points for improving training provision.

References
2. European Court of Justice, Case C-303/98, Sindicata de Médicos de Asistencia Publica (Simap) and Conselleria de Sanidad y Consumo de la Generalidad Valenciana.
3. European Court of Justice, Case C-151/02, Landeshauptstadt Kiel and Norbert Jaeger.
The Mallampati score remains one of the key tools in predicting difficult intubation. Since its introduction in 1985, it has been revised twice. Even within studies it has been noted that the definition of what constitutes the different classes varies widely and many studies do not state which version of the Mallampati score they are using. We surveyed 74 consultant and training grade anaesthetists in the South West region to find whether there is consistency in scoring.

The authors showed the picture in Fig. 1 to individual subjects and asked them: “What is this patient’s Mallampati score?” The answers received, along with the subject’s professional grade were noted and collated. The results are summarised in Tables 1 and 2:

**Table 1**
Mallampati scores given by subjects to the picture in Figure 1.

<table>
<thead>
<tr>
<th>Mallampati</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Subjects (% Total)</td>
<td>10 (13.5)</td>
<td>60 (81.0)</td>
<td>4 (5.5)</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

**Table 2**
Mallampati scores given to picture in Figure 1 broken down by grade of anaesthetist.

<table>
<thead>
<tr>
<th>Mallampati</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (%)</td>
<td>8 (22)</td>
<td>25 (67)</td>
<td>4 (11)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>SpRs (%)</td>
<td>0 (0)</td>
<td>21 (100)</td>
<td>0 (0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>SHOs (%)</td>
<td>2 (13)</td>
<td>13 (87)</td>
<td>0 (0)</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

Seventy four anaesthetists were interviewed; 37 consultants, 21 specialist registrars and 15 senior house officers. No one declined to be interviewed.

We felt that the picture represented a Mallampati score II, in that the uvula was partially obscured, although the posterior pharynx and soft palate were both visible. Almost one in five anaesthetists disagreed with this, giving it a score of I (13.5%) or III (5.5%). No one deemed it to be a Mallampati IV. Most of the disagreement was in the consultant grade, where only 25 of the 37 interviewed (67%) considered it to be Mallampati score II. Eight of the 37 (22%) considered it to be a Mallampati score I, and 4 (11%) a Mallampati score III. All 21 SpRs interviewed agreed that the picture represented a
Mallampati score II. Amongst SHOs, 13 of the 15 (87%) interviewed deemed the picture to be a Mallampati score II, and 2 (13%) decided that it was a Mallampati score I.

It is interesting that even amongst anaesthetists, there is such disagreement about what constitutes different Mallampati scores. Grades I and II are generally assumed to be predictors of uncomplicated intubation, whilst III and IV are markers of difficulty. Therefore, it is pleasing to note that 94.5% of respondents would not predict any difficulty in intubation in this picture. Whilst this in itself is unremarkable, by extrapolation there are likely to be differing opinions over other, higher Mallampati scores, which may be markers of difficult intubation. The wider disagreement between consultants is likely to be due to the greater cross section of time over which these anaesthetists were trained. Each is likely to use the Mallampati score in common use at the time of their training.

There has recently been a call to standardise airway training in the UK and the adoption of a ‘standard’ Mallampati score should form a part of this. This would ensure that anaesthetists could communicate effectively with each other when discussing difficult airways and would avoid confusion during patient handover.

Although the number of people interviewed was not large, we feel it is a representative sample of the anaesthetic population. The number of consultants, SpRs and SHOs interviewed represents our consultant led specialty.

Most work, including a recent meta-analysis suggests that although the Mallampati score is important, it should not be used as a sole predictor of difficult intubation. Increasing the number of tests undoubtedly increases sensitivity. A combination of the Mallampati score, thyro-mental distance and some measurement of lower jaw mobility (either as a jaw protrusion or the “upper lip bite test”) gives a far more sensitive and specific prediction.

References
5. Cook TM. (Still) time to organise training in airway management in the UK. Anaesthesia 2006; 61: 727-730.
Intravenous Paracetamol: A Sensible Choice for Postoperative Analgesia?

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Senior House Officer¹, Consultant Anaesthetist²
Department of Anaesthetics, Royal Devon & Exeter NHS Hospital

Paracetamol is the most widely used analgesic in the UK. This short article reviews the three routes of administration and discusses the benefits of the newer intravenous formulation.

Analgesic Efficacy

There is good evidence to show paracetamol as an analgesic is effective and safe. A Cochrane systematic review of oral paracetamol use in acute postoperative pain¹ analysing 47 studies, including 4186 patients, found the number-needed-to-treat (NNT) for at least 50% pain relief over 4-6 hours was 3.8 (95% CI 3.4-4.4), with no significant differences in the frequency of reported adverse effects between paracetamol and placebo. Side-effects after paracetamol use are rare, and usually mild and transient. At therapeutic doses, paracetamol use is associated with an extremely low rate of liver dysfunction (less than 1 in 500000²) and there are only two contra-indications; paracetamol or excipient hypersensitivity and severe hepatocellular insufficiency. There are few known drug interactions and paracetamol may be used by breast feeding women. Paracetamol has been shown to have a comparable benefit to ibuprofen and diclofenac in general and orthopaedic surgery,³ and it can significantly reduce the opiate requirement postoperatively.⁴

Intravenous(IV) Paracetamol

As well as being available for oral and rectal administration, paracetamol has previously been available for intravenous use in the form of its pro-drug, propacetamol. Used in France since 1985, propacetamol, provided as a powder for reconstitution, is water soluble and rapidly hydrolysed by plasma esterases to form paracetamol and diethylglycine; a dose of 1g propacetamol provides 0.5g paracetamol after hydrolysis.

The analgesic benefit of propacetamol is well recognised. In a double-blinded study of analgesia following gynaecological surgery, Varrassi et al⁵ randomised 200 women to receive either two intravenous doses of propacetamol 2g, or ketorolac 30mg, alongside morphine via PCA. Patients were monitored for 12 hours and propacetamol was found to be comparable to ketorolac both for pain scores and for reduction in morphine consumption. Moller et al (2004)⁶ performed a randomised, double-blinded, placebo controlled trial of analgesia after 3rd molar surgery, showing propacetamol to be significantly better than placebo for all the measured parameters; pain relief, pain intensity, patient’s global evaluation and duration of analgesia. More recently, in a randomised, double-blinded placebo controlled trial of propacetamol and diclofenac following total hip arthroplasty, Hynes et al⁷ failed to demonstrate a significant difference in any measure of analgesic activity between the two interventions, while both were found to be effective and superior to placebo for the total duration of the study. Although an effective analgesic, propacetamol has a relatively high incidence of adverse effects (up to 49% of patients will develop local pain at the injection site⁸) and there have been reports of contact dermatitis in health-care workers administering the drug. Perhaps as a result of this, propacetamol has never held a product license in the UK.

Intravenous paracetamol (Perfalgan, Bristol-Myers Squibb) has been available in the UK since 2004 and is formulated as a 10mg/ml aqueous solution in 50 ml and 100 ml glass vials for infusion over 15 minutes. Solubility is achieved through addition of the hydrophillic ingredients mannitol and disodium phosphate, while hydrolysis to
4-aminophenol, a toxic nitrogenous compound, is avoided by the addition of buffers to sustain neutral pH. Containment in glass vials prevents oxidation. Advantages of intravenous paracetamol over propacetamol are that it is available in a preformed solution, and it is not associated with pain on injection or contact dermatitis.

Bioequivalence with propacetamol has been established in a study of the intravenous administration of paracetamol and propacetamol to 24 healthy volunteers. Subjects were randomised to receive either 0.5 g/1 g paracetamol or 2 g propacetamol, both as a 15 minute infusion, and serum concentrations were measured at several points post dose. Values for peak serum concentration, (C[\text{max}]), time of peak, (T[\text{max}]) and area under the serum concentration-time curve extrapolated to infinity, (AUC[\text{inf}]), were all within accepted bioequivalence intervals. Mean C[\text{max}] was 29.9 µg/ml (SD 8.3) for 1 g paracetamol, and 24.7 µg/ml (SD 6.0) for 2 g propacetamol. Mean values for AUC[\text{inf}] were 57.6 µg h/ml (SD 10.4) for 1 g paracetamol and 51.0 µg h/ml (SD 9.1) for 2 g propacetamol. Median T[\text{max}] was 0.25 h for both (range 0.17-0.28 for 1 g paracetamol, 0.25-0.33 for 2 g propacetamol) typically coinciding with the end of infusion. The mean terminal half-life of 1 g paracetamol was not significantly different to that of 2 g propacetamol (2.72 h compared to 2.79 h).

A number of trials have shown comparable efficacy between intravenous paracetamol and propacetamol. Recently, two randomised, double-blinded placebo controlled trials of paracetamol analgesia after major orthopaedic surgery (Sinatra et al, 2005) and dental surgery (Moller et al, 2005) found no difference between intravenous paracetamol and propacetamol, with both interventions significantly superior to placebo for pain relief, time to morphine rescue, and overall morphine sparing. Both studies showed intravenous paracetamol to have a rate of adverse effects almost identical to that of placebo, and no cases of injection site reaction were reported. Intravenous paracetamol can therefore be assumed to equate to propacetamol in studies observing the efficacy of paracetamol for injection.

Differences in Route of Administration
Plasma concentrations of paracetamol between 10-20 µg/ml are known to produce an antipyretic effect but the concentrations required to provide analgesia are not well defined. Anderson et al observed one hundred and twenty children given oral or rectal paracetamol post tonsillectomy, concluding an effect site concentration of 10 µg/ml was needed to achieve pain scores of less than 4/10. However, both higher and lower values have been suggested. There are significant differences in the absorption of paracetamol, and therefore in the time to reach peak plasma levels, when it is given orally, rectally or intravenously. All three routes are able to achieve adequate plasma concentrations, but intravenous administration can achieve these levels in a shorter time.

Oral
Paracetamol is well absorbed from the gastrointestinal tract with low first pass metabolism in the liver, and oral bioavailability is estimated at 63-89%. Two recent trials have compared the administration of oral and intravenous paracetamol. In a study of thirty-five patients undergoing day-surgery, Holmer-Pettersson et al found intravenous propacetamol reached therapeutic plasma concentrations more quickly and predictably than oral paracetamol. Paracetamol plasma concentrations were observed for the first 80 minutes after administration of either 1 g/2 g oral paracetamol or 2 g intravenous propacetamol. After 20 minutes, median plasma levels were 0 µg/ml (range 0-7.4) for 1 g oral, 3.4 µg/ml (0-12.9) for 2 g oral and 12.8 µg/ml (9.8-24.4) for 2 g propacetamol. At forty minutes, the values were 2.7 µg/ml (0-16.6), 13.4 µg/ml (0-44.4) and 13.2 µg/ml (6.4-13.6) and at eighty minutes, the values were 4.8 µg/ml (0-13.6), 22.8 µg/ml (3.1-46.3) and 9.7 µg/ml (6.5-12.3). Intravenous paracetamol provided an average concentration within the therapeutic range after 20 minutes, while the authors commented on huge and unpredictable variability with oral administration; some patients who received 1 g orally did not achieve detectable plasma levels within the 80 minute study period, and the average plasma concentration after receiving this dose was subtherapeutic throughout. Two grams of oral paracetamol achieved a median plasma concentration within the therapeutic range after 40 minutes, suggesting that when paracetamol is given orally, a loading dose can reduce the time needed to achieve therapeutic levels.

Clinically, this difference has been shown to lead to a faster onset of analgesia when paracetamol is given intravenously. Moller et al compared the onset of analgesia for oral paracetamol and intravenous
propacetamol after 3rd molar surgery, and found propacetamol infusion provided a significantly faster onset of analgesia than oral paracetamol, with greatly reduced time until meaningful pain relief (8 minutes propacetamol vs. 37 minutes oral paracetamol) and maximal pain relief (15 minutes propacetamol vs. one hour oral paracetamol).

**Rectal**

Rectal absorption of paracetamol is more unpredictable with bioavailability between 24-98%.[14] The variability in the rate and extent of absorption of suppositories is thought to be due to several factors. Regarding the suppositories, lipophilic bases provide greater bioavailability than hydrophilic bases, and absorption is affected by the volume of the suppository, the number of suppositories used, and the particle size of the paracetamol.[14] Rectal pH may also influence the absorption of paracetamol, altering the degree of dissociation and therefore the ability of the drug to pass through biological membranes. In children, rectal pH can vary from 7.8-11.4, and in this range the degree of dissociation of paracetamol will vary from 2-99%.[15]

Several studies have shown the time needed to achieve therapeutic plasma levels with rectal administration is significantly less than with the oral or intravenous routes. Mary Stocker and Jane Montgomery in Torbay[16] investigated the administration of paracetamol suppositories to ten healthy adults, measuring plasma concentrations up to 8 hours post dose. They gave doses of 15 mg/kg, 25 mg/kg, 35 mg/kg and 45 mg/kg, and found that only doses of 35 mg/kg and 45 mg/kg provided concentrations above the minimum therapeutic level of 10 µg/ml for median time periods of 5.5 and 6 hours respectively, but a minimum duration of 1-2 hours was needed before this level was achieved. A dose of 15 mg/kg failed to achieve a median plasma concentration above 10 µg/ml at any time, while 25 mg/ml achieved plasma concentrations at the lower end of the therapeutic range. A higher loading dose (45 mg/kg) was not associated with a significantly greater risk of overdose, as the highest plasma concentration measured in the study was 25 µg/ml, substantially less than the accepted toxic concentration of 120 µg/ml. Hahn et al[15] studied the pharmacokinetics of paracetamol after repeated rectal administration of 25 mg/kg, 6 hourly, in 23 children following major surgery. The mean maximum plasma concentration (C (max)) after the first dose was 10.71 µg/ml (SD 3.09), while the mean time to C (max) was 2.37 h (SD 1.10). Large variations were seen in the absorption and resulting steady state concentrations: At steady state, the mean plasma concentration was 15.2 µg/ml (SD 6.8), while the mean time to reach 90% of the steady state concentration was 11.4 h (SD 8.6).

In a randomised study of 48 patients admitted to ICU after cardiac surgery,[17] half received paracetamol as suppositories and half received intravenous injections. Mean plasma concentration peaked at 14.4 µg/ml (SD 5.5) within 20 minutes after intravenous administration of 1 g, while after a 1 g suppository, the mean plasma concentration at 80 minutes was 1.2 µg/ml (SD 1.0). Stable plasma concentrations within the therapeutic range were not reached until after the 3rd rectal dose. Similarly, a study of oral and rectal paracetamol in 24 women following minor gynaecological laparoscopic surgery found that after the administration of 2g rectally, the mean plasma concentration at 4 hours was below the minimum analgesic level (8.4 µg/ml, range 4.2-16.3).[18]

There is some evidence to show that the delay in reaching therapeutic plasma levels may limit the usefulness of rectal paracetamol as analgesia in the immediate postoperative period. Hein et al[19] performed a randomised controlled, double-blinded trial involving 140 women undergoing elective termination of pregnancy. Following surgery, patients were randomly allocated to receive either 1 g paracetamol rectally, or a placebo suppository. There was no difference in postoperative pain scores between the two groups, and no difference in the need for additional analgesia or for time to discharge.

**Cost**

The major advantage of oral paracetamol over IV paracetamol is cost; a 1g dose of oral paracetamol costs about 2p, compared to £1.50 for a 1g dose of IV paracetamol. Bizarrely, paracetamol suppositories cost £1.98 per 1g dose.[20]

**Conclusion**

Given the similar cost, intravenous paracetamol should be considered as a more effective alternative to suppositories when oral dosing is not possible. It may also have a role to play when prompt analgesia is required and oral administration is not appropriate. Oral paracetamol is a simple well tolerated analgesic;
however an enlarged loading dose is needed if meaningful early plasma concentrations are required. Intravenous paracetamol provides a method of achieving rapid therapeutic concentrations of paracetamol that can subsequently be maintained by oral absorption. The disproportionate cost, slow onset time and wide variation in bioavailability make rectal paracetamol less attractive in the presence of the intravenous formulation.

References.

FENELEY TRAVELLING FELLOWSHIP

A variable sum of money awarded annually to support a "mission abroad". Applications to Dr E. Morris, Hon. Sec., Southmead, Bristol.
We report a potentially hazardous anomaly in a Datex-Ohmeda Aestiva 5 anaesthetic machine, which may not have been detected using the standard ‘machine checklist’ as recommended by the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

The anaesthetic machine in the main obstetric theatre was checked according to the AAGBI guidelines before the start of a morning list. The guidelines state that whilst checking the ventilator it is important to ensure ‘adequate pressure is generated during the inspiratory phase’. Adequate pressure was duly generated over time, however in doing so it was noted that the ventilator (bag in a bottle type) was moving slightly abnormally. With a 2 litre reservoir bag connected to the patient end of the breathing circuit, the ventilator was set to cycle on volume control at a frequency of 12 minute$^{-1}$ with a fresh gas flow of 0.5L minute$^{-1}$ after the circuit was primed. The tidal volumes generated were significantly lower than those programmed. Only after a period of at least 120 seconds, when the mean airway pressure exceeded 20cmH$_2$O did the ventilator begin to deliver the correct tidal volumes, a period over which it was thought that some degree of foeto-maternal compromise could have arisen following emergency induction of anaesthesia.

The gas flow sensors on the Aestiva 5 machines consist of a differential pressure transducer sited either side of a restrictor. The differential pressure recorded as gas flows through the restrictor is correlated with gas flow via a calibration curve. The flow of gas obtained is compared with that set on the ventilator controls and any compensation that is needed in order to equate the two values then occurs.

Further examination of the breathing system revealed a kink in the upstream inspiratory flow sensor as illustrated (Fig. 1). This resulted in erroneous upstream pressure readings, which was interpreted by the processor as excessive upstream flow. The inevitable correction in ventilator excursion resulted in the small tidal volumes observed. Only when the mean airway pressure was great enough to force open the kink in the sensor tubing was the pressure transduced truly indicative of airway pressure and only then could the computerised feedback system lead to production of the pre-programmed tidal volumes.

Lack of careful observation of the ventilator function during the machine check may have missed this hazardous fault with potentially disastrous consequences to both mother and foetus in the setting of emergency caesarean section under general anaesthesia. We emphasise the importance of ensuring not only adequate pressure generation during the inspiratory phase as outlined by the Association of Anaesthetists, but also of the prompt delivery of the pre-programmed tidal volume at normal airway pressures, as part of diligent and thorough checking of the anaesthetic machine.

References
1. Datex-Ohmeda Inc., P.O. Box 7550, Madison, WI 53707-7550, USA.
A New Zealand Experience

Dr Gilly Ansell, Anaesthetic SpR
Southwest Peninsular School of Anaesthesia

I have just returned from a year in Middlemore Hospital, South Auckland and I return to the NHS more experienced of course but also I hope with my eyes opened and my horizons broadened to the way that anaesthesia is practised around the world.

I can wax lyrical about the experience I gained in management of adult and paediatric burns; I can talk about my time spent looking after and anaesthetising acute spinal injuries; I can talk about the challenging obstetric population we dealt with in a delivery unit with 7500 deliveries a year or even my paediatric experience as there was a paediatric hospital on site. For me though, the benefits of working in a new system and in a new country were less tangible than the cases I came across and more about doing things differently and seeing new ways of working that I would have discounted in theory but have now seen working very effectively in practice.

The most extreme example of this was the way emergency work was tackled. At our hospital we ran five dedicated emergency theatres from 8am until 5pm Monday to Friday, reducing to three theatres after 5pm and one after 10pm. At the weekend there would be four in the day falling to three after 5 pm and one after 10pm. Every day there was an anaesthetic consultant, ‘the supervisor’, in the theatre suite but not responsible for a specific list. His job was to allocate lists to available staff and coordinate the emergencies until 10pm. He was also available for help/advice for the others on duty, received all phone calls booking emergency patients and ensured all the anaesthetic staff got meal breaks without disrupting the list. In my experience this system worked really well. There was a constant flow of patients through the emergency theatre and list alterations were easily made. You could be sure you would get lunch without stopping the list, there was a ready source of advice on hand and the more complex patients had already been discussed with a consultant so tended to be well prepared. There was also practical help available if required.

From a hospital point of view patients had short waiting times for emergency surgery, particularly in those groups who traditionally sit on list after list because their clinical priority is low- the plastics trauma patients, abscesses, fractured mandibles and changes of dressing. Many of these patients occupy hospital beds for hours if not days waiting for relatively minor surgery in the UK at considerable expense. They also spend time in hospital beds developing complications, being repeatedly starved and deteriorating clinically which then prolongs recovery and time to discharge. Elective lists were almost never cancelled to do emergencies and lists tended to keep to time. Emergency lists were well policed and didn’t get elective patients smuggled onto them and because each emergency theatre was dedicated to a particular speciality there was much less squabbling between surgeons over whose case was most important.

Clearly there would need to be huge changes in the way most NHS hospitals staff and run theatres in order to incorporate these kinds of changes but I thoroughly enjoyed working in that environment and it was very satisfying to see huge volumes of work being got through in a day. My feeling was that it was very much more efficient than the NHS way of working and intuitively must save money.

Another difference was in the pre-op visit. Most elective work was done at a separate site hospital but at both sites all patients brought in on the day of surgery were seen in a centralised admissions area plus some of those that had been in hospital the night before. For an all day list patients were brought in at intervals over the day so you might do a couple of cases and then have to have a short break for both you and the surgeon to see the next patients on the list. Surprisingly this did not seem to delay
lists as much as you might have thought. Lists tended to start very promptly and the admissions area was well organised. I also wondered if a little break mid morning, allowing the staff a few minutes to organise themselves actually made everyone more productive.

For emergency work patients were seen in the anaesthetic room immediately prior to induction rather than the anaesthetist wandering round the hospital looking for the right ward/bay. All patients had been discussed with a senior anaesthetist already so appropriate investigations had mostly been done. Surprisingly few patients were sent back as unprepared although it was very acceptable to do so and you could always opt to visit an especially sick patient on the ward if required. Thus changes and substitutions to the emergency list were easy to implement and again time seemed to be saved.

Part of the reason this was so successful was down to the hospital IT system, the best I have ever worked with. It was user friendly, up to date and fast. Since 2000, all discharge summaries including medication prescriptions, operation notes, clinic letters and A&E attendance notes are computerised. You can also access all investigations including ECG’s, blood results, Echo results, X-rays and their reports and even lung function tests via the same system. Pre 2000AD hospital visits are summarised in a ‘history document’. Huge amounts of time were saved as you didn’t have to sift through pages of notes, and a lot of information was available about the patient before they even got as far as seeing you. You could also check whether requested investigations had been done such as coagulation studies, prior to sending. Anaesthetic charts were not computerised, but pre-assessment visits were, including anaesthetic pre-assessments so the only piece of paper you really needed to see was the previous anaesthetic chart.

There were some disadvantages to this system. There was no planning time for a more difficult case as you had little or no warning of unexpected

*The author reflecting on whether to catch the plane back home.*
difficulties and minimal time to prepare for a complex anaesthetic (particularly frustrating for the anaesthetic technicians). Also the hospital policy was for the patient to be delivered accompanied to the anaesthetic room which was otherwise unused and then after being checked in to wait alone and unmonitored there until theatre was ready. Although I didn’t hear of any problems associated with this, I felt a little unsettled by the thought of a potentially unstable patient waiting around unobserved for a period of time. A staffed patient holding bay could easily deal with this worry.

Of course it wasn’t all good. I enjoyed getting used to working without an anaesthetic room and am now a convert, however I am quite pleased to have our ‘kingdom’ back in the UK and it is certainly less stressful putting in blocks and lines with a smaller audience and fewer distractions! We had an anaesthetic trolley in theatre with basic drugs and equipment but compared to the choice of drugs, fluids, lines etc in an anaesthetic room, the choice was quite limited which meant you were very reliant on your technician to fetch and carry for you.

The issue of controlled drugs was also a bit of an eyebrow raiser. In the morning you would go to the main CD cupboard in recovery and sign out into a very stylish bum bag all the CDs you thought you might need for the whole day! The bags were not checked and counted again until the end of the shift when leftover drugs were signed back in. It would have been very easy to pretend to give the drugs to the patient and keep them yourself as you were the only check during the whole list. I think even the best systems have enough loopholes to allow a tenacious individual to obtain CDs but this one seemed especially insecure. More worryingly, however, was the possibility of losing, leaving around or having stolen a bag full of opiates. The bags were often left in theatre or taken to the canteen, they were taken to delivery suite and also taken to your room overnight and I didn’t enjoy the responsibility of carrying one around.

I thoroughly enjoyed my time away and would recommend it highly. New Zealand is a fantastic country to spend some time in and we certainly tried to make the most of it. Professionally I learnt and consolidated my technical and practical skills and have come away with new useful techniques and more confidence in my own ability. I expect this would have happened had I stayed in the UK. What I have also come home with is a change in attitude. I think I am now more open minded to different ways of doing things, more questioning of the traditional way and more inclined to embrace and encourage change within the organisations in which I work.
The blood-brain barrier is extremely important to anaesthetists. Long before trainees get their first exposure to neurosurgery, they must be fully familiar with the barrier, and aware of the best way to keep it intact throughout the operation no matter what the surgeons might do. A determined surgeon can always breach it, but the anaesthetist must make it as difficult as possible.

First, you need two drip stands that you are not going to share with the surgeon. If the surgeon needs their own bags of fluid, then they need their own drip stand. Sharing a drip stand is too much of a temptation; the surgeon will ask for it to be moved, or raised, and the blood-brain barrier will be a goner. If the drip stands have equipment on them such as a warm-air blower or an infusion pump, put it as low as it will go on the stand to make it more stable, and turn each device to make sure you can get at its controls, with the control panel pointing at you.

The best membrane for the barrier is a cloth drape. A paper drape will do, but if you intend using pointed towel clips they are likely to tear through the drape. My advice is to shun pointed towel clips. They have a nasty tendency to perforate fingers, which is painful.

Blunt towel clips are best for maintaining the barrier. There are three methods. Best of all (‘clip-on-pole’) is when the radius of the clip is about the same as the radius of the drip stand. The clip when closed will clamp the drape firmly to the pole (Fig 1), but the drape can be easily raised should pressure get too high on the surgical side. Almost as good is ‘clip-off-pole’. The trick here is to bunch up a goodly amount of drape before closing the clip, or the drape will pull out of the clip too easily. The clip is then hung from the top of the drip stand (Fig 2). Again, it is easy to adjust the height of the barrier.

The third method (‘clip-up-pole’) needs tape. The temptation with clip-up-pole is to think it sufficient simply to bunch up the drape and apply the clip to tense the drape around the pole. That might work with a cloth drape, which has some elasticity to grip the pole. It will not work with a paper drape, which
has no elasticity. The barrier will slowly slide down the pole. Instead, apply the clip to a good bunch of drape around the pole, turn the clip so it lies vertically upward along the pole, and apply tape around the clip and pole just below the finger holes of the clip (fig 3). Fold over the end of the tape, so you can release it quickly if needed. In this, and all other uses of tape (see below), make sure you never let the tape adhere sticky side to sticky side or it will take hours unpicking with your finger nails to take the barrier down at the end of the case.

Whether using tape and a towel clip, or just tape, the best tape is the white cloth tape. Most anaesthetists using tape alone simply wrap tape round and round onto the drape and the drip stand. It doesn’t work, because only half the width of one circumferential length of tape is actually stuck to the drip stand. The key to it all is the Nubbin™ shown in Fig 4. Pull the drape across the drip stand, as shown, so that a length of tape can be applied vertically up the pole: the tape will be firmly adherent below, across and above the Nubbin™ (Fig. 5). Now wrap a second piece of tape around and around the boundary between drape and drip stand, making sure that this piece sticks well to the vertical piece.

Of course, if you use tape in this way, later raising the blood-brain barrier means raising any infusion bags as well, but this is a small price to pay for a barrier that only a really determined surgeon can breach.

Now you can sit behind it in comfort, sheltered from blood, bone chips, irrigation fluid, and bad language.
The other day, I was confronted with a statement so at odds with my personal wine philosophy that I was (temporarily) struck dumb. This person offered the opinion that the only reason to drink wine was to get drunk. Examine this for a moment and reflect upon the crashing absurdity of the position. It disregards the subtleties of soil, light, weather, heritage and skill that make each bottle of wine unique and often delicious. It’s like saying “I only eat to get fat, I only drive to cause pollution or play sport to smell bad”. It misses the entire point. And for this reason (and several others), I will not be inviting this person around to sample my Sauternes when I break it out of its case.

For you see, Sauternes is not only the ultimate indulgence in wine but the antithesis of everything cynical and commercial.

Sauternes are the greatest of the “Dessert wines”, so called because you’re supposed to drink them with pudding. A criminal waste in my opinion. Hemmingsway said “any man eating dessert is not drinking enough” and he had a point. If you’re lucky enough to have some Sauternes to hand at the end of a meal, you’ll be getting plenty of sugar and a better partner for a salty Roquefort or Stilton has yet to be invented.

Sauternes derives from the village of the same name, south of the river Garonne, on the south-eastern outskirts of Bordeaux. In this area, the Semillon, Muscadelle and Sauvignon Blanc grapes are ripened by the warmth of summer but then drenched by the misty autumnal evenings prevalent in these parts. This nightly dousing with warm, wet air allows the formation of an unusual fungus on the grape skins. Called Botrytis Cinerea by microbiologists it’s rather more poetic name is “La Pourriture Noble.” The “Noble Rot” renders the skins more permeable and as the water evaporates, the retained juices become richer flavoured, sweeter and more complex as the grapes shrivel. They come to resemble a distinctly unappetising heavy web of grey mould with short hairs projecting from the surface.

Astonishingly, the wine emerges golden and clear from the barrel tasting of honey, peaches, nuts and sweet citrus fruits developing a glycerol-like viscous texture with age. Not since Baudelaire smoked opium, has such corruption resulted in such beauty. It is utterly glorious and quite mad in commercial terms.

Because the bunches don’t develop noble rot at an even pace, the grapes are harvested as individual berries with up to ten pickings per harvest season. It’s costly and time consuming. Not only that, but the grapes being shrivelled produce much less juice. Hectare for hectare, a red vineyard across the river in the Medoc will produce four to five times the yield of its counterpart in Sauternes. Some years, the Botrytis doesn’t develop at all, leaving quality way down. And if it rains you’re buggered. You may get no crop at all.

So it’s expensive. I wouldn’t expect change from a tenner for a decent half bottle of Sauternes and the pinnacle of its expression, Chateau D’Yquem, is beyond everyone but Russian oil barons. And yet it’s the least profitable wine area in France. It has to be expensive because if the growers couldn’t make any money, they’d dig up their vines and plant apples. But think what you’re getting for your money. You’re drinking bottled dedication, idealism and hope. And blimey does it taste good!

Current Perris household special treat is:

Chateau La Tour Blanch Premier Crus. 1998. I got mine through the Wine Society and it’s wonderful.

The wines of the nearby villages of Barsac, Monbazillac, Loupiac and Cadillac are slightly less grand and more widely available. Similarly luscious experiences with a less daunting price tag. 2003 was apparently the vintage of the century.
THE ANAESTHETIC MACHINE OF THE FUTURE?

A.D.R.E.N. PREVENTS AUDIT:
(Automated Anaesthetic Record Keeping).

1. AIR DOLE & NOISE:
Vaccinating headphones to neutralise abusive surgeon.

2. CAPRISING MACHINE (Drunk models only)
Has several modifications to increase safety:
- Interpreting flow controls to prevent inadvertent delivery of haemodynamically hazardous
- Drugs.
- Renal filter prevents filling up of poor-quality coffee.
- Cuffs have non-invasive system to prevent accidental connection of cuffs from non-anaesthetic personnel.

3. GASUZER was fingerprint scanner.
Information can be related back to CO.
Enables on-the-spot fines for persistent offenders.
(Those who have an A.S.O.D. Behaviour Order will be arrested).

Pressure gauge:
Warms of potentially dangerously high pressure's upstream of the blooddraw barrier, allowing anaesthetists to take cover from surgical missiles.

Monitor doubles as polychrome to detect surgical inaccuracies.

(Taken from Anaesthesia News)
Sheets

From an unthinkable dark,
your first landing, softened by
a quilt of February snow.

The early years: long nights
stretched into arctic winters.
Sheets, sharers of secrets.

At twelve, boarding school.
A dormitory. The hard to hide
shame of the wet dream.

First girl, fumbled love . . .
In the morning the strangeness
of someone else in the same bed.

Afterwards, alone, that longing,
the scent of her, early evenings
in the corridors of summer. Still

those sheets to comfort, a tent
to take you dreaming to a desert
in Arabia, sultry nights, soft thighs . . .

By day, a mother launders them,
pegs them outside with her own
dreams of white sails blowing

her cleanly to blue islands.
After the loving years, the familiar
sheets wrapped round you, to let

you go as gently as they’re able;
the priest at his white altar
with the words you will not hear . . .

Robin Forward
Crossword

Dr B. W. Perriss

Clues Across

7. Breathe in and out at the seaside? (5,3)
9. These can introduce medication via 19 Down. (6)
10. Get closer to the border. (4)
11. Process that can change pink to blue. (10)
12. Refuse a stretcher. (6)
14. Eccentric host takes everyone vegetables. (8)
15. Lost without an amber newt. (6)
17. Independently I go in search of the dye. (6)
20. A conjurer's beam? (5,3)
22. Part of foot in stepmothers shoes. (6)
23. Sounds like she addresses it but wrongly. (10)
24. Chief spanner. (4)
25. Gladdens one's absent friends. (6)
26. Lessen by ironing? (8)

Solution to Crossword in
AUTUMN 2006 Anaesthesia Points West

Clues Down

1. Hallo, North Devon, a supporter on the back leg. (4,4)
2. Lock up silver in church. (4)
3. Get a good look at the goose. (6)
4. Hold back if others fall. (8)
5. Complaints that could be difficult to face. (10)
6. Overtake despite having decreased ability. (4,2)
8. Hold out against the weird Sister. (6)
13. Ends at unusual Main Street. (10)
16. One doesn't need to stamp! (8)
18. Mine not closed to actors. (8)
19. In rear being a farm servant. (6)
21. Get off to see a blonde. (6)
22. Trendy party given by a crawler. (6)
24. Could mean having the last word. (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. Submission of articles to Anaesthesia Points West implies transfer of copyright to the Society of Anaesthetists of the South Western Region.

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