

BRITISH GERIATRICS SOCIETY

SE Thames Regional Meeting – 3 April 2008

King's College Hospital

King's Weston Education Centre, Lecture Room 2
Denmark Hill, London SE5 9RS

Hosted by: Dr Dan Wilson

IN ATTENDANCE FOR THE EDUCATIONAL MEETING:

Dr Balogun	Dr S Burns
Dr A Elmarimi	Miss N Hayes
Dr P Reddy	Dr J Davies
Dr D Wan	Dr V Riley
Dr T Doherty	Dr R Yadaw
Dr N Sengupta	Dr D Ramsey
Dr A Qureshi	Dr T Li

Dr M Chellapah
Dr J Dennison
Dr A Evans
Dr W Fitzpatrick
Prof. Jackson
Dr M Jenkinson
Dr K Pettingale (Retired 2003)
Dr J Potter
Dr P Reynolds
Dr C Thom
Dr D Wilson
Dr E Ekp
Dr Gunathilahuj
Dr A Abdulla

APOLOGIES:

Dr G Noble, Dr N Forseka, Dr S Bruce, Dr M Patel, Dr S Jones, Dr J Hawkins, Dr D Harari, Dr D Smithard, Dr J Hussein, Dr K Kelleher

SPEAKER LECTURES:

The first talk was:

Percutaneous Aortic Valve Replacement – now a definitive therapy? Dr Phil MacCarthy, Consultant Cardiologist at King's College Hospital

Dr MacCarthy gave an informative lecture on Percutaneous Aortic Valve Replacement which is now coming into practice and is especially useful for older people who cannot tolerate open heart surgery. Dr MacCarthy gave an overview of the procedure, the outcome and results for the Centre at KCH.

The second talk was presented by:

Professor Sir George Alberti, National Director for Emergency Accessing/Clinical Director for Service Reconfiguration entitled "Older People and the Reconfiguration of Acute Services"

Professor Alberti presented a concise overview and his vision for the proposed merger of services in the South East sector. He highlighted the importance of incorporating elderly care services in any future models of emergency, acute and elective care within the sector and encouraged all those in attendance to participate actively in formulating the decisions and planning of these services within outer South East London. Attached is a copy of Professor Alberti's review report detailing his plans. **(Appendix 1)**

SpR Abstract Presentations

Determinants of a Positive Response to Carotid Sinus Massage and Head-up Tilt Testing – Dr J Milton, SpR, Maidstone Hospital (A study while at King's College Hospital)

Methods - Retrospective analysis of the database and reports from tests carried out between 1995 and 2006 at a tertiary referral centre. Patients age, presenting symptoms, sex and test result were examined.

Results- Orthostatic hypotension (OH) was present in 402/1583 patients (25.4%), of whom 175 (11.1%) were symptomatic. 188/1464 (12.8%) patients undergoing carotid sinus massage had evidence of carotid sinus hypersensitivity (CSH). Both OH and CSH were significantly more common in men than women (OH male 29.3% vs. female 23.8% ($p=0.025$); CSH male 18.7% vs. female 10.6% ($p<0.0001$)). Both OH and CSH were uncommon in those aged under 60 years (OH 8.5%, CSH 5.3%) and became more prevalent in all age ranges above 60 years (OH 21.9-28.4%, CSH 12.5% to 17.6%). Both OH and CSH were more common in those patients referred with syncope (OH 30.3%, CSH 14.1%), followed by dizzy spells (OH 26.2%, CSH 11.2%) and then falls (OH 23.9%, CSH 10.5%).

Conclusions - Being male, aged over 60 or being referred with syncope all increased the likelihood of receiving a diagnosis of either carotid sinus syndrome or orthostatic hypotension

Nutritional Supplementation Out of Hospital/in the Community – what is the evidence? - Dr E Mucci, SpR, Conquest Hospital

There is a large evidence base for nutritional intervention in acutely ill and post-operative hospitalised patients, but the evidence base for nursing home (NH) residents is small. The prevalence of poor nutrition in NHs is high and baseline nutrition appears to be an important determinant of response to nutritional intervention. Residents with mininutritional assessment (MNA) scores above 23.5 tend to show less response than those with lower scores. This relates in part to failure to increase intake in the better nourished as well as to actual response to increased intake. At the low end of the MNA spectrum, the increasing prevalence of multiple pathologies tends to result in a reduced response, but randomised controlled studies in this group are probably not ethical. Most studies have tended to investigate the intermediate group with MNA scores of 17-23.5 or equivalent using other scales. Interventions have usually resulted in increased intake of calories and micronutrients. Other end points have variously shown responses including weight, immunological measures, infection rates, decubitus ulcers, falls and fracture rates. Many studies have been too small to demonstrate benefit and some are likely to have suffered from type 1 errors-showing benefit by chance. Poorly quantifiable variables likely to be of importance include the local environment and catering as well as pathophysiological variability. Published under the title "Nutritional Supplementation in Community-Dwelling Elderly People" in *Annals of Nutrition & Metabolism* 2008;52(suppl 1):33-37 E Mucci, S.H.D.Jackson

Crisis Intervention of Sub Acute Patients at Day Hospital –

Dr R Rangasamy, SpR, King's College Hospital

Background - The BGS compendium document (2006), recommends that all geriatric medical day hospital should provide Crisis intervention and sub-acute assessment.

Innovation- We looked at the outcome of crisis intervention in a community-based Day Hospital. Data collected from Day Hospital notes and Electronic patient records of patients seen for sub acute crisis intervention from 09/01/2003 to 31/12/2006.

Evaluation - Total of 325 patients were seen, 57 (17.5%) patients admitted, 125 (39%) discharged, 119 (36.6%) followed up as day hospital patients and 24 (7.4%)

referred to other clinics for follow up. The common reasons for referral were dizziness and falls (23.3%), confusion and failure to cope (18.4%) and pain control

(17.5%). There was no significant relation between reasons for referral and the need for admission. Among the 268 patients whose possible admissions were initially prevented, only 32 (12 %) patients were subsequently admitted to hospital in the next one-month from the initial visit. More people were admitted from the group discharged after the first visit as compared to patients followed up in day hospital, (21/125) 16.8% versus (11/119) 9.2%.

Conclusion - Crisis intervention can be effective in preventing possible hospital admission.

We suggest a low threshold for following up patients referred, to monitor the success of intervention to prevent later admissions.

Management of Acute Stroke Patients – experiences from a DGH

Dr K Saha, SpR, Brighton & Sussex Hospital

Introduction: the publication of the National Sentinel Stroke Audit has shown that there is scope for improvement at the District General Hospital level. The objective of this audit was to assess some aspects of the management of stroke patients in our hospital.

Methods: Medical notes of fifty randomly selected patients admitted between January and June 2007 were retrospectively analysed. The specific aspects examined were: use of antithrombotic therapy; performance of CT brain imaging; and time spent on the stroke unit, among others. Comparison was made between results of local audit in 2003, and the results of NSSA 2004 and 2006.

Results

Indicator	2004	2006	2007
% of patients in SU	81%	80%	83%
% of patients >50% in SU	81%	75%	76%
CT scan within 24 hours	84%	60%	86%
Aspirin within 48 hours	85%	65%	80%

The majority of delayed scans (86%) occurred over weekends. The mean time of transfer to SU was 4.1 days (range 1-24).

Conclusions: Better organisation of services is needed to improve NSSA targets.

Investigation, Assessment and Management of Hyponatraemia at the Royal Sussex County Hospital, Brighton –

Dr V Shrivastva, SpR, Brighton & Sussex Hospital

Introduction - Hyponatraemia is the commonest electrolyte disturbance among in-patients. Symptoms are non-specific, and subjective concerns had been observed regarding its investigation and management.

Methods - Retrospective case note study for patients with a serum sodium <135 mmol/l over a 6 month period regarding: investigations, clinical diagnosis; retrospective diagnosis; management; and outcome. All patients with serum sodium <125 mmol/l should have: investigation for SIADH; glucocorticoid and thyroid status assessment; fluid administration appropriate to sodium level and aetiology. Expected standard 100%.

Results – 54 patients studied. Aetiology was multifactorial in 60%. The commonest aetiologies were diuretics (especially thiazides), congestive cardiac failure, renal failure and dextrose infusions. Of the 18 patients with SIADH, retrospectively only 2%

met the accepted diagnostic criteria. Overall 26% died during admission; mortality was linked to aetiology and not sodium concentration.

Discussion - A poor outcome is associated with severe hyponatraemia in the elderly. Areas of concern included: inadequate assessment and investigation; poor fluid management; and poor medication review.

Action plans

- Create guidelines linked to trust Intranet through pathology results system
- All non-medical patients to be assessed by physicians
- Education regarding IV fluids for F1 / 2 training programs
- Include section for biochemistry results on fluid charts

Quadriplegia – Lesson to Learn –

Dr U Umasankar, SpR, Princess Royal Hospital, Farnborough

Case summary

An 89 year old lady presented with a 2 day history of upper back pain and weakness in the limbs. The pain was initially sharp and severe but began to subside after a couple of hours, with some residual mild back ache remaining. The weakness started in the left arm the next day and extended to the left leg, right arm and right leg. She was unable to move her legs on the day of admission and was admitted to AE.

Her PMH included a TIA in 1998, locally advanced breast carcinoma June 2001, initially treated with Tamoxifen for 6 months and later Arimidex. She was also given palliative RT as the tumour was progressing. She developed peripheral arthropathy possibly secondary to arimidex and discontinued. Instead wide local resection was advised as a palliative measure, which she underwent in late 2003. There was further progression of the disease and she underwent mastectomy in June 2006 and was commenced on exemestane 25mg od.

In 2005, she was noticed to have AF and was referred to the Rapid Access Medical Clinic, when she was commenced on warfarin.

On admission she was on ramipril (10mg), pravastatin (40mg), atenolol (25mg), omeprazole (20mg), exemestane (25mg) and warfarin. She lived alone in a bungalow, mobile with a frame, and needed assistance with personal care and shopping.

Neurologically, she was alert and orientated. Both lower limbs were paralysed, hypotonic and areflexic. Both plantars showed a flexor response. Upper limbs were weak with a power 2-3/5. RUL had brisk reflexes and the LUL was areflexic. Touch and pinprick was lost up to T4 segment and in both UL's. position sense was absent and bladder distended.

The clinical diagnosis was acute cord compression, possibly C5 level. Cause - Metastatic disease?

The investigations on admission were:

- INR 4.5
- Hb 10.9
- Renal, LFT, calcium NAD
- MRI spine – epidural bleed with cord compression C3-C7 worst at C6

She was transferred to the neurosurgical unit KCH. Prior to transfer her warfarin was discontinued; she received vitamin K 10 mg IV FFP. Her INR came down to 1.8. However her condition progressed and she died 12 days later.

We will discuss spinal cord bleeds and the risks of anticoagulation, and lessons to be learnt from this case.

King's College Hospital – 3rd April 2008

BUSINESS MEETING

ATTENDED:

Dr E Mucci
Dr C Steves
Dr N Sengupta
Dr K Saha
Dr S Malde
Dr A Andrews
Dr W Fitzpatrick
Dr J Dennison
Professor S Jackson
Dr P Reynolds
Dr J Potter
Dr A Abdulla
Dr D Wilson
Dr F Martin

APOLOGIES FOR ABSENCE

Dr G Noble, Dr N Forseka, Dr S Bruce, Dr M Patel, Dr S Jones, Dr J Hawkins, Dr D Harari, Dr D Smithard, Dr J Hussein, Dr K Kelleher

MINUTES OF PREVIOUS MEETING

The minutes from the last meeting on the 20 September 07 at Conquest Hospital were viewed by Finbarr Martin and acknowledged by those present as an accurate reflection of the meeting.

NEW MEMBERS/APPOINTMENTS

It was noted that Dr Indo Koshi, one of our Regional SpRs, was appointed as an Acute Physician in Brighton.

BGS REGIONAL ADMINISTRATION

The latest statement of our account is attached for information. **(Appendix 2)**

REPORT FROM THE BGS ENGLAND COUNCIL MEETINGS

Dr Patel had given his apologies for the meeting but circulated a summary of the last two meetings for the England Council on the 31 October 2007 and the 13 February 2008. There were also copies of the Minutes for both Council meetings. FM (Finarr Martin) went through the summary and highlighted the issue of Dignity Framework proposed by the Department of Health and the recommendations by England Council. The summary also included information about the Immediate Care Audit which Health Care Commission is planning to conduct nationally. There was also concern of the lack of SpR training on the subject. Further discussion was around the point of getting the right balance between service and dignity, especially in regards to single sex wards and the availability of beds in an acute setting.

(Appendices 3 and 4)

FEEDBACK FROM THE STC AND PLANS FOR FUTURE SpR TRAINING

Dr Roger Lewis, Chair of Regional STC, could not attend the meeting but he communicated that at present there were no plans for change in reconfiguration of the structure of training for SpRs. Dr Claire Steves, representative for the SpRs, had

recently attended the BGS Education and Training Committee meeting and updated members in attendance of the recommendations for the use of assessment tools

training for those newly appointed to ST3 posts. There was some discussion about the exit exam and also certification in geriatrics and acute medicine. Attached is a copy of Claire's report of the meeting (**Appendix 5**).

Professor Jackson commented that he would not be in favour of having specific allocation for roles or responsibilities to a particular year in the SpR training programme but was more in favour of it being non-descript unlike the other specialties. Finbarr Martin commented that orthogeriatrics, as a sub-specialty, is putting in place specifications and identifying work based assessments but this is still work in progress.

Attending numbers were supportive with Finbarr Martin's suggestion of inviting a member of the BGS Training Committee for an update presentation at the next meeting. It was also suggested that it was probably worthwhile if the Regional Training Committee would nominate one of its' current members as co-ordinator with our SpR representative, Claire Steves.

SUGGESTIONS FOR FUTURE REGIONAL MEETINGS

- 1) Finbarr Martin raised the issue of poor attendance at the Business Meeting. Although there has been significant increase in attendance for the Scientific Meeting, which usually happens in the first part of the afternoon of the day of the Regional Meeting, there is usually only a core die-hard members left by the time the Business Meeting starts. It was suggested by PR (Paul Reynolds) that the Business Meeting perhaps should be conducted between the two sessions of the Scientific Meeting, i.e. after the lecture and before the SpR presentation. All those in attendance agreed that this change should be tried out as early as the next meeting.
- 2) Updated BGS compendium statements; it was agreed that Dr J Potter, in his role as Chair of the Standard's Committee at the Royal College, would probably be the best person to act as a vehicle for promoting issues of national relevance for geriatrics, for example, NICE guidelines. Given the importance of these reports, it was felt that presentations on these important issues should be encouraged by SpRs, perhaps one presentation per Scientific meeting.

ELECTION OF OFFICERS TO NATIONAL BGS

Finbarr Martin reminded that the office of President Elect will be coming up shortly and that he intends to nominate himself for the role.

DATE OF NEXT MEETING

Guy's & St Thomas' – 18th September 08