… patients [with an upper gastrointestinal haemorrhage following ACS] are elderly and have a poor outcome despite the prescription of PPI therapy. Shortening the duration of dual action antiplatelet therapy in the elderly should be considered…

… In this pilot study [in 6 centres of flexible sigmoidoscopy as part of the bowel cancer screening programme] overall uptake was only 44.1%….

… The eportfolio is currently structured around a curriculum. A more patient-centred eportfolio could address its aims whilst retaining its valued content…..

… There is no difference in clinical care or preventability of death based upon the time of day or day of week that patients are admitted to our acute medical unit…..

Abstracts of the meeting held on Saturday, 7 November 2015 at South Tyneside District General Hospital
INCIDENCE AND OUTCOME OF GASTROINTESTINAL BLEEDING FOLLOWING ACUTE CORONARY SYNDROME

JL Hulley, PD Higham
Northumbria Healthcare NHS Trust.

Dual anti-platelet therapy (DAPT) for 12 months following an acute coronary syndrome (ACS) is recommended by NICE but carries a risk of bleeding. The incidence and outcome of patients who have an upper gastrointestinal (UGI) bleed whilst taking DAPT is not known. We studied readmission rates with UGI bleeding and subsequent outcomes, including PPI use, in 585 ACS patients admitted in 2012. 12 (2%) were readmitted with a diagnosis of UGI haemorrhage within 12 months of their ACS. Nine were male with a median age of 82 years; 3 female with a higher median age of 90 years. Lansoprazole 30 mg daily had been prescribed for 8 of the 12 (66%). Four were not on a PPI. Seven (58%) died (mean age 85). In those taking a PPI the mortality rate was 50% (4 of 8) and in those not taking a PPI the mortality rate was higher at 75% (3 out of 4). 227 of the 585 who suffered an ACS were 80 years or older. Nine of these were admitted with haemorrhage of whom only two survived.

Conclusion: The risk of readmission with UGI haemorrhage in the first year following an ACS whilst on DAPT is low (2%). However, patients who are admitted are elderly and have a poor outcome despite the prescription of PPI therapy. Shortening the duration of DAPT therapy in the elderly should be considered.

REPEAT CHEST IMAGING FOLLOWING AN EPISODE OF COMMUNITY ACQUIRED PNEUMONIA

B Pippard, R Jain
South Tyneside District Hospital

The British Thoracic Society (BTS) recommends a repeat chest radiographs at 6 weeks following an episode of community acquired pneumonia (CAP) for those at increased risk of underlying malignancy, particularly smokers and those over 50. We audited patients with a new diagnosis of CAP, excluding those aged less than 50, those who died within 6 weeks of initial imaging, those already known to have a diagnosis of lung cancer, those with a presentation consistent with a hospital acquired pneumonia, and those with an alternative diagnosis on review of patient records (e.g. pleural effusion). 97 patients were identified as having a radiologically confirmed diagnosis of CAP. Of these, 69 patients (71%) had repeat chest imaging performed at the recommended 6 week interval. 1/69 was identified as having an underlying lung cancer. Repeat imaging was performed by chance in 11/69 after readmission to hospital. 28 of 97 patients (29%) failed to have repeat imaging performed within the 6 week period. In 4 of these cases, there was a legitimate explanation for not having repeat imaging (e.g. not felt clinically appropriate).

Conclusion: A quarter of patients with CAP did not have repeat chest imaging performed as per BTS guidance. Clarification of clinical responsibility for ensuring appropriate patient follow up may help address this issue.

ARE WE MAINTAINING STANDARDS FOR OESOPHAGEAL VARICEAL HAEMORRHAGE PRIMARY PROPHYLAXIS IN PATIENTS WITH CIRRHOSIS?

C Johnson, S Todd
Freeman Hospital, Newcastle-upon-Tyne Hospitals

Variceal haemorrhage is associated with significant morbidity and carries a mortality of up to 50% per episode. 90% of patients with cirrhosis develop oesophageal varices over 10 years. In January 2015 the British Society of Gastroenterologists released updated guidelines suggesting patients with cirrhosis need screening for oesophageal varices at the time of diagnosis with an OGD, the results of which dictate the frequency of subsequent OGDs and prophylaxis. This audit looked at how closely clinical practice adheres to these guidelines. Of 111 patients with cirrhosis in the study, only 59% had an OGD at diagnosis, with 43% of those failing to have further screening OGDs. 21% of patients never had an OGD. Where varices were found, 98% were on correct prophylaxis, though there was little evidence of propranolol up-titration. There was little difference in the results between those with alcohol-related, viral-induced, non-alcoholic steatohepatitis, and other causes of cirrhosis.
Conclusion: We are not following the guidelines as regards initial and subsequent screening OGDs. However, once varices are identified, the correct prophylactic management is initiated in the majority of patients.

“BOWELSCOPE” SCREENING - RESULTS FROM PILOT SITES
LJ Neilson, R Bevan, C Nickerson, J. Patnick, R. Loke, BP Saunders, J Stebbing, R Tighe, A Veitch, CJ Rees, South Tyneside District Hospital and others

A UK study of single flexible sigmoidoscopy (FS) in patients aged 55-64 with referral for colonoscopy where high risk features were present, demonstrated a reduction in colorectal cancer (CRC) incidence by 23% and CRC mortality by 31% in intention-to-treat analyses. This provided the rationale for a new arm of the Bowel Cancer Screening Programme (BCSP), offering a single FS to all 55 year olds in England, known as BowelScope. This was introduced to 6 pilot sites in May 2013. It is to be rolled out across the country by 2016. In this pilot study overall uptake was only 44.1%. 1 cancer was detected. Mean adenoma detection rate (ADR) was 9.2% (range 7.6-11.1%). The mean number of colonoscopy conversions was 4.2%. Mean complication rate was 0.1%, including bleeding, discomfort, difficult polyp excision and unwell patient. There was wide variation in entonox use.

Conclusions: Uptake remains lower than for the FOB arm of the BCSP, and varies between sites. The ADR is lower than reported in the FS screening trial (12.1%).

EXPLORING FOUNDATION DOCTORS’ EXPERIENCES AND PERCEPTIONS OF INCIDENT REPORTING THROUGH THE USE OF HERMENEUTIC PHENOMENOLOGY
Dr Basil James Richard Monks
Durham University

This study aims to explore the experiences and perceptions of Foundation Doctors working towards incident reporting. Ten Foundation Doctors participated in individual, in-depth, semi-structured interviews. These were digitally recorded then transcribed verbatim. Interview data was subsequently analysed using a phenomenological approach. Nine themes emerged which characterised the cohort’s experiences and perceptions of incident reporting practice: 1) The role of incident reporting in learning, improving practice and patient safety; 2) the incident form as a barrier; 3) feedback; 4) the consequences of incident reporting; 5) the relationship between the severity of the incident and the need to report it; 6) blame culture; 7) misappropriation of incident reporting system; 8) the influence of experience on subsequent incident reporting practice and 9) the differences in practice between doctors and other healthcare professionals.

Conclusions: Foundation doctors appeared broadly supportive of incident reporting for facilitating improvement in organisational and patient safety. However, the narratives describe how many of the well-recognised practical and cultural barriers to incident reporting influenced perceptions within the group.

SURVEY OF JUNIOR DOCTOR ATTITUDES TOWARDS THE FOUNDATION PROGRAMME EPORTFOLIO 2015
T Tabiner, ST Wahid, South Tyneside NHS Trust

The Foundation Programme eportfolio is used as the sole means of assessment at Annual Review of Competence Progression (ARCP). This survey reviewed doctors’ attitudes towards the eportfolio to better understand why some doctors do not engage with it. The survey asked first for the doctors’ views on whether the eportfolio met fundamental aims, and second, their views of specific content within it. An anonymous online survey was sent to 52 F1 & F2 doctors working at South Tyneside Foundation Trust. The response rate was 85% (44 respondents). 64% felt they had not improved as a doctor by utilising the eportfolio; 77% felt it had not led to better patient care; 77% did not feel it provided an accurate reflection of their clinical competence; 61% felt that the eportfolio did not provide accountability for unsafe doctors. However, between 70 – 75% found Case Based Discussion, Clinical Evaluation Exercises and Direct Observation of Procedural skills useful or extremely useful. 77% found Clinical Supervisor Reports useful or extremely useful. 89% found Multi-
source Feedback useful or extremely useful.

**Conclusion:** The eportfolio is currently structured around a curriculum. A more patient-centred eportfolio could address its aims whilst retaining its valued content.

**MORTALITY REVIEWS IN AN ACUTE MEDICAL UNIT: THE IMPACT OF CONSULTANT INPUT, TIME OF DAY AND DAY OF WEEK**

Tahir Hayat, Shaz Wahid  
South Tyneside District Hospital

All deaths on the Emergency Assessment Unit are reviewed using standard methodology. We present more than 5 years data reviewing all deaths using the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) grading system and preventability of death assessed by the HOGAN classification. 316 deaths were reviewed between March 2010 and September 2015: 184 (58%) males; age range 31-105 years. Top 5 causes of death: pneumonia (49%); sepsis (39%); cancer (34%); COPD (29%); IHD (25%). 81% of patients had had consultant input and 19% registrar input. No deaths were definitely preventable. 7 (0.02%) patients had less than satisfactory care, with majority having good care. Consultant input vs registrar input did not affect the NCEPOD grade (p=0.07), whilst the HOGAN grading showed preventability of death was more likely with consultant input (p<0.01). There was no statistical difference in NCEPOD grade or HOGAN classification comparing: weekday vs. weekend (p=0.28 and p=0.07, respectively); in-hours vs. out of hours (p=0.81 and p=0.29, respectively).

**Discussion:** There was no difference in clinical care or preventability of death based upon the time of day or day of week that patients were admitted to our acute medical unit. We identified consultant input was associated with an increase in the chance of preventability of death, but this did not take into account the case mix.

**TRAVELLING ABROAD WITH CYSTIC FIBROSIS (CF)**

R Miller, L Blanch, S Lenaghan, L Blanch, A Anderson, S Doe, SJ Bourke  
Royal Victoria Infirmary

We undertook a study to identify the extent to which CF patients were travelling, looking at any limiting factors and what difficulties and medical problems had arisen abroad. Of 100 patients studied 96 had travelled abroad. They travelled frequently and extensively. Their mean age was 25 (range 17-48) years; mean FEV1 was 67% predicted (range 23-135%). Only 14 now limited travel due to health reasons, but 18 travelled without any travel insurance and 23 without insurance for their CF. Many patients limit travel to Europe and rely on the European Health Insurance Card. 25 patients reported that they were subjected to delays and extra searches at airports due to medications and nebuliser equipment. Many reduced or stopped physiotherapy, nebulised treatments and nutritional supplements while abroad. 10 patients had experienced a CF-related illness abroad (7 exacerbations of CF lung disease, 2 dehydration and 1 pancreatitis); 6 consulted a doctor and 3 required a brief admission to hospital.

**Conclusions:** Patients with CF are travelling often and widely. They experience some delays in security checks at airports and have substantial issues relating to travel insurance. Travel was generally safe with few serious medical problems. As with other chronic diseases, travel advice is an important aspect of management.

**THE NHS BED CRISIS AND THE IMPACT OF DISCHARGE PLANNING**

Nicola Wyatt, Jennifer Hamilton, Kilimangalam Narayanan and Clive Kelly  
Queen Elizabeth Hospital, Gateshead.

We conducted a prospective audit of all admissions to one medical ward over a 28 day period in January 2015. We collected data on whether an expected date of discharge (EDD) was set within 24 hours of admission, length of stay (LOS) and reason for (any) delay in discharge once the patient had been deemed medically fit by their consultant. 91 patients were admitted and discharged with a median age of 66 (18-96) years. Half were female. An EDD was set in 46%. Discharge was delayed in 15% of those with an EDD and in 40% of those without (p=0.015). LOS was shorter in those with an EDD than in those without (4.9 vs 7.9 days) p=0.029. This equated to 102 lost bed days in one month on one ward, costing £28,000.
Reasons included poor planning, delay in social services and patient anxiety.

Conclusions: We failed to establish an EDD in over half of admissions. This should be improved as the evidence supports shorter length of stays and less likelihood of delays in discharge in patients with an EDD.

NARROW BAND IMAGING OPTICAL DIAGNOSIS OF SMALL COLORECTAL POLyps IN ROUTINE CLINICAL PRACTICE

PT Rajasekhar, J Mason, A Wilson, H Close, MD Rutter, B Saunders, J East, R Maier, M Moorghen, C Rees
Northern Region Endoscopy Group and others

Narrow Band Imaging (NBI) assisted optical diagnosis was compared with histological diagnosis in a prospective, blinded calibration study in adults undergoing routine colonoscopy in 6 general hospitals in northeast England. Participating colonoscopists (N=28) were trained using the NBI International Colorectal Endoscopic (NICE) classification. Test sensitivity was determined at two thresholds: presence of adenoma and need for surveillance. Determinants of accuracy of characterising adenomas <10mm at polyp level were also evaluated. Of 1688 patients recruited, 723 (42.8%) had polyps <10mm with 567 (78.4%) having only polyps <10mm. Test sensitivity (presence of adenoma, N=499 patients) was 83.4% (95%CI: 79.6% to 86.9%). Test sensitivity (need for surveillance) was 73.0% (95%CI: 66.5% to 79.9%). Both were below the recommended 90%. At polyp level, test sensitivity (characterisation of an adenoma, N=1620 polyps) was 76.1% (95%CI: 72.8% to 79.1%). In fully adjusted analyses, test sensitivity was 99.4% (95%CI: 98.2% to 99.8%) if ≥ 2 NICE adenoma characteristics were identified.

Conclusion: NBI assisted optical diagnosis cannot yet be recommended for application in routine practice. The variation in test accuracy observed may be related to polyp characteristics or colonoscopist training.

AUDIT OF THE INITIAL ASSESSMENT, BASIC COUNSELLING AND APPROPRIATE REFERRAL OF PATIENTS PRESENTING WITH A FIRST EPISODE OF SEIZURE

Nick Jones, Will Hinchliffe
Northumbria Healthcare trust

This retrospective audit of 75 patients presenting with suspected first seizure found ECG formed part of the initial investigation in 77% of cases, eye witness accounts of events were sought in 76%, and some form of neuroimaging was undertaken locally in 71% of those to be considered for referral to specialist clinic. Of those undergoing neuroimaging, 20% underwent MRI head with or without a preceding CT. There was a referral rate of 94% for patients in which specialist clinic review was indicated. Provision of patient safety advice was evident in 22% of cases and provision of driving advice was documented in 45% of those involving known or potential drivers.

Conclusion: Important areas for improvement were in the counselling on safety measures to be taken in the event of seizure recurrence and provision of information about driving and the legal obligation for discussion with the DVLA. In addition, there should be more widespread use of 12 lead ECG and detailed eye witness accounts to avoid the mislabelling of syncope as seizure. The use of MRI head as a first line investigation in the place of CT when available should be considered in order to reduce cost, patient radiation exposure, clinic waiting times and the delay to final diagnosis.

IMPROVEMENT IN ADRENOCORTICAL FUNCTION FOLLOWING ACTH ANALogue (SYNACTHEN) TREATMENT OF AUTOIMMUNE ADDISON’S DISEASE

Earn H Gan, Anna L Mitchell, Beverly Hughes, Petros Perros, Steve Ball, Andy James, Richard Quinton, Shu Chen, Jadwiga Furmaniak, Wiebke Arlt, Simon HS Pearce
Newcastle University, Newcastle upon Tyne and others
Adrenal cortical cells undergo continuous self-renewal under the influence of ACTH. We aimed to determine if synthetic ACTH analogue could revive adrenal steroidogenic function and ameliorate autoimmune Addison’s disease (AAD). We performed an open-label trial of synacthen in adults with established AAD for more than 1 year. In phase I, depot synacthen 1mg was administered subcutaneously alternate days for 10 weeks. In phase II, participants were randomised to either a continuous 24h infusion, or overnight 12h pulsatile synacthen. Dynamic testing of adrenal function was performed every 5 weeks. Twelve subjects were treated for either 10 (n=2) or 20 weeks (n=10). One participant withdrew after 5 weeks. Serum cortisol and aldosterone levels remained under 100nmol/l in 10 of 12 participants. However, 2 participants both with detectable baseline serum cortisol (219 and 179 nmol/l) achieved peak serum cortisol concentrations >400nmol/l, after 10 and 29 weeks of synacthen therapy, respectively; allowing withdrawal of replacement medication. One of them remains well 42 months after stopping all treatments. The other participant had a gradual reduction in serum cortisol and aldosterone concentration, hence steroid therapy was recommenced at week 64.

**Conclusion:** This is the first study to demonstrate that established AAD may be amenable to a regenerative therapy. We have also shown that AAD is a heterogeneous condition in terms of residual adrenal function, and that identification of patients with residual steroidogenesis is an important priority for future therapies.

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**Guest lecture**

**CARDIAC DEVICES – A WIRELESS FUTURE?**

Dr Mickey Jachuck, Consultant Cardiologist South Tyneside NHS Trust

Since the first cardiac pacemaker was implanted in 1958, the principles of pacing have changed very little. But wireless technology now plays an integral role in many aspects of our lives today, and is increasingly being adopted by cardiac implantable electronic device (CIED) therapies. These include pacemakers for bradycardia, cardiac resynchronisation therapy (CRT), implantable cardioverter defibrillators (ICDs), and implantable cardiac monitors (ICMs).

Using a wireless transmitter in the patient’s home, similar to a broadband router, electrophysiological data from an implanted device can be sent via the global system for mobile communications (GSM) network to a secure server, which can be accessed by the patient’s cardiology team. Information relating to device function, cardiac rhythm and heart failure diagnostics can be viewed in real time. This reduces the need for patients to attend hospital for routine visits, and allows for earlier detection of problems which may require specific device programming changes or other treatment. Studies have shown that remote follow up is cost effective without any adverse impact on patient outcomes, and is associated with improved patient satisfaction.

The leadless pacemaker offers several advantages over the conventional pacemaker. Devices such as the St Jude Nanostim and Medtronic Micra are the subject of ongoing trials – though the data so far is promising. These devices are small enough to be securely implanted directly into the right ventricle via a transfemoral approach, with an estimated battery life of 10-15 years. At present, only single chamber pacing is available, although future developments may offer multi-chamber leadless pacing.

CIED therapy is at an exciting stage of development. Just as the smartphone has revolutionised telecommunications, fundamentally changing both how and what we communicate, the next few years may well see similar advances in the ways that we manage diagnostic information in patients with implanted devices.
Association Business

Date of next meeting:
The provisional date for this is Saturday March 6th 2016 at University Hospital of North Tees.
Refreshments and buffet supper will be provided free of charge. Three hours CME approved.

Abstracts for poster or oral presentations from consultants, trainees and medical students are all welcome. Presentations should reflect the full range of clinical medical practice including original research, clinical series, audit and case reports. Please submit by email (around 250 words including a short conclusion) before 24th January to the secretary clive.kelly@ghnt.nhs.uk.

A generous legacy has enabled us to increase the value of the Margaret Dewar prize for the best junior doctor or medical student’s presentation. There is now an annual prize of £150 for the best oral presentation of the year, £100 for the runner-up and £50 for the best poster.

We have had three exceptional submissions this year for the Dewar Research Prize from Earn Gan, Jayant, Karkala and Abigail Sharpe. This year’s prize will be shared between them. We congratulate them all and look forward to this year’s Research Prize submissions.

We are keen to encourage all consultants and specialist registrars to join the association. Please e-mail the names of any new consultant colleagues or your own name if you are not already on the mailing list to the secretary. Also a big welcome to all medical students. We would love you to attend, present your research and join the Association.

Lastly, do look at the web site of the Association on http://anep.co.uk/ which contains details of future meetings plus back numbers of the Proceedings over the past 10 years and other issues relating to the Association.

We hope to see you in March