Anaesthesia News

April 2021

ISSN 0959-2962 No. 405

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Pregnancy and Lactation: Use in pregnancy may impair placental perfusion and induce foetal bradycardia, with the potential to exert a contractile effect on the uterus leading to foetal asphyxiation in late pregnancy. The risk to the foetus should be weighed against the benefit to the mother. No information is available on use in lactation.

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Overdose: Overdosage may result in severe hypertension, reflex bradycardia, marked increase in peripheral resistance and decreased cardiac output. These may be accompanied by violent headache, photophobia, retrosternal pain, pallor, intense sweating and vomiting. In the event of overdosage, treatment should be withdrawn, and appropriate corrective treatment initiated.

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Date of Preparation: August 2020
Job Bag Number: SINT053g

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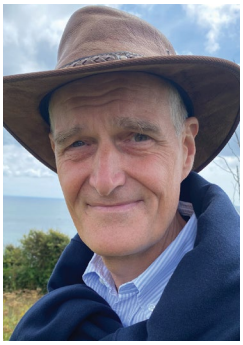
Welcome



I always though that a strapline was something to do with suntanning, till I discovered journalism.

Welcome to the April issue of Anaesthesia News. There is no over-riding theme this month - think of it as a Heinz 57 issue. In an unusual step we are advertising for a possible competitor journal – Trainee Today – see page 7.

We start with some history - Charles Gillbe describes the perils (or not?) of ECT anaesthesia during his first impromptu list, and then we have the prize-winning 2020 Thomas Boulton anaesthesia history essay for trainee or medical student members of the Association, written by Serkan Cakir. A precis is provided here, but the full version can be found on the Association website.

Life has been different for virtually everyone this past year, by a little or a lot, and this is reflected in many of the contributions. Continuing the selection of important articles from *Anaesthesia* journal on its 75th anniversary, we have the two most impactful from last year; you can guess the topic. Population immunity is crucial, and we hear some confidential insights from the vaccination clinic from Jabber the Nut.

Robyn Lee and Dan Wise introduce remote exam practice from the Mersey Video Viva Club, and Aparna Prabhu describes her journey from lapsed doodler to amazingly proficient artist – just a few illustrations here, but many more on her website – do have a look!

Also, not COVID-related, Chris King considers whether prehabilitation can change behaviour (patients'? doctors'?).

We also have a full correspondence section. David Whitaker's article on syringe labelling and pre-filled syringes in the February Safety Issue has stirred a number of readers to respond. Other letters cover: prioritisation for the RCoA Primary Examination; Association debates; virtual mock OSCEs; proning; and use of English.

As *Anaesthesia News* is a serious scientific publication, you can also find your horoscope, collated by Jason Walker.

Enjoy the ride.

Mike Kinsella
Editor, Anaesthesia News

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Anaesthesia Associate Editors

The Editorial Board of *Anaesthesia* (the official journal of the Association of Anaesthetists) is looking for a team of dynamic Associate Editors to assist with the ongoing development of the journal, which will include attracting new and established authors, contributing to debates on social media and advising on journal policy and scope.

The journal positively seeks to reflect diversity in the composition of the whole editorial team so it can respond to the needs of the diverse population of readers and authors around the world and therefore we encourage applications from throughout the medical workforce.

Applicants should submit a brief summary, up to 500 words, of what they think the Journal does well and/or could improve, by email to the Editor-in-Chief at **anaesthesia@anaesthetists.org**, together with a brief CV (no more than two A4 pages) to include: a summary of current activities and professional areas of interest, reasons for applying and recent publications.

The appointments will run for 3 years and can be extended for two further terms with agreement from both parties (max 9 years).

Association of Anaesthetists

The closing date for applications is **31 March 2021**

The way things were.... My first anaesthetic list

Time: late winter 1972. Place: Kingseat Hospital, Aberdeenshire.

For reasons of impecuniousness, I was spending my last year studying medicine as a Clinical Clerk at Kingseat Hospital. This large psychiatric hospital, now converted to private residences, took most of the acute and chronic patients from the city of Aberdeen. Such hospitals have now disappeared and been replaced by care in the community. My duties were not onerous, but came with free board and lodging. I had a patchy record as a medical student, and had decided to take the day off for no better reason than the fact I had a good novel to read.

At about 10.00 I went to the mess to have a cup of coffee and was accosted by Dr R., a venerable gentleman in his sixties who was a Clinical Assistant. He had spent his early life in the Indian Medical Service and was now working out the time until he retired. He asked me if I would mind very much giving the anaesthetics for a list of eight electro-convulsive therapy (ECT) treatments, since the anaesthetist had not shown up. I demurred. He insisted. I refused. We reached a compromise whereby we would discuss it with the Department of Anaesthesia 10 miles away in Aberdeen. The anaesthetist with whom we both spoke asked me if I had done my surgical block, which included a week of anaesthesia. He didn't ask me about my competence; he didn't even ask me if I could maintain an airway. He told me how to go about it: look at the previous notes; give the patient oxygen while he is breathing spontaneously; give the patient the same quantity of methohexitone and suxamethonium as the previous anaesthetist; ventilate the lungs briefly; stand back and let Dr R. give the ECT; ventilate the lungs until such time as the patient resumes spontaneous breathing; turn him onto his side and maintain the airway until he recovers consciousness; repeat seven times.

No monitoring was available, not even a blood pressure measuring device. This was, of course, long before the days of pulse oximetry. Only one of the patients became blue and bradycardic. He survived.

Any reader who has got this far may be wondering how many of today's rules were broken. I recount this tale only to show how standards have improved in our profession. I should add that my chosen career path at the time was in psychiatry, and this experience had nothing at all to do with the fact that I subsequently went into anaesthesia.

The sequel: my first anaesthetic list on my own as a formal trainee came close to having a worse outcome. That involved nearly losing a 19-year old girl to an anaphylactoid reaction to Althesin. But that's another story.

Charles Gillbe
Formerly Consultant in Anaesthesia and Critical Care
Royal Brompton Hospital, London

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Promoting the highest standards of anaesthetic practice in the care of mother and baby

Obstetric Anaesthetists' Association

Obstetric Anaesthesia Annual Scientific Meeting 2021 goes virtual

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www.oaa-anaes.ac.uk/OAA_Annual_Scientific_Meeting

Trainee Today

The Must-Read Journal for Anaesthesiology Trainees

Vol 1, Issue 4, Apr 2021

LIST CANCELLED?

12 ways to look busy when you're totally idle!

"I SURVIVED MY WORST NIGHTMARE"

How one stoic trainee made it through ALL DAY in theatre …without a phone charger!

There's a PROTOCOL for that:

What to do when you've no idea what the anaesthetic nurse's name is (and it's far too late to ask!)

THE SOUND OF SILENCE:

7 meditation and zoning-out tips for coping with the orthopaedic surgeon's *"eclectic"* playlist

SELFIE-CARE:

Curating that perfect on-call snap

PLUS:

Your **BEST** PPE hashtags for social - RANKED!

Ann-Marie Crowe
Paediatric Anaesthesia Fellow
CHI, Crumlin, Dublin

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Spinal anaesthesia during the 19th and 20th Centuries – cocaine and controversy

Thomas Boulton anaesthesia history prize-winning essay 2020

Spinal anaesthesia involves the administration of local anaesthetic into the spinal (subarachnoid) space to produce a transient loss of sensation in the lower part of the body. This makes it an excellent alternative to general anaesthesia for obstetric procedures and other surgery to the lower abdomen, pelvis, and legs. From cocaine injections to court cases, prilocaine to pencil-point needles, this essay investigates the significant developments in spinal anaesthesia from its origins in the late 19th Century to the present day.

J. Leonard Corning's experiments in 1885 were, for a time, believed to be the first example of spinal anaesthesia. Corning investigated the effects of cocaine on the nervous system of dogs by performing injections between the spinous processes. Believing that the cocaine was being transported along blood vessels to the spinal cord itself, he then performed an injection in a male patient, successfully achieving temporary lower limb weakness. However, later research suggests that Corning's technique was, in fact, an epidural anaesthetic, given that the dose of 3% cocaine he employed would have been likely to have proved fatal if it had reached the intended target!

The first true spinal anaesthesia in humans is now known to have been performed by August Bier in 1898. Using a lumbar puncture technique described by Heinrich Irenaeus Quincke, Bier injected 15 mg cocaine into the spinal space of a patient undergoing surgery on a tuberculous ankle joint. The operation was a success, and the patient reported no intra-operative pain. A further five similar operations were also successful. Bier then took the remarkable decision to try his technique on himself, with the aid of his assistant August Hildebrandt. Unfortunately, Hildebrandt failed to use the correct syringe size to inject the cocaine, causing the experiment to fail. The roles were then reversed, with Bier performing the injection, and this time the technique was successful. Over the next 45 minutes Bier performed a series of sensory tests on Hildebrandt, who did not report pain even when Bier repeatedly hit his shins with an iron hammer. Unsurprisingly, Hildebrandt later developed bruises over these areas! Side effects suffered by both colleagues included headaches, dizziness and vomiting, which lasted for several days before resolving. Bier did not perform any further spinal anaesthetics himself, but several other leading surgeons of the time, such as Theodore Tuffier, were impressed with Bier's work and helped promote his technique in Europe and the USA. Indeed, the first recorded spinal anaesthesia in the USA was soon performed by F. Dudley Tait and Guido E. Caglieri, closely followed by Rudolph Matas a few weeks later.

Another major development in the history of spinal anaesthesia occurred in 1900, when Oskar Kreis successfully employed this technique for labouring women. However, uncertainty around the effect of spinal anaesthesia on the fetus, coupled with the side effects reported by Bier, meant that many obstetricians remained reluctant to follow Kreis' example.

Early experiments on spinal anaesthesia utilised cocaine. However, significant effects on the heart, cardiovascular and nervous systems meant that there was a need to develop safer alternatives. Novocaine (procaine), invented in 1905 by Alfred Einhorn, and amylocaine, synthesised by Ernest Fourneau, were the first two agents developed. Later came dibucaine and tetracaine, which had a lower incidence of allergic reactions. The early part of the 20th Century also saw improvements in the design of the spinal needle. Gaston Labat and Herbert Merton Greene are both credited with creating safer needle tips that allowed separation, rather than cutting, of tissues. This meant less trauma to the dura mater and therefore reduced leakage of cerebrospinal fluid, in turn reducing the incidence and severity of post-dural puncture headache.

The mid-1940s saw several more significant advances. Lidocaine, synthesised in 1943, was employed for shorter operations, although more recent reports of post-operative transient neurological side effects have affected its current use. The technique of continuous spinal anaesthesia was also re-introduced during this decade by William Lemmon. Although

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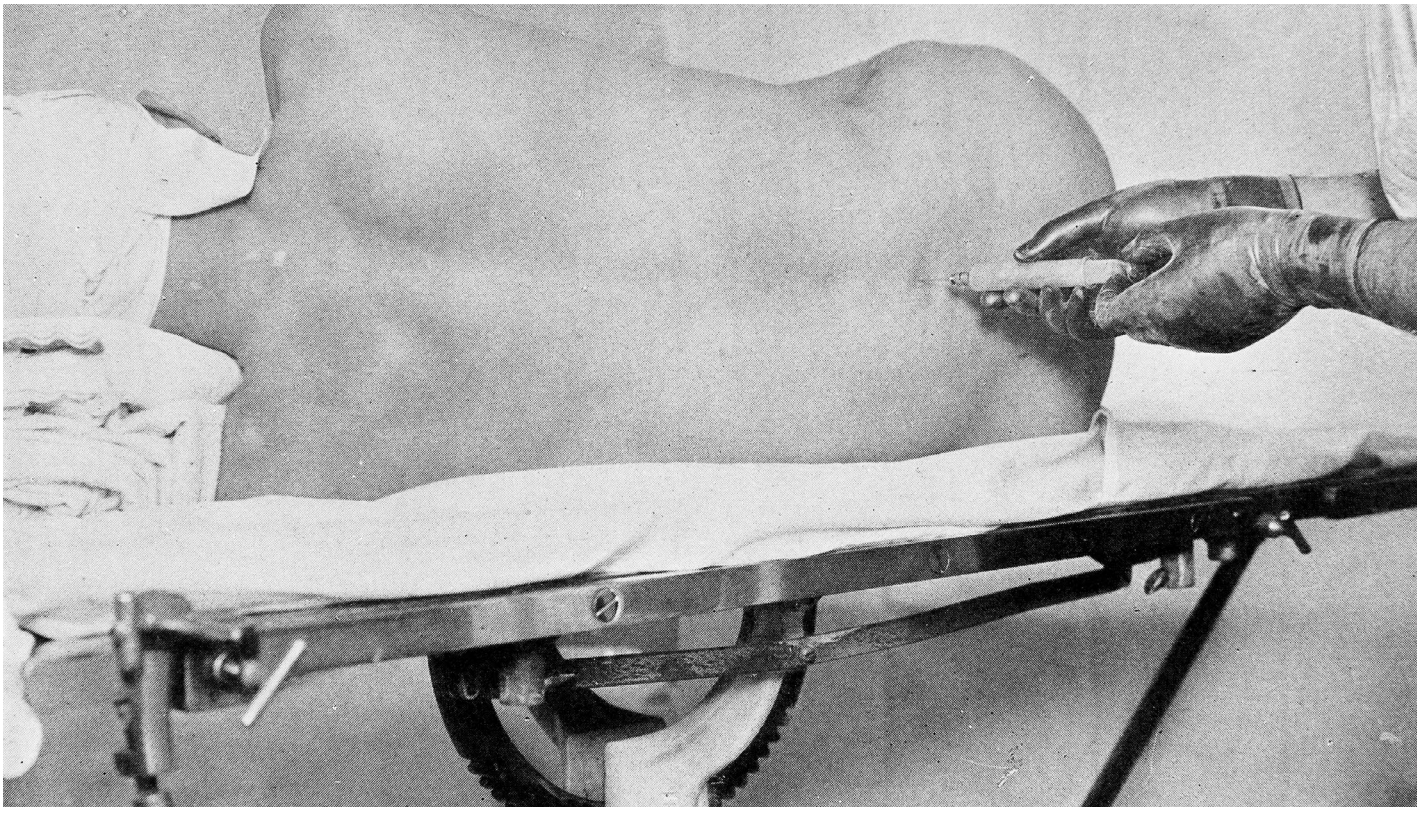

Spinal anesthesia (subarachnoid radicular conduction block) : principles & technique by Charles H. Evans

first described by Henry Dean in 1907, Lemmon made it a reliable technique for prolonged surgery. However, a higher risk of post-dural puncture headache, and case reports of cauda equina syndrome, limits its popularity today.

The 1940s also saw one of the major controversies surrounding spinal anaesthesia in the UK. On 13th October 1947 two patients, Albert Woolley and Cecil Roe, developed acute cauda equina and paraplegia the day after receiving spinal anaesthesia at Chesterfield Royal Hospital. In a case that gained significant attention, Woolley and Roe took the hospital to court several years later. Despite the court ultimately ruling in favour of the anaesthetist (it was believed wrongly that ampoules containing the local anaesthetic had become inadvertently contaminated with the sterilising agent), the popularity of spinal anaesthesia was significantly affected for many years in the UK. Attempts to reassure the scientific community over the safety of the technique were made; most notable was a long-term follow up study published in 1954 by Dripps and Vandam, reporting an absence of serious neurological complications such as cauda equina syndrome or spinal cord infection in 10,000 patients.

The 1950s also saw key advances in needle design and anaesthetic agents. The Whitacre 'pencil-point' needle had a tapered point design to reduce the risk of damage to the dura mater, thus reducing the rate and severity of post dural-puncture headache. The amide local anaesthetic bupivacaine, synthesised in 1957, demonstrated a fast onset of action coupled with a lower rate of minor neurological side effects such as headache, leg pain and backache compared with its predecessors. It remains in use today, along with its stereoisomers ropivacaine and levobupivacaine that were produced in the 1990s.

2-chloroprocaine and prilocaine are other agents developed during this decade that also remain popular. However, following the description of the Whitacre needle in the early 1950s, no further notable design improvements took place until the introduction of the Sprotte needle some 30 years later, developed in 1987 and refined in 1993. A longer, wider tip facilitated needle insertion while also reducing local tissue damage.

How have these major developments over the years contributed to modern-day practice? One example relates to the use of spinal anaesthesia for day surgery, utilising a combination of the Whitacre needle, with a very low post-procedure headache rate, and short-acting local anaesthetic agents such as 2-chloroprocaine. This allows quick and safe post-operative recovery and discharge. Another modern day example is the use of 'rapid sequence spinal anaesthesia' for category 1 obstetric emergencies. As the name suggests, this approach saves precious time compared with the standard approach, and its favourable risk profile compared with general anaesthesia promises enhanced safety in the most urgent cases.

Clearly, spinal anaesthesia has come a long way since Bier's remarkable experiments with cocaine at the end of the 19th Century. There have been setbacks along the journey - notably with the Woolley and Roe controversy of the 1940s - but improvements in needle design and local anaesthetics have allowed spinal anaesthesia to become established as a key technique within the fields of surgery and obstetrics today.

Serkan Cakir
Medical Student
Blandford Forum

The full version of of Serkan Cakir's essay can be accessed here: http://ow.ly/AsfZ50DIK2M

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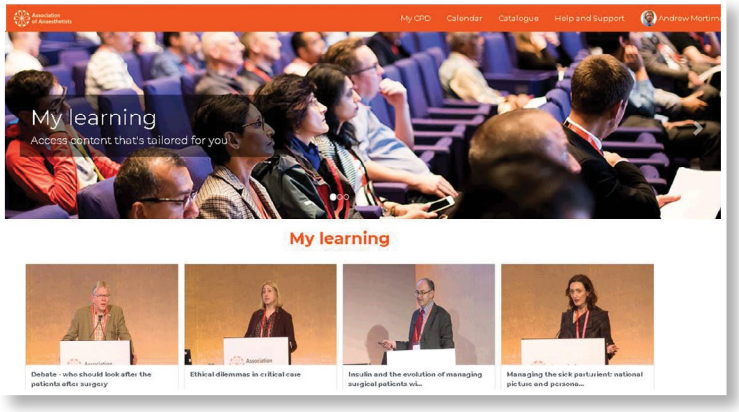

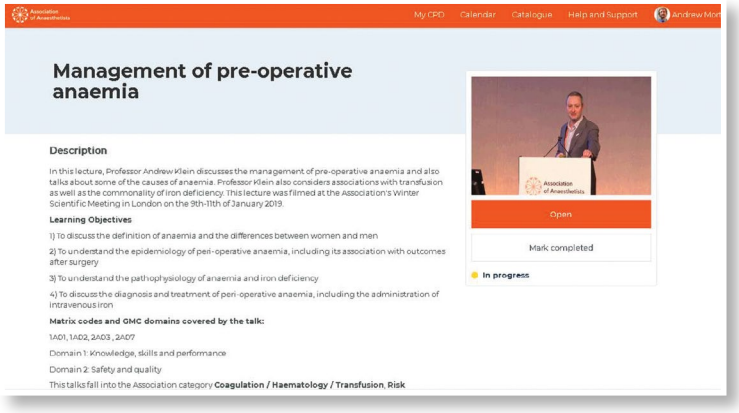

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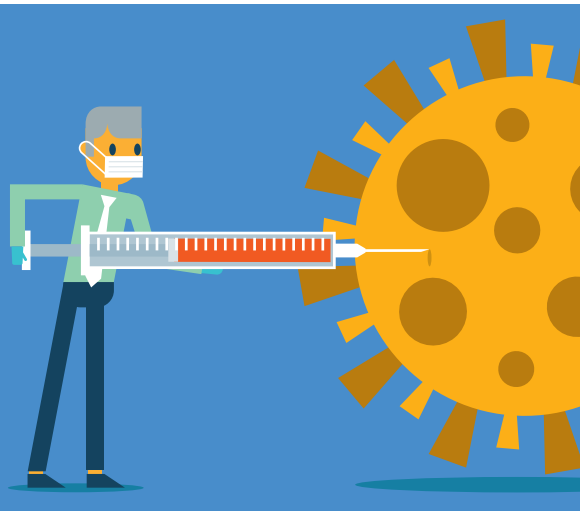
Tales from way behind the front line. A retired anaesthetist in the vaccination clinic tells all

Jabber and his colleague, the Queen Bee, having finished the last jigsaw and been comprehensively blocked by Boris from visiting their respective grandchildren, have decided to throw in their lot with the ever-expanding COVID vaccine force. If nothing else, it's an excuse to get out of the house that doesn't involve Waitrose and a sudden and inexplicable shortage of quinoa.



Despite the media fuss, the online training package was a breeze. Without this essential preparation, we could easily have finished up administering vaccines without knowing, for example, that a wet floor is a hazard that can cause harm, or that someone clenching their fists might be exhibiting warning signs of impending conflict. The potential consequences of such ignorance cannot be lightly dismissed.

No, it was the form-filling that nearly did us in. Although I had left only four months earlier after more than 30 years at the coal face, Occy Health at my old employing Trust did not have any record of my existence, and the Other Trust, managing the community hubs, wanted my bank account number actually spelled out in words (yes, as in 'one, nine, eight' etc). I had to take my passport and a gas bill to the hospital to show what appeared to be a 10-year old from Human Resources that I was actually me as part of my DBS check, and submit a cheek swab for DNA confirmation (one of these may be untrue). The only bright light was that, NHS bureaucracy being what it was, nobody had yet got round to cancelling my hospital parking permit.

Since then, it's been all hands to the pumps. Our hospital Trust has two or three doctors on duty at any time, largely involved in helping the 'assessors' who are doing the screening, or in signing prescriptions for the vaccine. In the community hubs, prescriptions are not needed at all, for some reason relating to PGDs which I learned on line and then instantly forgot. I say not needed at all, but in the first two weeks we had to prescribe every sixth dose of Pfizer, since only five doses from each vial are licensed - amazingly this is not the most pettifogging rule we have encountered, as will become apparent.

Each community hub has at least one GP 'lead', who does exactly the same job as me and the Queen Bee but gets paid twice as much for doing it. The actual task of jabbing is, quite reasonably, regarded as easy to learn and teach and is often performed by medical or nursing students, and we are left with the vital and skilled task of saying "Yes, she's good to go despite the apixaban", a phrase which we should really have emblazoned on our foreheads to save time. As anaesthetists, we tend to get a bit busy checking the emergency equipment; this led me to search out a bloke with a hacksaw the day before one of our hubs opened, when it became apparent that the legs on the examination couch were so long that you'd have to be Richard Osman on a step-ladder to have any chance of performing effective CPR.

There are, of course, few more important tasks than helping with the vaccination drive. The multidisciplinary teams are highly motivated and great fun, the customers almost entirely happy, and the atmosphere as positive as a proton blessed with incurable optimism. But, for those of us accustomed to a patient bleeding out in a trauma room or a rapidly-deteriorating CTG in a BMI 60 primigravida, it's not the most exciting place to be. The biggest thrill in the last fortnight was when a vaccinator, faced with a morbidly obese patient, whispered to me, in a manner reminiscent of Roy Scheider in *Jaws*, "I think I'm going to need a bigger needle". Clinic nearly went into meltdown as I replaced the standard blue needle with a whopping 21-gauge green, and I had to justify myself to none other than a pharmacist. But more of pharmacists next time…

Jabber the Nut

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Cook TM, El-Boghdadly K, McGuire B, McNarry AF, Patel A, Higgs A,

Consensus guidelines for managing the airway in patients with COVID-19: Guidelines from the Difficult Airway Society, the Association of Anaesthetists the Intensive Care Society, the Faculty of Intensive Care Medicine and the Royal College of Anaesthetists.

Anaesthesia 2020; **75:** 785-99.
Citations: 325

Summary
Severe acute respiratory syndrome-corona virus-2, which causes coronavirus disease 2019 (COVID-19), is highly contagious. Airway management of patients with COVID-19 is high risk to staff and patients. We aimed to develop principles for airway management of patients with COVID-19 to encourage safe, accurate and swift performance. This consensus statement has been brought together at short notice to advise on airway management for patients with COVID-19, drawing on published literature and immediately available information from clinicians and experts. Recommendations on the prevention of contamination of healthcare workers, the choice of staff involved in airway management, the training required and the selection of equipment are discussed. The fundamental principles of airway management in these settings are described for: emergency tracheal intubation; predicted or unexpected difficult tracheal intubation; cardiac arrest; anaesthetic care; and tracheal extubation. We provide figures to support clinicians in safe airway management of patients with COVID-19. The advice in this document is designed to be adapted in line with local workplace policies.

Armstrong RA, Kane AD, Cook TM, 2020.

Outcomes from intensive care in patients with COVID-19: a systematic review and meta-analysis of observational studies.

Anaesthesia 2020; **75:** 1340-9.
Altmetric score: 1527

Summary
The emergence of coronavirus disease 2019 (COVID-19) has led to high demand for intensive care services worldwide. However, the mortality of patients admitted to the intensive care unit (ICU) with COVID-19 is unclear. Here, we perform a systematic review and meta-analysis, in line with PRISMA guidelines, to assess the reported ICU mortality for patients with confirmed COVID-19. We searched MEDLINE, EMBASE, PubMed and Cochrane databases up to 31 May 2020 for studies reporting ICU mortality for adult patients admitted with COVID-19. The primary outcome measure was death in intensive care as a proportion of completed ICU admissions, either through discharge from the ICU or death. The definition thus did not include patients still alive on ICU. Twenty-four observational studies including 10,150 patients were identified from centres across Asia, Europe and North America. In-ICU mortality in reported studies ranged from 0 to 84.6%. Seven studies reported outcome data for all patients. In the remaining studies, the proportion of patients discharged from ICU at the point of reporting varied from 24.5 to 97.2%. In patients with completed ICU admissions with COVID-19 infection, combined ICU mortality (95%CI) was 41.6% (34.0–49.7%), I2 = 93.2%). Sub-group analysis by continent showed that mortality is broadly consistent across the globe. As the pandemic has progressed, the reported mortality rates have fallen from above 50% to close to 40%. The in-ICU mortality from COVID-19 is higher than usually seen in ICU admissions with other viral pneumonias. Importantly, the mortality from completed episodes of ICU differs considerably from the crude mortality rates in some early reports.

The scientific and medical community responded heroically to the COVID-19 pandemic. Information was shared freely around the world, paywalls were demolished, and journals including *Anaesthesia* worked tirelessly to expedite publication.

I have selected papers based on two metrics: the conventional one is citations and the more modern is Altmetrics, which takes account of social media interest. Whether one of these supplants the other, who can tell, but by any standards these are fantastically important papers. The turnaround time for the guidelines paper is astonishing – accepted 17th March, first published online 27th March, and appearing in the June print issue.

Mike Kinsella
Editor, Anaesthesia News

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Reflections on prehabilitation – changing behaviour

It is often said that nasogastric tube insertion can be the greatest challenge in anaesthesia. Following my recent observations in the prehabilitation clinic, I am not so sure. It seems that attempting to change patients' behaviour during prehabilitation may be even trickier than inserting the most warm and flexible of nasogastric tubes in the most anatomically challenging of airways.

Medway is a district general hospital in an area of Kent with pockets of significant social deprivation. The anaesthetic department runs a consultant-led clinic with a same-day service for pre-assessment, cardiopulmonary exercise testing, and initiation of a prehabilitation programme, supported by an exercise physiologist.

Some patients are extremely motivated and engaged in this, but others considerably less so. During my time in the clinic, one patient reported aversion to nearly every novel high protein foodstuff suggested to them in an attempt to avoid dietary change. Another was simply unable to afford the nutritional protein supplementation that was strongly recommended. Anxiety, depression and social isolation were all key themes emerging in patients reluctant to engage. Another driver for lack of engagement appeared to be not understanding why they had been referred to the preassessment/ prehabilitation clinic in the first place; for others it appeared to be a defensive shield when discussing their lifestyle choices.

The most effective solutions tend to be those volunteered by the patient rather than clinician. It is the role of the clinician to help tease out those suggestions, and avoid being overly didactic. Framing questions on what the consequences of inaction might be is often a successful strategy at breaking a deadlock.

"What do you think might happen if you don't get fitter before this operation?"

Another effective approach hammered home at medical school, but often since forgotten, is the use of open questions. However, rather than information gathering, the key benefit here is

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generating patient dialogue. This provides the opportunity to reflect some of this content back onto the patient, and make the most of potential 'teachable moments' while the patient is engaged.

One clear advantage of prehabilitation behavioural modification is the immediacy of the need to change. It is one thing to stop smoking to prevent a heart attack in the next decade. It is quite another to stop smoking to avoid a peri-operative heart attack next month. Another luxury of these prehabilitation sessions is time. Clinicians have appointments of over two hours, a time window GPs can only dream of. This allows the opportunity to develop rapport in order to address lifestyle changes sensitively.

I saw a particularly memorable 'eureka' moment with one diabetic patient whose HbA1c had proved refractory. They had clearly never been given simple dietary advice about which foodstuffs contained 'sugar', and the difference between carbohydrates, fat and protein. Suddenly it became immediately apparent to both doctor and patient why multiple diabetic medications in escalating doses hadn't altered their glycaemic control. I had often considered nutritional advice the sole domain of the dietician; however, the information shared with the patient often doesn't need to be particularly advanced, and is well within the anaesthetist's remit.

The key reflection from my time in prehabilitation was the importance of using teachable moments whenever they occur and 'making every contact count' [1]. Every day we ask patients at their pre-operative visit about smoking and alcohol, yet it seems rare we ever address these vices. By the very nature of being in hospital, individuals are already in a better position to change their behaviour as their usual routine is disrupted. I've tried to incorporate much of the above into my routine practice. Time will tell if I too can maintain my behaviour change for the better.

Acknowledgement: I would like to thank Dr Manisha Shah, Consultant Anaesthetist, who contributed to the preparation of this article.

Chris King
ST5 Anaesthetist
Medway Maritime NHS Foundation Trust, Gillingham

Twitter: @chk29

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1. NHS Health Education England. Making Every Contact Count, 2020. https://www.makingeverycontactcount.co.uk/ (accessed 14/10/2020).

Mersey Video Viva Club - a virtual collaboration

If there's one thing the COVID-19 pandemic has given us, it's the new ability to perform most tasks online. Whether it be the mundane (grocery shopping), the administrative (team meetings, tutorials), the personal (catching up with family and friends), or the utterly nerve-wracking (examinations), we have learnt to do it all virtually. For the purposes of medical education, taking things online means doing away with the boundaries between counties and even countries.

The Mersey Video Viva Club

I am a Trust Grade doctor in anaesthetics at the Royal Bournemouth Hospital, having previously worked in Ireland and in South Africa from whence I hail. The Mersey Video Viva Club (MVVC) [1] is a peer-to-peer educational tool created by Dr Dan Wise, an anaesthetic trainee in the Mersey deanery. I heard about MVVC through word of mouth, and thought that I could perhaps be of use as a faculty member, having had the misfortune of doing the Primary FRCA structured oral examination (SOE) twice myself!

The MVVC is an online platform that consists of two components. Firstly, SOE practice, where candidates from all over the country pair off in Zoom chats and practice viva technique. Members consist of 200 candidates studying for the Primary and 106 for the Final. Each candidate prepares examination questions, and will in turn act as examiner and examinee. Faculty members observe and offer feedback and sage advice during these sessions. Secondly, a YouTube channel and podcast [2]. At the time of writing, this channel has approximately 1380 subscribers. Contributors provide PowerPoint presentations on various topics that are edited and turned into tutorials. Candidates can also opt to have their sessions recorded and uploaded onto the channel.

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Global reach

The MVVC has allowed for a network of like-minded individuals from all over the country to work together to gain confidence for this much-feared, stressful examination. As is evident in trainee testimonials, members benefit not just from exam practice, but from the camaraderie of colleagues who are going through, or have been through, the same experience.

As the virtual platform has allowed us to traverse geographical boundaries, we are pleased to see that the YouTube channel has started moving globally. Our statistics show that about 43% of viewers are from the UK, with the remaining viewers spread all over the world, including approximately 12% of viewers from developing countries. We received a voice note from an anaesthetic trainee in Libya who is currently preparing for the Irish Primary exams. He has been watching the free anaesthetic tutorial videos, and has found them hugely helpful.

Going Forward

Going forward we hope to expand the SOE practice club and extend the reach of the tutorial channel, both nationally and globally. We are aiming to gather a greater pool of contributors and faculty members to make the teaching and support of our future anaesthetists a truly collaborative effort. We invite anyone who wishes to contribute a teaching presentation or to get involved with the SOE sessions to email merseyvideovivaclub@gmail.com.

We would like to thank Kirstie Gray from the Mersey School of Anaesthesia and Drs Tobias Chanin, Katherine Gillespie and Hannah Mulgrew, as well as the numerous faculty members who make the sessions possible.

Robyn Lee
Trust Grade Doctor
Royal Bournemouth Hospital

Dan Wise
SpR
Wirral University Teaching Hospital

Twitter: @FreeAnaesthetic

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1. Mersey Video Viva Club. Welcome to Mersey Video Viva Club, 2020. https://videovivaclub.com/ (accessed 18/11/2020).
2. YouTube. Mersey Video Viva Club, 2020. https://www.youtube.com/channel/UCPBYHeDgT4puhW9Mwwwxqqg (accessed 18/11/2020).

Laryngoscope to paint brush – a COVID journey

2020. What an unusually stressful year it has been! Escape from the distressing scenes on the frontline of the pandemic and the 24-h news cycle has been crucial to maintain sanity. Wellbeing has never been more important. Currently, at the peak of the second wave, I reflect over my last eight months. Towards the end of the first wave, one evening in late May, I decided to pick up a pencil to attempt something new, something to de-stress. Art! My sole intention was distraction for the kiddo and myself. Little did I anticipate where this journey would take me. From a complete amateur sketcher to a commissioned painter! Yes, I too am an artist born in COVID times, like hundreds of others.

My inspiration was a friend, also a doctor, who had mastered Zentangle. To keep my enthusiasm going, I swiftly graduated from Zentangle doodling to monochromatic silhouette sketching, and finally to painting. Zentangle is definitely one to start with as it is simple, engrossing, and very uplifting, and the end product always looks great, irrespective of ability.

Picking up the brush was more daunting, especially as I hadn't painted since my school days. My first painting, though amateurish, was quite impressive. My soul guide and teacher through the initial days was YouTube for tutorials, and Pinterest for inspiration. Pinterest, an app, is a treasure trove of ideas. YouTube tutorials worked well for me. It provided a range of teachers and styles, with the flexibility of time. As my confidence increased, I moved from paper to canvas, and finally to mixed media like wood and board. Commissioning requests began pouring in as I shared my work with friends and colleagues. This was perfect so that I could continue exploring without stacking the house with canvases. Donating the proceeds to charity was even more rewarding. Now I have come far enough technically to express myself through my own creations. My progress in the last eight months is a continuing source of joy, but there is still so much to learn and do.

Like COVID, painting is very contagious. I was inspired by a friend, and in turn have motivated at least a dozen more people. Is it time to change my career? No, definitely not. The one thing the pandemic has done is to reaffirm the primary reason why I chose to be a doctor - I love my job even more now. Art will keep me occupied once my little birdies have

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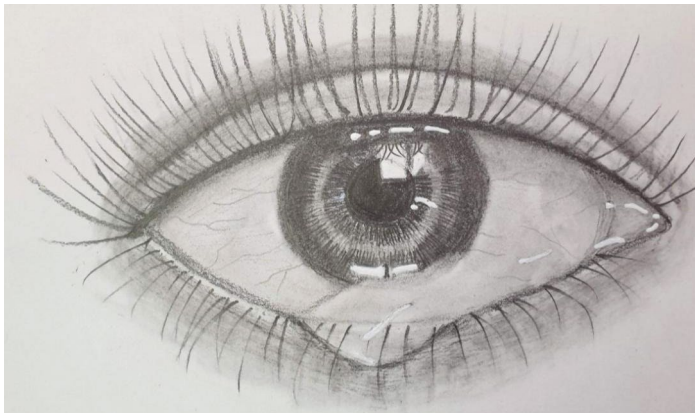
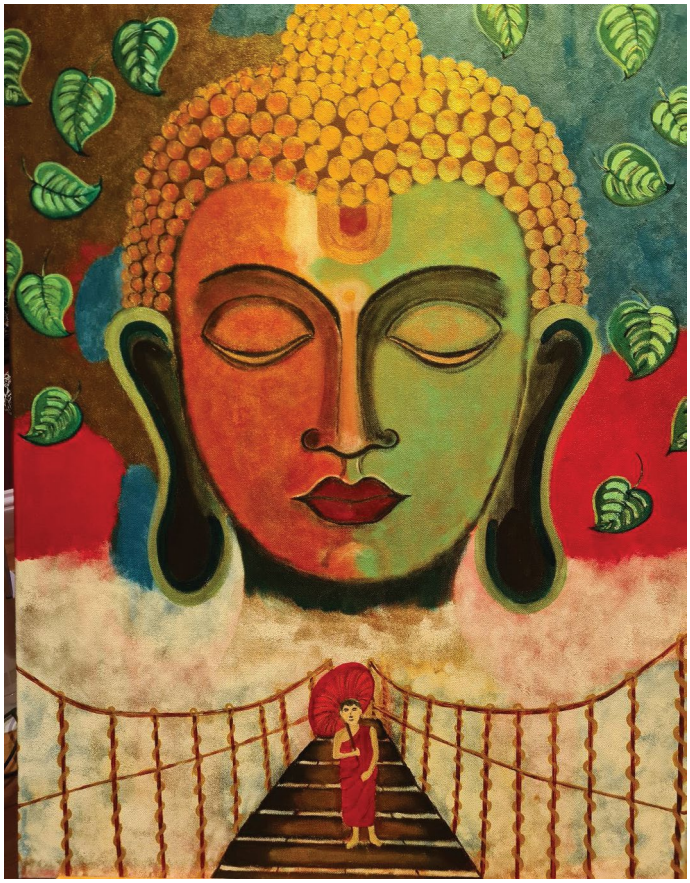




flown the nest, and will no doubt be my post-retirement plan. Although being a full-time doctor, wife and mother is challenging enough, I believe one can always find time for oneself.

The support and encouragement of my family, friends and colleagues has been pivotal to my journey. My husband and kids especially, who have tolerated the living room being transformed into an art studio and the house into an art gallery. What started as a distraction is now a passion. Rejuvenating and rewarding!

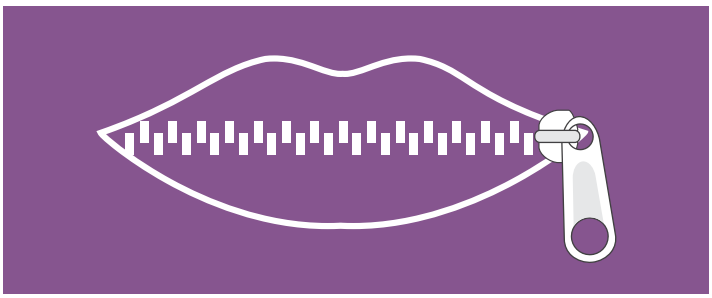
You can visit my blog at https://covidocarts.wordpress.com

Aparna Prabhu
Consultant Anaesthetist
Northwick Park Hospital, London

Talk may be banned in all operating theatre suites!

The unprecedented COVID-19 pandemic, which has not happened before, has led to major regulatory attention from the British Allied Council of Infection Control Nurses (BACICoN), as it has become clear that this disease is transmitted through the air. Research conducted at No Evil Foods in North Carolina has shown that a minority of subjects exhale significantly higher particle concentrations than the population average (Edwards et al., Proceedings of the National Academy of Sciences of the USA 2021;118: e2021830118). As it has also been noted that particle emission is associated with speech loudness (Asadi et al., Scientific Reports 2019;9:2348), it has been determined that staff who speak loudly will be, in the first instance, identified and humane muffling apparatus applied.

However, the latter study also identified 'speech superemitters' who release an order of magnitude more particles than the norm, independent of speech volume. In the event that infection rates remain resistant to these first-tier measures, then BACICoN will empower local task forces to identify individuals who will have gagging orders applied, with the use of gags. Your correspondents consider it likely that 99% of speech superemitters will be readily identifiable by 99% of passive aural recipients.



Promising experiments in medical student volunteers on breath-holding, and phlogisticated air breathing, to reduce particle transmission unfortunately had to be terminated unexpectedly early.

Further research on the possible beneficial effect of teeth bleaching on buccal viral load may be carried out by a research team led by an unemployed golfer.

From your Association of Anaesthetists Department of Stealth liaison officers, Beauvine G and Audure PH.

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Anaesthesia Digested

April 2021

COVID-19 vaccines: one step towards the beginning of the end of the global impact of the pandemic

Cook TM, Farrar JJ.

Have you booked your summer holidays yet? Although the Journal (and its editors) are suffering from COVID fatigue, there is some light at the end of the tunnel as vaccines are rolled out. This excellent editorial presents the latest information on these vaccines, how they have been developed, how they work, who should receive them, and much else, in a very readable and educational fashion. It discusses other important issues such as anti-vaxxers, herd immunity, and how this novel viral infection could continue to affect us in the future.

False individual patient data and zombie randomised, controlled trials submitted to *Anaesthesia*

Carlisle JB.

The Walking Dead, Shaun of the Dead (my favourite), and now zombies trying to get into your favourite journal! In a 2017 paper in this journal, John Carlisle suggested that 2% of randomised controlled trials contain false or fraudulent data. As it is surprisingly difficult to simulate randomness, he looked at the baseline demographic data reported in trials and tested whether it really matches what is expected. He has now prospectively analysed the summary baseline data in randomised controlled trials submitted to, but not published in, *Anaesthesia*. This is a result of his endeavour over the years to help us identify possible fraud or, occasionally, honest error. The findings make interesting reading.

The effect of advanced recovery room care on postoperative outcomes in moderate-risk surgical patients: a multicentre feasibility study

Ludbrook G, Lloyd C, Story D, et al.

We are only as strong as the weakest link. Even with meticulous intra-operative management postoperative complications still occur, and better postoperative care in the recovery room may reduce in-hospital complications in moderate- and high-risk surgical patients. Rather than typical short stay, these investigators evaluated whether advanced recovery room care for 12–18 h is feasible in moderate-risk patients (predicted 30-day mortality of 1–4%) undergoing non-cardiac surgery. Although various logistic issues were identified, the authors suggest that a definitive randomised controlled trial of advanced recovery room care appears feasible. This could be another critical role for our specialty in improving peri-operative care, and we look forward to seeing such research in due course.

N.B. the articles referred to can be found in either the latest issue of *Anaesthesia* or on Early View (ePub ahead of print)

M.G. Irwin, Editor, *Anaesthesia*

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Horoscopes

Aries (21 March – 20 April)
The alignment between Jupiter and Venus while Scorpio is in the ascendant can only possibly mean one thing: there's going to be a delay in sending for your first patient. Again.

Taurus (20 April – 21 May)
Today you'll say tocilizumab in a sentence as if you have the slightest idea what you're on about. Your pronunciation will be confident and assured. In response, that nurse you fancy (yes, that one) will pretend to be impressed. You'll then ruin it all by walking into a door.

Gemini (21 May – 21 June)
You know that thing where you do a really tricky intubation and you look at the monitor and the capnometer chooses exactly that moment to calibrate itself? That's just you, that is. It doesn't happen to anyone else. It's your superpower. Embrace it.

Cancer (21 June – 23 July)
Stop worrying. The amount they're going to spend to discover that it was you who used the sugammadex will far outweigh the cost of the sugammadex. It'll be fine. Probably.

Leo (23 July – 23 August)
You are scheduled to work with a junior colleague who insists on convincing every patient to have their procedure done under a regional technique. Your only hope is to see all the patients before they do.

Virgo (23 August – 23 September)
Your perfectionism is preventing you from achieving your full potential. If you repeat this to yourself every day, you'll be well on the way to getting your appraiser to believe it.

Libra (23 September – 23 October)
One day you will understand why it was so important to learn about the Wheatstone bridge. Today is not that day.

Scorpio (23 October – 22 November)
You are scheduled to work with a senior colleague who insists on convincing every patient to have their procedure done under general anaesthesia. Your only hope is to see all the patients before they do.

Stephanie (23 November – 22 December)
You wake to discover that your star sign has changed. Use this upheaval as a catalyst to reinvent yourself as a beatboxing TikTok influencer with strong opinions on monoclonal antibodies. Begin by looking up what some of those words mean.

Capricorn (22 December – 20 January)
You enter a competition and win £50. You also realise that your horoscope was shamelessly plagiarised from a Monopoly 'Chance' card. Go back two spaces.

Aquarius (20 January – 19 February)
The ODP has brought an ultrasound machine and a bronchoscope into the anaesthetic room 'just in case'. You have no idea why, and now you're worried. Particularly as the list is finished.

Pisces (19 February – 21 March)
The colour purple indicates renewed strength and a fresh beginning. This is definitely the start of an exciting chapter in your life, so be ready. Or maybe they've just changed the branding on the boxes of reversal again.

Jason Walker
Consultant Anaesthetist who clearly has too much time on his hands
Ysbyty Gwynedd, Bangor, Wales

Twitter: @jasondwalker

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Particles

Schnabel A, Reichl SU, Weibel S et al.

Adductor canal blocks for postoperative pain treatment in adults undergoing knee surgery

Cochrane Database of Systematic Reviews 2019; **Issue 10:** CD012262.

Background

Knee arthroscopy and arthroplasty are very common procedures, yet postoperative pain control continues to be a challenge for both anaesthetists and surgeons. Multimodal analgesia is often used, and regional anaesthesia may have a place within this. In theory, adductor canal block may produce analgesia without interfering with motor function. This Cochrane systematic review compared the analgesic efficacy and adverse events of this block with other regional anaesthetic techniques used for knee surgery.

Methodology

The review included randomised controlled trials comparing single-shot or continuous adductor canal block, independent of the technique used and the level of provider's training, with: sham treatment (saline block instead of local anaesthetic); femoral nerve blocks; or techniques such as periarticular infiltration and psoas compartment block.

The primary outcomes were: mean difference in postoperative pain at rest and during movement; rates of opioid-related adverse events; and rate of accidental falls during postoperative care. Other secondary outcomes included: cumulative mean morphine requirement; rate of chronic post-surgical pain; and rates of block-related adverse events. The authors used standard Cochrane methods for searching, selection, risk of bias judgement, analysis and interpretation.

Results

The review identified 25 trials (23 trials within meta-analyses) including 1688 participants, aged between 29 and 72 years. In 18 studies, participants underwent total knee arthroplasty, whereas seven trials investigated patients undergoing arthroscopic knee surgery. Adductor canal block was compared with sham treatment in eight trials, and femoral nerve blockade in 15 trials. No trials showed significant differences in postoperative pain intensity either at rest or during movement. Two trials compared adductor canal block with periarticular infiltration, but there were insufficient data to pool in a meta-analysis. Again, there was no evidence of a difference in postoperative pain on movement, though participants who received both an adductor canal block and periarticular infiltration required significantly less opioid 36 h after surgery. There were no significant differences in the incidence of nausea or vomiting.

The single trial comparing adductor canal block with psoas compartment block showed significantly lower pain scores at rest until 2 h postoperatively, but this benefit was not seen at later time periods. Only one study included falls as an outcome, and the data were insufficient to draw any conclusions as no falls were observed.

Conclusion

The overall evidence level presented was mostly low or very low, and therefore this paper still leaves us uncertain whether patients who receive adductor canal blocks for knee arthroscopy or arthroplasty experience less pain and other side effects. Further research might change the conclusion; the authors note that there are almost as many ongoing trials, or studies awaiting inclusion in a future update, as were analysed in this current version.

Muataz Amare
Cochrane Anaesthesia Dissemination Fellow
Locum Consultant, Salford Royal NHS Foundation Trust

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Your letters

Send your letters to: The Editor, *Anaesthesia News* at **anaenews.editor@anaesthetists.org**

Please see instructions for authors on the Association's website **www.anaesthetists.org**

Dear Editor

The RCoA and the lost tribe of trainees - prioritisation for the Primary FRCA examination

The RCoA have recently issued revised regulations for the Primary examination [1]. COVID has constrained the number of candidates that can be examined, and therefore formal prioritisation has been adopted. Those allocated to Category A take priority over Category B; the latter, if similar selection is repeated, might be excluded for some time - in effect a lost tribe of upset and disillusioned trainees. Those with a Deanery number achieve a higher rank, and the term 'time critical' helpfully applies to those with, rather than those aspiring to, a number.

Possibly this is the first time that a Royal College has defined a differential value for candidates, and then uses that to deny examination access. All these candidates are equally eligible, pay the same examination fees, and most pay the same membership fees – note no such discrimination is taking place at the difficult and dangerous work face.

As a Chairman of Examiners for the old FICM examination, I find this prioritisation grossly unfair and unwarranted, and in days gone by I would have refused to examine knowing eligible candidates were arbitrarily excluded on a whim. Allegedly the College has sought legal opinion. Surely if such an opinion is required to decide if a system is reasonable and fair, then it is at least dubious even if not illegal.

This is allegedly affecting 60 trainees who have no redress. I call for the immediate withdrawal of this offensive prioritisation, and reinstatement of proper and fair access to the examination for all eligible candidates, or we will have an even larger lost tribe. If you are a trainee disadvantaged by this, or have trainees, I am sure that your College would be pleased to hear from you, and should be appropriately sympathetic to your problem of their making.

Neil Soni
Previously Consultant Anaesthetist, Chelsea and Westminster Hospital.

Declaration of interest: my son is taking the Primary examination, which is how I became aware of this issue.

References

1. Royal College of Anaesthetists. Primary and Final FRCA examination regulations, 11 December 2020. www.rcoa.ac.uk/documents/primary-final-frca-examinations-regulations/section-4-prioritisation-applications (accessed 20/1/2021).

A response

Thank you for giving me an opportunity to respond to Dr Soni's comments. The RCoA has a statement on its website that gives a detailed account of the current situation with the FRCA exam (https://www.rcoa.ac.uk/news/examinations-statement). We will continue to provide updated information over the coming months via our usual channels.

I can confirm that no part of the prioritisation process will affect a doctor's eligibility for ST3 recruitment rounds.

Chris Carey
Chair of the RCoA Education, Training and Examinations Board

Dear Editor

Our current method of winning a debate is inherently biased

Our current method of winning a debate is inherently biased. The current convention is that the winner of the debate is the person that swings the audience to their side of the argument. We have adopted this convention because if one only voted after the debate, the accepted norm will always defeat the minority. To make progress we wouldn't want a system that inherently favours the norm.

I was amazed by the quality of the recent Association Winter Scientific Meeting. There was a debate as to whether we should drop the FRCA examination. Both speakers presented a high quality pitch, and the swing was towards dropping the examination. However, let's look at the psychology of this. Those with firm conviction are very unlikely to be dissuaded. Voting because of familiarity is less likely to be with firm conviction. Those that voted against the FRCA initially have rejected the norm, and will have a higher degree of conviction. Thus the current convention favours the non-conventional argument, because those voters had higher conviction from the outset. For instance, in a debate over veganism, veganism will always win because vegans won't change their minds. Voting is undoubtedly a vehicle to enhance people's education on both sides of an argument in an atmosphere that avoids conflict, but conversely it is not correct to say that it serves no purpose in the validation of the merit of either side. Perhaps we will stick with the current convention for the same reason we tell our children Santa Claus is real (it makes everyone happy), but I throw down the gauntlet to one of my colleagues who perhaps is a lateral thinker, psychologist and statistician to come up with a better way of evaluating the winner of a debate.

Antony Richards
Consultant Anaesthetist
Royal Oldham Hospital, Oldham

A reply

Dr Richards poses an interesting question. How do we measure the results of a debate? Who 'won' or 'lost'? He alludes to a common argument, that one should not have excessive confidence in the power of rational debate. There is, some might say, no reasoning with some people.

So, what could we do better?

The question
What should we be asking? We could ask who a delegate was most convinced by, or impressed with. Should we prompt for quality of performance or content, as in more formal debating contests? We could just ask "Who do you think won?"

The fixed position and higher degree of conviction of entrenched views could be addressed by prompting open-mindedness with "Leaving aside your previous opinions…."

The sample
How do we account for the self-selecting population? Perhaps we could identify the floating voters, those without a firm position at the beginning of a debate. YouGov and other pollsters use 'rim weighting', also known as 'raking', which ensures that the marginal proportions in a sample match those of the target populations. I'm not sure that this would work in the context of a Pro/ Con debate – we are all very similar.

Timing
Do we poll immediately after a debate? Do we poll before and after? Or do we let things sink in for a bit; perhaps a delayed poll might give us a clue as to whether the rhetoric has stuck. Or were we charmed, only to change our mind later?

More questions than answers I'm afraid, but here at the Association we like a challenge. Perhaps it's time to freshen up Pro/ Con debates, but we must retain the spirit of friendly jousting and the light-hearted bonhomie that I think the Association does best (and I acknowledge my bias).

Chris Mowatt
Chair of the Education Committee, Association of Anaesthetists

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Your letters

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Dear Editor

Standardisation, syringe labelling and pre-filled syringes - 1

David Whitaker's article on syringe labelling touched upon a labelling obsession that only pedantic anaesthetists can have [1]. The figure in his article shows 'left handed' and 'right handed' syringes, labelled with the sticker longitudinally along the barrel of the syringe. While this clearly shows the contents when the label is uppermost, rarely are drug trays so orderly and syringes often find their way into different orientations. Moreover, the labels often then conceal the volume markers on the barrel.

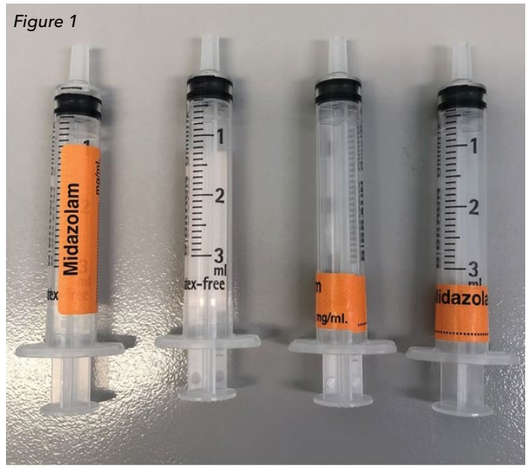
Our Figure 1A shows the label clearly when the syringe is orientated with the label uppermost; however when the label of the syringe is concealed (Figure 1B), it is entirely unclear what drug the syringe contains and thus it could be reached for in error. Although the label is not legible in its entirety in Figure 1C, the colour will alert the anaesthetist as to the class of drug; of course the label should be checked before the drug is administered.

Until pre-filled syringes are universally available, we would suggest that the safest way to label syringes is to apply the sticker around the base of the syringe so that it can be visible whatever the orientation of the syringe (Figure 1D). We all have our 'right' way of doing things: this is one of ours!

Vanessa Skelton
Consultant Anaesthetist

Kathryn Laver
ST7 Anaesthetist
King's College Hospital NHS Trust, London

Figure 1



Dear Editor

Standardisation, syringe labelling and pre-filled syringes - 3

Colour coded labels are commonly used to improve safety during anaesthesia, however, this is not fool-proof or devoid of scope for improvement. We note recent concerns raised over a lack of standardisation, prompting the development of a guideline by the Association of Anaesthetists [2]. In addition to this, Lo and Plaat raised concerns that syringe labels do not stick adequately to the syringe, leading to the possibility of error if a label falls off [3].

We conducted a short experiment by placing labels in different orientations on the four most commonly-used syringe sizes; these were: single circumferential; longitudinal; and two circumferential overlapping labels (Figures 3 and 4). We photographed the syringes one hour after the labels were applied.

Labels were less likely to lose adherence when placed longitudinally or doubled, compared with the single circumferential orientation, although the longitudinal labels on the 2 ml and 5 ml syringes can be seen to adhere imperfectly. This suggests that two labels placed circumferentially is the best strategy to promote label adherence, followed by the longitudinal orientation.

William Simpson
Anaesthetic CT1

John Vernon
Anaesthetic Consultant
Nottingham University Hospitals NHS Trust.

Figure 3. Left to right: circumferential; longitudinal; doubled circumferential. Upper 2 ml; lower 5 ml

Figure 4. Left to right: circumferential; longitudinal; doubled circumferential. Upper 10 ml; lower 20 ml

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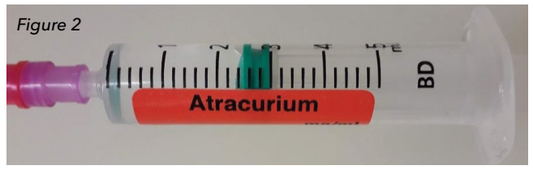
Dear Editor

Standardisation, syringe labelling and pre-filled syringes - 2

I was cheered to see the standards for labelling of syringes in the recent safety issue of *Anaesthesia News* [1]. I would like to make two points on the instruction to place the label lengthways along the syringe barrel. The first is that I feel the label should be placed in such a way that the wording is as close as possible to the syringe graduations. This allows the clinician to view both the drug name and the volume delivered at the same time, which is an important safety consideration (Figure 2).

Figure 2



The second point addresses the complaint often made by advocates of circumferential labels: the difficulty in quickly identifying a drug when placed label down. If drug labels were manufactured so that the colour was present on both sides of the label (i.e. the label was made from coloured paper and not just printed on white paper), this would allow quick identification of the agent type even when a syringe label is turned label-down; makers of prefilled syringes often use this as an added feature.

Jason Walker
Consultant Anaesthetist
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A reply

Thanks to the safety aware anaesthetists for valuable comments on my article [1]. Syringe labelling has improved, but to raise it to the next level anaesthesia, intensive care and pain medicine require all their injectable drugs to be supplied in prelabelled prefilled syringes. Prefilled syringes have additional advantages of correct contents, sterility, and rapid availability. As medication safety is a global priority, anaesthetists should be urging the speedy introduction of prefilled syringes locally in their own hospitals, nationally and internationally.

Whilst working to introduce prefilled syringes, standardising current labelling practice can still improve the situation. Dr Walker correctly says that the volume graduations on the syringe barrel should be visible, and ideally manufacturers should re-orientate the siting so that the graduations are still visible when a label is stuck uppermost along the barrel and the syringe is resting on a flat surface. Making labels from coloured paper, and also printing the drug name on both sides, would be helpful. Sticking two labels along the length of the barrel could help, as having two of everything is another good safety principle.

Drs Skelton and Laver are correct to say that drug trays are rarely kept in an orderly fashion. However this is a safety area that is directly under anaesthetists' control and where we can most easily make a difference. After introducing a standardised 'medication template' (Figure 5), Grigg et al. found no medication errors in six of the next 13 months [4]. Labelling syringes circumferentially ensures that the colour can be seen, but rarely the complete name of the drug (Figure 1C and 1D).

Drs Simpson and Vernon clearly demonstrate the need for reliable label adhesive. As labels get old, the adhesive dries out and the colours fade; they should be thrown out and replaced on safety grounds.

David Whitaker
Chair, Patient Safety Committee, European Board of Anaesthesiology
Manchester

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1. Whitaker D. Standardisation, syringe labelling and prefilled syringes. *Anaesthesia News* 2021; **Issue 403:** 12-3.
2. Association of Anaesthetists. Standardisation, syringe labelling and prefilled syringes, 2021. https://anaesthetists.org/Home/Resources-publications/Anaesthesia-News-magazine/Anaesthesia-News-Digital-February-2021/Standardisation-syringe-labelling-and-prefilled-syringes (accessed 10/02/2021).
3. Lo Q, Plaat F. Non-sticky sticky syringe labels. *Anaesthesia* 2017; **72:** 654.
4. Grigg EB, Martin LD, Ross FJ, et al. Assessing the impact of the anesthesia medication template on medication errors during anesthesia: a prospective study. *Anesthesia and Analgesia* 2017; **124:** 1617-25.

Figure 5

Your letters

Send your letters to: The Editor, *Anaesthesia News* at **anaenews.editor@anaesthetists.org**

Please see instructions for authors on the Association's website **www.anaesthetists.org**

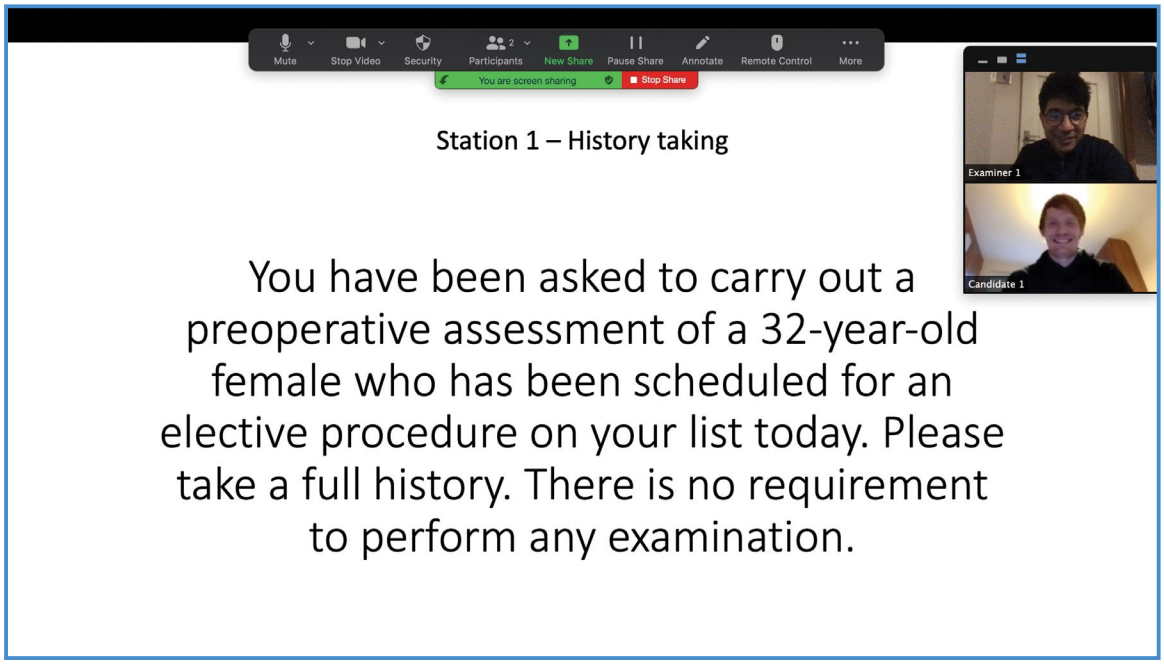
Dear Editor

A virtual mock OSCE

COVID-19 has had major impacts on medical training, including the cancellation of courses and examinations. The RCoA decided to deliver the latest round of the Primary OSCE and SOE via video-conferencing technology, a change that could be here to stay.

Having recently taken the exam ourselves, we knew that practice was vital. With courses postponed, we decided to set up a 'virtual mock OSCE' to provide some all-important practice for candidates. We gathered information regarding the new format, and developed 14 realistic stations and mark schemes covering the curriculum topics. Some were simpler to devise than others - how do you perform interactive resuscitation or simulation virtually? We recruited 14 examiners who kindly donated their Saturday mornings, a task made easier by the fortuitously-timed second lockdown, and advertised our OSCE to trainees. Word spread quickly, and places filled within days.

We used Zoom to run the OSCEs. Candidates and examiners were placed into 'breakout rooms' for seven minutes, two for a brief via the 'shared screen' and five for the station itself. We then reallocated candidates to the next station and, subsequently, they received individualised feedback.



Unfortunately, there were a few teething issues. Screen sharing was not always available, requiring the host to enter rooms and enable this remotely, leading to some delays. No pattern has been identified, and Zoom have been contacted for advice.

Our overall experience was positive. The feedback has been excellent and, importantly, we were able to provide this for free. We hope to resolve the technical issues, and with feedback from candidates who sat the real examination plan to make it more realistic. One thing is certain, hosting a Zoom call with multiple breakout rooms is arguably as stressful as sitting the real exam!

Shilen Shah
Clinical Teaching Fellow

Rory Dennis
Anaesthetics Trust Grade

Kavita Upadhyaya
Consultant Anaesthetist

Broomfield Hospital, Chelmsford

Dear Editor

The baker's dozen of COVID proning

I suspect the following 'tummy-time' observations may be familiar to the legion of amateur intensivists honing their proning skills over the last year:

1. Physiotherapists are your proning friends - they are freakishly strong, always roam in packs, and they know which direction limbs cannot and should not go.
2. D.I.Y. head rings that look like a crown of thorns will turn out exactly as you suspected.
3. You can never have enough i.v. bungs and caps.
4. You will always forget to disconnect the pulse oximeter just before the turn.
5. ICU red slide sheets really are very slidy (unlike their operating theatre cousin, the blue slide sheet).
6. If the BIS™ strip is hanging off the forehead before you start, it will not miraculously work after you have flipped.
7. The larger the body habitus, inevitably the fewer and smaller the available staff members for turning.
8. A disconnection in the breathing circuit on turning is seriously frowned upon.
9. A disconnection in the bowel management system is a Never Event.
10. There is always a proning/ de-proning to do just before handover.
11. There is never more than one prone/ de-prone in a row - they are always frustratingly spaced out throughout the night.
12. Despite these new found proning skills, we will continue to kick up a fuss when a surgeon requests it for pilonidal sinus or varicose vein surgery.
13. It turns out not many people know what a Cornish pasty looks like, or if they do, they certainly wouldn't win a Hollywood handshake for their "Bake-off" creation.

Patrick Ward
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Dear Editor

Proning to prone

Dr Weller - and you too - should read Oliver Kamm's liberating book 'Accidence will happen'. It should free you from concerns about whether prone is an adjective alone or not. To verb is human. A different but equally liberating perspective on the use of English is 'The Sense of Style' by Steven Pinker.

Both books consign old-fashioned prescriptive guides written by old buffers to the trash-can where they belong. The 'rules' turn out to be not rules at all. In short: relax.

Yours cheerfully

Steven Cruickshank
Consultant Anaesthetist
Newcastle upon Tyne

Editor's note

With regard to pandemic neologisms, I discovered this on Twitter:

"I'm going to COVIDize the OR." – Anesthesia resident. COVIDize [verb]: to prepare one's operating room for a COVID patient.

We are definitely not going to relax that far, even if that makes me an old buffer.

Letter of the Month prize

It's your *Anaesthesia News*... and we'd love to encourage more of our readers to share their opinions and experiences. A Letter of the Month prize will be awarded to the best letter each month. The winner will receive a £50 voucher to use against the cost of one of the Association of Anaesthetists educational events.

To increase your chances of winning:
- Keep it short (no more than 300 words)
- Be clear and accurate
- Use humour where appropriate
- Keep it topical

The award will be made at the discretion of the Editor, and his/her opinion will be final. No cash alternative will be available. The voucher will remain valid for 12 months.

Send your letters to:The Editor, *Anaesthesia News* at **anaenews.editor@anaesthetists.org**

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Panel of Quality Assurance assessors for **Learn@** videos

The Association of Anaesthetists makes videos from its three major annual conferences (Winter Scientific Meeting in January, Trainee Conference in the summer, and Annual Congress in September), and occasional other events, available online on Learn@ as a powerful educational resource.

The Association has a rigorous Quality Assurance process that includes on-site assessment by a member of Council. In addition, all videos are checked and undergo further Quality Assurance before being added to the Learn@ platform.

The Education Committee is now seeking to appoint additional members to its Quality Assurance Panel, to assist with this process. We anticipate 5-6 videos to review per Panel member during the few weeks following each conference, using a standardised assessment template. Training/support will be available as appropriate/required. An individual report of QA activity can be provided for appraisal purposes.

Association of Anaesthetists

We welcome applications from all sections of the membership, but Irish and SAS (non-consultant non-trainee) doctors are currently under-represented in the panel.

Interested candidates must be Association members and can be of any grade; they should have a clear interest in medical education. Applications should be by email to **learn@anaesthetists.org** and should include a brief (< 300 words) personal statement describing their suitability for the position. Appointment to the Panel is for three years in the first instance.

The closing date for applications is **30 May 2021**

For further information please contact Chris Mowatt, Chair of the Education Committee, via **learn@anaesthetists.org**

Anaesthesia Trainee Fellowship

Applications are invited for a 1-year Fellowship attached to the Journal, starting at the Journal Editors' meeting in November 2021.

The appointment will run concurrently with the Fellow's usual anaesthetic training programme.

The Fellow's roles will include involvement in general journal business including handling submissions (but not with direct responsibility). The Fellow must also:

- Attend the 6-monthly Editors' away days and Editorial Board meetings during their term;
- Attend the Association's Winter Scientific Meeting in January 2022, and **either** the Trainee Conference in July 2022 or Annual Congress in September 2022, and assist in the programmes as required.

The Fellow will be answerable to and supervised by three designated editors on a rotational basis throughout their Fellowship, and the Editor-in-Chief and Editorial Board. There will be no payment or honorarium but reasonable travel expenses to attend the above meetings will be met, according to usual Association policy. The Fellow and Editors/Editor-in-Chief will compile a brief report at the end of the Fellowship, to be submitted to the Editorial Board and School of Anaesthesia/Deanery as appropriate.

Association of Anaesthetists

Suitable applicants must:

- Be post-FRCA (or equivalent);
- Not have a substantive non-training appointment offered or accepted at the time of taking up the post;
- Be a member of the Association of Anaesthetists;
- Have an interest in, and commitment to, advancement of the specialty via the areas described in the Association research strategy (http://www.anaesthetists.org/research);
- Undertake to maintain strict confidentiality regarding all journal/Association activities;

Selection will be by a panel comprising the Editor-in-Chief, an Editor and a Trainee Committee representative.

Applications should comprise:

1. A brief (maximum one A4 page) CV, to include your current position, Association membership number and CCT date;
2. A summary (max. 300 words) of a) how you meet the criteria; b) what you can bring to the Fellowship; and c) what you hope to gain from it;
3. In your covering email, please include: i) the name and email address of your current or immediate past Educational Supervisor, who must be available to respond within a few days if contacted shortly after the closing date; ii) a statement that you hereby commit to informing the Editorial Office if you are offered or take up a non-training position between the date of application and the beginning of the Fellowship.

Applications must be received via email by **midnight on 31 May 2021** to **anaesthesia@anaesthetists.org**

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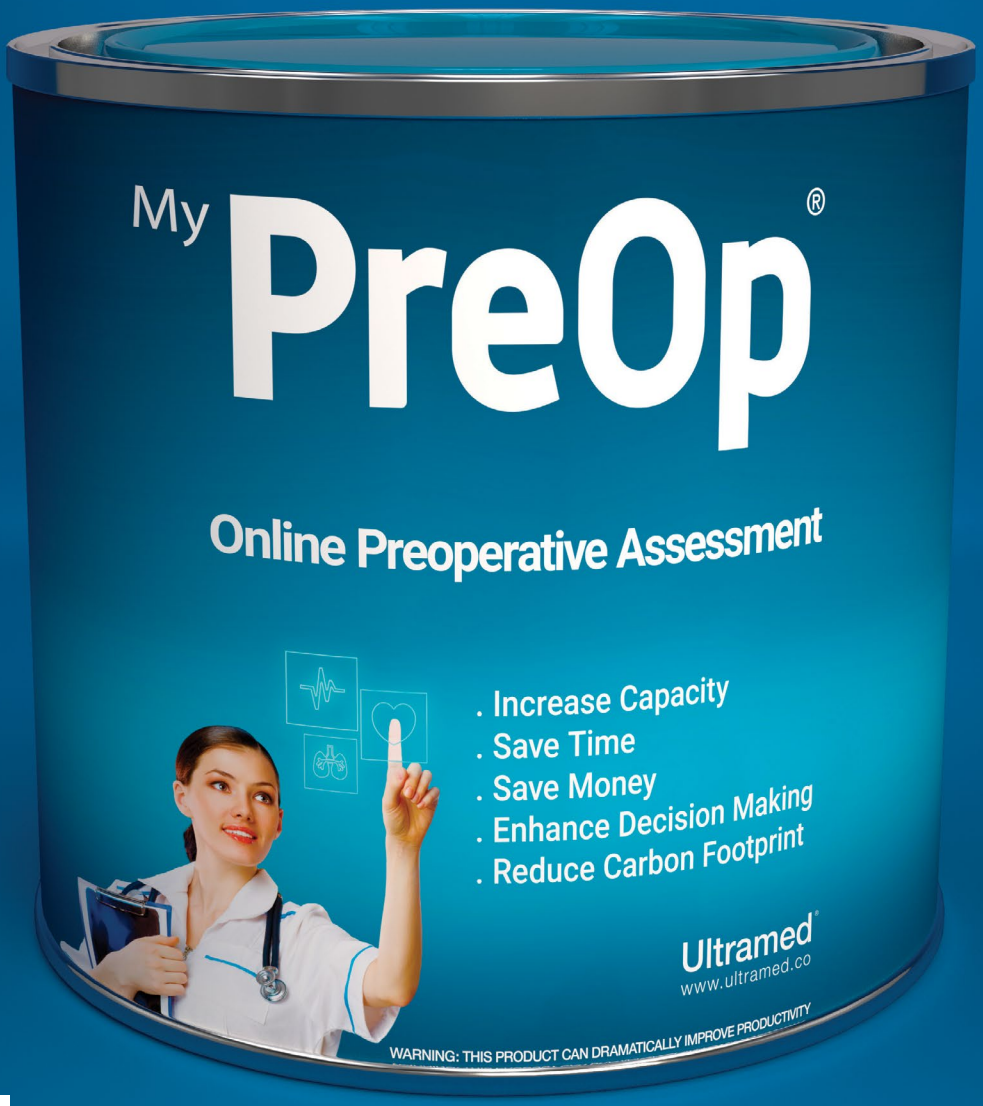

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