bida JOURNAL

THE JOURNAL OF **THE BRITISH INTERNATIONAL DOCTORS' ASSOCIATION**
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Fixing behaviours, health and the NHS

Inside:

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Editorial

Mr Amit Sinha FRCS (Tr&Orth) Consultant Orthopaedic Surgeon Media & Communication Lead, BIDA Editor, BIDA Journal.

New Year's Honours List

It is such an exhilarating news to recognise that our BIDA President, Dr Chandra Kanneganti has been included in this year's Honour's list to receive the CBE for his services to General Practice. His contributions have been manifold towards the community of Stoke-on-Trent as a GP offering clinical and management services, as a Councillor and a Mayor, and taking centre stage for BIDA, and other organisations: RCGP, the BMA and the GMC. We take pride in his achievement.

New Year – Time of hope

New Year is a time of optimism for the future. We seek to remain happy and positive in our own lives Unfortunately this year has seen continued political and economic turmoil in the world, which has affected all of our lives. The constant TV news footage of conflict is unnerving and brings a picture of doom and gloom. I was surprised to know that "The Geneva Academy" estimates that there are currently more than 110 conflicts on-going. The situation in Gaza and Israel is a humanitarian tragedy of lives lost, and ruined, by violence. Let us hope, a solution is eventually found that after so many years of warfare and violence in Israel and Palestine, that the desire for peace can be heard and acted upon in the coming year.

New Year - NHS

The NHS is facing an "existential threat" because of years of under-investment, serious staff shortages and the demands of the ageing population, according to a group of leading doctors and NHS leaders. It's an unending list of issues, which will continue to beleaguer the functioning of the NHS. Is this the tipping point? Should the next government, whosoever comes in power consider doing a national poll and ask the public's opinion and to do what they can to help save it?

A recent article in the BMJ indicated that record numbers of patients are being denied timely cancer treatment. This was by a commission of experts assembled by the BMJ, as new figures show that since 2020 more than 200,000 people in England have not received potentially life-saving surgery, chemotherapy or radiotherapy within the NHS's supposed maximum 62-day wait. The NHS target is that 85% of cancer patients should receive their first treatment within 62 days of being urgently referred by a GP. International research shows that every four weeks of delay in receiving treatment can lead to a 10% increased risk of dying from the disease. In my view, this is a "National Emergency".

Industrial strikes

I am afraid the government has not taken any positive step to implement workforce changes with respect to their pay demands nor helped in any way to take measures which improve staff well-being and workload nor to consider increase resources. Patient backlogs through the winter pressures have made things worse and left doctors feeling over-worked and with limited resources to deliver care

Earlier this week, it was announced that trainee doctors will be balloted on industrial action in Northern Ireland and the longest ever medical staff strike in the history of the NHS, six days of withdrawal of labour by junior doctors in England, came to an end. As a Royal College, we have continued to urge respective governments across the UK to implement workforce changes, particularly measures that improve staff wellbeing and workload. Patient backlogs, and what appear to be perpetual winter pressures, have left doctors feeling over-worked and with limited resources to deliver care.

The cost to the NHS of the industrial strikes has been calculated to be more than £1.5 billion. The cost of delayed operations, scans, and procedures, rearranging clinics and providing cover during the strikes could ultimately mean that figure could double.

BIDA once again urges the NHS Employers, the government and the BMA to work together to resolve the disputes in the interest of patients and our doctors.

Pharmacy First Scheme

This new scheme is a valuable initiative aimed to enhance patient access to healthcare. It is now in action as the initial point of contact. They can offer advice and supply NHS medications for seven common health conditions.

Pharmacists can help with over-the-counter medications and minor illnesses, but they cannot diagnose more complex conditions. The issues are whether this has been advertised well enough for all patients to be aware of this flagship programme. The other issue is that there are bound to be conditions, which may be beyond the scope of their expertise. These patients will be referred to the GP surgery for urgent appointments. This will create cause problems for the GP surgery to accommodate them in their already busy schedule.

Articles

Prof McNally's article of "Fixing behaviours.." focuses on improving team working in the NHS by Equality and Diversity training, acknowledging unconscious bias, by learning the skills to value every person and value every moment and cultivating the health of the nation by paying attention to preventative medicine.

The concept of Cardio-metabolic medicine is almost another specialty dealing with complexities of a number of provoking factors working together. The article by Dr Mbagaya highlights these extremely well. The conversation between Dr Kaushik and Mr Sharma poses thought provoking idea of "funeral services" in the context of preserving a cleaner environment.

It was such a pleasure to interview Prof Narinder Kapur for this edition. His life suggests dedication and commitment and innovative ideas.

BIDA can boast of another highly successful International Congress 2023. We look forward to the next one.

Amit Sinha

Editor, BIDA Journal

Instructions for Authors

BIDA Journal is a peer-reviewed journal. We welcome original articles from physicians and surgeons, medical students from any part of the world. These include review articles, scientific articles, case reports, audits and letters to the Editor. Each submission would be peer-reviewed and then discussed by the members of the Editorial committee at a meeting prior to publication and then either accepted for publication or rejected by the Editor.

Proofs of the edited paper are emailed to the corresponding author for correction and to respond to any queries from the Editor. Once the article is published the authors would receive a free PDF version of the journal. The printed copy would be sent to the author if requested for.

Manuscript guidelines

1. Review articles do not have a word limit but all other submissions would have a limit of 4,000 words or less.
2. We only accept papers that have 5 authors or less. Please list only those authors who have positively contributed to the article.
3. Papers should be divided into headings, which are relevant to whether it is a review article, scientific article or case support etc.
4. The conclusion should be clear and relevant to the work described in the article. Do not repeat the introduction.
5. References in the text should include only those are important and have been studied in full by the authors.
6. It is expected that each article should have a take home message wherever relevant. Please write a brief text or learning points, which should be put in a box as a take home message to explain the relevance of the article.

References

1. References should only be used for published work.
2. For case reports it is preferred to have less than 10 references unless deemed essential for the text.
3. They should be presented using the Vancouver system by superscript numbers in the order of the appearance and not in alphabetical order.
4. The list of the references at the end of the text should be with details and punctuation as follows:
   - List names and initials of up to 3 authors after which you could add et al.
   - There should be space between words up to the year after which no spaces.
   - The Journal title should be in italics and preferably in the abbreviated form as it appears in Pub Med. If the journal is not Pub Med index linked then put in the whole name.

Examples:

Journal Reference:

Phillips AM, Wiliams DJ. Ultrasound and the diagnosis of metabolic disorders. J Metabolic dis 2013;95-B:1 – 5.

Book reference:

Watson-Jones R. Fractures and joint injuries. Vol. 2. Fourth ed. Edinburgh: Churchill-Livingstone, 1955:744-5.

Chapter in a Book:

Wilson RA, Frank VH. Complications of implant use.
In: Epps CH Jr, ed. Complications in ENT surgery Vol.1. Philadelphia: JB Lippincott Company, 1978:99 – 129.

Web reference:

International commission on radiological protection.
http://icro.org (date last accessed 20 September 2009).

Abstract reference:

Sinha L. DVT in Shoulder surgery [abstract]. BOA Congress, 2011.

Figures

Please include as many figures as it is relevant to the article but you must ensure that you split the figures into separate images, as they will need to be uploaded individually. Each figure would require a short description. For x-rays, please ensure that you state the view used for that radiograph. The figures should be numbered as 1, 2 and 3 separately.

Tables

We do accept as many tables as it is relevant to the article. Each table should have a short descriptive heading or legend. Tables must not duplicate information already in the text.

Acknowledgements

These should be made onto a separate page at the end of the text.

Submission

Once you have read the guidelines and are ready to submit your article please ensure all elements are included in the same document. They are to be sent to the BIDA office or the Editor. The email address is as follows:

office@bidaonline.org

amitani2000@yahoo.co.in

1. On a separate page with the articles heading please include the details of all the authors, their designation and their place of work.
2. The author who submits the article must include his/her email address for further correspondence.
3. Once the article is accepted then it is the Editor who would be asking for photographs of the lead author, which will be uploaded and printed with the article in the journal. Please ensure that these photographs are in JPEG format.

Letters to the Editor

We do welcome letters to the Editors on matters of general medical concern, the NHS or about any recently published article. To submit letters please write directly to the BIDA office or the Editor – all letters should be under 300 words.

Copyright agreement

If the paper is accepted for publication it is to be accepted by the authors that they are bound to an assignment of copyright. The articles become the property of BIDA Journal.

Conflict of Interest

A conflict of interest statement (if applicable) should be submitted by the author/authors to the Editor for any article, which is accepted for publication. This statement would have no bearing on a decision whether to publish or not to publish.

Amit Sinha FRCS (Tr&Orth)
Editor, BIDA Journal *Date: 15.01.2024*

National President's Report

Dear Friends,

I hope all members had a good New Year's Day along with their families. We have been actively campaigning for BIDA member's interests and issues in the last few weeks.

On a personal note, I am both humbled and honoured to have received a C.B.E. in the New Years Honours. I would like to dedicate my award to all the hard working international doctors in the NHS who have contributed enormously to patient care for many years.

Thanks to our Junior Doctor Chair, Dr. Sai Pillarisetti's guidance, our BIDA Student Wing conducted an excellent National Conference on 20th January, which was attended by international medical students from various medical schools. I spoke in this conference about our organisation's work and history. Thanks to all BIDA SW officers for organising this.

We also had an amazing BIDA International Conference in Vietnam and tours of Vietnam and Cambodia after that. My special thanks to conference scientific chair Dr. Sanjay Arya and conference coordinators Dr. Ashish Dhawan and Dr. Leena Saxena for their excellence in organising this.

BIDA has continued to work hard on getting a time-line for implementing Prof Singh & Prof Forde's recent report recommendation by the GMC. I have also been selected as Interim Chair for Centre for Race Equality in Medicine, which is a new organisation to support race equality issues, particularly with our key stakeholder, GMC.

Please continue to encourage Junior Doctors and Medical Students to join BIDA and to participate in the number of campaigns and educational programs we are organising.

Dr Chandra Kanneganti
National President, BIDA.

G.P. Forum Chairperson's Report

Dear Members,

NHS GP practices in the UK are currently facing a crisis, with unprecedented pressures that threaten the very fabric of primary healthcare services. Financial constraints, increasing patient demand, and a dwindling workforce have pushed many practices to the brink, compromising their ability to provide essential care and forcing some to consider drastic measures such as reducing staff or shutting down entirely. This situation underscores the urgent need for significant investment and support to ensure that GP practices can continue to serve their communities effectively.

The British Medical Association's GP England committee has issued a critical warning about the dire state of general practice, highlighting that the current government offer of less than 2% increase in funding is vastly insufficient. The 1.9% uplift in the national GP practice contract is deemed inadequate to prevent the reduction of services or the complete shutdown of practices. This comes against the backdrop of a survey revealing significant concerns about the viability of nearly two-thirds of GP practices in England, with many facing severe financial strain and contemplating staff cuts to remain operational. Despite ongoing discussions with the government, the current contract offer for 2024-25 is unlikely to provide the needed stability, hope, or safety for the profession. The committee points out the irrationality of adhering to outdated budget lines amid soaring inflation, emphasizing the need for substantial investment to avert the closure of practices, potential unemployment for GPs, and compromised patient care. The situation underscores a pressing need for cost-effective proposals and solutions to sustain general practice amidst these challenges.

At a meeting on 1st February, GPC England has unanimously instructed its leadership team to continue talks with the Government and NHS England to address its concerns, and intends to put the final contract offer to a referendum vote of members on March 1st.

Thank you for all your support and please vote in the referendum when it comes out on 1st March .

Dr Preeti Shukla *Chair, BIDA G.P. Forum*

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National Chairman's Report

Dear BIDA Members,

A very happy New Year to you and your loved ones. I hope you had a relaxing time with your families during the Christmas Break. As you are well aware the Government's pay offer has been narrowly rejected by consultant colleagues. I am hopeful that BMA and DoH can engage in a meaningful dialogue. I am sure we can reach a mutually agreeable deal.

Those of you who travelled with us for the 14th BIDA International Congress in Vietnam and Cambodia must still be reminiscing in the wonderful educational and cultural memories of the amazing conference. I must congratulate all the organisers of the Educational Congress and Full congress on this stupendous effort. On behalf of BIDA, I would also like to extend a huge thank-you to our tour operator Bolton Travel, without whom this would not have been possible.

It gives me immense happiness to share that BIDA's Executive Committee has decided to organise 15th International Congress towards the end of this year. Our tour agents Bolton Travel and convenors are working on the itinerary. Please keep an eye on your email for further updates.

The current edition of BIDA journal once again has a perfect mix of various medical fields that ensure there is something to read for everyone.

Dr Ashish Dhawan *National Chairman, BIDA.*

Postgraduate Doctors' Forum Report

Dear BIDA Members,

It has been another eventful few months for the BIDA Postgraduate Doctors Forum!

Since industrial action started just over a year ago, we have heard from many IMGs who have been wrongly advised by members of their department/managerial staff that they would not be allowed to strike as they are on IMG-specific contracts or because the Trust is sponsoring their visa. These arguments are all unfounded and it is concerning that this issue has been so widespread.

To tackle this misinformation and raise awareness, the BIDA PG Forum has led a series of online webinars - in collaboration with the BMA - aimed at dispelling these myths and empowering PG doctors with accurate information on their right to strike.

The events were very well received, and the North-West webinar especially, which was led by a key member of our BIDA PG Doctors Committee – Dr Alisha Maini (FY1 in Wigan). This session was also co-chaired by Dr Vivek Trivedi who many of you may recognise as Co-Chair of the BMA JD Committee who is leading the effort for full pay restoration at the BMA. We are thankful to them and all the other BIDA & BMA members across the UK who have contributed towards this effort.

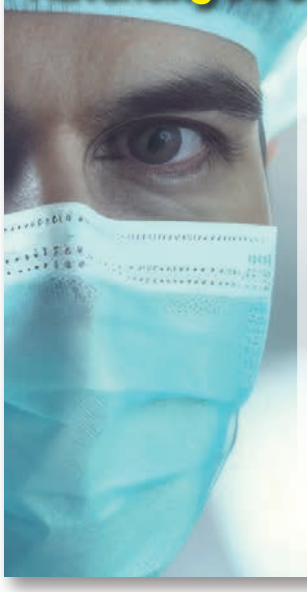
The 'Beauty in Diversity' Charity Initiative we launched in 2020 to raise money for charity and promote diversity themed artwork in hospitals & GP surgeries across the UK has made more progress, with the artwork now being displayed across all 3 sites of the Liverpool University Foundation NHS Trust (LUFT). The framed paintings and a BIDA Information box have been displayed prominently across all sites. We were honoured to have the Acting Lord Mayor of Liverpool, Mr Richard Kemp CBE, unveil the artwork alongside LUFT Chief Medical Office Dr Jim Gardner.

Since founding the BIDA Student Wing 4 years ago, it has been a privilege to continue to advise & support the committee through my role as Chair of Trustees. Our most recent 2024 BIDA Student Wing Conference (virtual) was a resounding success and welcomed 180+ student delegates from 25+ medical schools across the UK - Renee has more to say on this with an article in this edition of the BIDA Journal!

Warmest regards

Dr Sai Pillarisetti *Chair, BIDA PG Doctors' Forum*

Advancing the Surgical Workforce: 2023 UK Surgical Workforce Census Report



The report published on 18 January paints a stark picture of a surgical workforce working long hours and in stressful environments.

The main findings showed that:

- 56% of respondents cited that access to theatres was a major challenge and this was specifically cited by 61% of all surgical trainees.
- 50% of respondents across all career grades indicated that they have considered leaving the workforce in the past year.
- 61% of respondents cited that burnout and stress is the main challenge in surgery – due to excessive workloads.
- 64% of the 55-64 age group of consultant surgeons plan to retire in the next four years.
- Surgery remains a popular career choice, however, 52% of all surgical trainees reported a lack of adequate time for training.
- 47% of respondents said they believed that 'system challenges' had an impact on their ability to deliver their work – such as balancing clinical work with managerial responsibilities.
- 67% of consultants always or frequently work beyond their contracted hours.
- 42% of respondents did not take their annual leave entitlements in the past year.

Fixing behaviours, health and the NHS

Prof Scarlett McNally FRCS (Tr & Orth), MA, MBA Consultant Orthopaedic Surgeon President, Medical Women's Federation

I was delighted to be invited to speak at the excellent BIDA conference in Wigan in 2023! I spoke about women in leadership, but I feel this links together multiple other concepts needing tackling to get through the huge pressure that the NHS and its workforce, especially doctors, is under.

I have been a Consultant Orthopaedic Surgeon for 21 years, and got an MBA 10 years ago. Leadership is about the vision, listening, amplifying and developing; management is about ensuring processes work effectively. Right now, it feels that what we doctors lack is time. We don't have time to deliver perfect care, to look after each other or to create change. That's why I have argued for more postgraduate training posts for doctors – it is crazy that we turn away over half the doctors who apply for some specialties, including Emergency Medicine and Geriatrics [1]. Also, in my Trust, we created a new role of 'Doctors' Assistant', at Band 3, trained up from HealthCare Assistants, doing admin and basic clinical duties [2,3]. We won awards for this and proved they freed up doctors' time [2,3]. This supporting role is needed everywhere.

We need time for three things: firstly, improving behaviours; secondly, ensuring good general health and thirdly, sharing key skills and team-working so that every patient's journey is better. I suggest that our historical expectations limit us. In the 1990s, when I was a registrar, we were expected to operate all night if there were operations to be done. The only surgeons who survived training were those who could cope with sleep deprivation. Also, continuously fighting to prioritise our surgical patients made us demanding or scary. Some specialties were ridiculously competitive [4, 5]. This meant people modelled themselves on those already there and thought they were being helpful by demanding their narrow idea of perfection from all involved. None of us is perfect every day over a forty-year career. Many people still think this way, even though work was limited to 48 hours per week since 2009, operations limited to life-or limb-threatening at night since CEPOD [6] in 1997, and humiliation is proven to have worse outcomes for staff and for the patient [7].

Improving behaviours

I think mandatory NHS Equality and Diversity training may have made things worse. It was designed with lawyers, to stop people mentioning a candidate's turban or pregnancy at an interview, to prevent the organisation being sued. This is fine for equality or a summative assessment – there is a standard to the exam or interview. But this approach makes diversity worse. If someone is on your team, you have a duty to support them to be the best that they can be. Ask and listen, perhaps away from stress or others. Their uniqueness might need acknowledgement, practicalities, details, phrases, welcome or facts. For example, the British Orthopaedic Association has a comprehensive guide to pregnancy in surgeons [8]. A supervisor only needs a general awareness and can signpost this when needed. Another practical example is the #TheatreCapChallenge whereby named reusable cloth theatre hats can be compatible with hijab-wearing or Afro hair and the embroidered name helps team-building [9]. Techniques for diversity mean staff feel included and belong, but to my mind are the opposite of the narrow teaching about equality. Leadership that values different perspectives means the organisation survives shocks better.

WHY and HOW to improve behaviours, acknowledging unconscious bias

To get change needs WHY and HOW. 91% of women doctors reported sexism in a large recent BMA survey [10]. This is from supervisors, other staff and patients. This means: being assumed to be the nurse, being talked over, not given the assistance required and not being 'tapped on the shoulder' to apply for higher roles. The Kennedy review showed microaggressions in surgery and a worse experience for women and people from minority ethnic groups [11].

We all have unconscious bias. When I was on the council of the Royal College of Surgeons of England, I wrote my college's 2016 booklet 'avoiding unconscious bias – a guide for surgeons' [12]. Our brains are wired to make instant assumptions about what we expect someone to do. I believe many senior surgeons or doctors bully by mistake – because they don't have the skills to deal with people who appear different. Bullying is how the victim feels, not what was intended. We need robust reporting mechanisms, but these can be prolonged and painful. So, we also need prevention. Skills to embrace diversity can be learnt. The key is to treat each person with respect. It helps to set a minimum standard and an aspirational standard. We should be very clear about expectations and listen if there is some reason a supervisee cannot meet these. We also need some skills as active bystanders, to interrupt and stop bad behaviour. For example, "you can't say that" or "let's focus on the patient"; the Association of Anaesthetists recommends 'declare or distract' eg "I notice you are stressed, is there anything the team can do to help?" [13]. Following up after an incident, us senior staff should be prepared to have a "cup of coffee" conversation in private [14]. The Royal Australasian College of Surgeons reports great success with this [14] and has a free app we can all use [15].

I am currently President of the Medical Women's Federation. Women in general tend to be different from men in general. It is OK to make general assumptions about women's experience (for example that more women than men will work part-time). But it is important not to assume than any individual woman will fit the stereotype. Some processes need to change. There are still too few women in medical leadership roles. Part of the problem is the leaky pipeline, with too few applying for middle-ranking roles, so we lose talent. These roles seem set up to fail. They often occur when the burden of child-rearing that falls more heavily on women is most intense. We should argue for role-shares, deputy roles, administrative assistance and adequate time/money remuneration in these early/middle roles to promote better, more diverse leadership talent. This is a small cost for hugely

impactful leadership in an organisation with immediate and future benefits.

Health in general

We all pay lip service to prevention. Yet we assume it is someone else's role, or that it is too late. The NHS seems built to do tests with the expectation of an intervention. Yet 14% of operations have a complication, 14% of patients regret going ahead with surgery and 14% of older people decide against an operation after a 'Shared Decision Making' consultation with a geriatrician [16]. Preparation for surgery can reduce the risk of complications by around 50% [16]. As surgeons and doctors, we need to make clear recommendations, eg "go for a walk every day" or "stopping smoking will halve the chance the graft will fail"; we can learn motivational interviewing in a few minutes from www.movingmedicine.ac.uk and encourage other staff to do this and 'Making Every Contact Count training. I led the Academy's 2015 'Exercise the miracle cure' report highlighting that exercise reduces dementia, depression, diabetes and bowel cancer by 30% or more – and getting started is simple [17]. It is often a 'teachable moment'. After my own diagnosis of Myeloma and cardiac amyloidosis five years ago, I got an electric-bike, and rode daily, to be fit enough to be eligible for a stem cell transplant in 2020, not just the standard chemotherapy. (I'm doing great now, thanks!)

Skills and team-working

We are not born with many skills. Most are teachable. For example, I tell my students that there is no need to be a man to chair a meeting and that they may need tips such as how to stop certain people talking too much, identifying committee-members in advance for tasks, or being clear about which items are for information and which are for discussion. (See section in [12].)

For clinical work too, we need skills to value every person and value every moment. We often work with new people, agency staff and people whose role is unclear. Guessing can be demeaning or dangerous. My report 'What we should call Junior Doctors?' demanded that every doctor is acknowledged as a doctor and suggested that if a doctor's contract in a training programme needs to be identified, 'Junior doctor' should become 'postgraduate doctor' [18]. The Centre for Perioperative Care has written new guidance on the 'Team Brief' before surgery [19]. We can do it well, to allow every staff member to understand what should happen during the session, where the tricky bits will be, when breaks might occur and what other kit might be needed; it also means each person feels they belong and are valued. This improves patient safety and team working.

The population is ageing: 20% are over age 65, of whom 72% of patients have multiple co-morbidities [20]. Doctors, with our education experience and skills, are needed to deal with this level of complexity. The NHS should acknowledge this and have doctors leading the team. Doctors or very senior clinicians should undertake Shared Decision Making [21] with the patient, decide with the patient which scans or interventions are unwarranted and plan care. Other staff should understand patient pathways and be up-skilled to manage the details around this. This would maximise our scarcest resource – doctors. Sometimes a 'Multi-Disciplinary Team (MDT)' approach makes things worse, because everyone defers to one expert – who may not be available [22]. What may be better is increasing sharing of skills, so that there is a 'Trans-disciplinary team' [22] – for example, the receptionist can give specific patient information, doctors' assistants and other non-registered staff such as HCAs can give 'Making Every Contact Count' lifestyle education, and physiotherapists can advise pre-assessment nurses on simple exercises for patients in general to practice pre-operatively (eg sit-to-stand exercises). Good team-working means everyone feels valued and the patients feel supported [23].

We are woefully short of doctors. The NHS should value doctors, but we need a team working alongside us, to maximise our time to think, provide care and lead.

Summary

We should value every moment and every person. It is OK to make assumptions – so long as we do not act on them, but offer respect to all. Skills, tips and tricks are needed. We can learn behaviours, motivational interviewing, doing managerial roles and working in a team. Similar skills are needed to keep patients and their health at the heart of all we do.

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For further information:

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Please also use the FREE resources at **www.cpoc.org.uk** and **www.scarlettmcnally.co.uk.**

For those who are eligible (women and non-binary doctors and medical students) we need your energy in the **Medical Women's Federation** to help us – please join in to make the future better.

Cardiometabolic Medicine:

Care beyond a single specialty

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Introduction

Cardiovascular diseases (CVD) account for 45% of all deaths in Europe. These include myocardial infarction, cerebrovascular accidents, peripheral vascular disease, and heart failure. CVD is estimated to cost the EU economy €210 billion a year.[1] High cholesterol, obesity, smoking, and high blood pressure are key medical risk factors for CVD. As the smoking population reduces, diet has the largest contribution to behavioural risk factors of CVD mortality in Europe.[1] High systolic blood pressure makes the largest contribution of all the medical risk factors. Other medical conditions contributing to CVD include non-alcoholic fatty liver disease (NAFLD), inflammation due to autoimmune disease /chronic infections, mental health conditions, hyperuricaemia, and polycystic ovarian syndrome/menopause. The interplay between metabolism and cardiovascular disease calls for a greater understanding of cardiometabolic processes in reducing cardiovascular disease.

This article uses a clinical vignette to demonstrate the need for a cardiometabolic approach in the management of a patient with high cardiovascular disease risk.

Clinical Vignette

A 51-year-old sales director relocated from Manchester to Bristol and arranged an appointment with his new general practitioner (GP). He was a keen rugby player with a busy job. He reported tiredness and poor sleep which he attributed to his busy work schedule. He was an ex-smoker and drank 30 units of alcohol each week. There was no significant family history. He was not on any medication.

His examinations included: weight 119 kg BMI 36.3 BP 164/93 HR 80/min. His booking-in blood tests were as follows.

Sodium	140	mmol/L	133 - 146
Potassium	4.5	mmol/L	3.5 - 5.3
Creatinine	* 111	umol/L	59 - 104
eGFR/1.73m2 (CKD-EPI)	68	mL/min	

LIPID PROFILE

Fasting Sample?	No		
Cholesterol	9.7	mmol/L	
Triglyceride	*(HI) 2.9	mmol/L	0.5 - 1.70
HDL Cholesterol	1.8	mmol/L	
Cholesterol: HDL Ratio	5.4		
LDL Cholesterol	6.6	mmol/L	
Non LDL Cholesterol	7.9	mmol/L	
Haemoglobin A1c (IFCC)	* 85	mmol/L	
Urate	* 612	umol/L	200 - 430

Total Bilirubin	12	umol/L	< 21
ALP	96	U/L	30 - 130
ALT	* 76	U/L	10 - 50
Albumin	41	g/L	35 - 50

Management

This is a gentleman with a new diagnosis of diabetes, hypertension, hypercholesterolaemia, and high uric acid. These are important cardiovascular risk factors that need to be managed. Each of these factors has to be addressed simultaneously, but independent of each other. The table below illustrates the common management for each of the factors.

Medical Condition	Management
Diabetes	Metformin, SGLT2 inhibitor
Hypertension	ACE inhibitor, calcium channel blocker
Hypercholesterolaemia	Statin and or Ezetimibe
High uric acid	Allopurinol

Table 1: Current medical conditions and their management

This patient is likely to develop atrial fibrillation at a later date. He will need a beta-blocker and an anticoagulation agent.

Our current practice means that any general practitioner will need to review at least 6 specialty guidelines to treat this patient. Each condition is managed independently of any co-morbidities.

Discussion

This patient illustrates the need for a change in the approach of patients with more than a single health condition. Most guidelines are disease or specialty-specific and thus fail to serve the multimorbid patient. A review of NICE Guidelines shows that there are more than 25 guidelines and treatment advice guidance related to diabetes, lipid modification, and cardiovascular disease. This calls for a new approach to the management of cardiometabolic patients. A move from diagnosis to understanding the mechanisms underlying the disease process is key. This patient would be considered as **obesity with metabolic decompensation.**

Health professionals should understand that obesity is a key driver in this patient's ill health. This means that any management strategy should include the treatment of obesity. This could be achieved through diabetes reversal programmes, early introduction of Glucagon Like Peptide -1 (GLP-1) agonists, and early consideration of the use of Sodium-glucose co-transporter-2 (SGLT-2) inhibitors. Any management strategy should target the patient's cardiovascular outcomes. The role and cardiovascular benefit of GLP-1 agonists in obese type 2 diabetes is well established. Landmark clinical trials on Liraglutide (LEADER) and Semaglutide (SUSTAIN-6) have demonstrated the cardiovascular benefit of GLP-1 in type two diabetes. Recent studies have also demonstrated the cardiovascular benefit of Semaglutide in patients without type 2 diabetes. SGLT2 inhibitors have also demonstrated cardiovascular benefits with important outcome trials such as CANVAS , EMPA-REG OUTCOMES , DECLARE-TIMI 58.

Cardiovascular disease remains the major cause of death in diabetic patients, with two thirds of deaths attributed to cardiovascular disease. Major international guidelines for the management of diabetes have shifted from a glucocentric approach in the

management of diabetes to a cardiometabolic approach as cardiovascular outcomes are a priority. However, daily primary care guidelines lag, stuck in silos of specific specialties or disease conditions. This calls for the evolution of a cardiometabolic specialist, to offer holistic care to such patients. It will precede the development of complications or referral to cardiologists, nephrologists, or endocrinologists. This would target patient-specific outcomes with personalised care for each patient.

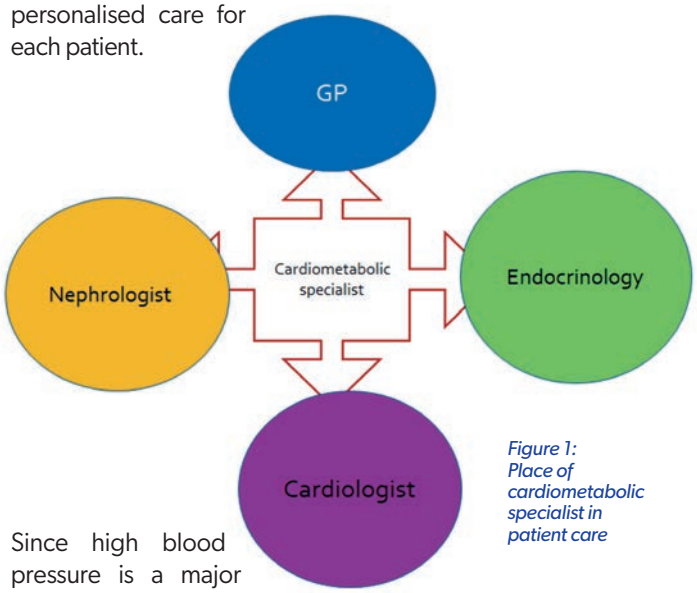

Figure 1: Place of cardiometabolic specialist in patient care

Since high blood pressure is a major contributor to cardiovascular disease, its management and drivers of hypertension should addressed early. Drivers of hypertension include obesity, alcohol intake, hyperuricaemia, and stress.

Previous cardiovascular risk calculators

Cardiovascular disease risk has routinely been calculated using 10-year risk as in QRISK, Joint British Societies risk calculator 3 (JBS3) . Later iterations of these risk scores acknowledge other risk factors such as non-alcoholic fatty liver disease, chronic immune-mediated inflammation, major psychiatric disorders, and chronic kidney disease. 10-year cardiovascular risk calculators may underestimate young people who have low absolute risk levels but high relative risk. This has called for the use of lifetime risk, which may have a larger impact on younger patients or patients with borderline 10-year CVD risk. Individual patient CVD risk should include factors such as family history of CVD

A holistic approach to cardiovascular risk reduction
Personalised care for complex patients
Switch from 10-year risk to lifetime risk
Understand obesity as a key driver
Diabetes reversal program
Early introduction of GLP-1RA
Blood pressure management and drivers of high BP
Lifestyle as a key component of care

Table 2. A holistic approach to cardiovascular risk reduction.

Challenges in providing cardiometabolic care

Optimal cardiometabolic care requires a cross-specialty approach to patient care with emphasis on diabetes care, hypertension, lipids, nephrology, and fatty liver disease. This means that patients are likely to be on several medications addressing each single system. Such patients run a risk of polypharmacy and its attributed problems. These include drug interactions, increased side effects, and cost.

Guidelines need to be updated regularly and should consider providing care to patients with more than a single condition such as in cardiometabolic syndrome. Increasing obesity and life

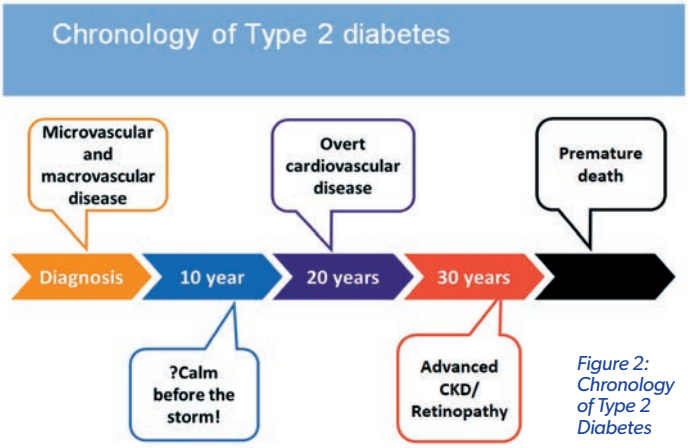

Figure 2: Chronology of Type 2 Diabetes

expectancy means that there are more complex patients with multiple co-morbidities. This also has an impact on the cost of healthcare. We currently do not have any primary care-focused cardiometabolic guidelines.

Opportunities to provide cardiometabolic management

Healthcare records and systems allow quick identification of at-risk patients. This offers opportunities for timely and optimal patient care. Centralised patient identification applications can be used to monitor patients and offer interventions when required. This can include appropriate prescribing and choice of first-line treatment options.

The incorporation of menopause care, prediabetes care, and mental health can be an important tool in providing cardiometabolic health. These are underserved groups who have a higher cardiovascular risk compared to the general population. Lifestyle remains a central part of the prevention and management of cardiometabolic disease. Important lifestyle choices include exercise, carbohydrate moderation, smoking cessation, and quality sleep.

Conclusion

Cardiometabolic medicine is an opportunity to provide holistic, single-point of care for complex patients. Prevention and management of cardiovascular disease would need greater understanding of cardiometabolic processes while addressing all risk factors. This can be offered by a cardiometabolic specialist working in collaboration with other specialties.

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Extra-Levator Abdomino Perineal excision (eLAPE):

early post-operative complication of perineal hernia

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Summary

A 70-year-old woman presented with parastomal hernia and large perineal hernia causing a significant compromise in quality of life with progressive increase size, 2 months after extra-Levator AbdominoPerineal Excision (eLAPE) procedure for low rectal cancer. The hernia repair is done in a combined abdominal and perineal approach. She underwent primary perineal hernia repair with VRAM (vertical rectus abdominus muscle) flap cover and primary repair of parastomal with anterior abdominal meshplasty. Her postoperative recovery was complicated by postoperative ileus, bibasal consolidation and worsening lung infection for which she was treated with antibiotics. She was discharged to community care services for wound care. In this case report, we raise awareness of postoperative eLAPE complications can occur much early than expected and describe a case where timely perineal hernia repair is required to prevent unforeseen complications.

Background

Extra-Levator AbdominoPerineal Excision (eLAPE) has been associated with better oncological outcomes and is an alternative to conventional AbdominoPerineal Resection for the treatment of low rectal cancer.[1,2] Postoperative perineal hernia is a complication caused by herniation of the intra-abdominal organs through the pelvic floor after complete removal levator muscles (anorectal complex). Up to 44% of patients will experience postoperative hernia, wound break down or infection.[3] This is an unusual case of parastomal hernia with prolapse of small bowel loops into the pelvis within a month of surgery. We highlight this case as the complication occurred within in a month after surgery. In addition, progressive increase in the size of perineal hernia causing dramatic compromise in quality of life if left un-addressed could have led to complication of small bowel protruding from the perineum. We discuss the case and the surgical management of this patient to highlight the need of timely repair to prevent untoward emergency complications. Also, to be aware of technically challenges to be faced during the reconstructive surgery for which a multidisciplinary team approach is mandatory.

Case presentation:

A 70-year-old woman presented with PR bleeding and was found to have a mass in the low rectum on per rectal examination. Following a biopsy of the rectal mass, she was diagnosed as poorly differentiated carcinoma suggestive of adeno-carcinoma (TNM staging T1 N0 M0 at diagnosis). She was considered for a TEMS procedure but felt unsuitable and therefore underwent an ELAPE on the July 2021. Somewhat surprisingly the post-operative histology demonstrated this to be a poorly differentiated squamous cell carcinoma. Her case was discussed in the anal cancer MDT and specifically the role of prophylactic radio-therapy to the inguinal regions given what the final histology. On balance it was felt that there is no clear evidence that this would be of benefit to her and there is significant small bowel dropping into the pelvis so she would be at risk of toxicity relating to this. The recommendation is therefore to proceed with active surveillance. Post-surgery she had significant pain on sitting. She noticed a large swelling protruding from her back passage, and she was diagnosed with large perineal hernia. A year later she also developed a bulge near the colostomy on the left side, with a stoma active. This was having a significant impact on her quality of life. She had difficulty sitting, difficulty finding clothes and underwear to fit over the area and had significant low mood as a result. Her medical history includes depression, asthma and a low thyroxine, also had an SCC of the salivary gland and hysterectomy. She takes regular inhalers, Sertraline, Pregabalin, Montelukast, and Levothy-roxine. She doesn't smoke or drink. She had not required any adjuvant or neoadjuvant chemo-radiotherapy for the rectal carcinoma. The patient was reviewed in a preoperative outpatient clinic; details of the surgery, expected benefits, risks, and complications were discussed. Then, written surgical consent was taken and surgery was scheduled.

Investigations

Pre-operative before the eLAPE, MRI (May 2021) showed intermediate intensity mass at the anorectal junction closest to the external sphincter with no definite invasion. Mass extends into upper anal canal. T2 N0 M0 (anal staging). Post operative PETCT (Aug 2021) showed linear uptake in the perineum in keeping with post-surgical change. Small bowel loops down in pelvis. Loop stoma in left iliac fossa. No distant metastatic disease or nodes.

CT scan of abdomen and pelvis with contrast done in Aug 2022 showed a left-sided end colostomy with associated parastomal hernia containing fat (new finding, no complaints from patient). The reconstructed pelvic floor is deficient, with pro-lapse of several loops of small bowel onto the perineal surface (increase in the size of the hernia). No metastases seen within the solid abdominal or pelvic organs. No ascites or measurable peritoneal disease. No features of bowel obstruction.

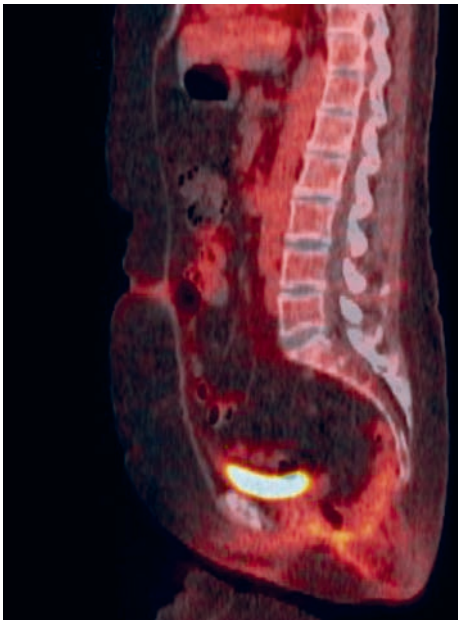
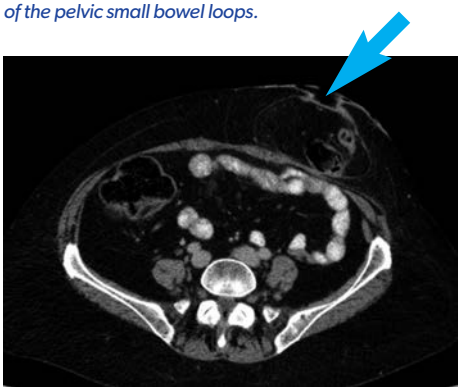


Figure 1: FDG PET/CT Scan shows some inferior descent of the pelvic small bowel loops.



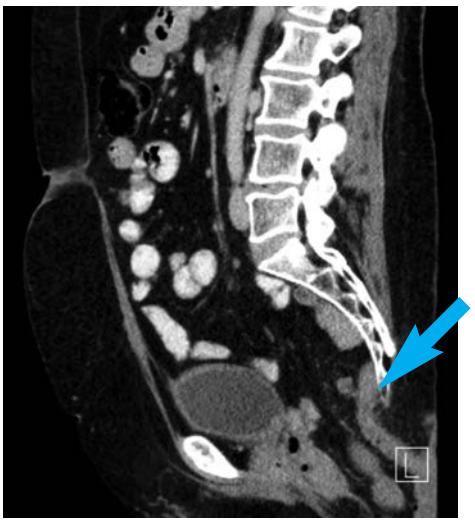


Figure 2: CT abdomen & pelvis with oral & IV contrast (Aug 2022) showing a left-sided end colostomy with associated parastomal hernia and prolapse of several loops of small bowel onto the perineal surface.

Her chest xray done following fever spikes on post-operative day 4 showed new blunting of the right costophrenic angle suggestive of pleural fluid. There was patchy consolidation in the mid and lower zones bilaterally. CT abdomen pelvis done showed post-surgical inflammatory changes in the pelvis and perineum. No evidence of intra-abdominal collection or bowel obstruction. No evidence of metastatic disease.

Differential diagnosis – not applicable in this case. Can it be omitted ?

Treatment

She underwent Laparoscopic ELAPE in July 2021. Following which she started to develop pain and progressively increasing in size of the perineal hernia.By the end of a year she also developed asymptomatic para-stomal hernia. Later in Feb 2023, she had perineal hernia repair with VRAM flap cover and parastomal hernia primary repair with anterior abdominal wall meshplasty. Post-operative day 4 she spiked fever with deteriorating respiratory symptoms. She was evaluated by doing necessary blood and radiological investigations. She was found to have pleural effusion which was treated with IV piperacillin and tazobactum along with incentive spirometry and active chest physiotherapy. She was told to avoid pressure on the bottom area for which she was nursed in lateral positions. She also developed paralytic ileus which resolved with conservative type of management. There were 3 drains placed as mentioned – right upper quadrant, pelvis and perineal suction drain. These drains were removed sequentially as the drain outputs decreased. The last one to come out was the perineal drain. She developed superficial perineal wound infection which was managed conservatively. She was sent home with 1 week course of antibiotics for the chest infection and regular follow up by district nurses for wound care.

Outcome and follow-up

Postoperatively, the patient was transferred to the CCU for one night and then transferred back to the colorectal ward. She was managed by the colorectal and plastic ward team with input from the dietitian and specialist nurses. She suffered florid bilateral consolidation with worsening of saturation levels, requiring high flow nasal oxygen support, appropriate antibiotics and active chest physiotherapy. She also had postoperative ileus and her stoma took 10 days to start functioning. During this time, she was commenced on TPN. Albumin level baseline was 24 g/L. She suffered a superficial perineal wound serous discharge that responded to regular dressings alone. The wound culture was sterile. She was discharged 16 days postoperatively with daily district nurse review of the wound in the community. She was reviewed in clinic with good healing of all wounds and no further complaints.

Discussion

With recent advances in surgical treatment for low rectal cancers, extra-levator abdominal perineal excision of rectum (eLAPE) a more radical approach which has better oncological outcomes and almost replaced the standard abdomino-perineal resection. eLAPE involves a two way approach for complete wide excision of the pelvic floor muscle (levator ani complex of muscles) surrounding the distal mesorectum to achieve negative margins and prevent perforation of the rectal stump.[1,2,3]

ELAPE achieves better ontological results but with extensive removal of the pelvic tissue is associated with higher rates of perineal complications than with conventional abdominoperineal resection [4,5,6,7]. There is no standard technique for perineal reconstruction following eLAPE. To avoid post operative perineal hernia (PPH) following ELAPE, some form of reconstruction is mandatory like mycocutaneous flap or mesh repair.[3,8,9] Laparoscopic surgery has reduced the risk of ventral/incisional hernia[10], while increases the chances for PPH[6]; hence some form pelvic reconstruction is essential.

Studies have shown using different techniques like closing the pelvic peritoneum during the primary cancer surgery has significantly lower incidences of perineal hernia.[11] But pervious pelvic surgeries and a disease free pelvic peritoneum is required for this technique, which poses difficultly to close the pelvic peritoneum.

There are alternative surgical ways of performing pelvic floor reinforcement which has been described. Like omentoplasty, bladder peritoneal flaps, hysteropexy, resuturing of elevator muscles or use of synthetic mesh. Out of all these methods, several studies has shown that bio mesh repair is most successful in decreasing the incidence of PPH.[12,13,14] Levator ani muscle suturing[15] and omentoplasty [16] did not yield satisfactory results in reducing the incidence of PPH. Unfortunately, the availibity of Bio-mesh is limited to western countries due to financial constraints. The use of bladder peritoneal flaps in men and the uterus in women could prevent PPH, when pelvic peritoneum closure can't be achieved [17,18].

Generally PPHs are small and asymptomatic which doesn't require any surgical correction, in some patients it presents as continuous dragging pain, discomfort, urinary dysfunctions, perineal bulge as the size gradually increases later on leading to wound dehiscence and prolapse of bowel loops or intestinal obstruction [19,20]. This significantly compromises the quality of life.

In this case, our patient presented with bowel herniation, a month after eLAPE. Factors which could have precipitated the post operative hernia in our patient are lack of pelvic peritoneum closure, absence of uterus which could have been for obliterating the defect, duration of anaesthesia for prolonged surgery led to just removal of the disease,nutritional status hindering recovering or chronic cough due to asthma leading to weakening.According to current literature review it is found the median interval for the diagnosis of perineal hernia after surgery is 10.5 months.[6] So this is not an typical immediate postoperative complication to occur. She had some risk factor for hernia formation and affecting healing process including asthma, weak pelvic floor muscles and age.

This is one of few reported case of perineal hernia to occur this early after surgery, and therefore, we highlight the importance for repair along with primary surgery to improve quality of life. Especially in patients with risk factors for poor wound healing.[6] Cancer, itself being a immuno-compromised condition can hamper wound healing and recovery, general co morbid conditions adds on to increase the risk rates.

The recommendations from this case report are, firstly, to adequately repair the pelvic floor defect during the primary surgery in order to prevent future re-do surgeries which are more complicated due to radiotherapy, adhesions, difficulties to procure flaps or poor healthy conditions. Secondly, the role of a multidisciplinary team approach is vital in achieving good outcomes.

Learning Points

- Perineal hernia is most common complication seen after extra-LevatorAbdominoPerineal Excision (eLAPE), elderly patients are more at risk due to multifactorial reasons.
- Extra care needs to be taken during the pre op assessment (patient-specific risk factors) to plan and decide if primary pelvic floor repair can be considered to prevent future complications.
- Perineal hernia following eLAPE can occur in the immediate postoperative period within initial few months, hence needs regular follow.
- If failed to treat timely can lead to perineal wound dehiscence and prolapse of bowel through the wound.

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How does Icosapent Ethyl fit into today's Clinical Practice?

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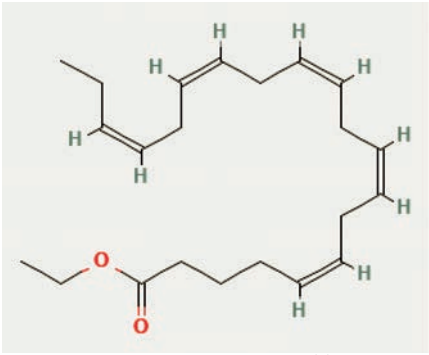
Introduction

In England alone there are 6.3 million people living with circulatory disease, with over 160 people dying from coronary disease daily and costs to the NHS amounting to £7.4 Billion a year[1]. Icosapent Ethyl has recently made its way into clinical practice having only been licensed for use in the UK in 2022[2]. The Reduction of Cardiovascular Events With Icosapent Ethyl–Intervention Trial (REDUCE-IT) was fundamental in the evaluation of the effects in lowering serious cardiac events, complications and deaths associated with having high levels of triglycerides[3,4,5]. This and other randomised control trials (RCT) such as the Effect of Icosapent Ethyl on Progression of Coronary Atherosclerosis in Patients With Elevated Triglycerides on Statin Therapy trial (EVAPORATE) have shown the benefits of this drug[6] and it has been noted that the effects are not only limited to the aforementioned but also of benefit in conditions such as heart failure and atrial fibrillation[7,8].

Clinical structure and Mode of Action

Icosapent ethyl is a synthetic derivative of eicosapentaenoic acid (EPA), a naturally occurring omega-3, and is a long-chain fatty acid ethyl ester[9]. EPA reduces secretion and/or synthesis of triglycerides from the liver, enhances triglyceride clearance, and increases plasma lipoprotein lipase activity[10].



Chemical structure of EPA [9]

Trials

The REDUCE-IT was a phase 3b randomised, double-blind, placebo-controlled trial which was used to assess two composite sets of data; primary and secondary. These were defined as:

'The primary composite end point was cardiovascular death, non-fatal myocardial infarction, nonfatal stroke, coronary revascularisation, or hospitalisation for unstable angina. The key secondary composite end point was cardiovascular death, nonfatal myocardial infarction, or nonfatal stroke.' (3, p367)

This study was performed in both USA and non-US populations separately. The findings were that icosapent-ethyl reduced these primary-end point events with a 31% relative risk reduction and 6.5%, and had similar reductions in secondary-end point events (31% and 4.6% respectively)[3]. These benefits were more pronounced in the non-US cohorts, who had lower primary-event rates than the US groups 58.7 versus 93.2 per 1000 patient-years, respectively[3]. This reduction in primary endpoints was noted in patients currently on both dual antiplatelets and statins and has the added benefit of not increasing bleeding risk further[4]. This improvement in clinical effects correlates with the reduction in triglyceride levels noted in participants given icosapent-ethyl, whose total median triglyceride level decreased by 18.3% after 1 year [5]. Indeed, in the EVAPORATE trial, formation of low-attenuation atherosclerotic plaques (LAP) was reduced in individuals taking icosapent-ethyl, these plaques being the most vulnerable and thus prone to causing adverse events[6]. As well as an overall reduction in triglycerides Icosapent-ethyl caused a beneficial shift in triglycerides, increasing omega-3 fatty acids and decreasing omega-6 fatty acids and monounsaturated plasma concentrations[11]. These effects were shown to be dose responsive, with the more substantial effects being at a dose 4g compared to a 2g dose [12]. The clinical benefits of Icosapent-ethyl also extended to patients with new onset heart failure, including that requiring hospitalisation by increasing the omega-3 levels[7,13]. However, caution should be extended to those groups with a diagnosis of atrial fibrillation/flutter (AF). It was suggested that although beneficial EPA could lead to higher hospitalisation and serious bleeding rates, these findings were not of statistical significance[8].

Current Guidelines

Currently statins are the mainstay of treatment for lowering serum lipid levels. The aim of statin therapy is to reduce non-HDL cholesterol levels by over 40%. Statins are considered in individuals under 85 with a QRISK3 of 10% or greater, type 1 diabetes mellitus, having had previous cardio- or cerebro-vascular events or peripheral arterial disease. Other secondary agents may be added by specialists when statin and adherence to lifestyle modifications have been insufficient, ezetimibe being a primary example of this[14]. Icosapent ethyl is currently licensed by The National Institute for Health and Care Excellence (NICE) as a secondary prevention agent, largely because it has been deemed as non cost effective as a primary prevention drug. It is used in individuals with very high levels of triglycerides who have trialled statins with no success[2].

Conclusion

The clinical trials surrounding Icosapent Ethyl show promising results with improvements in outcomes for patients who were started on that therapy. It is unclear how well these will translate into a wider population demographic, and how it will compare to our current medical treatments. Especially given that the placebo agents used in trials like REDUCE-IT were mineral based oils. Currently the UK has licensed Icosapent Ethyl for a small proportion of patients with high levels of triglycerides so it will take some time to evaluate its cost-effectiveness and clinical benefits.

Key Points

1. Icosapent Ethyl is a relatively new drug used to treat hyper-lipidaemia, and is currently licensed in the UK as a method of secondary prevention.
2. Multiple studies have shown promising results when using Icosapent Ethyl in reducing events like cardiovascular death or stroke.
3. The true effectiveness of Icosapent Ethyl when used in wider populations, and whether its use will be a truly cost effective option are yet to be fully understood.

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BIDA International Congress 2023

Prof Sanjay Arya FRCP (London)
Consultant Cardiologist & Executive Medical Director, Responsible Officer & Caldicott Guardian, Wrightington, Wigan & Leigh Teaching Hospitals
Cardiology Clinical Lead, Edge Hill University Medical School. BIDA Hospital Doctors Forum Chairman

Message from the Chairman, 14th BIDA International Scientific Committee.

BIDA International Congress has been very popular among our members. It is an important event in the diary of our organisation and has always been oversubscribed. I am pleased to inform you that we held the 14th BIDA International Scientific in Ho Chi Minh City, Vietnam on the 23rd & 24th November 2023. The International Congress was hosted after a gap of five years as a result of the Covid pandemic. The two day Scientific Programme covered major topics in healthcare delivered by Primary and Secondary care colleagues, and was attended by over 100 delegates.

Ho Chi Minh is the largest city, business and financial hub of Vietnam. Also known as Saigon, it has a prominent history going back hundreds of years. There are plenty of museums showcasing the country's dark wartime history and classic colonial architecture built by former French rulers.

The Scientific Congress helped us interact with twenty four speakers who are experts in their own fields. It enabled the healthcare professionals to keep up to date with important research, learn directly from the experiences of the specialists, share best practices and develop new skills and techniques. I am sure this will have a direct impact on our daily clinical practice, helping us deliver high quality and safe care to our patients.

I would like to express my gratitude to the distinguished speakers and chairpersons for their contribution to the scientific congress. I would also like to thank the members of the scientific committee including Anita Sanghi, Aprajay Golash, Sanjiv Sinha, Sanjoy Bhattacharya and Uday Kanitkar. I am grateful to them for their help and support in laying out such an enriched scientific programme.

My special thanks to Chandra Kanneganti, National President, Ashish Dhawan, National Chairman & Convenor, Leena Saxena, Vice ARM Chairperson & Co-Convenor and Alison Sherratt from BIDA Central office for their initiative in organising the 14th International Scientific meet. The congress would not have been successful without the help of Sebi and Yogesh from Bolton Travels.

Hope to see you all the next International Scientific Congress. Details will be circulated by the BIDA Central Committee in due course.

2023 Speakers & Abstracts

The Knee - Awkward Questions from patients to GPs

Prof. Videsh Raut *Consultant Orthopaedic Surgeon, Wrightington Wigan & Leigh Teaching Hospitals*

This presentation is about certain unusual Knee Conditions and an Update on Recent Trends in the management of some Common Knee Conditions.

Recent treatment modalities such as Visco-supplements, Platelet Rich Plasma injections, Uni- compartmental Knee Replacements and their role for the present-day patient has been laid out. Procedures that have become outdated such as Arthroscopic Debridement has been highlighted. Osteo-chondral Allografts for traumatic knees, Different types of Knee replacements or Custom-made (Patient Specific) Knee Replacements or Robotic Surgery for Arthritis are discussed to give an insight into their role in the management of the patient. Usefulness of such Newer Surgical techniques are discussed and some guidance on how to help the patient make a choice of the type of surgery.

Contraception for women in their 40s

Dr Asha Kasliwal *Consultant/ Clinical Lead in Community Gynaecology and Reproductive Health, Manchester Foundation Trust*

- Although fertility declines with age, effective contraception is required until menopause to avoid unintended pregnancies. Age-related increased background risk of cardiovascular disease, obesity and of breast and most gynaecological cancers as this may affect choice of contraceptive method.
- No method is contraindicated by age alone.
- Change from Combined pill or Progestogen only injectables for most women at 50.
- Stop contraception at age 55, chances of pregnancy are rare.
- FSH level is valid in amenorrhoeic women over 50 if progestogen only or non-hormonal method is used.
- Any 52 mg Levonorgestrel Intra Uterine Device (LNG-IUD) can be used for 5 years as endometrial protection as part of HRT.
- All progestogen-only methods of contraception are safe to use alongside sequential HRT.

Post COVID pulmonary syndrome and other sequelae

Dr Jasbir Singh Chhabra *Consultant Intensive Care, Lancashire teaching Hospitals NHS Trust, Preston*

New data is emerging in the last 2 years regards the long-term co-morbidities of Covid disease and its toll on health and productivity of people in all walks of life amongst all age groups.

Its long-term effects are multisystemic and can be persistent for a long time. Rehabilitation is challenging and sometimes nonspecific and non-satisfactory. It effects people's efficiency, their mental and physical health, and results in a huge economic burden on society and saps the already stretched NHS resources. This talk summarises the research available so far on the long-term effects chiefly on the Cardiovascular, CNS, and musculoskeletal systems and the increase in mental health problems especially amongst the otherwise most economically productive members of the society. The main limitations of this talk are also summarised as the research evidence is slowly emerging in the last 2 years or so only and post Covis rehab clinics have only just started to emerge on only a few Intensive Care follow up clinics!

Pain management in the current NHS

Dr Vinod Gadiyar *Consultant in Anaesthesia and Pain Medicine, Northern Care Alliance NHS Foundation Trust*

Pain management in the UK has been transformed in the last few years. The model where the patients got referred to individual pain clinics has changed. Now the patients are being seen by GP or the primary care service (Teir1) and referred to Teir2 service where they are assessed and offered treatments including pain education, physio-therapy, Psychology and medications and investigations. The majority of these patients are managed in Teir2 and only a few are referred to specialised service in secondary care (Teir3) for advanced medication trials, and interventions. Musculo-skeletal pain is the most common of the presentations and back pain is the commonest. The patient with back pain goes through this journey and by the time they are being discussed at Tier 3 they would have been engaged with all the treat-ments. I have discussed some of the interventions that are available to patients with back pain with or without sciatica. In general terms, patients who have back pain may have facetogenic pain or discogenic pain or Sacroiliac joint pain. The treatment for these is different to each other. Hence it is important to diagnose them and do appropriate interventions. I will discuss these in my talk.

Recent Advances in Obstetrics and Gynaecology

Dr Anita Sanghi *Consultant Obstetrics and Gynaecology & Caldicott Guardian, Barts Health NHS Trust*

Recent advances, research and national U.K. audits In Obstetrics and Gynaecology of interest to primary care colleagues are discussed.

Interesting findings from MBBRACE Report on maternal mortality (Oct 2023), Perinatal mortality surveillance report (September 2023) and National Pregnancy in Diabetes (October 2023) are highlighted. The progress towards the Government ambition to reduce maternal mortality by 50% between 2010 and 2025 (Department of Health 2017) is assessed by comparing maternal death rates between the 2009-11 and 2019- 21 triennia. The role of primary care in women with Diabetes in preventing unplanned pregnancies and how to adequately prepare women who are planning a pregnancy is pivotal. The recommendations of the NPID for commissioners and ICB are discussed.

In Gynaecology new medical treatments of Adenomyosis, Fibroids are discussed. 3-8% of women are affected by severe Premenstrual Syndrome (PMS0 , including Premenstrual Dysphoric Disorder (PMDD). 86% of women with PMDD consider suicide. The latest updates by British Association of Sexual Health and Herpes UK on guidelines on Vulvovaginal Candidiasis and Trichomonas vaginalis are highlighted.

Common STI presentations in Primary Care

Dr Ashish Sukthankar *Consultant in GU Medicine, Manchester University Hospitals NHS Foundation Trust*

Primary care plays an important role in the management of Sexually Transmitted Infections (STIs) as the investment in dedicated Sexual Health services has deteriorated in the past decade in the UK. Following the Health and Social care Act of 2012, the commissioning of sexual health services was transferred to Local Authorities resulting in fragmentation of services and introduction of private providers and social enterprises. Due to a combination of factors the prevalence of STIs has continued to increase. A significant proportion of these are asymptomatic, thus increasing the importance of screening tests. A systematic approach to common clinical presentations such as vaginal discharge, dysuria, urethral discharge in men and ulcers, rashes, lumps and bumps in genital area will be discussed. The presentation will focus on epidemiology and clinical presentation of Gonorrhoea, Chlamydia, Herpes and Warts with helpful hints on how to investigate and manage these in primary care. Unusual presentations of emerging conditions such as Mycoplasma and monkeypox as well as those of syphilis and HIV will be touched upon in the presentation. Solutions to common conundrums such as partner notification and confidentiality issues will be suggested.

Beyond covid, innovation & sustainability for medical profession

Prof Nirmal Kumar *Consultant Otolaryngologist – Head & Neck Surgeon, Wrightington, Wigan & Leigh Teaching Hospitals*

Covid pandemic proved that we must be innovative in the practice of medicine and that some of the practice was destined for the dustbin of history. It showed the fragility of human life and the experience of health care professionals in rapidly innovating such as the development of vaccines, adapting current practice is essential if we are to provide sustainable evidence-based modern healthcare. There are many opportunities for use of Artificial Intelligence (AI) and machine learning (ML) and we are seeing the convergence of these exciting technologies which will result in significant innovation. However, there are dangers and the unregulated use of these can prove damaging in the long run.

Think about AI like the first automobile (Stephen Fry) – impressive but not the finished article! Computer aided diagnostics (CAD) may revolutionise certain screening techniques such as radiological imaging or other routine laboratory testing, but the practice of medicine requires Emotional Intelligence (EI) especially with clinical aspects of medical and surgical management.

Sustainable healthcare delivery while reducing the carbon footprint is the holy grail for the future of medicine driven by the exciting tools that are available but need capable clinicians to oversee this transformation for the benefit of our patients.

Urinary symptoms – how to solve the conundrum of prostate cancer.

Mr Anurag Golash *Consultant Urologist and Clinical Lead, University Hospital of North Midlands, Stoke on Trent.*

Prostate cancer is the most common cancer in men. With the advent of PSA testing, the diagnosis of prostate cancer has increased, with subsequent decrease in prostate cancer related mortality. With expanding armamentarium available to diagnose and treat prostate cancer, changing medical landscape and ever-changing guidelines, management of prostate cancer remains a conundrum, especially for non-urologists.

Although PSA is a simple blood test, there are a lot of factors to be considered when considering it. With increasing awareness and media frenzy about prostate cancer, it is pertinent for the general practitioners and specialists to be aware about the nuances of PSA testing and its consequences. We aim to simplify the interpretation and application of PSA testing in the talk.

PSA can lead to a wide array of imaging as well as biopsies. This often opens a pandora's box of treatment options available. This is often a source of anxiety for the patient and the doctor alike.

Another factor compounding decision-making is the indolent nature of most prostate cancers, which often culminates in no treatment required. We aim to snapshot the journey of patient navigating the diagnosis and treatment of prostate cancer, aiding the audience in making an informed decision.

Mental health awareness & The Mental Health Act in the UK

Dr Tulika Prasad *Consultant Psychiatrist, Black Country Partnership Foundation Trust , Penn Hospital, Wolverhampton*

Mental health awareness is the act of learning and spreading accurate information with the goal to take action to help people who are experiencing problems to receive the assistance and treatment required and reducing the stigma.

An awareness of mental health allows us to preserve our wellbeing, address potential problems, notice warning signs as they emerge, and help others to do the same. It is about opening conversations, engaging with our communities, and building tools to improve our individual and collective mental well-being.

Mental health awareness specifically aims to improve the lives of people suffering from mental illness. Raising awareness helps people to find support, guidance, and treatment. And, as the statistics show, plenty of people in the UK and beyond can benefit from such support.

Development of Shoulder arthroplasty and current practice

Mr Paresh Sonsale *Consultant Orthopaedic Surgeon , University Hospital Birmingham*

My practice entails doing three subspecialties, Knee, Shoulder and Hands. Shoulder surgery was non-existent when I started medicine in Mumbai in 1982. The only operation that was popular was Putti Platt for stabilisation of the shoulder. Since then, shoulder surgery has evolved. Arthroscopic and Arthroplasty techniques have also improved significantly. Most shoulder surgery is now done arthroscopically, apart from joint replacement.

Some of the progress has been with material such as polyethylene insert that was used for Glenoid replacement. This was a direct transfer of technology from hip and knee replacement. But major change came through when Shoulder surface replacement was reintroduced. The next breakthrough came on the introduction of Reverse shoulder replacement when this concept was revisited with newer design of implants which could be used even in absence of rotator cuff. Rotator cuff provides majority of movements in shoulder joint. With advancing age there tends to disruption of these tendons resulting into painful and reduced ROM, termed as Cuff arthropathy. Computerised planning has helped with positioning of implants.

So, we will be looking into the history of shoulder replacement with the evolution of implants and newer implants like stemless implants, Reverse shoulder replacement, and revision of reverse shoulder replacement.

Tackling the current Obesity epidemic: What are our Strategies?

Prof Siba Senapati *Consultant Upper GI and Bariatric Surgeon, Salford Royal University Hospital*

Obesity is a chronic disease due to excess accumulation of fat sufficient to cause harm to health as defined by The World Health Organisation. However currently many countries do not accept it as a disease but define it as a condition. Currently we are in an Obesity epidemic due multiple environmental and developmental causes which has led to increased availability of dense caloric foods and less physiological activity. Obesity leads to or associated by a host of diseases as a not a single organ of the body is spared by the wrath of obesity. To list a few are Type II Diabetes, Obstructive sleep apnoea, Cardiovascular risks, joint and back problems, infertility and higher risk of various cancers.

The simple dictum of "eat less and walk more" is not effective as the root causes of obesity are many. We must deal with not only the individual but also the environment they live in. There has been some increasing advances on the medical management of obesity, however currently metabolic surgery is the most effective treatment as it not only leads to significant weight loss but also leads to cure or long-term remission of the diseases associated with obesity.

Our policies, various initiatives and approaches should be not only to arrest the current rising global obesity epidemic but also to reduce it so that we can enjoy a healthier and happier life.

Doctor, why I am dizzy?

Dr Suresh Chandran *Consultant in Acute Internal Medicine and the Revalidation Lead at the Oldham Care Organisation.*

As an Acute Internal Medicine Consultant, one of my areas of interest is having simple but effective management strategies for common medical conditions presenting at the front door.

Dizziness is one such condition that presents at the front door which in many patients is a self-limiting illness, but they end up having unnecessary investigations or have a prolonged stay in the hospital.

My talk will be an interactive case-based discussion and will begin with highlighting the salient points that need to be teased out in history and clinical examination. I would also focus on identifying patients with red flag signs and talk briefly about vestibular testing and the indications of various radiological investigations.

Finally, I would focus on treatment options and identify those patients that can be safely discharged home. Of course, the challenge will be to fit all the above in my allocated time of 15 minutes and I will have to be ruthless at the editing table!

To reiterate, my talk is not aimed at making you an expert in managing dizziness but having a concise management strategy at the front door for a common medical condition.

General Practice – is the future bright?

Dr Shikha Pitalia *General Practitioner, Chief Medical Advisor & Co-founder SSP Health, Manchester.*

In the appropriate grouping, the future of General Practice can indeed be bright.

General Practice is perceived to be at crisis point and the partnership model at risk. The GP workforce is at a critical juncture with many choosing to emigrate, retire early, go part-time or simply locum ad hoc.

CQC still poses an omnipresent threat, wielding unparalleled punitive power - misaligned with the current reality of General Practice. Robust governance processes on a larger footprint can help hugely. For example, with their super-practice infrastructure, all SSP Health practices are rated as GOOD or OUTSTANDING.

In many areas, PCNs have failed to deliver the outcomes needed. However, using innovative group solutions individual practices can survive, indeed thrive. SSP Health's unique model cares for over 210,000 patients across 40+ locations. This model has helped practices at risk of closure, because of financial pressures or threats such as CQC, to remain open; and resolved premises issues for GPs who own the surgery building and are planning to retire.

Reducing the admin burden is key so doctors can use their clinical skills to focus on patients in core General Practice or develop portfolio careers in a fully supported environment. The SSP model has evolved over 20+ years to deliver excellent patient services and allows doctors to enjoy general practice again.

PICU – an experience

Dr Priyadarshan Joshi *Consultant Community Psychiatrist, Gibraltar*

Psychiatric Intensive Care Unit is a Trust wide and sometimes the regional tertiary inpatient unit. In the Psychiatric Intensive Care Unit, psychiatric care is delivered in a secure and safe environment to the most disturbed, aggressive, and even violent patients with severe mental illness. The Psychiatric Intensive Care Unit is unlike any other average psychiatric inpatient unit or ward, in the level of security provided and the level of dangerousness that is contained while delivering treatments or therapies. The patients are managed by a multidisciplinary team with focus on teamwork in a very hostile environment. The talk provides an insight into the workings of the Intensive Psychiatric Care Unit. The talk describes or highlights the distinctive features of a Psychiatric Intensive Care Unit that makes such risky work possible.

Diagnosis and Management of Ovarian Cyst

Dr Vivek Malhotra *Consultant Radiologist, West Herts Teaching Hospitals, Watford*

Asymptomatic Ovarian Cysts Imaged at USS & Management.

There are multiple incidental lesions including ovarian cysts picked up on routine ultrasound. The talk is to understand the appearances of different cysts, the terminology explaining and describing the cysts and their management, both at primary and secondary levels.

Several images and appearances with a few interesting findings are also presented.

The talk is broadly divided into four subheadings:

Normal Appearances

Cysts with benign characteristics.

Cysts with indeterminate but benign characteristics.

Cysts with characteristics worrisome for malignancy.

Simple measures can make a difference to our bone and joint health.

Mr Ashok Goel *Consultant Orthopaedic Surgeon, Bangor . Specialist in Hip, Knee and Sports injuries.*

- Neck pain is common in people with chauffer driven cars requiring travel on busy bumpy roads – neck bolster can help relieve spasm/ pain.
- Shoulder impingement pain can be a trouble. Simple change in position of the computer, the way one carries the bag can help. Appropriate size breast support can make a difference.
- Tennis elbow can be precipitated with lifting heavy pans while cooking. A new test comparing the extension and supination with the opposite site can help with the diagnosis. Lifestyle modification and manipulation (a series with superior results) can help.
- de Quervain's tenosynovitis is common and may be caused by overuse of the thumb and wrist. It is also associated with breast-feeding. Supporting with a pillow and steering the baby's position with the knee can help.
- Tight hamstrings can cause low back and anterior knee pain. People may walk with a typical posture - 'I call it the flat bum syndrome' Simple stretching can avoid unnecessary MRI scans and surgeries on the knee and the back.
- Stair riser can be very crucial for knee health. Why use a standard equation?

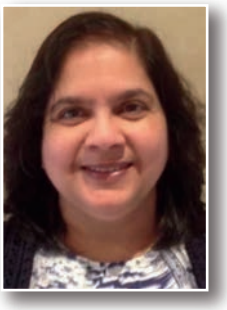
Emerging Trends in Aesthetic Reconstructive surgery

Mr Ram Prasad *Consultant Breast Surgeon, Wrightington, Wigan & Leigh Teaching Hospitals, & Consultant Breast and Body Aesthetic Surgeon, Pall Mall Medical*

Increase of aesthetic surgeries 101% in 2022 compared to 2021. With the NHS targeting resources to cancers and emergencies, increasing numbers are done in private. Lifestyle changing surgeries such as Breast reductions and abdominoplasty are not funded in NHS. Emerging trends in non-invasive aesthetic procedures. Diverse types of non-invasive fat reduction techniques have evolved. The majority is self-referral. For Trans patients we insist on gender certification. Increasing surgeries performed in UK so that people avoid going abroad. Breast Augmentation is the most requested of all cosmetic procedures. The majority of procedures are done as day cases. Mental health issues are especially important consideration. 30-40% of people undergoing aesthetic surgery are on anti-depressants. Body dysmorphic patients are difficult to please. Significant mental health issues in about 5% including self-harm. We need psychiatric clearance in these situations. Procedures increasingly appealing to modern generation for emotional and physical reasons and asymmetry correction. Software such as Crysalix incorporating CGI and AI used for consultation and to assess post op outcome. Satisfying and challenging but significant number of complaints do arise which could escalate to legal issues.

Aesthetic surgery should be performed more in UK at a competitive and yet sustainable way to prevent people travelling abroad.

Common Gastrointestinal Problems in Infant



Dr Shaila Sukthankar *Consultant Paediatrician, Royal Manchester Children's Hospital*

Common symptoms of gastrointestinal problems in infancy include vomiting, diarrhoea, constipation and abdominal pain. These may occur together in various combinations.

Vomiting alone is often associated Gastro-oesophageal reflux disease. If significant and untreated, it can lead to crying, feed aversion and failure to thrive.

Vomiting with diarrhoea is commonly associated with infections, though milk allergy/ food intolerances and FPIES will need to be considered. Toddler diarrhoea is a common benign condition to consider though often difficult to define.

Constipation may be physiological in breast fed babies. Features suggestive of more significant pathology need consideration if associated with failure to thrive or delayed development.

Abdominal pain with/ without vomiting, excessive crying and belly distension may be due to common causes like infantile colic and aerophagia. But it is important to consider and rule out more serious underlying pathology such as acute or intermittent obstruction, or non-gastrointestinal causes like sepsis and trauma.

Approach to some of these common symptoms/ conditions to reach diagnosis and management will be discussed in this talk through case presentations. While common conditions should always be considered first, it is important to recognise features that suggest rare, complex and unusual diagnoses by developing an increased awareness.

If you plan to work/move to India - Our Experience

Dr Vandana Goel *Consultant Anaesthetist, St Helens & Whiston Hospital.*

- We progressed through our training – Consultant Appointment.
- We were keen to move back to India, made regular visits to explore the venues. Support from parents was helpful to choose schooling, accommodation and transport.
- Negotiated contracts while still working in UK.
- We practised as per the UK standards, easier for surgeon as could choose patients. Husband had support of the hospital management.
- Anaesthetics being a dependent specialty- must rely on the requirements of the Hospital.
- This I found was very commercialised and felt uncomfortable.
- I soon joined another Hospital in Delhi, appointed as HOD, was able to introduce several positive changes within the Hospital in a short period of time. This was easy with the support of the management.
- I was met with a lot of resistance from retired senior surgeons in the Hospital, felt demoralised.
- Positives- domestic help, parents nearby, interaction with family, good international schools.
- Mindset- must be definitive. Option of returning to UK swayed me and decided to return.

Sepsis: Principles and initial management

Dr Subash Nandalan *Consultant in Anaesthesia and Intensive Care Medicine, Wrightington, Wigan & Leigh Teaching Hospitals*

Sepsis remains a topic of utmost relevance to all clinical disciplines and subject to intense media scrutiny. Sepsis is defined as 'life-threatening organ dysfunction due to a dysregulated host response to infection'. This session explores the 'who, why and how' of life-threatening physiological derangement due to infection. Excessive responses (of vasodilatation, vascular permeability, oxygen demand, and anaerobic metabolism) are described in detail to show how they lead to the signs and symptoms seen in sepsis. The NEWS2 scoring system and the UK Sepsis Trust clinical tools (GP and in- hospital) are explored to show how red flag sepsis and amber flag sepsis are identified. Special focus is given to the GP Red Flag Bundle and to Sepsis Six for patients with red flag sepsis. Sepsis Six components aim for timely senior review, test & treat infection (with blood cultures, other tests and antibiotics), and to optimise physiology (oxygen, intravenous fluids, and monitoring lactate, NEWS2, and urine output). The presentation concludes with a reminder to the importance of timely antibiotics and to timely source-control measures.

Artificial Intelligence in Ophthalmology

Mr Shreyas Deepak Raj *Consultant Ophthalmologist, Blackpool Victoria Hospital*

AI has become a very important topic of discussion nowadays with often positive as well as negative news about AI.

AI has been used in some form or the other since 1960s. We have heard the name (Dr) Watson of IBM created in 2011 which could answer your medical questions and make a diagnosis.

AI already been used in our health care setting for several years, but often we clinicians are unaware of what it does and the how it works.

Ophthalmology is a branch which very heavily relies on visual and imaging-based diagnosis. This makes it very suitable for analysis using AI.

I am going to give a small overview of what is happening in ophthalmology AI, which would be of interest to all doctors.

Management of Common Adult Hip Pathologies-Pitfalls and red flags

Mr Mukesh Hemmady *Consultant Orthopaedic Surgeon, Wrightington, Wigan & Leigh Teaching Hospitals NHS Trust.*

450 patients per 100,000 population will present to primary care with hip pain. In older adults it affects approximately 11% of the population. This is an overview of some common hip pathologies like Osteo-arthritis, RA, AVN, impingement, greater trochanteric pain syndrome etc and their differential diagnoses and management strategies. Red flags and pitfalls in diagnosis and treatment of these conditions are also discussed as also the newer developments in managing the painful hip in patients not suitable for surgery. A good history and physical examination supplemented by good quality radiographs can diagnose 90% of these conditions in primary care with only a minority of these patients requiring advanced radiological imaging. Various treatment options are also discussed.

So, you have hoarseness?

Dr Anita Sonsale *Consultant ENT Surgeon, Queen Elizabeth University Hospital, Birmingham*

Voice is unique and special to every individual. The larynx serves a significant role in the protection of the airway voice production and swallowing. Voice can be affected by inflammation, neoplasm, neurological, psychological, and a combination of all. History is key even before the examination. Voice and swallowing are intricately linked and hence may be affected simultaneously. The neurological supply of the larynx is complex. Understanding the dynamic anatomy and physiology of the larynx is fascinating. The laryngeal examination has evolved from a laryngeal mirror to present-day fibreoptic nasal laryngoscopy technology has improved significantly for the evaluation of structure, function, and details of mucosal vibration and the versatility of doing the procedure as an out-patient procedure. Evaluation and distinction between neoplastic and non-neoplastic pathology and specialist voice disorders is key to optimum treatment.

Empowering communities: The Health Mela experience

Prof Romesh Gupta OBE
Founding Chairman, National Forum for Health and Wellbeing (NFHW)

Dr Abhay Vaidya
Steering Committee member, National Forum for Health and Wellbeing (NFHW)

Mr Ravindra Shah
Trustee, National Forum for Health and Wellbeing (NFHW)

Despite higher incidence of CVD, CHD, HT, DM, and CKD amongst the BAME communities their access to the health services remains poor. To address this issue, engage local community and improve their health awareness, free Health Melas are held in the community in a friendly, informal and non-threatening environment. Breakfast meetings are important part of the event where political; health and social care leaders sit together with public, discuss a local health issue and explore ways of improving access and delivery of services. Exhibitors from the NHS, charities and voluntary organisations provide important health and wellbeing related information and signpost service users. Free health MOTs include measurements of BMI, BP, blood glucose and lipids followed by counselling and personalised advice including lifestyle changes. These health checks have picked up several undiagnosed health conditions over the years. Complementary medicine taster sessions are also available. Children enjoy many educational, interactive and entertaining activities. This event not only brings all aspects of health information fostering the concept of comprehensive approach but also provides a platform for healthcare students to enhance their knowledge and skills. This Health Mela model has been replicated by several health authorities in the UK and overseas.

Leaving a cleaner environment!

Mr Nikhil Kaushik Consultant Ophthalmologist

Editor's Comment:

The 28th Annual United Nations (UN) climate meeting (COP 28) held at Dubai has just ended with some welcome agreements that aim to limit the damaging impacts of climate change [1]

The 200 countries have pledged to implement transition away from fossil fuels.

Steps needed to stem the impending environmental doom, should not be left to Governments and politicians alone but engage us all. Civil societies must now engage in debates how best to achieve the aims of COP 28. An editorial in a widely read Hindi web magazine, "Purvai" draws attention to the environmental damage that is inflicted by the rituals surrounding the disposal of the deceased humans.

***Mr Nikhil Kaushik**, a Consultant Ophthalmologist from North Wales, caught up with the editor of Purvai – **Mr Tejinder Sharma MBE**, a scholar and well-known Hindi writer.*

***Nikhil:* Your editorial in Purvai has generated much interest and discussion around the disposal of human corpse, why do you think it is important to engage in this aspect of human behaviour?**

Tejinder: Of all the living objects, humans alone have the privilege of engaging in activities that require exploitation of natural resources. In simple terms if you are a non-human than your survival- demise and disposal is left to nature, but as a human you depend upon managing natural resources that are modified and processed with obvious consumption of resources. The main purpose of such acts is to make our living comfortable and satisfy our emotional needs. It is important that we engage and limit practices that harm the environment and affect us all. Continuous awareness and steps that may seem very trivial such as recycling a small carrier bag to everything that relies and exploits fossil fuel consumption. Each drop should be counted.

***Nikhil:* You have drawn attention to the rituals, surrounding the final rites that rely on fossil fuels, trees, and land.**

Tejinder: You see, human civilisation demands that the body is given a graceful sent off and cremated to satisfy our emotional and religious needs. Performing the last rites is the ultimate send-off we give to our near and dear ones. The mode of cremation has its origin in the practicality of available resources and geography. In Hindu tradition the body is cremated by burning and disposing the remains in rivers because of ready access to wood for burning and rivers for disposal of ashes. In drier places where water and trees are scares, the body is buried and allowed to decay in land, and this became the norm in Islamic world. The Parsis, leave the corpse unlocked in the 'Tower of Silence' so that the body is allowed to become feast to vultures or other animals. The Buddhists in Tibet perform last rites in the sky. The Buddhist monks worship the body and after performing prayers, the body is processed and made into small pieces that are offered to vultures and eagles.

***Nikhil:* I agree that it is important to look at all aspects of human behaviour, and however small an act may seem, the impact on environment must be considered. Do you think we should engage in debates around death and related rituals, after all death and cremation is the final act of human life.**

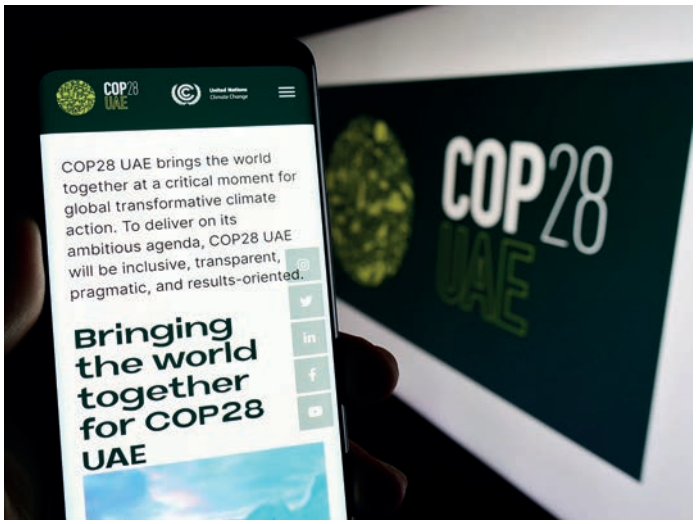
Tejinder: Of course! I think it is of paramount importance that we look at this aspect of human behaviour with some scientific outlook and environmental impact, respecting religious and emotional needs of course!

***Nikhil:* Although death is the ultimate truth of life, we shy away from talking about it, because our emotions are involved and to come to terms with loss of our near and dear ones is not easy.**

Tejinder: This is quite understandable, but the reality must be faced and behaviour modified. I think Doctors and other health-care workers have a significant role to play in changing behaviour.

***Nikhil:* How do you think we can achieve this?**

Tejinder: You see, the human population of the world now is estimated to be 8 billion (Billion: 1,000,000,000). In the last year 58 million deaths and 128 million births took place, with a nett increase in world population by 70 million. If we are to look at these figures, we can see that there is resource requirement for disposal of 58 million bodies and counting upwards. No matter how modern we portray ourselves, all religious rituals are followed in the matter of funerals. There are some variations in the performance of final rites in different countries and communities, but essentially, they consume important resources and contribute to environmental pollution and poor health.



For instance, 400-500 kg of wood is required for the traditional burning of a body. For burial, two yards of land, a wooden coffin, cloth for the shroud is used. In countries like America a concrete grave is made before burying a coffin.

In India around 50 to 60 million trees are burnt during cremations every year. In the United States, 1.6 million tons of concrete and 14,000 tons of steel are used every year for burial of corpses.

In Britain, several burial grounds are now closed for new burials and shortage of land for burial of corpses is becoming an issue.

Nikhil: **This is alarming, I just worry about the future with human population rising expected to reach 11 billion by the end of the twenty-first century.**

Tejinder: Absolutely, as the population increases so does the number of the dying, and the number of funerals will increase accordingly. Funerals are becoming a heavy burden on the environment. There have been studies that have looked at various methods of cremation, no method is without its impact on the environment, with burial probably being most harmful to the environment.

Nikhil: **It is said the funerals are only a thousandth of the burden a person puts on nature in his/her lifetime, nevertheless the whole traditional cremation and performing the last rites takes a heavy toll on the nature.**

Tejinder: Yes, I think it will not be right to expect us to give up traditions and do away with rituals, as our experience with electrically heated furnaces tells us. The electrically heated furnaces have been available since 1933, even so a vast majority of traditional methods of burning and burial persist.

Nikhil: **Surely there must be innovative developments that should satisfy the ritualistic needs as well as eliminate or minimise the impact on the environment. We hear about 'eco-friendly' or 'green funeral' at least in UK and USA these days.**

Tejinder: And these should be promoted. There is need to change our thinking and challenge myths associated with ancient rituals. Eco friendly cremation is gentle on valuable resources like trees and water. Processes such as 'alkaline hydrolysis' that dissolve the body with chemicals are also being used. We are learning about other innovative cremation such as "'Capsula Mundi'". The ashes are held in an Urn that is placed alongside a tree being planted. It is hoped that soon the body will be placed in the organic burial capsule that is made of starch plastic which will dissolve 100% in the ground.

The elements that will come out of the decomposing body will help the plant to grow. In some places there is a move to introduce a new type of cemetery in which trees appear instead of graves. Families would go and feel like clinging to these trees as if they are cuddling their loved ones.

Nikhil: **I think your editorial in 'Purvai' will make your readers think and they could also talk with healthcare professionals to modernize the final steps of our lives.**

Tejinder: We all know that nothing in this world is permanent. The cycle of birth and death will continue. So why not survive as trees after we die? We can decide in advance which tree would we like to live as. Our children and descendants may remember us as a tree that will become our identity and inspire poems and stories about us for our loved ones.

Nikhil: **Thank you!**

Medical Quiz

Can you spot the diagnosis?

Answers on page 26

Q1. Fig 1: A 72 year old gentleman, reasonably fit and well, has been complaining of a gradual onset of pain in his left shoulder for 12 months, which has increased in intensity over the past 2 months.

Q2. Fig 2: A 75 year old Welsh farmer presents with mild discomfort and swelling of both shoulders, the left worse than the right over 12 months. He never had any injury. He is not a diabetic. All inflammatory markers are near normal.

Q3. Fig 3a & 3b: A 15 year old keen footballer complained of mild pain in his left ankle for several years. Previous investigations some years ago did not reveal any fractures. Inflammatory markers are normal.

Q4. Fig 4: A child who has remained fretful for several months. Multiple admissions and investigated earlier for pyrexia of unknown origin.

Q5. Fig 5: A 35 year old with a history of repeated episodes of pain in the left shoulder over several years. Has had a sudden increase in the intensity of the pain.

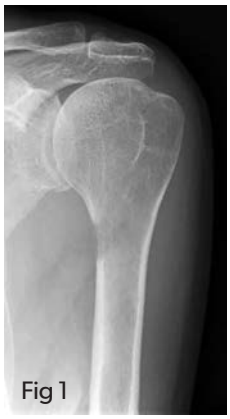


Fig 1

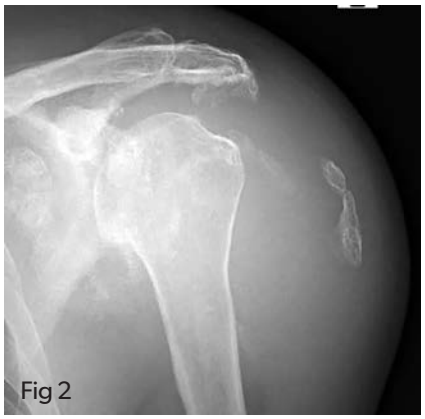


Fig 2

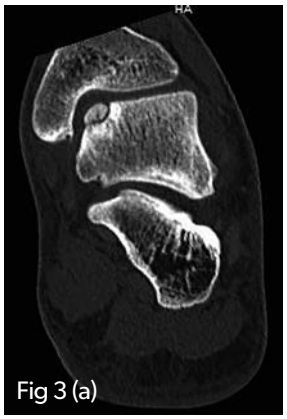


Fig 3 (a)

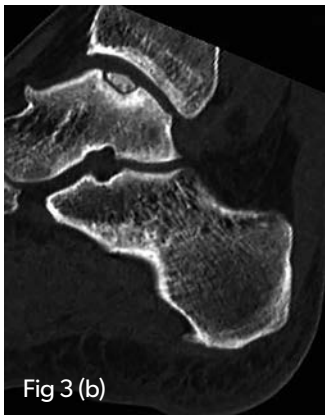


Fig 3 (b)

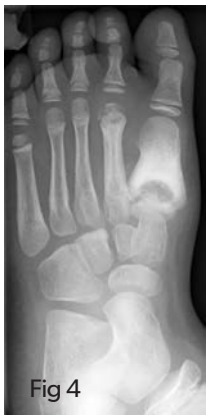


Fig 4

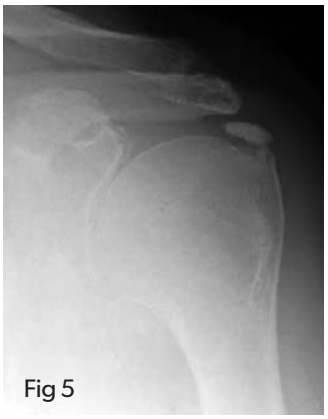


Fig 5

An interview with Dr Narinder Kapur

A brief resumé

Narinder Kapur was born in India, but grew up in Northern Ireland. He is a consultant neuropsychologist, visiting Professor of Neuropsychology at University College London, and honorary consultant neuropsychologist at Imperial College Healthcare NHS Trust. He is past-President and a founder member of the British Neuropsychological Society and received a Lifetime Achievement Award from the British Psychological Society.

He is Human Factors Advisor to the Confidential Reporting Systems for Surgery (CORESS) committee which meets to discuss and learn lessons from surgical safety incidents. He has been given patient safety awards by both the British Association of Physicians of Indian Origin and the British Indian Nurses Association.

He has published around 160 journal articles and book chapters, and has authored/co-authored or edited/co-edited seven books, six in the field of Neuropsychology, one of which ('The Paradoxical Brain') won an award from the American Medical Writers Association.

What was your best career move?

Being able to make a difference to patient care and being able to make a difference to the wellbeing of healthcare staff have been the most rewarding. For the former, it is articles and books I have written on patient care, and trainees I have taught on the subject. For the latter, it is articles I have written and specific support I have been able to give to doctors in distress. I am particularly proud that my *How to Live like Gandhi* book has been taken up by the Eye Foundation of America to help raise funds for the wonderful eye care work the foundation does in India (*www.eyefoundationofamerica.org*).

What was the best decision you made for your career?

The best decision I made was applying for and getting a travel fellowship to spend a post-doctoral year in Boston, USA learning all about Neuropsychology.

What has been the most inspiring moment in your career?

The most inspiring moment was in the 1970s, when I got a fellowship to spend time at the All India Institute of Medical Sciences in India, going to the Outpatients Department of the hospital and seeing inscribed on the wall the words of Mahatma Gandhi, *'It is not our patient who is dependent on us, but we who are dependent on him. By serving him, we are not obliging him; rather, by giving us the privilege to serve him, he is obliging us.'*

What was the worst mistake you made in your career?

In 2003, moving from working in Southampton to working in Cambridge, where I then worked for 7 years, but not taking my family with me, rather coming back home every weekend. I also made the mistake of being a whistleblower at Addenbrooke's Hospital in Cambridge, as I then suffered terribly as a result.

What motivated you to set up the Memory Aids Clinic?

An amnesic patient whom I treated for many years greatly benefited from a portable camera system that I developed as a memory aid along with Microsoft Research Labs in Cambridge. This inspired me to use memory aids to help patients. We also then got funding to run a three-year Memory Aids Clinic trial at St Thomas' Hospital, and the results of that trial got published.

What is your view on work-life balance?

Healthcare work, as well as clinical-academic work, can at times be quite stressful, so having a good frame of mind as well as other meaningful activities is critical. Having altruistic/charitable work as part of your non-work activities has been shown in psychological studies to lead to good mental wellbeing. So, that is a win-win situation – those in need benefit from your input, and you also improve your own mental wellbeing. I frequently tell patients, and try to regularly remind myself, of the 3 P's – be Patient, be Positive, and Persevere.

What single change would you like to see made to the NHS?

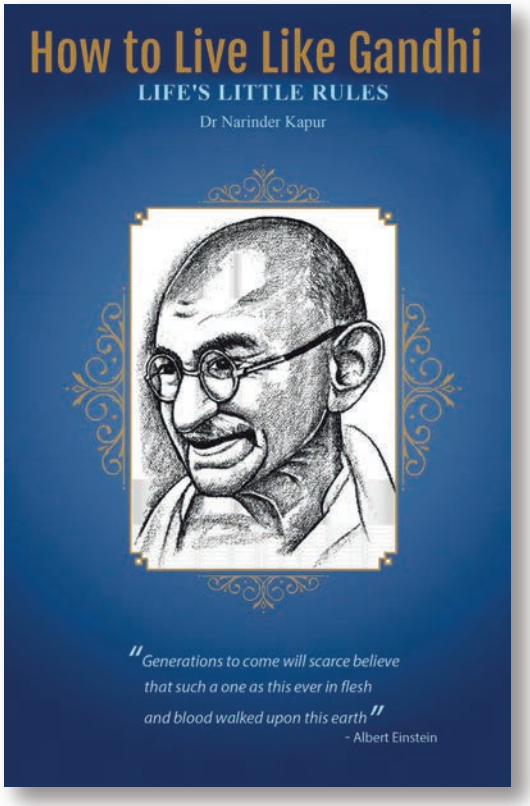
The NHS recently published its workforce plan and its NHS Equity, Diversity, and Inclusion plan. Implicit in the goals of both of these plans is for patient care and staff wellbeing to be of the highest standard. There is increasing recognition of the fact that psychological factors play a key role in both patient care and staff wellbeing. One single change I propose is for each major Hospital NHS Trust to have two dedicated corporate psychologists, to deal with strategic and conceptual issues relating to patient care and to deal with strategic and conceptual issues relating to staff well-being. In the case of staff wellbeing, the corporate psychologist would ensure that fair and unbiased systems were in place for the treatment of NHS staff.

What is your contribution to BIDA?

Supporting doctors in difficulties, and more generally trying to help inform BIDA members about the role of psychological science in improving clinical practice.

What are other contributions you have made to society?

The most important contribution to society are two that have nothing to do with clinical practice or clinical research. They are firstly, the book I wrote, called The Irish Raj, about Indians who came to Ireland, and Irish who went to India. Secondly, the award schemes I have set up in memory of two people, a doctor and a nurse, who have inspired me in unique ways. The doctor is Dr Karen Woo, a UCL-trained doctor, who was murdered by terrorists in 2010 while providing aid in Afghanistan. I was drawn to Karen's tragedy because it partly resembled how I and other NHS whistle-blowers have been treated. Like Karen, we went out of our way to help others, only to be victimised as a result of our efforts. Her suffering was, of course, beyond comparison. I have been privileged to support her mother over the years in keeping Karen's memory, and her Afghanistan work, alive. The nurse in question is nurse Amin Abdullah, a dedicated, award-winning nurse who was the victim of a gross miscarriage of justice ('kangaroo court') when he was unfairly dismissed in 2015. He was also in part an NHS whistleblower, drawing attention to patient safety issues. Unable to bear the injustice and the loss of a career which he valued so highly, Amin then burned himself to death outside Kensington Palace in 2016. Looking back on my career, I regard my greatest achievement (little to do with Neuropsychology) as, following Amin's suicide, working successfully to bring about the introduction of principles of fairness – PIE principles: Plurality, Independence and Expertise in disciplinary panels – into some parts of the NHS that had been shown not to have the high moral standards and competence in people management which are expected of such a wonderful institution. The two award schemes are described in an article I published in the UK Health Service Journal (Kapur, October 28, 2022), and also on this website that I created, ***www.abetternhs.com***.



What new technology or development would you like to see in the modern NHS?

I would like to see the application of Artificial Intelligence to help with clinical decision making, especially in settings such as a busy ward, in the Emergency Department, and in General Practice.

What advice would you give to your medical colleagues, who plan to retire from the NHS now?

I would give two bits of advice. Firstly, look after your physical and mental wellbeing, and that of your family, keeping mentally and physically active. Secondly, do voluntary NHS or other charity work to help those who in need, both in the UK and overseas.

What is your favourite book?

Get Smart by the late Professor Art Shimamura, a past colleague of mine. Published in 2017 by Amazon Press.

What makes you really happy?

Making a positive difference to those who are less well off than me

Do you ever get stressed? If you do, how do you deal with it?

I occasionally get stressed, and I have two strategies to deal with this. Firstly, I think of people who have suffered much more than me, and I also see what I can learn from how they coped. Secondly, I go on my treadmill for an hour first thing in the morning and an hour last thing at night, and while I am on the treadmill I have a TV close by and watch a clinical or non-clinical webinar on YouTube, listen to a podcast, listen to/watch favourite songs, etc.

BIDA Student Wing National Conference 2024

Renee Punia Conference Chair – BIDA Student Wing. 4th Year Medical Student, UCLan

As Conference Chair of the 2024 BIDA SW National Conference, it gives me great pleasure to share with you the outstanding success of our recent conference which was held virtually on 20th January 2024.

Our event witnessed significant interest, with 185 attendees from more than 25 medical schools in the UK - marking almost double the delegates we had last year (95 to 185). Having played several key roles in the BIDA SW since its inception in 2020, this event was particularly meaningful to me as it served as a striking reminder for how far we have come as an organisation and equally, how we have evolved into a leading national organisation recognised for supporting International Medical Students across the UK.

BIDA was established in 1975 and stands as the oldest organisation representing International-origin doctors working in the UK. It was formed with the objectives of promoting fairness and equality for all doctors working across the United Kingdom irrespective of their gender, race, religion, country of origin or sexual orientation.

The BIDA Student Wing was formed with the aim of extending the same fairness and equality to the international student doctor community in the UK. Founded by Dr Sai Pillarisetti, the BIDA Student Wing is the very first organisation dedicated to representing International Medical Students studying in the UK – we are proud to represent students who hail from 40+ different nationalities / countries.

In recent times, there has been a rapid rise in the number of international medical students in the UK and the need for a united, diverse and inclusive platform like the BIDA Student Wing is crucial to highlight our collective voice. Our annual conference serves as a forum for this, with sharing of ideas, issues and a vision for the future of the profession. To this end, we were thrilled to welcome speakers from various disciplines and branches of practice who were incredibly engaging and showed keen interest in sharing their insights with the students.

We were delighted to be joined by the **General Medical Council (GMC)** as our primary sponsor for the conference – during a session lasting an hour, they engaged with the diverse group of international medical students on a range of topics related to the upcoming UKMLA, regulatory concerns and what to expect from the regulatory body in the time to come. The conference is proud to be supported by 3 nationally recognised institutions of excellence – **The University of Bolton IoM**, **CESOP**, and **CRST**, whose contributions have enhanced the conference's impact & influence. The BIDA SW was pleased to welcome an exceptional line-up of speakers who shared their expertise on various aspects of medicine. Their insightful presentations not only contributed to the overall quality of the conference but also provided attendees with valuable perspectives on current medical challenges and advancements.

We also had the distinct honour of welcoming **Professor Iqbal Singh CBE, Pro-Vice Chancellor (Medicine) and Chair, Institute of Medicine, the University of Bolton**, as our first keynote speaker. Professor Singh shared thought provoking perspectives and the story behind the launch of the proposed Undergraduate Medical School at the Institute of Medicine, University of Bolton. He emphasised the institution's commitment to producing patient-cantered, compassionate, and culturally competent doctors. Additionally, Professor Singh highlighted the success of the Singh-Forde Review – an independent review commissioned by the GMC - which he led as co-author. These recommendations encompassed crucial improvements to the GMC's approach to data collection and monitoring, along with the integration of cultural competence, diversity intelligence, and compassion into the fitness-to-practice process. Those in attendance were delighted to hear that the GMC accepted all of Prof Singh's recommendations as well as making a commitment to implement them. The GMC also publicly apologised for their handling of the Arora Case – a first for the regulator and marking a significant milestone in ensuring fairness and equality within the GMC.

The BIDA SW was delighted to host **Professor Scarlett McNally, President of the Medical Women's Federation (MWF)**, as another keynote speaker at the conference. Professor McNally shared her remarkable journey as a surgeon, MWF President, and BMJ columnist, touching on critical themes such as sexism, equality, and diversity in medicine. Her insights into life as a female surgeon were particularly impactful, inspiring attendees and enriching the conference with a focus on the challenges and successes of women in the medical field.

Dr. Chaand Nagpaul CBE, Chair of the BMA Racial & Ethnic Equality Forum, delivered a keynote address at the conference. He shed light on race and health inequalities, emphasising how ethnicity influences disease prevalence. He highlighted the greater prevalence of mental health problems in ethnic minority populations and underscored the importance of raising awareness about race and health inequalities. Dr. Nagpaul advocated for promoting culturally competent care to address these disparities, contributing significantly to the conference's discourse on fostering equitable healthcare practices.

The conference also featured a keynote address by **Professor Chandra Kanneganti CBE**, our **BIDA National President**, who provided an overview of BIDA's 50-year history, forums, and impactful work. He highlighted the annual BIDA Conferences and discussed the organisation's activities and campaigns supporting international-origin doctors, emphasising BIDA's commitment to enhancing the professional environment for international-origin doctors.

Dr. Eman Toeima, National Lead & Chair of SAS-Led Committee at the Royal College of Obstetricians and Gynaecologists (RCOG), delivered an enlightening keynote address on Equality, Diversity, and Inclusion (EDI) within RCOG. Dr. Toeima emphasised RCOG's commitment to fostering a more diverse, inclusive, and reflective environment, aligning with the needs of the communities they serve. She outlined the RCOG's proactive approach, including the development of an EDI Action Plan, aimed at ensuring concrete steps are taken to achieve these goals. Dr. Toeima's insights added a vital perspective to the conference, highlighting the importance of EDI in shaping the future of obstetric and gynaecological care.

Professor Sanjoy Bhattacharyya, Director of Assessment at the University of Bolton Institute of Medicine & BIDA Executive Committee Member spoke on the crucial theme of assessment in medical school. With fervour and expertise, he delved into various assessment methods, shedding light on both formative and summative evaluations. Prof. Bhattacharyya discussed the common pitfalls associated with these assessments, emphasising the challenges students face and the importance of addressing them. His insightful tips for students to excel in assessments resonated with the audience, providing valuable guidance on effective study strategies, time management, and stress reduction.

The conference also witnessed enlightening talks delivered by

- **Miss Raghavan Vidya** - ISTP Breast Surgery Lead at the Royal College of Surgeons of England
- **Professor Azeem Majeed** – Professor of Primary Care at Imperial College London

Other speakers included **Mrs Jade McCann** (UoB IoM), **Dr Vanessa Msosa**, **Dr Alireza Sherafat**, **Dr Momna Raja** and **Dr John Raj**.

Furthermore, the conference welcomed 28 abstract submissions showcasing a broad range of research and innovation in the field of medicine. The authors of the top abstracts were invited to present their posters during the conference and the winning poster received an Amazon Gift Voucher of £100. The conference facilitated meaningful exchanges, fostered connections, and advanced discussions on various key issues and topics in our profession.

I would like to take this opportunity to extend my sincere gratitude and appreciation to all contributors for the resounding success of the BIDA SW National Conference 2024. **Dr. Sai Pillarisetti**'s unwavering support and exceptional leadership were instrumental in organising and executing the conference. I express my gratitude to **Paarth Gupta**, serving as the co-chair, for his invaluable dedication and collaboration. I extend my sincere gratitude to **Dr Rakesh Sharma** for his exemplary chairing of the first session of the conference. His adept conduction of the Q&A segment received excellent feedback, characterised by engaging and insightful discussions, contributing to the success of the conference. I would like to extend profound gratitude to **Professor Iqbal Singh CBE**, **Professor Chandra Kanneganti CBE**, and **Professor Sanjoy Bhattacharyya** for devoting their valuable time, not just to deliver their presentations but also behind the scenes with academic support. It has been a great honour to serve as the Conference Chair for BIDA SW, and I am hugely grateful for the wealth of knowledge, insights, and experiences I gained through this remarkable opportunity.

"**This conference is our flagship annual event and is supplemented throughout the academic year** with weekly teaching sessions (online), career guidance and mentorship support for which the BIDA SW has gained national and international appreciation and recognition. You can find more information on our Instagram page where most of our events are advertised as well as through targeted email bulletins to our members. Membership is free and we encourage anyone interested in our mission to join!"

Renee Punia *Conference Chair, BIDA Student Wing*

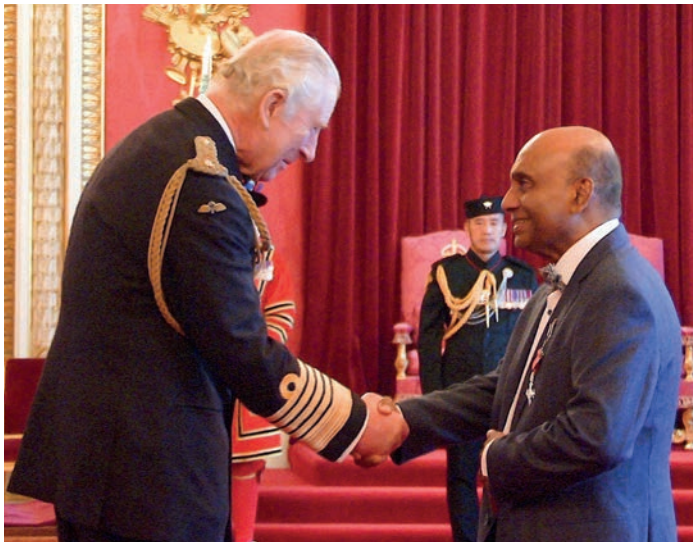
BIDA Awards

Dr Chandra Kanneganti C.B.E.

Dr Chandra Kanneganti CBE needs no introduction being BIDA's current President. He has been the youngest and the longest serving Chairman of the organisation. His contributions on the national stage to represent doctors have been steadfast and well recognised.

He received the CBE in the New Year's Honours list for his services to general practice. He has been a GP partner at Golden Hill Medical Centre at Stoke--on-Trent for 17 years and has served the communities across the city. He is also the director of the North Staffordshire GP Federation and a lay member of the Royal College of General Practitioners.

He has represented the Stoke-on-Trent ward of Sandyford and Goldenhill on Stoke-on-Trent City Council since 2019. He has served as the Lord Mayor from 2021 – 2022.



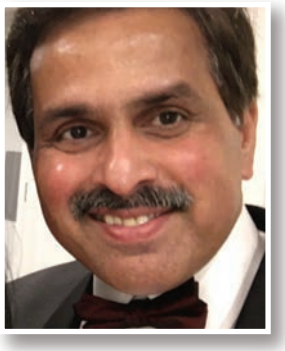
Prof. Nihal Gurusinghe M.B.E.

Prof Gurusinghe MBE is a Consultant Neurosurgeon currently working at Royal Preston Hospital, Preston. Having qualified as a doctor in Sri Lanka, he moved to the UK in 1975. After training in neurosurgery at prestigious institutes in London, he was appointed as a substantive consultant in 1985. He is the first Neurosurgeon of Sri Lankan origin to be appointed as a Consultant in the NHH and later on as a Professor.

Throughout his long and illustrious career Prof. Gurusinghe has made important contributions to British Neurosurgery and trained many neurosurgeons in the UK as well as those from other countries, including India and Sri Lanka.

More importantly, his contributions to charitable services has been recognised in King Charles III's New Year Honours List in 2023 and the investiture was at Buckingham Palace on 8th Nov. 2023.

BIDA Sports 2024



Mukesh Hemmady FRCS (Tr&Orth)

We had extremely successful Cricket and Golf tournaments last year, with the latter being an inaugural one.

We propose to continue with these two tournaments this year too, although there might be a change in the format of the cricket tournament after discussing it with the captains and the Division leads. This is in response to the feedback we have received from the teams over the years.

Last year, the Golf tournament, which was extremely well received, was held at the Haydock Golf Club on the day before the Annual Conference on 29th September. Fortunately, the weather gods were kind to us and everyone had a good game, and Mr Raghunandan Kanvinde from Bangor was the winner. I am thankful to Kaushik Jain and Muthu Jeyam for their help in the organisation of the tournament. Being a weather dependent sport, it may well have to be moved in to one of the summer months this year, but we will keep you posted.

Last but not the least, if there is sufficient interest, we may have table tennis and badminton tournaments too this year.

Best wishes

Mukesh Hemmady *BIDA National Sports Co-Ordinator*

Medical Quiz Answers

1. **Fig 1: Metastases proximal humerus**
2. **Fig 2: Charcot's joint of shoulder**
3. **Fig 3a & Fig 3b: Osteochondritis dissecans of talus**
4. **Fig 4: Osteomyelitis of base of big toe**
5. **Fig 5: Calcific tendonitis of rotator cuff**

Erratum

ARM Motions published in BIDA Journal, Nov 2023; Page 18

We acknowledge the following corrections to the ARM motions as specified by Dr S Chandran, BIDA ARM Chair

Motion 2B: Proposer - Dr Sai Pillarisetti, Junior Doctor Forum Chair

The BIDA Student's Wing delivers excellent undergraduate medical teaching.

We urge this A.R.M. to agree to the creating 'BIDA Academic Forum' to deliver post-graduate medical teaching

Result: Motion was carried unanimously.

Emergency Motion: BIDA to start with activities in recruiting AHPs from the Asian sub- continent.

Result: Motion was carried unanimously.

1

ARE YOU READY FOR?

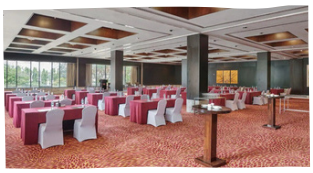
AFRICA

TANZANIA

15TH BIDA INTERNATIONAL SCIENTIFIC CONFERENCE 2024 -TANZANIA

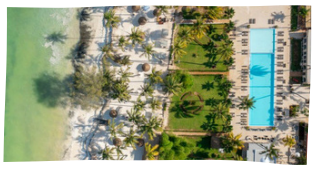
ZANZIBAR | ARUSHA | LAKE MANYARA| SERENGETI | NGORONGORO |

5th-15th November 2024



ZANZIBAR

5 Nov - 9 Nov (4 Nights)
TUI Blue Bahari Zanzibar
2 days Conference
Welcome Dinner
Stone Town & Spice Plantation Tour
Gala Dinner with Free Flow drinks for 2 hrs & DJ



ARUSHA

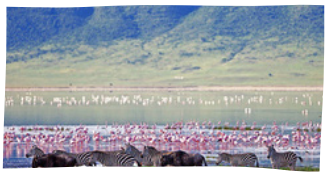
9 Nov - 10 Nov (1 Night)
Arusha Serena Hotel, Resort & Spa /
Four Points by Sheraton Arusha
Arusha Town Sightseeing

LAKE MANYARA

10 Nov - 11 Nov (1 Night)
Lake Manyara Serena Safari Lodge
Lake Manyara Game Drive

SERENGETI

11 Nov - 14 Nov (3 Nights)
Serengeti Serena Safari Lodge/
Mbuzi Mawe Serena Camp
Serengeti Game Drive



NGORONGORO

14 Nov - 15 Nov (1 Night)
Ngorongoro Serena Safari Lodge /
The Retreat at Ngorongoro
Ngorongoro Game Drive

Total Cost: £ 3380 Per Person (Conference Attendees) excluding international flights

Total Cost: £ 3280 Per Person (Non-Conference Attendees) excluding international flights

Inclusions:

- ✓2 days Conference in TUI Blue Bahari Zanzibar
- ✓10 Nights Hotel stay included
- ✓All meals included from 5 Nov Dinner till 15 Nov
- ✓All-inclusive meal plan in Zanzibar
- ✓Safaris Entrance Fees, Concession Fees
- ✓Welcome & Gala dinner
- ✓All taxes included
- ✓Safari Game Drives & Transfers by SUV
- ✓Picnic lunches during Safaris
- ✓Internal Flights:
  - Zanzibar to Arusha
    (Eco Class – 20 Kgs)

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The invoice will be sent to you as soon as it is received by Bolton Travel Ltd, in association with Brightsun Travel, with whom you have a contract.
Full details of your booking will be shown on your 'confirmation invoice' and your booking is subject to the terms and conditions of Bolton Travel & Brightsun Travel.

Select your package (Please tick)

1: CONGRESS PACKAGE 3 Nights, 4 Days ☐
(Including Flights from Manchester or London)
£2300 per person

2: CONGRESS PACKAGE 3 Nights, 4 Days ☐
(I will book my own flights)
£1420 per person

3: CONGRESS & TANZANIA PACKAGE ☐
10 Nights, 11 Days *(Excluding Flights)*
£3380 (Conference Attendees)
£3280 (Non-Conference Attendees)

BIDA MEMBER *(Please delete as appropriate)*: **YES / NO**

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Address: ..... Postcode: .....

Mobile: ..... Email: .....

Packages are exclusive to BIDA Members & their immediate family (Spouse & Children). Other relatives of BIDA may be able to join at a supplement of £100.00 Per Person, subject to availability.

Traveller Details

Title	First Name	Surname	Date of Birth	Passport No.	Nationality	Payment Ref. for Bank Transfer

NB. Please ensure that the above details are as per passport. (All Passports must be valid for at least 6 months after ARRIVAL in the U.K.)

Declaration

I agree on behalf of all persons on the booking form, which I have submitted, to accept the unaltered Booking Conditions and the Insurance Conditions and warrant that I have the authority of all persons named to make the booking subject to these conditions. I am over 18 years of age. I also agree that, where applicable, I authorise Bolton Travel Ltd in association with Brightsun Travel to make this booking on my behalf.

Signature: ..... Print Name: ..... Date: .....

To Reserve your place, please bank transfer the initial deposit amount (as per payment schedule), print this form, fill in your details, sign and send it (as scanned copy or photograph) to **accounts@boltontravel.com** You will receive a confirmation email within 3 working days, confirming your Payment and Booking Reference.



15th BIDA International Congress Booking Information

Payment Schedule

Initial deposit Amount of £ 1500 (Non-Refundable) per passenger payable at the time of booking **excluding international flight options.**

Initial deposit Amount of £ 2000 (Non-Refundable) per passenger payable at the time of booking **including international flight options.**

Bank details for direct transfer: **Bank name: Co-operative Bank Branch: Harrow Account Name: Bolton Travel Ltd**
Sort Code: 089299 Account No: 63000694 IBAN: GB24CPBK08929963000694 BIC/Swift Code: CPBKGB22
Payment Ref: Whatever payment reference you use please fill it in the Travellers Details on the Booking Form.
(Preferred Payment Reference is BIDA24 and passenger's name, i.e. BIDA24 John Smith)

Second Additional Deposit on or before 15 April 2024. (Non-Refundable)

CONGRESS PACKAGE (including FLIGHTS) £ 500 ; CONGRESS & TANZANIA £ 1000

Full and final payment of remaining money is due by 15th July 2024. (Non-Refundable)

CONGRESS PACKAGE (including FLIGHTS) £ 100 ; CONGRESS & TANZANIA : Whatever is outstanding amount as per the booking invoices.

Please note: Prices mentioned is on a on Double / Twin Sharing. Your invoice will have an accurate price for your booking.
Deposit paid is non-refundable/non-transferable in the event of cancellation/ postponement.

Places will be allocated on a first come first served basis, as places are strictly limited.

Closing date for bookings: As soon as all places are filled, or by the 15th March 2024 (whichever is earlier).

To Reserve your place, please bank transfer the deposit amount £2000 / £2000 per person, print the Booking form (overleaf), fill in your details, sign and send it (a scanned copy or photograph of completed form) to accounts@boltontravel.com.
You will receive a confirmation email within 3 working days, confirming your Payment and Booking Reference no.

Card Payment: 2% Handling Fees will be applicable.

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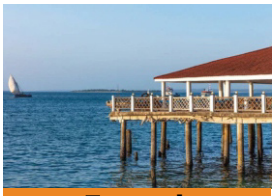
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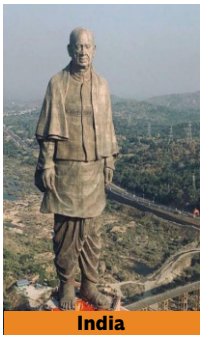
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