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Studying effectively at Medical School (and beyond)

Inside:

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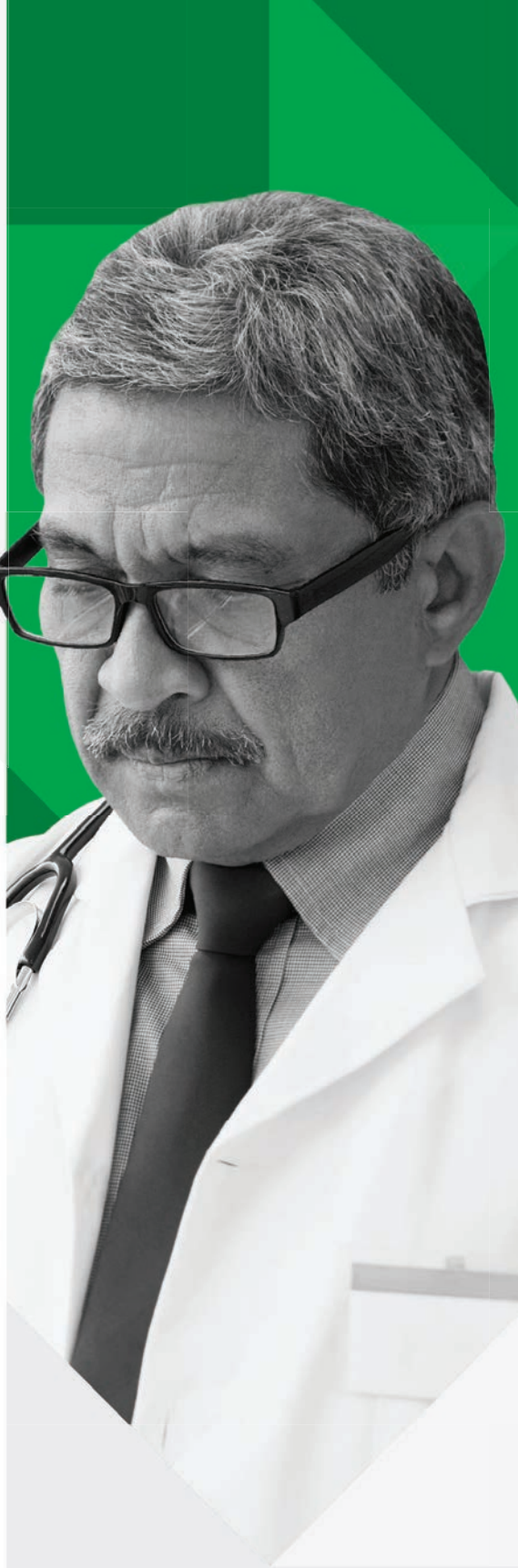

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Editorial

Prof Amit Sinha FRCS (Tr&Orth). Consultant Orthopaedic Surgeon. Editor, BIDA Journal.

New NHS

Sir Keir Starmer has promised the world to us. He talked about changing the NHS into a "neighbourhood health service".

This would mean "more tests, scans and healthcare offered on high streets and towns centres" alongside bringing back the family doctor and offering digital consultations to those who want them.

The intention has been positive starting with Lord Darzi's strong contribution with a no-nonsense list of recommendations. The junior doctor's pay dispute was amicably settled. This is now followed by Rt Hon Wes Streeting's invitation for the public and organisations to participate in a survey as to how to change the NHS. However, I remain sceptical whether the latter may end up as a futile paper exercise.

Resident Doctors

This new term is being rolled out across UK Government communications. 'Resident doctor' is already used widely internationally, including in North America, parts of Europe, Australia and in India. When I joined post graduation in India my title was as a "Resident". In those days the term was used because we were actually resident in hospitals, which provided basic accommodation for all doctors during their term of work, principally because of the long hours and intense rotas, which were the norm at that time. This change in the UK does not imply that actual residence within the hospital is expected, or that we are planning to return to the working hours of the 1980s.

Lord Darzi's Report

We have all read Lord Darzi's independent investigation into the health service. BIDA endorses these proposals made in his report, which provides a vision of hope for the future, while recognising that reform will require long-term commitment and investment. BIDA is committed to our role in realising a better future for the NHS, by ensuring that the experience, and expertise, of our members is recognised and heard. We know that health care professionals are driven by dedication and passion to provide best care.

Obesity

Obesity-related illness remains a significant challenge in the UK and across the world. It is important that we continue to champion for a healthy weight environment, in our role as health care professionals. What the public doesn't realise that obesity affects each and every part of our body systems. We would encourage the government and the Public Health units of the country to take appropriate measures. BIDA fully supports the aims of OASIS GB, Chaired by Prof S Senapati and Jack Carney. The recent conference on 4th October at Salford Hospital was a great success in inviting healthcare professionals from across the country. A report is included in this issue of the Journal.

Articles

Prof Brigden and his team of medical students have written 2 extremely useful articles on Studying effectively at medical school and the Art of reflective practice. Both articles outline the respective themes extremely well. The article by Drs Anita Sharma & Shalini Gadiyar on Intra-uterine contraception fills its educational objectives in relaying its message in a question and answer format. These are practical questions, which have been expertly answered. The article on Chronic subdural haematoma from Aberdeen Infirmary explains the various complexities of the condition.

I must thank Nick Milne and Marguerite Smith, who are the Chairman and Secretary respectively of the Blackpool Fylde & Wyre Haemochromatosis support group for submitting the article on Haemochromatosis. I had met them at a recent Health Mela organised by the National forum of Health and Wellbeing. The article is very informative.

You must read the article by Alice Thankachan, whose presentation at our BIDA National Oncology Conference won her the first prize. This is a very well organised observational research study done in India on the patient's and caregiver's needs when dealing with progressive neurological conditions.

BIDA EC 24 - 27

There is excitement amongst our BIDA members. We now have a fresh set of Executive Committee group following the recent elections, with a number of young faces. They are our future. The Editorial Board conveys their congratulations and the best wishes to all the EC members.

On behalf of the Editorial Board, I must thank Nick Sample, our graphic designer who always turns the Journal into a piece of art. My thanks also to Alison Sherratt, BIDA Office Manager who co-ordinates the rest of the administration very efficiently.

My heartiest congratulations to our BIDA 2024 Fellowship awardees, Dr Syed Naqvi and Dr Suresh Chandran.

Greetings for Christmas and the New Year to all colleagues and their families.

Prof Amit Sinha *Editor, BIDA Journal*

"You will never find rainbows if you keep looking down"
Charlie Chaplin.

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Instructions for Authors

BIDA Journal is a peer-reviewed journal. We welcome original articles from physicians, surgeons and medical students from any part of the world. These include review articles, scientific articles, case reports, audits and letters to the Editor. Please visit BIDA's website for instructions.

Contents:

Editorial Address:

The Editor
BIDA Journal
Suite 6, Princess Chambers
2 Brown Street
Stockport
Cheshire
SK1 1RJ

Telephone:
0161-456 7828

E-mail:
amitani2000@yahoo.co.in
bida@btconnect.com

Website:
www.bidaonline.co.uk

Message from the National President

Dear BIDA Friends,

I wish to thank you all to accept me as our organisation's National President. It is such an honour and prestige. Having served as the General Secretary, Media and Communication lead and editor of BIDA Journal, I fully understand this responsibility. As the constitutional head I have prepared myself to serve the organisation to the best of my ability.

I welcome the new EC committee, which has a lot of new and young faces. This is extremely encouraging as fresh members are expected to bring in innovative ideas and suggestions. This is an exciting change, a huge opportunity to continue striving forward and to take BIDA to greater heights.

The current year has been packed with several activities, the most recent ones being the National conference and the AGM/ARM at Worsley Country Park, Manchester and the International Conference at Zanzibar. Both were huge successes. The enthusiasm I witnessed amongst all who attended fills me with pride and joy.

Next year is special, as it's BIDA's 50th year. I would like to celebrate and honour all our seniors, who have navigated the organisations since 1975 and stood the test of difficult times to uphold the motto of "Equality & Fairness". The "Overseas Doctors Association" blossomed into "British International Doctors Association". The fight for International Medical Graduates is still not over. We need to foster the spirit of unity, friendship, mentorship and support.

Christmas greetings and best wishes for the New Year.

Prof Amit Sinha
National President, BIDA.

National Chairman's Report

Dear Friends,

I sincerely hope you and your loved ones are keeping well. I would like to express my sincere thanks and gratitude to all BIDA members for electing me as National Chairman for another three years. I reassure all of you that I will do everything possible to keep the BIDA flag flying high. I would also like to pass on a huge thankyou to all outgoing members on BIDA EC who contributed selflessly to BIDA activities. At the same time, I would like to extend a warm welcome to our new EC members. I look forward to working with all of you. It is the result of these volunteer efforts that BIDA today is a strong force in British National Medical political field.

We have had a busy few months with some very successful National and International meetings, including BIDA National Conference 2024 hosted by Bury and Rochdale Division and the recently concluded 15th BIDA International Congress, Zanzibar and Tanzania. I was a part of both these events and my heartiest congratulations go to the organisers for putting on such an amazing show.

We are now officially into the 50th Year of the inception of this organisation. To celebrate this landmark year, we are planning to have multiple events spread throughout the year. Please keep an eye on your e-mail. I would urge all of you to get involved in this celebration year.

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.

Best wishes,

Dr Ashish Dhawan
National Chairman, BIDA.

BIDA National Executive Committee 2024

Name	Position
Professor Amit Sinha	*President*
Dr Sanjiv Sinha	*Vice President*
Dr Chandra Kanneganti	*Immediate Past President*
Dr Ashish Dhawan	*Chairman*
Dr Alka Trivedi	*Vice Chairman*
Dr S Sarker	*Immediate Past Chairman*
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Dr Leena Saxena	*ARM Vice Chairman*
Dr Ravish Katira	*Chairman, Hospital Doctors Forum*
Dr Rakesh Sharma	*Chairman, GP Forum*
Dr John Raj	*Chair, Public Health & Community Health Forum*

Name	Position
Dr Anita Sharma	*Chair, Women's Doctors Forum*
Vacant	*Chair, Post-Graduate Doctors Forum*
Professor Sanjoy Bhattacharyya	*Chair, BIDA Academic Forum*

Executive Committee Members	BIDA Division
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Dr Shikha Pitalia	*Wigan*
Dr P Sirigiri	*Stoke-on-Trent*
Dr Lenin Vellaturi	*Stoke-on-Trent*

National Treasurer's Report

Dear BIDA Members,

I am really pleased to write this report as we have had an AGM recently where I have been given an opportunity to serve as your treasurer for another term and it is my pleasure to fulfil this responsibility.

I have presented the accounts at the AGM on 20th of October and I wish to report to you that our BIDA finances are in a healthy condition and in a positive balance. I would like to thank everyone in our team including Dr. Ashish Dhawan and Prof. Amit Sinha and our accountant Amir Zahur. We will strive hard to maintain a positive balance in the coming year.

As you know, our beloved ODA house has been sold in September 2021 since it became a liability with tremendous expenditure to keep up. Money we have received from the sale of the property has been deposited in a fixed deposit account which is already paying us good returns. We intend to continue to do the same. The current BIDA office is a rented accommodation in Stockport which has adequate facilities serving our purpose.

I would like to wish you a fantastic festive season of Diwali and Christmas.

Best wishes,

Dr Vinod Gadiyar
National Treasurer, BIDA.

G.P. Forum Chairman's Report

Dear Colleagues,

It is a privilege to take on the role of Chair of the GP Forum within BIDA, and I would like to begin by extending my heartfelt thanks to our outgoing Chair, Dr Preeti Shukla for her dedicated leadership during a time of immense challenge for general practice.

The NHS is facing a period of unprecedented strain. With increasing patient demand, an ageing population, and the lingering effects of the pandemic, the pressure on healthcare services continues to mount. For general practice in particular, workforce shortages, escalating administrative burdens, and inadequate funding are creating unsustainable conditions. These challenges are driving a recruitment and retention crisis, with many GPs experiencing burnout.

At BIDA, we recognize the critical need for collective action to tackle these issues. We are working closely with the GP Committee of the BMA (GPCE) to advocate for practical solutions, including increasing resources for general practice, ensuring fairer working conditions, and reforming the funding model to meet the growing demands on primary care.

We are committed to supporting international doctors, ensuring that they have the opportunities and support necessary to thrive within the NHS. By joining forces with the GPCE, BIDA will continue to champion the interests of GPs, fighting for the changes needed to create a sustainable, well-supported general practice.

Through collaboration and unified action, we can strengthen our profession and ensure that GPs remain at the forefront of delivering high-quality care for our patients. I look forward to working with all of you as we face these challenges together.

Warm regards,

Dr Rakesh Sharma
Chair, G.P. Forum, BIDA.

Why I joined BIDA

"As a foreign graduate, one is more likely to be unsuccessful in their ARCP/membership exams and also be bullied at workplace. Yet very little has been done to help foreign graduates and worryingly, there is much of an appetite to change this. BIDA is one of the very few platforms that challenges the norm and does its best to empower foreign graduates. Moreover, it is empowering to meet people with similar sensibilities all striving to achieve the best for themselves and the NHS."

Mr Puskar Bura *SpR Cardiology*

Chronic Subdural Haematoma

Dr William Robbins BSc, MBChB FY1, Bristol Royal Infirmary, University Hospitals of Bristol and Weston NHS Foundation Trust, Bristol, BS2 8HW.

Mr Pragnesh Bhatt MS, MCh, FRCS, FEBNS
Consultant Neurosurgeon, Aberdeen Royal Infirmary, Aberdeen, AB25 2ZN

Introduction

Chronic subdural haematoma (CSDH) is a common neurosurgical presentation and is characterised by the abnormal collection of blood beneath the dura. It develops over the course of a few weeks, usually after a minor head injury. It is a condition predominantly seen in the elderly population and is increasing in incidence. The pathophysiology of CSDH is complex and remains poorly understood, with multiple theories evolving over time[1]. Its clinical manifestation varies from an asymptomatic event to a neurosurgical emergency. Surgical intervention is the choice of management for CSDH, although conservative management can be considered for small and asymptomatic haematomas. The prognosis varies following surgical treatment, with recurrence remaining its primary complication.

Epidemiology

The overall incidence of CSDH is estimated to range from 1.72 to 20.6 per 100,000 persons per year[2]. A significantly higher incidence of up to 58 per 100,000 persons per year is reported among individuals aged above 65 years[3]. Furthermore, a large epidemiological study conducted in Japan demonstrated that the most common age group in their cohort of 63,358 individuals was 80 years or above[4].

The incidence of CSDH has been observed to be increasing markedly over the recent years. It was demonstrated to increase from 8.2 to 17.6 per 100,000 persons per year from 1990 to 2015 by a retrospective study conducted in Finland[5]. Furthermore, it is projected that incidence may increase by 53% by 2040[6]. This may be explained by the shift of an ageing population and the increasing use of antiplatelet/anticoagulant medication[5].

Risk Factors

Several risk factors have been identified that predispose for CSDH formation, although a combination of these risk factors is usually present. It commonly occurs following a minor head injury, particularly in the elderly population. However, a history of head injury might be absent in 30 to 50% of cases. Furthermore, approximately 50% of cases have a history of a fall but without a head injury.[7] Indirect injury may be more important for CSDH formation.

Craniocerebral disproportion may increase the risk of CSDH formation. It is defined as the mismatch between brain volume relative to cranium volume and can occur as a result of age-related cerebral atrophy or chronic alcoholism. It is hypothesised that craniocerebral disproportion can heighten the chance of dural membrane rupture and provide space for haematoma growth by increasing subdural space from 6 to 11%.[8,9]

The use of antiplatelet/anticoagulant medication and the male gender are other risk factors implicated for CSDH formation. At least 4 to 6 out of 10 cases are reported to be on antiplatelet/

anticoagulant medication[8], and its use has been reported to increase the risk of 30-day mortality rates. Vitamin-K antagonists in particular is associated with the highest risk for CSDH formation.[10] The male gender has traditionally been attributed as a risk factor for CSDH formation in epidemiological studies. It was believed to be a result of increased incidence of head injury and/or alcohol abuse, although this is not supported by current literature.[8]

MGS	Neurological Status
0	Neurologically normal
1	Alert and orientated; with mild symptoms such as headache; absent or mild neurological deficit, such as reflex asymmetry
2	Drowsy or disorientated with variable neurological deficit, such as hemiparesis
3	Stuporous but responding appropriately to noxious stimuli; severe focal signs such as hemiplegia
4	Comatose with absent motor responses to painful stimuli; decerebrate or decorticate posturing

Table 1. An adapted Markwalder grading system of CSDH severity. MGS = Markwalder grading scale. [17]

Pathophysiology

The pathophysiology of CSDH is complex and remains poorly understood. Multiple theories describing formation and expansion have been put forward. The earliest concept, described in 1857 by Virchow as *"pachymeningitis haemorrhagica interna"*, suggested that an infection (meningitis) drove a chronic inflammatory response in the dural membrane leading to eventual CSDH formation[11]. In 1914, Trotter proposed that injury to bridging veins of the subdural space resulted in what he termed as a *"subdural haemorrhagic cyst"*[12]. Subsequent hypotheses suggested that CSDH was a state of chronic or recurrent bleeding, resulting from expansion through increased osmotic pressure as proposed by Gardner in 1932[13] or recurrent microhaemorrhage from an initial haematoma as supported by Apfelbaum et al in 1972[14]. However, it appears through recent evidence that CSDH formation may be more intricate, involving a complex interplay of angiogenesis, fibrinolysis, and inflammation[15].

Clinical Presentation

The clinical presentation of CSDH varies from an asymptomatic event to a comatose state. Neurological severity of symptoms is dependent upon factors such as haematoma thickness, speed of haematoma expansion, haematoma location, and the presence of any mass effect.[8] The most commonly reported symptom is headache, followed by focal neurological deficit, speech disturbance, and altered mental state[16]. Most patients present with a Glasgow coma score (GCS) ranging from 13 to 15. Around 8% of patients present with a GCS between 9 to 12, and 3% of patients present with a GCS between 3 to 8.[8]

The clinical progression of CSDH can be categorised in three distinct stages: initial formation, latent period, and clinical presentation. The first stage is marked by an initiating injury that triggers the pathophysiological processes for CSDH formation. This is followed by a latent period of gradual CSDH evolution over the course of three or more weeks, ultimately resulting in the manifestation of symptoms due to irritation and mass effect on the underlying brain parenchyma.[2] The clinical severity of patients presenting with CSDH can be classified in to five grades described by Markwalder in 1981, as shown in table 1[17].

Diagnosis

CSDH can be readily diagnosed using computed tomography (CT) scan, showing a slightly hypodense crescent-shaped collection lying on the cerebral convexities either unilaterally (figure 1) or bilaterally. Increased density on CT scan may represent CSDH evolution or the presence of recent bleeding.2 CT scan can also provide additional information about CSDH, including its location, age, thickness, presence of membranes, and any associated mass effect[8]. Around 9-22% of CSDH cases are bilateral[8], with a higher occurrence observed in children[18]. In the literature, there is a noted predominance of left-sided cases of CSDH. While the exact reason remains elusive, it may be attributed to the prevalence of left-hemisphere dominance in the population (95%), leading to a clinical presentation with more apparent symptoms.[8,19]

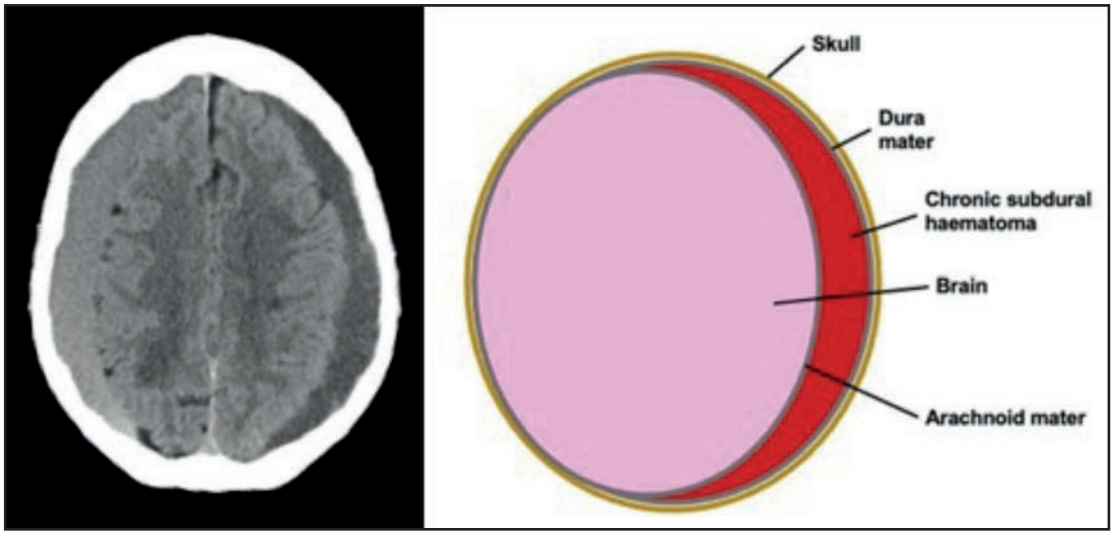

Figure 1. CT scan and schematic of a unilateral left sided CSDH. Case courtesy of Euan Zhang, Radiopaedia.org, rID: 66577.

Management

The management of CSDH is dependent on the severity of clinical presentation and radiological findings. Conservative management is a potential option that involves regular follow-up with CT scan, although this is normally limited for asymptomatic patients with small haematomas.[8]

Above: A graphic illustration showing (left to right) Acute Subdural Haematoma, Subacute Subdural Haematoma and Chronic Subdural Haematoma.

Surgical treatment is the primary choice of management for CSDH, with the most common options including twist-drill craniostomy, burr-hole craniostomy, and minicraniotomy. Despite the common practice and an abundance of literature on surgical management, there remains no consensus surrounding the best surgical option or a standardised guideline for treatment of CSDH. With a lack of consensus, the surgeon is therefore left to decide based on factors that are usually not related to the clinical outcome of the patient.[20] Regardless, burr-hole craniostomy is the most common procedure performed worldwide, with recent literature favouring it as the superior surgical option due to its low recurrence and complication rate[21,22]. Additionally, mini-craniotomy may be useful for complicated cases of recurrent CSDH[23]. Furthermore, twist-drill craniostomy may be an effective alternative for being performed at bedside in emergency conditions, and for patients with multiple co-morbidities and high anaesthetic risk[24]. The routine insertion of a post-operative subdural drain has been demonstrated to reduce the risk of recurrence[25].

Recent efforts in CSDH treatment include medical approaches that utilise drugs including corticosteroids, tranexamic acid, statins, and angiotensin converting enzyme inhibitors, either as a monotherapy or as an adjunct to surgical treatment[8]. Interestingly, a recently developed minimally invasive procedure known as middle meningeal artery embolisation has demonstrated early promising results[20].

Prognosis and Complications

The outcome of CSDH following surgical intervention varies, with morbidity approximately between 0 to 25%, and mortality rates of 0 to 32%[26]. A retrospective study conducted in Finland found that the highest mortality rates occurred in the oldest age group post-operatively. Moreover, an association between the presence of co-morbidities and mortality rates was observed.[27] Neurological status at the time of surgical management appears to be the most important prognostic factor[28]. Recurrence is largely focused as one of the major complications of the surgical management of CSDH and often requires re-operation. The rates of recurrence requiring re-operation ranges between 9 to 33%, with several factors associated including diabetes mellitus, use of antiplatelet/anticoagulant medication, pre-operative seizure, initial width of haematoma,bilateral haematoma, presence of membranes, and midline shift of 5mm or above. Other surgery specific complications of CSDH may include brain contusion, seizure, subdural empyema, infection of surgical site, pneumocephalus, and acute subdural haematoma. Non-surgical medical complications that may pose significant risks particularly in the elderly population could include respiratory and urinary infections, deep vein thrombosis, pulmonary embolism, myocardial infarction, and cerebrovascular accide.

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Answering patients' questions on Intra-Uterine Contraception

Dr Anita Sharma GPwSI in Gynaecology Oldham
Chair of Women's Doctors Forum BIDA. GP member NICE GDG Menopause and Breast Cancer
Dr Shalini Gadiyar GPwSI Gynaecology, Ashworth Street Surgery, Rochdale.

Introduction

This article presents some of the questions that GPs and other healthcare professionals (HCPs) who fit IUD (Intra-uterine device) or IUS (Intra-uterine system) are likely to face from patients and provides information that will enable GPs and HCPs to answer them succinctly.

Questions cover the effectiveness of the coil, its suitability for women in different circumstances, the process of coil fitting and what women can expect afterwards.

The Faculty of Sexual and Reproductive Health (FSRH) produced updated guidance on contraceptive provision during the COVID-19 pandemic in October 2020, which stated only do emergency contraception IUDs. Since the restrictions are eased, non-urgent face to face procedures is taking place.[1]

Case scenarios are also presented.

Key learning points cover the risks and benefits of the IUD and the IUS, as well as their contraindications.

Educational objectives

After reading this article, healthcare professionals should be better able to:

- Advise women on the risks and benefits of IUD and IUS
- Inform women about what to expect during fitting.
- Advise women about what may happen once an IUD or IUS is in place.

Question 1: Effectiveness of the coil

"I'm thinking about having a coil fitted, would it be a good contraception method for me?"

Intrauterine contraceptives comprise the Cu-IUD (Copper coil) and the levonorgestrel-releasing IUS of which are Mirena, Levosert Jaydess and Kyleena. These are plastic, T-shaped devices that contain the progestogen Levonorgestrol which is gradually released in the intrauterine cavity. Mirena is currently licensed for 8 years for contraception as per recently revised guidelines. Levosert IUS can be used for 6 years and Jaydess for 3 years and Kyleena for 5 years.

The Cu-IUD is also a T-shaped plastic device with copper and depending on the type of the device, lasts either 5 or 10 years.

Fewer than 2 in 100 women over 5 years will have a pregnancy with a copper IUD (this figure is fewer than 1 in 100 women over 5 years for the IUS).[2]

IUDs, the IUS and implants are more cost-effective than the injectable contraceptives.[3] An IUD is a good choice of contraception for all women, especially if they have had children.

All LARC (Long-acting reversible contraception) methods are suitable for nulliparous women, women who are breast feeding, women who have had termination of pregnancy (at the time of termination or later), women with BMI > 30 kg/m2, women with diabetes, women with contraindications to oestrogens, and women with migraine with or without aura.

It is important for women to use effective contraception to prevent an unplanned pregnancy until after the menopause. When prescribing oral contraception, the clinician should be guided by UKMEC.[4] Unless there is a medical contraindication to pill use such as cerebrovascular accident, VTE, migraine, obesity, or smoking, the combined pill can be used up until the age of 50 and the POP until 55 years.[5,6]

Women should be advised that LARC methods can be as effective as sterilisation and can be an alternative for women who do not want to be sterilised.[2]

A copper-bearing IUD.

Question 2: Copper vs Hormone-releasing coils

"What is the difference between the copper coil and Mirena?"

Copper-bearing IUDs work by creating a local inflammatory reaction within the lining of the womb, making it resistant to implantation. Also, copper is thought to be toxic to the sperm and the copper content in the cervical mucus inhibits sperm penetration. Some women prefer this method, as they do not wish to use any hormones.

The hormone-releasing IUS releases progesterone, which prevents thickening of the lining of the womb and prevents implantation. It also thickens the cervical mucus, which impairs the sperm penetrability of the cervical fluid. In some women it can suppress ovulation.

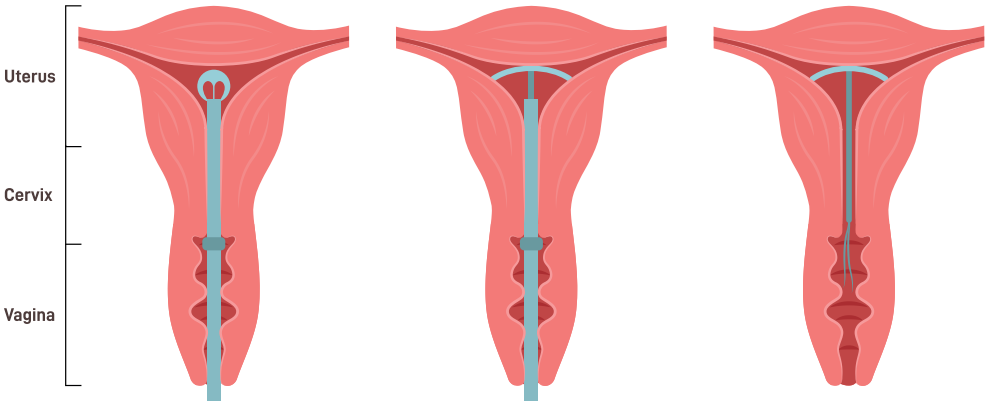
The added advantage is reducing periods and therefore the IUS can be an excellent choice for women with heavy, painful periods.[1] it also offers endometrial protection and is therefore also licensed as part of HRT in older women.[4]

Question 3: Previous STIs

"I've got a new partner; can I have a coil fitted in spite of having a sexually transmitted infection in the past?"

A careful sexual history will identify women at risk of an STI. Risk factors for STIs include unprotected sex, age under 25, multiple sexual partners, a new partner within last 3 months, past history of STIs, and use of drugs and alcohol.

STI screening should be offered routinely to all women who are identified to be at risk of STI and asking for intrauterine contraception. Self- taken vulvo-vaginal swabs are the best option that can be tested for both chlamydia and gonorrhoea. If an STI is suspected, complete the treatment for the infection before inserting the IUD.



An illustration of the insertion of an Interuterine Device

Question 4: Past H/O Cancer

"I've had cancer, can I have the coil?"

There are few absolute contraindications to IUDs and the IUS, and these include undiagnosed vaginal bleeding, possible pregnancy, and hormone-dependent cancers in IUS users.7 Current and past history of breast cancer or endometrial cancer will need discussion with the cancer specialist.

Question 5: Timing

"Do I have to be on my period to have my coil fitted?"

No, provided it is reasonably certain that the woman is not pregnant or at risk of pregnancy. Extra precautions will be required for 7 days after having an IUS fitted, whereas the IUD will be effective immediately post-insertion.

Question 6: Pain

"Will it hurt having a coil fitted?"

Women are often deterred from using the coil because of fear of pain. Coil fitting can be an uncomfortable procedure, but it does not require local cervical block. The risk factors for pain are nulliparity, no history of vaginal delivery, anxiety, and lack of periods for some time. The insertion procedure can be made more comfortable by prior use of NSAIDs, topical lidocaine agents and misoprostol for cervical ripening. Good counselling and use of `vocal local' is helpful in most cases.

Question 7: Complications

"What can go wrong?"

Sometimes, some women feel light-headed and faint during the procedure. This can be due to cervical shock during cervical instrumentation. All GPs and HCPs who fit coil have training in resuscitation if there is profound bradycardia and hypotension.

Another potential complication that is rare but serious is uterine perforation. The risk is up to two per 1000 insertions and is higher in breast-feeding women.

Sometimes it is not possible to fit the coil despite trying and this should also be discussed the woman at counselling. If this happens and she is keen to have a coil, she can be referred to secondary care for the procedure.

Question 8: The coil as emergency contraception

"I've had unprotected intercourse. Can I have a coil fitted to prevent me becoming pregnant?"

Copper coils are a first line option for emergency contraception (EC) due to their lower failure rate as compared to emergency hormonal contraception. A copper coil can be inserted within 5 days of the first episode of unprotected sexual intercourse or in case of multiple episodes, within 5 days of the expected date of ovulation (that is, up to day 19 of a 28-day cycle). The hormonal IUS is contraindicated for EC use as it takes 7 days to become effective.

Question 9: Postpartum coils

"When is the best time to have the coil fitted after giving birth?"

Following childbirth, the risk of pregnancy starts from day 21, therefore it is recommended to use contraception from this time onwards. Coils can be inserted any time after four weeks following a vaginal or caesarean birth, although waiting until six weeks is recommended to lower the risk of expulsion.

Question 10: Ectopic Pregnancy

"What is the risk of ectopic pregnancy with the coil?"

IUS and IUDs reduce the absolute risk of ectopic pregnancy when compared to using no contraception because they are such effective methods of contraception. However, if a pregnancy occurs with an IUD/IUS in situ, the relative risk of ectopic pregnancy is increased.

NICE recommends that IUD/IUS users should be informed that the overall risk of ectopic pregnancy is very low; at about 1 in 1000 at 5 years.[3] The EURAS-IUD study reported an ectopic pregnancy rate for IUS of 0.02 per 100 woman-years and for the copper IUD a rate of 0.08 per 100-woman years.[8]

Question 11: Periods

"Will I have regular periods with the IUS?"

Periods tend to change with the IUS. They can be frequent or longer

post insertion for up to 3 to 6 months before they settle to a very acceptable light monthly period. In about 20 per cent of women periods may stop altogether, which is not harmful.[2]

Question 12: Expulsion

"What are the chances that the coil might come out again?"

It has been estimated that expulsion of intrauterine contraception occurs in approximately 1 in 20 women, is most common in the first three months after insertion and often occurs during menstruation. There is some evidence to suggest that a past history of expulsion increases the risk of future/subsequent expulsion.

Question 13: Fertility

"How soon will I become fertile again if I have my coil removed?"

There is no evidence that the IUD or IUS cause any delay in fertility after removal.

Question 14: Replacing Coils

"What should I do if my coil is due for replacement?"

Copper IUDs, such as T-Safe, are licensed for 10 years but do not cause health problems if used for longer and are likely to be effective for contraception for up to 12 years.[9]

52mg levonorgestrel intrauterine systems (IUS) Mirena is licensed for 8 years and Levosert is licensed for 5 years. They do not cause health problems if used for longer. If fitted after the age of 45, these can be used safely for contraception until the age of 55.

If a woman has a copper IUD with a 5-year licence, she should not rely on this contraceptive after this time. But if she had the device fitted after the age of 40, she can rely upon the IUD until the menopause.

The low-progestogen IUS, Kyleena and Jaydess, should not be relied on beyond their normal duration: 5 years for Kyleena and 3 years for Jaydess.

We should recognise that women may feel anxious about change, but they can take POP (progestogen-only pill) if they are beyond the duration.[10]

Question 15: Vaginal Discharge

"I have noticed smelly discharge, what should I do?"

Women can be reassured there is no need to worry if they have no pelvic pains, abnormal bleeding, or temperature. They can be reviewed, and a swab taken to check for infection. Vaginal infections can be treated easily.

Case Scenario 1: Lucy

Lucy is 20 years old and a veterinary medicine student. She is not in a relationship currently but wishes to have an IUS fitted in case she needs contraception in future. She has previously been on the combined contraceptive pill, and this had not agreed with her. It caused mood changes etc and is not keen to try the depot injection or the implant. She has heavy periods and has found that the Mirena coil can help with heavy periods and is a good contraceptive. She is nulliparous and wants to know if she can still have the IUS. How would you advise her?

Lucy is knowledgeable about the Mirena and is keen to try this method. She has already tried the COCP that did not suit her. She also has heavy periods. She was counselled that being nulliparous is not a factor for trying the Mirena. She was informed that it can sometimes be a little difficult to fit the IUS but with good local anaesthesia, cervical dilators can be used if needed and she should be able to have the Mirena fitted.

Case Scenario 2: Shahida

Shahida is 44 and has 5 children who are in their teens. She used to have regular periods and recently when she missed a period. She was very scared that she might be pregnant again. Although her period came and she found she was not pregnant, she decided to have contraception to avoid any future scares. She is not keen for any hormonal methods and does not want to not have periods. She came to discuss what her options would be. What would you advise her?

Women in mid to late 40's can still get pregnant and it is important to have contraception cover. As Shahida was not keen for hormonal methods, the copper IUD would be a good choice for her. She needs to be counselled about getting heavier periods, which may worsen, around the menopause. She may benefit from the 10 year copper IUD which can be left until 55 when she no longer needs contraception or until one year after her last period after 51 years.

Key learning points:

- An IUD is a good choice of contraception for all women, including nulliparous women.
- IUS have additional uses for heavy menstrual bleeding and as part of HRT (Mirena only) in addition to contraception.
- Copper coils are a first line option for emergency contraception.
- Extra precautions will be required for 7 days after having an IUS fitted.
- Expulsion of intrauterine contraception occurs in approximately 1 in 20 women.
- There is no evidence that the IUD or IUS cause any delay in fertility after removal.

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Test your knowledge (True or False):

Q1. Researchers believe that the main mechanism of action of copper-bearing IUDs is: (Circle T or F. Answers on page 23)

a. Prevention of fertilization. T / F
b. Changes in the woman's uterus that prevent a fertilized egg from implanting. T / F
c. Changes in the woman's uterus that destroy a fertilized egg. T / F

Q2. The following statements pertain to characteristics of copper IUDs. Please indicate whether each:

a. The IUD has no systemic effects. T / F
b. Return to fertility takes at least six months after IUD removal. T / F
c. IUDs are easy to use, long-lasting and easily reversible. T / F
d. IUDs should not be used by breastfeeding women. T / F

Studying effectively at Medical School

Ethan Little 2nd Year Medical Student Lancaster University,
Abhinav Chakradhar Yeeda 2nd Year Medical Student Lancaster University,
Prof David Brigden University of Bolton, Lancaster University

As undergraduates our focus is on learning the volume of material delivered in the medical curriculum. As busy healthcare practitioners, there is a need to study to maintain and update professional skills and knowledge. However, as postgraduates, issues of time management take on a different meaning with increased pressures of juggling a busy career, home life and continual professional development.

In this article we will identify some of the strategies available to use study time the most effectively, and how to balance that study with the other commitments of medical-student and postgraduate life.

Identifying your learning preferences:

You need to be aware of your learning preferences and understand the times when you can study most effectively. In order to do this you need to consider:

1. When during the day are you at your most receptive to study?

The ability to reflect on one's own performance is at the heart of studying effectively, and, as simple as it sounds, there is no use in trying to study when you aren't focused. Studying throughout the day, it will become evident that there are times when you feel your productivity and concentration is high, and other times when you feel unfocused. By identifying these times of alertness, you can schedule study time for these periods, and allow time to complete less mentally-taxing tasks in the latter. Studies show that as our body temperature rises in the morning, so does our alertness, memory, and concentration, so this could be a good place to start if you are unsure [1].

2. What inflexible commitments do you have?

Medical school places are hard-fought, and there is a distinct pressure to have extracurricular commitments to stand out from the crowd during the application process. Ironically though, upon reaching Medical school, it can often feel as though the workload is simply too much to even consider having separate hobbies outside of the course. However, it is vital to have these interests, as it not only provides a much-needed mental break from academic endeavour, but also allows you to relax, exercise and thus feel better refreshed for when you return to study [2].

3. What time can you create in which to study?

Different study techniques take different amounts of time to work effectively. For example, by creating flashcards (either online or in physical form), these can be used as a quick and easy revision resource to use in that otherwise unproductive 15 minutes on the bus ride home. Or, perhaps practise 'blurting' for 5 minutes on the week's lectures in between ad breaks whilst watching a show. To study effectively at medical school is not all about long night-shifts in the library, but more grounded in efficiency and time management [3].

4. What environment do you find most conducive for study?

Finding the appropriate environment for your study is paramount in ensuring that you study effectively. Do you prefer the silence of a library, or the rowdy background chatter of a campus coffee shop; with friends or not, outside or inside, music or no music? How often do you find yourself wanting to change your environment and enter a new, fresh space? There are myriad options, but you can only know which ones work for you by trying them.

5. What do you do when you are studying?

During study periods, it is important to find a way of working that is effective for you. Popular amongst students is the Pomodoro technique, which comprises 25 minutes of uninterrupted study, followed by a 5-minute break, and repeat. Although for others, having this strict regimen of when to start and stop may be distracting. How you monitor your study time may be different depending on your task. For example, if you are making notes from a textbook, perhaps having a set time to take a break would be preferred. However, if you are writing an essay or a creative piece, it makes more sense to take a break upon concluding an idea or theme. Importantly though, it is essential to take regular short breaks during longer periods of study to maintain focus and stay mentally fresh.

It is now no doubt obvious to you that people learn differently. We accomplish different tasks differently, and all methods will have varying levels of success depending on the student's preferences and what suits them the best. There is no golden rule that works for everyone.

These are general ideas that may help you to work out your own system for organising your time and a considerable amount has been written in connection with learning styles and learning style inventories [4]. If you have a good idea of what it takes for you to learn something, it may still be useful to get a cursory overview of one of these categorisations so you can try different techniques to help you broaden your approach to learning.

What motivates you to learn?

Understanding what motivates you to learn is essential to being an effective studier, so, working out the source of your academic drive is a vital first step in adapting and improving your current study routine [5].

Is it a perceived gap in your knowledge? If so, it is important to develop a sense of purpose, i.e. why are you studying and what do you want to get out of each study session? If you are a postgraduate and your study is to satisfy your continuing professional development, what you need to study and learn will possibly be determined by Royal Colleges or Specialities you are working in.

Is it friendly competition? As a medical student, seeing others studying or discussing unfamiliar topics may inspire you to learn and revise knowledge that you feel uncertain about. If so, adapt your study regime to involve yourself more with others, and be inspired by them to work towards your goals together.

How do you approach learning?

A considerable amount of research has been conducted into the ways in which people learn. The difference between deep and surface learning has been well documented and rote memorisation, a learning technique often favoured by medical students has been shown to be effective only for short term needs; whereas deep learning embedded through understanding can allow new knowledge to be integrated with what is already known [6].

A further distinction that can be made between learners and types of learning is the serialist versus the holistic approach to learning.

Adopting a serialist approach means that there is a very narrow focus on understanding each element in turn. The holistic learner will seek to appreciate the whole topic, before engaging with any part in detail. Neither approach should be seen as preferable, nor is there any correlation between these and deep and surface learning [7].

Both serialist and holistic learners are equally likely to be trying to understand rather than simply remember, but it is somewhat helpful to consider what particular style(s) you adopt when studying.

The importance of revision:

Studying at medical school is not all about learning new academic content and clinical techniques, a lot of our time is also spent on revision. Without revision, our efforts spent learning would arguably be pointless as, over time, we forget the details of what we have learnt.

Effective revision improves your ability to actively recall information when required, and prioritises keeping relevant knowledge at the forefront of your mind by practicing it regularly. Ebbinghaus' forgetting curve reveals that by revisiting topics at increasingly lengthened spaces of time from when it was initially learnt, we maintain that knowledge much more effectively and are slower to forget it. So, regularly revising previous information is key to studying effectively [8].

Time management techniques:

Rather than prevaricating about lack of time it is more helpful to think in terms of setting realistic goals for how and when activities can and will be undertaken. Try to think 'SMART' in terms of planning your learning.

SMART OBJECTIVES:

Specific *– set yourself clear goals*

Measurable *– record progress. This will enable you to maintain your interest*

Action related *– identify the steps necessary to achieve the goal*

Realistic *– set goals that can be achieved within your constraints*

Time based *– set a time frame and plan for this*

For most of us, it does help to have a clear picture of what the end product will be and adopting a SMART approach to studying will enable you to make effective use of each study period. As well as helping streamline the structure of a study plan for students, SMART objectives promote self-assessment and self-reflection which is crucial for their future in the medical field. However, the implementation of the SMART approach into a study schedule might be challenging due its rigid nature. If not used conscientiously, it may shift from a super tool into yet another burden students need to cope with.

Formal vs Informal Learning Activities:

You will be met with various formal learning activities from undergraduate study to health practitioners which range from lectures, seminars, clinical training programs and professional conferences. Formal learning activities are essential for the development of essential skills in a disciplined environment that will be reflected in future practice. Educational institutions such as Lancaster University Medical School maintain strict attendance records for these formal learning activities, as they believe that it is the best way to indoctrinate students into the curriculum while preparing them to become competent practitioners in the future.

On the other hand, there are many informal learning activities that you can turn to, namely self-directed and group study. Self-directed study promotes independence and will let you take the material at the pace that is best for you. Group study offers a more relaxed method of studying with peers to consolidate material without the pressures associated with formal educational activities. Furthermore, other forms of informal learning methods fall into this category, such as engaging with informative YouTube videos on social media or seeking advice from more experienced individuals during social events.

The value of Effective Reading:

Effective reading is the process of reading actively to further analyse and reflect on a text, and critically appraising the worth of the information that is provided [8].

Before you start reading, ask yourself why you are reading a particular text. How detailed does or should the read be? Are you reading in depth and in breadth or are you simply focusing on the same narrow band of information and in so doing not expanding your range of knowledge and understanding? To have an idea about what you want to gain from a particular text allows you to be more thorough in identifying the information that is of value to you. For example, as a medical student, textbooks you receive may bury the pure facts within swathes of description and complicated terminology. However, by reading actively, you practise the skills to identify these facts, and hence become able to deconstruct walls of text into a few, individual, concise bricks of key information.

You can work at improving your reading speed in order to save you time, but this is a false economy if in doing so you sacrifice your level of understanding or your ability to remember what you have read. In truth, active reading it may take twice as long, if not more, for you to properly digest the piece by: highlighting key information, re-reading complex ideas, researching new terminology, taking time to understand the main points, and condensing the text into a more manageable size by removing information that may be irrelevant to you at this time. Although it may seem slow and cumbersome at first, with practice, it will become easier and quicker, and you will find your memory of what you have read increases too.

Moreover, reading with others allows you to debate concepts and perceptions of what you have read. By accessing different perspectives, this can help to solidify your understanding of the main points of a text, but also debate the finer details in an active and engaging way. It is a common idea that explaining your understanding of a concept to someone else supports not only their appreciation for the topic, but also your own as it will strengthen the memory retention of the concept which will give you an enhanced understanding of the material. Another advantage to reading with others, is that it is expected to aid in the development of social skills like communication and teamwork. These are crucial skills that are required for your future in the field of medicine.

Conclusion

To conclude, the art of studying effectively is a refined practice, and no method is exactly the same for anyone. However, there are ways for you to develop this craft. Most importantly: identify and cater to your own personal learning needs and preferences; develop efficient time management; and set clear, achievable goals to keep yourself motivated and invested in your learning. By pursuing these objectives, you work towards a practice that will stand you in good stead for studying effectively at medical school and beyond.

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The art of Reflective Practice: A Key to Lifelong Growth in a Medical Career

Abhinav Chakradhar Yeeda 2nd Year Medical Student Lancaster University,
Ethan Little 2nd Year Medical Student Lancaster University,
Prof David Brigden University of Bolton, Lancaster University

Introduction

"There is an art of which every man should be a master - the art of reflection. If you are not a thinking man, to what purpose are you a man at all?"

~William Hart Coleridge [1]

Although this quotation may seem austere, it can highlight how reflective practice is a fundamental tool for progressive growth in a career of medicine. It is a ubiquitous commitment from the student level all the way to consultancy.

Medical Students

The need for UK medical students to be aware of reflective practice stems from GMC recommendations set out in TOMORROW'S DOCTORS [2]. It states that students should be able to reflect on practice and be self-critical. This is because the capacity for reflection is regularly cited as a key attribute for doctors by healthcare regulators [3]. Medical students have a diverse scope of educational assets that can help them through the processes of reflection. Thie next section focuses on how Lancaster University Medical School incorporates clinical reflection into their MBChB course.

Self–Evaluation Tools

The GMC achieves this by ensuring that medical schools must make room within their curricula to allow students to engage in reflection and personal growth throughout their studies. An example of this is at Lancaster University Medical School, where students are mandated to reflect on their study through a self-evaluation tool called Risr/advance. It serves as an e-portfolio that is utilized to review sessions such as Problem-Based Learning, clinical placements and communication skills workshops (more detail later). The system enables self-reflection, giving students the opportunity to evaluate their own performance in conjunction with logged feedback that was given by tutors.

Additionally, students update a careers management section that prompts research into professional attributes and medical specialties. It includes a 12-month action plan that outlines the steps the student will take up to acquire these attributes and further explore specific medical specialties.

Furthermore, this tool is used to create mock exam reflection plans to highlight and address the gaps in the revision process for the important end of year exams. Overall, Risr/advance is an invaluable resource for learning and reflection that is paramount for preparing the students at Lancaster Medical School for a successful career in medicine.

Appraisal Meetings

An appraisal meeting is when a medical student has a conversation with their academic tutor about their approach to life at medical school. This is routine at many medical schools, such as Lancaster Medical School, who encourages students to reflect on and evaluate their professional, educational and personal development in a face-to-face discussion over the academic year. Students are prompted to set goals in each of these areas to work towards for the next year, which will be set for review in their next appraisal meeting. Emphasis is placed on the importance of these sessions as they mirror annual appraisals that doctors undergo for their revalidation. Involving students in this reflective practice early allows them to develop these skills for use in their professional lives [4].

Communication for Medical Practice

An elemental skill for an aspiring or practising medic is effective communication. It is a crucial component of medical training that is implemented at all medical schools in the UK. Thus, the Communication for Medical Practice (CMP) course at Lancaster University Medical School aims to equip students with the necessary techniques to communicate in a clear, logical and professional manner. It involves students engaging with simulated patients and receiving feedback from peers and educating professionals, who observe their style and approach. This facilitates a healthy discussion of differing perspectives. In addition, it develops the invaluable skills of giving effective feedback and advice to others. Furthermore, by having the sessions filmed, the students are advocated to critique and self-evaluate their own performance.

Problem-Based Learning

Medical Educators are familiar with the concept of zones of proximal development [5], which allows for the transmission of knowledge and skills between peers and near peers as a highly effective format for learning [6]. Lancaster University Medical School employs a variation of this process known as Problem-Based Learning (PBL). PBL is incorporated at 12 UK medical schools such as Hull York Medical School, Manchester Medical School and Edinburgh Medical School.

Much like a seminar, PBL places a heightened focus on collaborative discussion. Furthermore, the implementation of a spiral curriculum with continual adjustment will lead to cognitive development in line with

Vygotsky's theory of social development [5]. PBL strikes a quintessential balance between independent learning and constructive feedback to a group of students in a collaborative setting. This way gaps in knowledge can be addressed by group members. This can spark discussions and debates of ideas among the group, offering fresh perspectives to everyone involved. Peer to peer support enables individuals to engage with and support each other with an extension of this level of engagement and collaboration to include a wider network of 'critical friends'. Additionally, explaining your own point of view to peers will reinforce the foundation of your own understanding of the concept.

Post-Graduate

According to GMC guidelines, medical graduates should be reflective practitioners. The prominence of the role of reflection and reflective practice in medical education has grown rapidly in the last 30 years [7,8,9,10]. Now there is widespread use of portfolios, learning journals and reflective diaries for professional development. Collaborative study is increasingly being advocated as a direction for development in relation to Continuing Professional Development (CPD).

There are substantial benefits in creating opportunities for practitioners at all stages of their careers (students to consultants) to actively engage in discussion and debates about educational issues and educational processes. Enabling CPD activities to include study skills sessions and reflective writing workshops at the postgraduate level can be a major help, in terms of learning [11].

Learning Sets

The isolation of independent study can sometimes be unappealing and discouraging. Informal learning sets can be utilised to help overcome these difficulties. An example of this is an action learning set, which is a process by which a group identifies common learning needs and collectively meets them through shared learning, or through external expertise or facilitation.

Learning sets are based on self-directed learning and participants can decide on specific topic areas they wish to cover and what approach it is done in. They provide a confidential forum that enables participants to test and clarify ideas. Learning sets can encourage individuals to take action and provide a support network with which to reflect and learn.

Conclusion

Reflection is a crucial asset for clinical practice from the undergraduate to the postgraduate level. There are many tools that will be used to enhance and strengthen it over a medical career. Lifelong continuing professional development has no shortcuts and requires dedication. However, effective organisation of time can ensure an efficiency in terms of the depth and breadth of the reflection that can be achieved.

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BIDA Quiz

1 *Question 1:* Mental Health

A 20-year-old patient with schizophrenia is being treated with clozapine. During a follow-up visit, the patient mentions that their lifestyle has recently been changed. Which of the following factors related to this lifestyle change may impact the therapeutic effectiveness of clozapine?

1) **Smoking**
2) **Dietary Fat Intake**
3) **Physical Exercise**
4) **Alcohol Consumption**
5) **Caffeine Consumption**

2 *Question 2:* Geriatric

An 82-year-old patient with a history of dementia is admitted to the hospital with a hip fracture and develops new signs of agitation, confusion, and fluctuating alertness shouting in the emergency department. What should be the first-line management approach?

1) **Start low-dose antipsychotic medication**
2) **Prescribe low dose oral sedatives**
3) **Reorient the patient and provide a calm, well-lit environment**
4) **Urgently admit for surgical management of hip fracture**
5) **Administer analgesia medication to manage pain symptoms**

3 *Question 3:* Respiratory

A 75-year-old patient with long standing COPD presents with increasing shortness of breath and fatigue. An arterial blood gas (ABG) test reveals the following results:

- pH: 7.36
- $PaCO_2$: 7.2 kPa (above normal)
- PaO_2: 6.5 kPa (below normal)
- HCO_3^-: 32 mmol/L (above normal)

Based on these ABG results, which of the following is the most likely diagnosis?

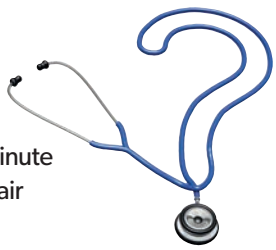
1) **Type 1 respiratory failure**
2) **Type 2 respiratory failure with metabolic acidosis**
3) **Type 2 respiratory failure with metabolic compensation**
4) **Metabolic alkalosis**
5) **Mixed respiratory and metabolic acidosis**

4 *Question 4:* Gastroenterology

A 56-year-old patient presents to the emergency department with right upper quadrant abdominal pain and jaundice. Blood tests show elevated white cell count, bilirubin, and liver enzymes (ALP and GGT). Other blood results are pending.

Vital Signs:

- Temperature: 38.5°C
- Heart rate: 110 bpm
- Blood pressure: 100/60 mmHg
- Respiratory rate: 22 breaths per minute
- Oxygen saturation: 96% on room air



What is the most likely diagnosis?

1) **Cholecystitis**
2) **Pancreatitis**
3) **Cholangitis**
4) **Hepatitis**
5) **Appendicitis**

What is Haemochromatosis?

Marguerite Smith Secretary of Blackpool Fylde & Wyre GH Support Group

Haemochromatosis (GH) is an inherited disorder which causes the body to absorb too much iron over a number of years. Excess iron gradually accumulates, usually in the liver, pancreas, joints, heart or endocrine glands causing serious tissue damage. It is one of the most common genetic disorders. Surveys have shown that 1 in 200 people are likely to be at risk of developing iron overload. Diagnosis can be confirmed by a simple blood test. But if the excess iron is not removed irreversible damage can eventually occur, especially in the liver.

Symptoms and Signs

The most common symptoms noticed by people with iron overload are: Arthritis in any joint but particularly in the knuckle and first joint of the first two fingers; this is highly suggestive of GH Lethargy/feeling tired all the time, chronic fatigue, weakness Abdominal pain the stomach region, upper right hand side Mood swings, impaired memory, irritability, depression Reduced sex drive, impotence in men, early menopause in women Skin colour change, permanent tan, paleness or greying Shortness of breath/heart irregularity Diabetes (late onset type) Liver disorders, abnormal liver function tests, enlarged liver, cirrhosis

Most of these symptoms are found in other disorders. For example chronic fatigue may be due to after-effects of a viral infection and abdominal pain to irritable bowel syndrome. Similarly liver disorders may be down to excessive alcohol intake, even in someone who is only a moderate drinker. However, if some of the symptoms listed above are present, GH should be considered as a diagnosis.

Most individuals who have GH will, if untreated, develop at least one or two of the above symptoms.

Fatigue … liver problems… joint problems is a 'typical' order of symptoms developing (though this does vary of course). Joints complaints are typical of the elderly and sexual problems typical of younger people at diagnosis.

Diagnosis

A simple blood test to check your iron status can confirm or rule out iron overload. The blood test will measure:

1. Transferrin Saturation (TS) – indicates how much iron is readily available for use in the body. The average is 30% (slightly higher in men than women). If on two occasions this is over 50% in men or 45% in women, GH is very likely. This test is not often requested but it is the most specific and sensitive test of GH

2. Serum Ferritin (SF) – indicates the amount of iron stored in the body. Levels significantly over 300mg/l [micrograms per litre] in men and post-menopausal women and 200mg/l in younger women suggest GH. In the early stages of iron accumulation serum ferritin may be normal.

3. Gene Test – a simple blood test for the HFE gene mutation is positive in over 95% of people with GH. It will identify family members at risk of loading iron even before they have increased body iron stores.

4. Liver Biopsy – this is only usually requested if GH is diagnosed by the gene test and the serum ferritin level is over 1000mg/l, the liver function tests are abnormal, or the gene test is negative. A biopsy shows if the liver is damaged. If tests indicate GH is likely, a referral to a Haematologist (blood specialist) or Gastroenterologist (digestive system specialist) is usually the next step.

Treatment

Treatment is simple and effective, and consists of regular removal of blood. Known as venesection therapy, similar to being a blood donor. The aim of the treatment is to reduce the stored iron (Ferritin) in body tissue to the lower end of the normal range. Each unit of blood removed contains 200mg of iron. The body then uses some of the excess stored iron to make new red blood cells.

Initially venesection will usually be performed around once a week, and continues until the iron level is satisfactory, which may be a year or more. During the course of treatment the size of the remaining iron stores is monitored. After the stores have been depleted a second phase of treatment is usually required. Iron levels should be monitored regularly, and if necessary occasional venesections continued to keep iron levels down. The TS should be maintained below 50% and the SF below 50mg/l.

Effectiveness of Treatment

Early diagnosis and treatment is vital. Venesection leads to the reduction in the body's stores of iron to the normal range and many symptoms will improve. Providing this begins before cirrhosis has developed life expectancy will be normal. It will not cure some serious conditions caused by iron overload such as diabetes or cirrhosis if they are already present at the time treatment is started.

How Haemochromatosis is inherited

To develop GH a defective HFE gene must be inherited from both parents. People who have inherited a defective gene from only one parent are carriers and will not usually be at risk of iron overload, but some do suffer from iron overload. Their children will have a 1 in 2 chance of also being carriers. If both parents are carriers, their children will have a 1 in 2 chance of being carriers and a 1 in 4 chance of being at risk of developing GH. It is estimated that 1 in 8 people in the UK are carriers.

If both parents are carriers

On average a quarter of the children will develop haemochromatosis, half will be carriers, and a quarter will be normal.

If one parent has GH and the other is a carrier

On average half the children will develop GH and the other half will be carriers.

If both parents suffer from GH

All the children will inherit two defective genes and ate more likely to develop GH.

Haemochromatosis and Family

Because GH is inherited it can be passed on from parents to children. When one member of a family is diagnosed close relatives should be informed so that they can get themselves tested. Discuss this with your doctor.

Diet and Haemochromatosis

It is not possible to eliminate iron overload by a low iron diet because many foods contain iron. A balanced diet of good lean meats, fruits, vegetables and grains that are not heavily fortified with iron is recommended.

The rate of iron absorption can be slowed by:

Avoiding vitamin supplements or tonics containing iron.

Vitamin C enhances absorption of iron.

Bacteria:

Raw shellfish such as oysters can be infected with a bacteria called Vibrio vulnificus, which can be deadly to a person with high iron.

Limiting alcohol intake, particularly with meals. Alcohol enhances absorption of iron and contributes to liver disease.

Tobacco smoke contains iron and is absorbed directly into the blood.

Water: Being properly hydrated, especially during the therapeutic removal of blood, will reduce the amount of time it takes to remove a unit of blood. Also a person will not run the risk of becoming dehydrated following therapy.

Please note: Some well water contains iron.

An interview with

Dr Satya Sharma

Dr Sharma has been a General Practitioner at Wolverhampton for 31 years. He retired 12 years ago and has continued to serve the society in multiple ways. Awarded MBE in 2011, Fellowship of BIDA and BMA, he has been bestowed the Honorary Doctorate of Science of Wolverhampton University. He served as President of the British Red Cross in West Midlands and awarded the 'Courageous Award'. He has been the Deputy Lieutenant (DL) of West Midlands for 10 years (2014–24). He was awarded the prestigious 'Global Indian Excellence Award' in London Summit in 2014 by World Consulting & Research Corporation, India. His passion for 'Organ donation' has led him to serve as an Ambassador for NHSBT since 2018

What was your best career move?

Moving from general medicine to General Practice was the best career move since I was interested in people. In general practice it is a human being who has certain illness. In the hospital it is the illness which dominates. Often one hears "what was the name of this lady who had SLE"? (Or some rare illness).

What was the best decision you made for your career?

Meeting Gita (my wife) was the best, she was already in the UK and we met here through our parents, an arranged marriage took place and that has been such a turning point, the best decision for my life!

What motivated you to promote "Organ donation"?

As SHO in general medicine at Corbett Hospital, Stourbridge in 1978, looking after ICU was part of the job. A diabetic doctor had taken an overdose of insulin due to matrimonial disharmony. His wife was a doctor as well. Both were lovely Muslim couple. Soon it became clear that the male doctor could not be saved. I suggested to the consultant to approach the wife for organ donation. He was very reluctant and asked me to approach. I discussed with the wife, and she readily agreed. His organs were gifted and many lives were saved. This was no less than a miracle. The feeling that I could make the difference was great. The same feeling has blossomed and over the years and the achievements have been amazing.

In 2017, I chaired a voluntary group and successfully arranged MoU between Mohan foundation of India (Non-Governmental Organisation) and NHS blood and transplant (NHSBT) UK. The MoU was very successful for both countries. The positive outcomes were inspirational to arrange MoU for Commonwealth countries through a project called "Commonwealth Tribute to life". This was successfully launched by the U.K.'s Health Minister in Wolverhampton in 2022. 44 countries and 19 national/international organisations have signed this MoU, benefitting over 2.3 billion people, 98% population of Commonwealth countries. The outcomes have been phenomenal and encouraging. If an opportunity arises it would be good to discuss the details. BIDA as an organisation could sign the MoU.

What is your view on work-life balance?

It is necessary but many of the first-generation immigrant doctors had never heard of it! They came to the U.K. for higher qualifications or to improve their financial situation. For them and for me the priority was to serve patients day and night. You may have heard of "one in two" rotas which were heavy going and many consultants and the rest of the team of doctors were on call every other day! Looking back, it was punitive and no one should be asked to do it since tired doctors could make more mistakes. Work life balance has been a very positive move and should be fully supported.

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

Morale booster for doctors is one change that is absolutely essential. Now the demands of patients have gone over the top and politicians support patients as the voters. Morale boosting can be achieved only through discussions with the doctors. Happy workers are better workers.

What is your contribution to BIDA?

The principles of BIDA persuaded me to join and be a life member in early 80's. Discrimination was rife in Health departments and this caused unpleasant feelings. Over the years BIDA has been successful in minimising the same.

My contribution has been to enhance the credibility of BIDA through its involvement in various organisations such as BMA, NHS blood and transplant and many others.

As Vice Chairman of my local division for three years in the 80's, I arranged successful educational meetings. I have attended several A.R.M.s of BIDA and on most occasions my positive contributions have been well received by the audience, e.g. my motion for organ donation was passed unanimously by BIDA Conference. My efforts have been towards discussing wrong from right and advising BIDA to remain a credible organisation within the health spheres. It has been an honour to be a keynote speaker at various BIDA International Conferences.

What are other contributions you have made to the society?

In 1981 my wife and I established a charitable trust to support poor medical students in the medical college in Haryana, India from where I graduated. The trust was run by our family to help such students and continued to do so for 10 years.

It was an honour to serve as President of British Red cross West Midlands for six years and to be bestowed 'courageous award' for my multiple contributions to the charity. As a Deputy Lieutenant (DL) of West Midlands for 10 years (2014-24) and lead DL for 7 years in

Wolverhampton, it was a huge privilege to serve the society in various ways. I served as a Queen's Award assessor for voluntary organisations (now King's award) and connecting fringe communities to the lieutenancy were due to personal efforts. The examples are numerous. This was a great opportunity for community cohesion and community harmony as patron of an active Inter-faith division in Wolverhampton.

It was gratifying to visit Nepal in April 2015 for earthquake relief work within three days of the disaster and our team distributed 30,000 kg of rice, helmets and blankets. We managed to raise £80,000 for building 2,100 tin shelters in Nepal. A second visit was made in September for sanitation and compliance, established projects for sanitation through EduVision Hetauda, Nepal. The project was to award the schools through competitions for sanitation and was selected as top 3 out of 1,800 international entries.

It was a great opportunity to visit Kenya in April 2017 for water drought relief, and we completed the project to build four sand dams. It was a real pleasure to serve as Head of a team of volunteers and two charities, Sikh Aid International and Midlands International Aid Trust U.K. This will provide water for 3,000 homes indefinitely without further costs.

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

Get there as fast as you can to enjoy the 'golden period' of life where you can do what you wish to do rather than what you have to do!

Plan retirement at least for 5 years and, if you can, then start winding down for five years. The choice of retirement is individual for everyone but only two things are important, namely health and finances – in that order. For finances plan as early as you can to reap the benefits. 20-30 years or longer will ensure healthy financial rewards. For health, regular exercises advocated by doctors but sadly not followed by many would be useful. I play golf regularly and started 3 years prior to retirement.

What is your favourite book?

I am not an avid book reader although I have written forewords for two books! It is a contradiction!! Nelson Mandela's autobiography *Long Walk to Freedom* is my favourite book.

What makes you really happy?

Nature makes me happy. Visiting rivers, lakes, trees with rich colours, long walks, seeing beautiful landscapes.

Live musicals and concerts fill me with joy.

Positive outcomes of projects and serving communities are joyous.

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

Yes, like all human beings, getting stressed occurs on occasions. As we all know 'stressors' are individual. Something may cause extreme stress in one whereas it may be nothing for another person. When stressed, I discuss it with my wife – she is a great person, very balanced in life and very wise. Often, I would discuss with the person responsible for stress and it gets sorted out. Time is another healer.

Where is your favourite destination in your travels and why?

Alaska is simply beautiful, the holiday of a lifetime. As I said above, nature has such beautiful places. Snow covered mountains with blue glaciers... amazing! I could visit many times but not live there!!

BIDA Fellowship Awards 2024

Dr Suresh CHANDRAN FRCP(London) FRCPath(ME)

Dr Chandran is a Consultant in Acute Internal Medicine at Oldham Royal Hospital. He was the Divisional Clinical Director in Medicine for Oldham Care Organisation Northern Care Alliance, which is one of the largest group of hospitals and healthcare providers in the NHS. An appraisal and Revalidation Lead, Specialist advisor for CQC, Assessor for CERS applications for the GMC, he also holds the post of the Lead Medical Examiner of the hospital. He has been the Training Programme Director for the Northwest deanery and also served in the Consultant appointment advisory committee of the Royal College of Physicians and on the SCE examination board.

His contributions to BIDA are manifold. He has served in the Executive Committee since 2019 and as the ARM Chairman for BIDA since 2022. He has shown his expertise in organising both National & International Scientific Conferences.

Right: Dr Suresh Chandran receives his BIDA Fellowship Award from BIDA National President Dr Chandra Kanneganti.

Dr Syed Naseer Haider NAQVI FRCP (London)

Dr Naqvi has been a Consultant Physician in Elderly Medicine since 1984 at Chorley and South Ribble NHS Trust. Since retirement, he has continued to offer his services as a Consultant and is presently working at Royal Albert Edward Infirmary, Wigan.

He has been an administrator, clinical tutor and educational supervisor and a mentor to numerous juniors. He has been a researcher as well with several publications and book chapters. He has helped to produce guidelines for the rehabilitation services especially the role of the day hospital and rehabilitation beds. He has worked with the elderly health visiting team to produce high quality, easily accessible services, which value its role in educating patients and carers.

He has been a lifetime BIDA member and regularly attends all the BIDA educational activities and conferences. His passion for golf is well known to all of us.

Right: Dr Naqvi is presented with his BIDA Fellowship Award by BIDA National President Dr Chandra Kanneganti.

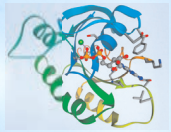
Sincerest Congratulations to our Fellows!

ASSESSMENT OF ALPHA-FETO PROTEIN IN PATIENTS WHO ARE DIAGNOSED WITH HEPATOCELLULAR CARCINOMA AFTER COVID-19 INFECTION AS A MARKER OF PROGNOSIS

NATIONAL HEPATOLOGY & TROPICAL MEDICINE RESEARCH INSTITUTE

AINSHAMS UNIVERSITY

AUTHORS : **KHALED AZAB[12]**, *OSAMA ASHRAF[1], HESHAM HAMDY[1], KHALED RAFAAT[1], SAHAR MOSTAFA[2]*



INSTITUTE /AFFILIATIONS:

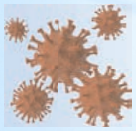
1 AINSHAMS UNIVERSITY INTERNAL MEDICINE DEPARTMENT

2 NATIONAL INSTITUTE FOR HEPATOLOGY, GASTROENTEROLOGY AND INFECTIOUS DISEASES HEPATOLOGY & GASTROENTEROLOGY DEPARTMENT

AINSHAMS UNIVERSITY/NATIONAL INSTITUTE OF HEPATOLOGY, GASTROENTEROLOGY & INFECTIOUS DISEASES , CAIRO ,EGYPT

BACKGROUND:

Hepatocellular carcinoma (HCC) is the most common primary malignancy of the liver. It is the fifth most common cancer in men, worldwide, and seventh among women, with over half a million new cases diagnosed annually worldwide. It is the second leading cause of cancer related mortality in the world.



Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes.

METHODS:

This is a cross-sectional study conducted over 6 months starting from August 2021. The study population consisted of 60 Egyptian patients with hepatocellular carcinoma (HCC) who presented to a multidisciplinary clinic during the COVID-19 pandemic. The patients were divided into two subgroups: Group I consisted of 30 patients with HCC and COVID-19 infection, while Group II consisted of 30 patients with HCC not infected with COVID-19.

Inclusion Criteria:

- Both Sex
- Age: 18-75
- Confirmed Hepatocellular carcinoma diagnosis by imaging & lab criteria
- Covid infection proved by either Positive PCR or CT Scan

Exclusion Criteria:

- Age:younger than 18 or older than 75
- Combined other primary malignancy
- Patient not willing to stick to plan of management & follow up
- Patient has any associated comorbidity that prevent him from proceeding in any management plan

Study Tools:

- Full history including information on age, sex, co-morbidities (Hypertension& Diabetes Mellitus), previous medical illness and previous drug intake
- General Physical examination.
- Imaging: CT scan confirming Hepatocellular carcinoma diagnosis

Laboratory work including:

- Full blood count
- Liver Function test
- Kidney Function Test
- INR
- Alpha-feto protein

Khaledazab9319@gmail.com/Khaled.azab@uhb.nhs.uk

ASSESSMENT OF ALPHA-FETO PROTEIN IN PATIENTS WHO ARE DIAGNOSED WITH HEPATOCELLULAR CARCINOMA AFTER COVID-19 INFECTION AS A MARKER OF PROGNOSIS

NATIONAL HEPATOLOGY & TROPICAL MEDICINE RESEARCH INSTITUTE

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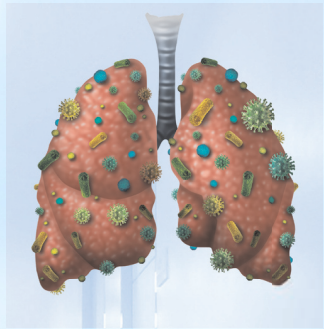

RESULT:

There was highly significant difference between both studied groups as regards AFP (p = 0.002).

There was highly significant difference between both studied groups as regards Liver presentations (P<0.001)

There was highly significant difference between both studied groups as regards tumour size and tumour stage (p < 0.001).

There was significant difference between both studied groups as regards Liver function tests (p <0.05).

There was highly significant difference between both studied groups as regards MELD score (p < 0.001).

Child Pugh class, MELD score, AFP and COVID-19 infection were theindependent risk factors associated with poor survival among HCC patients.

Using a cutoff value of 100.85 ng/ml, AFP had sensitivity and specificity of 100% and 92%, respectively, with a diagnostic accuracy of 95.7% of HCC among Covid-19 patients.

CONCLUSIONS:

Tumour marker parameters, including AFP, can be used as a prognostic tool for HCC patients with COVID-19. There was a higher mortality rate among HCC with COVID-19 with higher levels of AFP.

Abbreviations: AFP: Alpha-feto protein ,HCC: Hepatocellular Carcinoma

Khaledazab9319@gmail.com/Khaled.azab@uhb.nhs.uk

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Unattended Supportive Care Needs and Caregiver Distress in Progressive Neurological Conditions: An observational study

Dr Alice Thankachan Senior Resident, Department of Pain & palliative care, Lisie Hospital, Kerala.
Dr Noel Shaju Resident Medical Officer, Department of Emergency Medicine, Carithas Hospital, Kerala .

Introduction

Neurological disorders have emerged as the leading cause of Disability Adjusted Life Years (DALYs) accounting for about 9 million deaths per year[1] and it is estimated that they will account for half of the global economic burden by the year 2030[2]. Neurological conditions present a multifaceted care environment characterized by progressive decline in communication, daily living activities, and independence. The complex nature of this care necessitates a comprehensive, multidisciplinary approach that addresses the patient's diverse needs.

A Lancet commission report estimates that approximately seven million individuals in India require palliative care. Despite this significant need, only four percent of the affected population have access to palliative care services[3]. Sutton has delineated the concept of neuro-palliative and rehabilitative care in progressive neurological conditions as a patient-centred holistic approach which encompasses diagnosis of clinical conditions irrespective of the stages, rehabilitation to preserve functional abilities, coordinated care, and appropriate palliation to alleviate symptoms[4]. It is recommended by European Federation of Neurological Societies (EFNS) in their pivotal neurological guidelines that all patients with progressive neurological diseases receive multidisciplinary care and have access to both general and specialized palliative care services[5].

Randomized controlled trials investigating palliative care interventions in neurology have demonstrated promising outcomes for patients with Parkinson's disease[6], multiple sclerosis[7], dementia, and stroke[8]. Evidence suggests that both outpatient and inpatient palliative care services can improve patient-centred outcomes, quality of life, and reduce symptom burden. Traditionally, palliative care for neurology patients has been provided using the 'early' model, which involves concurrent curative and palliative care, or the 'dynamic' model, where palliative care is administered intermittently based on patient needs. To effectively address the multifaceted causes of suffering, diverse palliative care models should be tailored to specific patient needs at different stages of the disease trajectory, considering the unique context of each healthcare system and culture. However, India currently lacks unified national policies regarding the optimal timing for integrating palliative care into the care of neurology patients.

Existing research on patient and caregiver well-being in progressive neurological conditions in India is limited. This study seeks to investigate the multifaceted care needs of patients and their caregivers, with the goal of identifying and addressing the complex challenges they face. Furthermore, it aims to serve as a tool for identifying the primary obstacles that hinder the delivery of high-quality care to these patients.

Materials and Methods

An observational cross-sectional study was planned at the Department of Neurology, Neurosciences centre, AIIMS in 2020.According to the NCI thesaurus any disease with worsening course in its extent or severity which is indicated by change in clinical, pathological or molecular finding can be termed as progressive disease[9]. Patients admitted in the neurology ward fulfilling the criteria of progressive disease were approached for study. Those above 18 years of age who have expressed their consent to participate were included in the study. Those who refused to participate and under 18 were excluded from the study. Participants fulfilling the inclusion criteria were provided with the Patient Information Sheet available in local language (Hindi) and English and offered participation in the study. The study duration and benefits expected from the research were explained. The maintenance of confidentiality and the freedom to withdraw from the study at any point in time were also disclosed.

After obtaining written informed consent for participation in the study and using the patient data for research and educational purposes, socio-demographic details and information about the timeline of disease, and treatment modalities received were sought. Information collected from participants was broadly categorised into three parts: an elaborate sociodemographic profile, clinical information about their disease, and about their symptoms. The Needs Assessment Tool is one of the unique clinicians led tool which helps in concurrent assessment of patients and their caregivers. It is utilised to ascertain the types and levels of needs of patients, to identify to complex needs or ongoing support. Additionally, it serves as communication tool between primary and specialist clinician and provides information from caregiver perspective.

Each patient's medical records were searched and analysed to understand their symptom burden at presentation, investigations and treatments received. An unbiased convenience sampling was done among patients admitted in neurology ward. A clinician led data collection was done and information was collected from patients and caregivers. On completion of the recruitment and data collection, data cleaning and appropriate coding was done. Values obtained from the study about the qualitative variable was expressed as absolute and relative frequencies, whereas those containing continuous variables was analysed as mean (SD) along with 95% CI.

Results

Forty-four patients were approached, and of which fourteen participants were excluded due to their inability to communicate, being too sick to complete the questionnaire, and collusion between patients and their families. The participants had an average age of 39.5 ±15.54 years. A majority of participants were male (65.62%), with a predominance of rural residents (69%) from Uttar Pradesh (19.89%), followed by Delhi (11.1%). Demographic analysis revealed that 90% of participants were unemployed or had lost their jobs due to their health condition at the time of the study. Multiple sclerosis, amyotrophic lateral sclerosis (ALS), and stroke were the predominant neurological conditions represented in the study sample.

Patient needs: Over ninety percent of participants reported financial or legal concerns as the most significant challenge hindering their well-being. This was followed by challenges in managing their activities of daily living which impacted their independence and quality of living. Additionally, sixty six percent of patients had difficulty in managing the medication and sought information on their disease status and condition. This study demonstrated that 66% of patients had unresolved physical symptoms and 16% of patients endured symptoms of significant concern.

Furthermore, 23% reported spiritual or existential issues of potential concern. It is noted that patients encountered challenges in discussing the impact of their disease symptoms on sexual functioning and relationship. Given the diverse ethnicities and cultural beliefs and their subsequent implications on healthcare practices necessitates the need for a detailed and comprehensive exploration that should be addressed independently.

Caregiver Needs: The majority of caregivers were spouses, primarily females and were responsible for providing physical, social and emotional care at home. More than sixty percent of caregivers expressed their difficulty in coping with patients' disease status which adversely affect their ability to take care of them. Psychological needs, when compared to physical, social, spiritual, and legal needs, consistently emerge as the most prominent area of concern for caregivers. Notably, more than seventy percent of caregivers reported their lack of awareness regarding the availability of support groups and psychological services, even though they recognized a pressing need for such resources. Approximately forty four percent of caregivers expressed associated with patients' physical symptoms. Additionally, twenty percent of caregivers expressed notable concerns about their ability to provide effective care.

Caregiver wellbeing: Approximately eighty percent of caregiver identified distress contributed by the physical and psychosocial issues as the primary factors which posed the greatest obstacles to their well-being and ability to provide care for the patient. Furthermore, seventy percent of caregivers reported problems in family and interpersonal relationships. The greater symptom burden exhibited by patients and caregivers warranted the need for appropriate referral plan. Forty percent of patients required semi-urgent specialist palliative care referrals while, twenty percent needed urgent referrals. Additionally, forty-eight percent of patients required referrals to occupational therapists. All referral decisions were thoroughly discussed with patients, who subsequently provided their consent.

Discussion

This cross-sectional study in progressive neurological conditions demonstrated significant concerns and unattended care needs among patients and their caregivers which could impact their quality of life and care provided. Financial and legal concerns were identified as the primary contributors to the symptom burden followed by difficulty in performing activities of daily living. Despite the presence of substantial physical impairments, psychological issues were found to be the most formidable barrier to patient well-being. The study emphasized the importance of providing patients with adequate information about their disease and their potential outcomes. It also highlighted the need for support groups to assist both patients and caregivers. Furthermore, this study identified caregiver distress and their difficulty in coping as major obstacles in achieving their well-being.

It is estimated that in 2020 the cumulative economic burden of neurological disorders in Europe reached a staggering $1.06 trillion equalling the combined costs of cancer, heart disease, and diabetes[10]. This encompasses both direct healthcare expenditures related to medication and services, as well as indirect costs, which can account for up to 50% of the overall burden. The high financial concerns reported by patient in this study can be explained by the productivity loss, unemployment and early retirement. Additionally cognitive decline associated with many progressive neurological conditions can adversely impact their daily activities, financial decision making, and management of assets according to their need. Our findings align with numerous studies conducted globally on specific conditions, including Parkinson's disease[11] and dementia[12], which emphasize the substantial financial strain on individuals and families, particularly in regions with limited healthcare infrastructure.

Despite the significant role caregivers play in patient care, their own needs and well-being are often underappreciated. Many caregivers report a lack of support in managing patients' medications and symptoms, leading to mismanaged symptoms and missed opportunities for both patients and caregivers. This is further underscored by a study examining caregiver burden and family functioning across different neurological conditions, which found that caregivers of individuals with amyotrophic lateral sclerosis (ALS) and acquired brain injury experience particularly high levels of burden, approaching burnout [13].

A joint consensus review made by European Academy of Neurology (EAN) and the European Association for Palliative Care (EAPC) in 2016 emphasised the importance of early integration of palliative care in trajectory of neurologic disease depending on the prognosis[14]. Recent studies have demonstrated the efficacy of palliative care in neurological disorders. A randomized controlled trial involving patients with multiple sclerosis revealed that those receiving immediate palliative care services experienced improved symptom burden, whereas the control group exhibited deteriorating symptoms. Furthermore, the intervention group reported a reduction in caregiver burden compared to the control group[15]. In addition, a similar study in neuro-degenerative conditions demonstrated superior quality of life and reduced symptom burden among individuals receiving specialized palliative care services[16].

This centre does not have specific referral guidelines for palliative care teams and the decision to refer is made on a case-by-case basis by the neurology team. Given the diverse prognoses, disease progressions, and variations across different disease groups, it is imperative to develop tailored guidelines that streamline referrals to appropriate departments based on individual patient needs. Barriers to palliative care referral can originate from both patients and clinicians. Patients may harbour misconceptions about palliative care, often associating it with imminent death. Conversely, clinicians may exhibit resistance to referring patients who are still receiving active treatment or to initiating end-of-life discussions.

Despite the substantial social and economic consequences of neurological disorders only 28% low- and middle-income countries have policies with specific plans outlined by governments to address these conditions, even though they bear 70% of the global burden[17]. Prioritizing research into neurological disorders and implementing informed policies will maximize societal benefits and enhance palliative care. Amplifying international cooperation and resource sharing is crucial for mitigating the global impact of neurological disorders, particularly among low- and middle-income countries that disproportionately bear the burden with limited resources. Furthermore, a dearth of palliative care specialists and nurses, coupled with limited resources, hinders the accessibility of palliative care services, particularly in rural regions.

One of the most important aspects of integration of palliative care in neurology involves sensitising and equipping the frontline medical staff. A national survey among neurologists in Netherlands reported that more than half of the neurology consultants and residents believed that they needed additional education and training to perform effective conversations involved in treatment restrictions and end of life care[18]. This underscores the necessity to bridge the substantial gap in clinicians and staff in navigating pivotal conversations through implementation of educational programme and workshops.

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National Obesity Conference

The impact of Obesity; Strategies to tackle obesity and diabetes

Prof Siba Senapati Consultant Bariatric Surgeon, Salford Royal Hospital. Organising President and Chairman, OASIS-GB

Prof Siba Senapati and his team members from OASIS-GB (Obesity Awareness Support Group and Information Services – Great Britain) spearheaded this conference with the support of Northern Care Alliance NHS Foundation Trust, The University of Salford and British Obesity and Metabolic Surgery Society of UK.

This 6th Obesity Conference by OASIS-GB was held on 4th October at the Humphrey Booth Lecture Theatre at Salford Royal Hospital to update on the impact of obesity on health and current practice and advances in management of Obesity. The introduction had a great start with ***Dr O Williams OBE***, *CEO of Northern Care Alliance* highlighting the rising concerns of Obesity in the UK. This was further substantiated by ***Prof Syed***, *Consultant Physician in Diabetes and Endocrinology*. ***Prof S Arya***, *Consultant Cardiologist* compared the state of affairs in the UK with all other developed countries. His erudite lecture demonstrated the frightening changes, which may occur in heart muscles of an obese person. The risks to the skeletal structures, namely the spinal column and the weight bearing joints of the hips and knees, are not spared. This was expertly presented by ***Mr A Saxena***, *Consultant Spinal Surgeon* and ***Prof A Sinha***, *Consultant Orthopaedic Surgeon*. ***Dr S Adam***, *Consultant Endocrinologist* examined the relationship between obesity and

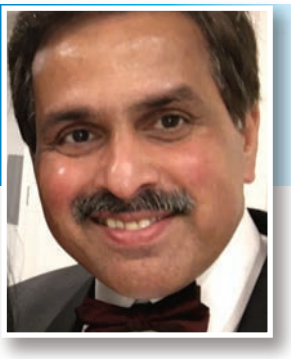
cancer and touched on the epidemiology of the two conditions. ***Prof E Crosbie***, *Consultant Gynaecologist,* through her research demonstrated a strong link between obesity and endometrial cancer.

The morning session continued with ***Prof J S Bamrah***, *Consultant Psychiatrist* presenting the psychological matters which besets a morbidly obese person. He explained the usefulness of the psychiatric drugs. ***Dr S Flint*** talked about Weight Stigma and its implications for practice. ***Dr W Majeed***, *Consultant Physician* lectured on the advances of medical therapies. This was followed by a detailed lecture on the advances of surgical approaches by ***Prof S Senapati***, *Consultant Bariatric Surgeon* and *founding chairman of OASIS-GB*. All such treatments need to be supported by further suitable follow up treatments which are specific to obesity treatments. This was aptly presented by ***Dr R Mudaliar***, *Consultant Physician in Diabetes and Endocrinology*.

The afternoon session was extremely beneficial listening to the personal experiences of 2 patients. ***Dr N Kanumilli***, *Chairman of GM Diabetes Network* and ***Ewan Jones***, *Programme Lead of Diabetes GM ICB* tackled the difficult subject of the current vision of diabetes in Greater Manchester. ***Prof Jane McAdam***, *Associate Dean of the University of Salford* talked about the role of universities for planning manpower to tackle the current obesity epidemic. This was followed by a lecture by ***Mr J Carney***, *Co-chair of OASIS-GB* who presented the strategic and localised prevention initiatives to tackle diabetes and obesity.

This hybrid conference was well attended by Consultants, GPs, Physiotherapists, Dieticians, Occupational health personnels and other healthcare workers from across the country. The sessions were interactive with regular participation of the delegates. ***Mr J Carney***, *Co-chair of OASIS-GB* gave the vote of thanks.

BIDA Sports 2024



Mukesh Hemmady FRCS (Tr&Orth)

This year we made some changes to the format of the cricket tournament after extensive consultations with the stake-holders.

From a knockout tournament, it was made into a 'quasi' league format, which was very well received by the players. The main issue in the past was that in the knockout format, a division may end up playing just one game in the sporting calendar should they lose a game. In the new format, a division was guaranteed to play at least two games and three if they were to make it to the finals

I did consider all the other formats, but playing cricket in England has its own issues and weather plays a big part that can at times be a logistical nightmare.

In this year's tournament, six-time winners Wigan were surprisingly upset by the eventual finalists, North-East in the first round after they travelled to Newcastle. Although they had an excellent run rate in the next game against Blackburn, it was a case of too much too late and they were unable to make it to the finals. The final was played between North-East and Stoke-on-Trent at Ponteland Leisure Centre in Newcastle on the 18th of August 2024.

North-East won the toss and chose to field. Stoke made 258 runs for the loss of seven wickets in the allocated 30 overs (Wahid Abbasi 86 and Salim 47). In reply, North-East were 153 all out in 23 orders into (Shubham 35, Parag 25) Stoke-on-Trent went on to lift their maiden BIDA Presidents cup cricket trophy!

Another sporting event which attracted a lot of attention was the BIDA golf tournament which was earlier scheduled to take place at the Worsley Marriot golf club on the 18th of October, however due to inclement weather, the golf course was not in a fit state to play and therefore we had to move the tournament to Bolton golf club.

There were 11 participants and the weather gods were kind to us. Mr Muthu Jeyam, Orthopaedic Consultant from Salford was declared the winner followed by Mr Iqbal Shergill, Urologist from Wrexham coming a close second. Mr Rip Gangahar was in third place. The Golf tournament was very well received in its second year and I will not be surprised if the numbers swell in the coming years in which case we may have to form teams.

Wishing you all a Merry Christmas! Best wishes,

Mukesh Hemmady *BIDA National Sports Co-Ordinator*

Test your knowledge (True or False): ANSWERS

Q1. Researchers believe that the main mechanism of action of copper-bearing IUDs is:

a. Prevention of fertilization. **False**
b. Changes in the woman's uterus that prevent a fertilized egg from implanting. **True**
c. Changes in the woman's uterus that destroy a fertilized egg. **False**

Q2. The following statements pertain to characteristics of copper IUDs. Please indicate whether each:

a. The IUD has no systemic effects. **True**
b. Return to fertility takes at least six months after IUD removal. **False**
c. IUDs are easy to use, long-lasting and easily reversible. **True**
d. IUDs should not be used by breastfeeding women. **False**

An Orthopaedic Expert at the Paris 2024 Olympic Village

Ravi Badge Consultant Upper Limb Surgeon, Warrington and Halton Hospitals NHS Foundation Trust (NHS)
Diploma in Sports Medicine (International Olympic Committee)
Honorary Clinical Senior Lecturer- Edge Hill University & Liverpool University, U.K.

It was a great honour and moment of pride for me to be associated with Paris 2024 Olympics as an orthopaedic expert in the Olympic Village. I was able to spend 23 days at Olympic village clinic during the recently concluded games. I am sure many of you would like to know how this got unfolded and what was my experience being part of such a global sporting event.

The process for this incredible journey began during the COVID-19 pandemic when I decided to undertake a two-year sports medicine diploma with the International Olympic Committee (IOC). Unfortunately trust didn't offer any support towards the funding of course fees but I was determined to undertake this and decided to self-fund leading successful completion of this 2-year diploma. Although this diploma was not an essential criteria to get into the role but clearly added some weight to my application. The application process started in August 2023 to get a confirmation from Paris Olympic organising team in September to acknowledge my roles and responsibilities during games. I realised that commitments of this scale would need at least three weeks of my personal time, and I did not hesitate to utilise my annual leave to pursue my dream of being part of the Paris Olympic family.

The preparation leading up to Olympics needed multiple online webinars to understand the Olympic Village setup, IOC protocols, electronic patient record system with integrated PACS and approved medication formulary to run the sports injury clinic as per the standards required.

The Olympic Village: a mini planet

When I arrived at the Olympic Village, I was struck by the sheer diversity and energy of the athletes, coaches, and medical teams from all over the world. It felt like a global community bound by a shared passion for sport and excellence, and I was fortunate enough to be the only one from the UK as part of the orthopaedic team in the Olympic Village.

The polyclinic set up at Olympic Village included a multi-storey building with ground floor reception, ED, pharmacy, radiology department which included x-ray, ultrasound and outdoor MRI scan facilities with support from at least four MSK radiologists available throughout the day. Along with support from MSK physiotherapists. I joined the medical team on 22nd July, nearly 4 days before the opening ceremony. I worked with a team of clinicians ranging from sports medicine physicians, cardiologist, gynaecologist, podiatrist and psychologist available to provide necessary support during the games. The clinic also provided state of art treatment facilities and had provision of dentistry and opticians on site.

A day in the life: fast-paced and high stakes

I signed up to support most of the days for the duration of Olympics as I didn't want to miss a single day being part of that extraordinary environment at the Village. Each day began early, with the first shift starting at 7.30am until 3.15pm and the second shift covering the facility from 2.30pm to 10.15pm. The workload varied as the competition progressed. I had the privilege of working with athletes involved in rugby, wrestling, taekwondo, judo, boxing, weightlifting, water polo, volleyball, high jump, sports climbing, fencing, javelin, badminton, hockey along with track and field. Each sport presented its own set of challenges and clearly the pressure is immense - not just for the athlete, but for the entire medical team.

Every decision taken by the medical team was critical, as it impacted the athlete's performance and their future career.

We had an instant access to diagnostic tools like ultrasound, MRI and the reports from MSK radiologist would be available within an hour on requesting the scans. Can you imagine that happening here in the current NHS!

The emotional rollercoaster: wins, losses, and everything in between

One of the most rewarding parts of my job was supporting athletes emotionally as well as physically. Injuries, no matter how minor, can be devastating in such a high-stakes environment. Some athletes had trained their entire lives for this moment, and even a slight sprain could mean the end of their Olympic dream.

I worked closely with sports medicine physicians across the globe to help athletes manage the stress and emotional toll of injuries. Whether it was offering words of encouragement or helping them refocus their energy.

One of the most fulfilling moments for me was watching the athletes I looked after on the podium and knowing the hard work and pain they had overcome, was incredibly rewarding.

However, there were also moments of heartbreak. Athletes who had to withdraw from events due to injuries often carried a weight of unfulfilled potential. As much as we try, not every injury can be healed in time for competition, and that's a harsh reality to face.

Reflecting on Paris 2024: A career-defining experience

The Paris 2024 Olympics was not only a showcase of the world's best athletes but also a testament to the power of great teamwork behind the scenes. As an orthopaedic expert with sports injury interest, I witnessed the display of collaboration on working towards a common goal, adaptability, and quick decision-making in an environment where every second counts.

Beyond the high-profile victories and world records, the true essence of the Olympics lies in the stories of resilience, determination, sacrifices and the human spirit. Being a part of that, helping these elite athletes pursue their dreams, was an honour I will carry with me for the rest of my career.

In the end, the Paris 2024 Olympics for me was not just about sports but was about pushing the boundaries of human potential on world best sporting platform. Even though I was not participating as an elite athlete during this event, but I played my role as a professional to support their dreams and this experience makes me feel like an Olympian too.

I feel there is lots that can be delivered at the same scale working in the NHS, provided there is visionary and inclusive leadership, a great team to work with, high morale and engagement with stakeholders.

I hope one day we can see the similar vibes at our local NHS Trust as an Olympic Village, with all of us working in a happy environment as I witnessed during Paris 2024 and playing our role to support our patients to achieve the best possible outcome. Having reflected on the entire experience I would really like to ask everybody a question: "Would you like to be part this beautiful journey too?".

Thanks for reading, please do feel free to get in touch to hear more inside stories from Paris Olympics 2024.

BIDA Quiz Answers

Q1. Correct Answer: 1) Smoking

Explanation: Smoking can induce the CYP1A2 enzyme, leading to increased metabolism of clozapine. This may reduce clozapine levels in the body, potentially impacting its effectiveness and requiring dose adjustments.

Q2. Correct Answer: 3) Reorient the patient and provide a calm, well-lit environment

Explanation: We need to first address the delirium that the patient is experiencing. NICE guidelines recommend conservative measures as the first-line management for delirium. This includes non-pharmacological interventions such as reorienting the patient, ensuring a calm and supportive environment, providing adequate lighting, and addressing any potential underlying causes of delirium (e.g., dehydration, infection). Medications like antipsychotics are reserved for cases where there is severe distress or risk to the patient or others and are not recommended as a first-line approach.

Q3. Correct Answer: 3) Type 2 respiratory failure with metabolic compensation

Explanation: Type 2 respiratory failure is characterized by high $PaCO_2$ (hypercapnia) and low PaO_2 (hypoxemia). The elevated HCO_3^- level indicates metabolic compensation, as the kidneys retain bicarbonate to help maintain a near-normal pH. The pH in this case is slightly low-normal, indicating that partial compensation has occurred..

Q4. Correct Answer: 3) Cholangitis

Explanation: The combination of right upper quadrant pain, jaundice, and fever (temperature of 38.5°C) aligns with Charcot's triad, which is characteristic of cholangitis. Cholangitis is an infection of the biliary tree, often caused by biliary obstruction, and presents with these symptoms alongside elevated inflammatory markers and liver enzymes.

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King William House, 202 Manchester Road, Bolton, Lancashire BL3 2QS
Phone: 01204 397522 E-mail: info@minervaprint.com
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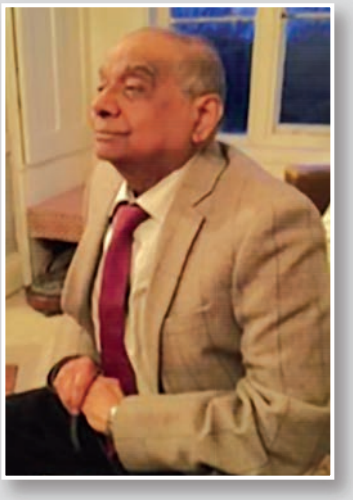
Remembering...

Dr Shankar Narayan Verma 8th January 1939 – 24th October 2024



Dr Shankar Narayan Verma was born in Patna on 8th January 1939. A gifted student, he completed his MBBS at the Prince of Wales Medical College, Patna. He was always active in student politics and fought for equality and student rights. He carried these traits to the UK, where he made tremendous contributions to the Overseas Doctors Association and served as National Chairman of the Organisation in 2000.

He was a highly respected Consultant Physician at New Cross Hospital and initiated many innovative care pathways, including an early local version of what became the national Stroke pathway.

He was a committed and sincere Rotarian. He was community minded and a mentor and guide to many young doctors.

A man of great perception and acute intelligence, kindness and independence, Shankar died as he lived, on his own terms after struggling with a short and difficult chest infection. He died peacefully on 24th October this year. He is survived by his daughter, son and grandchildren.

Mr Sanath Kumar Shetty

Sanath was born in Manipal, India, grew up in Mumbai and returned to Mangalore and Manipal to complete his medical and post-graduate qualifications in Orthopaedics.

After a brief stint in India, he moved to the UK for his advanced training and eventually completed his MRCS and FRCS (Orth). He worked at Glan Clwyd Hospital, North Wales and was integral to the set up and working of the Department of Orthopaedics.

A popular teacher, an excellent clinician and surgeon, an exemplary doctor for his patients and yet a humble, soft-spoken and simple human being. Sanath, as popularly known to his colleagues, had an excellent sense of humour, which many colleagues miss him for today.

Sanath was very popular in social circles as an organiser and had a deep interest in music and art, which was evident in each of the events organised. Together with his colleagues, he was instrumental in organising conferences for the BIOS, BOA and the Welsh Orthopaedic Society on various occasions. His loss is tragic to the hospital, friends and family and more importantly to his patients.

He died of Myocardial Infarction on 6th November 2024. He leaves behind his wife Usha and children Pranav and Vibha.

Dr Vinit Sheshnath Vedpathak

Vinit was born in Mumbai, India. He graduated from Maharashtra University of Health Sciences in 1981 and came to the UK in 1989. After working in Dover, Lincoln and Birmingham he settled in Chester and worked in the department of Anaesthesia for Betsi Cadwaladr University Health Board, initially at Glan Clwyd Hospital, then shifted to Wrexham Maelor Hospital. Vinit was a well-respected mentor known for his expertise and dedication to his job.

Vinit was a proud family man. His love and commitment extended beyond his immediate family: he was a lively member of his community, with lots of friends and often hosted local gatherings. He retained his smile and optimism right till the end.

He died of Myocardial Infarction on 12th September 2024. He leaves his wife Nutan, his son Omkar and his daughter Shreya and two grandchildren.

Autumn Budget 2024

Graham Crossley comments on the Autumn Budget for NHS employees.

In the run-up to the Budget, there was widespread speculation about potential changes to pensions. This included reducing the tax-free lump sum limit to £100,000, introducing a flat rate for tax relief, and reintroducing the lifetime allowance. As a result, we saw an increase in members considering retirement before the Budget announcement.

We now know that none of the speculated changes were included in the Budget. Some members may feel frustrated if they felt pressured to take benefits earlier than planned, especially as this could mean a reduced pension since recent increases in pensionable pay would not have been fully accounted for in their final pensionable pay. Pensionable pay increases typically require 365 days in payment to be fully included in final pensionable pay calculations.

The Budget has introduced some fundamental changes to pensions. The Chancellor announced that from 6 April 2027, unused pension funds and death benefits will be included in a person's estate for Inheritance Tax purposes. A move that will certainly make inheritance tax and retirement planning more complicated.

So, how does this impact the NHS pension? Well, not significantly.

The NHS pension provides lump sum and pension benefits to eligible dependants in the event of a member's death.

Lump sum death benefits from the NHS pension scheme are already included in a person's estate for Inheritance Tax purposes if those benefits are paid to a qualifying scheme partner or nominated individual who is not the member's spouse or registered civil partner. Payments to a member's spouse or registered civil partner are currently excluded and will continue to be excluded from Inheritance Tax assessment. Dependants' pensions from defined benefit pension schemes will also remain excluded from the value of the estate for Inheritance Tax purposes.

Some members may have set up NHS Money Purchase Additional Voluntary Contributions (MPAVC), these are a separate retirement fund, which you invest and are used to supplement your main scheme benefits at retirement or later. MPAVCs will be treated like all other defined contribution pension schemes and will be subject to the new rules.

As a result of the changes to defined contribution pension schemes, we may see an increase in the number of members who use voluntary scheme pays from their personal pensions to settle annual allowance charges derived from their NHS pension, particularly for 2024/25 where we expect to see an increase in members subject to annual allowance.

The Government has launched a consultation, set to close on 22nd January 2025, to gather input on the processes required to implement these changes.

In summary, whilst there were widespread predictions of fundamental changes to pensions, the actual impact on NHS pensions has been limited. Although the new rules will make inheritance tax and retirement planning more complex, NHS pensions remain largely unaffected. Lump sum and pension benefits for NHS dependants retain their existing inheritance tax treatment, meaning members' primary NHS pension benefits are shielded from the latest inheritance tax adjustments.

McCloud Remedy: Remediable Pension Savings Statement (RPSS) update

The RPSS is issued to individuals affected by the McCloud remedy, detailing changes to pension savings during the remedy period (April 2015 – April 2022) due to the rollback of members' benefits into their original 1995/2008 scheme, effective from 1st October 2023. This statement helps members determine if they are entitled to compensation or a refund for overpaid annual allowance tax during the remedy period, or if they have any new or revised annual allowance tax charges between 2019/20 and 2022/23.

The deadline to report a new or revised annual allowance tax charge to HMRC is 31st January 2025 if you originally joined the 2015 scheme before 1st April 2022 and have not taken your NHS pension benefits before 1st October 2023. If you receive a late RPSS, the deadline extends to 3 months from the date of receipt of RPSS.

NHSBSA has sent over 57,000 Remediable Pension Savings Statements (RPSS) to members via their automated process since the beginning of October. There are still thousands of RPSSs that still need to be sent out, these will include those that require manual calculation or have data missing during the remedy period.

You are not currently able to request an RPSS from NHSBSA. They have stated "We cannot accept requests for on demand statements. Only Remediable Pension Savings Statements (RPSSs) produced through the automated process are being sent at this time. Your RPSS will be sent at a later date. There's no timescale for this"

Unfortunately, we have found some errors with RPSSs, most are related to niche circumstances such as those with MHO status reaching maximum service levels, Choice 2 revocations where members originally had added years contracts, and members where pre-remedy pension growth changes between the summary page and carry forward page. These have been reported back to NHSBSA

McCloud Remedy: Cost Claim Back Scheme (England & Wales)

The Cost Claim-back Scheme provides support for members directly affected by the McCloud remedy, allowing them to claim reimbursement for certain financial losses incurred due to discrimination or the application of the remedy. This includes covering costs of up to £1,000 (including VAT) for professional assistance in using the HMRC Digital Service to reassess annual allowance tax charges.

McCloud Remedy: Contingent Decisions

If you opted out of the NHS Pension Scheme due to the discrimination highlighted in the McCloud judgment, you may be eligible to reinstate some or all of your membership between October 2014 and April 2022. This could lead to some complex choices for members, particularly as some may benefit from reinstating partial membership, rather than full membership, as sometimes less membership can result in higher pension benefits.

For reinstated service contributions, active or deferred members can pay through a lump sum or instalments, while pensioner members may have these deducted from their pension in payment. We are still waiting for the final details on how this operate, however the Cost claim-back application form has now been updated to include costs associated with advice on the potential purchase of that scheme membership.

In conclusion, the McCloud remedy introduces complex changes to NHS pensions, with elements like the RPSS, Cost Claim-back Scheme, and Contingent Decisions, all designed to address past discrimination. Support is available, and upcoming webinars will provide additional guidance, helping members make informed decisions about their pensions and related tax matters.

Quilter Financial Advisers