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Considering an Out of Programme Experience? A guide to what you need to know

Rivaroxaban for treating pulmonary embolism and preventing recurrent venous thromboembolism
ULTRASOUND GUIDED REGIONAL ANAESTHESIA – BEYOND INTRODUCTORY

These courses are organised by Regional Anaesthesia UK (RA-UK) in conjunction with SonoSite Ltd for training in ultrasound guided regional anaesthetic techniques. Previous experience in regional anaesthesia is essential.

2014 Course Dates: Introductory Ultrasound Guided Regional Anaesthesia 29-30 April 6-7 October Ultrasound Guided Venous Access 5 June 23 October Ultrasound Guided Paediatric Venous Access 17 February 28 July Ultrasound Guided Chronic Pain Management 23 May All courses qualify for CPO Accreditation.

Venue: Sonosite Education Centre, 240 The Village, Basingstoke, RG24 8LG. Cost: £400 / £500 includes VAT, lunch, refreshments and course materials.

Location Organisers
Bristol (A) Dr Barry Nicholls/Dr Tony Allen
Brighton(U) Dr Suanne Krone
Liverpool Dr Steve Roberts
Nottingham (A) Dr Nigel Siddarth.

Faculty will vary depending on location
10% Discount for ESRA members – 15% Discount for RA-UK (FULL) members.

Pre-course material can be downloaded once registered on the course – including US physics, anatomy of the brachial / lumbar plexus, current articles of interest

For further information and to register logon to www.sonoeducation.co.uk

There is an interesting article this month on the difference between scientists and doctors. This explains, using a mountaineering analogy, what most of us do day-to-day in assessing risk and benefit, perhaps without even realising it. We consider the often incoherent and limited evidence base, add a dash of bias from experience, and then apply both to the individual patient. I have always been critical of those who claim an anaesthetic technique should be applied to most patients in a particular group. I know anaesthetists who use total intravenous anaesthesia (TIVA) for almost everyone, spinals for nearly all knee arthroscopies, intercalane blocks (IBS) for all shoulder surgery, or awake fibroptic intubation (FOI) for all dental abscesses. I can use TIVA, put in a spinal, do an awake ISB and perform FOI. However, I apply each skill as the patient and I decide is best. I believe that all consultant anaesthetists should have a full range of skills that they can apply according to the needs and wishes of individual patients, who are assisted in making an informed choice. Each of these techniques is fairly straightforward to teach and learn, but the wisdom needed to apply them appropriately takes many years, and is the real art of medicine.

However, it seems that we will not be long before we appoint the consultants of the future after only 4-6 years of training, some 6-8 years after graduation. It seems that the GMC’s Shape of Training Review (GOTR) is to be implemented with almost immediate effect, and suggests that we all train as generalists. Further specialist training will take place as required by local services. In anaesthesia, we already train generalists and are therefore relatively protected, but training is likely to be further reduced in duration. I cannot see how the intensity of training can be increased further if the Working Time Regulations remain in their current form, so we will inevitably appoint more inexperienced consultant anaesthetists to jobs that bear very little resemblance to the terms and conditions we have at present. Will these new consultants have the clinical judgement, range of skills and the motivation required, or will they become protocol-directed automations? Will these be the consultants treating me when I f& and fracture my neck of femur in my 80s?

For more information and to register logon to www.sonoeducation.co.uk
Chairman Independent Practice Committee

sean Tighe

some favourable adjustments as a result. Sadly, however, the insurers have escaped any significant "Independent Departments of Anaesthesia", seem to have been in defence of Anaesthetic Groups, which we now refer to as place, these finding are likely to be ratified in the final report, to and via the RCoA joint workforce planning group but it seems that expansion of anaesthesia to general practice, undermining the authority of HEE, In this respect, it is very concerning that Local Education and workforce. It is therefore alarming that the GMC has published this document at this time, without considering these quality issues more carefully.

In this respect, it is very concerning that Local Education and Training Boards are already diverting ST training numbers from anaesthesia to general practice, undermining the authority of HEE, who have done this is the outcome of the overall workforce planning consultations. A Deanery in the North of England will lose nearly 12% of ST numbers from now, February 2014, and a further 14% over the following two years. The theory is that expansion of GPs and community care will reduce the requirement for hospital admissions, and therefore anaesthetists. It beggars belief! Rest assured, we will be scrutinising this issue directly with the HEE and via the RCoA joint workforce planning group but it seems that the world really is going mad!

Since my last editorial, the Competition Commission has published its "Provisional Findings"10. Although further consultation will take place, these recommendations are to be finalised in the final report, to be published in March or April 2014. Our extensive arguments in defence of Anaesthetic Groups, which we now refer to as "Independent Departments of Anaesthesia", seem to have been accepted. Sadly, however, the insurers have escaped any significant criticism. The AAGB has made a further submission11 and I still have some confidence that the Competition Commission may make some favourable adjustments as a result.

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My February message to you is therefore this: let’s do what we can to get the whole thing joined up. I am not saying that we should have a single, monolithic NHS and a number of global NHS guidelines that should be imposed from on high on hospitals throughout the four corners of the NHS – far from it. However, I do think it would be a good idea to ensure that all key safety elements of care are useful, are well integrated, and that everyone knows what to do if certain life-threatening problems occur, checking that the nerve block or operation is being done on the correct side of the patient, not leaving swabs inside, handing over patients’ care in a methodical way, and so on. Other elements of the structured process would cut in if the patient was old or over patients’ care in a methodical way, and so on. Other elements of the structured process would cut in if the patient was old or.

I will leave you with words echoed by two visionary proponents of change for the better: Barack Obama and Bob the Builder: “The NHS is broken. Can we fix it? Yes we can!”

The author acknowledges that he has borrowed good ideas from Isabeau Walker, Richard Marks and others in the preparation of this article.

The process can be complex and will require approval by:
1. The Anaesthetic Department (Training Programme Director and Educational Supervisor)
2. The Postgraduate Deanery
3. The Royal College of Anaesthetists
4. The GMC

This will take time, so plan in advance and allow sufficient time before starting the post.

Finding a post

It is important to speak to your educational supervisor, college tutor, regional advisor and training programme director about your interests, any ideas you may have, or if you wish to try for a specific post. You will need their approval to go out of programme and you may be asked whether you have taken an interview, and you will also need references for your application.

Once you have secured a placement, there are a number of things you will need to do next:

1. Complete the necessary paperwork for Deanery approval. You can obtain this paperwork by contacting the Deanery personnel responsible for your training specialty (this is usually the same person who organises your ARCP), or by contacting the Deanery directly who will put you through to the relevant person. The standard form can also be found on the BMA website and usually on the relevant NHS Education website.

You will need to provide details of the post, including dates/length of post/whether you wish to count the post towards training, and obtain signatures from your Educational Supervisor and Training Programme Director. Once you have completed the form, return it for approval by the Postgraduate Dean. Ideally a minimum of 3 months notice should be given prior to commencement of the post.

Next you will need to complete a form for The Royal College of Anaesthetists. This is available on the RCoA website document store. For college approval you will also need to provide:
SKYDIVING AND ANAESTHESIA
A vehicle for reflection on human factors?

Much is made of the lessons available to anaesthetists from aviation. Three trainees who enjoy skydiving have been struck by the similar attitudes and non-technical skills required to undertake both parachuting and anaesthesia safely.

The similarities

Anaesthesia and skydiving both require the management of risk. Both have potential for poor outcome due to equipment failure, but, in both, the majority of untoward incidents result from human error. Both specialties have representative bodies that promote a culture of safety and we believe that the attitudes encouraged by skydiving are relevant to anaesthesia.

The importance of drills

Anaesthetists are familiar with failed ventilation drills. These are time-critical, require rapid problem recognition and then the execution of a series of steps during a period of extreme emotional arousal in order to avert a potentially catastrophic outcome. A comparable scenario exists in parachuting: canopy malfunction. Management of a ‘mal’ involves the execution of a drill that cuts away the malfunctioning canopy and deploys a reserve in its place. This requires acknowledgement of a critical incident and a certain amount of thinking clearly under pressure. Canopies are deployed at around 3,000 ft while falling at 120 mph, and so the pressure of time is real! Malfunction drills are learnt at the rate of a skydiver learning how to swim on the ground before their first jump. Skydivers continue to rehearse them regularly and it is common to see jumpers in the aircraft perform a confirmatory touch of the necessary handles. Parachutes are also equipped with an automated device that deploys a parachute close to the ground – an engineering solution to reduce the impact (literally) of human error.

In summary

Skydiving develops a culture of safety, risk management, situational awareness and the ability to perform time-critical drills under pressure. We tentatively suggest that it be included in the curriculum, and that at the very least it should be considered an acceptable use of study leave.

Maj Matt Campbell
ST4 Anaesthesia, Queen Alexandra Hospital, Portsmouth. (90 jumps)

Maj Kate Blethyn
ACC3, Queen Alexandra Hospital, Portsmouth. (650 jumps)

Maj Nick Dennison
ST3 Anaesthesia, St George’s Hospital, Tooting. (100 jumps)

Pay/On-call

Most posts will come with on-call commitments and will have a banding supplement attached to them. For posts without an on-call commitment, you may be able to choose to partake in on-call activities. This can be on a locum basis, or you can negotiate a fixed on-call commitment with the department.

How you are paid for this variable – you may need to complete a locum for each month and be paid for hours worked, or you may be able to opt to retain a banding supplement. The banding supplement will depend on the frequency and timing of on-call, and if you can opt to follow a similar pattern/frequency as other fellows with a fixed on-call commitment, it will be clearer what you should be paid. However, if you opt for more or less on-call, then, if you are working in the UK, your exact pattern of working may need approval to ensure that you remain EWTD compliant and to determine what your supplement should be. If you are employed outwith the NHS, the way you are paid for your on-call can vary. You may need to complete additional forms from HR/payroll to enable on-call pay through the NHS Trust. Some institutions, e.g. a university, may pay your on-call along with your basic salary then claim back from the NHS Trust. This will require a bit of organisation.

Pensions

If you are moving outwith the NHS, then it is likely you will be moved to a different pension scheme. In some institutions (e.g. a university), you can choose to opt out of the new scheme and continue to pay contributions into the NHS scheme. In some cases, you will only have 3 months in which to decide this and complete the relevant paperwork. If you choose to remain in the scheme with your new employer, you can carry over any NHS pension you have with the same pension conditions, as long as you do so within 2 years. After this period, you would be moved into whichever is the new NHS pension scheme.

Key Contacts

- Your Educational supervisor and Training Programme Director
- The Postgraduate Deanery
- The Royal College of Anaesthetists
- Human Resources
- Payroll
- Other useful contacts
- NHS pensions website – www.sppa.gov.uk
- BM&A Advice – email support@bma.org.uk

Jolene Moore
ST3G Anaesthesia, Aberdeen Royal Infirmary

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I’d said goodbye to my family and I tried to distract myself by shopping at the airport, but I was still thinking “What have I done and done this time?”. Well, what I’d done was move to South Africa for a year to work in one of their government hospitals as an anaesthetist. I’d spoken to several other doctors who had worked there previously whose stories and advice was invaluable in encouraging me to go, but also in how to go about organising it. I’d like this article to do the same for you, mainly to inspire you, but also to give you an idea of what you would be letting yourself in for if you did choose to seek adventure and experience in South Africa.

Everyone who’s worked in South Africa will have a different story; there are a variety of types of hospital to work in and, as a result, a wide range of experiences are open to you. The rules are that you have to work in a place of need, which usually means working in a rural government run hospital. Having just finished my CT2 in anaesthetics, I had managed my own surgical lists, done plenty of obstetrics, some paediatrics and felt well trained, ready for my venture. I chose to work at a relatively large rural hospital where I could work solely as an anaesthetist, instead of being the surgeon and the casualty officer and the anaesthetist and the paediatrician or whatever combination of specialties they were in desperate need of. Wherever you go, the common experience is the long and frustrating process of completing the relevant paperwork required. The main delay is acquiring membership to the HPCSA, the South African version of the GMC. A company called African Health Services helped me. They ran an on-call system of day shifts, then 24 hour on-calls. The consultant is very knowledgeable and is available to discuss any problems, but as one of my previous UK consultants said, you can’t be in the hospital all the time if you’re on-call 24/7, so you have to rely on your team to perform. This autonomy results in plenty of adrenaline moments, but also the gaining of valuable experience. Probably my biggest drama was a twenty-year-old patient who had been stabbed though the heart over the Christmas period. The trip from casualty to theatres had dropped his systolic from 60mmHg to zero and they came flying into theatre doing CPR. My initial thought was: whatever I do, I couldn’t make him worse. So we got on with it. Dr. Sangoma first, allowing diseases to advance or deteriorate from whatever ‘muli’ (traditional medicine) had been given to them.

As well as trauma, the other big specialty workload is obstetrics. Pre-eclampsia is a common problem in South Africa, often presenting with neurological symptoms or even eclampsia itself. This led to several challenges anaesthetising patients for caesareans, including HELLP syndrome, reduced GO2s and impressive oedema that made spinals a challenge. There were many emergency caesareans, and postpartum haemorrhages. I often had to help with neonatal resuscitation simultaneously. Many women were very anaemic either from acute haemorrhage or late presentation with chronic blood loss. The lowest haemoglobin I saw was 3g/dl. Getting to hospital was a frequent challenge for patients, who had often visited their Sangoma first, allowing diseases to advance or deteriorate from whatever ‘muli’ (traditional medicine) had been given to them.

One difference between South African and British patients was that the Zulus never wanted a general anaesthetic; they preferred a regional technique if possible. A perfect learning opportunity! With our ultrasound machine and willing patients, the trauma list became a day of regional anaesthesia heaven, and with ward nurses stretched, this also provided good post-op analgesia. I managed my own lists daily in Stanger, which allowed me to make all the decisions and develop a route of managing my team, my equipment and preparing myself for any eventuality as I didn’t have skilled ODA’s. In South Africa, an anaesthetic nurse will get your controlled drugs for you in the morning and will hold a facemask on for you, although you can’t guarantee they’ll maintain the airway in the process. If there is an emergency, they won’t have what you want to hand, you’ll need to be prepared for any problems and have any equipment you might want within arms reach. Your will definitely develop an awareness for potential problems and a Girl Guide type ‘be prepared’ attitude.

There was much to learn in South Africa, but there was also an opportunity to teach. Every intern has to complete two months of anaesthesia training before they become community service officers, who are expected to perform anaesthesia for minor surgery and obstetrics. This is a massive responsibility and the consequences of inexperience were highlighted in The Saving Mothers Report 1, which details the 121 deaths related to anaesthesia between 2008 and 2010. Two-thirds of the deaths secondary to spinal anaesthesia related to well recognised complications such as hypotension and high motor blocks. Seventeen deaths resulted from general anaesthesia, of which half were the result of difficult or failed intubation. This does emphasise the importance and responsibility of giving these interns adequate tools, knowledge and training in order for them to become competent.

South Africa is a beautiful place with lots to do, lovely people and very good wine! You will probably also work with other foreign doctors, mostly British and Dutch, who are a self-selected group of people; kind enough to want to help by working in the South African government hospitals, motivated enough to organise it and adventurous enough to do it. Overall, working in South Africa is a great experience and I can’t recommend it highly enough. If you want to get off the training treadmill and gain a valuable experience while having an amazing time, South Africa is for you. Finally, in answer to my initial thought ‘What have I done and done this time?’. Well - I think I made one of the best decisions of my life!

Dr Catherine Harris
ST3, Imperial Deaneay London

References:

I worked in Stanger Hospital, a busy 450-bed district hospital that is referred to by several smaller rural hospitals in the region, mainly providing a service to the Zulu population. On my arrival the busy casualty department was staffed by only three doctors. Chaos! So I was asked to complete a month in casualty. Although this was not casualty department was staffed by only three doctors. Chaos! So I was asked to complete a month in casualty. Although this was not...
Report on the Trainee Forum held at AAGBI Annual Congress, Dublin, 19 Sept 2013

At the recent AAGBI Annual Congress, Irish trainees were given the opportunity to participate in a forum aimed at identifying particular issues facing those participating in anaesthesia training in Ireland. The forum was jointly chaired by members of the CAT committee and the Committee of Anaesthetic Trainees (CAT) of the College of Anaesthetists of Ireland (CAI), and followed on from an article written by Dr Roseita Carroll, outgoing Chairperson of the CAT, and published in Anaesthesia News earlier this year.

Discussions took place among the attendees in relation to their experiences of training in Ireland, and both positive and negative opinions on aspects of our training programme were aired. Particular attention was paid to the nature of training delivery (currently in the form of modular training), and suggestions were made as to how an ideal training programme might deliver appropriate training.

An initial analysis of the discussions has identified a number of themes that arose in the course of the forum. Some of these themes will come as no surprise to those of us who have spent time rotating in departments. Irish trainees feel that there is considerable variability in the quality of mentoring and supervision at different hospitals, including in relation to the training of novice anaesthetists, exam preparation, and assessment of, and feedback to, trainees.

The delivery of training modules causes some issues for trainees. While modules are generally planned at the start of a rotation, service considerations often interfere with adequate exposure to the planned modules. Assessment at the end of modules was felt to be cursory and of little educational benefit.

Trainees have noted that the criteria for eligibility for the Final Fellowship (FCAI) exam has changed with the introduction of the run-through training programme. Trainees must now have entered SAT4 prior to sitting the exam. Differences of opinion were expressed as to whether this change in the regulations was positive or negative.

Positive aspects of training in Ireland

The recent introduction of a run-through training programme in Ireland has been interpreted as a beneficial change to training in this country. Trainees had praise for their consultant trainers around the country, who are generally approachable, supportive and provide excellent training. Irish trainees feels that the CAI staff are friendly and helpful.

Issues to be addressed:

Access to Training Opportunities

In spite of the positive comments made about the Irish training programme, a number of issues were identified that cause concern among the attendees at the forum. The challenge to strike a balance between commitments to service provision and access to training opportunities was one of the most frequent issues mentioned by trainees.

This conflict has been exacerbated by recent difficulties experienced by many Irish hospitals in recruiting sufficient numbers of Non-Consultant Hospital Doctors (NCHDs) - particularly in non-training posts - and the result has been increased pressure on trainees to cover on-call activities and theatre rotes. Training modules are not always being prioritised ahead of service provision in this climate and trainees are worried that full implementation of the provisions of the European Working Time Directive (EWTD) will place further strain on their ability to gain access to appropriate training opportunities in future.

Possible Solutions

With the able assistance of Dr Nancy Redlem, Chair of the AAGBI Welfare and Support Committee, the trainees in attendance sought to identify an ideal training programme that might look.

Nature of Training

Trainees would like to see greater accountability for the provision of training, both at local and national level. The model of Training Program Directors, Educational Supervisors and College Tutors used in the UK was mentioned as an alternative to the Irish system of College Tutors in each hospital with centralised allocation of rotations. Irish trainees feel that there is considerable variability in the quality of mentoring and supervision at different hospitals, including in relation to the training of novice anaesthetists, exam preparation, and assessment of, and feedback to, trainees.

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Training in anaesthesia continues to be associated with a cost to the quality of life of trainees. There is a recognition that training activities are not limited to the hours spent at work, and there is – as one trainee put it – “the inevitability of coming home to work”. Recent media publicity in Ireland has drawn light on the stressful nature of the work of an NCHD, and anaesthesia trainees experience the effects of stress due to long working hours. Uncertainty in relation to the future of fellowship opportunities, career progression into the future and financial stability may also contribute to work-related anxiety.

Other contributory factors mentioned by anaesthesia trainees in the forum included the financial and social cost of moving house and family on a sometimes six-monthly basis, as well as the inconvenience associated with completing paperwork in relation to Garts clearance, occupational health, mandatory training, payroll, etc.

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Trainees have noted that the criteria for eligibility for the Final Fellowship (FCAI) exam has changed with the introduction of the run-through training programme. Trainees must now have entered SAT4 prior to sitting the exam. Differences of opinion were expressed as to whether this change in the regulations was positive or negative.

Access

Trainees would be guaranteed access to modules, which would be protected and prioritised over service delivery considerations. Modules would be assigned appropriate to the experience and requirements of the trainee, and training opportunities would take place in a decentralised, local environment. Trainees could avail themselves of sub-specialty training opportunities abroad in the course of their training. Sub-specialty training could also be provided regionally.

Supervision

Consultants should provide one-to-one coverage on module training lists.

Assessment

Modules would be assessed regularly, in a meaningful and formative way. The efficacy of training would be reviewed on a regular basis.

Competyency-Based Training

A module-based proxy might be replaced by a competency-based approach to training. Training should be structured to ‘fill the gaps’, i.e. to ensure proficiency in all aspects of sub-specialty practice in the course of training. The end product of this training programme should be a competent, confident, consultant-level anaesthetist.

Planned Training

Clear, agreed, planned and guaranteed learning outcomes should be identified at the beginning of any period of training by the trainee and their supervisor. Educational activities should be individualised to meet the needs of the trainees, and should be designed to meet specific end-points rather than be fixed to a particular time limit.

Training Delivery

A modern training programme should make full use of technology to deliver modules and examinations. Remove learning barriers and online educational resources should be used to complement traditional training techniques. Trainees should be encouraged to take “ownership” of their training, however there must be a dual responsibility on the part of trainees as well as trainees to ensure that training is adequate. Training should equip trainees to the practice of anaesthesia in a variety of settings.

Patient Safety

Patient safety should not be compromised by training activities.

The Trainee Forum provided an opportunity for trainees to inform their representatives on the CAT, CAI, on the CAT committee and in the AAGBI as to how they regard the state of anaesthesia training in Ireland. Having identified a range of measures that could be implemented to improve the CAI Anaesthesia Specialist Training Programme, the CAT is determined to ensure that these views are taken into account in the future delivery of training in Ireland. In particular, we hope that the recommendations of the Trainee Forum will be incorporated into the impending update of the Training Regulations of the CAI, in which it is proposed that training will change from a module-based system to a competency-based system.

Mort Kelleher & Colm Keane
Committee of Anaesthetic Trainees, College of Anaesthetists of Ireland
The exhibition honours the work of doctors, especially anaesthetists, in treating injuries caused by wars and terrorist attacks and explores the development of pain relief, paying tribute to those who have been affected by wars and disasters.

Did you know?
- Before 1950, seriously injured people received little or no life-supporting treatment before they arrived at hospital.
- At the Moorgate tube disaster in 1975, 16 out of 18 doctors on site were anaesthetists.
- The earliest recorded use of anaesthesia during wartime is March/April 1847 during the Mexican/American War - less than one year after the first public demonstration.

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Also featured: An interview with Dr Andrew Hartle who treated the victims of the 2007 London Tube bombings and shares his recollections of the aftermath.

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Dr Andrew Hartle

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Guideline Update: NICE guideline No. TA287 (issued June 2013)

Rivaroxaban for treating pulmonary embolism and preventing recurrent venous thromboembolism

Since its introduction in the 1950s, warfarin has been the mainstay of oral management of venous thromboembolism (VTE). Almost 60 years later in 2008, oral rivaroxaban was licensed for VTE prophylaxis for elective hip and knee replacement surgery.¹

In June, NICE released new guidance recommending rivaroxaban as an option for treating pulmonary embolism (PE) and also for the prevention of deep vein thrombosis and PE recurrence in adults. The guidelines state that the drug should be available for prescribing in hospitals and community.²

For the initial treatment of acute PE, the recommended dose is 10mg twice daily for the first 3 weeks followed by 20mg once daily for continued treatment and prevention of VTE.²

The guideline recommends at least 3 months treatment for people with transient risk factors such as recent surgery and longer for those with permanent risk factors or unprovoked VTE.

Rivaroxaban is a direct reversible competitive antagonist of activated factor X (Xa). Factor Xa is the active component of the prothrombinase complex that converts prothrombin to thrombin.¹ (See diagram below)

The pharmacological profile of rivaroxaban has a number of advantages over warfarin; foremost its predictable pharmacokinetics means that it does not require regular monitoring and dose adjustment. Unlike warfarin it has a low potential for interactions with other drugs and diet. Additionally rivaroxaban has a rapid onset within 30 minutes and therefore avoids the requirement for injections of heparin until warfarin takes effect. NICE have based their decision on the results of the EINSTEIN-PE trial which involved 4832 patients. The evidence review group concluded that rivaroxaban is as effective as warfarin in preventing VTE recurrence. The group also concluded that the drugs have a similar rate of clinically relevant bleeding and a similar rate of discontinuation due to adverse events.

Currently no specific antidote to rivaroxaban exists and neither vitamin K nor plasma infusion will reverse its effects. It is unclear as to the best management of clinically relevant bleeding but NICE describes prothrombin complex concentrates and recombinant Factor VIIa as options. The review group went on to highlight that treating a 70kg adult with recombinant factor VIIa cost £19,000 and its effects last just 2 hours.²

Finally, and importantly, the committee concluded that using rivaroxaban appears to be less costly than warfarin (when taking into account the price of INR monitoring).

In summary, rivaroxaban is now licensed for treatment of PE and for VTE prophylaxis. It appears to be cheaper and just as effective as warfarin and has a number of important advantages, particularly the absence of a need for monitoring.

Dr William Packer
ST3 Anaesthesia, Raigmore Hospital, Inverness

References
1. http://www.australianprescriber.com/magazine/33/2/38/41
It occurred to me as I finish three years of part-time research (the other part being clinical work in cardiac anaesthesia and ICU), that this is the difference between doctors and scientists. Doctors are not scientists (regardless of what they might think) and scientists are not doctors. The bottom line is that people expect doctors to know what the answer is. Scientists do not live with this burden. Scientists live with uncertainty, but do not have to use that uncertainty. Doctors do.

The difference between doctors and scientists is the difference between mathematicians and mountain guides. I know several brilliant mathematicians who create mathematical models based on biological data and then test those models in biological systems. This is ‘real world’ mathematics. I also know several mountain guides, none of whom have a degree in mathematics and most of whom don’t have an A-level in mathematics. The mathematicians could work out fairly simply and quickly the forces on three ice screws being used as a belay in a snow gully. But I’d be pretty unkeen to strap myself to any of the mathematicians on an alpine north face being used as a belay in a snow gully. But I’d be pretty unkeen to work out fairly simply and quickly the forces on three ice screws don’t have an A-level in mathematics. The mathematicians could none of whom have a degree in mathematics and most of whom

...and so back to uncertainty and integrating risks. The scientific methods of hypothesis testing and evidence that medicine absolutely key to providing the best treatments to our patients. Without robust, clinical, randomised controlled trials, we would still be using leeches to treat a variety of clinical conditions. However, we must remember that science provides us with experiments under controlled conditions and with data as central tendencies, with spread and error and outliers. We perform a statistical test on the data to see if there is any difference, generating a ‘p-value’ and compare it to our agreed (but based on nothing in particular) standard that we think a probability of the result being due to chance is less than 1 in 20 makes this significant (NB. This does not mean Surely doctors (regardless of what they might think) and scientists are not. The premises that are in your head and with the data as central tendencies and spread. We perform a statistical test with an answer of what is probably the right thing to do. And this is why I have to go and see patients to get the ‘right’ answer and this is why I don’t really know what the ‘right’ thing to do is. Should I give them more fluid, should I give them more blood, more clothing products or should I start noninvasive...or dobutamine...or enoximone. What I have to do is integrate the knowledge I have from population based studies, with their associated errors to come up with an answer of what is probably the right thing to do. This is not a plea to abandon evidence based medicine. Not at all. Without robust, clinical, randomised controlled trials, we would have nothing to base our decisions on. Particularly in anaesthesia and intensive care medicine, we lack large, adequately powered randomised controlled trials to guide us. This is the rub of it.

Patients are becoming more demanding about risk and uncertainty. Emily Oster is a Professor of Economics at the University of Chicago. While pregnant, she wanted a glass of wine on a hen weekend. The advice from all health professionals she saw was that no level of alcohol consumption has been proven to be safe during pregnancy, therefore you should consume none. She was told the same about soft cheeses and cured meats. This was an anathema to an economist who is used to making mathematical trade offs and offsets. Surely this could not be an all or nothing phenomenon. It wasn’t. And Emily Oster set about reading all of the evidence relating to risks and pregnancy...and she wrote a book about it. “Expecting Better”. It turned out that she could have a glass of wine on weekends and friends birthdays with minimal risk to her unborn baby. However, avoiding the ripe, unpasteurised cheeses from the deli counter was probably a sensible idea. She said in a recent interview “the training in medical school is not as suited to integrating this kind of evidence or doing this kind of decision making...as the training I had as an economist”. Medical school doesn’t train you to integrate evidence and offset one thing against another. We do this on a day-to-day basis in our own lives. We do this with evidence for our patients. I’m a big fan of a really good burger and chips, with a lot of cheese on it. I know that fatty burgers with a good dose of cheese does not statistically improve my health. However, I offset this against my misery of never eating a burger again and the relatively small increases in risk to my health of eating a burger about once a month...

...and this is why I have to go and see patients to get the ‘right’ answer and this is why I don’t really know what the ‘right’ thing to do is. Should I give them more fluid, should I give them more blood, more clothing products or should I start noninvasive...or dobutamine...or enoximone. What I have to do is integrate the knowledge I have from population based studies, with their associated errors to come up with an answer of what is probably the right thing to do. This is not a plea to abandon evidence based medicine. Not at all. Without robust, clinical, randomised controlled trials, we would have nothing to base our decisions on. Particularly in anaesthesia and intensive care medicine, we lack large, adequately powered randomised controlled trials to guide us. This is the rub of it.
Efficacy

A review of current literature showed TLT insertion to be highly successful with no significant difference in quality of life at one year between patients receiving TLT or surgical tracheostomy.

Key outcomes included reduced trauma, bleeding, infection and good cosmetic result. This potentially makes TLT a more appropriate technique in patients with coagulopathy and was also noted to be of use in patients with neck masses or altered tracheal anatomy as the airway is easier to find ‘from within’.

References


Summary

TLT may lead to reduced incidence of trauma, bleeding, infection and may be a more appropriate technique in certain patient groups. TLT is still associated with significant complications however, especially in those patients requiring long term airway support due to potential difficulties with tube replacement. There is a lack of familiarity with TLT compared with traditional techniques. NICE advocates that clinicians should receive sufficient specialised training before attempting the technique due to this lack of familiarity and the different skills required compared to the more common percutaneous methods.

Procedure

Translaryngeal tracheostomy (TLT) is usually carried out under general anaesthesia with the patient supine and the head extended. An introducer needle is inserted between the second and third tracheal rings under endoscopic guidance. A guide wire is passed through the needle in a retrograde direction through the mouth and the existing endotracheal tube is replaced with a smaller diameter tube until the procedure is complete, to aid insertion of the TLT tube.

A device consisting of a flexible plastic cone attached to an armoured TLT tube is passed over the guide wire and drawn through the mouth, oropharynx, larynx and trachea until it is brought out onto the surface of the neck via the small incision made by the introducer needle.

Traction is applied to the neck and the guide wire and cone are removed before the TLT tube is rotated 180° so that the distal end faces the carina. Correct placement can then be confirmed by endoscopy, capnography and auscultation.

Complications

<table>
<thead>
<tr>
<th>Complication</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemorrhage</td>
<td>Can occur during insertion or due to erosion through vessel wall.</td>
</tr>
<tr>
<td>Loss of airway causing hypoxia</td>
<td>Generally occurs due to difficulty during re-intubation with smaller diameter endotracheal tube.</td>
</tr>
<tr>
<td>Damage to tracheal wall</td>
<td>Associated with 180° rotation of TLT tube towards carina.</td>
</tr>
<tr>
<td>Infection</td>
<td>Cases of atrial infection were reported.</td>
</tr>
<tr>
<td>Problems with tube placement</td>
<td>Includes; pulling the TLT tube completely out of the neck during insertion, breakage of the guide wire, difficulty in retrograde passage of the guide wire.</td>
</tr>
<tr>
<td>Narrowing of tube lumen</td>
<td>The TLT tube has no inner lumen and subsequently needs to be completely replaced in the case of blockage.</td>
</tr>
<tr>
<td>Embedding of tube in stoma</td>
<td>In patients requiring long term tracheostomy the TLT tube can become embedded in the stoma, requiring surgical replacement or removal.</td>
</tr>
<tr>
<td>Blood gas exchange</td>
<td>Patients undergoing TLT have been found to have a significant decrease in post-procedural PaO₂ compared to the forceps dilatational technique.</td>
</tr>
</tbody>
</table>

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Translaryngeal tracheostomy

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Applications are invited for the role of co-opted Trainee Representative on the Board of the National Institute of Academic Anaesthesia (NIAA). Trainees who hold a National Training Number in Anaesthesia, and are either Academic Clinical Fellows, Academic Clinical Lecturers or are undertaking/have completed an MD(Res) or PhD are eligible to apply.

The appointment will be made for two years or until achievement of CCT in the first instance, with the potential for re-appointment for a second two year term.

The successful applicant will be expected to attend Board meetings and participate in activities to promote and enhance the work of the NIAA and academic anaesthesia in the UK. The trainee representative will also be invited to attend meetings of the Health Services Research Centre’s Executive Management Board.

If you wish to apply, please provide a covering letter explaining why you are interested in the role, a one page CV, and the names of two referees (one academic and one clinical) to the NIAA Administrator, Clare Bunnell.

The closing date for applications is Friday 28 March 2014. Those called for interview will be notified by Wednesday 9 April 2014.

Further information:
NIAA Terms of Reference
www.niaa.org.uk/article.php?newsid=374

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If you require any further information please contact Miss Clare Bunnell, NIAA Administrator, crbunnell@rcoa.org.uk.

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Dr Martin Smith, President of Society for Neurosciences in Anesthesiology and Critical Care, and Honorary Professor in Neurocritical Care, National Hospital for Neurology and Neurosurgery, University College London Hospitals

Dr Irene Osborne, Associate Professor in Anaesthesiology at Mount Sinai School of Medicine, New York City, New York

Dr Wade Smith, Director of the Neurovascular Service, University of California, San Francisco

Professor Fiona Lecky, Research Director of Trauma Audit and Research Network, Consultant in Emergency Medicine

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Dear Editor,

Medial students and obtaining consent: An anaesthetic take on GMC guidance

An incident has recently been investigated at our hospital, which brought to light a few interesting points regarding GMC guidance and good medical practice. I wanted to make all anaesthetists aware of the possible repercussions for many of us may face fairly regularly as part of our practice.

The incident occurred when a supervised medical student performed a procedure on an anaesthetised patient. A recognised complication arose, was dealt with appropriately, and ultimately the patient came to no harm. However, the issue of consent was subsequently raised, as neither the student nor the medical student had specifically obtained informed consent for the student to perform the procedure under supervision, while the patient was under anaesthesia.

After consulting specific guidance from the medical school involved, and referring to the GMC’s guidance ‘Tomorrow’s Doctors’,1 it became clear that guidelines had been breached. It is stated very clearly that the responsibility lies with the supervising clinician, that the patient should be asked if they object or agree to the student being involved and that they are under our care, and if they agree to allowing the student to perform a procedure on them under supervision. The medical student should then introduce him- or herself to the patient before performing any procedure, and may contribute to the consent process, for example by providing information.

While students learn to cannulate veins on awake patients on the wards, it seems less likely that guidelines could be breached. However, the anaesthetic room is a completely different environment. Patients are anaesthetised and under our care, and medical and anaesthetists and surgeons are under time pressures to keep the list running smoothly. It is really the best place to be asking patients if students can perform certain tasks under our care.

Moreover, should the same principles of consent apply to the first patient. Furthermore, should the same principles of consent apply to the first patient. Furthermore, should the same principles of consent apply to the first patient. Furthermore, should the same principles of consent apply to the first patient.

Dear Editor,

We would like to highlight the importance of thoroughly checking airway devices before they are used. A patient presented for minor maxillo-facial surgery under general anaesthesia, for which we planned to manage the airway with a flexible laryngeal mask airway. A Size 3 reusable flexible laryngeal mask (LMA FlexTrach®) was selected, removed from its package and checked for cuff patency. No abnormality was observed (Fig. 1) and induction of anaesthesia was performed. As the foreign body was seen within the proximal lumen (Fig. 2), the LMA was immediately removed and general anaesthesia maintained with sevoflurane by facemask ventilation. Another LMA was checked and inserted without incident, after which surgery proceeded uneventfully.

References


Dr Laurie Cohen Consultant Anaesthetist, Northwick Park Hospital Limited

Dear Editor,

I read Drs Phillips’ and Lamb’s, Cardiac arrest in the prone position, with great interest as I was at the same question to my senior colleagues during our neuroanaesthesia module.

There are several case reports suggesting that prone position should be considered as the optimal choice for CPR in certain limited circumstances, even if the supine position is achievable.1 Such one case described in Case Studies of Near Misses in Clinical Anaesthesia in which the surgeon placed both palms below the lower border of the patient’s scapula with the aim of providing counter-pressure and performed effective chest compression saving his patient’s life in the process. And when counter-pressure is not available, a clenched left fist must be placed under the sternal while the right hand compresses the mid-thoracic spine. CPR would be more effective if performed by two people – one doing counter-pressure and one performing compression. As stated by the authors, Mayer et al concluded that prone CPR generated sufficient mean blood pressures and the presence of an arterial line would be a useful tool to show its effectiveness.

There are many risk factors associated with cardiac arrest in a prone patient, and these include cardiac abnormalities, respiratory compromise, wound irrigation with hypotonic, perioperative blood pressure and occluded venous return.2

Fortunately, cardiac arrest in a prone patient is extremely rare, but we should be confident that CPR in a prone position can work just as well as in a supine position and that should not delay immediate chest compression.

Dr L Jie
ST6 Anaesthesia, North Western Deanery

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References


Dr L Jie
ST6 Anaesthesia, North Western Deanery
A prospective multicentre observational study of adverse iatrogenic events and substandard care preceding intensive care unit admission (PREVENT).

Garry DA, McKechnie SR, Culliford DJ et al.

Human error is an inevitable part of medical intervention, and can have severe consequences resulting in intensive care treatment, as this prospective analysis of 280 unplanned admissions in 5 hospitals over 6 weeks shows only too well. Using NCEPOD-style consensus agreement methodology, four consultant intensivists considered retrospectively whether any adverse event (through omission or commission) in the 7 days before ICU admission fell below and acceptable standard of care, defined as acceptable ‘for (the intensivist’s) relative’, and graded the severity of each event. In 95/280 patients, 149 potential adverse events were examined, consensus eventually identifying 104 events in 76/280 patients, 28 (27%) events directly causing (and 55 [53%] contributing to) ICU admission. Medical events were the most common type of adverse event (39/104 [38%]), most commonly, failure to manage care appropriately (15/39 [38%]) and death (11/104 [11%]) were relatively common outcomes. The authors acknowledge some of the weaknesses of studies such as these, including selection bias and observer bias (would physicians have classified ‘medical’ errors differently to anaesthetists?), but did not comment on the limitations of retrospective consensus analysis at the end of the prospective data gathering period or how 77% of cases were potentially preventable. There is a tendency with studies of iatrogenesis to adopt an ‘isn’t this terrible, something must be done’ tone in the discussion, which the authors have done well to avoid, given that one could interpret their results as indicating that clinical care was apparently faultless in 66-73% of unplanned admissions to intensive care in their study. Nevertheless, that a chain of causation from iatrogenic error to adverse event to unplanned ICU admission to permanent harm/death was apparent for 11-21% of patients in this study gives cause for concern, and reminds readers of their obligation to ensure that the care they provide should always be first and foremost to the standard of primum non nocere.

The properties of an improvised piston pump for the rapid delivery of intravenous fluids.

Smart CM, Primrose CW, Peters AL, Speirits EJ.

Now here’s a clever idea that reduces the problems of quickly and accurately infusing intravenous fluids, emergency drugs and drugs via port-free cannulae. By introducing two one-way valves correctly either side of a three-way tap interposed into an intravenous giving set, the authors of this paper have invented a piston pump: when a syringe is connected to the side-port of the three-way tap, withdrawing the plunger fills the syringe from the fluid bag only; when the plunger is depressed flow occurs into the patient only; when the syringe remains untouched the syringe fills automatically by hydrostatic pressure. Using this pump in vitro, the authors were able to infuse 2000mls (4 x 500ml bags of 0.9% saline) via a fluid warmer and 16G cannula significantly faster than using a pressure bag infuser inflated to 300mmHg (352 v 495 seconds). In a secondary experiment, use of the piston pump was not found to cause turbulence-related haemolysis when blood was rapidly infused. The safety of the pump was further assessed by measuring peak pressures (as high as 635mmHg), which, by reference to other pressure conductions studies, the authors assert would be attenuated downstream, through fluid, tubing and vascular compliance. I tried the piston pump during complex revision arthroplasty soon after reading this paper, and found it to be most effective: like all the best inventions – ingenious, simple, cheap and effective.
This article reviews clinical trials investigating the efficacy of peri-operative gabapentin and pregabalin in acute and chronic post-operative pain. Gabapentinoids exert their neuro-modulatory effects by binding to pre- and postsynaptic voltage-gated neuronal sodium channels. Both drugs appear to be bioavailable; gabapentin has a substantial absorption capacity in the small intestine, whereas pregabalin is absorbed from the duodenum. Both are renally excreted without significant metabolism. They are generally well tolerated, with the most common side effects being sedation, dizziness, headache, and visual disturbances.

Current evidence supports the use of gabapentinoids (particularly gabapentin) peri-operatively to reduce immediate surgical pain. This has been demonstrated in several meta-analyses of clinical trials through reduced pain scores, an opiate sparing effect and increased mobility. Previous assumptions that pre-operative dosing was necessary appear to be unfounded, since research demonstrates efficacy of gabapentinoids in established post-operative pain.

There have been just two studies directly comparing gabapentin and pregabalin. Both studies found improved pain scores and analgesic sparing effects in comparison with placebo, but neither showed a significant difference between the two.

Few clinical trials have attempted to identify the optimum dosing, but there does appear to be more significant efficacy with higher doses of post-operative gabapentin (900–1800 mg daily). However, the evidence for gabapentinoids is conflicting. We conclude that gabapentinoids are effective in reducing immediate post-operative pain and opioid consumption. Gabapentinoids appear also to be effective in reducing chronic post-operative pain. However, higher-powered longer follow-up clinical trials are required to definitively test this. In addition, further work is needed to delineate the optimal timing of pre-operative and post-operative dosing, investigate side effect profiles, and compare the two gabapentinoids.

The authors state that current evidence is sufficient to recommend the use of 1200mg of gabapentin or 300mg of pregabalin over 2 hours pre-operatively for patients at risk of developing severe acute pain or prolonged pain, and continued at doses of 600mg TDS for gabapentin or 100mg TDS for pregabalin.

Dr Olav Bjerve
Clinical Research Fellow in Intensive Care, Chelsea and Westminster Hospital

References
2. Ozgencil E, et al: Perioperative administration of gabapentin 1,200 mg/day and 1,800 mg/day on pain after thoracic spine surgery: a randomised, double-blind, placebo-controlled trial. Clinical Research Fellow in Intensive Care, Chelsea and Westminster Hospital

Delirium is a neuropsychiatric disorder defined by acute confusional and alteration in consciousness that fluctuates through the day. In the intensive coronary care unit, delirium is a common disease affecting 30% of patients. It has significant implications for patient outcomes with those affected at three times more likely to die at six months, than those unaffected. The most commonly used drug to treat delirium is haloperidol but life exists of its efficacy and safety. The study was designed to assess whether early treatment with haloperidol would decrease the time that survivors of critical illness are in delirium or coma.

Methods
This single centre prospective double blinded randomised placebo controlled trial at Waltham General Hospital included 142 patients after agreed exclusion criteria. Critically ill patients within 48 hours of requiring mechanical ventilation, irrespective of whether or not they exhibited delirium or coma, were randomised to haloperidol 2 mg 8 hourly. The study was demonstrated from a National Survey evaluating common dosing regimens of haloperidol for ICU. Presence of delirium was assessed using the CAM-ICU® questionnaire. The intervention was discontinued after two delirium free days, 14 days of treatment or ICU discharge. Primary outcome was delirium or coma free days 14 days post randomisation. Secondary outcomes measured included agitation assessed with Richmond Agitation Score.

Results
Using a Blizzard rank coefficient for non-parametric data and the intention to treat principle, no significant difference in days without delirium or coma (P=0.16) were found between the intervention and placebo group. Of the secondary outcomes, patients in the intervention group had a significantly lower Richmond Agitation Score than the placebo group (13 [9.7-17.5] vs. 20 [15.26-27]) (P=0.007). Despite this, during the trial, 18 patients in the placebo group and eight in the intervention arm required open label antipsychotic drugs for agitation.

Discussion
The study’s authors suggest the results show haloperidol has no effect on either coma or delirium. However, it did demonstrate a significant reduction in agitation, one of the study’s secondary outcomes. In the study’s secondary outcomes was used as both primary analysis and treatment of delirium not making it possible to derive a significant treatment benefit in these patients subsets. It would appear that while the placebo group receiving antipsychotics, the study was contaminated and might not be sufficiently powered to detect a difference between the two groups.

Thomas Carter
ST3 Anaesthesia, Chelsea and Westminster Hospital

Dr Marcella Vareczkipdi
Consultant Anaesthetist and Intensive Care, Chelsea and Westminster Hospital

References
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Trainees - submit abstracts for Oral/Poster Presentation

Have you booked your place at the GAT Annual Scientific Meeting taking place in Newcastle on 11-13 June 2014? Trainees can submit an abstract for oral or poster presentation. Deadline for submission is 17 March 2014.

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www.aagbi.org/safety/incidents-and-alerts

Learn@AAGBI – use this resource for your appraisal
Learn@AAGBI offers lots of CPD content and the opportunity to complete a reflective learning template on and store it as part of your completed CPD within the site. This is available to AAGBI members only. You need your membership number and password to access the platform. Contact members@aagbi.org if you need these details.

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Regional Anaesthesia and Patients with Abnormalities of Coagulation
Published by
The Association of Anaesthetists of Great Britain & Ireland
The Obstetric Anaesthetists’ Association
Regional Anaesthesia UK

Call for abstracts
Dingle 2014
16th Current Controversies in Anaesthesia & Peri-Operative Medicine
Dingle, Co. Kerry, Ireland
15th-17th October 2014

£950 + VAT. Any requests for acceptance will be made as published in your newsletter prior to the abstract deadline of 18th July 2014.

Trainees with abstract accepted for poster presentation will be entitled to a £50 discount on registration and we will also fund travel. Abstracts will be peer reviewed by peer reviewers on presentation. Paper awards will be judged by the conference’s own peer reviewers.
www.aagbi.org/education

GAT ASM 2014
Trainees - submit abstracts for Oral/Poster Presentation

Have you booked your place at the GAT Annual Scientific Meeting taking place in Newcastle on 11-13 June 2014? Trainees can submit an abstract for oral or poster presentation. Deadline for submission is 17 March 2014.

We have a great educational programme lined up for trainees and first year consultants including lectures, problem based learning, workshops, exam streams and the established Wylie Lecture which will be delivered by Dr Kevin Fong... Not to be missed!

Additionally we have planned:
• Fun social events including the Annual Dinner to be held at The Assembly Rooms
• Professional development opportunities including mentoring, consultant interviews, posters and prizes.
• Parent & baby room with live streaming of conference lectures.

www.gatasm.org

For breaking news and event information follow @AAGBI on Twitter

New guideline
Regional Anaesthesia and Patients with Abnormalities of Coagulation
Available to download at: www.aagbi.org/publications/publications-guidelines

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GAT ANNUAL SCIENTIFIC MEETING

NEWCASTLE
VENUE: NEWCASTLE CIVIC CENTRE

Abstract submission available
Deadline 17 March 2014

BOOK ONLINE TODAY!
WED 11 - FRI 13 JUNE 2014

www.gatasm.org

ANNUAL CONGRESS
17-19 SEPTEMBER 2014
HARROGATE
HARROGATE INTERNATIONAL CENTRE

Programme coming soon

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