THE NEWSLETTER OF THE ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND

ANAESTHESIA NEWS

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INSIDE THIS ISSUE:

Editorial

It's July and most of you will have some sort of break planned over the summer. The best bit about a holiday is the anticipation but, often, you get so busy just before the holiday you almost wish you had more time to get organised! So, this time, take a deep breath, close your eyes and think about your upcoming break at least once a day.

This issue is not themed and has a potpourri of articles submitted by you. The year 1846 was so interesting that it has inspired Matthew Down to write an article about it. Steve Yentis and Andy Klein tell us how to get the most out of our journal, *Anaesthesia*, in this digital age of apps. If you are still confused after reading their piece, go on to the next which is all about how you can find the most interesting articles in scientific journals using Twitter and other social media!

Our subspecialist interests and differences sometimes lead to a healthy banter between us, however in my opinion we should always be able to laugh at ourselves. I thoroughly enjoyed the April issue of *Anaesthesia News* and the hilarious 'Farcical' from Dr Phillips-Bong. This issue features a response from Drs Pointless, Utterly and Pointless in a similar vein.

We all love to have a rant and some readers who have spent a long time in the NHS will empathise with Victor M's article. I am now looking for a suitable Mrs M who might be able to write in and tell us how tedious it is to be surrounded by someone who is forever ranting and complaining!

Some of us don't complain but move on to greener pastures, which is literally what Paul Cooper did when he took up an anaesthetic consultant post in Orkney, as well as sheep farming. He tells us all about the challenges and life of a rural anaesthetist in his piece.

I do hope you are planning to come to the Annual Congress in Edinburgh. The programme looks amazing. For the sporting souls who are cycling to Edinburgh, take care, be safe and have fun. I am waiting for there to be cycling lanes with bollards and an official cycling test before I venture on the road on my bike!

Anaesthesia News continues to be widely read by our membership and I would urge all of our readers to write in with suggestions, articles, letters and comments.

Upma Misra

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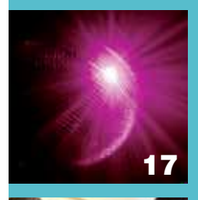

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Getting the most out of *Anaesthesia* in the digital age

The times they are a-changin'

Publishing has changed dramatically over the past ten years and there has been an inexorable rise in electronic versions of the more traditional media. Books are increasingly consumed as e-books and downloaded to a virtual library, and more and more people now read newspapers, magazines and journals in this format. In medicine, journal articles may be identified via a search engine and then downloaded and either read immediately or stored for future reading. And many readers prefer 'bite-sized' reading – they don't sit down to read a whole journal any more, but instead only read articles that are relevant to their practice, one at a time, when they are released.

Another change is the expansion of Open Access. Instead of the traditional model, in which readers/institutions pay publishers via subscriptions to journals, the content of which is closed to non-subscribers, Open Access articles are free to all and the costs of publishing are paid by the authors or funders of the research. Like most society-owned journals, *Anaesthesia* currently remains a subscription-based journal (with all published content becoming free after one year), while encouraging Open Access publication when authors/funders wish to go down that route.

The Journal, too, has undergone significant changes in the past few years. The *Anaesthesia* website looks nothing like it did a decade ago; there are now over a million article downloads per year, and several new features and developments are either in place, in progress, or planned. With a new Editor-in-Chief (AK) gearing up to take over from the current one (SY) in late September 2015, this seems an appropriate time to review how best to access these features.

If you want it, here it is, come and get it

Here, we list various features of the online presence of *Anaesthesia* and try to answer common questions that readers/members ask us at meetings.

Online content

The *Anaesthesia* website (www.anaesthesia-journal.org) can be accessed by anyone, for free, and all content from 1946 right up to the year preceding the current volume can be freely accessed as part of Wiley Online Library. (This free access to the back catalogue is something that most anaesthetic journals don't offer without charging readers). Selected items are made free as soon as they're published (e.g. Open Access articles and those designated 'Editor-in-Chief's Choice'; see below).

- Members of the AAGBI can also access the Journal via the AAGBI website (www.aagbi.org/publications/anaesthesia), using their membership number and password, (these can be acquired by emailing members@aagbi.org). They, like direct subscribers, can then access all the current content
- The Journal website includes a link to Early View (http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2044/earlyview), which is where most articles are first published before being allocated to a specific journal issue, and a great place to preview up-and-coming literature. One other useful feature of the Journal's website is the ability to sign up for a monthly email, listing the table of contents of each issue of the Journal with links to newly released articles. This requires a login to Wiley Online Library (top right of the homepage), and adding an alert to your profile via the 'Journal Tools' on the far left of the homepage.

Featured items and what's hot

Each month, the Editor-in-Chief selects two or three articles as his 'Choice'; these are featured immediately below the most recent issues of the Journal and are free to access for all. Readers can also see which articles are being most 'talked about' online (in newspapers, blogs, social media, etc.) in the last month by looking at the 'Altmetric' feature on the homepage. This new tool (www.altmetric.com) collects mentions of scholarly articles from all across the internet and calculates a score that can be used to assess an article's impact in the days and weeks after it has been published. All original articles, reviews and editorials in *Anaesthesia* now receive an Altmetric score, and this can be seen by clicking on the coloured logo just below the list of authors on each article's page.

Special features

In January each year *Anaesthesia* publishes a special educational supplement, and this is sent to all AAGBI members along with the January issue of the Journal. The 2015 supplement, *Transfusion, Thrombosis and Haemostasis*, has been very well received; other recent supplements include *Anaesthesia for the Elderly* (2014) and *Emergencies and the Anaesthetist* (2013). Further online supplements contain all the abstracts accepted for presentation at the AAGBI's Winter Scientific Meeting (January), Group of Anaesthetists in Training Annual Scientific Meeting (June) and Annual Congress (September); these can be downloaded without restriction from the Journal homepage, meaning that those unable to attend meetings can keep up with newly presented research material.

Recent articles covering specific subject areas are grouped together as 'Special Collections' – they can be found on the left-hand side of the Journal homepage and include Awareness, Cardiothoracics, Obstetrics, Paediatrics and Research Misconduct.

Classic Papers

At intervals during the year, *Anaesthesia* publishes Classic Papers online; in these, invited authors describe a particular paper from the Journal – going as far back as they wish – which they feel has special importance to them personally or to the specialty. These commentaries are published along with the original paper for readers to access. The link for Classic Papers is included in the list of features on the left-hand side of the Journal homepage.

Journal CPD

Every couple of months, the *Anaesthesia* editors select an original article or a review for Continuous Professional Development (CPD), and multiple choice questions are written by the authors to accompany these articles. These can be accessed via Learn@AAGBI (www.learnataagbi.org), where members need to log in with their AAGBI membership number and password, then access Content Directory, then *Anaesthesia* Articles. You can read the article, answer the MCQs and complete the reflective feedback form to receive a CPD certificate.

iPad/iPhone app

The *Anaesthesia* app was released two years ago and has proved very popular. It can be downloaded from the App Store (https://itunes.apple.com/gb/app/anaesthesia/id673564155?mt=8 or search 'Anaesthesia journal') and an Android version is planned for launch later this year. After downloading the app, members will need their AAGBI membership number and password to unlock the content. The app will load up new articles automatically every time it is accessed, and it allows easy links to read references. Issues or articles can be downloaded to be read later, when offline, and then removed from your device once read, as you wish.

Correspondence website

The correspondence section of *Anaesthesia* is both lively and interesting, and readers can post their letters online as soon as they have written them (www.respond2articles.com/ana/); most of these are then printed in the Journal itself. Currently you can only submit an e-response to items that have been allocated into a specific issue of the Journal, and not to items published on Early View, though we are looking into ways of enabling that. Meanwhile, if you wish to comment on an item on Early View, just get in touch with the Editor-in-Chief.

Social media

The use of Facebook (over 3500 'friends') and Twitter (more than 4600 'followers') to access *Anaesthesia* has increased dramatically over the past 2–3 years. The editors tweet at least once a day with links to new articles and, from this year, all articles accessed via Twitter are free to download for 24 hours to all Twitter followers – 'Free For a Day'. Articles are often retweeted multiple times, and this has proved to be a very popular way to access new Journal material on the go, mostly using smartphones and iPads.

Nice 'n' easy does it every time

In summary, there are many ways to access and interact with your Journal, apart from reading the paper version itself – it's easy when you know how. If you are stuck with passwords or need any technical advice, the membership department at the AAGBI is a good first port-of-call (members@aagbi.org). Inevitably, there will be calls from some to phase out the paper journal in due course, especially as online access, either via the website, the app or social media, continues to grow. At the moment, we can reassure AAGBI members this is not on the agenda, but we will continue to review demand and interest in the print and digital versions.

As ever, we welcome your feedback and views. You may have noticed the *Anaesthesia* team next to the AAGBI stand at the WSM in London each January and the Annual Congress around the country in September. Please do drop into our Journal 'cosy corner' and let us know what you think, or just have a chat. It's your Journal and we want it to be accessible to you.

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Editor and Editor-in-Chief Designate, Anaesthesia

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AAGBI INNOVATION

The Association of Anaesthetists of Great Britain & Ireland

The Annual AAGBI Prize for Innovation in Anaesthesia, Critical Care and Pain

The Association of Anaesthetists of Great Britain and Ireland invites applications for the 2016 AAGBI Prize for Innovation in Anaesthesia, Critical Care and Pain. This prize is open to all anaesthetists, intensivists and pain specialists based in Great Britain and Ireland. The emphasis is on new ideas contributing to patient safety, high quality clinical care and improvements in the working environment. The entries will be judged by a panel of experts in respective fields.

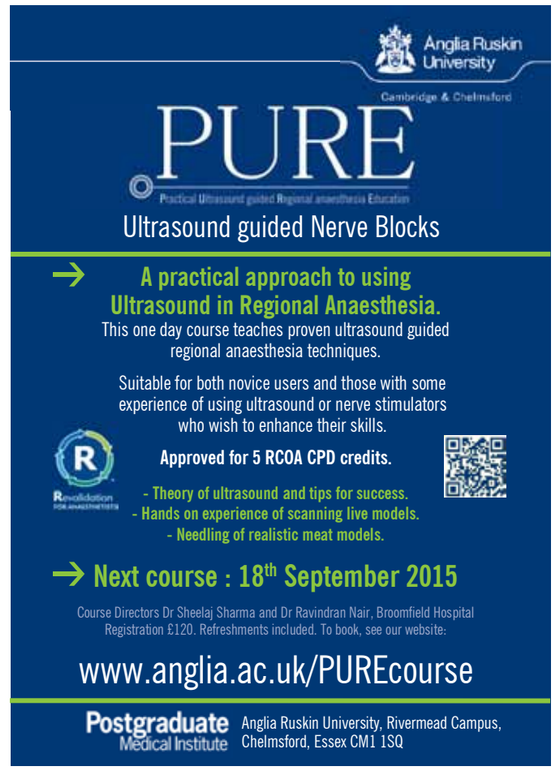
Applicants should complete the application form that can be found on the AAGBI website **www.aagbi.org/research/innovation**.

The closing date for applications is Wednesday 30 September 2015.

Three prizes will be awarded and the winners will be invited to present their work and collect their prizes at the Winter Scientific Meeting in London on 15 January 2016.

www.aagbi.org/research/innovation

Kindly sponsored by: Dräger



ASA & NZSA 2015 Combined Scientific Congress

Darwin, Northern Territory

12-15 September 2015

ASA & NZSA 2015 Combined Scientific Congress

EARLY BIRD CLOSES JULY 2015

REGISTER AT: WWW.CSC2015.COM

New Zealand Society of Anaesthetists (Inc)

ASA Australian Society of Anaesthetists

University Hospitals of Leicester NHS Trust

Paediatric Anaesthesia Meeting
Friday 9th October 2015
Holywell Park, Loughborough University

We would like to invite you to the 9th Paediatric Anaesthesia Meeting in Loughborough, Leicestershire.

Topics to include:

- Peri-op fluid management in infants and children
- Fibre-optic intubation: How do I make it work?
- RSI: The final breath?
- NAP5: Accidental Awareness under anaesthesia in children
- Management of the critically ill child for surgery
- TIVA: what works?
- Human error in paediatric anaesthesia
- Paediatric transport
-The child with sickle cell disease

5 CPD applied for to the Royal College of Anaesthetists

Registration fee: £120 (£60 for nurses/ODP's)
Enquiries: Jenisha Meisuria, Conference Manager, Leicester General Hospital, Gwendolen Road, Leicester, LE5 4PW
Phone: 0116 258 4244/4917
Email: ClinEd.Conferences@uhl-tr.nhs.uk

Free Open Access medical education and its relevance in anaesthesia: **using social media to keep up with the literature**

At some point during our professional development, most of us will have been advised to 'read more' and 'expand our clinical knowledge'. Sixty years ago the answer would have been simple:

'Basically, all that is required is the current issue of The Journal, an easy chair, pencils, a pad of paper and postal cards, along with a genuine, sustaining interest in all fields of medicine.'[1]

With an estimated 6000 papers published every day; keeping up with recent advances in medicine is an enormous challenge.[2,3] Social media, if used appropriately, can provide an effective way of optimising opportunities for self-directed learning, holding discussions with other healthcare professionals and reflecting on newly-acquired knowledge. It is possible to document these learning experiences for your personal record and as evidence for appraisals and revalidation.

The growth of social media as a tool for improving access to medical education resources has been astronomical over recent years. Healthcare professionals are increasingly using Twitter to share and discuss papers and resources; the emphasis on encouraging free Open Access medical education is embedded throughout these interactions. While a tweet, with its 140 character limit, doesn't lend itself to deep exploration, it acts as an effective carrier to encourage broader conversations a click away in blogs, podcasts and video chats.

Medical education in the UK is evolving at all levels. The exponential increase in the use of social media mirrors the rise in free Open Access medical education internationally. Traditional forms of medical media such as journals, societies and conferences have responded positively to this and most have created an enhanced online presence. It is very difficult to quantify the impact of social media using the techniques we are familiar with for traditional learning resources. Twitter attracts a high number of 'followers' and re-tweets are difficult to compare with traditional impact factors. However, many weblogs are used to host daily summaries of conferences and have demonstrated, via web analytics, an increase in visitor traffic over the duration of a conference, indicating the presence of a significant audience who make use of the social media resources.

Similarly, online resources providing peer-reviewed summaries of relevant publications (e.g. The Bottom Line[4]), have steadily gained momentum and readership via re-tweets and have generated publicity to capture interested readers as a result. Such resources have also been used to interview authors of trials. This allows authors to participate in a critical discussion of their results and methodology with a wide audience soon after publication, thus provoking earlier discussions and changes in practice than has previously been seen with more traditional methods of information dissemination.[5]

Other advantages of social media include the facilitation of global conversations about the latest medical practice and literature, allowing anyone to follow conferences remotely (but in real time), develop professional networking and friendships, and consolidate information with colleagues at home and abroad. The AAGBI Annual Congress this September has a dedicated Twitter hashtag, #ACEdinburgh15, to allow immediate audience participation, discussion and sharing of medical information.

IFTTT - If This Then That

With many of us now increasingly learning from blogs and podcasts it is important to reference these resources for the purpose of appraisals. The problem is how best to record this activity. Some methods include the use of If This Then That,[6] a web service that aggregates many other web apps into one place and can perform actions given a certain set of criteria. All you need to do is create your 'recipe' and let it store all your Twitter and Facebook activity. Other more specific resources include an online zone for AAGBI members (Learn@AAGBI[7]); this hosts a wealth of educational, learning and CPD resources where you can learn in your own time and keep a record of your completed CPD for use in appraisals and revalidation.

The RCoA encourages the use of social media and, in its guidance, states that the use of social media by doctors can benefit patient care, enhance learning and strengthen professional relationships.[8] As an educational resource, social media encourages the use of open access journals and time-limited free access to articles in subscribed journals (e.g. Anaesthesia journal 'free for a day' articles, #FFAD) to further distribute new information. But we must also remember to consider the 'side effects' and consequences of using social media. We need to be mindful that any information can be misinterpreted or distorted, especially when subjected to multiple layers of filtering through social media channels. However, the amount of live discussion between healthcare professionals transcending geographical boundaries is simply unprecedented, and hopefully will inspire continuing interest in medical education.

The GMC has issued specific guidance relating to the use of social media by doctors.[9] It states: 'The standards expected of doctors do not change because they are communicating through social media rather than face to face or through other traditional media.' More detailed guidance, written as a collaborative publication of Australasian groups of doctors in training, illustrates the application of professional standards with examples both fictional and based on previous cases.[10] Other guidance has been issued by the Medical Defence Union and the BMA.

Other potential problems could be related to the submission of manuscripts, comments and letters in relation to intellectual property and the effects of peer review (of sorts) with forums such as blogs etc. Opinions and postings may not be consistently regulated across different social media resources.

The incorporation of social media into our practice of exploring the medical literature seems to be the obvious direction of travel. It is easy to access, free, universally available and effective. It is important for us to consider using these methods to enhance and aid our continuing professional development.

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Steve Mathieu
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Undergraduate elective funding 2015

Up to £750

Applications are invited from medical students studying in Great Britain and Ireland (subject to confirmation of eligibility) to apply to the AAGBI Foundation for funding towards a medical student elective period taking place between October 2015 and March 2016. A further round of funding will be advertised in the autumn for electives taking place from April 2016 onwards. Overseas students should ensure that they are permitted to apply for charitable funding.

Preference will be given to those applicants who can show the relevance of their intended elective to anaesthesia, intensive care or pain relief. Applicants may wish to note that a key focus of the AAGBI is support for projects in the developing world.

For further information and to apply please visit our website: www.aagbi.org/undergraduate-awards, email secretariat@aagbi.org or telephone 020 7631 1650 (option 3)

Closing date: 17 July 2015 for consideration at the September 2015 Research & Grants Committee meeting

AAGBI FOUNDATION
Association of Anaesthetists of Great Britain and Ireland

Oxford University Hospitals NHS
NHS Trust

9th Oxford Paediatric Difficult Airway Workshop

Friday 2nd October 2015

The Paediatric Difficult Intubation Workshop is for trainees and consultants who anaesthetise children and wish to refresh and update skills in managing children with a difficult airway.

The course aims to discuss the management of the anticipated and unanticipated paediatric difficult airway. The format of the day is one of short interactive lectures, videos and hands-on small group workshops. The workshops cover care and basic use of the fibre-optic laryngoscope, modified airway and LMA access techniques using guide wires and exchange catheters.

Delegate numbers are limited to 24 places to allow maximum opportunity to interact and interrogate the faculty.

Registration fee includes refreshments and lunch.

Course organisers:
Dr. Karen Medlock & Dr. Arnie Choi

Early booking recommended

Registration Fee: £220 5 CPD points approved

All enquires: Karen Medlock, Nuffield Department of Anaesthetics, John Radcliffe Hospital, Headington, Oxford OX3 9DU
Karen.Medlock@ouh.nhs.uk Telephone: 01865 221590

Cheques payable to "Paediatric Anaesthesia & Resuscitation Fund"

Supported by STORZ KARL STORZ—ENDOSKOPE

PANEL OF EXTERNAL ASSESSORS FOR AAGBI UNDERGRADUATE AWARDS

The AAGBI makes two types of undergraduate awards – undergraduate elective funding twice per year and the annual Wylie undergraduate essay prize.

In the elective funding rounds, awards of up to £750 are made towards a medical student elective period where preference is given to those applicants who can show the relevance of their intended elective to anaesthesia, intensive care or pain relief. We ask applicants to note our particular interest in the developing world.

The Wylie essay is awarded each year for a 1000-word essay on a topic chosen by the Research & Grants Committee. Elective applications and essays are scored using a defined scoring system with marking guides to ensure consistency.

The Research and Grants Committee is now seeking to appoint a panel of 8-10 assessors (consultants and trainees) with a clear interest in undergraduate medical education to support them in reviewing and scoring the applications for these awards.

Interested candidates should apply to secretariat@aagbi.org with a covering letter and a personal statement of up to 300 words describing their interest in undergraduate medical education.

The closing date for applications is Friday 17 July 2015

For further information or an informal discussion please contact Dr Mike Nathanson, Chair of the Research & Grants Committee via secretariat@aagbi.org

AAGBI FOUNDATION
Association of Anaesthetists of Great Britain and Ireland

1846 A year of discovery

© http://en.wikipedia.org - Queen Victoria by Bassano

The year 1846 was a remarkable one in the history of medicine, science and the arts. But the year that had just ended – 1845, the eighth year of Queen Victoria's reign – was a relatively unremarkable one in the annals of the 19th century. It saw the death in July of the great reforming Prime Minister Charles Grey, now best known for his association with Earl Grey tea and for his statue on top of the magnificent Grey's Monument in Newcastle which rises 130 feet above Grey Street. In the same month, the reforming doctor and philanthropist Thomas Barnardo was born in Dublin. He would become famous as the founder of Dr Barnardo's Homes for orphans. In 1845 there were no great medical advances and anaesthesia was unknown. One might argue that it was known to Doctor Crawford Long of Georgia, USA, but since Long had not informed the world of his discovery of the anaesthetic effects of ether in 1842 and had hardly used it subsequently this is a moot point. Indeed, he would not publicise his work until as late as 1849.

Not having using it for dental extraction, Horace Wells tried, without success, to demonstrate nitrous oxide for surgical anaesthesia in the latter part of 1845 at Massachusetts General Hospital. After being discredited and publicly humiliated, Wells did not pursue any further attempts to invent or discover anaesthesia. Thus, at the end of 1845, nitrous oxide was still little more than an amusement at travelling shows and ether was a recreational drug on American university campuses. As long ago as 1800, Humphry Davy, the Cornish chemist and inventor, had hinted tantalisingly at the use of nitrous oxide in surgical procedures. In his landmark book Researches, Chemical and Philosophical, Davy made the now famous comment, tucked away on page 556, 'As nitrous oxide appears capable of destroying pain, it may probably be used with advantage during surgical operations in which no great effusion of blood takes place'. The world was not ready for such an idea to take hold. Thirty years after that, using techniques that unfortunately bordered on asphyxiation, Henry Hill Hickman experimented with anaesthesia using small animals for his research. There was still no receptive audience for his ideas and no global race to pioneer painless surgery. It was as if such a state of unconsciousness could not even be dreamed possible.

In 1846, the arts and science were far advanced by comparison with medicine. On 1 January 1846, Robert Schumann's great A minor piano concerto had its premiere in Leipzig and his wife Clara played the solo part. It has remained one of the most popular works of the Romantic period, its haunting melodies a reflection, so it is said, of Schumann's own melancholic depression. Later that year, Felix Mendelssohn's oratorio Elijah had its premiere in Birmingham where the industrial revolution was in full swing and was specially translated into English for the occasion. Mendelssohn's librettist had already translated Hear my Prayer which, 80 years later, would be EMI's first million selling classical disc for the treble soloist, London chorister Ernest Lough. Meanwhile the screams emanating from operating theatres were altogether more prosaic.

By May of 1846, America was at war with Mexico in a border dispute over the newly annexed state of Texas. However in France, Adolphe Sax, a Belgian musical instrument maker living in Paris, patented his new saxophone on 28 June. It would one day become popular with American marching bands. In astronomy, Neptune was discovered. Hitherto all the planets had been first observed with telescopes and therefore discovered by astronomers. Neptune, as it was later named, was the first planet whose position in the sky was predicted by a mathematician. Frenchman Urbain Le Verrier noted deviations in the orbit of Uranus due to gravitational effects from an unknown object and to within less than a degree predicted the position of Neptune. On 23 September, German astronomer Johann Galle received a letter from Le Verrier and in less than 24 hours confirmed the existence of the new planet at the Berlin Observatory. There then followed counter claims for priority of discovery. Similar arguments would play out in later years over the discovery of anaesthesia and telegraphy. Entirely independently, the English mathematician, another Cornishman John Couch Adams working in Cambridge, had performed his own calculations predicting the position of a new planet. However his analysis was not as accurate as Le Verrier and neither was he able to convince British astronomers to search the night skies with the same urgency as the Frenchman had. After intense lobbying by the English scientific establishment, John Couch Adams would eventually, and arguably rather generously, be credited with joint discovery alongside Le Verrier.

Less than three weeks later, and still predating the successful demonstration of anaesthesia, Neptune's moon Triton was discovered by British astronomer William Lassell on 10 October 1846. So now it could be said that all of the planets in the solar system had been discovered and many of the moons of those planets. Meanwhile which great scientist was striving for the great goal of abolishing pain in surgery? Perhaps the true answer is no-one. The only genuine scientist involved at all was Harvard lecturer Charles Jackson, but whether or not he really believed ether was an anaesthetic agent and told Thomas Green Morton to use it in preference to nitrous oxide is very controversial. Morton claimed that Jackson recommended only the topical use of ether and that he alone discovered the effects of inhaling ether. Morton, a dentist, was no scientist of any note. He was satisfied that teeth could be painlessly pulled out under its effects and probably experimented no further than that. After seeing a column in a newspaper which hailed Morton's use of ether in a dental extraction, it was junior surgeon Henry Jacob Bigelow who invited Morton to attempt to demonstrate ether anaesthesia. The operation was to be performed by the eminent John Collins Warren on 16 October in Boston, in the same Massachusetts operating theatre where Horace Wells had met with ignominious failure.

The story of that fateful day is too well known to need repeating. It was Bigelow, not Morton, who wrote the scientific paper describing anaesthesia and which resulted in the first operation under ether in England on 21 December 1846 at University College Hospital, London. It would be almost another year before chloroform anaesthesia was discovered, thanks to James Young Simpson's infamous after dinner experimentations around the table of his Queen Street townhouse in Edinburgh. Only when physician and epidemiologist John Snow became involved was anaesthesia finally put on a firm scientific footing. One might argue reasonably that John Snow invented the specialty of anaesthesia. A public house in London's Soho is named after him, near the site of the outdoor water pump on Broadwick Street where Snow had proved by the pumps' removal that cholera was a waterborne disease. If you were to visit that pub you might drink a pint of Peroni beer or a dram of Dewar's Scotch whisky in his honour. The Peroni brewery was founded in Lombardy, Italy, and Dewar's distillery in Scotland. The year in both cases was, yes, 1846.

Matthew Down

For the latest news and event information follow @AAGBI on Twitter

EVELYN BAKER MEDAL

The Association of Anaesthetists of Great Britain & Ireland

AN AWARD FOR OUTSTANDING CLINICAL COMPETENCE

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the 'unsung heroes' of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation. Nominees should normally still be in clinical practice.

Last year the award was won by Dr Sally Millett (Worcester). Details of previous award winners can be found on the website http://www.aagbi.org/about-us/awards/evelyn-baker-medal

Nominations are now invited for the award, which will be presented at WSM London in January 2016. Members of the AAGBI can nominate any practising anaesthetist who is also a member of the Association. Examples of successful previous nominations are available on request. Nominations should include an indication that the nominee has broad support within their department.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at HonSecretary@aagbi.org by 17:00 on Friday 18 September 2015

NELA sponsored Trainee Poster Prize at the AAGBI WSM

NELA will be sponsoring a Trainee poster prize at the WSM. This is for the best poster that uses your hospital's NELA data to bring about an improvement in care.

The aim of 'audit' is to improve patient care. However anyone who has read national audit reports or other guidelines will often see the same recommendations crop up year after year. The traditional model of 'clinical audit' generally involves this:

- Collecting data for a period of time
- Analysing it
- Discovering that 'we could be doing better'
- Presenting the results at a departmental audit meeting
- Asking everyone to 'please do better'
- Re-audit again in several months' time (and discover that not much has changed)!

The problem is that the traditional model of audit takes too long, and does not address the underlying reasons why things don't happen as they should. Quality improvement (QI) aims to address this. QI science emphasises the use of local data to drive small scale changes, carried out on short timescales.

So although NELA has the word 'Audit' in it, the only way improvements in patient care will come about is if clinicians use their NELA data to measure what is going on in their hospital, make a change, and measure the impact of making that change. The NELA website allows your hospital's NELA lead to download your own NELA data whenever you want to support QI initiatives.

The intention is that this prize will encourage trainees to get involved in driving improvements in the delivery of care to patients undergoing emergency laparotomy. It also has the added benefit of fulfilling some of the requirements of the CCT in Anaesthetics in Annex G. At the basic level, trainees need to 'Understand the difference between audit and quality improvement' with 'Evidence of active participation in a Quality Improvement project'. At Advanced level, it asks for 'Presentation of a Quality Improvement project through poster, case study or oral presentation ideally at a regional, national or international quality forum'.

The criteria for a successful poster will be judged on:

- Whether it demonstrates use of local NELA data
- Whether it uses established QI methodology
- Has multidisciplinary involvement (ideally)
- Whether it demonstrates an improvement in care, which could be improvements in process or outcome

For more information and to submit your abstract please visit www.wsmlondon.org

Closing date for abstract submission is 23:59 on Monday 31 August and a cash prize will be awarded to the winner

Further reading

- CCT in Anaesthetics (Annex G) http://www.rcoa.ac.uk/CCT/AnnexG
- RCoA. Quality Improvement in Anaesthesia http://www.rcoa.ac.uk/system/files/CSQ-ARB2012-QIA.pdf
- The Institute for Healthcare Improvement Open School http://www.ihi.org/education/ihiopenschool/Pages/default.aspx

Many hospitals will also have quality improvement/service improvement teams who can help with this type of work.

Dave Murray
NELA National Clinical Lead and Consultant Anaesthetist, James Cook University Hospital, Middlesbrough

Professor Carol Peden
NELA Quality Improvement Lead, Associate Medical Director for Quality Improvement; Consultant in Anaesthesia and Intensive Care at the Royal United Hospitals, Bath; Visiting Professor at Bath University's School of Management Centre for Healthcare Innovation and Improvement

A film our daughters enjoyed? It sprang to mind a few years ago, soon after ties and cufflinks were outlawed. One morning, striding past Sister's office I noticed the men cower while all the women hesitated, pupils dilated and eyes sparkling. I thought it was a natural response to my presence, or to my 'Flames of Etna' eau de cologne. 'You old Silverback. Haven't lost your magic', I thought, and flicked my flares with a lascivious hip roll one more time, just like that Travolta chap. Then I realised they were looking past me; behind me was the Deep Clean Team – and what a sight it was: all muscle, bright T-shirts and spray surface cleaner.

Anyway, the Deep Clean Team is back – saw them last month, and knew it could mean only one thing. My suspicions were confirmed as I fought my way to a computer in our hot desking lounge. The doors all were locked and the walls smelt more of paint than urine. Eventually a computer displayed the Trust's current news – I'd missed months of coaching: how to address their Eminences, how many steps to take backwards after utter prostration, recommended lines on predictable small talk and dreadful warnings of potential apocalypse. You've guessed it: the CQC inspectors were coming.

I bumped into them last week quite by mistake. As ever, I arrived late at the hospital. Ahead I heard the rattle of a trolley bearing tea to the boardroom. I hoped to slip in and trouser a few Garibaldi biscuits. But my plan rather fell through. There were no 'squashed flies', but an entire squadron of the great and good asking piercing questions. I sat quietly, tracking the biscuit tray. When the orthopods had hogged it for too long, I gave them a jolly wave. Imagine my horror when silence fell and the Chairman fixed on me over his half-moons. I should have hesitated, but didn't. I gave him both barrels, concluding that the past management's combination of idiocy, kleptomania and vaulting ambition made it difficult for mortals to guess what was coming next. Silence fell: even the orthopods stopped guzzling.

Since then the Deep Clean Team has moved on to dirtier pastures. And hereabouts the corridors seem rather emptier – I suspect I'm being avoided. But I still bump into the old crew in the consultants' car park. There's a whole sorrowful bunch of us. We used to sustain ourselves with self-righteous anger at the managers, the politicians, the nurses, the patients, everyone. We competed to find wilder examples of the disgrace which our hospital skirts; we promised how we'd instil a decent dose of common sense, if only they – the managers, politicians, nurses etc – if only they'd listen.

But when push came to shove, the old crew tripped. It seems they didn't speak to the inspectors. Or maybe they did, but don't dare let on.

I'm not sure what will happen next. I'll write again with the report. In the meantime, I think you'd better not reply to the hospital: I'm not sure if they'll forward my mail after security has frogmarched me to my desk with a bin bag.

Toodle Pip!

Victor Meldrew

IT STARTED IN A PUB – AS MANY THINGS DO

My wife is a knitter/spinner[1] (the Rumpelstiltskin variety, no Lycra in sight) and we had visited the Northern Isles for a holiday. At a wool-related trade show she met a spinning Orkney GP who suggested I should meet up with one of the local anaesthetists next time we were visiting. I did – in the aforementioned pub – and, among other things, we talked a bit about work. The conversation finished with '...and I'm retiring next year...'

I thought 'That sounds different and interesting...'.

Several months later I was interviewed for my third consultant job – six years as a cardiothoracic anaesthetist, then 17 years as a DGH anaesthetist/intensivist, and now remote and rural.

Balfour Hospital in Kirkwall, Orkney, is one of six rural general hospitals[2] in Scotland. It serves a resident population of around 22,000, scattered across 20 islands, as well as significant numbers of holidaymakers, and is at least an hour's flight away from a major hospital. The Balfour Hospital has approximately 49 beds which include a palliative care/chemotherapy unit, rehab ward, elective renal dialysis beds, a Receiving Unit (an A&E and medical/surgical acute admissions ward), a mixed medical and surgical ward (17 beds) and a three bed HDU.

We have consultant anaesthetists, obstetricians and gynaecologists, general surgeons and physicians, and a non-consultant rota of a mixture of GP trainees and speciality doctors. So it's a consultant-only anaesthetic service with three of us. A 1 in 3 on-call. Any nocturnal disturbance is for caesarean sections or treating and stabilising while waiting for the retrieval service or HDU queries. This 1 in 3 is certainly a lot less tiring than the 1 in 6-8 I was doing previously, mainly due to lack of frequent night-time disturbance. For patients who require level 3 care, they are stabilised and treated and then we wait for the retrieval service[3] to come and take them to a big shiny hospital in mainland Scotland. And this works well unless we are stormbound. In which case we keep and treat until the weather improves. So very occasionally a resident on-call rota has to be cobbled together while we have a ventilated patient.

The population of Orkney is very keen, quite understandably, to be treated locally where possible, particularly when giving birth. So we do elective and emergency sections but have no obstetric epidural service. Our general (stress the word general) surgeons undertake a wide variety of procedures and visiting surgeons fly in and do day case/overnight stay operations. The emergency work can be very varied – large agricultural equipment can make a mess of some bits of people. Cruise ships deliver an increasing number of people to Orkney, and some come our way for treatment and then repatriation.

But the local Orcadians are very stoical. The first patient who said to me 'I'm no too bad, really' had a CRP of 300 and enteral feed coming down her chest drain from a ruptured oesophagus. And there have been more like her with the most surprising pathology. The alternative for patients is a 45 minute flight to the mainland, many hours on a ferry and then several hours drive, or an overnight ferry (Monday, Wednesday and Friday) to Aberdeen. The significant disruption for patients, families and relatives can be avoided if it is safe and appropriate to treat them locally. And some emergencies wouldn't get to a distant hospital.

In my previous job I was doing gastrointestinal and orthopaedic ERAS and trauma lists. Now I'm an obstetric, ENT, eye, dental, gynaecological, trauma, and paediatric anaesthetist and, when required, neonatal resuscitator, major trauma stabiliser and ad-hoc intensivist. Our HDU is shared with the medics so I've learned quite a lot about acute coronary syndromes as well as sorting out their cardiovascular systems (under supervision from a local cardiologist!)

There are different issues to consider in the clinical decisions you make:

- Can we keep this patient or should we send them away now, before the weather closes in or their acute kidney injury gets worse (we have no CVVH)?
- The patient is very keen to stay (or even refuses to go) – do we have the resources to provide care locally?
- Do we have time to do the day case and allow the patient to recover sufficiently in order to catch the 3pm ferry for the 90 minute crossing back home to the outer islands?

Job satisfaction is different as well. In general, people seem to be glad that we are here – they realise the alternative could be a trip away from home of several days. My neighbour was able to report what I had said and done to her friend, to whom I had administered a spinal for her caesarean section. So in this small community, you don't need multisource feedback. You just ask a neighbour.

And then there are my sheep. I've got 23 acres of land and keep and breed Boreray sheep,[4,5] the UK's most endangered breed, and Gotlands.[6] I've realised that delivering lambs doesn't have a lot in common with the obstetrics I learned many years ago but I've learned a bit about ovine physiology. Toxaemia of pregnancy in sheep is a different disease to the human sort but joint ill (non-tender septic arthritis) is treated with co-amoxiclav, just as we would give to humans. Rebuilding drystone walls, making stiles across fences and becoming self-sufficient with chickens are all things I wouldn't have experienced had I stayed 'down south' – i.e. anywhere south of Wick.

With no orthopaedic surgeons consulting a local cardiologist about septic arthritits in a lamb .

Of course there are disadvantages:

- Local resources can be a bit limited if you are used to big city life. That may be a plus for you, or not. There is no Costa, Starbucks, McDonalds, Pizza Hut, Nandos, John Lewis, M&S or Primark, and many stores don't do mail order to the Islands
- Travel off-island, particularly at short notice, can be difficult to arrange and ruinously expensive
- There is the wind. Hail can drive into you horizontally at 60 mph and it stings a bit. And did I mention the wind?
- Staffing is a constant struggle. There aren't loads of people queuing up to work in the Islands
- If your interests are fine arts, the ballet or going to premiership football it will be difficult to pursue these hobbies

Some help from a neighbour during lambing

But there are advantages:

- Different clinical challenges
- Feeling you are part of a community and contributing to that community
- Spectacular scenery, wildlife and weather
- New experiences in and outside of work

If you are in a rut – take the bull, or the sheep in my case, by the horns and do something different!

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3. The Emergency Medical Retrieval Service. http://www.emrs.scot.nhs.uk/
4. Soay and Boreray Sheep Society. http://soaysheep.org/boreray.html
5. Rare Breeds Survival Trust. https://www.rbst.org.uk/watch-list/sheep/boreray
6. Gotland Sheep. http://en.wikipedia.org/wiki/Gotland_(sheep)

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- NHS Orkney Training. http://nhsorkneytraining.co.uk

AAGBI FOUNDATION
ANAESTHESIA HERITAGE CENTRE

A SILVER LINING THROUGH THE DARK CLOUDS SHINING : THE RIDDLE OF SHOCK

*A line from Keep the Home-Fires Burning by Ivor Novello

NEW EXHIBITION OPENS JULY 2015

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Dr M Rucklidge - King Edward Memorial Hospital Perth Australia

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Anaesthesia Digested

Anaesthesia July 2015

Calculating the probability of random sampling for continuous variable in submitted or published randomized controlled trials

Carlisle JB.

Probability screening in manuscripts submitted to biomedical journals – an effective tool or a statistical quagmire?

Miller DR.

This month's journal issue features a special article and accompanying editorial that at first glance some clinicians may feel is not for them – I urge anyone with an interest in science, research and the pursuit of truth, however, to read John Carlisle's impressive thoughts on the probability of random sampling for continuous variables in clinical trials. He builds on his 2012 work that used the chi-squared method to analyse Fujii's subsequently retracted papers, this time using a technique called Monte Carlo simulation that corrects for errors in the previous methodology. This methodology has the potential to be applied to all of science, and where it is shown that baseline continuous variables such as demographic data are statistically unlikely to have occurred by chance, editorial boards and readers may question why that is the case, whether the data are reliable, and whether research fraud may have taken place.

Miller's thoughtful editorial describes the fundamental importance of sampling in clinical trials, and allows clinicians less familiar with biostatistics to understand Monte Carlo sampling and the potential it may have to detect fraudulent behaviour by researchers. Both authors agree, however, that the onus still lies with university departments, as internal auditing of trials is more likely to detect and prevent the use of fraudulent data. The importance of preventing this cannot be under-estimated.

Assessing pain objectively: the use of physiological markers

Cowen R, Stasiowska MK, Laycock H, Bantel C.

As doctors, and especially as anaesthetists, we pride ourselves on our ability to relieve pain and suffering. At any one time 25–40% of hospital patients suffer moderate to severe pain. How, though, do we judge it, and plan our interventions? Is it enough to say that we can just ask our patients and react accordingly, when in every other aspect of our practice we seek out objective measures? Cowen and colleagues provide us with a state-of-the-art review of the techniques available to us.

They describe the five main strategies, namely monitoring changes in the autonomic nervous system, the measurement of biopotentials, the use of functional neuroimaging, research into biomarkers, and finally composite algorithms, which make use of several different physiological markers. These currently available tools are all indirect measures of pain or nociception, and may therefore be influenced by many factors, including disease, drug therapy or the effects of sedation. Other issues include the fact that while autonomic responses may detect the presence or absence of pain or nociception, they are unable to reliably predict severity, making it even harder to improve clinical care. The authors make the point that we ought to be distinguishing between the two, and treating nociception in unconscious or sedated patients to avoid the potential development of chronic pain states.

The dream of a reliable physiological marker of pain remains out of reach, for now – further development of the techniques discussed here may enable us to finally achieve it.

A.E. Vercueil,
Editor, *Anaesthesia*

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

Particles

Suresh S, Long J, Birmingham PK, De Oliveira GS Jr.

Are caudal blocks for pain control safe in children? An analysis of 18,650 caudal blocks from the Pediatric Regional Anesthesia Network (PRAN) database

Anesthesia & Analgesia, 2015; **120:** 151–6

Background
The anaesthetic use of caudal block in children was first described in 1933.[1] It is the most common regional anaesthesia technique used in paediatric patients. Neuraxial techniques are most frequently performed under general anaesthesia in paediatric patients and it has been considered a potential risk factor for the development of complications.

The main aim of this study was to evaluate the incidence of overall and individual complications associated with the performance of a caudal block and to evaluate local anaesthetic dosing in the same patient population.

Methods
This observational study used the data from the Pediatric Regional Anesthesia Network from 2007 to 2012. The paediatric patients (defined as age < 18 years) who received a caudal block for intra-operative or postoperative analgesia or anaesthesia were included. Demographic characteristics included patient specific characteristics in addition to the procedure specific characteristics.

A complication from caudal block was defined by the presence of at least one of the following intra-operative and/or postoperative factors: block failure, vascular puncture, positive intravascular test dose, dural puncture, seizure, cardiac arrest, sacral pain or other neurological symptoms. The presence of temporary or permanent sequelae was further evaluated if complications were reported. An exploratory analysis was also performed to identify local anaesthetic dosage.

Results
A total of 18,650 children who received a caudal block were identified. The estimated incidence (95% CI) of complications was 1.9% (1.7%–2.1%). The younger patients median age (IQR) 11 months (5–24) developed compared to those who didn't, median 14 (7–29) months, p = 0.001. The complication rate didn't change with the use of the ultrasound (6/450 compared to 307/16,343). The most common complications were block failure (1%), blood aspiration (0.6%) and intravascular injection (0.1%). Serious complications like cardiac arrest (0.005%) and seizure (0.005%) were extremely rare. No long term sequelae noted. A total of 4406 of 17,867 children received unsafe dosages of > 2 mg bupivacaine equivalent /kg. The serious complications were observed with the use of ropivacaine and lignocaine.

Discussion
The complication rate was low and no long term sequelae were detected. A large variation in local anaesthetic dose was detected (1.23mg of bupivacaine/ kg–1.98mg of bupivacaine/kg). Younger patients are at risk of receiving toxic dose. This study did not suggest that safety was improved with use of ultrasound. Future studies are needed to examine the efficacy of caudal block where safety issues should not be the barrier.

Venu Mehta
ST5, Stoke on Trent School of Anaesthesia

Yat Li
Consultant in Anaesthesia and Intensive care, The Royal Wolverhampton Trust Hospitals

Reference
1. Campbell MF. Caudal anesthesia in children. *American Journal of Urology* 1933; **30:** 245–9

Kieboom JK, Verkade HJ, Burgerhof JG, et al.

Outcome after resuscitation beyond 30 minutes in drowned children with cardiac arrest and hypothermia: Dutch nationwide retrospective cohort study

BMJ 2015; **350:** h418

Background
Drowning is the primary cause of accidental death in children aged 2–5 throughout the world.[1] Outcomes in those who do not recover with basic life support alone can be extremely poor.[2] In children where drowning is accompanied by hypothermia, prolonged resuscitation beyond 30 minutes (until core temperature of 32–34C is reached) is currently advocated, due to the potentially neuroprotective effect of low temperatures.[3] However hypothermia is generally considered a poor prognostic indicator in the emergency department.

Kieboom et al. aimed to evaluate outcomes in children with cardiac arrest and hypothermia secondary to drowning to determine whether there is benefit in prolonged resuscitation. They also examined whether a link existed between seasonal water temperatures and neurological outcomes.

Methods
Eligible patients aged 16 and under were retrospectively identified using the ICD-9 code for drowning, presenting between 1 January 1993 and 1 January 2012. Cardiac arrest must also have been diagnosed, and CPR performed. Those who had drowned indoors, or who presented with a core temperature > 34C were excluded. Children drowning as a result of trauma were also excluded. Final outcome was set at death at 1 year or, if alive, the neurological status according to the Paediatric Cerebral Performance Category Score (PCPC). Water temperatures were estimated using accepted mean water temperatures in a temperate, maritime climate for each season.

Results
A total of 160 children were included in the study. Prolonged resuscitation (> 30mins) was performed in 98 cases. None of these children was assessed to have a good neurological outcome at one year (PCPC score < 3) compared with 27% (n = 17; 95% CI 16%–38%) of children in the group that did not receive prolonged resuscitation. In the prolonged resuscitation group, 89% died within 1 year (n = 87; 95% CI 83%–95%) with 11% surviving in a vegetative state or with severe neurological damage (n = 11; 95% CI 5%–17%). The maximum duration of resuscitation eventually resulting in a good outcome was 25 minutes. Season (and therefore mean water temperature) was found to have a correlation with outcomes, with children drowning in winter having significantly better outcomes than those in other seasons: 29% (95% CI 8%–51%) vs 8% (95% CI 4%–13%); although the numbers in each of these groups was small.

Conclusion
Children with cardiac arrest and hypothermia after drowning are likely to have extremely poor outcomes if return of spontaneous circulation is not achieved within 30 mins. The findings of this study therefore question the therapeutic value of prolonged resuscitation beyond 30 mins in this group.

Inthu Kangesan
CT2b Anaesthesia, Severn Deanery

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Taenzer AH, Walker BJ, Bosenburg AT, et al.

Asleep versus awake: does it matter? Paediatric regional block complications by patient state: a report from the Paediatric Regional Anaesthesia Network

Regional Anaesthesia and Pain Medicine 2014; **39:** 279–83

Background
There has been considerable interest in whether it is safe to perform a nerve block in the anaesthetised patient. This study set out to try and establish the rate of adverse events in paediatric patients by patient state at the time of block performance.

Method
Data were collected from the Paediatric Regional Anaesthesia Network, a network of 20 centres across the US that record complete data for all regional blocks performed on patients younger than 18 years. Patients were grouped into age range and whether the block was performed while awake, sedated or under general anaesthesia (with and without neuromuscular blockade).

The study looked at 2 main outcomes:

- Post-operative neurological complications (PONS)
- Local anaesthetic systemic toxicity (LAST)

Outcomes were recorded as number of occurrences and rates per 1000 blocks.

Results
Over 50,000 paediatric regional blocks were analysed with an overall complication rate of 11.9/1000. PONS occurred at rate of 0.62/1000 in patients under general anaesthesia without neuromuscular blockade and 2.4/1000 in patients under general anaesthesia with neuromuscular blockade. In patients sedated or awake, the risk of PONS was 8.3/1000 and 3.4/1000 respectively. There were 5 cases of LAST with a rate of 0.08/1000 in the general anaesthesia group and 0.34/1000 in the awake group.

Discussion
This study suggests that blocks placed under general anaesthesia (with or without neuromuscular blockade) carry less risk than blocks placed in awake or sedated children. The study also supported previously reported data that major complications such as PONS and LATS are rare in children.[1]

The study has several limitations. It may not be possible for children to report mild sensory PONS, and many block types are not evenly distributed between ages. The authors stressed that care needs to be taken when interpreting the data and the results should not be translated into adult practice.

Conclusion
This paper is worth reading as it provides the largest overview of regional block complications related to patient state. Based on this and previous reports,[1] it appears that, in children, the practice of placing regional anaesthetic blocks under general anaesthesia is safe and should be the prevailing standard of care. With regard to adult populations, this remains a contentious issue but current opinion leans towards placing blocks in the awake patient.[2]

Katie Allan
CT2 Norfolk and Norwich University Hospital

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Dear Editor

I read with interest the report of the interference found by Drs Darwin and Tomlinson[1] between enFlow fluid warmers and pulse oximeters, and the fact that this seemed to be down to one particular device. A similar problem occurred in Ipswich when the enFlow device was introduced to the hospital with interference to the pulse oximeter trace, it did not affect the saturation value but, as happened in Salford, did affect the heart rate as read by the oximeter trace. After investigation by GE, who provide both monitoring and the enFlow it was discovered that a non-branded pulse oximeter probe with an unscreened cable was being used. When this was changed to the branded and screened GE pulse oximeter probe, the problem was resolved. This is an example of trying to save some expense but at the possible compromise of safety. Non-branded oximeter probes are no longer purchased here.

James Broadway
Consultant Anaesthetist, Ipswich Hospital NHS Trust

Reference

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Dear Editor

The Genius™ 2 Tympanic Thermometer[1] is largely used in our Trust for measuring patients' temperatures in several treatment areas. When auditing inadvertent peri-operative hypothermia,[2,3,4] I discovered that the device is able to give different readings depending on the 'equivalence mode' set on the device.[5] This can be 'ear' (default; Figure 1), 'oral', 'core' or 'rectal'. Our hospitals' devices, as in most hospitals in our region, are set to 'ear'. Very few, if any colleagues are aware that these devices do not actually measure core temperature as the default.

When the device is set to 'core' (Figure 2), it adds 1.04ºC to the 'ear' reading. Thus having the device set on 'core' will probably make a significant difference in meeting the recognised standards (and not persisting in trying to warm patients who actually have a core temperature >36ºC). There are wider implications for patient care in the rest of the hospital, e.g. patients on critical care with apparently mild pyrexia at 37.3ºC, may actually have a core temperature of 38.34ºC.

Figure 1 ***Figure 2***

My advice to users of these devices is to check the mode setting and consider putting the devices into 'core' mode if appropriate.

Dr Amir Rafi
Consultant Anaesthetist, Darlington Memorial Hospital

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Dear Editor

We thank Dr Topor and Dr Collins for their article[1] which raised the potential problems associated with air bubble formation in propofol. We wanted to highlight a similar issue in local anaesthetic preparations.

Very few papers mention the useful learning point that micro bubbles within local anaesthetics can cause artefacts from acoustic shadowing, and interfere with our ability to clearly visualise the image.[2]

Figure 1

Within our Trust, since moving to 18G non-luer lock Surety Intervene devices and the implementation of Surety Intervene 5μm filter needles, we have noticed a discernible decrease in micro bubble formation as compared to drawing up with a standard 18G Braun needle (Figure 1). This is in keeping with the similar benefits of filtering propofol found in this study.[3]

We would therefore like to advocate the use of a filter needle when drawing up local anaesthetic to avoid image disturbances that occur with too many bubbles, which we have termed the 'champagne' effect.

Thomas Goddard
CT2 Anaesthetics, Lewisham and Greenwich NHS Trust

Arun Kochhar
ST5 Anaesthetics, Lewisham and Greenwich NHS Trust

Beenu Madhavan
Consultant Anaesthetist, Lewisham and Greenwich NHS Trust
Deputy Chairman of London Society of Regional Anaesthetists

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your Letters

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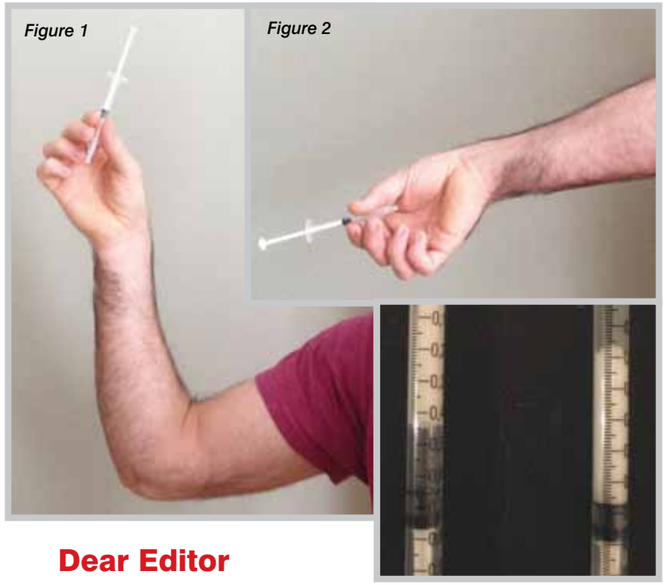

Dear Editor

Bubbles in a 1ml syringe can cause frustration and difficulty for the anaesthetist. Getting rid of these bubbles in a high stress situation such as a rapid sequence spinal for an emergency obstetric case, can increase cognitive load and interrupt procedural flow. This could cause delay, unnecessary stress and increase procedure related risks to the patient. The diameter of the 1ml syringe and surface tension of the liquid makes it particularly difficult to get rid of air bubbles. I have devised a simple, reliable and repeatable technique to get rid of all air bubbles and ensure an accurate quantity of drug can be measured.

1. Draw up more than a sufficient volume of drug from the ampoule into a 1ml syringe using a blunt filling needle (the bubble will be by the plunger).
2. Remove the blunt filling needle and hold the syringe by the barrel between finger and thumb with the plunger pointing distally. Move your forearm at the elbow from an "elbow flexed" position (figure 1) to an "elbow extended" position (figure 2) in one swift movement with the wrist held firm. Bubbles will move to the top of the barrel whilst liquid will move toward the plunger.
3. Now attach a 27G needle, express all air and any excess drug. Add the measured amount required to the drug mixture for intrathecal administration.

This technique could help reduce procedural delay, cognitive load and patient risk from a rapid sequence spinal. It could also ensure good procedural flow and reduce stress for the anaesthetist.

Richard JB Ellis
CT3 Anaesthetics, University Hospital Wales

Dear Editor...

We read with great interest the commentary on our recent study.[1] We are sure that Dr Phillips-Bong will agree that this was a vital study designed in order to improve the quality of analgesia in caesarean section, the patient experience for our parturients and our CVs. It has also allowed us to gain much needed funding via the NIHR for the anaesthetic department quails eggs and champagne fund, now that our trust has deemed us so unworthy it will not even provide us with tea, coffee and milk. We understand the water and toilet roll supply will be the next, frankly unnecessary, conveniences to be removed in the continuing plan to cost-cut while improving doctors' morale.

We would like to make a few points in defence of our study. First, our chosen patient population was actually fascinated by the literature we provided in our patient information pack. We have had vigorous pre-orders for the supporting interactive DVD, iPhone app and branded toiletries. As an additional surrogate endpoint to the study (not previously reported) we found satisfaction of obstetric anaesthetists (particularly the obstetric fellows currently working a 1:2 rota with internal prospective cover – all EWTR compliant) much improved. We postulate this was because the women wished to talk about the study protocol during the procedure rather than the usual endless small talk of baby names, just how bad the last delivery was that led to them having the elective caesarean this time, the results of their Google searches into hospital litigation processes and whether or not it is possible to combine hypno-birthing with a caesarean delivery.

Second, we would like to reassure readers that, despite our use of perhaps less mainstream methods to test the block, no birds (duck, goose or albatross) were seriously injured during this study and all feathers were reattached with RSPB-approved rivets. Unused petals were also retained to be showered over the Chief Executive in the next business unit meeting.

Third, we feel that the Kolgorov-Smirnoff-Stolichnaya test is an entirely appropriate statistical tool to have used when comparing these two groups of data. Dr Kolgorov, it is believed, is the third cousin once removed of both one of the researchers of the study and Kim Kardashian and, besides, it was the only test we could get to give us the results we wanted.

Finally, in preparation of this response we felt it important to understand Dr Phillips-Bong's own research interests and expertise. On performing a literature search using the usual methods (PubMed, LinkedIn, Facebook, Instagram and Tinder) we could not help noticing that a recent article by him shows a worrying bias towards our research.[2]

Overall, we are very proud of our research and firmly believe that our specialty has such work as the bedrock of its continued excellence. We relish Dr Phillips-Bong's interest in our article especially given his prominent position in the Society for Anaesthesia of the Left Little Finger and take onboard his comments, but would like to remind him that we frankly don't care what he has to say.

A Pointless, B Utterly, C Pointless, et al.
University of the Bleeding Obvious

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SAFETY MATTERS

Obstruction to auxillary oxygen port

We would like to report a potentially serious problem with the auxillary oxygen port of an anaesthetic machine. The rubber adaptor (oxygen nipple outlet to 15 mm connector) was removed to allow oxygen tubing to be attached directly. It was noticed that the removed adaptor was partially blocked with a sideways inserted intravenous cap (Figures 1 & 2). Although the machine had been checked, the adaptor was not removed or visually inspected, but did 'hiss' when the oxygen port was turned on. No harm came to the patient and it is impossible to know for how long the adaptor had been obstructed. We suggest that the use of a transparent adaptor (for example that made by Covidien) would allow easier visual inspection.

Andrew Prenter
ST6 Anaesthetics

Pete Murphy
Consultant Anaesthetist, Alder Hey Children's Hospital, Liverpool

Figure 1

Figure 2

Avoid the flack, check your MAC

The NAP5 report has rightly stated that transfer of patients (from the anaesthetic room to theatre, or from bed to operating table) has the potential to cause harm to patients, as it requires discontinuation of anaesthesia and monitoring[1]. This 'gap' may lead to accidental awareness during general anaesthesia (AAGA) for which a checklist may be helpful. The 'Stop before you Block' campaign was introduced to reduce the incidence of wrong-sided blocks[2]. Combining the two, we have a few suggestions for raising awareness (or not, actually!) of the anaesthetic gap:

- 'Glance before you dance'
- 'Avoid the flack, check your MAC'
- 'Will they listen before you reposition'
- 'Don't be harassed, put on your gas'

Use of one of these (for example, see Figure 1) may make for a smoother transition for patient, and the anaesthetist.

Figure 1

Caroline Dean
ST7 Anaesthetist

Sandeep Sudan
Consultant Anaesthetist, Royal Sussex County Hospital, Brighton

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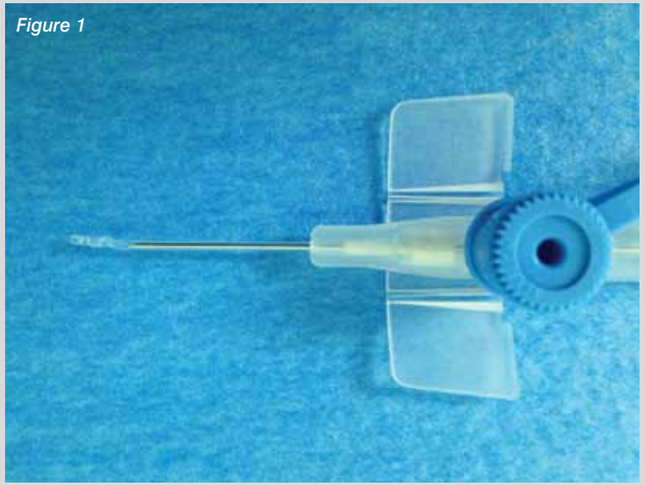
SAFETY MATTERS

BD Venflon™ 22G IV catheter

Figure 1



Dear Editor

On of us (EB) recently began a paediatric rotation at the RHSC in Glasgow. The acquisition of a new yet familiar skill set in the paediatric population presents its own unique challenges, not least the cannulation of small children. It was with considerable frustration that we noticed on several occasions that the BD 22G cannulae EB was attempting to insert into small children were 'kinking' before puncturing the patients' skin. On closer examination we observed that the plastic stylet had 'concertina-ed' up the needle of the cannula. We have since discovered that many others in our department, consultants and trainees alike, have recently experienced this problem. It seems unlikely that as a large group of anaesthetists our technique had changed; it was more likely that the manufacturing process or materials had changed without discussion. We have returned a selection of cannulae to BD Plastipak for examination and await their response

Elizabeth Beattie

Tony Moores

Royal Hospital for Sick Children, Glasgow

Response from Becton Dickinson

Thank you for sharing the correspondence from Dr Beattie with regard to her experiences during the use of the BD Venflon™ 22G IV catheter. We would like to reassure you that we have taken Dr Beattie's concerns extremely seriously.

BD manufactures and distributes in excess of 49 million Venflon catheters worldwide each year with an historical complaint rate of approximately 0.00001% of annual turnover per year in Europe. The problem that Dr Beattie refers to is a relatively recent observation for the BD Venflon 22G IV cannula and investigations were carried out immediately. We concluded that the condition Dr Beattie remarked upon, relating to the catheter tubing, which is at times was causing 'crumpling' to occur at the insertion point, was not related to either a design or manufacturing change made by BD. The problem was concluded to be related to some minor variations in supplied raw materials that are used to make the catheter. As a result of this investigation BD immediately implemented more stringent acceptance criteria for raw materials, as well as improved product testing, and we are confident this specific issue has been resolved. BD is reviewing closely the performance of this catheter and so our investigations are still not completely closed until all feedback data is collated and reviewed. Once the investigations have been fully concluded, we will update customers who have reported experiencing the problem.

From a clinician point of view BD is committed to driving for first stick success, however we understand that every patient is different and there are many subtle factors that contribute to the effective placement of an intravenous catheter. We fully appreciate that this matter has been frustrating for Dr Beattie and her colleagues and BD apologises for the inconvenience and potential discomfort caused.

E. Lynne Kelley
Vice President Medical Affairs
Becton Dickinson

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