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The Abstracts Submitted

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## The assessment of Neurovascular status documentation of patients presenting with Upper Limb Injuries and introduction of sticker.

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Introduction
A good initial clinical assessment involves examination and documentation of these findings. The idea is to ensure not missing any potential injuries or complications with appropriate medicolegal record keeping. The aim of this audit was to evaluate neurovascular assessment documentation in upper limb injuries in accordance with the current NICE guidelines (ref 1) followed by introduction of a sticker to ease this process.

Methods
A closed loop audit was performed, which focused on the neurovascular documentation of patients admitted between October 2020 - January 2021 (N = 22) and February 2021 - April 2021 (N = 22). There were 7 parameters evaluated, aiming for 100 % completion in each. After the first Loop we implemented an "" Upper Limb neurovascular examination sticker "" with the aim of improving assessment and documentation which would ultimately benefit in identification of associated injuries with prompt correction.

Results
In the first loop 6/7 assessments achieved <20 % completion. In the second loop, 4/7 assessments achieved >75%. Most notably, a large improvement in radial pulse documentation was found (from 13% to 77%). Sensory and motor nerve documentation (from 27% to 83%)

Conclusion
The sticker allows any physician to know the examinations to be carried out with simultaneous documentation. The sticker is available in Orthopaedic wards and ED floors where maximum upper limb injuries are encountered, eliminating chances of unavailability. We have introduced this in the Orthopaedic clerking sheet enabling improved outcome alongside a separate sticker for lower limb injuries as well to improve documentation standards. We hypothesise this sticker will help reduce injuries, complications, error risk and enhance patient optimisation pre as well as post operatively.

Reference
(1)https://www.nice.org.uk/guidance/ng37/evidence/full-guideline-pdf-2359957649

## Challenges that international medical graduates face when settling in their first job in the UK medical practice

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Introduction
International medical graduates (IMGs) encounter many challenges during their initial period of NHS jobs and may take time to adapt to the system. The support and guidance are needed to overcome those challenges.

Aim
To identify the difficulties IMGs face by means of a survey and aim to facilitate and support these during their adaptation period.

Method
50 junior doctors (IMGs) who are in their first year/ first job of working in the NHS

(predominantly those in the UHL) were invited to participate in the online survey.

Results
Most of the respondents (76%) are from Asia and the rest are from Africa and Europe. As we have expected, more than half of them had cultural challenges. Language and communication challenges were felt in 58% whereas 28% felt financial difficulties. Two third of the respondents had clinical attachment prior to their first job and they became familiar with NHS more rapidly than those who did not complete clinical attachment. We found that majority had 1-3 years of clinical experience before joining their first job in NHS and people with >3 years' experience tends to start on calls faster than those with < 3 years of experience. Even though a vast majority (90%) received clinical induction/ shadowing period, only a minority (12%) obtained induction/ training on how to use e-Portfolio. Despite the opportunities to be involved in Audit/ QIP, teaching and presentations, it was reported that leadership roles are less accessible.

Conclusion
From this survey, we were able to detect that cultural and communication issues are the main challenges in newly joined IMGs and these should be supported certainly to promote the mental health of IMGs and to optimize the workforce contributed by them. We also understood that there needs to be more encouragement in terms of education and career progression.

**Hurdles to the path of an International Medical Graduate in the UK**

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Introduction
14.6% of NHS staff are of non-British nationality, and 20% of doctors within the NHS are non-EU International Medical Graduates (IMGs)(1).

Aims and Objectives
To understand the hurdles IMGs face en route to employment in NHS.
To build a support system to improve their experience.

Method
A structured questionnaire was formulated with the help of google forms and circulated among the IMGs within various stages of initiating a career. The doctors already in employment are excluded.

Results
1. Better work-life balance, advanced training, and career-building prospects are the main reason for opting for the IMG pathway, 80% reported.
2. 62.7 % expressed stress from financial commitments during the transition. About 65% had to rely on family support for their expenditure until their employment.
3. Although it's relieving to observe that 58.8% of the doctors who took the questionnaire feel that their preparation is adequate to start their professional life in the UK, a proportion are still apprehensive about transitioning into the NHS model of healthcare, counting in the unfamiliarity with IT applications.
4. An overwhelming 56.9% of the doctors are concerned about their integration into work and social environments, with 45.1% fearing some form of discrimination while doing so.

Conclusion
Lack of information about the UK Health care systems, financial burdens, and communication issues are a few hurdles

the IMG doctors highlighted. More than half of the doctors were apprehensive about the development of their medical portfolio. This survey, therefore, reinforces the need for proper guidance for medical portfolio development, improving clinical attachment / observership prospects for better awareness regarding the NHS system of healthcare, guidance regarding financial management to lead a comfortable life, as well as the rising need for an inclusive community within the medical profession.

References:
1.The state of medical education and practice in the UK: The workforce report [Internet]. www.gmc-uk.org. 2019 [cited 13 June 2022]. Available from: https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk---workforce-report_pdf-80449007.pdf

**Empowering International Medical Graduates (IMGs) as surgical Trainers in the UK**

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Introduction
The Intercollegiate Basic Surgical Skills Course (BSS) conducted by the Surgical Royal Colleges aims to instil core surgical skills at the start of a young surgeon's by teaching the correct, basic surgical techniques. Trainees, non-trainees or Allied Health Professionals interested in surgical career have an opportunity to train in a controlled surgical skills environment. This additional activity also enables to score more points in training application and building academic portfolio.
International medical graduates (IMG's) coming to the United Kingdom (UK) have varied training in their host nations but require a standardised competency assessment to practice and pursue a surgical career in the UK such as a BSS course. Initiatives have been underway to empower IMG's working in the UK to develop as 'trainers' following their initial successful, completion of Surgical Royal College BSS course.

Aims
To assess the experience of IMG's in the UK as surgical trainers at BSS course conducted at the Manchester Surgical Skills and Simulation Centre (MSSSC) in a controlled environment under supervised faculty.

Methods
A retrospective, Observational cohort analysis of subjective and objective experience of senior IMG's involved as trainers at the MSSSC, BSS course. Data was collected from Feedback survey over the last 2 years and analysed.

Results
Over the last 2 years 8 senior IMG's were involved as 'observer' trainers at the MSSSC, BSS course. They felt well supported and gained confidence in delivering surgical training in presence of senior supervising Faculty. Particularly IMG's trainers felt it will improve their teaching portfolio and specialist application process.

Conclusion
This supervised training episode provided an excellent opportunity for the IMG's to improve their teaching and training skills as a surgical trainer. Such initiatives can empower IMG's to strengthen their academic portfolio, support progress in their career in the UK and ultimately improving patient care.

**Closed plantar dislocation of the navicular bone with associated fractures: Single Case study reported in Surrey, UK.**

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Introduction
Navicular plantar dislocation with associated calcaneo-cuboid fracture is a rare injury. It carries significant risk of morbidity from ligamentous injury and post-traumatic arthritis.

Case presentation
We report a case of an 80 year old woman who presented to Accident and Emergency (A&E) following a slip and fall down 5 steps. She had no history of ligamentous laxity or neuropathy. On physical examination, her right ankle was swollen, tender and she was unable to weight bear. The plain x-ray of her right ankle and foot revealed collapse of the mid foot caused by plantar dislocation of the navicular with the medial cuneiform and fractures of the cuboid, anterior process of the calcaneum and the lateral cuneiform.

Management/Results
A closed reduction was done in A&E and a check CT showed satisfactory alignment. The patient was discharged with a back slab and advised to be non-weight bearing on the injured foot. She was reviewed in clinic at 10 days, given an Aircast boot and treatment options were discussed with her. Her imaging showed high level of comminution at the calcaneo-cuboid joint, particularly at the cuboid. The options of calcaneo-cuboid fusion and conservative management were discussed with her, and she decided on non-operative management.

Conclusion
Due to the rarity of this injury, there are no clear best management guidelines. We were only able to find three case reports of similar injuries. This injury presents a high risk of long term disability in the form of secondary post-traumatic osteoarthritis and ligamentous injury. In this case the injury was reducible with ease and this helped with allowing for conservative management. The decision for conservative management or operative management with primary fusion of calcaneo-cuboid joint should be based on injury morphology and patient factors such as previous level of activity.

**Persistent Cough and Progressive Dyspnoea – Diagnostic dilemma, A case of Pericardial Mesothelioma.**

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Introduction of the topic
Pericardial mesothelioma is a neoplastic proliferation of pericardial mesothelial cells and accounts for a small fraction of mesotheliomas. The aetiology of this tumour is unknown, and treatment options are limited. In the general population, it has a survival rate of less than 6 months due to its highly aggressive nature.
Autopsy data suggest that it is a rare tumour with a prevalence of 0.0022% and there is a high rate of misdiagnosis. Hence, survival depends on early detection of the disease.

Aims & Objectives
1. To describe our experience with pericardial mesothelioma

2. To highlight the importance of early diagnosis in patients with persistent cough and dyspnoea.

Method:
Investigating with CXR, ECHO, PET/CT, histopathology, immunohistochemistry

Results
A middle aged diabetic and hypertensive patient presented with dry cough and dyspnoea for the last 6 months, initially NYHA class II and progressed to class III. An extensive investigation with ECHO, PET/CT, histopathology, immunohistochemistry confirmed pericardial mesothelioma.

Conclusion
Patients with malignant pericardial mesothelioma have been reported in a broad age range of 2-78 years. Because of the non-specific symptoms and signs, it is often difficult to diagnose. In most cases, the prognosis is poor, as 50-60% of patients die within 5-6 months of diagnosis. Hence thorough investigations is important to reach at the diagnosis and help in early management.

**Burn out amongst working in the AMU/General Medical departments in a North West Hospital**

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Introduction
Doctors worldwide face burnout. Koutsimani et al. defines burnout as psychological syndrome characterized by emotional exhaustion, feelings of cynicism and reduced personal accomplishment. In 2021, about 1/3rd of trainee doctors in the UK reported feeling burned out as per GMC National Training Survey, however there is no data regarding LED doctors.

Aim
The aim of this study was to identify how many LED-IMG doctors at this hospital experienced burnout on average, relevant factors, and whether this has impacted their decision of coming to the UK.

Methods
During August 2022 there were a total of 26 LED IMGs working in AMU/GenMed at a North West Hospital – a survey was shared, consisting of questions in regards to experiences with burn out. There was a 96.1% response rate.

Results
Majority of the responses (64%) were from doctors between the ages of 26-30. Majority of doctors (48%) had been working in the trust between 6-12 months, stating it took them 3-6 months to adjust to the UK culture. 60% managed to develop work friendships within 3 months. 48% said they were able to adjust to the NHS, however, 80% said they felt burned out.
Burn-out was experienced atleast once a week by a 52.2% doctors, with staffing, work load, and attitude of co-workers being the top reasons.
48% felt they were unable to speak up about their problems, 76% stated they try to be positive about stress. 40% said they felt moderately homesick, however, majority (64%) said they are happy with their decision to come to the UK.

Conclusion
Working in the NHS is a vastly diverse experience for many new doctors. There is a rise in burn out amongst many doctors coming to the UK, and despite showing resilience in the face of adversity, a lot more support needs to be garnered.

**Hull Revision Days; Passing the Baton of Leadership to an LED**

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Hull University Teaching Hospitals NHS Trust

Introduction
I took on a leadership challenge to transform a successful face to face FRCA exam revision day program to a virtual format.

Aims and objectives
The aim was to revive the Hull's revision day program, which was suspended due to the pandemic. The objective was to run an accessible and sustainable revision day program, free from the barriers of grade and geography, prior to each sitting of the FRCA SOE exam.

Methods
The Revision Days are conducted on Saturdays to facilitate LED attendance. Our trust provided access to a virtual platform called Big Blue Button (BBB). I created breakout rooms in BBB, feedback forms on Google Docs, and pdf 'Thank you' letters. Letters of appreciation, development and networking opportunities attracted faculty members.

Results
I led seven revision days till date. For the first two iterations, I was responsible for all aspects of the program, including content preparation, registration, communication, conduct of the sessions, troubleshooting, collection of feedback and dissemination of Thank you letters. For the third iteration, the opportunity to co-organise and lead on content preparation was offered to former attendees. I retained overall responsibility and mentored the co-organizers. 53 attendees, including 9 LEDs gained from the program. Many returned as faculty members.
I won the Ian Williams Memorial Prize for this project. This also helped me win the LED of the year award, and I presented a poster at the Annual College Tutor's meeting.

Discussion
The various stages of leadership elements are outlined in the Transformational and Servant leadership styles. I noticed that my leadership style progressively evolved through different stages beginning from creating a shared vision, to a combination of responsible and distributed leadership.

Conclusion
The baton of Educational leadership, which is usually held by HEE trainees, is now with LEDs.

**Type 2 Diabetes – Why the Non-adherence?**

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Introduction
Diabetes is one of the leading causes of death globally, and in India around 77 million individuals suffer from the disease (2019 estimates). Diabetes is a silent killer, however complications can be prevented or delayed in most cases with regular follow up and lifestyle changes.

Aim
This poster aims to reflect the non-compliance to diabetes management and to investigate the reasoning behind non-compliance.

Objective

The objective is to help develop new measures to educate and improve patients adherence to diabetes guidelines.

Method
This retrospective study determined the number of people who follow medical advice and who are adherent with diabetes treatment, by using a questionnaire. This included questions establishing reasons for non-adherence. 150 individuals with diabetes were included in the study.

Result
1)Out of 150 included individuals, 38% were female. 75.3 % were above the age of 50
2)68% of people were going to the doctor for regular follow ups
3)Percentage of patients undergoing specific tests were also determined (annual diabetic follow up checklist)
4)Reasons for non-adherence was established.

Conclusion
After analysing the data multiple plans of action were sought out to tackle the compliance issue and to improve the management of diabetes.

**LED Leadership: Overcoming geographical and COVID challenges using Teams.**

Nyan Tint, Katarina Vojtekova.
United Lincolnshire Hospitals NHS Trust

Introduction
Locally Employed Doctors (LEDs) make up to one-fifth of the UK doctors' workforce. A GMC survey: "Specialty, associate specialist and locally employed doctor's workplace experiences" reported that their working environments are not as supportive as they should be. GMC Council 180107 (gmc-uk.org). They felt less able to raise concerns, as compared to trainees according to 2019 national training surveys (NTS).
United Lincolnshire Hospitals NHS Trust (ULHT) has initiated "Medical Workforce Management Project" which involved recruiting LEDs to help with staffing pressure.
These LEDs are geographically spread across the Trust's 3 different hospitals. Moreover, COVID restrictions prohibited staff gatherings. There was no collective representation for LEDs and their voices have not been specifically heard. We have created a LADs support group online using "TEAMS". Their concerns are presented to JDC/JDF and LNC by representatives from each site.

Aims
This poster reflects the use of online resource to lead LEDs by overcoming challenges and to efficiently help them adapt into NHS/Trust systems.

Methods
We conducted a survey to our 27 LEDs with focus on their learning opportunities, supervision, and safe working environment. 13 out of 27 LEDs (48%) responded.
Results:

- 31% said they haven't got supervisors.
- 84% has got e-portfolios.
- 69% can take part in educational opportunities.
- 92% has experienced exception reportable incidents but don't know the process.
- 50% don't have indemnity cover.

All responders said the TEAM group is helpful.

Conclusion

The survey result was presented to LNC. With the support of LNC, the trust management has agreed to carry out the improvements which include:

- providing supervisors and e-portfolios to all LEDs and providing more educational opportunities/skills lab.
- Setting up exceptional reporting channel for LEDs
- BMA has conducted sessions to promote LEDs understanding of their contractual rights and responsibilities.

**Assessment of administration Of VTE prophylaxis within 14 hours of hospital admission**

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Glenfield hospital

Introduction
Hospital acquired thrombosis accounts for 60%of vtes seen. As per NICE guidelines, vte prophylaxis should be started within 14hours of hospital admission to decrease risk of hat.

Aim
To assess whether vte prophylaxis is given within the time range or not in hpb wards, Glenfield Hospital

Method:
Exclude pre-op,post-op as well as patients with contraindications to vte prophylaxis

Results
39.2% patients didn't receive the treatment within 14 hours of hospital admission

Conclusion
Two factors were responsible

a) There is a fixed time regimen of giving vte prophylaxis at 17:00 in the evening. Hence, patients arriving after 21:00 to 24:00 were given prophylaxis on the next day (accounts for 73% of patients)
b) Patient refusal (27%)

**Varicella Encephalitis and COVID 19 Vaccination**

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Walsall Manor Hospital

A 47 years old gentleman who was referred by his GP after he presented with one week history of high-grade fever, sore throat, neck pain and occipital headache which started 3 weeks following his second COVID-19 jab. He reported feeling forgetful with spaced-out starring episodes.

Examination had revealed vesicular skin rash involving back of the head, right outer ear and right side of the neck. In addition, he had neck stiffness. However, he had no photophobia and he was alert and conscious (GCS 15/15) throughout the admission period with no focal neurological signs.

Diagnoses of shingles with viral meningoencephalitis was suspected. Therefore, he was admitted and commenced on intravenous acyclovir. LP and CT head were performed. The CSF analysis result was positive for varicella zoster DNA (PCR) with raised WCC (244 - 90% lymphocytes). CT head along with MRI head were normal. Hence, a diagnoses of Varicella zoster meningoencephalitis was confirmed. Neurology team has advised to complete 14 days of iv acyclovir and to repeat the LP following that. The patient has improved significantly and the repeated LP -which

was done at day 15 -showed a total of WCC (7 – 100% lymphocytes) with no detectable Varicella zoster DNA (PCR). Interestingly, a similar case of a 36 years old lady who was admitted – in the same ward during the same period-also with vesicular rash and headache. She had received 2nd COVID 19 jab 3 weeks earlier. She was treated for VZV meningoencephalitis as supported by the LP and the CSF analysis result (detectable VZV DNA).

Based on the above two case, a possible link between VZV reactivation and COVID 19 vaccination might be present. In other words, VZV with neurological involvement might be triggered by COVID-19 vaccination. This might be supported as well by few other similar case reports.

**Assessment of CT Scan reports as per standardized reporting guidelines**

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Introduction
Prompt diagnosis forms the mainstay of management of any trauma patient. In addition to clinical assessment, imaging forms an important component. In most developed settings, CT scans play a vital role in arriving at the patient diagnosis. In addition to including the patient's details, it should also take into account patient's clinical information, prior investigations (radiological and non-radiological) and the management plan. The reporting should follow predefined standards to improve the quality of the diagnostic process. Consequently, standardization of this component of the diagnostic chain can notably improve patient care.

Aim & Objectives
To assess reporting of various CT scans as per the reporting standards given by the Royal College of Radiologists which include every department aiming to deliver actionable reporting, every report answering the clinical question, including a definitive or differential diagnosis when an abnormality is described and giving appropriate advice for next step of management in patient's best interest.

Method
A retrospective review of Body CT scans was done across UHB in the month of October in the year 2021. 100 reports were selected at random, out of which 50 were from A&E and 50 were Inpatient reports. Data collection was done using CRIS (online portal). Outpatient scans were not included in the study. Normal CT scans, CT Head and CT Intracranial Angiograms were excluded from our study.

Result
Out of the 100 reports – 97 reports met the criteria of our audit. 1 inpatient CT report and 2 A/E reports did not meet the specified criteria.

Conclusion
After the 1st Audit, we are able to achieve almost 97% of reporting standards as compared to 95 % previously in a span of 3 months.

**LED – A little extra for the doctors**

Abinaya Seenivasan, Anshoo Dhelaria
East and North Hertfordshire NHS Trust

Introduction
LED- Locally Employed Doctors' Committee in East and North Hertfordshire Trust (ENHT) has been constantly

improving the services offered to the International Medical Graduates (IMGs).

Aims and Objectives
The salient initiatives of the ENHT- LED Committee are highlighted.

Methods
The following actions have been implemented in the Trust:
A dedicated LED committee including Trust directors and Human Resources. The committee meets every 2 months to discuss the concerns raised by LEDs. An LED Charter- includes action plan for the employer (ENHT) when a non-UK postgraduate doctor starts as an LED. International Doctors' Forum (IDF)- a monthly Forum where overseas doctors can give advice and share experiences on transition to the UK. Terms of reference (TOR) Document for the ENHT- LED Forum- emphasizes the need to include opportunity for professional development and regular appraisal. ACoLEDE (Annual Conference for the LEDs ENHT)- Yearly conference run at regional level (publicized at the national level in 2021). Mentorship program- A mastermind initiative to steer LEDs to the right channel.

Results:
The committee has put forth challenges like study leaves, study budgets and professional development for the LEDs. The charter explained challenges in 3 steps as Pre-transitional, Transitional and Post-transitional period for the LEDs. Following IDF, translocation allowance and concerns regarding accommodation have been looked into. The TOR draft offers a clear role and responsibility, support and opportunities to maintain health and well-being, personal development opportunities, and more. ACoLEDE remarked a distinct Induction program for the LEDs which was appreciated regional wide. The mentorship program is currently under phase 2 paired interested mentors to mentees giving them opportunity for one-to-one discussion.

Conclusion
The ENHT LED Committee has created unique stepping stones for the doctors and awaiting the bigger picture

**Pancoast tumour presenting as lower limb weakness; would you recognize it?**

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Introduction
Pancoast tumours were an obscure entity until Henry Pancoast first described them in the 20th century typically involving the apical chest wall and thoracic inlet structures. To characterise this, it must arise from the lung apices and cause neurological dysfunction such as pain in the shoulder girdle and arm (along C8, T1 and T2 dermatomes), weak or atrophied hand muscles and Horner's syndrome, a constellation of symptoms collectively known as Pancoast Syndrome. These tumours that form 5 per cent of all the NSCLC (Non-small cell lung carcinoma) have a high predilection for metastasis leading to an overall poor prognosis.

AIMS
The following clinical case study accurately describes a Pancoast tumour's signs and symptoms and emphasises the need for its early recognition by retaining a high index of suspicion even in the most routine of circumstances.

Methods

A 56-year-old man presented to the emergency department with sudden onset of left leg weakness associated with mild sensory loss and clumsiness of the left hand. The initial impression was that of a stroke, but the CT head was found to be unremarkable. It was only later that examination revealed a classical Horner's syndrome; miosis, partial ptosis and hemifacial anhidrosis, raising suspicion of an apical pathology. The chest radiograph was deemed normal, and hence a CT scan of the chest was requested, which showed a left-sided Pancoast tumour. MRI revealed cord compression at T2-T3 levels with tumour infiltration into the left brachial plexus. CT guided biopsy confirmed lung adenocarcinoma with distant spread.

Results

He underwent five cycles of radiotherapy, during which he developed neuropathic pain, particularly along the left shoulder and upper chest. His left-sided Horner's syndrome improved clinically. The left fingers' clumsiness did not worsen, and he continued to use his left hand despite some residual weakness but permanently lost bilateral leg function due to spinal cord metastasis.

Conclusion

This case demonstrates the significance of a thorough medical history (including smoking) and examination while assessing patients with seemingly unrelated symptoms. The presence of normal physical and imaging studies should provoke the clinician to think of an alternative possibility. Early recognition is the key since the prognosis is directly dependent on timely treatment, which affects patients' survival rate with lung adenocarcinoma.

**The first step to the journey of thousand miles – the success story of a locally employed doctor**

Abinaya Seenivasan, Anshoo Dhelaria
East and North Hertfordshire NHS Trust

Introduction

LED- Locally Employed Doctors' Committee in East and North Hertfordshire Trust (ENHT) has been constantly improving the services offered to the International Medical Graduates (IMGs) and has changed the lives of many aspiring doctors.

Aims and Objectives

To highlight the challenges faced by an LED and the support offered by the committee through a case report.

Methods

X had done highest medical degrees in India and arrived in the UK. She started as a junior fellow, and faced:

Challenges in relocation, understanding rota, payroll, study leaves, and budgets

Social deprivation and lack of peer support

Challenges in knowing the system of NHS and the pathways.

Lost on the road to nowhere with career progression.

Results

Support was offered from the Junior doctor's forum and Trust LED forum which happens once in 2 months. It gave opportunities to explore allowances and one-to-one sessions with Trust directors and Human Resources team. A Trust-wide LED WhatsApp group to get in touch with peers and understand the culture across the departments. A formal LED charter and Terms of Reference (TOR) document formalized the support. An LED induction and annual LED conference (ACoLEDE)

helped in the knowledge of indemnity cover, appraisals, and clinical governance. Mentoring/ shadowing in the clinical area helped her step up to middle grade given her experience; whilst having a dedicated educational supervisor led her to discuss career options and what to focus on.

Conclusion
X settled down successfully and stepped up to the registrar role in the first 3 months of starting her new job. Apart from getting into her dream training program in 2 years, she also mentored the next batch of LEDs and took up the role of Trust LED representative to steer them to their desired path.

**A Rare case report of Acute Hepatitis E infection presenting with severe myositis**

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Introduction
Infection due to Hepatitis E virus (HEV) is one of the most common yet least diagnosed aetiologies of acute viral hepatitis. HEV is endemic in Asian and African countries but now is increasingly being reported in western countries probably related to contaminated pork meat. Although HEV is known to cause extra hepatic manifestations, Myositis is rarely reported in a patient with HEV infection.

Methods
This is a case report of rare presentation of myositis in a patient with HEV Infection in Essex, UK.

Case Capsule
We report a case of 74-year-old female who presented with malar rash and acutely deranged liver function tests. While the patient was being investigated for the same, the patient suddenly developed rapidly progressing proximal muscle weakness and dysphagia. The patient's blood tests at that time showed raised Creatinine Kinase of 5104(Normal<200) and LDH of 1241U/L (Normal 240-480). Examination showed power of 2/5 (MRC SCALE) in proximal lower limb muscles bilaterally and 4/5 in neck flexion. No respiratory involvement. MRI thigh: High signal intensities within muscles involving adductors bilaterally, quadriceps and glutei in right and hamstrings of in left, suggesting bilateral myositis. EMG/NCS: findings confirmed myositis and ruled out peripheral neuropathy or Post- synaptic NM junctional disorder.
Muscle biopsy: Necrotising myopathy. Patient's liver screen subsequently came back positive for Acute Hepatitis E IgM. The patient responded well to a short course of steroids and recovered partially within 2 weeks with CK level coming back to normal in 3 days of steroid treatment. The power in both lower limbs improved to 4/5.

Conclusion
This case Highlights a rare manifestation of Hepatitis E virus infection with severe myositis in a patient with a background of Primary biliary cirrhosis which responded well to steroid treatment. To the best of our knowledge, there have been only 4 such cases reported yet. However, no clear pathogenesis has been identified.

**Erdheim-Chester disease: Pericardiectomy and MDT management of a patient with multisystemic manifestations**

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Introduction

Erdheim-Chester Disease is a rare multisystem disorder of non-Langerhans histiocytes. It was first described by Jakob Erdhiem and William Chester in 1930. The disease is characterised by excessive proliferation and infiltration of non-Langerhans histiocytes within multiple tissues or organs. The underlying cause is unknown although a 50 percent of the patients were found to have BRAF V600E mutations implicating that it might be a histiocytic neoplasm. ECD has an unknown incidence and prevalence, with only over 500 cases reported in medical literature. The typical age of onset is between 40 and 60. Erdheim Chester Disease has extensive clinical manifestations depending on the organs affected. The common organs involved include skeleton, central nervous system, cardiovascular system, lungs, retroperitoneum and skin. There has been no randomized controlled trial in managing ECD. Therefore, treatment in the form of clinical trial is indorsed.

Case presentation:
This report details the case of a 52-year-old lady of Bangladeshi origin who presented with symptoms of congestive cardiac failure and raised inflammatory markers. Investigations revealed a large pericardial effusion on echocardiography and subsequent CT-Thorax/Abdomen/Pelvis showed retroperitoneal inflammation extending to involve the renal hila bilaterally and causing peri-aortic cuffing. Genetic analysis of histopathological samples confirmed detection of a V600E or V600Ec missense variant within codon 600 of the BRAF gene, with BRAF variants confirming diagnosis of Erdheim-Chester Disease. Management consisted of a multidisciplinary team approach involving pericardiocentesis under Cardiology, followed by referral to Cardiac Surgery for pericardiectomy due to persistent pericardial effusions, after which she was referred to Haematology for further specialist treatment with pegylated interferon and consideration of BRAF inhibitor therapy, which is ongoing.

Conclusion
Interferon-alpha and pegylated interferons have the strongest supporting evidence in management of ECD.
Effective team work and communication amongst the multidisciplinary team is vital in managing complex conditions such as Erdheim Chester Disease.

**A rare case of Synovial Chondromatosis**

Tharun Adithya Natesan, Adnan adnan, Jishad Kollathodi
Northampton General Hospital

Introduction
Synovial chondromatosis is a rare benign tumour of the synovium membranes of the joint, synovial sheaths or bursae around the joints, due to metaplasia of the intimal layer of the synovium. The tumour typically affects the third -fifth decade of life and is almost universally monoarticular.

Case Presentation
A middle-aged man presented with an atraumatic progressive right-sided knee pain over a few days, which was noted to be only apparent during weight bearing. Plain X-rays demonstrated the classic multiple loose oval-shaped cartilaginous calcifications in the posterior aspect of the knee. Although Synovial Chondromatosis was initially not on the list of differentials, the imaging investigations soon changed that. The radiological images and the deeper features of this case are discussed, with learning points regarding the approach to atraumatic subacute and acute knee pain.

Conclusion
The objective of this clinical case report is to highlight that although normally considered as a differential with chronic progressive joint pain, it should also be thought of, in the case of acute and subacute scenarios. It should be ruled out as a more serious cause of acute atraumatic joint pain, as done in the following case.
This condition mimics osteoarthritis however is treatable and curable in most cases with a minimally invasive surgical procedure in symptomatic patients, improving the patient's quality of life and decrease the disease burden.

**Post COVID Trauma and Orthopaedics national speciality training selection process**

Uday Mahajan, Sonu Mehta, Amit Kotecha
University Hospitals Birmingham NHS Foundation Trust

Introduction
Large number of doctors prefer to pursue their career in Trauma and Orthopaedics (T&O) making it very competitive. Securing a national training number (NTN) is even more challenging for doctors with more experience in T&O.

Aims
This study aims to provide latest insight into preparation for the T&O UK's national selection interview.

Methods
The person specification and self-assessment score were evaluated from the Health Education England (HEE) website. In addition other online resources were analysed using the keywords in internet search engine: ST3 Trauma and Orthopaedics.

Results
A candidate with a valid GMC (General medical Council) number who has achieved CT/ST2 competences in core surgery and MRCS degree are eligible get long-listed for interviews. Further short listing of candidates is done on basis of self-assessment questions with a maximum score of 32. The doctors who have more than 5 years of work experience in T&O can only score a maximum of 25 marks and do require more number of audits, presentations and publication to get those points. The candidate with 9 as self-assessment score was appointed for NTN in year 2019, while in year 2020 when COVID struck the doctors with score of 21 and above were selected. In the following years candidates with self-assessment score above 15 were invited for interviews. It is noted that a subtle changes in questionnaire is made each year. There is drastic variability in the overall selection process in the last 4 years.

Conclusions
Post COVID the selection process for T&O NTN has undergone a vast change and it has become more difficult for experienced doctors. If the findings through this study are taken into consideration securing a call for interview and eventually a NTN is possible.

**Availability of information and support for career progression: A survey of experience and opinions of international doctors working in the NHS**

Uday Mahajan, Sonu Mehta, Amit Kotecha
University Hospitals Birmingham NHS Foundation Trust

Introduction
A quarter of medical workforce in UK represents international medical graduates

(IMGs). Their migration in pursuit of career progression faces numerous obstacles.

Aims
This study assesses the views of IMGs on the information resources available and supportive measures offered by the employers to enable career progression.

Methods
In August 2022, an anonymous online survey was distributed nationally to international doctors working in NHS through a messaging portal. The eleven question survey was divided into three sections: doctor's demographics details, their views on information sources and support available and finally a free text section to express their opinions.

Results
43 doctors responded to the nationally circulated survey. The respondents were working in various specialities. Majority of respondents were at registrar level and few were at junior level. Most of the participants were either very unsatisfied (13) or unsatisfied (11) and 16 had neutral opinion when asked about availability of the resources. Majority of them recorded that they do not have support to progress to next level. Self-research was predominant methodology used by 38 doctor to get information, followed by information from seniors and colleagues (32) with the last being information from employer (1). 20 doctors had a fair idea on exam requirement while 17 had poor to very poor knowledge on the same topic. There was lack of awareness on portfolio requirements. Almost all of the doctors said that there is requirement of more readily available resources on ways to progress in their career.

Conclusion
There is clear need of curation of information on career progression. Once there is a one stop source of information available these doctors may feel supported.

**Embolic stroke in LV thrombus**

Fizza Saifullah, Ian Loke, Noman Irshad
Glenfield hospital

Introduction
Acute ischemic stroke (AIS) is a feared complication in left ventricular (LV) thrombus. A Virchow's triad of factors – reduced ventricular motion, local myocardial injury and hypercoagulability/stasis of flow contribute to formation of LV thrombus. Standard transthoracic echocardiography (TTE) is typically the screening modality of choice for LV thrombus detection. Cardiac magnetic resonance (CMR) is the gold standard in diagnosing LV thrombus.

Aims
The aim is to recognize importance of early recognition of LV thrombus with early imaging, knowing the high risk of embolic stroke in LV thrombus despite being on anticoagulation. The poster reflects the importance of clinical judgement, outweighing the risks and benefits and timely management of embolic stroke in LV thrombus.

Method
We present a case of 48-year-old female referred to the heart failure clinic from emergency department with a week's history of breathlessness, leg swelling and a BNP of 15,000. She was seen in the clinic within two days of referral. There was no previous history of myocardial infarction, angina, hypertension or diabetes. No family history of heart disease. She was anaemic to 85. Hand

held echo showed severe left ventricular systolic dysfunction and there was a large highly mobile LV thrombus. She was therefore admitted directly to the coronary care unit and was started on IV heparin and scheduled for cardiac MRI. Decision for IV heparin rather than LMWH was made in view of the consideration that she might need urgent intervention for LV thrombus. After few days she developed acute right sided weakness. Her NIHSS was 8, she had left PACS (partial anterior circulation stroke). CT brain showed a small filling defect in left MCA and mechanical thrombectomy was not indicated. Hence, she was thrombolysed.

Results

Her stroke symptoms were fully resolved with NIHSS 0 after thrombolysis. Post thrombolysis CT brain showed no areas of infarction or bleed.

MRI heart showed severely impaired systolic function with ejection fraction 15 to 20% and no LV thrombus.

Conclusion

Urgent imaging is needed for early diagnosis of heart failure. Patients with acute heart failure and mobile thrombus are at risk of acute stroke and should be referred for appropriate emergency thrombolysis or thrombectomy where available. In this case, the use of bedside echocardiography enabled us to make a rapid diagnosis which enabled prompt treatment leading to an excellent outcome for the patient.

**Candida Glabrata infection of a Pancreatic Pseudocyst in a COVID – 19 patient: A case report and review of the literature**

Reema Alsufyani, Mohammad Aasim Khan, Talal Almas, Muneeb Ullah, Maha Alkhattab, Sufyan Shaikh, Isha Bagwe, Meetty Antony, Tarek Khedro, Vikneswaran Raj Nagarajan, Dana Almubarak, and Majid Alsufyani.
Royal college of surgeons in Ireland.

Introduction

Pancreatic pseudocysts remain a feared complication of acute or chronic pancreatitis and are often characterized by collections of fluids due to underlying damage to the pancreatic ducts, culminating in a walled-off region bereft of an epithelial layer but surrounded by granulation tissue. While fungal infections of pancreatic pseudocysts are rarely encountered, candida albicans remains the most frequently implicated organism.

Case presentation

A 55-year-old male presented with pain in the left-hypochondriac region, accompanied by non-bilious emesis and nausea. Interestingly, the patient also tested positive for a COVID-19 infection. Investigative workup divulged enhancing pancreatic walls with a radiologic impression consistent with a pancreatic pseudocyst. An ultrasound-guided external drainage was performed; the drainage was conducted unremarkably, with the resultant fluid collection revealing the presence of Candida Glabrata. The patient was commenced on antifungal therapy and continues to do well to date.

Discussion

Infectious ailments of pancreatic pseudocysts remain a widely known complication of acute pancreatitis. While it is rare, fungal infection is a crucial consideration for patients with pancreatic pseudocysts, especially in the context of a lack of an adequate response to antibiotics, deterioration, comorbidities, and immunocompromised states.

Conclusion

Rapid identification of the microbe responsible for pancreatic pseudocyst infection is vital for time-sensitive treatment and a more rapid recovery, curbing associated morbidity and mortality.

**Local Inpatient Use of Variable Rate Insulin Infusion VRII against JBDS guidelines At Royal Blackburn Hospital**

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Royal Blackburn Hospital

Introduction
The use of variable rate intravenous insulin infusion (VRIII) is a tool commonly used to achieve normoglycaemia in hospital inpatients. However, there is noted variation in practice amongst trusts, widely recognised by the JBDS, mainly in terms of indications for its use, in rates of infusion, or duration of use. This heterogeneity increases the risk of errors which can potentially lead to significant morbidity and mortality. Therefore, with a main goal to identify areas of needed improvement, data collected are covering patients who were placed on VRII during admission at Royal Blackburn Hospital for comparison against the JBDS guidelines.

Aims and objectives
To assess the local implementation of VRII in terms of indications, monitoring, duration of use, rate of complications and criteria of Termination in comparison to JBDS guidelines.

Method
Data collection was done using A form based on the JBDS current recommendations. Simple Random Sample was obtained from Adult patients who were placed on VRII during inpatient admission at Royal Blackburn Hospital.

Results
Majority of the patients placed on VRII were type 1 patients with high levels of HBA1C and poor compliance to medications. Nearly 48% of the patients had previous admission with DKA. Hyponatremia is the most commonly occurring complication whilst on VRII. Noted variance in the frequency of Blood Glucose monitoring while on VRII

Conclusion
Potential areas of improvement have been highlighted to be followed up with recommended modifications in the current used VRII form to ensure better compliance to monitoring and less frequency of complications. Daily kidney function testing ensures close monitoring for complications whilst on VRII. Importance of close monitoring of Glucose whilst on the VRII, and 12-hour post stepping down to rule out any rebound derangement

**Burnout In Orthopaedic Doctors of University Hospitals Leicester**

Amrita Dhar, Mohammad Faraz Omair, Amr Ahmed, Muhammad Asif,
University Hospitals of Leicester NHS Trust

Introduction
Burnout can occur in all professions but burnout in doctors is a topic that is often ignored and is even mistaken for laziness. Doctors are always expected to be at the top of their game without showing any signs of weakness, but physician burnout is a syndrome recognized by the WHO, marked by emotional exhaustion, depersonalization and low job satisfaction. This leads to low self-esteem, poor quality of care, high drop-out rates. Surgical branches like orthopaedics can be an intensive place to work where doctors are

expected to turn up for unplanned, emergency jobs that can go on for hours longer than anticipated. The uncertain nature of jobs predisposed them to burnout.

Aims
To assess prevalence of burnout in orthopaedic doctors at all levels from foundation doctors to consultants working at University Hospitals Leicester (UHL). We propose ideas on how to stop this from happening, and remedial measures should a doctor be found suffering from burnout.

Methods
Data collection was done prospectively through Microsoft forms which was shared on online platforms like WhatsApp, trust emails. All forms were anonymized and information was objectively assessed using the Maslach Burnout Inventory (MBI) scale which is a psychological assessment tool.

Results
There was higher level of emotional exhaustion at senior level, lower at middle and junior levels but significantly high personalization, bordering on nearly half, among doctors at all levels. Sense of personal achievement was notably low among senior doctors.

Discussion
The assessment showed significant high level of burnout in orthopaedic doctors that is comparable to published data. We need to address the legitimate existence of this significant problem in order to ensure good and safe patient care. Some useful starting points would be increased awareness through self-assessment tools, improving awareness of support services within the trust, measures such as flexible work arrangements, reducing non-clinical and technological burden.

**Calx In Corpore Humano!**

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University Hospitals of Leicester NHS Trust

Introduction
Calcium metabolism is a common topic in medicine. It can present as a life-threatening emergency or insidiously over a lifetime with porosis of bones resulting in fractures. Much of the management pertaining Calcium will be in the long-term pursuit of bone protection. The 1-year mortality following a hip fracture is 21.1%, many factors including reduced mobility will contribute to this. A comprehensive understanding of the intricacies of the endocrinology of Calcium and its metabolism in the body is required to manage this safely.

Aims and Objectives
To assess the knowledge of doctors in managing Calcium pathologies we collected cross sectional data from doctors across 3 hospitals in England by distributing a forum of 10 questions regarding the management of: calcium; hyper and hypothyroidism; osteoporosis and vitamin D. Vitamin D was included due to its vital play in Calcium absorption and the ubiquity of vitamin D deficiency. Approximately 40% of Europeans are vitamin D deficient and 14% are severely deficient.

Methods
The questions included required investigations, interpretation of results and treatment decisions. Included in our study are consultants, registrars, senior house officers and foundation doctors across different medical and surgical departments. The limitation of this study was in the number of questions asked as

there were specific areas of knowledge left unassessed.

Conclusion
Our data has highlighted areas where clinical knowledge can be supplemented to attain best practise.

**A Novel Case of Lupus Nephritis and Mixed Connective Tissue Disorder in a COVID-19 Patient**

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Introduction
Mixed connective tissue disease (MCTD) is a rare autoimmune condition characterized by Scleroderma, Polymyositis, and Systemic Lupus Erythematous (SLE). Though a possible relationship between COVID-19 and autoimmune diseases has been recently reported, its pathophysiological mechanism behind flares in Lupus Nephritis (LN), a complication of SLE, remains unknown.

Case presentation
A 22-year-old COVID-19 positive female presented with anaemia, bilateral pitting oedema, periorbital swelling, and posterior cervical lymphadenitis. Further inspection revealed lower abdominal striae, hepatosplenomegaly, and hyperpigmented skin nodules. Complete blood counts showed elevated inflammatory markers and excessively high protein creatinine ratio. Antinuclear antibody titres were elevated (anti-smith and U1 small nuclear ribonucleoprotein) and Rheumatoid Factor was positive. She was diagnosed with MCTD associated with a flare of LN. To control her lupus flare, a lower dose of steroids was initially administered, in addition to oral hydroxychloroquine and intravenous cyclophosphamide. Her condition steadily improved and was discharged on oral steroid maintenance medication.

Discussion
We present a rare phenomenon of newly diagnosed LN, a complication of SLE, with MCTD in a PCR-confirmed COVID-19 patient. The diagnostic conundrum and treatment hurdles should be carefully addressed when patients present with lupus and COVID-19 pneumonia, with further exploration of the immuno-pathophysiology of COVID-19 infection in multi-systemic organ dysfunction in autoimmune disorders.

Conclusion
In COVID-19 patients with LN and acute renal injury, it is critical to promptly and cautiously treat symptomatic flares associated with autoimmune disorders such as SLE and MCTD that may have gone unnoticed to prevent morbidity from an additional respiratory infection.

**Quality Improvement Project on Documentation of Clinical Frailty Scale for Patients Aged 65 and Above at The Time of Acute Medical Admissions**

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Mid and South Essex NHS Foundation Trust

Introduction
Frailty is associated with increased mortality, fewer people returning home and poorer quality of life following a critical care episode. Rapid NICE guidance produced in response to the COVID outbreak clearly outlines the importance of identifying and grading frailty using the Clinical Frailty Scale. Managing the acute admission for older patients is a challenge in hospitals across the UK with increasing elderly populations. Length of inpatient stay, inpatient mortality and the 90-day readmission rates are significant in this group of patients.

Aims and Objectives:
To remind junior doctors on the importance of Clinical Frailty Scale as a part of comprehensive, holistic geriatric assessment to guide complex clinical decision making, goal-oriented care and provide evidence-based interventions.

Method:
The first cycle of audit was done by looking into the admission booklets of patients aged 65 and above in acute medical wards to check if CFS was documented. The intervention to remind junior doctors of the importance of documenting CFS on admission was done by sending out trust wide emails and followed by the second audit, 3 months after the intervention. The findings of two audits were compared to look for the improvement.

Results:
1st cycle: Total number of admission notes analysed: 51. CFS documented: 31.3%
2nd cycle: Total number of admission notes analysed: 50. CFS documented: 60%

Conclusion:
29% improvements had been made with regards to documentation of Clinical Frailty Scale following an intervention. By placing CFS posters in doctors' offices, briefings at handover meetings, and updating clerking proformas to include CFS, the improvement on junior doctors' awareness of the importance of documenting CFS on acute medical admissions can be maintained.

**Career Transition Experience of International Medical Graduates (IMGs) within the NHS Post-COVID: Evaluation of Challenges and Support**

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University of Leicester

Introduction
NHS relies heavily on the International medical graduates (IMGs) since it was established, their numbers had not declined even with the pandemic restrictions, which mutually benefit the NHS to meet the shortage and the IMGs to seek their career plans, for that they have to go through career transition and its challenges in order to adjust and integrate while the world was living in a crisis time of COVID19 pandemic.

Aims
To identify the challenges facing the IMGs in their transition particularly post-pandemic and evaluate the organisational support offered to them, its significance and effectiveness, based on the practice of inclusion, in easing the transition.

Methods
A cross-sectional retrospective study was done using a mixed-methods design, quantitative data were collected firstly by an online questionnaire followed by semi-structured interviews with part of the participants in the first stage. Statistical analysis was done on quantitative data

whereas, for qualitative data, thematic analysis was done.

Results
The study showed positive insights regarding the support offered to IMGs throughout the pandemic, particularly from seniors and colleagues. The equality of support was a point of concern when it comes to the nature of the position (training/non-training) whereas other factors such as the migrant status and cultural identities should be carefully considered further in future studies. The findings of the study point out the crucial role of the support, organisational support as well as seniors and colleagues' support, in facilitating the transition of the IMGs within the NHS in order to fulfil their capabilities and benefit the service as well as move up in the career ladder.

Conclusion
High level of support should be offered at the early stages with organisational interventions and programmes followed by ongoing seniors' and peers' support to get the functional adjustment level of the newcomer IMGs to assist them in their development.

**Workplace Sexism: Doctors Vs Non-Doctors**

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St George's Hospital

Introduction
The British Medical Association's (BMA) recent 'Sexism in Medicine' report found that 91% of female junior doctors have experienced sexism in the workplace, with women aged 26–34 years most commonly affected.

Aims
To evaluate whether experiences of sexism differ from young women starting work in other professions.

Method
An anonymous cross-sectional survey was adapted from the BMA report. Doctors and non-doctors (ND) who identify as women, in their first 5 years of work, were recruited using a snowball sampling method.

Results
100 responses, compromising 47 doctors and 53 NDs, were collected. The average age was 25.6 years (range 21–34). 79% of the doctors were in foundation training. 72% of NDs were in 'professional occupations' according to the ONS standard occupation framework, such as accountancy and marketing. Doctors reported significantly more experiences of sexism compared to NDs, across multiple elements of the survey. 58% of doctors experienced sexism at least weekly, compared to 13% of NDs ($p<0.0001$). 75% of doctors felt the main driver of workplace sexism was 'individuals', whilst 59% of NDs felt it was 'structural and institutional' factors ($p=0.0001$). Compared with NDs, doctors more often felt that due to being a woman: they were disproportionately asked to do specific tasks (79% vs 39% $p=0.03$); were perceived to be in a different or more junior role (95% vs 71%, $p<0.0001$); and their ability was doubted or undervalued (81% vs 62%, $p=0.01$).

Conclusion
Young women across the professions are experiencing workplace sexism. This is significantly more prevalent amongst junior doctors. Unlike NDs, doctors felt 'individuals', rather than 'structures and institutions', were the greatest driving factor. NDs highlighted methods employed in their workplaces to combat

this, which this study proposes might help to tackle unconscious bias. We enacted hospital-wide training for senior and junior staff to promote our findings.

**Wellness Amongst Trust Grade Doctors**

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Ashford and St Peter's Hospitals NHS Foundation Trust

Introduction
Wellness survey was conducted at Ashford and St Peter's hospitals NHS Foundation Trust, Surrey for international medical graduates in the trust. These doctors have left their country of origin to work for the NHS as 'Trust grade' doctors while preparing their portfolios for specialty training. We believe that it is important to look after ourselves before we look after others. Hence, we have designed a survey to evaluate the well-being amongst trust grade doctors in our trust.

Aim
The aim of this study is to evaluate the subjective well-being of trust grade doctors.

Methods
A cohort of 40 doctors filled in a 10-question survey in May 2022 focussing on workplace environment, support from seniors and satisfaction with rota.

Results
Our analysis showed that 62% (25) of doctors felt well supported by seniors and colleagues and 50% (20) of them were satisfied with their current rota. When questioned about the work environment, 40% (16) of them felt there was an open approach to discuss professional and personal challenges and only 25% (10) disagreed. However, 58% of the doctors often skipped their meals and did not sleep well because of work. 25% (10) of the doctors felt anxious about coming to work almost every day while 37% (15) felt anxious once a week and only 17% (7) never felt anxious at all.

Conclusion
From our survey we understood that more support was needed overall and particularly to ensure that they did not skip their meals/sleep because of work. To address this, we have elected a Well-being lead and created awareness around the 'Take a break' sessions organised by the trust to get together and create a sense of community. Our plan moving forward is to conduct these surveys quarterly to identify such problems and address them appropriately.

**The Development of The Sustainability of Medical Practice**

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Nottingham University Hospitals NHS Trust

Introduction
Over the past decade, the reality and urgency of climate change has become more evident. Calls to reverse this damage have risen globally, aiming increase awareness on the severity of the situation and promote the use of alternate, greener options with smaller carbon footprints. One contributing factor is the high carbon footprint of healthcare systems, which has inspired many to act on changing the current medical practice, making it sustainable and less harmful to the environment.

Aim:
To explore and identify valid strategies and goals to call for and start development on

a standardised sustainable medical practice.

Method:
A qualitative collection of opinions and views from multiple reviews, citations and publications (13 Total), along with a statistical analysis of the overall trajectory in regards to sustainable medical practice.

Results
A unanimous agreement on the need to address climate change was observed. All opinions were headed towards finding revolutionary and innovative eco-friendly alternatives. However, opinions varied on the suitable approach and priority of actions. The majority (38%) was directed towards a low carbon footprint through optimising medical practice, decreasing waste and use of electricity. Another approach (23%) was targeted at inappropriate use of pharmaceuticals, such as excess prescribing. A third approach (23%) preferred the education of practitioners and people, in turn leading to greener choices. Lastly, one strategy (16%) aimed to prevent disease and promote health in general, meaning less people would turn to healthcare services, in turn reducing the volume of medical services provided.

Conclusion
Despite the various approaches, the major consensus is pro-change and towards protecting the environment. Whilst it's not expected to reach a point where we compromise patient care for environmental reasons, it's enough to prompt individuals to create and consider alternate options when applicable.

**Rare Presentation of Patent Large Atrio-Portal Shunt (Vertical Vein) In Adulthood: Infra-Cardiac Type**

Prathima Gogineni, Ullah, Ashley Dennison
University Hospitals of Leicester NHS Trust

Introduction
TAPVC (Total Anomalous Pulmonary venous connection) is a congenital heart condition involving venous system, where all four pulmonary veins (PVs) fail to form a direct connection to the left atrium (LA); instead, they drain into the right heart through different routes of systemic venous return. It constitutes between 1 - 1.5% of all children with congenital heart disease. Based on the different associations, TAPVC is subclassified into cardiac, infracardiac, supracardiac and mixed. The surgery for this involves connecting all of the veins back of the left atrium, while all other routes for pulmonary venous drainage (such as the abnormal vessels which had carried pulmonary vein blood to the supracardiac or infracardiac areas) are closed off. Most prominent of these is the vertical vein, found in supra and infra cardiac varieties. There is a difference in opinion about tying or not tying this vessel. Also, if we decide to tie, when to tie, i.e., in neonatal stage or at a later stage of life. This case is the 2nd case of delayed closure of Vertical vein in adulthood and falls under infracardiac type.

Case Report
A 32 yr. old female who was diagnosed with infracardiac total anomalous pulmonary venous connection (TAPVC) at birth and had repair and ASD repair on the 12th day of life. Few significant events during these years are, an episode of severe pneumonia in 2016 at age of 27. She Presented in adulthood with

symptoms of shortness of breath on exertion and sleeping on left side. Felt more tired and breathless with bluish lips at times, subsequently she had a Cardiac MRI after multiple visits to different health services. The MRI in 2013 showed a Persistent Vertical vein from pulmonary venous confluence to portal vein. Her symptoms progressively got worse. Owing to the size of vessel it was decided after MDT discussion that it's not suitable for complex intra cardiac procedure and would need ligation through intra-abdominal approach.

Investigations

Cardiac Angio congenital anomaly study confirmed normal pulmonary artery pressure and no obstruction to the pulmonary venous confluence as it enters the left atrium. Figure 1: A triple-phase computed tomography (CT) scan showed a large vessel (Vertical vein- white arrow) connecting the posterior aspect of the LA and the portal vein. Figure 2: A 3D reconstruction with CT scan was performed to further clarify the anatomy. This confirmed a large vessel (Vertical vein- blue arrows) connecting the posterior aspect of the LA and the portal vein (white arrow). The findings were discussed in multi-disciplinary meeting involving both cardiologists and hepatobiliary team. Endovascular approach to ligate the vertical vein was decided to be unsafe. Hence, laparotomy and ligation of shunt between left atrium and portal vein was considered as the best approach in this case. Laparotomy and ligation Surgery was done successfully in 2021. Post-surgery she was in ITU for couple of days and then discharged home with 28 days of prophylactic dose of anticoagulants. She had done very well after the surgery and Transthoracic congenital Echocardiography after 3 months of surgery, showed good systolic function in both left and right ventricles, while right ventricle mildly dilated. Follow up after one year, symptomatically she is feeling a lot better. Has returned to normal exercise including strength training.

Discussion

Total anomalous pulmonary venous connection (TAPVC) is a venous malformation where all four pulmonary veins (PVs) fail to form a direct connection to the left atrium (LA); instead, they drain into the right heart through different routes of systemic venous return. This case is important because, for infra cardiac variety there is a tendency to leave VV open with a belief that the high resistance of the hepatic capillary bed leads to the eventual cessation of flow through a descending VV.(1) . However, we have now seen that there is a possibility of late presentation with no obstructing shunt between atrium and portal vein. Treating with laparotomy and ligation of the vertical vein has been found successful and one year follow up with the patient showed it was very effective. Most of the available literature shows treatment options for supra-cardiac VV, with only one article available on infracardiac VV closure using a novel technique but that is in an infant with vessel size comparatively small. Our centre has already published one similar case where an adult underwent closure of VV. We need more studies and cases on these to evaluate which is a better treatment option.

## Findings Of a Local Audit to Evaluate Safety And Diagnostic Adequacy Of Ultrasound Guided Liver Biopsy

Damayanthi Tati, Vinoy Shenoy
James Paget University Hospital NHS Foundation trut

Introduction

Liver biopsy is a procedure done to obtain liver tissue to aid in the diagnosis and management of different liver pathologies. Liver biopsy can be done in several methods of which per-cutaneous liver biopsy is most commonly used. Image guidance is increasingly used to increase the safety and to reduce complications.

Aim
The purpose is to evaluate the documentation, diagnostic adequacy and complications of ultrasound guided liver biopsy at a single centre

Methods
Data was collected retrospectively for all the cases who underwent ultrasound guided liver biopsy at James Paget University Hospital over a period of one year from April 2021 to April 2022 including focal and non-focal biopsies and compared against the standards published by RCR. Data collection was done using EHR, PACS and ICE.

Results
The RCR standards are- documentation of 100%, diagnostic adequacy of >98%, Complications-shoulder tip/abdominal pain <30%, severe hypotension <3%, Significant bleed <0.5%, perforation of organs, death <0.1%. A total of 63 biopsies were performed out of which 37(59%) were focal and 26(41%) were non-focal. 18G needle was used in 47 cases and 16G needle used in 14. Adequate documentation in view of consent, procedure, needle gauze used, no: of passes, post procedural instruction found in 93% of cases. Sample is not diagnostically adequate in 8 cases with diagnostic adequacy of 87.3%. complication of abdominal/shoulder tip pain in 19% (18G needle used in 15%) hypotension in 1.58% (with 18G needle) and complications like significant bleed, perforation of organs, death is 0%.

Conclusion
Results of this audit confirms that u/s guided liver biopsy is performed safely at our trust, with complication rates within the expected parameters. Complications observed are comparatively higher with 18G needle. Diagnostic adequacy is lesser than target owing to difficult procedure/location of lesion requiring further investigations and documentation could be improved to achieve 100%.

**First Week of Transition to A Fully Paperless Trust. What Went Well and What Went Wrong**

Gavin Reid
Manchester University NHS Foundation Trust

Introduction
In September 2022 Manchester University NHS Foundation Trust transitioned to a fully paperless organisation across 10 hospitals on the same day. This presentation will aim to recount the successes and failures from a tertiary plastic surgery department's perspective.

Aims & Objectives
To Identify key learning points for future hospitals and departments aiming to take the transition from paper to paperless in order to help improve their outcomes and profit from previous experiences.

Method
75% of the doctors working in plastic surgery during the first week of integration were interviewed with a focus on what went well and what went wrong and how the process could have been improved. Nursing staff working across 3 sites were

interviewed to obtain their input on managing a ward on a day-to-day basis.

Results
19 of 60 of the plastic surgery doctors did not have IT access to the new electronic patient records system EPIC on the day of launch. Of the doctors with system access that were surveyed they all felt underprepared and were unsure how to perform their day-to-day activities. The doctors without logins were unable to perform any administrative activities. 100% of nurses interviewed had system access and had had appropriate training but 100% of the nurses felt that they were unable to do their job to same level that they were doing it prior to implementation. 95% of all planned plastics surgery operations were cancelled on the day of implementation and 50% of operations were cancelled on day two of implementation due to technical problems.

Conclusion
The complete transition across 10 sites to a paperless system caused widespread difficulties across every aspect of the hospital and were difficult to mitigate and had far reaching ramifications to patient care especially elective work.

**Compliance To GMC Guidelines on Intimate Examination and Chaperones**

Shashi Kumar Kallikere Lakshmana, Umair Ahmad, Chiho Song, Adam Lunt
University Hospital Plymouth NHS Trust

Introduction
Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient. Before conducting the examination, you should explain, gain consent and offer a chaperone.

Aims & Objectives
To compare current practice in the surgical assessment unit of chaperon provision and documentation of intimate examinations against GMC guidance. If deficient, to formulate methods to improve compliance. Re-audit following intervention.

Method
Inclusion criteria: All patients admitted to surgical assessment unit between March-June 2022 who had an intimate examination recorded in medical notes. Documentation of Consent taken, Chaperone offered – Name and profession.

Results
Nearly all documented the procedure and findings. Less than 20% had documented that the procedure was explained, and consent obtained from the patient. Less than 10% documented the chaperones-name and profession.

Conclusion
Although most us work in a busy environment, ignoring to follow the GMC guidelines which could be due to lack of staffing or patient overload could land the treating doctor in medico-legal problems, as allegations can be made by patients even when the examination was clinically indicated and properly conducted.
As we can see from this AUDIT, the documentation of consent gained and chaperon offered didn't meet up-to the standards of GMC guidelines and we plan to bring about a change by creating awareness via Local and National

presentation, posters. Changes in Surgical clerking booklet to include relevant information. Re-audit.

**Time to NRT prescription in smokers and stock availability level of NRT in CDU**

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Reason for Project
Better Care Pathway NRT prescription for the purpose of providing relief from withdrawal symptoms, for service users who require support for the temporary abstinence from tobacco smoking, or who wish to stop smoking whilst in the care of the Trust.

Aims & Objectives
To audit the time to NRT prescription to smokers and the stock availability level of NRT in CDU. As per UHL guidelines, NRT should be prescribed within 2 hours of admission. To list the number of patients who were admitted to CDU in one month who were current smokers and accepted to be referred to the Smoking Cessation Team. Check on eMeds whether NRT was prescribed for these patients or not. If NRT was prescribed, when it was prescribed and whether it is within 2 hours
or not. To check with CDU pharmacy the stock availability level of NRT in CDU in that month.

Project Methodology:
Data source for identifying the audit population - Clinical Coders. eMEDS. Pharmacy. Audit population: 53 patients. Sample size: 53 patients. Data collection method: Retrospective. What time period is being used to identify the population? 01/07/2021 to 31/07/2021.

Main Results:
Stop smoking pharmacotherapy [NRT] is provided to smokers within 2 hours of admission, NRT should be available
in CDU. Pharmacies and managers ensure that inpatients have access to stop smoking pharmacotherapies [NRT] at all times during their hospital stay.
Other audit findings: - NRT was prescribed in 15 out of 53 patients, None was prescribed within 2 hours of admission, NRT was prescribed between 2 and 4 hours in 5 patients, 7 and 10 hours in 4 patients, 11 and 13 hours in 2 patients, 1 and 2 days in 2 patients, up to 26 days in 1 patient.

**Atypical Haemolytic Uremic Syndrome: A Rare Cause Of Recurrent Renal Failure Mimicking Thrombotic Thrombocytopenic Purpura**

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Introduction
Atypical haemolytic uremic syndrome is a rare, genetic thrombotic microangiopathic disease due to deficiency of complement regulators characterized by triad of haemolytic anaemia, thrombocytopenia and acute kidney failure. It is one of three major TMA syndromes: TTP, Shiga toxin-producing Escherichia coli, and aHUS.

Case presentation
A middle-aged man presented to the Acute medical unit with vague feelings of illness, fatigue, irritability, myalgia and petechiae following upper respiratory tract infection. Investigations revealed acute renal failure associated with haemolysis and thrombocytopenia. Autoimmune screen, septic screen, stool culture, viral screen, and Shiga toxin-producing Escherichia Serology was negative. Coagulation profile

revealed normal PT, PTT and fibrinogen levels. An abdominal Ultrasound signified normal kidneys. His past medical history was unremarkable. He was treated initially for postulated thrombotic thrombocytopenic purpura with dialysis and plasma exchange which resulted in significant improvement in the clinical and biochemical parameters. Few months later, He presented again with a similar clinical manifestation preceded by viral infection. Further testing revealed an ADAMTS 13 activity level >40% which ruled out TTP, and STEC remained negative. Consequently, diagnosis of AHUS was made. Our patient was started on Eculizumab which reversed the effects of TMA.

Conclusion:
The importance to distinguish aHUS from HUS and TTP as 65% would progress to end stage renal disease or die within a year of diagnosis without the appropriate treatment. AHUS can be distinguished from TTP which is characterized by low ADAMTS13 levels. AHUS can be distinguished from HUS which is characterized by positive STEC serology. Normal PT, PTT and fibrinogen levels rules out DIC as a possible cause of TMA. AHUS may occur at all ages, but most frequent in adults and may occur with or without prodromal diarrhoea.

**Cardiology Guide - App Based Guides for Hospital Departments**

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Summary
I developed a web app (Cardiologyguide.co.uk) to improve the experience of rotational junior doctors. The app serves as a hub for departmental induction, contains documents such as local Trust guidelines and department policies, links to clinical tools critical to the speciality and a platform for learning. Usage analytics demonstrate that in the first 18 days there have been over 335 site sessions as well as regular daily engagement, from a team of just 13 cardiology central doctors.

Objective
The rotational nature of modern medical training results in trainees moving between departments on a frequent basis. While this enhances their learning opportunities, it can create issues, as each department functions in a different way and has a unique focus. Recognising this issue, I sought to develop an application where important information for trainees could be stored, to facilitate their transition into a new department.

Methods
I developed a web app (Cardiologyguide.co.uk) to improve the experience of doctors in training during changeover with 4 key criteria: Easily accessible across all platforms and devices, cost efficient & easy to update, Intuitive to download and use, Scalable. The app serves as a hub for departmental induction, contains documents such as local Trust guidelines and department policies as well as links to clinical tools critical to the speciality. The app also functions as a platform for learning by hosting monthly journal clubs and copies of our weekly teaching sessions. In our next update, we plan to add functionality which will allow the sharing of interesting local case reports and encouraging trainees to engage better with learning opportunities. The webapp format allows for easy access on multiple devices while also allowing content to be updated on-the- go. Trainees can easily access resources and participate in teaching at

their own convivence, all from their smartphone or laptop. Accessing the app has been made deliberately simple through the use of a dedicated QR code. Although this specific web app was designed for the cardiology department at University Hospital Plymouth NHS Trust, it was designed to be easily scalable and flexible to ensure it could be adapted to other departments/Trusts.

Results
Qualitative feedback was collected during rotational changeovers following the introduction of the Cardiology Guide app. Responses have been unanimously positive from both junior doctors, senior trainees, and Consultants. Users have found the app "very useful and informative", with all participants stating they are now more likely to refer to hospital guidelines given the ease with which they can be accessed on a personal mobile device. Usage analytics data since the launch of the Cardiology Guide app on 1/8/22 demonstrates that in the first 18 days there have been over 335 site sessions as well as regular daily engagement, from a team of just 13 cardiology central doctors. 93% of traffic to the web app has been through mobile with only 7 % through desktop clearly demonstrating the immediate benefit of providing doctors with a portable resource on their smartphone.

Conclusion
As the NHS continues to embrace the power of digital solutions, it is critical we harness the potential benefits not just in terms of their utility in healthcare but also in education and training. The Cardiology Guide app has proved a popular resource for medical staff at our unit and has the potential to be utilised in other departments and potentially across the region.

**Assessment Of Administration of VTE Prophylaxis Within 14 Hours of Hospital Admission**

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Introduction
As per NICE guidelines, VTE prophylaxis should be administered within 14 hours of hospital admission to prevent risk of hospital acquired thrombosis.

Aims and Objectives
We analysed patients admitted in HPB ward of Glenfield hospital to see whether the guidelines have been met or not.

Results
39.2% patients didn't receive the VTE prophylaxis within the time range (pre op, post op and in whom VTE prophylaxis were contraindicated were excluded from data analysis)

Conclusion
In hospitals across Leicester, there is a fixed time regimen of giving VTE prophylaxis at 17:00 in the evening irrespective of when patients get admitted and hence, patients getting admitted at 21:00 to 24:00 get the VTE prophylaxis on the next day.

**Clinical Features and Management of Saddle Pulmonary Embolism in Patients with Covid-19: A Systematic Review**

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Introduction
Saddle pulmonary embolism (SPE) is a rare type of pulmonary embolism (PE) that

causes sudden death. Little is known regarding the epidemiology, pathophysiology and prognosis of COVID-19-associated SPE. SPE occurs in about 2.6–5.4 percent of all acute PE patients and is expected to predict poorer outcomes if not treated aggressively. Standard anticoagulation, thrombolysis, percutaneous Intervention, and surgical embolectomy are all alternatives for treatment.

Aims and Objectives
We aimed to collect all published cases of SPE to explore mortality, length of stay and factors affecting prognosis in COVID-19 patients. Additionally, we intended to determine treatment modalities and their success rate in COVID-related SPE.

Methods
PubMed, Scopus, and Google Scholar were searched for articles (any date up to February 28, 2022) reporting patients with SPE. Data on SPE demographics, clinical characteristics, management, and outcomes were extracted and analysed.

Results
25 publications were identified with 34 cases. Average age was 45.6 years (SD: 16.0) with 10 females and 24 males. Dyspnoea, orthopnoea, cough were most common symptoms in 25 (73%), 14 (41.2%), and 10 (29.4%) cases respectively. O2 saturation on presentation was <90% in 46.7% (7/15) of the cases. Most common comorbidities were hypertension (20.6%), diabetes (17%) and lung disease (17.5%). DVT was reported in 5 cases, with 2 being bilateral. Right heart strain was identified in 4 patients on ECG and 13 patients on Echocardiogram. Mean LOS was 2.4 (±5.86 days) with 16 (47%) cases reporting admissions to ICU. Death was the final outcome in 13 (38.2%) cases. Mortality wasn't associated with any clinical presentation (cough, dyspnoea, chest pain, orthopnoea). Most common treatment modality were anticoagulation (21 cases), thrombolysis (13) and PCI (6).

Conclusion
SPE remains a disease with high mortality in the context of COVID-19. Further studies are needed to investigate factors associated with prognosis.

**Intracranial Penetration of Halo Pin Resulting in Brain Injury as A Consequence Of Poor Halo Care Technique: A Case Report And Literature Review**

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Introduction
The use of a Halo vest for temporary/definitive immobilization and retention of unstable fractures of the upper cervical and unstable fractures at the cranio-cervical junction is a common procedure being used. Halo fixation decreases cervical motion by 30% to 96%. Hence, follow-up of these patients with regard to appropriate halo care is critical.

Aims
To report a case of intracranial halo pin penetration resulting in brain injury secondary to overtightening and to increase awareness and responsiveness to minor complications to avert their potentially catastrophic consequences.

Methods
We report a case of a 22-year-old young male treated by means of a halo vest for a C1 Jefferson fracture sustained on diving into shallow water, who reported that his carer (mom) had been tightening the pins

at home. This led to cranial vault perforation by one of the screws into the brain parenchyma, resulting in cerebritis, cerebral oedema, and a heightened risk of seizure and brain abscess.

Results

The suspicion of complications rose on a routine clinic follow-up phone call in the immediate week following discharge after halo fixation where the patient had reported swelling and fluid around one of his pin sites. This led to an urgent review appointment with a CT imaging in 48 hours that confirmed a breach in the cranial vault and the position of the screw inside the brain parenchyma.

CONCLUSION:

The pins in halo devices require tightening owing to physiological osteolysis around its tip. Incidence of complications such as nerve injury, and dual penetration is quite uncommon. However, halo care itself along with proper techniques used for tightening the halo pins by the carer plays a crucial role in preventing serious complications and this case reiterates the importance of patient & carer education on halo care, an essential part of treatment with a halo vest.