SE Thames Regional Meeting – 18 September 2008
Guy's & ST Thomas Hospital
Centre for Postgraduate Professional Education

In Attendance

Prof Stephen Jackson	Kings College Hospital
Dr Adrian Hopper	GSTT
Dr Paul Reynolds	Maidstone, and Tunbridge Wells NHS trust
Dr James Dennison	Conquest Hospital
Dr S. F. Mukhtar	Lewisham Hospital
Dr Catherine Slide	St George's Hospital,
Dr Jonathan Birns	GSTT
Dr Paula McAvinia	GSTT
Prof Cameraon Swift	Kings College Hospital
Dr Olivia Martinovic	GSTT
Dr William Fitzpatrick	Darent valley hospital
Dr Thiru Rajeevan	Maidstone Hospital
Dr Conn Sugihara	Princess Royal University Hospital, Bromley
Dr Jugdeep Dhesi	GSTT
Anna Whittle	GSTT
Debbie Ramsay	GSTT
Dr Umasankar	Princess Royal University Hospital, Bromley
Dr George Noble	Maidstone and Tunbridge Wells NHS Trust
Dr Kalman Kafetz	GSTT
Dr D. Casarotto	Brighton
Dr Tak-Yan Li	Maidstone Hospital
Dr Mehool Patel	England Council
Dr Aza Abdulla (AA)	secretary, Princess Royal University Hospital, Bromley
Dr Finbarr Martin (FM)	Chair, GSTT
Dr Rebecca Shiff	Guy's Hospital
Dr D. Sivapathasuntharam	Brighton Hospital
Dr I R Thomson	King's College Hospital
Dr M Yeung	Queen Mary's Hospital
Dr J. Milton	Maidstone Hospital
Dr T.A. Ernest	Guy's Hospital
Dr R. Yadav	University Hospital of Lewisham
Dr B. Chan	St Thomas' Hospital
Dr Jonathan Porter	

APOLOGIES FOR ABSENCE

Dr M Chellapah	Pembury Hospital
Dr Kevin Kelleher	Queen Mary's Hospital
Dr Stuart Bruce	Conquest Hospital
Dr Martin Jones	Brighton Hospital
Dr Nicola Gainsborough	Brighton Hospital
Dr Michael Jenkinson	Queen Elizabeth Queen Mother Hospital
Dr Roger Lewis	Guy's Hospital

Educational Meeting

Session 1

SpR Abstract Session

1. Community Acquired Pneumonia (CAP) in the elderly: Are we following guidelines?

Catherine Slide & S Suman, Medway Maritime Hospital

Introduction: This audit was carried out at a large DGH in Feb 2008 where CURB-65 scoring was formally incorporated into the hospital CAP antibiotic prescribing guidelines in July 2007. British Thoracic Society guidelines regarding CAP state that severity assessment is the key to planning appropriate management

Aims:

- Is CURB 65 being used to assess severity of CAP in the elderly?
- Where used, is CURB-65 scoring correct and clearly documented in notes?

Methodology: A pro forma was devised and data gathered from 50 sets of notes from patients over age 75 presenting with CAP in Jan-Mar 2007 and 50 patients over 75 presenting in Oct-Dec 2007.

Results:
Is CURB 65 being used to assess severity of CAP?

- Used in 6% patients in Jan-Mar increasing to 24% in Oct-Dec.

Where used, is CURB-65 scoring correct and is the criteria clearly documented in notes?

- Where used, only correctly scored in 25% in Jan-Mar this increased to 40% in Oct-Dec.
- In all other cases it was underscored, underestimating the severity of the CAP.
- Documented clearly in 75% & 80% cases

Recommendations:

- Reiterate correct use of CURB-65 criteria.
- CURB-65 proformas inserted into notes of patients over age 75 with CAP.

2. End-of-Life Care within Elderly Care Unit, St. Thomas' Hospital

Before & After Introduction of the Liverpool Care Pathway - **Completing the Audit Cycle'**

Paula McAvinia. & Rebekah Schiff, *St Thomas' Hospital*

Introduction: The Liverpool Care Pathway provides guidance on end of life care mainly focusing on symptom control, discontinuation of inappropriate interventions and anticipatory prescribing of medications. It also provides comfort measures and offers care of the family (both before and after death)

Aim
To audit care in the last few days of life, before and after the introduction of the LCP
To determine the impact of the LCP
To identify what needs to be improved

Method
- Retrospective Case Notes Audit
- Pre-LCP implementation: Data from 05/03/07 – 05/06/07
- Post-LCP implementation: Data from 01/12/07 – 29/02/08

Results

	Before LCP	After LCP
No. of deaths	32	45
Notes reviewed	29 located 3 missing	38 located 7 missing
Numbers included	23 (1 no notes, 5 sudden deaths)	24 (14 sudden change/ treatment) *3 possible for LCP*

Conclusion:
Despite the limitations of the audit (retrospective, inability to access all notes, not all LCPs looked at as some were stopped), there was an overall improvement. However there is need for better communication with families and team work through further training.

3. Stroke Survivors Preference for long-term review after stroke. A pilot study.

MGG Soliman & DG Smithard, Richard Stevens, Stroke Unit, William Harvey Hospital - withdrawn

4. Survey of hospital admissions from bed-based intermediate care (IC) wards

Olivera Martinovic, Beryl Chan and Rebekah Schiff. Dept Ageing and Health, 9th Floor North Wing, St Thomas' Hospital, SE1 7EH

Aim; To determine the frequency and characteristics of hospital admissions from bed-based IC wards in Lambeth. To identify potential need for change in practice by referrers or within IC.

Design; People admitted to hospital from two IC wards over a seven month period were identified. Data concerning their admissions to IC and hospital admission/s were obtained from IC notes, summary admission documents and hospital electronic discharge letters (EDLs).

Results; 149 people were admitted to the IC wards during the seven month period. 27 (18%) were admitted at least once to hospital. These 27 patients had an average of 6 co-morbidities, 79% had been admitted from hospital and 21% from home. Median stay in IC

ward prior to transfer to hospital was 11 days (range <1 to 115). Reasons for hospital admission: Progression of pre-existing illness (12); New illness (7); Planned admission (1); Premature hospital discharge (2); Iatrogenic (1); Unknown (1).

Conclusion; About one-fifth of IC patients were admitted to hospital. The majority of admissions were for people with multiple co-morbidities with severe inter-current illness that required hospital intensity monitoring and treatment. A minority of admissions could have been prevented; 2 were transferred inappropriately early from hospital and 1 could have been managed in IC.

5. Secondary Screening for Low Bone Density in Men, Using DEXA scan, following a Fragility Fracture

Nadeem Aftab and D Hargroves, William Harvey Hospital

Introduction: Low bone density is an increasingly recognised problem in men. The national health and nutrition examination survey found that 6% of men have osteoporosis while 47% men are osteopenic over the age of 50 years (**Calcif Tissue Int.** 2001 Oct; 69(4):218-21. **Kanis JA *et al***). The objective of this study was to look at the prevalence of low bone density in men, between 50-75 years old, based on the outcome of DEXA scan, following a fragility fracture **(neck of femur, radius or vertebral)**.

Methods: 206 consecutive DEXA scans carried out at East Kent Hospitals NHS trust (3 sites) in 2007 were analysed. Hologic discovery A machine was used to measure bone density at hip and neck of femur. WHO Study Group (1994; 843: 1-129) categories were used to categorize the results into three groups; **Normal** (T-score above -1 in hip or spine); **low bone mass/osteopenia** (T-score between -1 and -2.5); ***osteoporosis*** in one or both sites (T-score below -2.5)

Results

Total Number of patients = 206		
Normal **(T score > -1)**	**Osteopenia** **(T score -1 to -2.5)**	**Osteoporosis** **(T score < -2.5)**
n= 98 (47.57%)	n= 82 (39.80%)	n= 26 (12.62%)

Conclusions: Osteoporosis/osteopenia are common among men who have suffered a low impact fracture. We suggest screening for osteoporosis in men, between 50-75 years old, following a fragility fracture.

6. Pitfalls of Falls: an illustrative case

Conn Sugihara & Aza Abdulla , Princess Royal University Hospital, Bromley Hospitals NHS Trust

An elderly female presented with recent unsteadiness, double vision, headaches and vomiting. She was fully independent but had become increasingly unsteady. 2 years previously she was diagnosed with poorly differentiated serous papillary cystadenocarcinoma for which she underwent palliative surgery and 6 Cycles of Carboplatin-Paclitexel.

She was seen at Royal Marsden Hospital a month earlier with headaches and had an MRI Brain which was reported as normal.
Investigations showed normal brain imaging but a mild lymphocytosis and positive antineuronal antibodies (anti-Yo, anti-Ma1) in CSF
Paraneoplastic cerebellar degeneration was diagnosed. Further chemotherapy was started with rapid resolution of symptoms but recurred within the following month, despite CT and CA-125 evidence of good response. 2 months later she **fell** and sustained humeral fracture.
The case illustrates the importance of thorough assessment in all patients with falls. The discussion was concluded with an **update on Paraneoplastic syndromes**

7. Audit of service change in fractured neck of femur care

Rohini Yadav & E Aitken, University Hospital of Lewisham

Background: Following the RCP 'National Clinical Audit of Falls and Bone Health for Older People', to improve the management of patients with fractured neck of femur patients UHL conducted a process mapping exercise leading to service change. Patients, who had previously been managed by orthopaedic teams with input from elderly care as required, were now admitted directly under elderly care. Management involved a shared care approach peri-operatively with daily ortho-geriatric input at middle grade, and orthopaedic review where necessary.

***Aim*:** Re-audit against the RCP audit. Parameters included; time to operation, falls assessment, bone assessment, pre-operative physician assessment, length of stay, and patient satisfaction

***Method*:** Retrospective notes audit of all admissions following the change in service (approx 80 patients).

***Results*:**

- Decreased mean length of stay
- Increased pre-operative assessments
- Increased falls assessments
- Increased bone assessments
- Increased number discharged to previous place of residence
- Good patient feedback
- No formal complaints
- No improvement in time to theatre,

***Conclusion*:** Overall care and assessment of these patients improved, however problems still exist with time to theatre.

On conclusion of the SpR presentation session, the members adjourned for a short tea break following which Business meeting was convened (see below)

Session 2

Invited speakers

Speaker 1: Ms Rachel Bell – vascular surgeon ST Thomas hospital

Modern Management of Aortic Aneurysm

Ms Bell presented an interesting lecture on the recent advances in the management of aortic aneurysm and minimally invasive endovascular repair and indications for intervention. She discussed the different types of aortic aneurysms particularly infrarenal and, management and the use of fenestrated grafts. Ms Bell then gave an overview on the results of the two endovascular repair trails (EVAR1 & 2 Trials) and showed her centre's experience and results.

Speaker 2: **Dr Vivienne Mak, Consultant Psychiatrist for all Older Adults, Department of Liaison Psychiatry for Older Adults, St Thomas' Hospital.**

How to run an effective hospital liaison old age psychiatry service

Dr Mak gave an illuminating presentation about the practice they have set in place in Guys and St Thomas' for old age psychiatry liaison service, what they do, and the input they provide. She started by illustrating the aims of the service, and proceeded to give an overview of how the service functions in practical terms explaining how it is accessed, and the treatment they offer.

The winner of the SpR abstract presentation is Dr Olivera Martinovic for her abstract entitled Survey of Hospital Admissions from Bed-Based Intermediate Care (IC) Wards

Business Meeting

The business meeting took place between the 2 sessions of the educational meeting.

MINUTES OF PREVIOUS MEETING

The minutes from the last meeting on the 18 September 08 at KCH were reviewed and acknowledged by those present as a fair record of the meeting. There were 2 outstanding issues from the previous minutes *(under suggestions for future meetings)* which were brought forward for further discussion

1. updated statements from BGS compendium which need to be highlighted
2. review of recent NICE guidelines but also other National guidelines which were relevant to Geriatrics and of particular interest to both trainees and consultants

It was felt that part of the educational meeting should be allocated to this, perhaps through presentations by the SpRs. Unfortunately there was little support to the suggestion from the trainees. A suggestion was put forward by FM to have the host hospital prepare a short presentation on a specific topic, either based on a new BGS compendium or a new NICE clinical guideline.

NEW MEMBERS/APPOINTMENTS
Two recent consultant appointments were noted; Dr Faheem Mukhtar at Lewisham hospital and Dr Jonathan Burns as Stroke physician at GSTT hospital. It was noted that Dr Anne Blackburn at KCH was retiring in September 08. Dr Paula McAvina was welcomed as member of the BGS Region.

Brighton Hospital will be advertising for at least 2 new posts in Geriatrics in the near future (SpRs - watch this space !!)

BGS REGIONAL ADMINISTRATION
Finbarr Martin (FM) was congratulated on his election for post of president elect for the BGS. FM thanked everyone for their support and announced that he will be demitting the office of regional chair in due course.

The financial position was read out. It was noted that the balance of our SE region (as of 31 August 08) was £ 5,460.73. Following a short discussion on how best to utilize our funds, it was agreed that the funds we have in place were not enough to support grant applications in the long-term. A suggestion was made by AA to increase the prize of the SpR presentation from £50 to £100 which was agreed by most members.

REPORT FROM THE BGS ENGLAND COUNCIL MEETINGS
Dr Patel provided a written summary of the council meeting dated 4th June 08 (attached). He also gave those in attendance a run through several of the important items notably the position of England Council on KBA and the CME journal. A discussion then took place about the benefits and use of the journal by members.
It was highlighted that Clinical Practice and Evaluation Committee which was previously a subcommittee of the Academic and Research Cttee of the BGS was now a standing committee in its own right. The plan is to change its name to Clinical Standards Committee.

FEEDBACK FROM THE STC AND PLANS FOR FUTURE SpR TRAINING
Carried over to the next meeting
Attending numbers were supportive of Finbarr Martin's suggestion to invite a member of the BGS Training Committee for an update presentation at the next meeting. It was also suggested that it was probably worthwhile for the Regional Training Committee to consider nominating one of its' current members as co-ordinator with our SpR representative, Claire Steves.

SUGGESTIONS FOR FUTURE REGIONAL MEETINGS
It was felt that by having the Business Meeting conducted between the two sessions of the Scientific Meeting guaranteed better attendance especially by the SpRs and it was agreed that future meetings should be conducted in this order.
Action: All Host Hospitals

ELECTION OF OFFICERS TO NATIONAL BGS
Finbarr Martin (FM) was elected for post of president elect for the BGS Finbarr Martin. It was noted that the role of Hon deputy Treasurer will be advertised shortly and AA has expressed an interest.

ANY OTHER BUSINESS

1. BGS and BOA Campaign on fragility fractures and Bone Health –
FM updated members on the results of the national audit on fractures and bone health. He remarked that there was on the whole an element of poor awareness regarding this important problem nationally especially when it comes to secondary prevention. He added that there are plans for commissioning a toolkit for falls and fractures which was aimed for PCT to give some direction and provide clarity on aims and goals. FM added that hip fracture as a specific code will be disappearing in HRG 4 which is procedure based for surgical patients. In addition, there is to be anew "best practice tariff" programme from the DH, with PCTs commissioning higher quality care for hip fractures.
National hip Fracture Database (NHFD) is likely to become a nationally recognized audit tool. The aim is create an interest and focus attention to this important area of care for older people and ensure delivery of good care. Part of this strategy is the creation of networks within regions and interface with SHAs. He also noted that London hip fracture network was already in place. Prof Jackson agreed that this was a good idea especially that the current move is towards regional issues and PCTs may be deciding their own priorities. FM commented that the system once in place it will encourage PCTs to commission services they perceive as important. Obviously quality measures and standards of care to assess outcome will need to be put in place.

2. Proposal for SE Thames Orthogeriatric Network.
The proposal was met with approval. However no decision on how to take this forward was made in this meeting.

DATE OF NEXT MEETING
The next regional meeting will be at Brighton Hospital 19th March 09

This meeting was awarded 4 CMEs