London
Breaking Barriers in EM

Global Emergency Medicine Programme
GEM

FEEDBACK FILE 4

EVENT NAME:

Ophthalmological Emergencies & Role Of ER Physicians By Dr Michael Traur

DOCTORS FEEDBACK

FEEDBACK # 1

Naveed Memon

Today's lecture start with presentation of Dr. Imran Azeem case on painless vision loss followed by detailed and comprehensive presentation by one of most handsome GEM faculty member Dr. Micheal.

We learnt today common opthalmic conditions in A&E, i.e conjectivitis, scleritis, uveitis viral (herpes zoster), glaucoma, orbital cellulits, thermal injuries and more with their approach and examination and management in ED before referring to specialist. Irrigation of eye in case of chemical injury aim to keep pH 7.0. POCUS guidelines to exam the eye. Thanks Dr. MIcheal and Dr. Ash for giving this flavour of ophthalmologist to us.

FEEDBACK # 2

Muhammad Azeem Imran

What a spectacular presentation by Dr Michael. The anomical way of thinking about eye problems is really appreciated . it makes ED Physician job easy regarding eye emergencies and correlation of clinical scenarios alongside Pocus was wonderful experience to learn today . And painful and painless vision loss classification really good for learning eye problems. the injuries in front & back of globe was amazing part of discussion. Nothing left in one hour session , very very comprehensive session by Dr Michael. Last but not least Dr Ash vision and leadership and advice about QIP empower us to set new standards in our hospital set ups.

FEEDBACK # 3

Nasir Hayat

This session was Amazing.
It was very systemic approach, started with:
History:
Hopc
Exposure/injury
PHx/Med/Allergies
Systemic symptoms
Contact lenses
Then Examination:
Anatomical
Functional
Pocus
Then the lecture became more structure specific where we were taught:
1. Conjunctivitis
2. Scleritis/Episcleritis
3. Corneal Ulcer
4. Acute angle closure glaucoma
5. Orbital/preseptal cellulitis
6. Uveitis
7. Ruptured Globe
8. Vitreous haemorrhage
9. Retinal Detachment
10. Central Retinal Artery Occlusion
11. Central Retinal Vein Occlusion

12. Optic Neuritis
13. Temporal Arteritis
14. Chemical Injury
15. Painful Loss of vision
16. Painless loss of vision

It was an amazing & wonderful session .
Specially pocus imagaes were amazing.High recommended for ER physicians to join it .

FEEDBACK # 4

Noman Ahsan

Today's session started with Dr.Azeem presentation related to unilateral vision loss and he presented it very well...
Then Dr.Micheal started the lecture with Differentials and how to approach on Anatomical and functional basis..Very well explained how to look for injuries starting from front of eye to back of eye..very systemic approach and discussed every single injury and disease I this way.. He discussed Conjunctivitis, Scleritis, Corneal ulcers, Orbital cellulitis, Uveitis , Ruptured globe, Vitreous hemorrhage, retinal detachment, CRAO/CRVO, Optic neuritis, painfull/ painless loss of vision...Ophthalmology is abit dry subject for me but Dr.Micheal explained in a good way for better understanding...At the end as always Dr.Ash bullet points regarding every single topic is very helpful and make lots of sense how to approach pt in ED and which instruments must b available in ED ..
Thanks for a wonderful session

FEEDBACK # 5

Shehzad Hussain

Thanks Dr Michael, Dr Ash it was wonderful presentation/lecture on Eye problems in ER.
Thanks Dr Azeem for wonderful presentation on CRAO.
Comprehensive lecture with practical knowledge like
DD, Approach, History n Examination, Investigations n treatment on Conjunctivitis, Scleritis, Corneal ulcers, AACG, Orbital cellulitis, CRVO, CRAO, Temporal arteritis, Chemical injury, Uveitis, Ruptured Globe, vitreous hemorrhage, Retinal detachment.
In such a short time it was excellent session on eye problems. Plenty of new stuff learnt which should be done in ER. Thanks Dr Ash n LGEM team for this session.

FEEDBACK # 6

Hani Suhail

Todays session was about ophthalmological emergencies, where w learnt about very important conditions and the role of the ED physician to diagnose and manage these conditions with precise diagnosis to prevent any mishap. Conditions like uveitis, scleritis, rupture of the globe, corneal ulcers and more conditions were differentiated according to anatomical parts, functional parts and pain presence differentiating anterior area from posterior making it easy to identify and manage. Thank you Dr. Michael and Dr. Ash i was a wonderful lecture with alot of information to help us.

FEEDBACK # 7

Mina Khan

Todays presentation was best and very important from emergency perspective. As this topic always remain untouched , though its significance was taught very well by dr michael. He also briefed how to manage these and when to refer. I was amazed regarding POCUS of the eye which I would never come across in our traditional teachings, as its 2022 we need these updated curriculum and teaching expertise. I grateful a millennial times that I hv become a member of **London Global Emergency Medicine** first batch .....JazakAllah khairan kaseera. 🎊🌹 I believe LGEM will boost my confidence and will enhance my personality as well ...10/10 to this platform 🙂

FEEDBACK # 8

Muhammad Yameen

Session started with case presentation by Dr. Azeem Imran.
He presented a case of CRAO of 59 years old hypertensive patient presented with acute painless loss of vision in left eye.
He was on HCQ.
Findoscocopy, OCT and FA was done which confirmed the diagnosis of CRAO
Then lecture started by Dr. Michael.
It was very systemic approach, started with:
History:
Hopc
Exposure/injury
PHx/Med/Allergies
Systemic symptoms

Contact lenses
Then Examination:
Anatomical
Functional
Pocus:
Make sure you are at lower possible power supply, otherwise it will heat anterior chamber
Then the lecture became more structure specific where we were taught:
1. Conjunctivitis
2. Scleritis/Episcleritis
3. Corneal Ulcer
4. Acute angle closure glaucoma
5. Orbital/preseptal cellulitis
6. Uveitis
7. Ruptured Globe
8. Vitreous haemorrhage
9. Retinal Detachment
10. Central Retinal Artery Occlusion
11. Central Retinal Vein Occlusion
12. Optic Neuritis
13. Temporal Arteritis
14. Chemical Injury
15. Painful Loss of vision
16. Painless loss of vision

In the end we had a session with Dr. Ash about QIP and how we can treat non surgical eye conditions in ED and basic equipments we can have.
It was an amazing session .
The things we learned, we weren't taught in that way in our eye rotation.
Specially pocus imagaes were amazing.
Regards:
Proud GEM trainee

FEEDBACK # 9

Afshan Salman

Wonderful session by Dr. Michael as always, starting from history taking, examination, conjunctivitis, sclerits, corneal ulcers, Acute angle closure glaucoma,

orbital cellulitis, Uveitis, vitreous hemorrhage, retinal detachment Central artery and vein occlusion, optic neuritis, Temporal arteritis, chemical injury & ruptured globe. It was really comprehensive and interactive. Learned how POCUS can help in diagnosing eye ds, something new for me. I am developing more interest towards POCUS. How effective this tool is in emergency, realizing it now. Dr. Ash presence and his pearls in the end add 5 stars ✨ to the lecture. Thankyou very much Dr. Michael, Dr. Ash & team LGEM

FEEDBACK # 10

Aurangzaib Ahmed

An amazing lecture by one of the best teacher of Gem faculty Dr Michael. His way of teaching is just amazing. The way he delivers the important topic is just outstanding. Opthalmology has always been a dry subject and a subject that most of us don't put alot of stress on that is why it gets a bit hard to undertstand the different presentations of opthalmic emergencies other than the open angle and close angle glaucoma. Today the way Dr Michael delivered his lecture was just outstanding in just one slide he summariezed all the different presentations of opthalmic problems and how to manage them accordingly. Dr Michael has a quality to making even the driest subject look interesting and once again he was upto his mark. Thank u for giving an Insight on such a dry subject and not just that but making it look interesting and helping us get knowledgeable abt some of the most common presentations of eye and being able to manage them. Thank you Dr Ash for arranging such and amazing session and thank u once again Dr Michael for such an amazing one hour of pure knowledge. Keep up the good work team Gem.

FEEDBACK # 11

Imran Khan

It was a wonderful presentation. Thanks to Dr Michael and Dr Ash

FEEDBACK # 12

Babar Hussain

Such an Amazing and comprehensive sesion on Ophthalmological Emergencies & Role Of ED Physicians By Dr Michael Traur Consultant EM London.
It started with an excellent presentation by Dr Mohammed Azeem Imran.
Almost all the topics about Eye related Emergencies were discussed breifly like
~History
~Anatomical approach
~Bacterial infection

~Viral infection
~Trauma related injuries
~Chemical injuries
~Acute angle glaucoma
~Central retinal artery and vein occlusion
~Retinal detachment with Mac on & off
~Temporal Arteritis
~Diagnostic and Management approach
~Especially at the end the point about painful vision loss mostly the cause is in front of eye
~ painless vision loss mostly cause is from back of eye, and never miss uveitis, AACG, Ulcers. Thankyou very much Dr Michael trauer for such a wonderful presentation.
I'm grateful to Dr **Ashfaque Ahmed** for always being there and highlighting about the QIP project related to eye and for arranging such an important session.
Proud LGEM candidate.

FEEDBACK # 13

Mominah Ahmed

Today's one hour explained us and made us grasp A&E required eye diagnosis along with that emergency treatments which should be done without waiting...
Dr . Michelle explained us beautifully anatomy of eye linked with anatomical clinical approach....
Covering injuries infections ischemia...all were comprehensively covered within 1 hour.... thankyou dr.micheal thankyou
Dr.ash

FEEDBACK # 14

Syeda Maheen Ejaz

Another excellent session I believe Dr Micheal is one the best GEM faculty, deliver the session so smoothly and flowy from history, and examination to important Opth emergencies
In his one-hour session, he comprehensively covered these topics
CONJUNCTIVITIS
SCLERITIS
ULCER
AACG

RUPTURED GLOBE
VITREOUS
HAEMORRHAGE
RETINAL
DETACHMENT
CRAO/CRVO
UVEITIS
ORBITAL CELLULITIS
TEMPORAL ARTERITIS/ OPTIC NEURITIS. Thank you so much dr Ash for arranging this session🙏

FEEDBACK # 15

Aakash

It was very great & amazing lecture today delieverd by dr micheal as usual.
It is very important topic from emergency perspective.
& it was very realy useful topic today for emergency doctors.
This topic had always remained untouched ,& always been referred to as an eye specialist .
Dr Micheal taught in a very easy & comprehensive manner.
The very first thing which I came to know is about POCUS of the eye which I have never seen in any hospital.
& beside that learnt many new things also .
Thanx again dr ashfaque for providing such a great platform to learn❤️

FEEDBACK # 16

Farheen Naseem

Today presentation was very help full and full clinical oriented lecture regarding eye emergencies in er we most of er physician un aware of eye problems and what are the role of er physicians in these emergencies .Dr Michael teach us very briefly and precise way the best thing is I like it examination of eye by 2 ways anatomically and functional in this way if we examine the pt most of eye emergencies covered in er .other thing is use of pocus which is more use able and less time consuming thing.thank u dr Ash Dr Michael for such amazing lecture and giving us this wonderfull platform for learning .thank I all gem team also
Dr farheen naseem

FEEDBACK # 17

Aleena Rahman

A wonderful lecture by Dr Michael, as always. He taught us to rule out and have differentials in mind based on anatomical approach, and also the use of POCUS for vitreous hemorrhages and various opthalmological emergencies. That was definitely something new we learnt today. Dr Michael taught in such a systematic manner when to refer, what management protocol must we initiate, and how to come up with a diagnosis. Moreover, we learnt about orbital cellulitis, uveitis, scleritis, angle closure glaucoma, and many other emergencies in a span of one hour. It was definitely a refreshing take on opthalmology after medical school. Thank you Dr Michael for this amazing lecture.

FEEDBACK # 18

Hira Nehal

Dr.Azeem presentation related to unilateral vision loss alot of learning points were discussed .

Dr.Micheal a wonderful teacher who taught opthalmological emergencies very well . Differentials and how to approach on Anatomical and functional basis..Very well explained how to look for injuries starting from face orbit front of eye to retina .a very systemic approach and discussed every different emergency presentations and disease. He discussed Conjunctivitis, Scleritis, Corneal ulcers, Orbital cellulitis, Uveitis , Ruptured globe, Vitreous hemorrhage, retinal detachment,ACAG, CRAO/CRVO, Optic neuritis, painfull/ painless loss of vision. Dr.Micheal explained very well .in the end Dr.Ash bullet points I missed those last minute minute summary .but over all a very nice session helpful and help us learn a proper Pproch towards how to approach in ED and which instruments must b available in ED .the use of POCUS and its association with opthalmic emergencies and precautions to be taken to reduce heat and gel to avoide harm to pt .the best part was evaluation to be devided in anatomical approach and functional.

Thank you

Dr Hira Nehal

FEEDBACK # 19

Aqsa Yaqoob

Session started with a very comprehensive case presentation by Dr. Azeem. Then Dr.Michael Traur (consultant EM St. Thomas Hospital London) taught an excellent topic on eye emergencies, The History taking, Hopc ,past medical, allergy hx, any previous injury hx and systemic symptoms, Anatomical approach . Episcleritis, scleritis, acute angle closure glaucoma, uveitis, ruptured globe. Use of

Pocus for vitreous hemorrhage and retinal detachment.chemical injury and use of Morgan lens was extremely helpful .Wonderful session by Dr.Michael and Im grateful to Dr.Ash for highlighting about the QIP project related to eye.

FEEDBACK # 20

Rida Rana

What a super amazing session it was and yet it was on a topic which A&E practitions find difficulty to deal with (Opthalmic Injuries) . Dr Michael delivered it with the most comprehensive approach possible. The basic approach (anatomical and functinal approach), history and immediate assessment , important pointers related to ocular conditions commonly encountered in ED ,live images of Pocus ultrasound correlating with the conditions and immediate management to be given in ED . Also the examination points that can help when referring a case to an Opthalmologist were highlighted . Dr Azeem's and Dr **Ashfaque Ahmed** 's cases signified the importance of correct approach examination - in case of ocular injuries. Last few minutes by Dr Ashfaque highlighted the practical approach and ways in which improvement can be brought up in ED (QIP) . Thankyou so mucj Dr Ashfaque , Dr Michael and Dr Azeem .AlhumdulliAAllah on being part of LGEM 😊

FEEDBACK # 21

Maimona Javaid

Lecture was good and interesting . First time saw the detachment of retina . I remember I got blunt trauma in eye last year . And I was praying for my retina to remain intact. There are billion things in life to pay gratitude for and eye is one of those treasures. Corneal ulcers , conjunctivitis , well discussed . I forgot the anatomy of eye . Will revise it inshallah and will listen lecture again. Some new terminologies we also learnt today .

Dr Azeem presentation was good 👍.

Inshallah look forward to learn more practically in EM workshop.

FEEDBACK # 22

Hk Danish

An amazing session by Dr Michael Traur & Dr Ash on Ophthalmological Emergencies & Role Of ED Physician . This was an amazing learning experience , It helped to how to approach a patient properly , how to examine and treat themThe eye emergencies are very common and sensitive . mentioning a few Things that I learnt in this session 1.History tacking : Speed of onset . (rapid onset

are mostly vascular) , Exposure / injuries , past medical history , medication and allergies . Systemic symptoms ,
2. How to examine : Anatomical --> Face /neck , Globes , lids (+ , - eversion) , conjunctiva / cornea , Pupils . Retina (how to properly examine optic disk . Functional exam ,
3.Brief introduction to ophthalmology ultrasound , vitreous hemorrhage findings , retinal detachment findings .
4. Conjunctivitis : contact lens , recent UPSI , dendritic fluorescein
5.Scleritis : localised , deep pain Associated with RA
6.Corneal ulcers :
7.Acute angle closer Glaucoma : patho physiology , Signs , treatment . acetazolamide 500mg IV ,ref to ophthalmology .
8.Orbital cellulitis , painful and limited eye movements , proptosis ,
9.Uveitis : associated with ankylosing spondylitis, syphylis . deep pain ,perilimbal erythema , miosis
10.Ruptured globe : Vitreous is precious so protect it as much as you can and get to surgery ASAP
11.Optic Neuritis
12.Chemical injury : irrigate ASAP
Take home points : Anatomical approach , ask nature of pain , distribution of erythema , Don't miss Uveitis / AACG / Ulcers Thanks Dr Ash and Lgem team for bringing Dr Michael such an amazing teacher to teach us

FEEDBACK # 23

Dr Javeria Wali

An outstanding lecture delivered today by Dr. Micheal on the topic of Ophthalmic emergencies in the ED. He started with important history and examination points which should never be missed and an easy to learn anatomical and functional approach towards diagnosis of eye injuries and disease. We learnt essential learning points about most commonly encountered ophthalmic conditions i.e. Conjunctivitis, corneal ulcers, difference between Scleritis and episcleritis, uveitis, acute closed Angle glaucoma, orbital cellulitis, prevent leakage of vitreous in ruptured globe, retinal detachment, vitreous hemorrhage, CRAO, CRVO, Optic neuritis, temporal arteritis and utmost importance of irrigation in chemical injuries to eye to bring ph to 7.0. Moreover, we were shown PoCUS findings in these

conditions which were brilliantly explained. It was a power packed session full of essential pearls and covered the entire topic comprehensively

FEEDBACK # 24

Dr Nouman

A wonderful lecture by Dr Michael covering the very important ophthalmological emergencies that we should be on the lookout for in ED. He started out with basic anatomy of eye, mentioning the unique way of examination as anatomical and functional. Many important diseases were discussed such as conjuctivitis, scleritis, CRAO(stroke of eye), CRVO(DVT of eye), Globe rupture, painless/painful loss of vision and many more.

The importance of Pocus as an investigative modality was again a unique idea for me.

This lecture has provided us with sufficient knowledge to furthur explore the topic and bring our clinical acumen to an uprecedented level.

Thanks Team LGEM, Dr Michael and Dr Ash for unique learning opportunity..

FEEDBACK # 25

Dr Muhammad Ghayoor Khan

It was again an amazing session by Dr.Micheal Trauer.

I have learned about ophthalmological emergencies in ED and also how to deal with them in ED,history taking and examination starting with Anatomical approach.

Beside much information,use of POCUS in ophthalmology was somethng new that I have learnt.

Importent Ophthalmalogical Emergencies were taught i:e;

-Conjunctivitis
-Scleritis
-Corneal Ulcer
-Acute Angle Closure Glaucoma
-Orbital Cellulitis
-Uveitis
-Vitreous Hemorrhage
-Retinal Detachment
-Central Retinal Artery Occlusion
-Central Retinal Vein Occlusion
-Optic Neuritis

-Temporal Arteritis
-Chemical Injury
Dr.Azeem has presented the case very brilliantly.
Thanks
Dr.Micheal And Team LGEM
Kind regards
Muhammad Ghayoor Khan

FEEDBACK # 26

Dr Muhammad Amash Khan

Today was another amazing session by Dr Michael on eye emergency diagnosis and management. He started with the anatomical and functional significance of eye clinically and discussed some diseases related to emergencies of all the parts of eye and the use of PoCUS which was new for me.
Thank you Dr Michael and Dr. Ash for this beautiful lecture.

FEEDBACK # 27

Dr Aiman Nazir

I don't have words to describe the beneficial effect of today's session. Topic was wisely chosen and the whole lecture was so on point and knowledgeable for an ED physician.
Dr Traeur doesn't let the lecture become boring for a second.His amazing way of delivery and presentation makes it more beneficial for us.
Approaching eye emergencies as an ED physician in the Emergency department was discussed in a comprehensive manner. History related questions , Examinations to be divided according to anatomical and functional exam and use of POCUS in ED was discussed and emphasised on its importance.
All the ophthalmologic emergencies were discussed like conjunctivitis , scleritis/episcleritis, corneal ulcers , angle closure glaucoma orbital cellulite(septal/periseptal),Uveitis,Vitreous Hemorrhage, CRA, CRVO, Optic neuritis ,clinical injuries and Temporal arteritis . Highlighting all the important points to keep in view according to the presentation of patients and examination according to it. Explanation of some emergencies like retinal detachment includes Mac-on and Mac-off and their management was explained in very simple manner. Some important points related to POCUS were discussed, also its side effects like infection transmission and heating injury of the eye were discussed which I was not aware of.

Overall an excellent lecture delivered so beautifully that all of it sticks in my mind. I Would love to learn more from Dr Traeur. Thank You so much Dr ASH for arranging this session .

FEEDBACK # 28

Dr Mariam Nawaz

Just when u start to think that the lectures cannot get better than this another amazing session is delivered! We had a lecture on Eye Emergencies today conducted by Dr Micheal. It's a topic I didn't know anything about....but by the end of 1 hour I had so much in my cup. Lesson started by an amazing presentation by Dr Azeem and an intresting case by Dr Ash followed by Dr Micheal's comprehensive lecture. The things I learned are as follows:

. For diagnosing the eye problems go with the anatomical approach, from front of eyeball to the back

. In History speed of onset of symptoms will help narrow down the diagnosis. Don't forget to take history of exposure, injury, any medicine used, past History and allergies. History of contact lenses use is essential pointer to diagnosis

. Examination: this should proceed with the anatomical approach as follows

.....take overview of face

.....globe

.....lids

.....conjunctiva and cornea

..... pupils

..... retina

. PoCUS also has a role in diagnosing many eye conditions

. Some eye Emergencies prentations are as follows

> Conjunctivitis: injection is peripheral, can be peufomonal, gonococal or herpes simplex infection

> Scleritis: localized blue voilet hue, deep pain that worsens with movement

> Corneal ulcers: use antibiotics drops

> AACG: acute onset with nausea and vomiting, injection is peripheral. Treat with betablockers, cholinergic drops and actazoamide 500mg IV

> Orbital cellulitis: painful condition with limited eye movements

> Uveitis: deep pain with photophobia and miosis

> Ruptured globe:save the Vitreous ! Don't squeeze it out

> Vitreous Hg

> Retinal detachment:flashes than curtain fall, can be mac on or mac off
> CRAO: stroke of retina with spared central vision, positive RAPD. Massage the globe and give O2
> CRVO
>Optic neuritis: presents with decreased visual acuity
> Temporal arteritis: Age and EDR more than 50. New headache with tender and pulseless temporal artery
> Painful vs painless loss of vision
Thankyou so much Dr Micheal and Dr Ash for this phenomenal session

FEEDBACK # 29

Dr Shahid Ahmad

It was wonderful presentation on Eye problems in ER by Dr traur.
Dr Azeem presentation on CRAO was also very interesting.
Comprehensive lecture with practical knowledge like
DD, Approach, History n Examination, Investigations n treatment on Conjunctivitis, Scleritis, Corneal ulcers, AACG, Orbital cellulitis, CRVO, CRAO, Temporal arteritis, Chemical injury, Uveitis, Ruptured Globe, vitreous hemorrhage, Retinal detachment.
Thanks Dr Ash

FEEDBACK # 30

Dr Mishal Shan Siddiqui

Sir,
The lecture by Dr Trauer was quite comprehensive and it taught a unique systematic approach of tackling the commonly encountered eye emergencies as an ED doctor. He listed the key signs and recognizing features of the diseases and showed their ultrasound appearances as well. It was eye opening how early intervention by the ED physician can be vision-saving for the patient. We were also prompted to learn the skill of fundoscopy as an ED physician, an examination tool that we most often ignore in our setting. Loved the lecture!

FEEDBACK # 31

Dr Azka Shamim

Aoa respected sir
Today we had an amazing session with Dr Michael regarding opthalmologic emergencies and I must say it was a comprehensive session covering each and every aspect various eye problems encountered in ER , the clinical features, basic

management to be done by ED physicians and proper timely referral to ophthalmologists..
Following important points were discussed in detail:
* Immediate identification of serious conditions and when to refer
* Differentials on basis of anatomical approach .. from front to back
*Points to be covered in history and examination
*POCUS in ophthalmologic emergencies
Following conditions were discussed related to presentation, management and referral
* Conjunctivitis
*Scleritis
*Corneal ulcers
*AACG
* Orbital cellulitis
*Uveitis
*Ruptured globe
*Vitreous hemorrhage
*Retinal detachment
*CRAO/CRVO
*Optic neuritis
Temporal arteritis
* Chemical injury
Dr Michael also talked about painful loss of vision and painless loss of vision ...
And Dr Ash gave an overview of examination and management of a child struck by a horse rope accidentally in eye .. apparently child was sitting comfortably but vigilant examination was done and revealed significant loss of visual acuity and loss of red reflex
Thank you so much Dr Ash for providing us this wonderful platform for learning and development
Proud LGEM trainee

FEEDBACK # 32

Dr Warda Yawar

Case was presented by Dr Azeem cbd was outstanding then proceeded with Dr Ash management on CRAO he suggest occular massage then give acetazolamide IV then paper bag ventilation

Then our great teacher Dr Michael discussed with us the systemic approach towards opthalmology emergency by starting the lecture with anatomical positions then history past medical illness allergy past drug history then taking systemic review followed by history of contact lenses
He introduced us the idea of front eye lesions and back eye lesions distinguish between painless and painful loss of vision
Give idea between scleritis and episcleritis
and also between peri orbital cellulitis and orbital cellulitis their diagnosis pictorial presentations of pocUs in different diseases
It was a wonderful lecture and very well summarized by dr Michael
Thank you so much for today's lecture

4th DECEMBER 2022

EVENT NAME:

Valvular Heart Diseases For EM & Acute Physicians By Dr Nahal Raza Cardiology Registrar NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Kamlesh Kumar Lilani

Dr Nahal Raza explained the topic very well and recalled it with new information. Causes and disease management plans was really good to know. But unfortunately missed the osce station due to network issue but will watch recorded lecture for that.
Thanks Dr Ash and Dr Nahal for dynamic session.

FEEDBACK # 2

Nasir Hayat

This session was very Amazing , informative and comprehensively covered.It was well organised and taught very well.Answered all the questions asked during session .Its difficult to cover such big topic in one hour and she did it very well and nicely. Topics covered today were heart valve anatomy, Different types of valvular disease its causes, pathophysiology, clinical features, signs and symptoms, and management.

Dr ash presented a good case which told us about importance of examining the patient so that we can reach our diagnosis or further plan really quick.
Another osce from Dr ash and Dr Imran was amazing and made us realize history and is the key to make a diagnosis .Enjoyed today's lecture .I would highly recommend for physicians to join it and become more skillful and get the deepth of practical knowledge and have bright future.Proud to be LGEM candidate

FEEDBACK # 3

Hamna Yaqub

Dr Nahal you are amazing. Today's session on valvular heart disease covers all the aspects in a comprehensive interactive and lively manner.
Most common presentations of valvular heart disease, how with good history taking and examination skills you can diagnose 80% cases correctly. My first session with Dr Nahal and she just make me fall in love with her as well as cardiology.
Osce case was very informative, congratulations Dr Imran for reaching the correct diagnosis and winning.
Thank you Dr Nahal for an amazing session.
Thank you Dr Ash for arranging this and sharing your experience with us.

FEEDBACK # 4

Zia Hayat

It was an excellent lecture by Dr.Nahal Raza Cardiology registrar ,she covered all the topics related to clinical diagnosis and management of Valvular Heart diseases including Aortic Stenosis and Regurgitation, Mitral Stenosis and Regurgitation, Tricuspid Stenosis and Regurgitation.She started off with basics like anatomy of heart ,auscultation points with slowly building up concepts about the clinical presentation which gave us all a wrap in an hour time.
The tables ,clinical scenarios and mnemonics used by her made us like learn high yield topics very efficiently .Later Dr.Ash gave an osce scenario which was again very interesting , was attempted by Dr.Imran Farooka and he executed the case very systematically giving us the diagnosis with clear history taking and clinical signs.Thankyou Dr.Ash for arranging such an amazing talk for today.

FEEDBACK # 5

Rabiyyah Bashir

A dynamic session from a vibrant tutor ❤️❤️❤️ the case of carcinoid syndrome was indeed fascinating. Thanku dr **Ashfaque Ahmed** sir ❤️ & **London Global Emergency Medicine** ❤️
Congratulations dr **Imran Farooka** sir 🎉🎉🎉

FEEDBACK # 6

Mina Khan

Todays session was indeed very comprehensive. We were taught about valvular heart diseases causing symptoms like fluttering chest sensations/SOB/lightheadedness/LOC/coughing/swollen ankles/abdominal bloating . Types of Valvular diseases included Aortic stenosis : causes Williams disease/calcification/bicuspid valve/radiation/alkaloid, chemotherapy drugs/pagets disease/ochronosis. Clinical signs were:ejection systolic murmur/slow-rising carotid pulse/thrusting apex beat(LV pressure overload)/narrow pulse pressure. Tx: valve replacement/ballon valvuloplasty depending upon severity and evaluation. AORTIC REGURGITATION: causes RAD CHEMISTS mnemonic to remember , symptoms : aortic valve incomplete closure backward flow--LVH-- inc Lft atrial pressure ---leading to widened pulse presaure. Systolic pressure>diastolic retrograde pressure. Signa corrigan's/de musset's/traube's signs .... Similar to this the tutor covered Mitral stenosis causes /signs and synptoms and ED management . Mitral regurgitation causes /signs and symptoms and ED management Tricuspid Regurgitation Very rare but presenting with pulmonary hypertension .... in the End Dr Imran Farooka and Dr Ashfaque members LGEM, presented a case and disscused as CBDs .... Thank You London Global Emergency Medicine 🌹🎊

FEEDBACK # 7

Babar Hussain

Today's session was on Valvular Heart Disease Commenced by Dr Nahal Raza.
It was an excellent presentation full of energy. Topics discussed are
~CHF
~AS
~AR
~PS
~PR
~MS
~MR
~TS

~TR
These diseases, their Causes and their Management plans discussed in detail. A lot of learning points for me.
Thank you very much Dr Nahal Raza.
At the end the session became more interesting when Dr **Ashfaque Ahmed** conducted an Osce session with Dr Imran Farooka.
I really Wana congratulate Dr Imran Farooka for the wonderful diagnosis skills and Diagnosing case of Carcinoid syndrome and winning 50 pounds.
I am very thankful and grateful to Dr Ash for this opportunity to learn so many things in a 1 and half hour presentation.
Proud LGEM candidate.

FEEDBACK # 8

Afshan Salman

Todays session on Valvular Heart Disease by Dr. Nehal was a very good session. It started from the basics of heart anatomy, heart sounds and auscultation areas. ERB's point was something totally new I learned today.
Valvular disorders, their pathophysiology, causes, symptoms and management, all were discussed comprehensively and in interactive way.
The OSCE station by Dr. Ash and Dr. Imran was really interesting and informative. Congratulations Dr. Imran for passing the station & winning 50GBP, very well deserved. Thankyou Dr. Ash for bringing such amazing learning opportunities for us and for all your efforts to impart great deal of knowledge.
LGEM platform is like a family now, we learn, enjoy, teach and help each other.
Thanks Dr. Nehal, Dr. Ash & team LGEM

FEEDBACK # 9

Syeda Maheen Ejaz

An amazing session enjoyed and love every bit of it. Dr Nahal's energy is next level. It was the first session with her Dr Ash please arrange more sessions with her❤️ Dr Nahal covered the topic very comprehensively. Case discussion by Dr Ash is also very important. Many
congratulations
to Dr Imran Farooka for winning pace. Thank you so much Dr ash for providing us these beautiful lectures❤️❤️

FEEDBACK # 10

Rida Rana

A session just perfectly taught in the most easy to learn pattern and with a very comprehensive approach . Yet it was on a lengthy topic of Valvular heart disease but Dr Nahal did an amazing job in summing it up in 1 hour . It started from basic anatomy , auscultation , pathophysiology of each valvular heart disease which was broadly classified as Stenosis and Regurgitation . Moreover the session was kept interactive by Dr Nahal who frequently asked basic questions related to the topic and elaborated the points that are commonly asked in MRCP Paces . Also the case discussion and osce scenario by Dr Ashfaque Ahmed highlighted the practical approach to be followed when dealing with patients in A&E setup . Truely a fully loaded informative session. Thankyou so much Dr Nahal and Dr Ashfaque . AlhumdulliAllah on being part of LGEM😊🌹

FEEDBACK # 11

Muneeb Ahmed

Attended most favourite/most awaited lecture by Dr.Nahal Raza (Registrar Cardiology)

Session started with very interesting case discussion by Dr.Ash then Dr.Nahal covered this topic in comprehensive and yet intractive lecture.

Everyone loved the way she taught with so much energy.We learnt about various aspects of valvular heart diseases starting from anatomy,causes,signs and symptoms,pathophysiology and management in a very comprehensive way.

In the end OSCE case with detailed Hx and to reach Dx of Carcinoid Syndrome was very interesting.

Congrats

to Dr.imran(one of the very few who can actually win price from Dr.**Ashfaque Ahmed**).

Thanks team LONDON GEM for this interesting session.

FEEDBACK # 12

Yasir Dilawar

Today's session was top class.this was a difficult topic for me.but now learnt the concept of aortic stenosis+Regurgitation.mitral stenosis+Regurgitation.all other murmurs and how to treat them.auscultation and how to palpate the precordium for auscultation.And as usual Dr Ash with his stuff.And today's Osce was all about Dr Imran Farooq and his history taking and reaching the diagnosis.

FEEDBACK # 13

فاطمہ ناصر

It was such a nice presentation with an energetic tutor.. She was so into the lecture.. She had such a clear cut concept which she delivered so efficiently.. Auscultation areas, types of valve disease, detailed pathophysiology and management was discussed.
Dr Ash conducted a osce session with dr imran farooka in the end.. it was really marvellous session..
jazakALLAH khairan kaseera Dr Ash for bringing Dr Nahal Raza.

FEEDBACK # 14

Bushra Imran

Dr Nahal presented CzhF,AS,AR,MS,MR,PS,Ts,TR with their causes,S/S,Pathophysiology which was discussed with learning points and renembrable mnemonics ...are very excellent.Mid session questions and answers of queries done well.In the end the Monday fresh case presentation and OSCE by DrAsh was brilliant ending ...Also great effort by Dr Imran Farook
Thank you GEM team
I learnt a lot in this session

FEEDBACK # 15

Bushra Khan

Yet another great teaching session by Dr Nahal Raza on valvular heart diseases. It's a very long topic to cover but she made beautiful tables and slides to cover the long topic. We learned about most important valvular condition Aortic stenosis, its causes, signs and symptoms, management. When to surgically treat and when to monitor. She explained all the valvular condition AR, MS, MR, TS, TR along with their pathophysiology, signs and symptoms and management.
Its a very important topic of MRCP and covered very nicely. Dr Nahal helps us understanding the basic concepts very well.
Dr Ashfaque did a great case base discussion of AS valve replacement failure and OSCE with Dr Imran Farooqa of Carcinoid syndrome was brilliant.
Thank u London Gem 💎

FEEDBACK # 16

Ali Kazim

Today's Session on Valvular Heart Disease by Dr Nahal was amazing in many ways .
I learned all the basics , esp

Erb’s point , all the types of valvular hear disease , their patho-physiology and Management.
At the end OSCE case of carcinoid syndrome was phenomenal.
Thank you Dr Ash and Dr Nahal .

FEEDBACK # 17

Hani Suhail

A wonderful session about valvular heart disease, comprehensively covered with great effort and beautiful explanation with revision of concepts. The topic revolved around the four valves of the heart making us more aware of what are the common presentation and diagnosis with respect to their signs and symptoms, Aortic, pulmonic, mitral and tricuspid valves where described with causes, starting from anatomy, pathophysiology towards management with ease. Thank you Dr. Nahal and Dr. Ash for those pearls and wonderful points to correlate and connect with.

FEEDBACK # 18

Aqsa Yaqoob

An outstanding session given by Dr.Nahal Raza, full of knowledge and many new points. Lecture started with basic anatomy of valves then Dr.Nahal emphasizes upon etiologies of different valvular heart diseases, what they are going to cause and their management (medical and surgical).
Erb's point(which i came to know for the first time) : 3rd Intercostal space on left side of sternum(S1 and S2 best heard).
Topics covered:
Aortic stenosis
Aortic Regurgitation
Mitral Regurgitation
Mitral Stenosis
Tricuspid Regurgitation and Stenosis
Pulmonary Regurgitation and Stenosis
Their Pathophysiology,clinical features and management were discussed. In the last a wonderful osce session done by Dr.Ashfaq and Dr.Imran on Carcinoid Syndrome .
Thanks to LGEM faculty and Dr.Ashfaq for providing this amazing session.

FEEDBACK # 19

Aurangzaib Ahmed

Our first encounter with Dr Nehal as our teacher. I must say she is another gem in the gem team. I have always had a great interest in cardiology and valvular heart disease has always been one of my interest at the same time as this topic can be interesting it can be tricky as alot of signs and symptoms can overlap and make it look difficult. Credit goes to an amazing young cardiologist in the making she not only made it look easy but delivered the most important points and a very timely manner. Covering such a huge topic n a short time of 1 hour is really commendable. This was followed by Dr Ash words of wisdom and before that the OSCE senarior by Dr imran farooka. All in all a very energetic 1 hour with alot of knowledge. Nicely done gem team especially Dr Nehal. Kudos to you and the whole team of gem and especially our mentor Dr Ash. Wouldn't be possible without your hard work.

FEEDBACK # 20

Muhammad Yameen

It was amazing session started with case presentation by Dr. Ash
Dr. Nahal Raza started the lecture with anatomy of valves.
The valves and heart sound
Auscultation Areas
Aortic
Pulmonary
Erb's point
Tricuspid
Mitral
Types of valve diseases
Aortic Stenosis
Causes:
Common
Uncommon
As per age
Pathophysiology:
Clinical Features:
Mild/Moderate- usually asymptomatic
Cardinal symptoms- Exertional Dyspnea, Angina and Exertional syncope
Management
Asymptomatic - under review

Severe - evaluated every 1-2 years with Doppler echo
Severe symptomatic - valve replacement
Congenital - Balloon valvuloplasty
Aortic Regurgitation
Causes:
RAD CHEMIST
Pathophysiology:
Clinical Features:
Collapsing pulse
Quincke's sign
Duroziez's sign
De Mussel's sign
Management:
Medically
Surgically
Treat underlying cause
Mitral Regurgitation
Causes:
Acute- IE, Ruptured chordae
Chronic - ischemic CM, Non ischemic CM, HCM, RHD
Mitral Stenosis
Causes:
RHD
Severe mitral calcification
Pathophysiology:
Clinical Features:
Atrial Fibrillation
Mitral facies
Loud S1 snap
Creps
Management:
Anticoagulation
Digoxin
Balloon valvuloplasty
Tricuspid Disease

Causes
Pathophysiology
Clinical Features
Management
Pulmonary disease
Etiology
Clinical Features
Management
The session ended with an interesting osce of Carcinoid syndrome by Dr. Ash
Dr. Imran Farooka diagnosed it very well.

FEEDBACK # 21

DrKiran Feroz

Dr.Nehal taught us valvular heart diseases today.... MashAlah what a confidence ...a gr8 grip over the subject... from basics to high tech knowledge.... everything explained sooooo v.beautifuly...aortic stenosis ...aortic regurgitation... aetiology... management...simply loved the session today...and yes Dr.gulraiz thanks for ur valuable comments at the end ..we all wait for ur wonderful feedback ...and

congratulations

Dr.Imran ..very well deserved...thanks London Gem for the hard work backstage ....❤️thanku Ashfaque bhai our all time favorite ...May Alah give u more successes always Ameen

FEEDBACK # 22

Ghulam Saddique Saddique

Dr.Nahal was at the height of her knowledge explaining and making us understand the most intricate and difficult topic Valvular heart disease. She explained the pathophysiology behind the disease so well that its easy to remember and relate. She started from the very basics anatomy, normally 3 cusps for each valve except bicuspid mitral valve, first and 2nd heart sound, Auscultation areas (I love the pnemonic "All People Love Time Magazine").
The new thing I learnt was ERBs area in left 3rd intercostal space for S1& S2.
Types of Valvular disorders and symptoms, most common being aortic stenosis and regurgitation then mitral valve disorders. She further discussed causes, pathophysiology, clinical features and management for all valvular disorders.

A very important learning point was that only MR has Acute presentation (mostly post MI due to rupture of papillary muscles of cusps)while rest of Murmurs have chronic presentation.
Second learning point Rt sided murmurs are louder on inspiration due to venous return while Lt sided murmurs are louder in expiratory phase.
Third point aortic regurgitation murmur is radiate to the carotid area while MR murmur radiate to axilla.
A very interesting case discussed in OSCE session by Dr.Ashfaque Carcinoid Syndrome.
Excellent job done by Dr Imran Farooka reaching the diagnosis and winning 50 pounds.
The knowledge we get through this platform is beyond words . Thankyou so much. I am proud to be a part of the London GEM programme.

FEEDBACK # 23

DrMuhammad Akber

This session was very nice and informative .It was well organised and taught very well.Answered all the questions asked during session .Its difficult to cover such big topic in one hour and she did it very well covered all important points, Regarding heart valve anatomy, Different types of valvular disease its causes, pathophysiology, clinical features, signs and symptoms, and management.
Dr ash presented a nice case of carcinoid syndrome, its signs and symptoms and told us about importance of examining the patient so that we can reach our diagnosis or further plan really quick.
Thank you Dr Ash and Dr Nahal...

FEEDBACK # 24

Zegham Abbas

Today we have amazing session with dr nehal on valvular heart disease it’s types , causes pathophysiology of stiffening and narrowing LVH and clinical features exertional dyspnea angina syncope management aortic balloon valvoplasty.
Causes of Aortic Stenosis
Paget’s disease
Calcification
Radiation
Drugs (Alkaloids)

Aortic regurgitation it's causes like cardiomyopathy aneurysm rheumatic heart disease pathophysiology back flow of blood to left ventricle due to aortic valve incompetency it's clinical feature dyspnea dizziness syncope collapsing pulse bounding peripheral pulse early diastolic murmur management aortic valve replacement ACE inhibitor Diuretic
And also OSCE session was conducting by Dr Ash and Dr Imran detail history and points for examination was also discussed it's was amazing session thanku Dr Ash for providing amazing opportunity.

FEEDBACK # 25

Khatija J. Farooqui

Valvular heart disease session by dr Nahal was excellent covered all related topics started from anatomy to clinical diagnosis and management in a very shirt duration. Dr ash case scenario was given informative and learning points. Thanks Dr Ash and team LGEM for conducting this wonderful session.

FEEDBACK # 26

DrShafik Zaid

Dr Nahal raza so friendly u discussed all stuf about valvular heart disease. As time passed we Gem trainee feeling it amazing how so much important stuff we are sponging to our minds so many valuable consultants are on boared its a blessing for all. DR ASHFAQ is proving to b a revolutionary personality to our medical field..1.5 hr but its full of knowledge 15 minutes an osce is worthless for its potential knowledge in few sentence of asce .wewere nill but know we r getting more frank to our mentors colleagues and the education that was so much difficult to think even about that. London gem polish the lenses of our brain eyes for a better and safe journey.

FEEDBACK # 27

Rana Gulraiz

Today had wonderful session by dr nahal. she started from basic anatomy , auscultation , pathophysiology of each valvular heart disease which was broadly classified as Stenosis and Regurgitation . Moreover the session was kept interactive by Dr Nahal who frequently asked basic questions related to the topic and elaborated the points that are commonly asked in MRCP Paces . Also the case discussion and osce scenario by Dr Ashfaque Ahmed highlighted the practical approach to be followed when dealing with patients in A&E setup .Always learn alot from the class Alhamdulilah.Moreover,sir also mentioned to excel knowledge

by teaching,Always get priceless advices and golden words by Dr ash 👍🏻 Thankyou sir G

FEEDBACK # 28

Hassan Tariq

This was an amazing lecture today about valvular heart disease she wonderfully explained the different valvular symptoms and signs how it present to ER/OPD .
Also types of valvular diseases

1. MS
2.MR
3. AS
4. AR
5. PS
6. TR & TS
7. Pulmonary regurgitation

They way she explained to pick the murmurs with pneumonic as

a) PASS= PS & AS has systolic murmurs
b) PAID= PR & AR has diastolic murmurs

Thanks Dr ash for his explaining the two case and teach the way to approach and the OSCE was amazing
Thanks to Dr Ash and London GEM
Thanks

FEEDBACK # 29

Muzna Ahmed

Today's session on valvular diseases conducted by Dr Nahal was very powerpack with lots of learning points and interactive.
Lecture started with basic valvular anatomy and pathophysiology of each and every valve just to ensure that cardiology is all about strong concepts so that knowledge flow uninterruptedly while making differentials in mind.
Dr Nahal is very exuberant lively tutor engaged participants throughout session just not to make them feel dry and out of zone.
She elaborated different etiologies of each valve comprehensively that it becomes easy to remember.
Some bullet points from lec were:-
Aortic valvular diseases being very common in old age and easily lead to death if not managed early and accordingly

One should not miss any kind of murmur regardless of any previous surgeries.
Erb's point is where S1 n S2 are best heard (3rd IC space left of sternum).
Mitral regurgitation is only acute pathology being presented rest are chronic.
Mitral clips are kind of new intervention.
Dr Nahal has elaborated aortic regurgitation/stenosis, mitral regurgitation/ stenosis, tricuspid regurgitation/stenosis and pulmonary regurgitation separately from pathophysiology to kind of murmur, radiations, pulse characteristics and management.
Lastly Dr Ash did a mock osce and it was wonderful amazing activity i thoroughly enjoyed and learned o lot
Thank you Lgem for bringing up this spectacular course and brushing our brains.

FEEDBACK # 30

Muhammad Azeem Imran

It was an awesome presentation on "Valvular Heart diseases". So many learning points of today's Session
aetiology, Sign& symptoms - pathophysiology of
° Mitral stenosis
° Mitral regurgitation
° Aortic stenosis
° Aortic regurgitation
° Tricuspid regurgitation
° Tricuspid stenosis
° Pulmonary stenosis
° Pulmonary Regurgitation
PASS - Pulmonary & Aortic stenosis Systolic murmurs
PAID - Pulmonary & Aortic Regurgitation Diastolic Murmurs
Reverse it for Tricuspid & Mitral valves
To me it feels I revised all my final year med school and learned these topics in easy digestible way and to recall at time of real life scenario . Dr Ash two Clinical Scenarios regarding Aortic stenosis and Carcinoid syndrome were amazing . I learnt the process to make diagnosis in logical way . Dr Imran Farooqa intelligently and logically picked up diagnosis in OSCE . so today I learnt the process of OSCE . Thank you sir for your endeavors to make all of us a successful story and proving wonderful plateform .
proud to be a part of LGEM program

FEEDBACK # 31

Syed Suhail Ahmad

An excellent session on Valvular Heart Diseases For EM & Acute Physicians By Dr Nahal Raza Cardiology Registrar NHS UK

Covering

Aortic Stenosis & Regurgitation

Mitral Stenosis & Regurgitation

Pulmonary Stenosis & Regurgitation

Pulmonary Stenosis & Regurgitation

Comprehensively covering causes, pathophysiology, clinical features and their management

Interesting OSCE based cinical cases of Aortic Stenosis and Carcinoid Syndrome shared by Dr. Ash with Dr. Imran Farooka

Great work London Global Emergency Medicine & Pema-Uk 👍👍👍

FEEDBACK # 32

Aakash

It was a wonderful & comprehensive lecture delivered by dr nahal raza.

She explained each & every thing in very comprehensive way from basics upto clinicals.

Learning objectives were :-

➡ S1 caused by Closure of AV valves &

S2 caused by semilunar valves.

➡ Significance of Erbs point.

➡ differnce between stenosis & regurgitation.?

➡ Sign & symptoms of valvular diseases.?

➡ Causes of aortic stenosis.?

A wonderful reply was given by Dr sidra about William Syndrome.

➡ pathophysiology & sign symptoms of following were discused in very easy way:-

° aortic stenosis

° aortic regurgitation

° Mitral stenosis

° Mitral regurgitation

° Tricuspid regurgitation

° Tricuspid stenosis

° Pulmonary regurgutation
° Pulmonary stenosis
➡Usually aortic stenosis is asymptomatic in the majority of patients.
➡ which murmurs are best heard on expiration.?
➡ Always see the radiation of murmurs must in examinaton.
and much more.
Once again thanks a lot dr ash for providing us such a wonderful platform ❤️

FEEDBACK # 33

Rajab Abbas

It was a power pack session on "Valvular Heart diseases" covered by Dr Nahal in just 1.5 hour and she amazingly covered it .
Her calm n cool method of interactive teaching made this lecture more digestible for all the candidates.
Imp learning points of today's session:
• *Causes, clinical presentation (signs n symptoms) , pathophysiology and management of*
° Mitral stenosis
° Mitral regurgitation
° Aortic stenosis
° Aortic regurgitation
° Tricuspid regurgitation
° Tricuspid stenosis
° Pulmonary stenosis
° Pulmonary Regurgitation
She covered all aspects of valvular Heart diseases comprehensively along with discussing knowledgeable pearls regarding MRCP PACES . She told how to listen for any murmur and how to reach to diagnosis in a systematic way.
Session ended with an astonishing OSCE case performed by Dr ASH n Dr Imran Farooqa and Dr Farooqa carried it in a beautiful way and it took him just 1 sec to reach the diagnosis (Carcinoid Syndrome).
Thank you Dr ASH for allowing to attend this lecture .
Thank you Dr Nahal for wonderful teaching.
Blessed to be part of this project.

FEEDBACK # 34

Imtiaz Ali Shah

Yet another great session by Dr Nahal regarding valvular heart diseases covering important aspects of different valvular lesions.The session covered the following.
Anatomy of heart.
Heart valves and Heart sounds.
Auscultation Areas.
Types of valvular diseases.
Mechanism of stenosis and Regurgitation.
Causes of Aortic stenosis along with sign symptoms and managment.
Causesof Aortic Regurgitation along with signs symptoms and managment.
Similarly causes of mitral stenosis, signs symptoms and managment.
Causes of Tricuspid stenosis along with managment
Pulmonary stenosis, signs symptoms and managment..
Overall it was an amazing session by dr Nahal .she was full of energy and she made the things easy to understand .
The session was concluded by a case scenario by dr Imran Farooqa and Dr Ash with diagnosis of carcinoid syndrome..
I want to thank dr Nahal for this wonderful presentation and also Dr Ash for providing this great learning opportunity.

FEEDBACK # 35

Javeria Wali

Outstanding session delivered by Dr. Nahal Raza on the topic "Valvular Heart Diseases for Emergency Medicine and Acute Physicians". The lecture was full of extremely important learning points discussed in a very fun and energetic way such that every one's interest was gripped till the very last second. Dr. Nahal started off with the anatomy of heart and examination of precordium and auscultation points and talked about Valvular heart disease from the most commonly encountered Aortic stenosis, Aortic Regurgitation, Mitral Stenosis, Mitral Regurgitation to the less common Tricuspid Stenosis/ Regurgitation and Pulmonary valve disease. All topics were covered under the headings of Causes, Pathophysiology, Management, surgical and Medical Treatment with relevant tables and mnemonics. Surgical treatments such as balloon valvuloplasty and valve replacement were discussed in great detail and understood perfectly. In the End, OSCE with Dr. Ash by Dr. Imran Farooka was brilliant as well with perfect diagnosis of Carcinoid Syndrome.

FEEDBACK # 36

Imran Farooka

Today session was on valvular heart diseases.session started with a case based discussion by Dr Ash . He presented a case seen by him in emergency, 87 year old man who presented with shortness of breath labelled as lower respiratory tract infection and cardiac failure managed with antibiotics and diuretics. On clinical exam he was found to have severe aortic stenosis and was referred for intervention and got better and discharged.
This was followed by discussion on different valvular lessions by Dr Nahal. She discussed etiology, pathogenesis clinical features and management of different valvular lessions. This was followed by an OSCE station with Dr Ash .
This was an excellent session where Dr Nahal comprehensively elaborated valvular lessions and Dr Ash in his own style made these clinically relevant by narrating his clinical encounters.

FEEDBACK # 37

Mariam Nawaz

Had an excellent session on valvular heart disease today by Dr Nahal. Session began with a very intresting geriatric case of aortic stenosis by Dr Ash, Sir told us so many im0 points of approaching a patient and the importance of asking the right questions and doing the right examination, like, always look for chest scar followed by examining limbs for scar in all patients of heart failure or aortic stenosis
This was followed by a very comprehensive and intresting session by Dr Nahal, few of the Things we learnt are as follows:
. Always auscultate the chest in s pattern
. Erbs point is where murmurs can be heard best, at 3rd left ICS
. All valvular heart diseases eventually lead to heart failure
. AORTIC STENOSIS: Rheumatic heart disease, calcifications and bicuspid valve are the most common causes
Exertional dyspnoea, angina and exertion syncope are most imp clinical features
Murmur is ejection systolic, heard best during inspiration and radiates to carotids
Valve replacement may be needed, anticoagulate of risk of afib
. AORTIC REGURGITATION: "RAD CHEMIST" is the mnemonic for causes
Awareness of heart beat specially while lying down, SOB and angina in severe cases
Collapsing pulse is an important sign
. MITRAL REGURGITATION:

Only valvular heart disease that can be acute
Afib, apical pansystolic murmur, soft S1 and apical S3
And finally in the end we had a loaded OSCE session by Dr Ash
Thankyou Dr Nahal and Dr Ash for this amazing session

FEEDBACK # 38

Ram Leela

It was good enough session on Valvular heart diseases, covered all heart congenital lessons comprehensively.
She delivered her lecture very well, explained pathophysiology of each condition, causes, signs and symptoms, clinical features and management.
I have learnt that Aortic stenosis is characterized by syncope & pain in chest mostly asymptomatic but kept under review. Signs of low cardiac out or hear failure requires immediate surgery. Moderate or Severe Stenosis is evaluated 1-2 with Doppler echocardiography and treatment of Severe aortic stenosis is Valve replacement while Congenital aortic stenosis requires Aortic balloon valvuloplasty. Causes of Aortic regurgitation are Rheumatic heart disease, Aortic aneurysm, aortic dissection, congenital aortic valve disease, hypertension, endocarditis, Marfan's syndrome and collagen vascular disease, ankylosing spondylitis, SLE, Trauma to chest, sedation. Aortic regurgitation results in left heart failure followed by right heart failure. Mild to moderate regurgitation is usually asymptomatic or palpitations when lying on left lateral position. Severe Aortic regurgitation results in breathlessness & angina. Its murmur is best heard to the left sternum during held expiration. Treatment includes correction of underlying cause, aortic valve replacement, asymptomatic patients require annual follow up with echocardiography.
Proper history, focused clinical examination and related investigations will reveal heart valvular diseases.
OSCE case was very good, Dr. Imran was good enough to diagnose it straightaway. Thank you Dr. Ash for great platform of learning.

FEEDBACK # 39

Beenish Manzoor

It was an excellent lecture by Dr.Nahal ,she covered all the topics related to clinical diagnosis and management of Valvular Heart diseases stated with basic anatomy , pathophysiology clinical presentation

Common causes sign and symptoms.along with management according to severity of the disease of following ;
*Aortic Stenosis and Regurgitation, *Mitral Stenosis and Regurgitation,
*Tricuspid Stenosis and Regurgitation.
"Pulmonary regurgitation and stenosis
She elobrated very beautifully about auscultation points with slowly building up concepts about the clinical presentation which gave us all a wrap in one and half hour
The tables ,clinical scenarios and mnemonics used by her made us like learn high yield topics very efficiently as usual session ended with Dr.Ash with few golden words along with an osce scenario which was again was volunterly perform by Dr.Imran Farooka and he executed the case very systematically giving us the diagnosis with clear history taking and clinical signs and won the reward .Thankyou Dr.Ash for arranging such an amazing platform
Thanyou LGEM team
Proud to be part of LGEM programme ❤️

FEEDBACK # 40

Shehzad Hussain

Thanks to Dr Nahal Raza n Dr Ash for an amazing session on Valvular Heart Diseases n thanks to Dr Imran for OSCE,
it was started with Anatomy, physiology, pathophysiology, etiology, signs, symptoms, auscultation during inspiration n expiration, investigation and treatment.
It was comprehensive lecture which included all necessary details about Aortic Stenosis n regurgitation, Mitral stenosis n regurgitation, Tricuspid stenosis n regurgitation, pulmonary valve stenosis n regurgitation.
Anticoagulation in Mitral stenosis.
In a short time very good teaching session learnt and reminded many things.
Thanks Dr Ash n LGEM team for amazing session.

FEEDBACK # 41

Noman Ahsan

Such a wonderful session conducted by Dr.Nahal...She is very energetic and delivered the lecture comprehensively while discussing every single topic in detail with to the point clear concepts ...She engaged us with her amazing energy till the end and I didn't get bored or out of focus...Learned lots of new concepts ..At the

end Dr.Ash conducted OSCE session with Dr.Imran and he won 50£ , which is a great accomplishment...Dr.Ash always engourage us to learn more n more every single day..
Thanks Dr.Nahal and Dr.Ash for this wonderful session...going to watch the recorded session again to memorise important topics...Thanks alot

FEEDBACK # 42

Sadia Abbasi

Its a wonderful session great learning day . Session was well organised and interactive i learnt alot including some new stuff which i did not go through in my career including Anatomy of heart, 5 areas for listening to the heart 5)ERB'S POINT(is new for me)S1S2 left 3rd intercostal.,types of valvular disease,valvular stenosis pathophysiology, valvular regurgitation pathophysiology, types of valvular disorders and symptoms, MS relation to AF ,importance of anticoagulation to these pt:,causes of valvular heart disease, RAD CHEMISTS aortic insuffiency cause mnemonic😀 and management plans.one beautiful thing i realised about London GEM MRCP programme is its not just for how to pass mrcp exam but its a unique program where u learn alot both for exam point of view and improving our clinical practice as well and this just because of Dr Ash my mentor thanking you Dr Ash.
Osces session by dr kamran and dr Ash excellent so many learning points from exam side.

FEEDBACK # 43

Muhammad Abubakar

An outstanding lecture given by Dr. Nahal on Valvular Heart Diseases, how to diagnose, etiology, pathophysiology and management. Many things were discussed today including…
S1 & S2
Aortic stenosis => which can cause Syncope, Angina, Exertional dyspnea, Heart Failure
Which can present with the symptoms include Cough, Abdominal Bloating, Dyspnea, Palpitation…
A.S can caused by Rheumatic Heart Disease, Valvular calcification, Bicuspid valve, Radiotherapy, Alkaloid Drugs, Congenital (subaortic membrane). Rare causes include; Ochronosis, Hypercholesterolemia in children, Paget’s disease, unicuspid or quadricuspid valve, supravalvular stenosis.

Signs which can present are Ejection Systolic murmur, Slow rising carotid pulse with low sound S2, thrusting Apex Beat, Narrow Pulse pressure. ”Appreciated during inspiration”
Can treated with Balloon Valvuloplasty and TAVI (Trans Aortic Valvular Implantation)
Aortic Regurgitation => can caused by Infective endocarditis, Aortic aneurysm, Aortic dissection, HTN, SLE, Marfan syndrome, Syphilis, Connective tissue disorder, Ehler Danlos syndrome, Rheumatic heart disease, Sedation (before paralysis) and Congenital
Collapsing pulse, Quincke’s sign, Duroziez’s sign can be seen in such patients
Mitral regurgitation
Mitral clips intervention
Atrial Fibrillation
Mitral Stenosis
Mitral Valvotomy
Mitral facies
Tricuspid Stenosis & Regurgitation
Pulmonary Stenosis & Regurgitation
And much more about these. 2 Case Based Discussions were also held 1 was about TAVI in Aortic stenosis and 1 was about Carcinoid syndrome which was very well presented by our mentor Dr. Ash and nicely accompanied by Dr. Imran Farooka. Thankyou LGEM for such great faculty and great topics which help us to be more efficient in our practice.

FEEDBACK # 44

Naveed Memon

Today's Lecture started by Dr Ash with Amazing scenerio on TAVR, followed by Dr Nehal Raza an amazing session on Valvular Heart Diseases like 2nd most common cause of HF is valvular heart diseases from which Aortic is most important. We learnt today
Aortic stenosis comon causes, like Rheumatic, calcific ,Bicuspid and congenital airtic stenosis their clinical manifestations and management.
Aortic Regurgitation cause RAD CHEMISTS, clinical features and management.
Also covered other Valvular disease MR,MS, Tricuspid stenosis and regurgitation their every single symptoms and presentation and management.
Area of auscultation in examination.

The way Dr Nahal cover topics in just 75 mins amazing.
Thanks Dr Nahal and Dr Ash.

FEEDBACK # 45

Mukhtiar Pathan

Superb Session by Dr Nehal Raza on Valvular Heart Diseases in which we learned, Anatomy & Physiology of Heart Valves.
We learned that Aortic Valve is the most common valve involved.
Second most common involved valve is the Mitral Valve.
In addition we learned following points,
● S1 Heart Sound is produced by closure of Atrioventricular valves.
● S2 Heart Sound is produced by closure of Semilunar valves.
■ Auscultation Areas
There are 5 areas to listen to, including,
○ Aortic
○ Pulmonic
○ Erb's Point
○ Tricuspid
○ Mitral
Following mneumonic can be used to remember 5 Areas of Auscultation
"All People Enjoy Time Magazine (APETM).
♡ TYPES OF VALVULAR HEART DISEASES.
There are two types of Valvular Diseases.
A) Vlvular Stenosis
B) Vavular Regurgitation
A) Vlvular Stenosis
The Valve opening narrows, obstructing the normal blood flow affecting the chamber behind the stenotic valve to greater stress, leading to Heart Failure.
- Most common cause of Heart Failure is Ischemic Heart Disease, & second most common cause of Heart Failure is Valvular Heart Diseases.
B) Vavular Regurgitation
The valvular disorder that allows blood flow back into the chamber behind Regurgitative Valve, resulting in Heart Failure.
♡ TYPES OF VALVULAR DISORDERS AND THEIR SYMPTOMS & SIGNS
1) AORTIC STENOSIS

- Narrowed Aortic Valve Disorder that results in reduced blood flow through the valve.
- Patients with Aortic Stenosis may present with Syncope & Angina, therefore History & Examination is important to reach at diagnosis.
- Mitral Stenosis may cause Atrial Fibrillation and we need to put patient on anticoagulant, and if we are not putting on anticoagulant, then patient may develop Stroke.

■ Causes of Aortic Stenosis

◇ Common Causes

- Bicuspid Valve
- Rheumatic Heart Disease
- Calcification

◇ Uncommon Causes

- Radiation
- Drugs
- Congenital for eg Subaortic Membrane

◇ Rare Causes

- Ochronosis
- Hypercholesterolemia in Children
- Paget"s Disease
- Other Congenital

Unicuspid or Quadricuspid Valve

- Supravalvular Stenosis

■ Clinical Features of Aortic Stenosis

◇ Symptoms of Aortic Stenosis

- Patients are usually asymptomatic specifically with mild to moderate Aortic Stenosis.
- But the symptoms can be,
- Exertional Dyspnea,
- Angina
- Exertional Syncope
- Episodes of Acute Pulmonary Edema,
- Sudden Death

◇ Signs of Aortic Stenosis

- Ejection Systolic Murmur

- Slow rising Carotid pulse
- Thrusting Apex Beat
- Narrow Pulse Pressure
- Signs of Pulmonary Venous Congestion

■ Management of Aortic Stenosis

- In asymptomatic patients no treatment is required.
- Advise yearly Echocardiography and explain red flag signs of Angina, Syncope, and symptoms of low cardiac output, as it has a poor prognosis, and indicate prompt surgery.
- In symptomatic severe Aortic Stenosis, treatment is valve replacement.
- Aortic Balloon Valvuloplasty is the treatment option in Congenital Aortic Stenosis.

FEEDBACK (PART - 2)

2) AORTIC REGURGITATION

Valvular Disorder that allows blood flow back into Left Ventricle.

■ Causes of Aortic Regurgitation

Mnemonic to remember causes of AR - RAD CHEMISTS

-Rheumatic Heart Disease
- Aortic Aneurysm
- Dissection of Aorta
- Congenital Aortic Valve Disease
- Hypertension
- Endocarditis
- Marfan
- Iatrogenic
- Systemic Disease (Ankylosing Spondylitis, SLE)
- Traumatic
- Sedation

■ Clinical Features of Aortic Regurgitation

◇ Symptoms of Aortic Regurgitation

- Patients wuth mild to moderate Aortic Regurgitation are asymptomatic or present with palpitation.
- Patients with severe Aortic Regurgitation are presented with symptoms of Shortness of Breath or Angina

◇ Signs of Aortic Regurgitation

- Collapsing Pulse
- Increased Pulse Pressure
- Quincke's Sign
- Duroziez's sign
- Mussel's sign
-Early Diastolic Murmur, Systolic Murmur, Austin Flint Murmur

■ Management
- Treat underlying cause
- In asymptomatic patients no treatment is required.
- Advise yearly Echocardiography and explain red flag signs.
- Systolic Blood Pressure should be controlled with Vasodilators for eg Nifedipine.
- Aortic Regurgitation with symptoms require valve replacement.

FEEDBACK (PART - 3)

3) MITRAL STENOSIS

Narrowed Mitral Valve Disorder that results in reduced blood flow through the valve.

■ Caises of Mitral Stenosis
- Rheumatic Heart Disease
- Severe Mitral Annular Calcification
- Congenital
- Secondry to Systemic Disease
- Infective Endocarditis
- Radiation

■ Clinical Features

◇ Symptoms of Mitral Stenosis
- Palpitation
- Fatigue
- Swollen Leg/Feet

' Shortness of Breath

◇ Signs of Mitral Stenosis
- Atrial Fibrillation
- Mitral Facies
- On Auscultation, Loud 1st Heart Sound, Opening Snap
- Mid Diastolic Murmur

■ Management of Mitral Stenosis

- Cases of Mitral Stenosis can be managed medically with Anticoagulant Digoxin, & Diuretics,
- Surgical Treatment Options include Mitral Baloon Valvuloplasty, Mitral Volvotomy & Valve replacement.

4) MITRAL REGURGITATION

Acute Valvular Disorder that allows blood flow back into the Left Atrium and Pulmonary veins during Systole.

■ Causes of Mitral Regurgitation

◇ Acute Causes

- Infective Endocarditis
- Ruptured Chordae
- Papillary Muscle Rupture

◇ Chronic Causes

- Ischemic Cardiomyopathy
- NonIschemic Cardiomyopathy
- HCM
- Rheumatic Heart Disease

■ Clinical Features of Mitral Regurgitation

◇ Symptoms of Mitral Regurgitation

- Palpitation
- Fatigue
- Pedal Edema
- Shortness of Breath

◇ Signs of Mitral Regurgitation

- Atrial Fibrillation
- Soft S1, Apical S3
- Pansystolic Murmur

■ Management of Mitral Regurgitation

- Medical Management includes Vasodilators and Diuretics
- If it is combined with Atrial Fibrillation then add Anticoagulant.

' Digoxin may be added.

- Surgical Options include Mitral Valve Repair, or, Mitral Valve Replacement.

FEEDBACK (PART -4)

5) TRICUSPID STENOSIS

- usually occurs with Aortic Stenosis or Mitral Stenosis.

- Tricuspid Stenosis Causes decreased blood flow from right Atrium to right Ventricle, leading to decreased right Ventricular Output and decreased left Ventricular filling resulting in decreased Cardiac Output.
- increases Systemic pressure.

■ Causes of Tricuspid Stenosis
- Rheumatic Heart Disease
- Carcinoid
- Tumors
- Congenital
- Regional Cardiac Temponade
- SLE
- Whimple Disease
- Fabry Disease
- Endomyocardial Fibrosis
- Infective Endocarditis
- Endocardial Fibroelastosis
- Methysergide Therapy
- Antiphospholipid Syndrome

■ Clinical Features of Tricuspid Stenosis

◇ Symptoms of Tricuspid Stenosis

Patients are usually presented with symptoms of right heart failure, including,
- Hepatomegaly,
- Ascites
- Peripheral Edema
- Engorged Neck Veins

◇ Signs of Tricuspid Stenosis
- Raised JVP
- Mid Diastolic Murmur

■ Management of Tricuspid Stenosis
- Valve Replacement
- Baloon Valvuloplasty

6) TRICUSPID REGURGITATION

Valvular Disorder that allows blood flow back into the right atrium during systole.

■ Causes of Tricuspid Regurgitation
- Functional

- Rheumatic
- Infective Endocarditis
- Carcinoid Heart Disease
- Congenital
- SLE
- Catheter induced
- Trauma
- Tumors
- Orthtopic Heart Transplantation
- Endomyocardial Fibrosis
- Antiphospholipid Syndrome

■ Clinical Features of Tricuspid Regurgitation

◇ Symptoms of Tricuspid Regurgitation

- Patients usually are asymptomatic, but may present with,
- Tiredness
- Edema
- Hepatic Enlargement

◇ Signs of Tricuspid Regurgitation

- Raised JVP

-Pulsatile Liver

- Pansystolic Murmur

■ Management of Tricuspid Regurgitation

- Treat underlying cause.
- Diuretics- Vasodilators
- Surgical Options include
- Valve Repair
- Valve replacement.

7) Pulmonary Valve Disease

Pulmonary valve disease is the disorder in which the pulmonary valve located between right Ventricle and the pulmonary arteryis affected.

FEEDBACK (PART - 5)

■ ETIOLOGY OF PULMONARY VALVE DISEASE

◇ Congenital

- Pulmonary Valve Stenosis
- Pulmonary Atresia

- Supravalve Pulmonary Stenosis
- Infundibular Pulmonary Stenosis
- Idiopathic Pulmonary Artery Dilatation
- Coronary AV Fistula

◇ Acquired

- Rheumatic Valve Disease
- Infective Endocarditis
- Carcinoid Heart Disease
- Tumors

◇ Iatrogenic

- Homograft dysfunction following Ross operation
- Homograft reconstruction for repair of
- Pulmonary Atresia
- Complex form of TOF
- Common Arterial Trunk
- Pulmonary Stenosis

■ Clinical Features of PULMONARY STENOSIS

◇ Symptoms of Pulmonary Stenosis

- Fatigue
- Dyspnea
- Poor weight gain
- Hepatomegaly
- Ascites
- Edema

◇ Signs of Pulmonary Regurgitation

- Ejection Systolic Murmur
- Wide splitting of second Heart Sound

■ Management of Pulmonary Stenosis

- Mild to Moderate Pulmonary Stenosis usually is isolated and requires no treatment.
- Severe Pulmonary Stenosis requires Percutaneous Pulmonary Baloon Valvuloplasty or Volvotomy.

😎 PULMONARY REGURGITATION

- A rare condition
- usually associated with Pulmonary Hypertension.

- Blood flow back into the right Ventricle leading to right ventricle and atrium hypertrophy resulting in symptoms of right heart failure.
In the last there was OSCE by Dr Ash and the participant was Dr Imran Farooqa in which a very interesting case of Carcinoid was discussed.
There were many learning points
including
- How to approach such patients,
- How to take history from such patients,
- How to examine such patients,
' How to narrow down the diagnosis,
And lot more
Dr Imran wisely reached the diagnosis and beautifully taught the audience how to practically approach the patient
A Day Full of Teaching with lot of learning.
Thank you Dr **Nahal Raza** for excellent teaching.
Many Thanks Sir Dr **Ashfaque** for your continuous guidance, help and support.
Truly blessed to be part of such a wonderful training program.
Proud to be part of **London Global Emergency Medicine** Program
Thank you **Pema-Uk**

FEEDBACK # 46

Haider Ali

Starting from the case Dr. Ash presented of Aortic stenosis and significance of physical examination and every scar on the body, then heading towards the lecture. Dr. Nahal was amazing throughout. Dynamic teaching techniques of her led to best ever understanding of this topic. Loved every minute of this session.
Ending the session with the OSCE station done by Dr. Imran, which was one of the best. 👌
Thankyou London Global Emergency Medicine .

FEEDBACK # 47

Aymen Bashir

Dr Nahal's session was very interactive and informative. She comprehensively covered the most difficult topic in 1 hour. We learnt the anatomy of valves and how to properly auscultate the precordium in front of the examiner. Moreover, the pathophysiology of each valve along with their signs and symptoms were

discussed in detail. Mitral stenosis, Mitral regurgitation, Aortic stenosis, Aortic regurgitation, Tricuspid stenosis, Tricuspid regurgitation.
The session ended with a wonderful case discussion with Dr Ash. Dr Imran proceeded in an amazing way to reach the diagnosis. It's a privilege to be a part of LGEM and Dr Ash as our mentor.

FEEDBACK # 48

Beenish Naveed

Another brilliant session conducted by Dr Nahal, she always puts her heart and soul to make us understand the each topic in depth.
Today's topic started with anatomy of heart, location of different valves, auscultation points, relevance with inspiration and expiration related to murmurs.
Discussed pathphysiology in depth.
She also discussed which is the most common type and how does it present, mentioned about how to differentiate between aortic and mitral calve disease.
How to identify the signs and symptoms, importance of history and examination in every case and also the high end management plan.
She discussed in details all the causes of aprtic stenosis and synptoms present with it from symptoms of acute to chronic heart failure.
The leactute has given an insight of all the main findings and its management.
Dr Ash discussed informative and amazing cases related to valvular heart disease and then Osce by Dr Imran was top notched.
Proud to be part of London gem and student of Dr Ash

FEEDBACK # 49

Ghazala Xhiekh

Dr Nahal Raza cleared a very complicated topic in a precise time with full of energy.
I learnt,

- Heart sounds
- Aortic Stenosis
- Aortic Regurgitation
- Mitral Stenosis
- Mitral Regurgitation
- Pulmonary Stenosis
- Pulmonary Regurgitation
- Tricuspid Stenosis

● Tricuspid Regurgitation
● their pathophysiology, management's and causes
● Osce session was amazing as doctor imran diagnosed immediately the case of carcinoid syndrome.
We are very lucky that we can interact with Dr Ashfaque Ahmed and can learn from you
Thankyou so much sir for your kindness

FEEDBACK # 50

Sana Hameed

What a detailed review of cases of valvular heart diseases by Dr: nehal Raza. Really appreciate Our mentor's hard work to encourage us to get to Learn new things to able to help patients with such disabilities.
Starting from the pathophysiology to their management in emergency without needing to get a separate sub specialists to manage patients. What else can you wish for on a Sunday with all mind set to Learn new things. Really greatful to sir **Ashfaque Ahmed** for his continuous efforts for his trainees.

FEEDBACK # 51

Dr Muhammad Saad

Such a brilliant session, much needed it. Dr Nahal Raza covered the whole valvular disorders in a very specific, concise and precise manner. I could feel the enthusiasm in the lecture. She explained all the valvular disorders, stenosis, regurgitation along pathophysiology, causes, symptomatology, treatment; medical and surgical both. All the participants were actively involved, slides were quite interesting and simplified. In the end OSCE was done by Dr Ash and Dr Imran, this was a case of 55 years old patient with shortness of breath. Learnt bundles of new concepts.
Thanks to Dr Ash and London GEM for such brilliant session.

FEEDBACK # 52

Dr Shahid Ahmad

Imp learning points of today's session:
° Mitral stenosis
° Mitral regurgitation
° Aortic stenosis
° Aortic regurgitation
° Tricuspid regurgitation

° Tricuspid stenosis
° Pulmonary stenosis
° Pulmonary Regurgitation

Session ended with an astonishing OSCE case performed by Dr ASH n Dr Imran Farooqa and Dr Farooqa carried it in a beautiful way and it took him just 1 sec to reach the diagnosis Carcinoid Syndrome.

Thank you Dr ASH and Dr Nahal

FEEDBACK # 53

Dr Tehmina Jamali

Firstly case was presented by Dr.Ash of a elderly pt.e HF& LRTI;had pneumonia,CCF was given ABX & steroids.Then while auscultating he saw a scar on midline& then he looked for another scar on the leg but there wasnt scar. He asked pt.but he didn't remember & most of the scars >10 yrs old go away.On listening the heart could hear murmur;further going deep the pt.had Aortic stenosis.If the pt.was sent home she would have died.Then TAVI procedure was planned for this elderly pt.where surgery cannot be done

Further the topic was discussed in detailed by Dr.Nahal.

Valvular heart disease :

The Anatomy

4 valves

Aortic most important

Mitral

Tricuspid

Pulmonary

Heartsound

Auscultation

APETM

Types of valve disease

Valvular stenosis

Valvular Regurgitation

Their effects

Types of valvular disorders Table from Davidson

Signs & symptoms of Heart valve diseases

Causes of Aortic stenosis

Pathophysiology

Clinical features/symptoms/signs/Management
Causes of Aortic Regurgitation
RADCHEMISTS
Pathophysiology/clinical features/symptoms/signs/management
Causes of Mitral Regurgitation
Pathphysiology/clinical manifestations/symptoms/signs/management/medically/surgically
Causes of Mitral stenosis
Pathophysiology/clinicalfeatures/signs/management
Csuses of Tricuspid disease
Management of TS& TR
Etiology of Pulmonary valve disease
Pul.stenosis/symptoms/signs/management
Pul.Regurgitation
You hear murmurs when you don't murmur.
Lastly OSCE session was held b/w Dr.Ash & Dr.Farooka.
It is good practice held by Dr.Ash on & off to have practical performance with theory.
Case was of Carcinoid syndrome.
Truly speaking Dr.Ash lecture was learning but quick to grasp.
Thankyou

FEEDBACK # 54

Dr Muhammad Amash Khan

Today's session on valvular heart disease was a brief lecture and clinically oriented which started with simple anatomy of vavles in heart then auscultation areas in which Erb's point was new to learn and then we learned about the valvular diseases, their causes, signs, symptoms and their treatment.
Thank you Dr Nahal for your time you delivered it beautifully.

FEEDBACK # 55

Dr Ramsha Tasnim

Amazing lecture deliver by dr nahal started from the basics antomy physiology to types of heart valve diseases. Important mcqs point and nemonics to remember them.
Areas of Auscultation (Aortic, pulmonary , Erb’s Point, Tricuspid, Mitral)
How to define Valvular stenosis

And Valvular regurgitation.
Types of valvular disease
Aortic Stenosis and Regurgitation (causes, pathophysiology, signs and symptoms, clinical feature and management)
Mitral Stenosis and Regurgitation (causes, pathophysiology, signs and symptoms, clinical feature and management).
Tricuspid Stenosis and Regurgitation (causes, pathophysiology, signs and symptoms, clinical feature and management).
Pulmonary Stenosis and Regurgitation (causes, pathophysiology,signs and symptoms, clinical feature and management)
Case discussion of AS valve replacement failure with Dr. Ash and OSCE Session with Dr. Imran Farooq of carcinoid syndrome was eye opening.
Thank you Dr. Nahal and Dr. Ash.

FEEDBACK # 56

Dr Qaisar Shah

CASE PRESENTATION by Dr Ash (AORTIC STENOSIS)
OSCE STATION By Dr Ash & Dr Imran Farooqa (Carcinoid Syndrome)
Dr Nahal discussed:
✪ANATOMY OF HEART & VALVES
✪ THE VALVES AND HEART SOUNDS
First Heart Sound (Lubb')➜Closure of the atrioventricular valves
Second Heart Sound ('Dupp)➜Closure of the semilunar valves
✪ 5 AREAS FOR LISTENING TO THE HEART (ALL PEOPLE ENJOY TIME MAAGAZINE)
✪ VALVULAR HEART DISEASE
Pulmonary Valve+Aortic Valve+Mitral Valve+Tricuspid valve
ANY DISEASE OF THESE VALVES ARE CALLED AS VALVULAR HEART DISEASE!
✪ TYPES OF VALVE DISEASES
Stenosis:
Valve doesn't open all the way, not enough blood passes through.
Regurgitation:
Valve doesn't close
all the way so blood

leaks backwards.

✪VALVULAR STENOSIS

THE VALVE OPENING NARROWS

the valve leaflets may become fused or thickened that the valve cannot open freely > obstructs the normal flow of blood.

✪VALVULAR REGURGITATION

LEAKAGE OR BACKFLOW OF BLOOD RESULTSS FROM INCOMPLETE CLOSURE OF THE VALVE

✪Types of Valvular Disorders and Symptoms

✪Heart Valve Disease

Signs and Symptoms

Fluttering chest sensation,Chest pain(angina),Shortness of breath+Fatigue or weakness+Tiredness+Rapid weight gain+Lightheadedness or loss of consciousness+Coughing+Swollen ankles+Abdominal bloating

✪CAUSES OF AORTIC STENOSIS

Rheumatic,Calcific,Bicuspid valve,Radiation,Drugs,Congenital e.g. subaortic membrane Ochronosis,Hypercholesterolaemia in children,Paget's disease,Unicuspid or quadricuspid valve,Supravalvar stenosis

✪Clinical features

Symptoms:

► Mild or moderate stenosis: USually asymptomatic

CARDINAL

SYMPTOMS:

►Exertional dyspnea

Angina (due to ↑ demands of hypertrophied LV)

Exertional syncope

► Sudden death

► Episodes of acute pulmonay oedema

✪Signs

Ejection systolic murmur

► Slow-rising carotid pulse

Thrusting apex beat (LV pressure overload)

►Narrow pulse pressure

Signs of pulmonary venous congestion (e.g. crepititions)

✪Management

► Asymptomatic aortic stenosis → kept under review
(as the cevelopment of angina. syncope.
symptoms of low CO or heart failure
has a poor prognosis and is an indication
For prompt surgery
> Moderate/severe ştenosis → evaluated every 1-2 years
with Doppler echočardiography (to detect progresion in severity)
Symptomatic severe aortic stenosis → valve replacement

► Congenital aortic stenosis → aortic balloon valvuloplasty
Atrial fibrillation or post valve replacement with a
mechanical prosthesis → anticoagulant

✪CAUSES OF AORTIC REGURGITATION

Aortic Insufficiency Causes:
"RAD CHEMISTS"
R:Rheumatic Heart Disease
• A: Aneurysm (aortic)
• D: Dissection (aortic)
• C: Congenital aortic valve disease
• H: Hypertension
E:Endocarditis
M:Marfan's and other collagen vascular disease
I:Iatrogenic (e.g., LHC)
S:Systemic disease (ankylosing spondylitis, SLE)
T:Trauma to chest
S:Sedation (Before Paralysis)

✪ Symptoms

Mild or moderate aortic regurgitation:

► Usually asymptomatic (because compensatory ventricular
dilatation & hypertrophy occur)
Awareness of heartbeat, 'palpitations'
particularly when lying on the left side.
which results from increased in stroke volume

BOF
Severe aortic regurgitation:
Breathlessness
Angina
✪Signs
► Pulses:
Lorge volume or 'collapsing' pulse
Low diastolic and increased pulse pressure
Bounding peripheral pulse
Capillary pulsation in nail beds: Quincke's sign
Femoral bruit('pistol shot'): Duroziez's sign
Head nodding with pulse: de Musset's sign
Murmurs:
Early diastolic murmur
Systolic murmur [increased stroke volume)
Austin Flint murmur (soft mid-diastolic)
► Other signs:
Displaced, heaving
apex beat (volume
overload)
Pre-systolic impulse
-4th heart sound
Crepitations
(pulmonary venous
Congestion)
characteristic murmur is best heard
to the leff stemum during held expiration
Signs.
✪Management:
Treatment may be required šor underlying conditions,
SUch as endocarditis or syphilis
Aortic regurgitation with symptoms> aortic valve
replacement (may be combined with aortic root
replacement and coronary bypass surgery)

Asymptomatic patients → annually follow up with
echocardiography for evidence of increasing
ventricular size
Systolic BP should be controlled with vasodilating drugs.
sUch as nifedipine or ACE inhibitors

✪CAUSES OF MR

ACUTE:
INFECTIVE
ENDOCARDITIS,
RUPTURED CHORDAE
PAPILLARY MUSCLE
RUPTURE
CHRONIC:
ISCHAEMIC
CARDIOMYOPATHY,NON ISCHAEMIC,CM,HCM,RHEUMATIC HEART DISEASE.

✪SYMPTOMS:

Fatigue & weakness - due to CO- predominant complaint
Exertional dyspnea & cough - pulmonary congesticon
Palpitations - due to atrial fibrillation (occur in 75% of pts.)
Edema, ascites - Right-sided heart failure

✪SIGNS:

Atrial fibrillation
Cardiomegally
Apical pansystolic murmur +/- thrill
Soft S1, apical S3
Signs of pulmonary venous congestion (crepitations, pulmonary
edema, effusions)
Signs of pulmonary hypertension & right heart foilure

✪Management:

Medically:
Vasodilators
(e.g. ACE inhibitors)
Diuretics

Surgically:
Mitral valve repair
OR
Mitral valve
replacement
To treat
mitral valve
prolapse
If atrial fibrillation
presents.
Anticoagulant+Digoxin

✪CAUSES OF MITRAL STENOSIS

Rheumatic heart disease
Most common cause worldwide. Commissural fusion, thick MV leaflets with restricted mobility, thickened and shortened chordae
Severe mitral annular calcification
Age-related changes, chronic kidney disease
Congenital
Double orifice MV, parachute MV (caused by either one papillary muscle, two fused papillary muscles, or chordae attached to one head of a
papillary muscle), congenitally thickened or dysplastic MV leaflets
Secondary to systemic disease (may result in thickened and restricted leaflets/chordae)
SLE, MPS, Fabry's disease, carcinoid disease, endomyocardial fibrosis, Whipple's disease
Infective endocarditis (vegetations)/tumor (left atrial myxoma)/ball valve thrombus
When large may obstruct MV orifice
Radiation induced
Thick MV with stenosis may occur 10-20 years after radiation

✪Signs

► Atrial fibrilation
>Mitral facies Abnormal flushing of the cheeks that occurs from cutaneous
Vasodilation in sitting of severe mitral valve stenosis)
Auscultation - Loud first heart sound. opening snap

(created by forceful opening of mitral valve)
-Mid-diastollic murmur (apex)
Crepitations, pulmonary edema, effusions
(raised pulmonary capillary pressure)
► RV heave, Loud P, (pulmonary hypertension)

✪CAUSES OF TRICUSPID DISEASE

Tricuspid Regurgitation:
Functional(structurally normal
tricuspid valve),Rheumatic,Infective endocarditis,Congenital (eg, tricuspid valve prolapse, Ebstein anomaly),Carcinoid heart disease,Systemic lupus erythematosus
Catheter-induced,
Trauma,Tumors,
orthotopic heart transplantation,
Endomyocardial fibrosis,Antiphospholipid syndrome
Tricuspid Stenosis:
Rheumatic,Carcinoid heart disease,Tumors
Congenital (eg, Ebstein anomaly)
Regional cardiac tamponade,Systemic lupus erythematosus,Whipple disease,Fabry disease,Infective endocarditis,Endomyocardial fibrosis,Endocardial fibroelastosis,Methysergide therapy ,Antiphospholipid syndrome.

✪Tricuspid Stenosis

Usually occurs together with aortic or mitral
stenosis
may be due to rheumatic heart disease (<5%),↓blood flow from right atrium to right ventricle, ↓4th right ventricular output, ↓4th left ventricular filing ,↓co,↑systemic pressure

✪Symptoms:

symptoms of right-sided heart failure, hepatomegaly, ascites,peripheral edema, neck vein
engorgement,↓CO-fatigue,hypotension
Signs:
Raised JVP,Mid-diastolic murmur (best heard at lower left or right sternal edge)

✪Management of TS

Valve replacement

• Balloon valvuloplasty

✪Tricuspid Regurgitation

Symptoms:

Usually non-specific

Tiredness (reduced
forward flow)

► Oedema

Signs:

Raised JVP

Pansystolic murmur (left
sternal edge)

Pulsatile liver

Hepatic enlargement
(venous congestion)

✪Tricuspid Regurgitation

Management:

Correction of the cause of right ventricular
overload (if TR is due to right ventricular dilatation)

► Use of diuretic and vasodilator treatment of CCF

► Valve repair

Valve replacement

✪Etiology of Pulmonary Valve disease

Congenital:

Pulmonary valve stenosis,Pulmonary atresia,Supravalve pulmonary stenosis

Infundibular pulmonary stenosis

Idiopathic pulmonary artery dilatation

Anomalous origin of coronary artery from pumonary trunk

Coronary arteriovenous fistula

AQUIRED:

Rheumatic valve disease,Infective endocarditis,Carcinoid heart disease,Tumors

IATROGENIC:

Homograft dystfunction following Ross operation,Homograft reconstruction for total correction of

Pulmonary atresia,Complex form of Tetrology of Fallot,Common arterial trunk

Transposition of great arterus with
Pulmonary stenosis,Pulmonary regurgitation following total correction of
Tetralogy of Fallot or following balloon valvotomy

✪Pulmonary Stenosis

Symptoms:

Fatigue, dyspnea on
exertion, cyanosis,Poor weight gain or failure to thrive in
infants,Hepatomegaly,ascites, edema

Signs:

Ejection systolic murmur (loudest at the left upper
sternum & radiating towards
the left shoulder)
Murmur often preceded by
an ejection sound (click)
May be wide splitting of second heart sound, delay in ventricular ejection
May be a thrill (best felt when
patient leans forward and
breathes out)

✪Management:

Mild to modearate isolated pulmonary stenosis is
relatively common and does not usually progress or require treatment

► Severe pulmonary stenosis :

percutaneous pulmonary balloon valvuloplasty
OR
surgical valvotomy

✪Pulmonary Regurgitation:

A rare condition
Usually associated with pulmonary hypertension
which may be
Secondary of the disease of left side of the heart
Primary pulmonary vascular diseose,Eisenmenger's syndrome,Blood flows back
into right ventricle → right ventricle
and atrium hypertrophy → symptoms of right-sided
heart failure,Trivial PR is a frequent finding in normal individuals and has

no clinical significance
✪YOU HEAR MURMURS WHEN YOU
DON'T MURMUR
Aortic Systolic Murmur:
Aortic stenosis,Aortic valve sclerosis,Flow murmur
Diastole:
Aortic regurgitation,Pulmonic regurgitation
Systole:
Hypertrophic obstructive
cardiomyopathy (HOCM)
Pulmonic Systolic Murmur
Flow murmur,Pulmonic stenosis
Trcuspid Systole:(TR,VSD)
Tricuspid Diastole:(TS,ASD)
Mitral Systole:(MR)
Mitral Diastole: (MS)
The session was full of knowledge+Bundle of important points regarding VULVULAR HEART DISEASE, their Hx,Clinical Features, Examination, Management+Case Presentation (Aortic Stenosis)+OSCE (Carcinoid Syndrome)
Thanks alot for this One

FEEDBACK # 57

Dr Faiq Khan

This exemplary lecture by Dr Nahal Raza revised basic concepts and gave us high yield history and examination pointers to keep in mind when treating patients and solving exam questions.
Her energetic and vibrant personality kept the audience engaged throughout the lecture .
In the end Dr Ash and his addons were brilliant as always .

FEEDBACK # 58

Dr Afifa Younas

Greetings of the day!
Today we had an amazing session on valvular heart disease in ED by Dr. Nahal Raza Registerara Cardiologist at NHS UK, It was a lively, engaging discussion and I enjoyed her enthusiasm and the way she explained such a tough topic was commendable.

The areas we covered today are aortic stenosis and regurgitation, mitral valve stenosis and regurgitation, pulmonary valve stenosis and regurgitation, and tricuspid valve stenosis and regurgitation. Had a thorough discussion on etiology, pathophysiology, and management of all.
This was followed by an excellent OSCE station by Dr. Ash and Dr. Imran Farooqa.
Overall it was a brilliant session.

FEEDBACK # 59

Dr Rehan Khalil

Just attended a very comprehensive session on Valvular Heart Diseases and it covered almost all heart valve diseases, their pathophysiology, their presentation and theie management. Additionally some important points regarding history taking and most importantly how to examine certain heart diseases were also diacussed. One of the new thing for me was the Erb's Point.
At the end their was a lovely OSCE Session by Dr Ash and Dr Imran Farooqa.

FEEDBACK # 60

Dr Mishal Shan

Genuinely loved each and every minute of the 1.5 hr lecture by Dr Nahal Raza. Lovely personality, great delivery and amazing content.
She covered a lot of important history and exam pointers that ED physicians should be keeping an eye out for. It was a good refreshment of basics along with alot of new knowledge. Valvular diseases will definitely be in our minds now when coming across patients with heart failure and respiratory symptoms of cough and wheezing.
The OSCE by Dr Ash and Dr Irfan was equally brilliant and entertaining at the same time. In short, there was alot to learn. Sunday well spent indeed!

FEEDBACK # 61

Dr Faisal Abdul Hannan Butt

This session started with Dr.Ash presenting an interesting case of Acute Stenosis and TAVI.
Dr.Nahal Raza Delivered a very detailed and comprehensive session on Valvular Heart Disease, it started with Basic Anatomy and physiology of heart valves. Types of Valvular Disease and related Signs & symptoms. Causes ,Pathophysiology,Examination,Investigation and Management of Valvular Heart Diseases (Aortic Stenosis & regurgitation

Mitral stenosis & regurgitation
Tricuspid stenosis & regurgitation
Pulmonary valve disease (Pulmonary stenosis and regurgitation)
Auscultation Areas for Aortic , Pulmonary, Erb's Point , Tricuspid ,Mitral , Having mnemonic "All People Enjoy Time Magazine (APETM)".
Session ended with a OSCE session by Dr.Ash and Dr.Imran Farooqa, Very nice job fone by Dr.Imran Farooqa.
Thanks Dr.Ashfaque Ahmed for facilitating the whole session.
Thanks Dr.Nahal Raza
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 62

Dr Ayesha Mushtaq

Excellent session.. Starting of the session with a very intresting case discussed by Dr Ash.. Afterwards Dr Nahal covered a very extensive and conceptual topic of Valvular Heart disease in very comprehensive way and her slides were really very helpful.. Even before exam night it would be a source of quick review of this topic.. At the end Osce session between Dr Ash and Dr Imran really made Sunday a funday.. it was very intresting 1 to 1 session and congrats to Dr Imran for making such quick diagnosis and ofcourse the right diagnosis..Overall the session was quite informative for both Mrcp and Mrcem candidates and it was enjoyable too.. Thanku Dr Ash for and the team

FEEDBACK # 63

Dr Aiman Nazir

Today's lecture on valvular heart diseases, though being quite a big topic , was comprehensively covered and delivered by Dr Raza. She started with anatomy and physiology which was excellent because recalling the normal before identifying abnormal variants is important. locations(All People Enjoy Time Magazine) and examination according to valve pathology was explained quite well, what to look at, echo, and identify murmurs on auscultation with proper techniques ,inspiration or expiration , their radiations etc.
All the information was beautifully summed up in tables and flow diagrams which made it really easy to remember and Dr Raza also highlighted the important points in each tables and flow diagram to emphasize on its importance so that no tiny bit of information is missed. Few mnemonics were shared which I think might be really helpful in learning.

Each of the valvular heart disease was discussed in detail including its causes, pathophysiology, clinical features and management in a very organised manner. Dr Raza made sure that everybody was awake and made the session more interactive by asking questions, answering questions and discussing real life scenarios encountered in hospitals.
In the end the OSCE session of Dr Imran Farooka and Dr ASH was really interesting and very informative. Learned quite a few interesting and new points which I think I will remember for life.
Thank you so much Dr Raza and Dr ASH for a brilliant session and making us confident in approaching patients with valvular problems.

FEEDBACK # 64

Dr Azka Shamim

AOA respected sir
Today we had an amazing session with Dr ***Nahal Raza (ST 4 trainee NHS UK)*** during which she talked comprehensively regarding heart valves and associated diseases.
Starting from the basic anatomy , first and second heart sounds, 5 areas of auscultation, valvular regurgitation and stenosis , etiology, pathophysiology and management of all valvular diseases , Dr Nahal talked about each and every point with clear concepts and excellent communication skills.
During whole session she was at maximum energy level,asked various questions, and kept all of us involved in the session.In fact she has excellent teaching skills .
We learnt so many important points, some of whic are:

Auscultation Areas

Aortic
Pulmonary
Erb's point
Tricuspid
Mitral

Aortic Stenosis

Causes: Common,Uncommon,as per age
Clinical Features:
Mild/Moderate- usually asymptomatic
Cardinal symptoms## Exertional Dyspnea, Angina and Exertional syncope
Management:

Asymptomatic - under review
Severe - evaluated every 1-2 years with Doppler echo
Severe symptomatic - valve replacement
Congenital - Balloon valvuloplasty

Aortic Regurgitation

Causes:RAD CHEMIST
Clinical Features:Collapsing pulse,Quincke's sign,Duroziez's sign,De Mussel's sign

Mitral Regurgitation

Causes:
Acute- IE, Ruptured chordae
Chronic - ischemic CM, Non ischemic CM, HCM, RHD

Mitral Stenosis

Causes:
RHD
Severe mitral calcification
Pathophysiology:
Clinical Features:
Atrial Fibrillation
Mitral facies
Loud S1 snap
Creps
Management:
Anticoagulation
Digoxin
Balloon valvuloplasty

Finally at the start and end of session **Dr Ash** (consultant NHS) discussed 2 important clinical cases.

1. An elderly pt with aortic stenosis murmur and signs of heart failure ,, suitable candidate for TAVI
2. A patient presented to ED with SOB treated as acute exacerbation of asthma .. diagnosed as a case of carcinoid syndrom by Geriatrician

Thank you so much Dr Ash for letting us have this wonderful opportunity to grab this knowledge

A proud GEM trainee

30th SEPTEMBER 2022

EVENT NAME:

Acute Stroke & Thrombolysis in ED by Dr Michael Traur Consultant EM London. PLAB 2 Exam OSCE

DOCTORS FEEDBACK

FEEDBACK # 1

Hani Suhail

Every tiny detail matters. Today's lecture made us look at the different sites of involvement and their effect on the human body function. Where a person can come with vertigo and the management relies on simple hand maneuvers or quick catch of the diagnosis and management to prevent further damage. Todays session regarding Stroke and TIA starts with recognition and when to transfer the patient to the right department for management, further than that importance of thorough history and examination with respect to signs symptoms and locations was laid to us with extreme simplicity. As well as we always get to know about the latest guidelines with comparison to old guidelines respectively. Thank you Dr. Michael Traur and Dr. Ash for providing us with your teachings and ways to improve every time we attend a session.

FEEDBACK # 2

Muhammad Ibrahim

A very comprehensive Lecture by Dr Michael Trauer About Stroke and Its management. Multiple studies implicating the use of different interventions and their benefits were shared. How to rule out Stroke mimics and diagnosis of TIA Was taught by Dr Michael. Thanks Dr Michael and Dr Ash

FEEDBACK # 3

Ghayoor Khattak

It was an excellent session arranged by LGEM presented by Dr. Micheal on the most common Case in ED i:e Stroke.
Sir Taught us how to recognize stroke by taking history and examination, also how to differentiate it from related D/Ds, then how to manage it quickly in ED
Specially the scoring system NIHSS and Modified Rankin, Thrombolysis

Indications and Contraindication. At last in Osce session Sir taught us important points while taking history and examination then management of stroke patient.
Thanks LGEM

FEEDBACK # 4

Hafsa Lodhi

Todays session by Dr Micheal was really amazing .He explained about diagnosis and management of stroke .The key points in history to diagnose patient as stroke or TIA and how to exclude other stroke mimics .it was a very comprehensive lecture. Thank you Dr Micheal and Dr Ash for arranging this session.

FEEDBACK # 5

Ali Kazim

Today's lecture on Stroke and TIA in ER was Amazing. Dr Micheal explained everything perfectly. How to diagnose the patient of stroke, diseases that mimic stroke, its management , TIA and its management.
Today's lecture helped me a lot and increased my knowledge. At the end OSCE session was also good!
Thank you Dr Micheal and Dr Ash!

FEEDBACK # 6

Warda Yawar

Thank you dr micheal for such an amazing lecture i truly appreciate you and your time you spent helping us
Today i learnt stroke its type and management
starting from history to management and then osce session which is very helpful in emergency cases
Thank you dr ASH for arranging this session and giving us precious time
All your efforts are getting us a step towards success 🙌 , you teach us with love energy and enthusiasm that draws in every student:D
Thank you londen gem course for this opportunity

FEEDBACK # 7

Umair Khalil

Every EM Physician has to see a lot of cases of stroke during his/her career. Differentiating actual Stroke form its mimics (syncope, seizures, migraine, catatonic depression) is important. Ambulance services use FAST method to early assess the stroke and take patient directly to HyperAcuteStrokeUnits (HASU).

Todays's session was unique in the sense of recognition of stroke & when to transfer the patient to HASU. Dr Micheal discussed in detail the localizing stroke, tips of HINTS and Scoring system for stroke and management of TIA. The session was closed by an OSCE session on Amaurosis fugax.
Thanks & regards.

FEEDBACK # 8

Faiq Uz Zaman Khan

Updated with the latest guidelines, Recognizing Conditions that mimic Stroke, Thrombolysis fiasco, admission and transfer protocol..... A GEM of a lecture

FEEDBACK # 9

Anila Zafar

Another very good session by Dr Micheal … he explained in a very precise manner. I learnt about the conditions that can mimic stroke. What areas and arteries are involved and how we can easily pick them through simple examinations. Learn about HINTS.
He did mention a video link which was amazing and very informative.
Thanks you.

FEEDBACK # 10

Javeria Siraj

Amazing session by Dr. Michael. Learnt about stroke, conditions mimicking stroke and how to differentiate them and manage them in the ER. Overall it was an interesting and detailed session. Many thanks to Dr. Michael

FEEDBACK # 11

Dr Mishal Shan

The 1hr lecture by Dr Trauer was quite useful as it taught us the recent updates in guidelines in the management of stroke and our role as an ED physician to maximize the chances of recovery for the stroke patient.
We were also taught how to pick up the more subtle strokes such as those involving the posterior circulation and this was followed by a wonderful OSCE session on how to take a quick yet comprehensive history of the stroke patient and give a management plan.

17th DECEMBER 2022

EVENT NAME:

Pneumonia & It's Management For GEM Trainees By Dr Jacob Baby Resp Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Syeda Maheen Ejaz

A very informative session…we have been to pneumonia many times but this session has been the best one extremely precise, practical oriented additionally exam-oriented as well. Thank you so much, Dr Jacob. Some of the pearls of the session

1. Atypical pneumonia features Diarhhea, bullous myringitis, and rash and should not be missed its less common but not rare
2. CRP utility in the case of LRTI is very useful
3. CRB 65 and CURB 65 score and clinical judgement in the management
4. When to follow up
5. Role of nebs, steroids and a lot more

Dr Ash both cases of lung abscess and the old lady with LRTI/Rt heart failure with multiple dx are interesting and eye opener for how should we approach patients amazing. Thank you so much Dr Ash for bringing such amazing sessions❤️

FEEDBACK # 2

Kamlesh Kumar Lilani

It covered all from defenation, presentation, Pathology investigation management, exam oriented Mcqs, CURB65 and CXR very well.

Thanks Dr. Jacob and Dr. Ash for amazing session.

FEEDBACK # 3

Imtiaz Ali Shah

Today we had a great session regarding pneumonia by Dr Jacob.It was a session with full of clinical l knowledge. Important learning points were ad followed.

TYPES OF PNEUMONIA.

Hospital acquired pneumonia. (HAP)

COMMUNITY ACQUIRED PNEUMONIA..

Lower respiratory tract infection.

ETIOLOGY. Bacterial, viral,fungal,protozoa.

Typical Agents...S pneumonia, H influenza, S aureus. Klebsialla pnumonae and pseudomonas.

ATYPICAL AGENTS..legionella mycoplasma Chlamydia, adeno viruses .
ETIOLOGY OF PNEUMONIA..
Alcoholism, COPD,smoking,dementia,stroke,lung abcess,exposure to birds and rabbits.
We also learnt the Utiloty of CRP in LRTI.
INVESTIGATIONS...Oxygen saturation,ABGS,chest radiography,urea electrolyte CRP.FBC LFTS.,Sputum culture.
ÙRINE ANTIGEN TEST..,legionella urine antigen
Throat swabfir mycoplasma PCR.
We also realised the importance of CRB65 SCORE AND CURB65 SCORE for severity assesment of pneumonia.
Drugs used for management of pneumonia were also discussed these are Amoxycyclin,clarithomycin doxycycline, Erythromycin,
Overall it was an excellent session and dr Jacob done it in a very professional way as he always does. I would like to thanks dr Jacob for this wonderful presentation and also Dr Ash for providing this great learning opportunity.

FEEDBACK # 4

Syed Suhail Ahmad

An excellent clinical-based session on Pneumonia & It's Management For GEM Trainees By Dr Jacob Baby Resp Consultant NHS uk
- Causes of Pneumonia
- Atypical and typical pneumonia
- Clinical presentation
- Diagnostic tests like CXR, Cultures, and their importance
- CRP as an indicator for giving treatment
- CRB65 and CURB65 Scores
- Admission and discharge criteria
- Severity
- Role of antibiotics, their doses, and when to give them
- Role of nebulization

Precise, Informative, and Important
Interesting CBDs by Ashfaque Ahmed were the icing on the cake 👏👏👏
Thank you London Global Emergency Medicine and Pema-Uk! 👍👍👍

FEEDBACK # 5

Saba Aslam Khan

It was amazing session about pneumonia, we have been learning about pneumonia since first year or medical school but today's session opened the new world of pneumonia for us , lecture started from the definition of pneumonia , causes and different clinical presentations, how to do lab diagnosis, CURB 65 scoring VS clinical judgement…. Management of patient and disposal options for different patients, almost all the aspects were touched beautifully in the session.
After the session Dr Ash presented two real life interesting case and gave the touch of geriatrics medicine to the chapter that was amazing….!!
Thank you so much dr ash for arranging this high yield lecture.
A proud GEM trainee,

FEEDBACK # 6

Muzna Ahmed

Today's session was really amazing mind opening regarding basic concepts which are misunderstood and being malpracticing in our region on pneumonia in light of NICE and BTS guidelines. Dr Jacob has explained everything presentation types caustive organisms, typical atypical agents CRB65 and CURB65 and treatment regimes with much clarity.
We got to know about CXR indication post rx i.e it is repeated after 6 weeks in elderly with complications too and in hospital setting it is repeated only if patient detoriorates.
He also make us understand that only CURB65 scoring is not sufficient to decide next plan clinical judgement is very important too.
This lecture will enable MRCP candidates to ace their exam as every information was there.
Lastly Dr ASH discussed two very interesting cases and how he managed and made diagnosis.
One of the case was of AKI in elderly pt which eventually after successful brains storming and investigations revealed a septic emboli which was the root cause of infarcts.
2nd case was first presented as LRTI pneumonia +/- RHF but it was cloaking behind 7-8 other diseases. It is surprising when any physicaian vigilantly dig out information from the case and it reveals many highlighting events and diseases.
Thank you so much Dr JACOB and DR ASH for this wonderful knowledge pack session and help us to practice safe Proud LGEM trainee.

FEEDBACK # 7

Qaisar Shah

CBD 1:Female/65 years with Pneumonia & Lung Abcess by Dr. ash EM Consultant NHS Uk

CBD 2: Complicated cmCase of Old age Female with Pneumonia+ Pulmonary HTN+Iron Deficiency Anemia+Hypothyriodism by Dr.Ash EM Consultant NHS Uk

Dr.Jacob Discussed:

°Pneumonia & It's Types (CAP +HAP)

°LRTIs

°CAP Diagnosis

°Etiology of CAP (Typical+ Atypical Agents)

°Epidemiological Factors & relating Causes of CAP

°C/F more common with Specific Pathogens

°DDs of CAP (Normal + Abnormal CXR)

°Atypical Pneumonia & their Features

°Zoonatic + Non-Zoonatic Atypical Bacterial Pneumonia & CXR finding in Atypical Pneumonia

°Causes of Viral Pneumonia

°CRP & LRTIs

°General INV for Admitted PTs in Hospital

°CRB65 Score In Primary Care

°CURB65 Score in Hospital

°Tests + Diagnosis & Treatment

°Guidlines for Antibiotics in Pneumonia

°Safe Discharge & BTS Vs NICE Recommendations on Duration of Antibiotics

The session was amazing covered all about Pneumonia & it's management

Thanks Dr Jacob & Dr.Ash for this nice session & two good case based discussions .

FEEDBACK # 8

Shehzad Hussain

Thanks to Dr Jacob n Dr Ash it was amazing teaching learning session, lot off knowledge delivered regarding, pneumonia presentations, etiology, pathology, investigation n management, when to admit n when to discharge the patient, CRB65 n CURB65, use of antibiotics and when to repeat CXR. Thanks to Dr Ash, presented very good informative cases plenty of exam MCQs discussed, discussion

about clinical presentation n reports was pretty informative n helpful. Thank you Dr Ash n LGEM team for wonderful teaching learning session.

FEEDBACK # 9

Sana Hameed

As the season calls for it and here our mentor dr. Ashfaque Ahmed was with a fresh session on pneumonia. And what a awesome session it was by the great dr. Jacob and he literally cleared

" every wheeze is not asthma and every white patch is not pneumonia".

Really detailed explanation of types of pneumonia it's scorings and BTS and NICE guideline for the antibiotics coverage.

And the end discussion lead by sir Ash with very rare and clinically different cases of pneumonia he managed and further input from our colleagues.

You do not get such sessions of discussion anywhere in the world but just LGEM gives its best to its trainees and we can't thank sir Ash for his efforts for us.

FEEDBACK # 10

Muhammad Abubakar

Lecture was great. Many new things I learnt today especially about different complications associated with pneumonia caused by different pathogens. The touch of BTS and NICE guidelines was really helpful. And the 2 cases presented by Dr. Ash was extraordinary and very much informative. Thankyou Dr. Ash and LGEM team to bring such topics which will have a huge impact in routine patient care. Thankyou Dr. Jacob for the great lecture.

FEEDBACK # 11

Khatija J. Farooqui

Yet another comprehensive lecture on pneumonia by dr Jacob lot of information about emergency management of pneumonia from causes presentation pathology investigation and management. And in last dr Ash points were very informative.Thanks to team Gem and dr Ash.

FEEDBACK # 12

Khalid Khan

Thansk Dr Jacob, informative, clinical based lecture on Pnemonia. Covering Typical and Atypical, radiological findings,

+/- correlation with asthama, diarrhea & cultures findings along with labs related. Pets and birds contact history. CURB65 scoring and as well categorization of Pneumonia and management plans as per recent NHS guidelines.

FEEDBACK # 13

Rida Rana

Attended such an amazing lecture on one of the most commonly encountered topic of Pneumonia by Dr Jacob Baby . Each and every aspect starting from types , mortality ratio , signs and symptoms , causative factors , important questions to be asked in history , relevant examination, presentation on Xrays , Role of CRP , choice of antibiotic by assessinh the severity by CURB65 and CRB 65 score was elaboratively explaimed during the session . And yes it was taught ij the most easy to learn pattern . The Cases discussed by Dr Ash were super interesting where the role of observation of a patient was examplified - in which Dr **Ashfaque Ahmed** looked up for Differentials by just observing day time somnolence of the admitted patient during the ward round . Such lectures are truely one of a kind which no one have attended before.All this has been possible because of LGEM and Dr Ashfaque . AlhumdulliAAllah on being part of LGEM 😉

FEEDBACK # 14

Abid Marwat

Aoa, Dr Jacob has been phenomenal today with pneumonia session today. He collectively summarised almost all types of pneumonias in a way one could retain for long and conceptually cleared many tangled questions. Pneumonias has been the major bulk of admissions besides CLD CKD and HF patients in Pakistan which now would be professionally cared of . Thank you I Dr Jacob , Dr Ashfaque Ahmed

FEEDBACK # 15

Afshan Salman

Session on pneumonia & its management in ER was a comprehensive and very useful session by Dr. Jacob. It covered:

Types of pneumonia, CAP & HAP

Community acquired pneumonia CAP discussed in detail with its specific pathogens, clinical features, differential diagnosis & management.

Atypical pneumonia-zoonotic & Nonzoonotic, CXR findings specific with each pathogen causing atypical pneumonia

Importance & utility of CRP in LRTI

Investigations of choice for hospital admitted patients, severity assessment through CRB65 & CURB65 Score

Choice of antibiotics according to the severity of pneumonia assessed through CURB score.
Expected recovery time, NICE & BTS recommendations.
Lastly the 2 cases discussed by Dr. Ash were very interesting and informative. It was like a brain exercise as how to reach the correct diagnosis, esp in elderly patients.
Thank you very much Dr. Ash, Dr. Jacob & team LGEM for bringing such amazing sessions.

FEEDBACK # 16

Nasir Hayat

This session was Amazing and nicely organised.
It was a wonderful session.I
Learn alot .
> pneumonia
> causes typical and atypical
> clinical presentation
> diagnosis
They way to order labs Radiology
> Decision on severity of pneumonia based on CRB65 and CURB 65
> management option as out pt , inpatient when and how to select pt admission, ITU selection for pt
> medication as per score system
> discharge criteria when to discharge
Important about CRP when to use the level for prescribing Antibiotics.
> F/U and repeat X-ray after 6 weeks to looks for complete resolution and to R/O other possibilities .
I enjoyed the session.I would high recommended it for Physicians to join it and get the deepth of knowledge and skills to be Great Doctor in future.Proud to be LGEM candidate MRCEM and MRCP .

FEEDBACK # 17

Aurangzaib Ahmed

Another amazing lecture from yet another very humble and excellent faculty member of LGEM. Pneumonia in EM can be a challenging situation yet again if a geriatric pt comes in Er with pneumonia that can be a challenging situation to diagnose.

Dr Jacob with his fine style of teaching and his detail oriented approach, made it look too easy. He explained the different types and etiologies and diagnostic tests related to different etiologies. Their specific management lines, when there is a need to admit the patient. The use of CURB65 and its important In assisting us in making a decision regarding admission of the patient.
He also made it clear that CURB65 is just a score that can be used to assist us but the real decision lies in the clinical correlation of the pt and that along with CURB65 should be used to make a clear decision.
He also emphasised on the importance of CRP which will direct the line to treatment when it comes to adding antibiotics in the treatment regimen.
CRP <20 no antibiotics between 20 and 100 hold antibiotics and if more than 100 start antibiotics.
Investigations include
O2 saturation
ABGs
Cbc
Uces
Lfts
Crp
In case of right sided heart failure there will be associated PAH then need to rule out pulmonary embolism by doing a CtPA
The lecture was then ended by 2 case presentations by Dr Ash. The second case is my favourite in which an old lady came with cough and was the diagnoses with pulmonary embolism and GI malignancy and anemia due to Dec iron.
Once again an amazing day of lectures with amazing presentations.

FEEDBACK # 18

Aqsa Yaqoob

A very excellent session by Dr. Jacob on Pneumonia,its types, etiology, typical and atypical pneumonia. Features of atypical pneumonia: constitutional symptoms predominate over respiratory symptoms (mostly caused by mycoplasma/walking pneumonia) , Chlamydia: unilobar involvement with patchy consolidation in lower lobes. SARS COV-2 : sub pleural consolidation. Exposure to animals and birds(Zoonotic Atypical bacterial pneumonia and Non- Zoonotic Atypical bacterial pneumonia) , Investigations, CRB 65 and CURB 65, Microbiological tests, Difference between BTS and Nice guidelines. Expected recovery time. Repeat

chest X- ray after 6 weeks .clinical manifestations more important than CURB 65. Use of hypertonic saline , indications and side effects . Indeed a wonderful and power pack session . Thanks to Dr. Jacob and Dr. Ash for providing such useful pearls to us.

FEEDBACK # 19

Hira Nehal

An amazing lecture on CAP
Eitiology
Pathology
Investigation
Managment
When to admit pt.
Classification of mild moderate and severe on CURB65 score and also treatment on the basis of this score .
Safe discharge if pt .
Along with score clinical presentation of pt and personal experiance of dr play an important role in managment and prescribing antibiotics and managing there doses.
Chest radiograph play role
With LRTI
Asthma associated
normal chest radiograph INFLUENZA, PERTUSIS
abnormal chest radiograph
CHF ,ASPIRATIONAL PNEMINIA ,PULMONARY VASCULITIS .
ATYPICAL PNEMONIA
has atypical symptoms .like fever diarrhoea and are not gram stained so are not treated beta lactums they are treated by flouroqunalone macrolids etc
Importance of CRP
When not to start antibiotics <20 when to hold antibiotic BTW 20 to 100
If more than 100 start antibiotics
Investigation to be done
Oxygen saturation (ABGs if needed)
CHEST X RAYS
Urea electrolytes
CBC
CRP

LFT
sputum cultures if suspect tb
PCR is gold standard for mycoplasma pneumonia.it is also associated with rash .
Lengionella is associated with anemia .
In elderly pt>60 Yr of age follow up xray will be after 6 weeks post treatment to rule out underlying possible malignancy.
If symptoms of RHF will be there there must be pulmonary HTN due to pulmonary embolism one should rule out.
Also difference in antibiotic treatment in number of days BTW BTS and NHS.

FEEDBACK # 20

Sadia Abbasi

Thank you Dr Jacob for a very organised ,updated and an eye-opener session .I learnt alot from presentation as well as CBD by dr Ash.
Learning points:Definition of pneumonia,Etiology, types CAP ,HAP, D/D of CAP on the basis of abnormal chest radiograph and Normal chest radiograph, investigation, management ANTIBIOTICS selection according to CURB65 SCORE,Use clinical judgment along with CURB65 SCORE Which is very important point ,CRAB score,CAP utility ,severity assesment ,Safe discharge from hospital over all its a power pack session 👍 this creadit goes to Dr Ash for London GEM MRCP programme 👏
I learn to many new things fron CBDS by dr Ash Thanking of you Great great session.

FEEDBACK # 21

Zegham Abbas

Another amazing lecture on the case we see on daily basis pneumonia so time it's become difficult to diagnose or differentiate between the Pneumonia COPD.
Community acquired pneumonia it's causative agents. Main features of today's lecture are
Pneumonia its definition
Types of Pneumonia
Causes like Typica and ATYPICAL organisms
Signs and Symptoms
Clinical presentation
Different criteria to rule out the severity of pneumonia like (CURB65)
Different approaches for the management of Pneumonia

Importance of CRP (determined either to start Antibiotics or not)
Other relevant investigations like
ABG Chest X RAY CBC
Importance of CTPA In pulmonary embolism
At the end Dr Ash discussed an amazing case related Pulmonary Embolism and Septic Emboli infarct.

FEEDBACK # 22

Amash Khan

Today's session was of high importance as pneumonia is a conmonly occuring disease and requires thorough knowledge and expertie in medicine for the diagnosis and treatment of pneumonia. Dr. Jacob beautifully explained the clinical, radiographycal and lab based diagnosis, types and their management as per different guidelines
and at the end the case presented by Dr. Ash was as usual amazing which emphasized upon to properly look into other associated diseases along with the primary diagnosis.

FEEDBACK # 23

Phota Ram

Another amazing lecture on one of the most commonly encountered topic Pneumonia By Dr Jacob.started with types of pneumonia typical and atypical pneumonia and causes of pneumonia different bacteria, viruses, protozoa etc, risk factors for pneumonia, differential diagnosis of pneumonia.how to diagnosis and severity of pneumonia CURB65 , signs and symptoms, important investigations,CXR,Sputum culture and treatment guidelines according to NICE guidelines.

FEEDBACK # 24

Muhammad Wajeeh Labar

Dr. Jacob Baby, Consultant Respiratory Medicine, NHS United KingdomDate: 1 hour the 17th day of December 2022
Just listened to a fantastic presentation on pneumonia by Dr. Jacob. It covered topics that helped me understand a lot of my ideas.some lessons include the following:
Pneumonia: a definition
2. The CAP and HAP types of pneumonia
3.The most frequent pathogen in CAP is streptococcal pneumonia.4

4.The most frequent pathogen in CAP is streptococcal pneumonia.
5. INVESTIGATIONS CBC CRP UREA ELECTRLOYTESSPUTUM CULTURE
6. Pneumonia's RADIOLOGICAL FINDINGS6. Elderly aspiration is a risk factor for CAP.
8. USE OF CRP IN GIVING ANTIBIOTICS8. Cause of Atypical Pneumonia
9.SEVERITY ASSESMENT OF PNEUMONIA
10.CURB 65 AND CLINICAL JUDGEMENT
11 .ANTIBIOTICS CHOICE FOR MILD,MODERATE AND SVERE PNEUMONIA
Dr. Ash also gave two unique situations in addition to the presentation above.The first instance was a cold abscess that resolved, while the second involved COPD with CO2 retention with LRTI plus right heart failure.I'd want to thank my wonderful mentors for these terrific session.

FEEDBACK # 25

Zia Hayat

It was an amazing session by Dr.Jacob ,started off with basic definitions and clinical presentations of Community Acquired Pneumoniae ,Typical and Atypical infections ,Xray presentations of different types of Pneumonia ,Association with Bronchial Asthma .He explained the criteria for admission of Pneumonia and its workup which should be done to ruleout other causes,sputum cultures and use of CRP as a modality in ED,Psitticosis Pneumonia to be suspected in bird handlers and Legomeillia Pneumonia is people staying in hostels ,military camps or closed area .He explained about the importance of CURB65 SCORE along with clinical correlation and judgement to be kept in mind before making clinical decisions about discharge of the patient.Expected recovery time and the need to repeat Chest Xray after atleast 6 weeks in elderly having any smoking history or other comorbidities ,Learned a lot of new things about patient approach starting from scratch.After that Dr.Ash presented with 2 real case scenarios that gave an insight to managing patients clinically with one single complaints ,learned a lot today ,Thanks a lot Dr.Ash for arranging such a wonderful talk.

FEEDBACK # 26

Farheen Naseem

In this session we learned about pneumonia and dr Jacob deliver lecture very nicely
Mainly focused on

What is pneumonia
Causes
Classification of pneumonia
Clinical presentation of pneumonia
Diagnosis of pneumonia on bases of clinical presentation
Severity of pneumonia on bases of CRB65 and CURB65
management of pneumonia
Step by step
How to manage pneumonia in pt and out pt bases
Selection of antibiotic according to score and
And importance of crp
This lecture amazingly delivered by Dr Jacob I never learn pneumonia like this way thanx alot dr Jacob and dr Ash and LGEM team
This platform everyday making us more confident in our clinical practice

FEEDBACK # 27

Aymen Bashir

Dr Jacob's session on pneumonia was very comprehensive. He taught us the clinical features of each organism causing pneumonia.
Streptococcus pneumoniae : acute onset , high fever and pleuritic chest pain.
Bacteraemic s pneumoniae : female, excess alcohol, Dm , copd, dry cough
Similarly he taught us legionella , mycoplasma pneumoniae , chlamydophilia , coxiell. Furthermore , we discussed in detail the epidemiologic factors suggesting possible causes of CAP and differential diagnoses of community acquired pneumonia . We understood the features of Atypical pneumonia and the pathogens causing it along with the chest radiograph findings. Moreover , which investigations to carry out in a patient admitted to hospital, the significance of CURB -65 for mortality risk assessment in primary care. The choice of Antibiotics for pneumonia according to curb score and safe discharge from hospital. The session ended with an amazing case discussed by dr Ash. It's a privilege to be a part of Gem programme

FEEDBACK # 28

Beenish Manzoor

Today we had a great session regarding pneumonia by Dr Jacob.It was a session with full of clinical l knowledge. Important learning points were ad followed.
Pneumonia Defination and clinical presentation

TYPES OF PNEUMONIA.
1.Hospital acquired pneumonia. (HAP)
2.COMMUNITY ACQUIRED PNEUMONIA..(CAP
Lower respiratory tract infection.
ETIOLOGY.
*Bacterial,
*viral,
*fungal,
*protozoa.
Typical Causative organisms are...S pneumonia, H influenza, S aureus. Klebsialla pnumonae and pseudomonas.
ATYPICAL causative organism are..legionella ,mycoplasma Chlamydia, adeno viruses .
ETIOLOGY OF PNEUMONIA..
*Alcoholism, *COPD,
*smoking,
*dementia,stroke,
*lung abcess,
*exposure to birds and rabbits.
We also learnt the Utiloty of CRP in LRTI.
INVESTIGATIONS...
*Oxygen saturation,
*ABGS,
*chest radiography appearance for different type of pneumonia
*urea electrolyte
*CRP evaluation for pneumonia
*FBC
*LFTS.,
*Sputum culture.
*ÙRINE ANTIGEN TEST..,legionella urine antigen
*Throat swab for mycoplasma PCR.
He also explain the importance of CRB65 SCORE AND CURB65 SCORE for severity assesment of pneumonia.
Drugs used for management of pneumonia were also discussed

Overall it was an excellent session and dr Jacob done it in a very professional way as he always does. I would like to thanks dr Jacob for this wonderful presentation at end of discussion **Ashfaque Ahmed** presented a case of lung abscess and old lady with RTI and right HF with multiple d/d were an eye opener Dr ash beautifully explain how we should apporch to patient.trurly blessed and thankful to dr Dr Ash for providing this great learning opportunity.
Thankyou LGEm
Proud Gem trainee.🙏

FEEDBACK # 29

Babar Hussain

Today's session on pneumonia was conducted by Dr Jacob.
It was a wonderful session. A lot of learning points for me. Topics discussed are
~Types of pneumonia.
~Dx of pneumonia.
~Their eitiology and epidemiological factors.
~Typical clinical features.
~Atypical clinical features.
~Curb score importance.
~Zoonotic bacterial pneumonia.
~Treatment plans.
In the end I am very grateful to our mentor Dr **Ashfaque Ahmed** for discussing a very interesting case.
So Thank you very much Dr Ash, Dr Jacob and **London Global Emergency Medicine** .
Proud LGEM candidate.

FEEDBACK # 30

Javeria Wali

Dr. Jacob's lecture on Pneumonia and its management was really informative and well presented. The session started with in depth explanation of Hospital acquired Pneumonia, Community Acquired Pneumonia, Atypical Pneumonias and the etiology, typical and atypical agents, investigations, CXR findings, CRB 65 score and its significance in diagnosis and management / antibiotic therapy, how clinical picture should be evaluated before making any decision regarding management and discharge, Antibiotics which should be prescribed according to severity and allergy / pregnancy, C reactive protein and its importance. All these were discussed

in detail and understood perfectly. Really amazing session which will be helpful in pneumonia management in emergency setting.

FEEDBACK # 31

Rana Gulraiz

The teaching learning session, lot off knowledge delivered regarding, pneumonia presentations, etiology, pathology, investigation n management, when to admit n when to discharge the patient, CRB65 n CURB65, use of antibiotics and when to repeat CXR. Thanks to Dr Ash, presented very good informative cases plenty of exam MCQs discussed, discussion about clinical presentation n reports was pretty informative. In the last the tremandous effort and gold words by Dr Ash the mentor ❤️❤️

FEEDBACK # 32

Muhammad Azeem Imran

CBD 1:Female/65 years with Pneumonia & Lung Abcess by Dr. ash EM Consultant NHS Uk

CBD 2: Old age Female with Pneumonia+ Pulmonary HTN+Iron Deficiency Anemia+Hypothyriodism by Dr.Ash EM Consultant NHS Uk

Dr.Jacob Discussed:

°Pneumonia & It's Types (CAP +HAP)

°LRTIs

°CAP Diagnosis

°Etiology of CAP (Typical+ Atypical Agents)

°Epidemiological Factors & relating Causes of CAP

°C/F more common with Specific Pathogens

°DDs of CAP (Normal + Abnormal CXR)

°Atypical Pneumonia & their Features

°Zoonatic + Non-Zoonatic Atypical Bacterial Pneumonia & CXR finding in Atypical Pneumonia

°Causes of Viral Pneumonia

°CRP & LRTIs

°General INV for Admitted PTs in Hospital

°CRB65 Score In Primary Care

°CURB65 Score in Hospital

°Tests + Diagnosis & Treatment

°Guidlines for Antibiotics in Pneumonia

°Safe Discharge & BTS Vs NICE Recommendations on Duration of Antibiotics
Thank you Dr Ash for arranging such a excellent speaker Dr Jacob .

FEEDBACK # 33

Dr Khizir

it was an awesome LECTURE over PNEUMONIA by Dr Jacob he started from basic to treatment which changed the my routine practice of managing pneumonia
Types of pneumonia
CAP
HAP
LRTI
acute illness present for 21 days or less
Fever
CAP DX
symptoms of acute illness
New focal chest examination
At least one systematic feature
No other explanation for illness so we will treat as CAP
CAP EITIOLOGY
TYPICAL AGENT'S
s.pnemunea (most common cause of pneumonia)
S.aureus
Atypical agents
Mycoplasma pneumoniae, legonilla (in pateints)
Epidiomoligical factors
Alcoholism Klebsiella
COPD
Structural lung disease
Dementia
Lung abcess
Exposure to birds
CLINICAL FEATURES
Strerptococcis pneumonia=> increasing age comorbidity high fever
Legonilla=> younger patients
Elderly patients with CAP presents with non specific symptoms and have comorbidity

Aspiration is also risk for CAP
Abnormal chest radiograph
CHF
Aspiration pneumonitis
Pulmonary infarction
Pulmonary vasculitis
Normal chest graph
Influenza
Pertussis
Asthma associated
Atypical pneumonia
Caused by atypical organisims
Most common
Mycoplasma pneumoniae
Atypical FEATURES
Fever
Low grade
Diarrhoea
Infections with pneumoniae
NON ZOONOTIC ATYPICAL BACTERIAL PNEUMONIAS
**ZOONOTIC ATYPICAL BACTERIAL PNEUMONIAS*
Psittacosis psiatti
Chest radiograph LIC findings in atypical pneumonia
Mycoplasma pneumoniae
Fluffy opacities
Utility of CRP in cases of LRTI
if CRP is less than 20 don't give antibiotics
If CRP is between 20-100 consider delaying of antibiotics
General investigations
Saturation
ABGs
Urea and S/E
CBC
LFts
Sputum cultures

Sent if no prior abxs
Test for legionnaires dx
Recommended for all patients
Test for Mycoplasma pneumoniae
Gold standard is PCR
Severity assesment*
CURB 65 score
Confusion AMT less than 8
Urea >7 mmol/l
RR =>30
BP =<90/60
Age >65
Low risk 0-1
Moderate risk 2
Higher risk 3 - 5
MICROBIOLOGICAL TESTS
if *curb score 0-1*
Amoxicillin 500 mg TDS
If allergic then Doxycycline
If pregnant then clathirmycin
Severe 3 or 4
Co amoxiclave plus clathromycin
If allergic then levoflaxocin
When to discharge from hospital
Expected recovery times
1 week fever should be resolved
4 weeks chest pain and septum production
6 weeks
TRIAGE
Result of chest X ray
Consolidation or no consolidation
Resasee if no
Is it CAP yes
Treat according to curb 65 score
Score 0-1

BTS AND NICE *RECOMMENDATIONS DIFFERENCE*
It's based on duration of antibiotics
At the end very interesting case presentee and discussed by our mentor dr ash
Thank a lot for an amazing session

FEEDBACK # 34

Mina Khan

Todays session was very comprehensive. Dr Jacob disscussed and taught clinical management of the disease. Common pathogens causing pneumoniae strep/legionella/mycoplasma/coxiella burnetti/ chlamydophila/ geriatric pts presents with non specific symptoms and has high mortality / Aspiration pneumoniae higher in nursing homes among elderly / differentials of CAP / typical /atypical pneumonias / CRP >20 prescribe antibiotics most probably but not mandatory / CRB 60 / CURB60 score with diff of Urea BUN ./ safe discharge from hospital . In the end Dr Ashfaque Discussed two scenarios. Thank you
London Global Emergency Medicine

FEEDBACK # 35

Syed Muhammad Zeeshan Hashmi

Starting from definition
Types ,epidemiology, CAP and HAP , the atypical pneumonias , those associated with immunocompromised states , all simplified in easily understandable high yield charts , the curb 65 score , criteria of when to send the patient home, how long to continue antibiotics, how long IV how long oral , when to discharge the patient ,one another very important thing was sometimes lab tests are as that if a patient is just about to die and actually the patient is as fit as nothing and sometimes patient seems to be critical but his labs say to you that he is ok ....end of story is treat the patient not the labs , and in the end of the lecture,Dr Ash's two cases were very very interesting, the importance of geriatric medicine once again lit in minds , and how broad minded one should be while being in ER too , all three cases discussed were very interesting
Thanks Dr Ash
Thanks London GEM team

FEEDBACK # 36

Ahmad Tanveer

Great Session
Learned alot in power pack lecture

Pneumonia
Infection of lung. Tissue
Sign symptoms of lower respiratory tract infection.
Types
CAP in community or less then 48hr of admission to hosp
Hospital. Acquired pneumonia
LRTI
Acute illness for 21 days or less .
Cough with 1 other LRTI symptoms
Fever ,chest discomfort wheeze crackles.
CAP
Cough fever + 1 systemic feature
All the pneumonia don't have chest signs
Etiology
Typical Atypical Bacteria
Fungal and viral
S pneumoniae
H influenzae
S aureus
Klabsiella
Pseudomonas Epidiomological factors discussed suggesting possible causes of PNEUMONIA
Clinical features more common with specific pathogens discussed
Aspiration is a risk factor for CAP in elderly patients
Differential diagnosis of CAP
CCF
ASPIRATION PNEUMONIA
PULMONARY INFARCTION
ACUTE EXACERBATIONS OF BRONCHIECTASIS
HYPERSENSITIVITY PNEUMONIA
NOEMAL CHEST XRAY
INFLUENZA
ASTHMA
BONCHITIS
PERTUSSIS

Atypical pneumonia
Mycoplasma
Chlamydia
Legionella
Have headach low grade fever
Diarrhea may accompany legionella
Bullous myringitis with mycoplasma
Nonzoonotic Atypical Bacterial pneumonia
Mycoplasma or walking pneumonia
Legionella from air conditioning and Chlamydia discussed.
Zoonotic Atypical Bacterial pneumonias discussed.
Psittacosis,Q fever ,Tularaemia discussed.
Chest X-ray findings of Atypical pneumonia discussed.
Mycoplasma fluffy
Legionella and then Chlamydia with lobar presentation and x-ray of COVID viral
Role of CRP
INVESTIGATIONS
CHEST X-RAY
SPO2.ABG
RFTs Sputum cultures
> Pneumococcal urinary antigen for streptococcus pneumoniae
Legionella urinary legionella antigen done
> Severity assessment
CRB 65 SCORE
CONFUSION
Raised respiratory rate 30 or more
Low BP 90/60
AGE 65 OR MORE
Low risk 0
1&2 intermediate risk
3-4 referral for tertiary care
CURB 65 WITH addition of BUN over 7 mmol / l
> Use clinical judgement in conjunction with score Antibiotics for pneumonia according to CURB 65 criteria scoring
>Safe discharge from hospital

Don't discharge if
temp is higher
Resp rate more then 24
Heart rate more then 100
Not able to eat
Expected recovery time explained.
>BTS and NICE RECOMMENDATION
CLINICAL JUDGEMENT IN CONJUGATION WITH CURB 65
> Single antibiotic as initial empirical therapy in PTS with low severity CAP. DUAL combination comprising amoxicillin and macrolide for moderate severity CAP.
Dr ASH presented case 1
Elderly lady 65 yr old with deranged RFTS generally tired and weak. With Acute kidney injury found out multiple renal infarctions ,on workup . Family history of protein C S Deficiency
Two weeks ago treated for pneumonia. X-ray shared Antiphospholids and other screening . Heparin inf for anticoagulation. Cavitating abcess lesion . Septic emboli from lung abcess .
This emboli can do stroke . Other causes ruled out . 6 wks cipro treatment along with anticoagulation with apixaban and to be followed in OPD
2nd case
Elderly PT with SOB and BL leg swelling LRTI chest infection and pneumonia and CCF and plan was to treat accordingly and then echo to be done . Examined Day time somnolence
CO2 retainer and LRTI and RHF .functional TR ,JVP was raised. Right heart failure with pulmonary hypertension diagnosed. Pulmonary thromboembolism . D dimers was raised. CTPA BL PE. Hb was anemic significant iron Def anemia. Malignancy endo and colonoscopy planned. GI malignancy
>These are Complex geriatric cases alot of learnjng .
> Repeat x-ray only for elderly after 6 wks if malignancy risk factors

Great lecture and very updated knowledge shared by Dr JACOB & Dr Ash
Thanks alot Sir
FEEDBACK # 37
Hareem Zakir

Thankyou Dr Jacob for enlightening such an important topic which is equally important for an emergency physician as well as an acute physician, they way you explained the etiologies individually was phenomenal. The diagnosis and therapeutic value of crp was very important. The judicial use of antibiotic was guided by you with the help of different guidelines. Thankyou for bringing out amazing stuff for us. Thankyou

FEEDBACK # 38

Ghulam Saddique Saddique

Amazing session conducted by Dr Jacob about topic Pneumonia
Infection of lung. Tissue
Sign symptoms of lower respiratory tract infection.
Types
CAP in community or less then 48hr of admission to hospital
Hospital. Acquired pneumonia
LRTI
Acute illness for 21 days or less .
Cough with 1 other LRTI symptoms
Fever ,chest discomfort wheeze crackles.
CAP
Cough fever + 1 systemic feature
All the pneumonia don't have chest signs
Etiology
Typical Atypical Bacteria
Fungal and viral
S pneumoniae
H influenzae
S aureus
Klabsiella
Pseudomonas Epidiomological factors discussed suggesting possible causes of PNEUMONIA
Clinical features more common with specific pathogens discussed
Aspiration is a risk factor for CAP in elderly patients
Differential diagnosis of CAP
CCF
ASPIRATION PNEUMONIA

PULMONARY INFARCTION
ACUTE EXACERBATIONS OF BRONCHIECTASIS
HYPERSENSITIVITY PNEUMONIA
Normal CHEST-XRAY
INFLUENZA
ASTHMA
BONCHITIS
PERTUSSIS
Atypical pneumonia
Mycoplasma
Chlamydia
Legionella
Have headach low grade fever
Diarrhea may accompany legionella
Bullous myringitis with mycoplasma
Nonzoonotic Atypical Bacterial pneumonia
Mycoplasma or walking pneumonia
Legionella from air conditioning and Chlamydia discussed.
Zoonotic Atypical Bacterial pneumonias discussed.
Psittacosis,Q fever ,Tularaemia discussed.
Chest X-ray findings of Atypical pneumonia discussed.
Mycoplasma fluffy
Legionella and then Chlamydia with lobar presentation and x-ray of COVID viral
Role of CRP
INVESTIGATIONS
CHEST X-RAY
SPO2.ABG
RFTs Sputum cultures
> Pneumococcal urinary antigen for streptococcus pneumoniae
Legionella urinary legionella antigen done
> Severity assessment
CRB 65 SCORE
CONFUSION
Raised respiratory rate 30 or more
Low BP 90/60

AGE 65 OR MORE
Low risk 0
1&2 intermediate risk
3-4 referral for tertiary care
CURB 65 WITH addition of BUN over 7 mmol / l
> Use clinical judgement in conjunction with score Antibiotics for pneumonia according to CURB 65 criteria scoring
>Safe discharge from hospital
Don't discharge if
temp is higher
Resp rate more then 24
Heart rate more then 100
Not able to eat
Expected recovery time explained.
>BTS and NICE RECOMMENDATION
CLINICAL JUDGEMENT IN CONJUGATION WITH CURB 65
> Single antibiotic as initial empirical therapy in PTS with low severity CAP.
DUAL combination comprising amoxicillin and macrolide for moderate severity CAP.
Dr ASH presented case 1
Elderly lady 65 yr old with deranged RFTS generally tired and weak. With Acute kidney injury found out multiple renal infarctions ,on workup . Family history of protein C S Deficiency
Two weeks ago treated for pneumonia. X-ray shared Antiphospholids and other screening . Heparin infusion for anticoagulation. Cavitating abcess lesion . Septic emboli from lung abcess .
This emboli can do stroke . Other causes ruled out . 6 wks cipro treatment along with anticoagulation with apixaban and to be followed in OPD
Great lecture and very updated knowledge shared by Dr Jaccob & Dr Ash
Thanks alot Sir
I am proud to be a part of LGEM Programme

FEEDBACK # 39

Dr Ghazala Sheikh

The lecture was covered comprehensively each and every aspect of pneumonia including CBD and presentation by Dr Ash, I l learnt,

● Pneumonia Definition, causes, etiology, types, signs and symptoms
● Curb_65 criteria for mortality risk assessment
● Community acquired Pneumonia
● Epidemiologic factors suggesting possible causes of CAP
● Differential Diagnosis of CAP on the basis of normal and abnormal chest radiograph
● Atypical pneumonia (mycoplasma pneumonia, chlamydophila pneumonia, legionella pneumophila)
● Atypical pneumonia features (fever, diarrhea, bullous myringitis, lung rales/crepitations and Rash)
● Nonzoonotic Atypical Bacterial pneumonia
● General investigations done to a pateint admitted in hospital (O2 saturation, ABGs where necessary, chest x rays, urea electrolytes, C reactive protein, CBC, LFTs)
● tests for legionnaire`s disease
● tests for mycoplasma pneumonia
● tests for chlamydia species
● Severity Assessment
● Microbiological tests
● timely diagnosis and Managment
● safe discharge from hospital
● BTS and NICE recommendations
Thankyou so much Dr Ash.

FEEDBACK # 40

Dr Leela Ram

It was an excellent session on Pneumonia, its causes, risk factors & management for different types of pneumonia.
Lower respiratory tract infections are characterized by fever, cough, sputum production, breathlessness, chest discomfort or pain & wheeze or crackles.
Dr Jacob explained Community acquired pneumonia, etiology, clinical features with more common specific pathogens, different diagnoses of CAP.

➡️ Typical agents: S. Pneumonae, H. Influenzae, S. Aureus, Klebsiella pneumonaepneumonae & Pseudomonas aeruginosa.

➡️ Atypical agents: Mycoplasma pneumonae, Chlamydia pneumonae & Legionella species in inpatients as well as respiratory viruses such as Influenza viruses, adenoviruses, human metapneumovirus & respiratory syncytial viruses.
I have learnt that differential diagnoses of Community acquired pneumonia in view of X-Ray radiological findings is abnormal in Congestive heart failure, aspiration pneumonitis, Pulmonary infarction, acute exacerbation of pulmonary fibrosis, acute exacerbation of bronchiectasis, acute eisinophilic pneumonia, hypersensitivity pneumonitis, pulmonary vasculitis, cocaine induced lung injury (crack lung)

➡️ Normal chest X-Ray occur in AECOPD, Influenza, acute bronchitis, pertussis & asthma with viral syndrome.

➡️ CRP utility in LRTI:

- CRP< 20mg/litre, don't give antibiotics
- CRP ranges between 20-100mg/litre depends upon symptoms and consider antibiotics
- CRP>100mg/litre requires antibiotics

➡️ Antibiotics for pneumonia in view of curb score is 0 or 1 first choice is amoxicillin and alternative antibiotics are Doxycycline, Clarithromycin & Erythromycin.
Severe pneumonia in view of Curb-65 3-5 includes Co-amoxickav, Clarithromycin, Erythromycin & Levofloxacin.
Diagnosing pneumonia requires detailed history, physical examination and investigation & deciding antibiotics in view of Curb -65 score or on signs and symptoms regardless of score.
Thank you so much Sir Dr. Jacob and Sir Dr. Ash for summarizing & presenting cases related to chest pathology and wonderful learning.

FEEDBACK # 41

Dr Muhammad Ghayoor Khan

It was amazing teaching session by Dr.Jacob on pneumonia, lots of knowledge delivered regarding pneumonia presentations, etiology, pathology, investigation and management, when to admit and when to discharge the patient, CRB65 and CURB65, use of antibiotics and when to repeat CXR,he literally cleared

“Every wheeze is not asthma and every white patch is not pneumonia”.
Thanks to Dr Ash, presented very good informative cases plenty of exam MCQs discussed, discussion about clinical presentation and reports was pretty informative and helpful.
Thanks
Dr.Jacob And Dr.Ash

FEEDBACK # 42

Dr Mubashir Hussain

It was amazing session delivered by Dr jacob about pneumonia
He thoroughly classify pneumonia .
Will explained it's all features .
All its investigations and management .
Thanks to Dr ash thanks to doctor jacob

FEEDBACK # 43

Dr Mariam Nawaz

Pneumonia by Dr Jacob Had an amazing module on pneumonia by Dr Jacob today, got to learn so much in 1 hour, the pearls i gathered are as follows: 1. Pneumonia is an infection of the lung tissue, confirm by CXR
Types
A) CAP: less than 24 hrs after admission
B) Hospital acquired pneumonia: occurs after 24hrs of hosp admission
Mortality rate increases if the hospital stay increases more than 8 days
2. LRTI:
Acute illness present for 21 days or less
Cough is the main presenting symptom,
3. CAP diagnosis
Cough + one other symptom
New focal sign on chest exam
At least one other systemic feature
No other explanation for illness
4. CAP etiology:
Bacteria:
• Typical agents: Streptococus, Staph aureus, Klebsiella,H flu
• Atypical agents:
Fungi

Virus
protozoa
5. Alcoholics can aspirate leading to pneumonia
Pseudomonas auregenosa is common organism in bronchiectasis pt
Lung abscess: look for poor oral hygiene, Staph are common organisms
Hotel and cruises, think of legionella
Exposed to birds: chlamydia
Exposed to rabbits, Francis taularenesis
6. Clinical features with common specific pathogens
Streptococus pneumoniae
Legionella pneumoniae
Mycoplasma pneumoniae
Coxiella
Chlamydia
Elderly present with non specific symptoms
7. DD of CAP:
• Abnormal chest radiograph
CHD
Pulmonary emboli
ILD
Aspiration pneumonia
Pulmonary fibrosis acute exacerbation
Bronchiectasis acute exacerbation
• Normal Chest Radiograph
COPD
Pertusis
8. Atypical pneumonia features:
Fever
Diarrhoea
Bullous myringitis
Lung rales
Rash: think of viral pneumonia
9. Chlamydia often has isolated single lobe involvement
Legionella has bilateral involvement
Covid has bilateral lung opacities, specially in the peripheries

If patient worsens then repeat the CXR, otherwise repeat CXR during treatment is not required

10. CRP utility in LRTI:
If < 20 don't give antibiotics or
Between 20 an 100: delay antibiotics use
¬ 100: Start antibiotics
11. General Investigations
Sputum cultures: needed to diagnose legionella,
If already started antibiotics culture has no use
Mycoplasma pneumoinia: not needed, if required do PCR
Chlamydia: chlamydia antigen
12. Severity Assessment:
¬ CRB65 score for mortality risk assessment in primary care:
Confusion
Raised RR: 30 or more
Low BP: diastolic 60 or less, or systolic less than 90
Age 65 or more
¬ Use clinical judgement along with CRB65 or CURB65 for admission decision
¬ CURB65 Score:
Blood urea is added
It calculates 30 days mortality
¬ Microbiological tests are done based on CURB65 score
13. Antibiotics
Amoxicillin if CURB65 0 to 1,
Amoxilcillin + Clarithro CURB 2
CURB 3 to 4 IV co amoxiclav with clarithromycin
NICE guidelines says give antibiotics for 5 days, BTS says give for 7 days
14. Safe discharge from Hospital
15. Expected recovery time:
1 week
4 weeks
6 weeks
3 months

6 months
16. BTS and NICE recommendations:
Start medications within 4hrs of hospital presentation
Difference is in the duration of use of antibiotics, NICE says 5 days, BTS says 7 days
Clinical judgement along with CURB65 score should be used to assess the severity of illness
Single antibiotic in patients with low severity
Dual combination antibiotics
Thankyou so much Dr Jacob and Dr Ash for this amazing session

FEEDBACK # 44

Dr Aiman Nazir

It was a wonderful session today on a very common yet challenging topic: Pneumonia .
Dr Jacob is really an amazing teacher to teach and share great knowledge in a very effective and simple way.
Never heard any better explanation of pneumonia than what Dr Jacob told today. Pneumonia is an infection of lung tissue where air sacs are filled with microorganisms, fluid and inflammatory cells and as a result of which lungs are not able to function properly. Diagnosis is based on history , signs and symptoms and imaging(cxray) showing new shadow that is not due to any other cause.Then comes the types 1- CAP and 2-HAP. How to differentiate between the two and risk of mortality with each of them.
Beautiful explanation given on etiologies of CAP(bacteria , virus , fungi, protozoa) including typical and atypical agents . Also stating the epidemiological factors suggesting causes of CAP, for example: alcoholism , COPD/smoking , structural lung diseases, lung abscess, travel history including hotel stay, influenza activity,exposure to birds and rabbits etc. to list a few . Dr Jacob further shared about organism specific clinical features , x-ray findings to make sure not to miss out anything.
Atypical pneumonias were explained in detail including zoonotic and non zoonotic causes ,kept in a table for good understanding and learning.
CRP relevance was discussed for LRTI in the community and initiating antibiotics according to it was a good learning point.

Investigations for diagnosis include O2 sats +/- ABG, U& E , Cxray,, CRP , CBC , LFT .Relevance of Pneumococcal and legionella urinary antigen was a new thing for me .

A very detailed explanation of CRB 65 and CURB 65 was given which helps in mortality risk assessment .

Management according to the NICE guidelines and CURB 65 score after severity assessment was explained in detail)starting with amoxicillin and adding of macrolides or further accelerating the treatment plan). Most important slide was about the safe discharge from the hospital, what to check and make sure whether to send the patient home or not?.

All of the essential details discussed today really made the session excellent .

Thank you so much Dr Jacob for your efforts .

FEEDBACK # 45

Dr Raja Mobeen Ahmed

Another important topic which was covered in detail by Dr Baby covering diagnosis, classification, etiologies, severity assessment and management of pneumonia. He started with the definition of Pneumonia as infection of lung tissue and that its diagnosis is based on presence of signs and symptoms of Lower Respiratory Tract Infection with Chest X-ray showing opacity which is not due to other causes such as pulmonary infarction, pulmonary edema, etc. Other things I learnt in this lecture were:

· Classification into Community Acquired Pneumonia and Hospital Acquired Pneumonia (if appearing >48 hours of hospital stay)

· The proper definition of LRTI as per NICE as an acute illness present for <21 days usually with cough as a main symptom AND with at least one other symptom such as sputum, breathlessness, chest discomfort, wheeze with no alternative explanation such as sinusitis or asthma. LRTI is a broad term and encompasses pneumonia, acute bronchitis and exacerbation of COPD

· The typical agents (Streptococcus pneumonia being the most common, Haemophilus influenza, Staph aureus, Klebsiella p, Pseudomonas) and Atypical agents (Mycoplasma, Chlamydia pneumophila and psittaci, Legionella, Viral etiologies such as Influenza, Adenovirus, RSV, SARS-COV2, Humanmetapneumovirus)

· Epidemiologic risk factors for possible causes of CAP e.g. In COPD H. influenza, pseudomonas is more common, In Alcoholics S.pneumonia, Klebsiella,

oral anaerobes, In Bronchiectasis Staph aureus and Pseudomonas is more common, In Dementia oral anaerobes and gram negative bugs, Lung abscess being more common with Staph aureus, Mycobacterium tuberculosis, Oral anaerobes, Exposure to ventilators or being on ship cruises/conferences suggestive of Legionella, Zoonotic exposures like birds (Chlamydia psittaci), rabbits (Francisella tularensis), Livestock (Coxiella)

· DDx of CAP with Abnormal Chest X-ray (CHF with associated viral syndrome, Aspiration pneumonitis, Pulmonary Infarction, Acute exacerbation of Bronchiectasis/ILD, Acute Eosinophilic Pneumonia, Pulmonary Vasculitis) and with Normal Chest X-ray (Acute exacerbation of COPD, Acute bronchitis, Influenza, Pertussis, Asthma with associated viral syndrome)

· Atypical pneumonia is caused by organisms (as told above) that cannot be detected with Gram stain and difficult to culture using standard medium. The constitutional symptoms predominate over respiratory findings. Examples of clinical and laboratory findings which point towards the bug e.g. Mycoplasma pneumonia with bullous myringitis, rash, cold hemolytic anemia with low complements and IgM, Legionella pneumonia with hyponatremia, hypophosphatemia, deranged liver and kidney function tests. The X ray findings caused by different organisms were also discussed

· Utility of CRP in LRTI. If CRP< 20, not to routinely offer antibiotic. If CRP 20-100, to consider delayed antibiotic prescription. If CRP>100, to offer antibiotics

· The general investigations in patients admitted with Pneumonia includes O2 sats and if low ABGs, Chest X-ray, CBC, U and E, LFT, CRP, Sputum cultures (from patients with moderate severity AND not received Antibiotic therapy), Pneumococcal urinary antigen and Test for Legionnaire's disease (in pts with High severity CAP)

· Severity assessment in Primary care with CRB-65 and to consider hospital assessment for all patient with CRB-65 greater than 0

· Severity assessment in Hospitals with CURB-65 (Score 0-1 low risk <3% mortality, Score 2 intermediate risk 3-15% mortality, Score 3-5 high risk >15% mortality). Dr Baby stressed the importance of also using Clinical judgement to help guide management and not to consider CURB-65 alone

· If CURB-65 0 or 1, no need of Sputum and Blood C/S

· The goal of diagnosing and starting antibiotics by 04 hours

· The antibiotic choices and their doses for pneumonia as per CURB score. In CAP, For CURB 0-1, Amoxicillin, if penicillin allergic or suspecting atypical organisms Doxycycline or Clarithromycin, if pregnant Erythromycin, all with duration of 05 days. For CURB 1-2, Amoxicillin with Clarithromycin or in penicillin allergy Doxycycline, in pregnancy Erythromycin. With high severity/CURB 3-4, Co-Amoxiclav with Clarithromycin or Erythromycin, if penicillin allergic Levofloxacin

· Criteria for safe discharge from hospital (Absence in the past 24 hours of Fever, Respiratory Rate >24, HR>100, SBP < 100 mmHg, O2 sats <90%, Abnormal mental status, inability to eat without assistance)

· Expected recovery times (Fever 01-week, Chest pain with sputum 04 weeks, Cough and SOB 06 weeks, Most symptoms 03 months, Most patients normal 06 months)

· Repeat Chest X-ray after 06 weeks in patients with Age>50 years and Risk factors for Malignancy so not to miss Lung Cancer

02 interesting cases were discussed by Dr Ashfaque. The first involved a patient with Acute Kidney Injury who had renal infarctions on CT scan and eventually cause was found to be septic emboli from a lung abscess. The other case started with Heart Failure but with Comprehensive history, examination and workup revealed COPD and Chronic Thromboembolic Pulmonary Hypertension.

Overall, there were many learning points discussed during the talk which comprehensively covered the topic of Pneumonia and I have learned a lot.

FEEDBACK # 46

Dr Rehan Khalil

Just attended an amazing lecture on Pneumonia by Dr Jacob. It covered things that cleared alot of my concepts.

Some of the things learnt are as follows:

1- Definition of pneumonia
2- Types of Pneumonia that is CAP and HAP
3- Definition of a type of Pneumonia
4- Causes of each type
5- Streptococcal Pneumonia being the most common pathogen in CAP.
6- Clinical and Presenting features of pneumonia
7- Aspiration is a risk factor for CAP in elderly.
8- Diffrentials of CAP with an abnormal CXR and with Normal CXR.

9- Atypical Pneumonia causative agents and their associated features.
10-Investigations tod o in suspected CAP.
11- Use of CRB65 and CURB65 score in severity assessment in Community and Hospital Setting.
12-In any patient >50 that presents with pneumonia, do a CXR 6 weeks after discharge from hospital to rule out MALIGNANCY!
Along with the above lecture there were two uniques cases presented by Dr Ash. 1st was the case of Cold resolving Abscess throwing emboli and 2nd was the case of COPD with retention of CO2 + LRTI+ Right heart failure.

FEEDBACK # 47

Dr Shahid Ahmad

Today's lecture on pneumonia was very interesting and informative.
Main points that we learned in this comprehensive session are
>Diagnosing pneumonia
>When to admit the patient and when to discharge
>Curb 65
>When to repeat chest x ray
>Prescribing appropriate Antibiotics

13th NOVEMBER 2022

EVENT NAME:

Pericardial Diseases MRCP 1-2 & PACES by Dr Nahal Raza Cardiology SPR NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Sadia Abbasi

It was an amazing and very informative session as usual by Dr Nahal Raza bundle of thanks.
I learnt a lot regarding pericardial diseases. Acute and chronic pericardial effusion, Cardiac tamponade and its ECG findings, X rays of pericardial effusion and constrictive pericarditis and treatment.
Each and every thing is organized and covered in every aspect exam point of view ➕ clinically. Thanking of you Dr Ash for London GEM Programme.

FEEDBACK # 2

Dr. Bushra Khan ·

Yet again very informative and interactive session, I really like the exercise of ECG's because that's what I need for MRCP prep. She covered almost everything related to pericardium along with latest guidelines for management of pericardial effusion, cardiac temponade, pericarditis.

Mostly covered what's been asked in MRCP and different scenarios. I always enjoy her talk and she keeps us all awake during the lecture. Keep up the good work Dr Nahal Raza. You will be a very good consultant.

In short of words for Dr Ashfaque dedication!

He always attends no matter what. Keep Rocking!

FEEDBACK # 3

Ghulam Saddique Saddique

Today's session by Dr Nahal was very wonderful and useful. Discussed pericardial diseases in detail and learned difference between the ECG of pericarditis and MI.

Acute (80ml) and chronic pericardial effusion (up to 2liters).

Signs if Pericardial effusion

1. Increased heart rate.
2. Juglar distention
3. Muffeled heart sound
4. Pulsus paradoxes
5. Poir pulse quality.

Cardiac Tamponade signs.

1. Hypotension
2. Muffeled heart sound
3. JVP distention

All 3 signs are called **Becks Triad**

Echo signs:

1. Valve closed RA collapsed
2. Valve closed RV collapsed
3. Plethoric IVC < 50% collapse
4. MV inflow > 25%.

Types of Pericarditis:

Serious

Fibrous & serofibrous (most frequent)

Heamirrhagic pericarditis.
Diagnostic Criteria of Acute Pericarditis
1. Acute
2. Incessant (>4-6weeks but < 3months without remission)
3. Recurrent (reoccurrence after 1st episode of documented pericarditis then free interval of 3 to 4 weeks)
4. Chronic (> 3months)
High risk patient of pericarditis
Fever > 38c
Cardiac temponade
Lack of response of NSAID after 1 week therapy
Treatment of pericarditis: X-rays of pericardial effusion and constrictive pericarditis. Each and everything was described efficiently. Thank you for such informative lecture today.
I am proud to be a part London GEM Programme.

FEEDBACK # 4

Faiza Baig

I learned about acute and chronic pericarditis, signs of pericardial effusion, ECG between pericarditis and MI, cardiac tamponade signs, and Becks Triad,
Echo signs. Diagnostic criteria and anatomical site for puncture, pathologies of pericardial fluid: constrictive and restrictive x-rays of effusions
As always Dr Nahal thank you for describing it smoothly. I always enjoy your session and thanks Dr Ash for arranging this informative lecture.

FEEDBACK # 5

DrShafik Zaid

Never find a tutor like Dr Nahal after this lovely session pericardial diseases its cause acute vs chronic stage and its management according to update guide line makes it finer to understand. Learning by self and getting knowledge by seniors has much difference Dr Ashfaque the founder of London Gem is a man whose master mind for the medical education is lamp in dark. All doctors are not the same to follow the drawn line not every mind is the same believe me London Gem is not only the life line but its efforts for making u something beyond the boundaries is worthless. A unique mind setup really anxious for its priceless future to see and to show others... Hats off Dr Ashfaque

FEEDBACK # 6

Dr Leela Ram

It was excellent session, full of knowledge including pictorial demonstration and clinical manifestations.

As ever, mode of lecture was cool, many important points for MRCP 1 & 2.

Regarding Pericardial diseases, it includes:

1. Acute pericarditis
2. Pericardial effusion
3. Constrictive pericarditis
4. Cardiac tamponade

Pericardial effusion ranges from 15-50ml, total protein is less but albumin concentration is high. It normally diffuses during diastolic pressure from right atrium & right ventricle. Acute condition fluid could be 80ml whereas chronic disease such as TB of pericardium, malignancy, traumatic, radiotherapy, dresseler syndrome and so on. Clinical manifestation includes increased heart rate, jugular distension & muffled heart sounds, pale mucous membrane, pulsus paradoxus & slow capillary refill time.

It is to note that Pericardial effusion doesn't cause murmur & diagnosed by X-ray which will show enlarged cardiac size(Silhouette).

ESC guideline is used to manage this condition which includes Pericardiocentesis & treating underlying pathology. Furthermore, Cardiac tamponade is accumulation of fluid in pericardial sac, impairs diastolic filling & reduces cardiac output. It's diagnosed by Beck's triad which includes hypotension, increased JVP & muffled heart sounds. Indications of Pericardiocentesis includes pericardial tamponade & periarrest, US guided, medical and traumatic effusion.

Yes, I should keep in mind about diagnosis of pericardial diseases in acute and general settings. First of all is to stratify stable and unstable patient then stepwise approach to management.

Thanks Dr. Nahal Raza for an amazing session & thanks Dr. Ash for further emphasizing on the importance of knowledge of specialists.

As always nice and great forum for all GEMs

FEEDBACK # 7

Dr Abubakar Tariq

Today I learned about presentation of pericarditis, its treatment, cardiac tamponade pericardiocentesis anatomical site for puncture, ECG presentation of pericarditis,

pathologies of pericardial fluid, how to differentiate between acute and chronic effusion, x-rays of effusion,
Thank you for very informative lecture today.

FEEDBACK # 8

Dr Nasir Hayat

This session was Amazing. Discussed everything and i liked it the approach to pericardial Diseases and ECGs shown was Amazing. I enjoyed it a lot. The session was run smoothly and answered all the questions. It was exam focus and very practical session. I would highly recommend for doctors and physicians to join it to get the depth of knowledge and be more skillful. Everything was taught in very nice way to memorize it very easily and get hold on the topic, such a wonderful session it was skillful. Everything was taught in very nice way to memorize it very easily and get hold on the topic, such a wonderful session it was.

FEEDBACK # 9

Dr Uzaima Nighat

Today's session by Dr Nahal was very useful. Discussed pericardial diseases in detail and learned difference between the ECG of pericarditis and MI.
Acute and chronic pericardial effusion, Cardiac tamponade and its echo signs and its treatment
Cause of pericardial effusion and tamponade, treatment of pericarditis, X-rays of pericardial effusion and constrictive pericarditis. Each and everything was described efficiently. Thank you for such informative lecture today.

FEEDBACK # 10

Dr Ramsha Tasnim

Today session by Dr Nahal was very comprehensive. Discussion about pericardial disease i.e. pericardial effusion
Its type causes physical examination of pericardial effusion treatment.
Cardiac tamponade its management
Pericarditis its type, cause, stages and treatment according to guidelines. Different ECG's to pick specific diseases. Thank you

FEEDBACK # 11

Dr Neelam Zehra

It was a wonderful session today. The way she starts from scratch and builds up the foundation in our minds is amazing. When I read the topic from the book her words keep popping in head how she emphasizes on all important things.

From revised the layers of pericardium to normal levels of pericardial fluid. Acute pericarditis can present on even 80ml of fluid and chronic pericarditis won't even show signs on 2 liters of fluid. Causes of pericarditis along with how will it present and what will be the management for acute and chronic both. Clearly differentiated how and when to treat it and when not to treat and determine the precipitating cause first.
How it will be seen on chest X-ray and How to differentiate between ECGs of acute MI and pericarditis?
Cardiac tamponade it's presentation, diagnosis and management and differentiating features.
I regret missing yesterday's lecture as I was in no reception area. Wait for it to get uploaded on portal.
Thank you all for your efforts and wonderful deliverance of lectures.

FEEDBACK # 12

Dr Shiraz Mehmood

Amazing session on pericardial disease discussed effusion and pericarditis. How to approach patients and clinically identifying tamponade, BECK's tirade and its management? Discussed ECGs and identifying pericardial issues. Thank you for delivering an amazing session Dr. Nahal. Thanks to Ash for organizing.

FEEDBACK # 13

Dr Mariam Sultan Khan

As expected another comprehensive lecture on Pericardial diseases starting from anatomy of heart , understanding fibrous and serous pericardium then moving towards Pericardial effusion inclusive of its causes, physical examination and cardiac signs of Pericardial effusion, X-ray finding of enlarged cardiac silhouette, ECS guidelines for management of Pericardial effusion. All aspects were discussed in great detail.
Moreover, Dr Nahal captured cardiac tamponade where she discussed becks triad, echo signs of tamponade collapsed RA and RV during diastole, then treatment perocardiocentesis was explained. Furthermore, an in depth discussion on Pericarditis including ECG findings, causes, types ,acute Pericarditis diagnostic criteria, treatment of Pericarditis according to stage of Pericarditis and ESC guidelines, causes of constrictive pericarditis.
Finally, In the end there was an excellent slide to differentiate constrictive persistent from tamponade and restrictive cardiomyopathy.

Every time Dr. Nahal delivers a lecture I feel there is no margin to even blink. It depicts her in depth knowledge and understanding. I intend to revisit her lectures multiple times as its not only helpful from exam point of view but also in managing patients in routine practice.
Can't thank enough Dr Ash and Dr Nahal for this great lecture. Brilliant work undoubtedly!

FEEDBACK # 14

Dr Rizwan Siddiq

Today's session by Dr Nahal was very useful. Discussed pericardial diseases in detail and learned difference between the ECG of pericarditis and MI.
Acute and chronic pericardial effusion, Cardiac tamponade and its echo signs and its treatment
Cause of pericardial effusion and tamponade, Treatment of pericarditis, X-rays of pericardial effusion and constrictive pericarditis. Each and everything was described efficiently. Thank you for such informative lecture today.

FEEDBACK # 15

Dr Muhammad

Topics covered in today's lecture were related to pericardium its anatomy and diseases. She started from pericardial effusion difference between acute and choric sign symptoms and echo finding of RA and RV collapse with management. She also explained cardiac tamponade, backs triad and indication for pericardiocentesis very well. Moreover she covered pericarditis. Difference between constrictive pericarditis restrictive pericarditis and cardiac tamponade, X-rays and last slide in her presentation made things more cleared. Over all it was a very informative session and ECG's she showed in her presentation made my concept clear and now I'm able to differentiate between STEMI and pericarditis ECG.
Thankyou Dr Ash a d Dr Nahal for this wonderful session

FEEDBACK # 16

Dr Zeeshan Ayaz

It was a wonderful session today. The way she starts from scratch and builds up the foundation in our minds is amazing, from revising the layers of pericardium to normal levels of pericardial fluid. Acute pericarditis can present on even 80ml of fluid and chronic pericarditis won't even show signs on 2 liters of fluid. Causes of pericarditis along with how will it present and what will be the management for

acute and chronic both. Clearly differentiated how and when to treat it and when not to treat and determine the precipitating cause first.
How it will be seen on chest X-ray and How to differentiate between ECGs of acute MI and pericarditis?
Cardiac tamponade it's presentation, diagnosis and management and differentiating features.
Thank you for such informative lecture.

FEEDBACK # 17

Dr Beenish Naveed

Another great lecture delivered by Nahal starting from the anatomy of heart and it's covering with the detailed explanation of layers from outside to inside, all the causes of pericardial effusion and teaching of acute and chronic types on the basis of amount accumulated. She explained how and when to treat it along with the diagnosis and differentiating points from normal to abnormal findings in cardiac silhouette.
She clear our all doubts about cardiac tamponade, how it could present, the Beck's triad, the ECG presentation, along with the Echo signs moving further towards Pericarditis , its types and causes. She also gave in depth knowledge of diagnostic criteria of acute pericarditis
Acute
Incessant
Recurrent
Chronic
The explanation in light of ESC guidelines was top notch and details of constrictive pericarditis differentiating points were amazing.
In the end she described very wall how to differentiate constrictive pericarditis from tamponade and restrictive cardiomyopathy.
The way of explaining the things was amazing. She always has a positive energy which keeps all the candidates engage and motivated throughout the class.
Thanks Dr Ash for his efforts and brilliant work.

FEEDBACK # 18

Dr Aiman Saeed

An amazing session
Starting with telling how does pacemaker looks on chest x-ray, how does defibrillator looks like, how to use it.

The coming to pericardial diseases… what is pericardial cavity, pericardial fluid and it's classification, difference between cardiac tamponade and pericardial effusion, how will pt present and it's management.
How will percarditis seen on ECG
How to differentiate between acute MI and percarditis and so on
Thank you so much Dr Nahal for such informative lecture, I always enjoy learning from your lecture.
Thanks Dr Ashfaque for your efforts.

FEEDBACK # 19

Dr Sidra Asad

Glad to be part of this amazing lecture by Dr. Nahal. In this lecture, we were taught how to classify different pericardial diseases on the basis of history, examination and certain investigations. Also, different ECG's and X-rays were explained with positive findings of acute pericarditis, cardiac temponade and we were expected to know the difference between ECG's of myocardial injury(Stemi) and pericarditis (global St elevation). Moreover, pathogenesis of pericardial effusion, temponade and constrictive pericarditis were well explained. We were given questions regarding these topics to brain storm our minds and Dr Nahal has covered all aspects of management plans according to updated NICE and European society of cardiology guidelines which are currently practiced in UK hospitals. Thank you so much for your efforts. It's truly an amazing programme and we are lucky to be part of it.

FEEDBACK # 20

Dr Ahmad Tanveer

Power pack lecture gave by Dr. Nahal. Classification of pericardial diseases discussed. Findings on ECG's and X-rays discussed pericarditis, cardiac temponade differentiation points, difference between ECG's of myocardial injury(Stemi) and pericarditis (global St elevation). Moreover, pathogenesis of pericardial effusion, temponade and constrictive pericarditis were explained well. Dr Nahal. Thank you so much for your efforts. It's truly an amazing lecture

FEEDBACK # 21

Dr Emmanuel Qammar

This much needed comprehensive lecture on Pericardial diseases beginning from cardiac anatomy including the fibrous and serous pericardium progressing towards pericardial effusion comprising of causes, physical examination and cardiac signs

of Pericardial effusion, X-ray points of enlarged cardiac shadow, ECS guidelines and management of pericardial effusion were explained well.
Distinguishing points between constrictive persistent,tamponade and restrictive cardiomyopathy were explained well.
Overall it was an excellent session !
Looking for next week lectures sessions
Thanks to Dr Ash and Dr Nahal once again :)

FEEDBACK # 22

Dr Syed Kamran Hussain

The session by Dr Nahal was very wonderful and useful and It was lovely discussion. She discussed 1 pericardial diseases
2 Anatomy and physiology
3 ECG of pericarditis
MI
4 Acute Percardial effusion
5 chronic Pericardial effusion
6 Signs of Pericardial effusion
Increaed heart rate.
juglar distention
muffeled heart sound
pulsus paradoxes
poor pulse quality
7 Cardiac Tamponade signs
Hypotention
muffuled heart sound
JVP distention
8 Becks Triad
9 Echo signs
10 Types of Pericarditis.
Serous
Fibrous & serofibrous (most ly)
Heamorhagic pericarditis.
11 Diagnostic Criteria of Acute Pericarditis
Acute
Incessant(>4-6weeks but < 3months without remission)

Recurrent (reoccurrence after 1st episode of documented pericarditis then free interval of 3 to 4 weeks)
Chronic (> 3months)
12 High risk patient of pericarditis
Fever > 38c
Cardiac temponad
Lack of response of NSAID after 1 week therapy.
13 Treatment of pericarditis
14 X rays of pericardial effusion
15 Constrictive pericarditis
16 Pericardiocentesis
17 Discusions on ECGs.
That lecture was organized and covered every aspect of exam.
Thank you Dr. NAHAL & DR ASHFAQUE for such informative lecture.

FEEDBACK # 23

Dr Ghazala Sheikh

Today I learnt,
Different Pericardial diseases in detail
Pericarditis, pericardial temponade.
Acute Pericarditis (can present on 80ml of fluid)
Chronic Pericarditis (don't present even when 2litres of fluid filled)
Presentation on chest Xrays
ECG Differences between Acute Pericarditis and MI which is a very useful tool clinically
Thankyou Very Much,
Dr Ash and Dr nahal Raza for making efforts to get things easier for our sake.
I feel very confident under London.gem for my MRCP journey

FEEDBACK # 24

Dr Memoona Hafeez

Today session by an energetic worthy dr.nahal…pictorial aid was realy helpful to understand the pericardial problems as well as nice guidelines oriented mangment plan is also explained …all aspects were taught explicitably ….thank u dr nahal for such great teaching.

7th JANUARY 2023

EVENT NAME:

COPD Management In ED & OPD By Dr Jacob Resp Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Babar Hussain

Today's session was about COPD conducted by Dr Jacob.
It was one of the best lecture, very well explained everything including risks, investigation, treatment plans.
A lot of learning points for me especially
Crico-sternal distance
Blue bloaters
Pink puffers
ABCD COPD assessment tool.
Thank you so much for the wonderful lecture Dr Jacob.
Thank you so much Dr Nouman and Dr Shafiq for the excellent case presentation.
In the end Thank you so much Dr **Ashfaque Ahmed** for arranging such an amazing session. Sir you are looking quite happy and so good today MashaAllah, have a safe flight ✈.

FEEDBACK # 2

Syed Suhail Ahmad

A excellent and up-to date session on COPD Management In ED & OPD By Dr Jacob Resp Consultant NHS UK.
- COPD and it's diagnostic criteria
- Clinical presentation and risk factors
- Investigations and its implications
- Centrilobular, Panacinar and Panseptal emphysema
- Alpha 1 AT deficiency
- CRICOSTERNAL disturbance and its importance
- Important examination points
- mMRC Scale, Gold Criteria and ABCD assessment tool
- Management plans involving SABA, LABA, LAMA, and ICS

- Role of NIV and IV

Excellent case presentations by Dr.Nouman and Dr.Shafiq to sum it all up.

Thank you London Global Emergency Medicine and Pema-Uk 👍👍👍

FEEDBACK # 3

Qaisar Shah

Dr.JACOB gave a detailed session on COPD (chronic obstructive pulmonary disease) management in the emergency department. COPD is defined as having chronic, progressive symptoms including coughing, difficulty breathing, and the production of sputum. It is often diagnosed in individuals over the age of 35 who are smokers or have exertional breathlessness. The most common causes of COPD include tobacco smoking, exposure to certain occupational environments and pollutants, and genetics. COPD has two components: chronic bronchitis and emphysema. Emphysema has different subtypes depending on the location of the damage in the lungs. The diagnosis of COPD is made through a combination of clinical examination, diagnostic testing such as spirometry and blood tests, and excluding other potential diagnoses. COPD is managed through a combination of lifestyle changes (such as quitting smoking), medications, and oxygen therapy. The role of non-invasive ventilation (NIV) in COPD exacerbations was also discussed, along with inclusion and exclusion criteria for its use. The presentation was comprehensive and amazing.

Thanks Dr.jacob & Dr.Ash

FEEDBACK # 4

Yasir Dilawar

It was a great session by Dr Jacob Baby.we learnt new things about COPD and it's long term management.i could not watch the full lecture as I had my duty.will watch the video.

FEEDBACK # 5

Javeria Wali

Brilliant session on COPD conducted by Dr. Jacob baby on 7th January, 2023. He covered alot of important points including and not limited to definition of COPD, Diagnostic criteria, MRC scale with helpful mnemonics, causes of COPD, COPD components namely

Chronic bronchitis & emphysema explained in extreme detail, important Clinical examination points of Emphysema and chronic bronchitis

Differential diagnosis, Investigations and management tO reduce symptoms and reduce exacerbation risk, criteria for NIV in COPD explained in detail.

FEEDBACK # 6

Bushra Imran

In today's session very comprehensive and in detailed explained COPD ,chronic respiratory symptoms due to abnormalities of airways and alveoli, Risk factors ,symptoms, MRC grading dyspnea scale,COPD types Blue bloaters and pink puffers.The discussion on differential diagnosis and then explained how to diagnose +manage in detailed which makes me memorize it for daily patients ER care and was easy to understand...Thank you dr Jacob and Dr Ash

The two case presentations after the session by Dr Nauman and Dr Shafique were also good

Thank you GEM team

FEEDBACK # 7

Imtiaz Ali Shah

Today we had a comprehensive session regarding COPD and its managment by dr Jacob. The session started with the definition of COPD and its relation with smoking history .Risk factors for COPD which includes smoking,occupational exposures, air pollution,asthma and genetics.Difference between ch bronchitis and emphysema along with its types.Dr Jacob also highlighted the genetic factors and A1ATD and mutation inSERPINA1 gene located in chromosome 14..

We also learnt about differential diagnosis of COPD AND ASTHMA.

Diagnosis of COPD by post bronchodilator spirometry, FEV1/FVC LESSTHAN70%.

DR JACOB then comprehensively explained the managment of COPD withABCD COPD assessment tool.SABA AND SAMA and LAMA PLUS LABA regime +ics.

Dr Jacob also defined exarbition and various factors responsible for it along with its managment.

It was a wonderful session and dr Jacob made the things easy and understandable.

It was asession full of new knowledge and learning points. The session ended with two short cases presented by dr nauman and dr shahid.

Thanks to dr Jacob for this highly valuable session and also to dr Ash for providing this great learning opportunity.

FEEDBACK # 8

Ghulam Saddique Saddique

Thorough and detailed session conducted by Dr.Jacob
COPD explained as having Cough,breathlessness,
sputum production,chronic progressive and persistent symptoms.
Diagnostic points
Suspected diagnosis in >35yr of age known smoker or exertional breathlessness.
Risk factors are Smoker and Environmental smoke
MRC scale explained in detail. From grade 1 to grade5.
Most common causes of COPD explained.
Tobacco smoking
Occupational exposure in coal grains and silica exposure
Air pollution
Genetics -alpha 1 anti trypsin deficiency in younger people.
Past Ho of Chest infection in child hood.
Asthma may be a risk factor for COPD.
COPD has 2 components
Ch bronchitis & emphysema
Emphysema types
Centrilobular in smokers
Paraseptal
Panacinar in A1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examination points
Barrel chest in Emphysema
Cricosternal distance reduced less than 3 fingers
Cyanosis in Blue Bloaters
PINK Puffers pink skin
Key S/s pursing of lips
Use of accessory muscles
Inc AP diameter of chest
Heart sounds loudest a epigastric
D/D
asthma
HeartFailure
BRONCHIECTASIS

Tuberculosis
bronchiolitis obliterens
Differentiation between COPD & Asthma
Explained in detail
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
FEV1 >80 % mild
FEV1 50--79% moderate
FEV1 30--49% severe
FEV1 < 30% very severe
Investigations discussed in detail
Sputum culture.
Routine blood
ABGs
Serial home Peek flow measurement
ECG / Pro BNP / ECHO for cardiac failure or cor pulmonale.
CT Thorax to find any other lung pathology
Serum a1AT levels if younger age of symptoms and with minimal or no smoking history .
TLCO
Emphysema on CT is an independent risk factor for Lung CA.
MANAGEMENT discussed
Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
OXYGEN THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV IN Exacerbations
Abx Azithromycin role in COPD in non smokers only
ABCD COPD ASSESSMENT TOOL EXPLAINED.

Pharamcological treatment alogrithm by Gold Grades discussed.
Inclusion exclusion criteria for NIV in COPD explained well in detail.
It was a detailed comprehensive session by Dr Jacob .
At the end 2 case presentations by Dr Nouman and Dr Shafiq was interesting and detailed investigated cases of COPD exacerbation .
Thanks to Dr Nouman and Dr Shafiq for presentations.
Thanks to be a part of London GEM Programme

FEEDBACK # 9

Suhail Ahmed

Todays session was amazing contains alot of information
COPD defination.
Diagnostic points
Suspected diagnosis in >35yr with MRC scale explained in detail.
Most common causes of COPD explained.
COPD components
Ch bronchitis & emphysema
Emphysema types
Centrilobular in smokers
Paraseptal
Panacinar in a1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examination :
Barrel chest in Emphysema
Cricosternal distance reduced
Heart sounds loudest a epigastric
Differentials: asthma ,HeartFailure BRONCHIECTASIS
Tuberculosis
bronchiolitis
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
Investigations discussed in detail
Sputum culture.

Routine blood
ABGs
Serial home Peek flow measurement
ECG ,Pro BNP, ECHO for Heart failure.
CT Thorax to find any other lung pathology.
MANAGEMENT :
discussed Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
O2 THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV.
Abx Azithromycin role in COPD in non smokers.
alogrithm by Gold Grades discussed.
criteria for NIV in COPD explained well in detail.
Thank you Dr. Ash and Dr. Jacob Baby.

FEEDBACK # 10

Dr Leela Ram

It was excellent session on management of COPD in the Emergency Department and long term management, it was described from definition & people who consume cigarettes for long time, they are mostly diagnosed at the age of 35 years. The most common causes include tobacco smoking, exposure to certain occupational environment, pollutants & genetics. COPD has two components ie; Chronic bronchitis & Emphysema. Emphysema has different subtypes depending on the location of the damage in the lung. The diagnosis is made through a combination of clinical examination & tests such FBS, CXR, CT & most important is Spirometry.

COPD management includes smoking cessation, encourage exercise, diet advice, mucoltyics & oxygen therapy. The Non invasive oxygen therapy has a role in its management.

It was comprehensive and detailed lecture.

I learnt that life style modifications have great role in preventing COPD, all measures should be taken while working in pollutant environment and seek immediate medical help if one develops shortness of breath and continuous cough. Annual flu and pneumococcal vaccine are essential for all lung and heart disease patients.
It will enable to take detailed history including smoking history, occupational history and family history of any lung disease and I will manage patients as per individual case.
Thank you Dr. Jacob for fantastic session on COPD & thank you so much Dr. Ash for great vision.

FEEDBACK # 11

Dr Warda Yawar

Amazing session.
Well organised
Dr jacob gave a lecture and my intrest in respiratory medicine is growing more day by day at the end of his every lecture
He gives us some clues to always rule out pneumonia before copd, PE and cardiac failure in any acute exacerbation of COPD
Smoking cessation is the key to good treatment outcome plus major cause of copd is by smoking
. Asthma should be ruled out in any COPD presentation
. For treatment 9f COPD combination of LAMA and LABA are started and ICS initially avoided whereas ICS are added on early asthma with copd and in exacerbation but should be avoided in stable copd
Role of tlco in copd and fibrosis
. Alpha 1 antitrypsin deficiency was taught in detail
. NIV was taught in detail
We learned about the ABCD approach to COPD and managed details
Clinical differences between blue bloaters and pink puffers.
Imp differentials and how to rule them out was taught we neeed such kind of guidance in near future to educate all doctors.
Thankyou Dr Jacob and Dr Ash

FEEDBACK # 12

Dr Nasir Hayat

Todays session was amazing and wonderful presentation,learned alot extraordinary contains alot of material
COPD defination explained as having Cough,breathlessness,
sputum production,chronic progressive and persistent symptoms.
Diagnostic points
Suspected diagnosis in >35yr of age known smoker or exertional breathlessness
MRC scale explained in detail.
Most common causes of COPD explained.
Tobacco smoking
Occupational exposure in coal grains and silica exposure
Air pollution
Genetics -alpha 1 anti trypsin defciency in younger people.
Past Ho of Chest infection in child hood.
Asthma may be a risk factor for COPD.
COPD has 2 components
Ch bronchitis & emphysema
Emphysema types
Centrilobular in smokers
Paraseptal
Panacinar in a1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examation points
Barrel chest in Emphysema
Cricosternal distance reduced
Cyanosis in Blue Bloaters
PINK Puffers pink skin
Key S/s pursing of lips
Use of accessory muscles
Inc AP diameter of chest
Heart sounds loudest a epigastric
D/D asthma ,HeartFailure BRONCHIECTASIS
Tuberculosis
bronchiolitis obliterens
Differentiation between COPD & Asthma

Explained in detail
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
Investigations discussed in detail
Sputum culture.
Routine blood
ABGs
Serial home Peek flow measurement
ECG / Pro BNP / ECHO for cardiac failure or cor pulmonale.
CT Thorax to find any other lung pathology
Serum a1AT levels if younger age of symptoms and with minimal or no smoking history .
TLCO
Emphysema on CT is an independent risk factor for Lung CA.
MANAGEMENT discussed
Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
OXYGEN THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV IN Exacerbations
Abx Azithromycin role in COPD in non smokers only
ABCD COPD ASSESSMENT TOOL EXPLAINED.
Pharamcological treatment alogrithm by Gold Grades discussed.
Inclusion exclusion criteria for NIV in COPD explained well in detail.
It was a detailed comprihensive and power pack lecture by Dr Jacob excellent Sir
At the end 2 case presentations by Dr Nouman and Dr Shafiq was interesting and detailed investigated cases of COPD exacerbation .
Thanks to Dr Nouman and Dr Shafiq also for nice presentations.I learned alot and highly recommended for ER physicians and physicians to gain the knowledge and

get the practical skills to have bright future and be best doctor.Proud to be LGEM candidate Mrcem and Mrcp.All the credit goes to SIR Dr.Ash for arranging such session for Doctors.

FEEDBACK # 13

Dr Amash Khan

Today's Topic by Dr Jacob was concise and informative about COPD it's diagnosis, difference between COPD and asthma, diagnostic criteria like NICE and Gold and ABCD assessment, Management plan and when to administer combine drug therapy like LABA, LAMA and ICS along with Non invasive and invasive oxygen.

Thank you Dr Jacob and Dr Ash for this beautiful lecture.

FEEDBACK # 14

Dr Ghayoor Khan

Yet another amazing session. A session filled with many practical and exam based points. We were taught COPD by Respiratory consultant NHS, and the session was loaded with learning pearls. Some imp points were as follows

. Always rule out pneumonia, PE and cardiac failure in any acute exacerbation of COPD

. Smoking cessation is the key to good treatment outcome

. Asthma should be ruled out in any COPD presentation

. For treatment 9f COPD combination of LAMA and LABA are started and ICS initially avoided whereas ICS are added on early 8n asthma

. Alpha 1 antitrypsin deficiency was taught in detail

. NIV was taught in detail

We learned about the ABCD approach to COPD and managed details

. Emphysema and chronic bronchitis are types of COPD

. Imp differentials and how to rule them out was taught

It was a very informative session.

Thank you

Dr Jaxob and Dr Ash

FEEDBACK # 15

Dr Shahid Ahmad

Today's session was so comprehensive and to the point, by Dr. Jacob Baby on COPD in ED.

lecture started with the classification, risk factors and moving on to further diagnostic criteria and accurate management.
new things for me in this lecture were
•ABCD COPD assessment tool,
•measuring crico-sternal distance in patient with COPD.
case based discussion was done at the end, which was very informative as well.

FEEDBACK # 16

Dr Mishal Shan

The lecture by Dr Jacob was quite comprehensive and a lot of important clinical pointers with exam clinchers were delivered in the talk. He talked about taking a comprehensive history and doing a clinical examination in COPD patients. We were taught to approach the patient systematically and not to miss signs of raised pulmonary pressure. We also learned the management of stable COPD as well as exacerbation. It was a good refreshment of our knowledge.

FEEDBACK # 17

Dr Nouman

The session taught by Dr Jacob was really helpful in understanding the fascinating clinical points regarding COPD.
He discussed the basic details like definition, phenotypes of COPD, their differences, differential diagnosis, how to categorize COPD patients into a 4 square chart, acute exacerbations and management of the cases along with their discharge protocol.
COPD is a commonly encountered medical issue and now we feel more confident than ever to deal with such cases in a more efficient & thorough manner.
Thanks Dr Jacob, team LGEM and Dr Ash for organizing a wonderful event

FEEDBACK # 18

Dr Ghazala Sheikh

The session was amazing overall thanks to Dr jacob for the informative session
I learnt,

- Definition of COPD
- Diagnosis of COPD
- Risk factors for COPD
- Grades of dyspnoea
- Types of COPD in detail

. Emphysema description (pink puffers)

~Centiacinar
~Panacinar
~Alpha1 antitrypsin deficiency
. Chronic bronchitis (blue bloaters)
● Examination features of COPD
● Differential Diagnosis
. TB
. Central Airways obstruction
. Bronchiectasis
. Asthma
● Difference between Asthma and COPD
● Treatment strategies
. Smoking cessation
. Inhaled therapy
. SABA
. LABA
. LAMA

FEEDBACK # 19

Dr Ahmad Tanveer

Todays session was extraordinary contains alot of material
COPD defination explained as having Cough,breathlessness,
sputum production,chronic progressive and persistent symptoms.
Diagnostic points
Suspected diagnosis in >35yr of age known smoker or exertional breathlessness
MRC scale explained in detail.
Most common causes of COPD explained.
Tobacco smoking
Occupational exposure in coal grains and silica exposure
Air pollution
Genetics -alpha 1 anti trypsin defciency in younger people.
Past Ho of Chest infection in child hood.
Asthma may be a risk factor for COPD.
COPD has 2 components
Ch bronchitis & emphysema
Emphysema types

Centrilobular in smokers
Paraseptal
Panacinar in a1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examation points
Barrel chest in Emphysema
Cricosternal distance reduced
Cyanosis in Blue Bloaters
PINK Puffers pink skin
Key S/s pursing of lips
Use of accessory muscles
Inc AP diameter of chest
Heart sounds loudest a epigastric
D/D asthma ,HeartFailure BRONCHIECTASIS
Tuberculosis
bronchiolitis obliterens
Differentiation between COPD & Asthma
Explained in detail
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
Investigations discussed in detail
Sputum culture.
Routine blood
ABGs
Serial home Peek flow measurement
ECG / Pro BNP / ECHO for cardiac failure or cor pulmonale.
CT Thorax to find any other lung pathology
Serum a1AT levels if younger age of symptoms and with minimal or no smoking history .
TLCO
Emphysema on CT is an independent risk factor for Lung CA.
MANAGEMENT discussed

Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
OXYGEN THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV IN Exacerbations
Abx Azithromycin role in COPD in non smokers only
ABCD COPD ASSESSMENT TOOL EXPLAINED.
Pharamcological treatment alogrithm by Gold Grades discussed.
Inclusion exclusion criteria for NIV in COPD explained well in detail.
It was a detailed comprihensive and power pack lecture by Dr Jacob excellent Sir
At the end 2 case presentations by Dr Nouman and Dr Shafiq was interesting and detailed investigated cases of COPD exacerbation .
Thanks to Dr Nouman and Dr Shafiq also for nice presentations.

8th JANUARY 2023

EVENT NAME:

Interstitial Lung Diseases For GEM MRCP Trainees By Dr Syed Wasib Consultant Resp Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Warda Yawar

This was an excellent lecture and i have learnt alot from it after this presentation i feel more confident ,from cases to treatment every thing was on point i never had this much understanding on this group of diseases and in GP setup they give treatment of asthma and tb for dpld which i could also do if I didn't attend this lecture.
Seriously change my diagnosis of many patients which I have seen already but didn't know how to diagnose and investigate before

and from now, my opinion of treating these patients will be different thank you dr Ash for this lecture and dr wasab is one of the best respiratory consultants out there he also told us about different exposure to plus from different cities of Pakistan which was so kind of him so we couldn't mix the diagnosis
Thank you for this amazing lecture, proud to be part of London Gem.

FEEDBACK # 2

Sidra Asad

This was and excellent lecture and i have learnt alot from it. This topic has always been diffcult for me but after attending this presentation i feel more confident. This lecture started from 5 cases related to different causes of ILDs. Following that, we were taught ILD definition, classification, clinical history, time course, skin GI Eye manifestations, important markers in PMH and occupational history. History, examination, investigations and different patterns of ILDs were well explained. I have learnt alot from this ppt. We were also taught treatment objectives in detail and how to treat IPF (stepwise), role of steroids and MTX; comorbidities and prognosis .
Thank you for this amazing lecture, proud to be part of London Gem.

FEEDBACK # 3

Saba Aslam Khan

It was comprehensive yet detailed lecture on ILD , Dr wasib started his presentation with the 5 cases on ILD and gave us adrenaline rush and got to know about our level of knowledge on ILD and then he descended down to our level and took us to the depth of the topic ….!! It was well explained lecture from sign and symptoms to the management of the patients and different presentations thank you London GEM and dr Ash for arranging this lecture …
Learned alot..
A proud GEM trainee,

FEEDBACK # 4

Sana Hameed

A difficult disease explained with such basic knowledge with help of scenarios. A nice intellectual session on ILD by Dr. Syed Wasib.
Starting from the signs and symptoms to the management and difficult situations the patient can present in.
Added many new things to the knowledge of this disease
Thank you dr. Ash for such awesome sessions for your trainees.

FEEDBACK # 5

Suhail Ahmed

An excellent lecture by Dr Syed.
he stated the Definition of interstitial lung disease with etiology.
He explained which part of the lung affected in different diseases.
HRCT:sensitive than X-ray.
He also explained the different investigations.
Treatment
He explained the different treatments for lung fibrosis including lung transplant.
Pirfenidone and nintanib also were discussed.
He also discussed steroid use and When steroid do not work: MMF and Azathioprine
Cyclophosphamide – fulminant disease
Methotrexate not a risk factor for RA-ILD, pulmonary toxicity is very rare, close monitoring is required
TNF inhibitors have both profibrotic and anti-fibrotic effects
Rituximab better survival compared to TNF inhibitors
Prognosis:
Median survival 7 years post diagnosis.
Thank you

FEEDBACK # 6

Dr Leela Ram

Overall it was informative with numerous cases with CTs. It is broadening our understanding of Interstitial lung disease in view of many aspects.
Dr. Wasib described UIP pattern on radiology which is minimal ground glass opacity, subpleural reticulation & honey combing with tractional bronchodilation occurs 8-66% & NSIP pattern with no HC occurs 19-57%. Organising pneumonia with reversed halo sign- 0-11% & LIP or DIP pattern<1%.
Lung manifestation of Rheumatoid arthritis: Most common extraarticular organ involved:
Parenchymal> ILD, Rheumatoid nodule,
Pleural involvement: Pleuritis, pleural effusion
Airways> Cricoarytenoids, bronchiolitis, bronchiectasis.
ILD is classified as histopathologic & clinical characteristics:
Etiology known:

Inorganic exposure: Asbestos, silica, hard metals, coal dust.
Oragnic exposure:
Birds, hay, mold, mycobacteria
Smoking: DIP, RB-ILD, LCH
Connective tissue disease: RA, Polymyositis/dermatomyosotis, scleroderma, Sjogren syndrome
Drugs: Nitrofurantoin, Amiodarone, Methotrexate, chemotherapy
Etiology unknown: Idiopathic interstitial pneumonia, rare LAM, Vasculitis,
Granulomatosis: Sarcoidosis:
Clinical history: typical dyspnea on exertion & abnormal radiograph, symptoms are progressive.
Acute: Cryptogenic organising pneumonia, AEP, acute hypersensitivity pneumonia & so on
Subacute to chronic:
Connective tissue disease associated ILD, IPF, Sarcoidosis, CHP, NSIP, DIP, RB-ILD, LIP, CEP.
Dermatologic symptoms: Heliotrope rash, Gottron's papules, SLE (Malar flush, Photosensivity reaction, hair loss,
•Musculoskeletal symptoms,
• Ophthalmic symptoms
PMH: Prior diagnosis of connective tissue disease
Occupational hx: Inorganic+organic exposure
Medication hx: Nitrofurantoin, Amiodarone
Physical examination: typical Velcro crepts, Inspiratory squeaks
Chest imaging: abnormal CXR
Distribution of lung disease: Upper lung zone+ lower lung zone
Investigation: HRCT Most sensitive
Lab: Inc. LFT, Hypercalcemia
PFT
Bronchoscopy: BAL is very useful
Ebus
Surgical lung biopsy
Treatment: Objective of ILD:
•Slow progression
• improve symptoms

• Improve quality of life
• Early referral to tertiary care center
• Antifibrotics or immunosuppression
• Oxygen inhalation
• Rule out Pulmonary HTN
• Pulmonary rehabilitation
• Treatment of co-morbities particularly GOERD
• Referral for lung transplant
• Start palliative care if not possible lung transplant
• MDT approach: Rhematologist, Radiologist, Respiratory

It was extraordinary session
Learnt so many new things including clinical presentation including inspiratory squeaks, velcro crepts, dyspnea on exertion, abnormal CXR.
It will greatly enhance practice of respiratory medicine.
Thanks Dr. Syed Wasib for incredible session & thank you Dr. Ash for elaborating many things on ILD & thanks to LGEM platform.

FEEDBACK # 7

Dr Faiza Arshad Baig

An excellent lecture by Dr Syed, with discussion on nonspecific interstitial pneumonia, sarcoidosis,pneumonitis, cystic lung disease, RA- ILD he stated the Definition of interstitial lung disease with etiology of lung disease.
Etiology known organic causes
Inorganic (asbestos, silica, coal)
Organic exposure (birds, hay, mold, mycobacterium)
Smoking (DIP, RB-ILD, LCH)
Drugs (Nitrofurantoin, amiodarone, methotrexate, chemotherapy)
Connective tissue disease (RA, polymyositis/dermatomyocitis, scleroderma, Sjogren syndrome)
Etiology unknown:
idiopathic interstitial pneumonitis
typical clinical presentation (Dyspnea on exertion, cough, progressive symptoms, 2/3 patients are above 60 years old at diagnosis. Women have LAM (lymphangiomyomatosis)
Acute:
1)Cryptogenic organizing pneumonia

2)Acute eosinophilic pneumonia
3)Acute hypersensitivity pneumonitis
4)Acute interstitial pneumonia
5)Acute exacerbation of IPF or other ILD
Subacute to Chronic:
1)Connective tissue disease associated ILD
2)Idiopathic pulmonary fibrosis
3)Sarcoidosis
4)Chronic hypersensitivity pneumonitis
5)Occupational lung disease
6)Nonspecific interstitial pneumonia
7)Respiratory bronchiolitis
8)Lymphocytic interstitial pneumonia
9)Chronic eosinophilic pneumonia
Physical examination includes:-
Wheezing
Typical crepts
pleuritic chest pain
Clubbing
Inspiratory squeaks
hemoptysis
rash, dermatomyositis
SLE malar rash, photosensitivity, hair loss
GI symptoms: esophageal motility problem
Eye changes muscle weakness
Chronic intermittent aspiration lead to lung fibrotic disease. Bloating and diarrhea due to IBD.
arthralgia, morning stiffness, joint swelling, erythema
Raynaunds phenomena in scleroderma.
Palpitations or syncope- cardiac sarcoidosis
Pleuritic chest pain, leg swelling, increasing dyspnea – acute pulmonary embolism
Past Medical History: prior CTD, HIV disease (LIP), history of chronic kidney disease(pulmonary renal syndrome, vasculitis, CTD) and liver problem (sarcoidosis, PBC)
Occupational history includes organic and inorganic exposure.

Chest xray shows abnormal chest radiograph is often the first indication of underlying ILD. It remains normal in Sarcoidosis, CTD, RB - ILD
Distribution of ILD:
Upper zones are involved in Sarcoidosis, silicosis, coal worker pneumoconiosis.
Lower zones involved Connective tissue disease associated asbestosis, DIP
HRCT: more sensitive than chest radiograph.
Lab test: elevated liver enzymes and hypercalcemia in Sarcoidosis, Renal insufficiency is pulmonary renal syndrome, Peripheral eosinophilia present in eoisinophilic pneumonia.
Serologic testing:
Pulmonary function test: most forms of ILD demonstrate restrictive ventilator defect due to decreased compliance and increased recoil of lung parenchyma.
Presence of obd
Bronchoscopy shows
Milky appearance typical of LAM
Surgical lung biopsy when diagnosis is not reached, and condition is not improving specially in parenchymal lung fibrosis.
Treatment Objectives of ILD:
Slow progression
Improve symptoms
Improve quality of life
Early referral
Antifibrotics, Immunosuppression
Rule out associated pulmonary hypertension
Referral for lung transplant
Start palliative care
Approach to rheumatologist, radiologist.
Therapeutic: Pirfenidone first line but have some side effects
Nintedanib is most successful, both should be continued for 6-12 weeks. Use when FVC is 50% and DlCo >15%
If condition worsen, then lung transplant.
Steroids:
Initial management or exacerbation
No significant difference in survival
0.5mg /kg and wait for 1-3 months then taper to 10mg per day

When steroid do not work: MMF and Azathioprine
Cyclophosphamide – fulminant disease
Methotrexate not a risk factor for RA-ILD, pulmonary toxicity is very rare, close monitoring is required
TNF inhibitors have both profibrotic and anti-fibrotic effects
Rituximab better survival compared to TNF inhibitors
Do not forget Co morbidities: GERD, COPD, Pulmonary Hypertension, Prevent osteoporosis, pulmonary rehabilitation, Lung transplan
Prognosis:
Median survival 7 years post diagnosis.
No doubt it is really a vast and time consuming topic Thank you Dr. Syed and Dr. Ash for providing us this platform.

FEEDBACK # 8

Dr Nasir Hayat

This session was wondeful and Amazingly presented.Learned alot .It was runned very smoothly and all the questions were answered.
It was comprehensive yet detailed lecture on ILD , Dr wasib started his presentation with the 5 cases on ILD ,The CT chest finding,and gave us adrenaline rush and got to know about our level of knowledge on ILD and then he descended down to our level and took us to the depth of the topic ….!! It was well explained lecture from sign and symptoms to the management of the patients and different presentations.I would highly recommend it for ER physicians and physicians to join it and get the skillful knowledge and be best doctors.Proud tonbe LGEM candidate

FEEDBACK # 9

Dr Mishal Shan

The lecture by Dr Wasib on Interstitial lung diseases was extremely comprehensive, full of new information, exam related pointers, and clinical pearls. He provided a detailed account of how to take a history and exam in an ILD patient and how to differentiate the condition from other respiratory illnesses. Furthermore, based on radiography and history findings, he also taught how to reach a diagnosis of the particular ILD which I found very interesting. He also gave us the concept of pulmonary rehabilitation which was a completely new practice that I had never heard of in my hospital. Looking forward to more lectures by Dr Wasib!

FEEDBACK # 10

Dr Ghazala Sheikh

I have No enough words to make a thanks to Dr wasib making efforts, sharing his knowledge with us. Each line of this session was informative

Today I learnt

● Interstitial lung disease

● Time course of disease Onset

♤Acute,,

. Cryptogenic organising pneumonia

. Acute eosinophilic pneumonia

. Diffuse alveolar hemorrhage

. Acute exacerbation of idiopathic Pulmonary fibrosis

♤ Subacute to chronic,,

. Connective tissue disease

. Idiopathic Pulmonary fibrosis

. Sarcoidosis

. Chronic hypersensitivity pneumonitis

. Occupational lung disease

. Chronic eosinophilic pneumonia

. Lymphocytic interstitial pneumonia

● Systemic Symptoms of ILD

. Night sweats, fever, fatigue and weight loss

. Wheezing especially with hypersensitivity pneumonitis, eosinophilic pneumonia and sarcoidosis

. Pleuritic chest pain

. Hemoptysis with diffuse alveolar hemorrhage

● Dermatologic Symptoms

. Heliotrope rash

. Detmatomyositis

● GI Symptoms

. Esophageal motility problems_ systemic sclerosis and polymyositis

. Chronic, intermittent aspirations can lead to progressive fibrotic lung disease

. Bloating and diarrhea_ IBD

● Muscuskeletal Symptoms

. CTD_ arthralgias, morning stiffness joint swelling and erythema

. Swollen fingers (sausage digits) _ systemic sclerosis and polymyositis
. Raynauds phenomenon_scelroderma, mixed CTD and SLE
● Ophthalmologic Symptoms
. Dry eyes_ Shogren syndrome
. Uveitis_ SLE and sarcoidosis
● increasing edema, syncopal events, exertional chest discomfort suggest P_HTN
● Palpitations and syncope in a sarcoidosis pateint suggests cardiac sarcoidosis
● pleuritic chest pain, swollen legs and worse SOB suggests PE
● past medical Hx is a must
. HIV disease is associated with lymphocytic interstitial pneumonia
. AKI or CKD suggests underlying vasculitis, Pulmonary renal syndromes and CTD
. Liver disease association with sarcoidosis and PBC
● MUST ask occupational Hx
Either organic or inorganic exposure
○ Inorganic exposure leads to
. Asbestosis, silicosis, berylliosis, coal workers pneumoconiosis,
○ organic exposure leads to bird breeders lung, farmers lung, ventilation pneumonitis, hot tub hypersensitivity pneumonitis
● Medication Hx Such as
. Amiodarone
. Nitrofurantoin
. NSAIDS
. Recent chemotherapy
. Immune modulating drugs
● physical examination which is a important part of PACES
. Velcro crypts_usually absent in sarcoidosis
. Inspiratory squeks_ COP
. Clubbing_IPF, DIP, IBD
. Skin involvement_ sarcoidosis, CTD, vasculitis and tuberous sclerosis
. Arthritis_CTD, sarcoidosis
. Eye changes(uveitis and conjunctivitis)_ sarcoidosis and CTD
. Muscle weakness_poly and detmatomyositis
. Neuropathy_sarcoidosis and CTD
. Lymphadenopathy_ sarcoidosis and CTD

● chest imaging
. 1st sign of ILD on chest Xrays
. Normal in sarcoidosis and CTD
● distribution of ILD
♤ upper zone
. Sarcoidosis
. Silicosis
. Coal workers pneumoconiosis
. Hypersensitivity pneumonitis
. Langerhans cell histiocytosis
. Berylliosis
. Chronic eosinophilic pneumonia
♤ lower zone
. Usual interstitial pneumonia
. Non specific interstitial pneumonia
. CTD associated ILD
. Asbestosis
. Desquamation interstitial pneumonia
● pattern of ILD
. Peripheral reticular
. Ground glass
. Nodular
. Cystic
● HRCT is more specific as compared to Chest X ray
● Laboratory Testing
. Elevated liver enzymes or hypercalcemia_ sarcoidosis
.Renal insufficiency_ Pulmonary renal syndromes
. Peripheral easinophilia_ chronic eosinophilic pneumonia, churg Straus syndrome and drug reaction
● Serological testing is must to check antibodies
● PFTS
● Broncoscopy
● Ebus
● surgical lung biopsy

● Treatment strategies in ILD
● Managment of CTD e ILD
● don't forget Comorbids
● Prognosis
. Median survival is 7 years post Dx

FEEDBACK # 11

Dr Ghulam Saddique

It was an amazing session conducted by Dr Wasib.Session started with 5 cases of ILD
The term diffuse parenchymal lung disease (DPLD) refers to a group of disorders affecting the lung parenchyma that can be categorized into those of known and those of unknown etiology. Early diagnosis is important since some forms of DPLD are characterized by a rapid progression to respiratory failure.
Etiology wise classes.
Etiology known: organic causes
Inorganic
Smoking
Drugs
Connective tissue disease
Etiology not known:idiopathic interstitial pneumonitis
Symptoms: non specific cough , Dyspnea on exertion, progressive symptoms, patients are usually above 60 years old.
Phenotypes
UIP (usual interstitial pattern) (bad prognosis)
minimal GO, basal , subpleural reticulation and honeycombing(HC) with tractional bronchodilation
NSIP pattern
Extensive GO ,basal, subpleural sparing , some tractional bronchodilation, no HC
Organizing Pneumonia (Good prognosis)
focal GO, consolidation ,subpleural and peribronchial, reversed halo sign
Others (LIP or DIP)
GGO, cysts, centrilobular nodules, upper lobe predominant, peribronchovascular septal thickening
CPFE (combined pulmonary Fibrosing Empyysema)
Coexistant Emphysema, 50% of patients with smoking history who have got RA-

ILD

Past Medical and occupational History is very important.

History of connective tissue disease, HIV disease, history of chronic kidney disease and liver problem

Occupational history: organic and inorganic exposure.

Medication history: Nitrofurantoin Amiodarone , NSAID and history of recent chemotherapy

Physical Examination :

• Typical 'velcro' crepts - IPF, crepts frequently absent in sarcoidosis.
• Inspiratory squeaks - COP.
• Clubbing- IPF, DIP, IBD.
• Skin involvement- Sarcoidosis, CTD, Vasculitis, Tuberous sclerosis.
• Arthritis- CTD, sarcoidosis.
• Eye changes (uveitis, conjunctivitis) - , Sarcoidosis, CTD.
• Muscle weakness- Polymyositis, dermatomyositis.
• Neuropathy- Sarcoidosis, CTD.
• Lymphadenopathy- Sarcoidosis, CTD.

Chest Imaging: • Abnormal chest radiograph is often the first indication of underlying ILD.

• Normal in Sarcoidosis, CTD, RB-ILD

Distribution of ILD:

Upper zones are involved in Sarcoidosis, silicosis, coal worker pneumoconiosis

Lower zones are involved in connective tissue disease, Asbestosis, usual interstitial lung pneumonia.

HRCT: more sensitive than other radiograph. Definitive UIP includes honey combing , peripheral sub pleural distribution etc

Lab test: elevated liver enzymes and hypercalcemia in Sarcoidosis, Renal insufficiency is pulmonary renal syndrome, Peripheral eosinophilia present in eoisinophilic pneumonia.

Serologic testing and

Pulmonary function test: most forms of ILD demonstrate restrictive ventilator defect due to dec compliance and inc recoil of lung parenchyma . Presence of obstruction suggest presence of obstructive lung disease or airway centered ILD.

Bronchoscopy : Bal is very useful

• Differential cell count , HP vs sarcoid

• Milky appearanc typical of LAM
(Lymphangioleio Myomatous)
• Sequential BAL for vasculitis like goodpasteur,s syndrome, wegner,s etc
• TBLB for sarcoid
• Cryotherapy for ILD
• Rule out other infection
• BAL eosinophil count may be high in drug related ILD
Surgical lung biopsy where diagnosis is not reached and condition is not improving specially in parenchymal lung fibrosis.
Treatment Objectives : • slow progression
• Improve symptoms
• improve quality of life
• Early referral to tertiarv care centres
• Antifibrotics or immunosuppression
• Oxygen inhalation
• Rule out associated pulmonary hypertension
• Pulmonary rehabilitation
• Treatment of comorbidities particularly Gord
• Referral for lung transplant
• Start of Palliative care if not for lung transplant
• MDT approach -> rheumatologist, radiologist, respiratory
Therapeutic: Pirfenidone first line but have some side effects
Nintedenib is most successful, both should be continued for 6-12 weeks. Use when FVC is 50% and DlCo >15%
If condition worsen then lung transplant: Management of Connective tissues related ILDs
• Steroids >
• Initial management or exacerbations
• Wonderful in OP & NSIP pattern
• In UIP pattern disease improved or stabilised disease in 50%, despite treatment group having worse lung volumes
• No significant different in survival
• Different to IPF
• 0.5 mg/kg, wait for 1-3 months, taper to 10mg per day.
When steroid do not work :MMF and Azathioprine

Cyclophosphamide (fulminant)
Methotrexate:
• Not a risk factor for RA-ILD
• Might be protective from RA-ILD
• Pulmonary toxicity is very rare -since 2001 in RCTs on MTX in RA no cases reported
• Possibly increased of infections
• Close monitoring if started
Do not forget Co morbidities:GERD , COPD , Pulmonary Hypertension, Prevent osteoporosis, pulmonary rehabilitation, Lung transplant
Biologics:
• TNF inhibitors have both profibrotic(worsen ILD) and antifibrotic effects
• Conflicting evidence
• Some studies showed progression of disease others improvement
• IF RA-Ild progressing with them STOP THEM
• Other biologics-
• Improvement or stability of lung functions
1. Rituximab better survival compared to TF inhibitors
2. Todilizumab
3. Abatacept
4. JAK inhibitors -tofacitinib, baricitinib. Don't forget comorbidities
• GERD -> 50%, PPI
• COPD
• Pulmonary Hypertension
• Prevent osteoporosis
• Pulmonary rehab, ambulatory Oxygen, Smoking cessation
• Lung transplant
Prognosis:
Median survival 7 years post diagnosis
I am proud to be a part of LGEM Programme`

8TH JANUARY 2023

EVENT NAME:

First Level 1 EM Ultrasound Workshop In Pakistan For GEM MRCEM Trainees

DOCTORS FEEDBACK

FEEDBACK # 1

Mina Khan

Attended Ultrasound workshop with international standards. What more one can ask for ? If you are getting updated knowledge right in your hometown. This workshop was totally hands on on repeat , learned about EFAST/AAA/fascia iliaca/advanced peng blocks , Identified the US image aquisitions on all four quadrants RUQ/LUQ/subcostal/PLAX/PSAX. It was totally worth attending the workshop . 100% recommended . Can't agree more with my colleages below.....❤️
Thank you London Global Emergency Medicine

FEEDBACK # 2

Syeda Maheen Ejaz

This is a unique kind of workshop so proud to have attended it. Thank you so much Dr Ash for bringing an amazing workshop for us all the way from London Dr Ali, you are an amazing, mind-blowing power pack boss!!
The presentation was very comprehensive learned about EFAST, AAA, vascular access, and fascia iliaca block. The hands-on practice was really helpful in visualising RUQ,LUQ AORTA. Speciality is every candidate practises probe handling visualizing scan him/herself. Thank ful to Dr Mukhtiyar as well for making the event organized and successful🙏

FEEDBACK # 3

Javeria Wali

A ground breaking Emergency Ultrasound Level 1 workshop conducted on 9th January, 2023 in Karachi. Facilitated and lead by Dr. Syed Ali Ahmed alongwith Dr. Ash, it was Brilliantly and effortlessly executed and an absolute treat to attend. Dr. Ali started with a comprehensive presentation with the basic indications and theoretical knowledge about Emergency Ultrasound, Fast Scans, Right and Left Upper Quadrants, different views of Abdominal Aorta uptil its bifurcation, Echo in life support, ultrasound guided IV access, in plane and out plane, PAN block, Fascia iliaca block. Dr. Ash shared extremely interesting cases managed through timely diagnosis with the help of ultrasound. Ample time and opportunity was given to each participant for hands on session with Dr. Ali and Dr. Ash supervising

and correcting techniques to have best possible outcome with least discomfort to patient. Thank you london GEM for providing us this platform and giving us such workshops previously unheard of in Pakistan.

FEEDBACK # 4

Dr Aakash

Amazing Workshop on level one ultrasound .
what we learnt from that was beyond our expectations.
Dr Ali summarized each & every thing . Also gave hands practically,
Dr Mukhtiar arranged each & every thing & made things easier for everyone.
The things that we learnt in the workshop are
👉 E- Fast Scan
👉How to locate the aorta , its dissecting
👉 four chamber view of heart , identifying the motion abnormality ,
👉Ultrasound I/V guided cannulation
👉How to identify free fluid in traumatic patients.?
and much more.
Really proud to be the candidate of Dr Ashfaque.
The power of his dedication towards his candidates is that he has travelled from london to pakistan just to teach his students.❤️❤️❤️

FEEDBACK # 5

Aqsa Yaqoob

An excellent workshop on level 1 EM Ultrasound was conducted in Karachi today. We learnt about the basics of Ultrasound,how to detect free fluid in pericardium, peritoneal cavity, pneumothorax. Ultrasound guided vascular access and much more. Hands on approach gives us so much confidence .Thank you Dr.Ashfaque, Dr.Ali and Dr.Mukhtiar for arranging this wonderful workshop for us.

FEEDBACK # 6

Muzna Ahmed

Fantastic, tremendous full of enthusiasm workshop it was and everyone felt blessed to be a part of it.
Everyone was so enthralled to greet and meet Dr Ash and Dr Syed Ali Ahmed in person.
It was a remarkable knowledge-pack workshop with so many learning gems and hands on practices which give confidence to hold probe and visualize the structures on screen. Through this one day training out mentors made it sure that everyone

gain enough confidence and pick up free fluid in abdomen, heart chambers, liver, spleen, bladder.
Dr Ash has also shared his clinical pearls which are always been very helpful for us and overall the workshop went great and smooth that even we can't realize time I feel so happy and lucky that Dr Ash all the way from London came here to teach us.
Thank you Dr Ash and LGEM

FEEDBACK # 7

Wajahat Khan

Level 1 Emergency Ultrasound Workshop As Per RCEM Guidelines Karachi
Tutor : Dr **Ashfaque Ahmed** and Dr **Syed Ali Ahmed**
Date 9th jan, 2023
Name : Dr Wajahat Khan
M starting my feedback with Alhamdulilah Alhamdulilah Alhamdulilah, we are soo blessed n fortunate enough to be first 30 candidates in whole Pakistan who have done this course, n feelng very honored and proud to b part of this Unique programme, ~London GEM.
1st we have theoretical session by Dr Syed Ali Ahmed, learnt how to scan? How to focus? When to do ultrasound? Importance of ultrasound in EM? Diifrnt types of ultrasound probes and when to use them, how to hold it? How to locate the Abdominal Aorta? What are the views of it, how to identify anerysm and its diffrnt type?
Ultrasound guided IV Access IN PLANE AND OUT PLANE
Importance of Echo in Life Support
How thrombus looks like in Heart and Vessel
FAST AND EFAST SCAN
Nerve Blocks,
Fascia iliac Block
Pan Block
Interesting cases by our mentor, our guide Dr Ash
Then we have hands on session, where every one of us did practice under supervision of Dr Syed Ali Ahmed, what an amazing feeling it was when i first myself identify Right and left kidney, liver, Spleen and at last my fav Abdominal Aorta with its bifurcation, eye catching view it was 😍 Dr Ali was saying to

everyone YES BOSS U CAN DO IT, now i can say, YES SR WE CAN DO NOW ALHAMDULILAH 😇.
I cant thanks enough to our supervisor Dr Ash as well who never failed to surprise us, gave us opportunity to b known by our EM Skills which he is imparting to all of us, i feel very blessd n proud to b part of LGEM 😊
Thanks you soo muuchh Dr Ash, Dr Ali Ahmed, Dr Mukhtiar Pathan and organizers of this session...

FEEDBACK # 8

Dr Afifa Younis Raja

Greetings of the day!!
What an amazing day we had today!!
Level 1 EM Ultrasound workshop!!
Honestly at the start of the workshop I had no clue on how to even hold a probe BUT after the work shop I just want to put a probe on every patient landing in my ER.
Dr Syed Ali and Dr Ash did a marvellous job in tutoring us about such a crucial technique that will immensely benefit us and our patients.
Dr Ali started the session with amazing learning materials on eFAST, ELS, Assessing AAA, ultrasound guided vascular access, fascia iliaca block.
Dr Ash enlightened us with his Pearl's and shared his personal experiences show POCUS helped making the exact diagnosis which were earlier missed and how its absoullety critical for an EM physician to have this knowledge.
The best part was the hands on training where we were able to practice all the discussed views and apply the theoretical knowledge. I hope we keep on practicong and sharpen our skill to benefit our Patients.
A big round of applause for Dr Mukhtiar, Dr Azeem and Dr Khizir for arranging such an amazing event.
Thankyou evercare hospital and team for your collaboration.

FEEDBACK # 9

Dr Azka Shamim

Assalam o alaikum All GEMS .. ✨
These were really blessed five days of our lives alhumdullilah.. after listening about level 1 US and 100 EM workshop in Karachi, we were anxiously waiting for these days to happen in Lahore .. and really after attending this power

pack ,intense session whole dimension is changed .. it's like our practical knowledge has just got the perfect foundation..
I would like to congratulate whole heartedly everyone

🔆for the official partner ship of LGEM with Evercare hospital

🔆achievements of all participants,

🔆 new GEM instructors Masha Allah @Dr Rida Rana @Dr Khizir @Dr Muhammad Azeem Imran @Dr. Yamin Bocha
Many thanks to our gems for coming all the way from Karachi, Maldives, Oman and making this event perfect.. specially @Dr Amir Ashraf ..
Many thanks to all the instructor for their hard work and patience during teaching and training at stations..
And many thanks to our mentor @Sir Ashfaque LCC UK for owning us and giving our lives a purpose ..
thank you so much Dr @ALI for training us during level 1 USG workshop.. it was completely a new experience to learn about POCUS
Bundle of thanks to @Dr M.A. Pathan Dr @Dr Abdul Qaiyoume Amini for teaching us at various stations with patience and dedicated
Thanks to @KB sir for coming all the way to join us and be a part of this ceremony
Thanks to Dr @Haider Ali for Ur efforts in making things work smoothly for us
And at the end I would like thank @Dr Khizir and @Dr Muhammad Azeem Imran for arranging everything amazingly.. looking forward for much more to come insha'Allah

proud GEM💕 trainee

FEEDBACK # 10

Dr Aakash

Amazing Workshop on level one ultrasound .
what we learnt from that was beyond our expectations.
Dr Ali summarized each & every thing . Also gave hands practically,
Dr Mukhtiar arranged each & every thing & made things easier for everyone.
The things that we learnt in the workshop are

👉 E- Fast Scan

👉How to locate the aorta , its dissecting

👉 four chamber view of heart , identifying the motion abnormality ,

👉Ultrasound I/V guided cannulation

👉How to identify free fluid in traumatic patients.?

and much more.

Really proud to be the candidate of Dr Ashfaque.

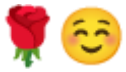
The power of his dedication towards his candidates is that he has travelled from london to pakistan just to teach his students. ❤️❤️❤️

FEEDBACK # 11

Dr Rida Rana

AlhumdulliAAllah enjoyed the exclusive perk of being an LGEM candidate . Yes it was first Emergency Medicince Ultrasound Course Level 1 which was conducted by Dr Ashfaque Ahmed and Dr Syed Ali Ahmed who travelled all the way from UK , to impart us with skills of Ultrasonography relevant to the Emergency Department. It was entirely a phenomenal session which included firstly a theoretical session regarding the types of scans , how to locate the imaging , what to focus on in US image as an EM physician and their relevant clinical significance was highlight by the numerous cases shared by Dr Ashfaque . Then hands on session was held , where each and everu candidate was taught and did practical simulation of Ultrasound with curvilinear probe on the volunteers (under the direct of supervision of Dr Ashfaque and Dr Ali) . It was in deed such an interactive session that such an 8 session seemed to pass by in no time . None of the candidate was exhausted and the best part was that the session was taught with the stress upon what was to be taken as a home take message . The workshop literally boosted up the confidence of each candidate as it was conducted in the most easy to learn patter. Fast Scan , locating the aorta , it dissecting , 4 chamber view of heart , identifying the motion abnormality , pan block , u/s guided cannulation (in plane and out of plane views) and alot more . I feel truely blessed of being able to be. part of this workshop .The concern of the supervisor for the candidates academic course and portfolio is a unique aspect of LGEM . The candidates are

given the flavour of each speciality knowledge relevant to the EM .

AlhumdulliAAllah on being part of LGEM 

8th JANUARY 2023

EVENT NAME:

Hypertensive Emergencies By Dr Nahal Raza Cardiology Registrar NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Sidra Asad

It was an amazing lecture which was well organized and well structured. The slides covered all aspects of this topic which is highly important for exam purpose. In this presentation, we were taught causes of HTN, stages, complications, investigations and updated NICE guidelines for management. Moreover, stages of HTN were beautifully explained and differenf scenerios were discussed at the end of the discussion which were precised and relevant. Choice of antihypertensives, NICE stepwise management, causes of secondary HTN, how to differentiate between HTN crises and emergency were all extensively taught, and end organ damage pointers were also taught. There were some useful points in this ppt, which i was never clear about; when and where to admit the patient, in patient care and follow up criteria.

This course is excellent. Thanks

FEEDBACK # 2

Javeria Wali

Interesting session conducted on 8th January, 2023 by Dr.Nahal on hypertensive emergencies in ED. It was a great session which covered the whole topic comprehensively. Definition of Hypertensive crises, urgency and emergency were discussed with Need of admission and initial goals of lowering B.P, Investigations to rule out organ damage, NICE guidelines of management of HTN, Choice of Antihypertensive drugs. Secondary causes of HTN, Hypertension in ACS, Aortic

dissection, HTN in Pregnancy and drugs of choice in all these. Overall a good lecture with good grip on all relevant topics

FEEDBACK # 3

Mohid Kanan

Interactive and informative session by Dr. Nahal as usual. Learned alot from this session.it was up to date information and guidelines.

Topic included :

Blood pressure stages:

Low BP, normal BP, pre-hypertension,HTN stage 1, HTN stage 2 and high BP crisis.

What to do next?

Clinic BP is b/w 140/90 and 180/120- offer ABPM to confirm HTN dx.

If ABPM is unsuitable then offer HBPM

If 180/120 or above on first visit - start meds and examine

Complications of HTN:

End organ damage- stroke,hemorrhage, LHV,CHF, CHD, PVD, RF,proteinuria, retinopathy

Examine in a patient with HTN:

Urine Dip, blood test, rft ,hba1c, fundoscopy, 12 lead ECG

ECG features with BP

Nice guidlines : HTN in adults (Dx and Tx)

Nice guidlines :Choice of Antihypertensive drugs: age ,with diabetes and ethnic with monitoring treatment and BP targets

<55 yrs - A

> 55 yrs or black African or Caribbean family - C

Then A+C

Then add A+C+D

For resistant HTN- A+C+D+ consider further diuretic or Alpha or BB

HTN stages recommendations as per BP readings

Ways to lower BP

HTN drug S/E table

CAUSES OF SECONDARY HTN

C: Conn's syndrome, Cushing's syndrome,

Congenital Adrenal Hyperplasia.

H : Hyperparathyroidism, Hyperthyroidism

A : Aortic coarctation, Adrenal carcinoma
R: Renovascular hypertension, Reninoma, Renal parenchymal disease
P: Pheochromocytoma
L: Liddle's syndrome, Licorice
E: Estrogen pills (oral contraceptive pill)
S: Sleep Apnea
HTN crisis - include HTN urgency and Emergency
Hypertensive emergency is a condition in which there is elevation of both systolic and diastolic blood pressure with the presence of acute target organ disease.
Hypertensive urgency is a condition where the blood pressure is elevated (diastolic > 120 mmHg) with the absence of acute target organ disease.
HOW TO CHECK FOR ORGAN DAMAGE IN HYPERTENSIVE EMERGENCY?
*Changes in mental status, such as confusion
*Stroke
*Chest pain (unstable angina)
* Pulmonary edema
*Myocardial infarction
*Aneurysm (aortic dissection)
*Eclampsia (occurs during pregnancy)
CAUSES OF HTN CRISIS
Known underlying cause of hypertension
Essential hypertension
Chronic renal failure with no evidence of underlying renal disease
Pyelonephritis
Glomerulonephritisa
Renal artery stenosis
Primary aldosteronism
Pheochromocytoma
Renal cell carcinoma
Polycystic kidney disease
Polyarteritis nodosa and systemic lupus erythematosusa
Progressive systemic sclerosis
Primary hyperparathyroidism
Prognosis of Malignant HTN

Clinical assessment of crisis
HTN urgency Tx:
Goal:reduce BP to < 160/100 over several hours to days
Elderly at high risk of ischemia from rapid reduction of BP, therefore slower reduction
Previously treated HTN- inc. dose or add drugs
HTN emergency: need admission
Goal: lower diastolic to approx. 100-105 over 2-6 hrs , max. Initial fall not to exceed 25%
May lead to ischemic stroke, MI, AKI
Parenteral meds recommended -GTN,Nitroprusside, labetalol, nicardipine.
HTN emergency in ACS
BP target: pain control and analgesia can influence BP- IV GTN is first line/ IV BB(esmolol)
HTN em. Aortic dissection:
Aim 100-120 systole within 30in
Firs tline IV labetalol/ esmolol them Nitroprusside or GTN or opioid analgesics
HTN in pregnancy:
Pre eclampsia:Mg(seizure prevention), labetalol, hydralazine,methyldopa
Target BP: 130-150/80-100
Pheochromocytoma crisis:
IV phentolamine - blocker of choice
or IV phenoxybenzamine
Vol. Expand/rehydrate
Cocain induced HTN:
Benzodiazepines (diazepam) TOC. Or consider phentolamine/nitroprusside,GTN
Take home messages :
25% reduction in diastolic BP over 2-6 hours for HTN em.
Start oral antihypertensive and follow up closely
Differentiate urgency from emergency on basis of acute end organ damage.
It was wonderful session overall.
Thank you Dr. Ash and Dr. Nahal.

FEEDBACK # 4

Ayesha Mushtaq

It was a nice and informative session regarding Htn.. difference between hypertensive urgency and emergency was clearly addressed..primary and secondary hypertension causes and management were addressed.. hypertensive emergencies were explained.. overall a good session but I request to add more slides regarding Emergency managements so that it can help Mrcem candidates...

FEEDBACK # 5

Shehzad Hussain

It was amazing session by Dr Nahal, She have delivered huge practical knowledge of hypertension.
Hypertension classification Bp figures explained very well management of Hypertension class wise explained, Hypertensive urgency and hypertensive emergency was explained well. Treatment as per NICE guidelines all explained stepwise. Complication n end organ damage investigation were explained in detail. We encounter in ER multiple patients with hypertension since this lecture my vision to treat hypertension is cleared. Thanks Dr Nahal for this wonderful session.
Thanks to Dr Ibrahim for good case presentation.
Thanks to Dr Ash n LGEM team for arranging this wonderful lecture.

FEEDBACK # 6

Bushra Imran

In today's session I learnt definition of hypertension,how to know,its complication,management ,HTN crisis and investigation.Also discussed Secondary HTN,causes,clinic assessment, diagnostic criteria although the session was interesting with questions &answers interactions.The informatively explained HTN urgency ,treatment ,ACS with HTN Emergency, HTN in pregnancy ,Aortic dissection...the overall session provided comprehensive lesson for us
Thank you Dr Nahal.and Dr Ash
In the end the cases presented by Dr Ibrahim was excellent

FEEDBACK # 7

Farheen Naseem

This session was an other treasure box of knowledge which nicely briefly concisely deliverd by Dr nehal raza she is one of the best teacher of lgem program in this session she taught more foxed and give us brief knowledge about hypertensive emergencies
Treatment plan according to age as per NICE guideline
Complication of HTN and organ damage risks

LABS roles in Htn
Importants of fundscopy for Htn retinopathy
Treatment plan
Life style modificatio
Salt restriction smoking cessation
Role of daily exercise in Htn pt
BP monitoring
Lot of more everything was nicely delivered by Dr nehal raza thanx to u and our mentor @Dr Ashfaq Sorathia he always support us jazakAllah khair

FEEDBACK # 8

Hk Danish

An amazing lecture by Dr Nahal Raza . A very serious disease with very serious complications HTN is very common
This session revised all the investigations management and treatment options of HTN in different age groups and stages of the patients . I am now able to deal with HTN according to NICE guidelines .
I learned a lot in this session like :
λComplications of Hypertension : End organ damage in various systems
λA few things to do when presented with hypertension , Blood testes ACR , RFTS , HbA1C , fundoscopy to see retinopathy , 12 leads ECG to see changes related to HTN
λDifference between BP management according to the age of patient
λBlood pressure targets , according to NICE guide lines
λIn older patients and diabetics always consider postural hypo-tension by checking BP on lying and standing
λStages of hypertension .
λTreatment options according to stage of hypertension
λMajor adverse effects of anti hypertensive
λCauses of secondary hypertension
λHypertension Crisis : Umbrella term for hypertensive urgency and emergency or malignant hypertension
λHow to check end organ damage in case of hypertension
λCauses of hypertension crisis
λPrognosis of malignant hypertension

λHow to clinically assess a patient with hypertension .
λHypertensive urgency treatment : Goal = reduce BP <160/100 over several hours to days , Rapid reduction of BP can cause ischemia
λHypertensive emergency treatment : Admit straight away , more aggressive decrease in Bp .
λHypertensive emergency + ACS . In this case stick to general rule
λhypertensive emergency + aortic dissection I/V Labetolol / esmolol is first line treatment
λSevere HTN in pregnancy : treatment option Magnesium
λPhaeochromocytoma crisis treatment
λCocaine induced hypertension : Diazepam
Thanks DR Ash , Dr Nahal Raza and Lgem team for this amazing learning opportunity

FEEDBACK # 9

Dr Leela Ram

Very much informative session by Dr. Nahal, she explained everything very well from definition ie; BP> 120-139/80-89 is Hypertension;
Stage-1: BP: 140-159/90-99mmHg
Stage-2: 160 or higher/100 or higher
HTN crisis: Higher than 180/higher than 110
Complications: Stroke, hemorrhage, LVH, Coronary heart disease, Congestive heart failure, Retinopathy, proteinuria, Renal failure, peripheral vascular disease
End organ damage in HTN include Cardiovascular damage, heart disease, Nephropathy, Vasculopathy.
Investigation: Blood tests: ACR, Renal function tests, HbA1C
Fundoscopy: look for hypertensive retinopathy
12 lead ECG: look for changes associated with HTN
Choice of anti hypertensive drugs include ACEI/ARB, Thiazide diuretic/Calcium channel blockers
Causes of 2• HTN: Conn's syndrome, Cushing syndrome, Aortic Coarctation, hyperthyroidism, Phaeochromocytoma
Hypertensive crisis:
HTN Urgency: BP spikes with no organ damage and can lower safely within few hours with BP drugs

HTN Emergency: BP is so high that organ damage can occur & must be reduced immediately to prevent imminent organ damage.
Organ damage is checked as changes in mental status such as confusion, Stroke, chest pain (UA), Pulmonary edema, MI, Eclampsia (during pregnancy)
Management: 1.First key decision to admit to HDU or CCU for IV anti hypertensive treatment to lower BP over the next few minutes to hours
2. Admit the patient for oral anti hypertensive treatment ensure the patient will be regularly monitored and aiming to lower BP over 24 hours
3. Advise oral anti hypertensive drugs & allow patient home with appropriate follow-up.
Ways to lower BP: Check BP, eat healthy food, limit salt, take blood pressure medicine, be physically active, maintain a healthy weight, manage stress.
Don't smoke, Do not drink alcohol, do not use drugs.
It will significantly improve our practice on daily basis while measuring blood pressure & detailed history for causes & management plan as per each case.
Thank so much Dr. Nahal Raza for great session & thank you so much Dr. Ash for such great LGEM learning platform.

FEEDBACK # 10

Dr Mubashir Hussain

What a good presentation by Nehal raza .well explained primary and secondary hypertension . Hypertension types on the base of its elevating values . hypertension urgency emergency .
She thoroughly explained it's management with various drugs choice .
At the end of lecture Muhammad Ibrahim demonstrate a case in ER a hypertension crises . Thanks to London gem and Dr ashfaq for increasing our exposure to more and standard knowledge

FEEDBACK # 11

Dr Ghayoor Khan

A very important and interactive session on hypertensive emergencies by Dr. Nehal.
It started from definition, complications of HTN and their management.
We learned NICE guidelines to follow while treating HTN,Secondary HTN, Pheochromocytoma, hypertensive emergency & urgency.

We got to know the treatment recommendations of HTN in ACS, Pregnancy, Eclampsia, and cocaine induced HTN.
Case presentation by Dr.Ibrahim on hypertension was brilliant.
Thanks
Dr. Nahal And LGEM

FEEDBACK # 12

Dr Aiman Nazir

It was a wonderful session on such a common and important topic conducted by Dr Raza.
Explaining in detail about hypertension , how to label someone as hypertensive and steps to follow after that.
Starting with the classifying Hypertension into stages , when to advise ABPM or HBPM, further examinations (like urine dip, fundoscopy,blood tests, 12 lead ECG) for diagnosis , explaining in detail about the test results , ECG changes in HTN, complications . Simply explained about the Hypertensive Urgency and Hypertinsive Emergency, difference between the two and how to act in both of the situations.
Next comes the management which was so beautifully explained according to the updated NICE guidelines arranged in charts and flow diagrams which made it quite simple and easy to learn. starting it with Lifestyle modifications and the cutoff value where medications should be considered like any target organ damage , any cardiovascular disease, renal disease, DM , QRISK >10% , patients with age >80years with SBP>150mmhg.
Secondary hypertension was also discussed along with the causes and management. Not to miss out HTN in pregnancy(pre eclampsia) and its management was really important .All the medications were discussed in detail along with its side effects .Dr Raza did a wonderful job by keeping it concise and interactive which has proven to be very beneficial for us . Thank you so much for conducting an amazing session .
I Would like to learn more from Dr Raza in future.

FEEDBACK # 13

Dr Faiq uz Zaman Khan

Almost everyone who works in the ER has come across a patient with HTN. And Dr Nahal's lecture gave us a simple way to manage such patients.

This lecture was a great source of revision of the topics we have studied and Dr Nahal emphasized on high yield exam pointers while guiding us on ways to improve our general practice .
Although network issues did disturb the momentum of the lecture but she explained the topic brilliantly as always .
Thank u LGEM for the opportunity.

FEEDBACK # 14

Dr Mishal Shan

The 1.5h lecture by Dr Nahal was extremely engaging and well delivered. I genuinely enjoyed each and every bit of it and loved how patiently she answered so many questions till the very end. We were taught about the NICE-recommended approach to hypertension along with the management of hypertensive urgency and emergency. We were also taught the preferred drugs in various clinical scenarios, which will prove very helpful in routine practice.

FEEDBACK # 15

Dr Rehan Khalil

Attended this amazing session by Dr Nahal. The best thing about it was that it was very interactive.
Some of the following points discussed are mentioned below:
1- What is high BP?
2- NICE Guidelines and AHA Guidelines on HTN Stages.
3- When to start medication?
4- When to manage only with Lifestyle Modifications?
5- When to to give which drug?
6- What is Hypertensive crisis, Hypertensive Emergency andHypertensive Urgency?
7- How to find out End Organ Damage?
8- Drugs in Cocaine I duced Hypertension.
9- Medicine for Pheocromocytome Hypertension.
10- Lowering BP in Aortic Disection and Hypertension.
11- Hypertension management in ACS.
At the end there was a case presentation by Dr Ibrahim.
This lecture refreshed my knowledge of HTN management and clarified confusion abouy Hypertensive Urgency andEmergency.
Thanks Dr Nahal for being interactive through out the session.

FEEDBACK # 16

Qaisar Shah

Dr. Nahal Raza gave an informative lecture on hypertension (HTN), a common and serious disease with serious complications. The session covered investigations, management, and treatment options for HTN in different age groups and stages of the patients. The speaker discussed the complications of HTN, including end organ damage in various systems, and explained how to assess end organ damage in patients with HTN. She also covered the difference in blood pressure (BP) management according to the age of the patient and provided guidelines for BP targets according to the (NICE). In older patients and diabetics, she emphasized the importance of considering postural hypotension by checking BP when lying and standing. She discussed the stages of HTN and treatment options according to the stage of the disease. The speaker also outlined the major adverse effects of antihypertensive medications and the causes of secondary hypertension. The speaker covered the concept of a hypertension crisis, which is an umbrella term for hypertensive urgency and emergency or malignant hypertension. She discussed the treatment options for hypertensive urgency, which involve a gradual reduction in BP, and for hypertensive emergency, which requires more aggressive BP reduction. She also provided treatment recommendations for hypertension in combination with other conditions, such as ACS and aortic dissection. In pregnancy, she discussed the use of magnesium in Eclempcia with Labetolol,Hydralazine,Methyl dopa , and cocaine-induced hypertension 1st line drug is diazapam.

Overall, the session provided a comprehensive overview of HTN and its management.

Thanks Dr Nahal for this amazing session.

FEEDBACK # 17

Dr Saad

Today's session was based hypertensive emergency. Dr Nahal comprehensively discussed the topic of hypertension. In the session following points were discussed:

>What is hypertension?

>Cutoff value of hypertension

>Diagnosis of hypertension

>ECG manifestations of hypertension

>Difference between hypertensive urgency and emergency

>Complications of hypertension
>How to look for hypertension?
>Stepwise management of hypertension
The topic was discussed quite interestingly.
At the end Dr Ibrahim presented the case.
Thanks Dr Ash and London GEM for such valuable Session.

FEEDBACK # 18

Dr HK Danish

An amazing lecture by Dr Nahal Raza . A very serious disease with very serious complications HTN is very common
This session revised all the investigations management and treatment options of HTN in different age groups and stages of the patients . I am now able to deal with HTN according to NICE guidelines .
I learned a lot in this session like :
l Complications of Hypertension : End organ damage in various systems
l A few things to do when presented with hypertension , Blood testes ACR , RFTS , HbA1C , fundoscopy to see retinopathy , 12 leads ECG to see changes related to HTN
l Difference between BP management according to the age of patient
l Blood pressure targets , according to NICE guide lines
l In older patients and diabetics always consider postural hypo-tension by checking BP on lying and standing
l Stages of hypertension .
l Treatment options according to stage of hypertension
l Major adverse effects of anti hypertensive
l Causes of secondary hypertension
l Hypertension Crisis : Umbrella term for hypertensive urgency and emergency or malignant hypertension
l How to check end organ damage in case of hypertension
l Causes of hypertension crisis
l Prognosis of malignant hypertension
l How to clinically assess a patient with hypertension .
l Hypertensive urgency treatment : Goal = reduce BP <160/100 over several hours to days , Rapid reduction of BP can cause ischemia

l Hypertensive emergency treatment : Admit straight away , more aggressive decrease in Bp .
l Hypertensive emergency + ACS . In this case stick to general rule
l hypertensive emergency + aortic dissection I/V Labetolol / esmolol is first line treatment
l Severe HTN in pregnancy : treatment option Magnesium
l Phaeochromocytoma crisis treatment
l Cocaine induced hypertension : Diazepam
Thanks DR Ash , Dr Nahal Raza and Lgem team for this amazing learning opportunity

10TH JANUARY 2023

EVENT NAME:

2nd LEVEL 1 EM Ultrasound course at Ever Care Hospital Lahore

DOCTORS FEEDBACK

FEEDBACK # 1

Imtiaz Ali Shah

Today I attended the first ever level 1 ultrasound work shop conducted by london Gem at Evercare hospital lahore.It was an amazing session and a wonderful appertunity for learning. The session was carried out by Dr Ash and dr syed Ali Ahmed.
In todays session we we had hands on practice of e FAST scan,scan of abdominal aorta and aneurysm,echo, lung scan.we also had hands on training of US guided vascular access ,Fascia iliac block etc.
It was a great session with full of new learning points and after today's session we realized the importance of US in Ed.It was a treat to see the US skills of dr Ash and dr Ali and the way they shared their knowledge and skills was amazing
Thanks alot dr Ash and dr Ali for such a wonderful teaching session and also to London GEM for providing this wonderful platform of learning.

FEEDBACK # 2

Rabiyyah Bashir

Speechless... Simply the best workshop i have ever attended, lead by the best mentors... ❤️❤️❤️
From free fluid to pneumothorax, vascular access to nerve blocks everything was phenomenal. 💕💕💕
It's rare to arrange separate hands on time under supervision for every participant. Commendable!
And the best part was to meet our mentors in person.. Dr **Ashfaque Ahmed** Sir ❤️ , Dr Ali Sir ❤️, Dr **Mukhtiar Pathan** Sir ❤️ Dr **Imran Farooka** Sir ❤️...
A big thanx for the hospitality Dr Khizir and Dr Azeem Sir ❤️.
❤️❤️❤️
Thanku **London Global Emergency Medicine**

FEEDBACK # 3

Saba Aslam Khan

Today we had Level-1 Ultrasound Training at evercare hospital Lahore, Under the kind supervision of Dr @Dr ALI and @Dr Ash…
Everything was well organised and properly timed …. We learned about E-FAST, POCUS, Abdominal Artery aneurysm, IV Assess and Usg Guideed IV guided Canulation and nerves block …
We had extensive handson practice and learned alot of new things .. Dr Ali and Dr Ash Taught us each and every detail and gave us many learning pearls …. ✨
Thank You so much for this much needed workshop…. We learned alot…
Dr Saba Aslam,
A proud GEM trainee ✨🌻

FEEDBACK # 4

Muhammad Abubakar

At last we was able to attend such EM related USG workshop in Pakistan which will enable us to timely diagnose and manage the patient in ER. It was well organised by LGEM & Evercare Hospital teams. Hands on practice done.
Today's we learnt about
Fast scan, about which we just familiarized with the name and it's purpose. Today, we learnt how to handle the probe, positioning, landmarks, what to see and how to see.
We learnt about Abdominal Aorta and it's complications like thrombus, aneurysm and it's types, Pneumothorax Ultrasound, Echocardiography windows, USG guided

Vascular access via In Plane and Out Plane approach & Nerve Block especially Facia ilaca block.
It was such a wonderful experience and lot of learning which will leave a huge impact in our management onwards. I want to thank our mentor Dr. Ash for all the things he is doing for us and ultimately for the mankind by his work in acute medicine. Thank you all the facilitators for the wonderful job. Thankyou LGEM. Proud to be a part of LGEM.

FEEDBACK # 5

Syed Suhail Ahmad

End of an exciting and impressive day, where we had the honor of being blessed and trained on LEVEL 1 EM ULTRASOUMD by the experienced LGEM instructors Dr. Ash & Dr. Ali and equally facilitated by Dr. Mukhtiar, Dr. Azeem, and Dr. Khizar.
Workshop started with Dr. Ali's presentation covering
- Goals regarding USG of LGEM
- eFAST indications, procedure and contraindications
- ELS and its importance
- AAA & Vascular Ultrasound
- Vascular Access
- Different EM USG views and their importance

It was followed by an extensive hands-on workshop where every candidate was given the opportunity to reproduce the skills taught by the instructors
- USG probe, its types and handling
- Usage of probe in different views
- eFAST scan to visualize free fluid in the abdomen/pelvis
- Visualisation of the bladder
- Visualisation of the Abdomial Aorta and its bifurcation
- Lung sliding in the pneumothorax
- Echo views (Parasternal/Short/Long axis)
- USG guiden vascular access
- Fascia Iliaca compartment block

Thank you LGEM, PEMA, EVERCARE hospital and also the volunteers, for making this all happen and providing this amazing opportunity. 👍👍👍👏👏👏

FEEDBACK # 6

Qaisar Shah

Today, on the 11th of January 2023, a Level-1 Ultrasound workshop was held at the Evercare hospital in Lahore. The workshop was led by two experienced trainers, Dr. Ali Ahmed and Dr. Ashfaque Sorathia (EM Consultant NHS UK) who were assisted by Dr.Mukhtiar Pathan,Dr. Azeem Imran and Dr. Ubaid-ur-Rehman-khizir.

The workshop was well-organized and timed efficiently. The attendees had the opportunity to learn about a variety of ultrasound techniques, including E-FAST (Extended Focused Assessment with Sonography for Trauma), POCUS (Point of Care Ultrasound), abdominal artery aneurysm, IV assessment, and USG-guided IV cannulation and nerve blocks. The trainers provided in-depth explanations of each topic, including the indication, techniques, and precautions of ultrasound.

The attendees also had the opportunity to gain hands-on experience through extensive practice sessions, which helped them to better understand and apply the techniques they had learned. The trainers also shared useful tips.

Participants was able to benefit a lot from the workshop, thank to the trainers Dr. Ali Ahmed and Dr. Ashfaque Sorathia for their valuable guidance and the facilitators Dr.Mukhtiar Pathan,Dr. Azeem Imran and Dr. Ubaid-ur-Rehman-khizir for their support.

At last the shields and certificates were distributed.

Overall, the Level-1 Ultrasound workshop was a valuable learning experience for the attendees. It provided them with knowledge and practical skills that will aid them in their professional development.

Kind regards

FEEDBACK # 7

Zegham Abbas

Today we attended well-organized workshop.The attendees had the opportunity to learn about a variety of ultrasound techniques, including

E-FAST (Extended Focused Assessment with Sonography for Trauma)

POCUS (Point of Care Ultrasound)

AAA

IV assessment

USG-guided nerve blocks

Echocardiography

Pneumothorax on Ultrasound

The trainers provided in-depth explanations of each topic, including the indication, techniques, and precautions of ultrasound.
Dr. Ali Ahmed and Dr. Ashfaque Sorathia for their valuable guidance and the facilitators Dr.Mukhtiar Pathan,Dr. Azeem Imran and Dr. Ubaid-ur-Rehman-khizir for their support.Level-1 Ultrasound workshop was a valuable learning experience for the trainees. It provided them with knowledge and practical skills that will help in managing patient in ER.

FEEDBACK # 8

Beenish Manzoor

Finally after a long long wait with the grace of Almighty Allah I met Dr Asfaque.it was just like dream came true meeting and direct interaction with Mentor .He is such a humble and down to earth person who is always ready to answer all queries and teach us.
This was the first ever EM Ultrasound workshop held in Pakistan and Alhumdulilah we are the 30 luckiest Doctors to get this opportunity and it was all possible due to dying hard efforts of Dr Ash and Dr Ali Ahmed Dr M Pathan
This workshop opened new eras of learnings and it just open new pathways for us and to think critically that how with just lil learning we can save patient life.
Insha'Allah after this level 1 ultrasound workshop LGEM CANDIDATES after learning these basics about USG will able to diagnose and relieve pain of patient with just USG guided blocks isn't it amazing that in just few moments following simple steps helps you to relieve pain via nerve blocks.after today's session all of us would be able to reduce mortality rate of sick patients in EM
All teachings of today's workshop was according to RCEM GUIDELINES and most important thing of this workshop Hands on skills , it cleared our concepts and boosted our confidence as Dr Ash And Ali put their 200% in teaching us the basics of USG from how to hold probe, position,fanning and sliding and how to give little compression where not to give compression and basic diagnosis
Some if important learning points are:
*Prob orientation and handling
•EFAST SCAN visualization of Morrison pouch for free fluid
*Abdominal Aorta it's bifurcation seagull sign how to see whole length of Aorta
*AAA its leaking
Sacullar Aneurysm
*Penumothorax on USG

Plural effuison pericardial effusion
Retrovasical fluid
•Echo
1.subxiphoid
2.long view
3.short view
4.parasternal
5.axis view
•US Guided Vascular acess' central/ peripheral
• IVC assessment in plane and out plane
•How thrombus looks like in Heart and Vessel
•Nerve Blocks
*Fascia iliac Block
*Cardic temponad
I truly feel really blessed to be part of this LGEM project Alhamdullilah and I can't thank enough to my Mentor Dr Ashfaque and Dr Ali for their ample hardwork ,last but not least special thanks to our colleagues Dr khizar and Respected Dr Azeem for arranging and making this journey possible.i am thankful to them for taking care of every single and small thing like arranging transport ,accomodation ,lunch , refreshment .Thankyou for making us feel like we are LGEM family🙏🙏
Thankyou Dr M Pathan it was really nice meeting you👍

FEEDBACK # 9

Rana Gulraiz

Mashallah started the most awaited workshop.
This workshop opened new horizon of learning .It opened our eyes how advanced level of pts management is being done in first world countries and Insha'Allah LGEM CANDIDATES after learning these competencies will able to alleviate the pain and prompt diagnosis. They would be able to lessen mortality rate of sick and pts ln emergency.
All teachings of today's workshop was according to RCEM GUIDELINES and most important thing of this workshop Hands on , it cleared our concepts and boosted our confidence.
We learnt :
• Prob orientation and handling

• FAST SCAN visualization of Morrison pouch.
• Abdominal Aorta it's bifurcation seagull sign how to see whole length of Aorta
• Penumothorax on USG
• Echo subxiphoid/long and short parasternal axis view
• Bladder visualizion
•US Guided Vascular acess' central/ peripheral
• IVC assessment IN PLANE AND OUT PLANE
•How thrombus looks like in Heart and Vessel
•Nerve Blocks, Fascia iliac Block
. Cat face (Aorta , SMA and Right hepatic artey)
I feel really blessed to be part of this unique LGEM project and it's really breaking the barrier.
I can't thank enough to my Mentor Dr Ashfaque and Dr Ali for all this. And thanku to all organizers of this workshop Dr Mukhtiar , Dr khizir , Dr Azeem
❤️❤️

FEEDBACK # 10

Azka Farhan

Attended first ever level 1 USG workshop at **Evercare Hospital Lahore** as per RCEM guidelines by UK faculty... It was a wonderful experience.. we had extensive hands-on practice and learnt alot ... Starting from machine specifications, probe placement,probe handling till eFAST, ELS(echo in life support) , AAA, Fascia iliaca compartment block, USG guided IV cannulation .. it was just amazing.. couldn't believe to gain this much knowledge at this stage ..
Thank you so much Dr **Ashfaque Ahmed** for this amazing opportunity

FEEDBACK # 11

Ahmad Bin Khalid

Alhamdolilah attended first emergency ultrasound workshop hands on practice done by **Ashfaque Ahmed** mentor and Dr Syed Ali such a polite and gentle man I've ever met.
Learnt alot of skills from probe handling to AAA, ECHO ,FASCIA ILIACA COMPARTMENT BLOCK, up to free fluid detection in abdominal cavities.
Thank you so much **London Global Emergency Medicine** for such a wonderful opportunity.

FEEDBACK # 12

Dr Mariam Nawaz

Wow what a workshop on USG. It was an honor to learn USG hands on from Dr Ash and Dr Ali. What a productive day it was. And the best thing of today was that I got to meet Dr Ash my mentor, and he is such a humble person.
We started off with presentations of the USG we were to learn by Dr Ali followed by USG practice taught by Dr Ash and Dr Ali
We got to learn so much today, like:
EFAST
ELS
AAA
Intravenous access
Different probe positions
How to use the probe
Various settings on the Y
USG
And so much more
Thankyou so much Dr Ali and Dr Ash, waiting eagerly for tomorrow's workshop

FEEDBACK # 13

Hk Danish

I had an amazing experience today at the emergency medicine level 1 ultrasound workshop at Ever care hospital Lahore. I was able to learn a variety of ultrasound skills such as EFAST, emergency echo, ultrasound-guided canulation and ultrasound-guided nerve block. The practical sessions were very hands-on and I was able to apply the knowledge in a simulation setting. The mentors Dr. Ash and Dr. Ali as always were extremely kind and patient. They provided helpful feedback and guidance throughout the entire session. Their teaching style was very engaging and they made the learning experience enjoyable. I would highly recommend this event to others looking to expand their ultrasound skills. Overall, I feel much more confident and prepared in my abilities to perform ultrasound.

FEEDBACK # 14

Sana Hameed

With the hard work of sir Ash and his team we the GEM trainees got to attend this ultrasound training held at Evercare hospital Lahore.
Ultrasound is such an important component of every A&E department of a hospital which I didn’t realise until I Attandant the workshop.

Starting from the EFAST scans and it's location to a AAA localisation and it's identification to passing an IV line with the help of a ultrasound who knew could not only help to diagnose and relieve pains of patient but also save so many lives which we have not even thought. I hope to make Sir Ash proud one day and atleast show him that what efforts he is doing for us and for Pakistan will not go in vain.

FEEDBACK # 15

نـا صر ف اطمہ

Event started off with words of our Dear mentor Dr Ash.. What a blessing of day to have him among us.. His presence always brings pleasure either its through online medium or live like today.. His passion is.. what is behind this big day... Passion of Dr syed Ali Ahmed too.. he was soooooo keen to teach us.. he delivered theoratical part so well.. He taught us so many modalities.. all with probe location.. with videos of normal anatomy and pathological videos too.. he kept it so interactive and full of knowledge booster.. he was open to any question.. this team is GEM itself.. Dr Mukhtiar was so sooo fascilitating throughout the event..
Then coming to hands on part.. they divided us in 2 groups.. first we were taught by Dr Syed Ali Ahmed.. and he literally stayed there until the last person was done with hands on session.
Dr Ash and Dr Syed Ali Ahmed taught us
•Fast Scan
•Transverse views of upper, middle and lower Aorta.. middle longitudinal view.. all to look for AAA
•Short Echo
•Bladder Visualization
•US Guided vascular access (central and peripheral)
It was just an amazing and comprehensive workshop.. so blessed to be a part of this programme.. literally words can't justify the efforts they are putting in..may ALLAH PAK g bless u all in both worlds..
Especial thanks To Dr Muhammad Azeem, Dr Ubaid ur Rehman Khizr, Dr Rida
And many thanks to Evercare team.. for being a part of organization.
Kind Regards,

FEEDBACK # 16

Rana Gulraiz

Alhamdulilah no doubt one the best session ever. 👍🏻👍🏻

FEEDBACK # 17

Muhammad Abubakar

A 30 year old male came with the trauma on the trunk and abdomen. He needed a fast scan to rule in any internal injury. Otherwise, the surgical team refused to admit the patient. It was 1am after midnight. Usually, we refer these patients because of the unavailability of the USG at that time, but last night I decided to do a Fast scan. I requested Gynae department to lend me their USG machine to do a quick scan in Emergency and they agreed. الحمد لله done my first Fast Scan. There was no free fluid in the peritoneal, pleural and pericardial cavity was found. However, patient was symptomatic, so got surgical team on board and admitted the patient for further workup. Thank You Dr. **Syed Ali Ahmed** and Dr. **Ashfaque Ahmed** to able us to do these procedures and with this I was able to save patient's money and all the hassle to go to lahore in the middle of the night. Thank you **London Global Emergency Medicine** & PEMA UK

Proud Member of LGEM.

FEEDBACK # 18

Rajab Abbas

Finally first time In History of EM in Pakistan Level 1 EMUS happened due to dedication and commitment of Dr Ashfaque and Dr Syed Ali Ahmed.

This workshop opened new horizon of learning .It opened our eyes how advanced level of pts management is being done in first world countries and Insha'Allah LGEM CANDIDATES after learning these competencies will able to alleviate the pain and prompt diagnosis. They would be able to lessen mortality rate of sick and pts ln emergency.

All teachins of today's workshop was according to RCEM GUIDELINES and most important thing of this workshop Hands on practice on live subjects. Which cleared our concepts and boost our confidence.

We learnt :

• Prob orientation and handling
• FAST SCAN visualization of Morrison pouch.
• Abdominal Aorta it's bifurcation seagull sign how to see whole length of Aorta
• Penumothorax on USG
• Echo subxiphoid/long and short parasternal axis view
• Bladder visualizion
•US Guided Vascular acess' central/ peripheral
• IVC assessment IN PLANE AND OUT PLANE

•How thrombus looks like in Heart and Vessel
•Nerve Blocks, Fascia iliac Block
I feel really blessed to be part of this unique LGEM project and it's really breaking the barrier.I can't thank enough to my Mentor Dr Ashfaque and Dr Ali for all this. And thanku to all organizers of this workshop Dr khizir Bhai.
A Proud GEM Candidate

FEEDBACK # 19

Hk Danish

Great session. Enjoyed every second of the learning process and felt great meeting our mentor Dr Ash and teacher Dr Ali

FEEDBACK # 20

Khalid Khan

Level-1 ultrasonography training attended at Evercare hospital-Lahore with first hand practice under the supervision of Dr Ali & Dr. Ash.
This practice which many of us were unfamiliar with. Highly recommendable in ED after observing its utilization capacity and capability during workshop.
(low cost, efficient, less patient mobility with high accuracy and precision in seconds & minutes!).
Application of extended focused assessment with Sonography in Trauma (E-FAST)
Point of care ultrasound (POCUS) in trauma care.
-Aorta examination and +/- bulge or ballooning in the wall of a blood vessel.
-Valves of the heart +/- abnormalities
-IV guided cannulation.
-Morison pouch/Free fluids
-Nerves blocks
-AAA assesment
-Pericapsular nerve block.
-Pneumothorax
-Cardiac tamponade
-Pleural effusion
-CHF
Thanks to every member of the LGEM team for this opportunity and looking forward to attend upcoming levels and learn more.

FEEDBACK # 21

Ahmad Tanveer

MashAllah LGEM is doing what no one else wants to do for ER physicians

FEEDBACK # 22

Afshan Salman

First level EMUS course by Dr ashfaque and Dr Ali was an excellent session, one of its kind .

We were taught EFAST,ECHO,AAA,FACIA ILIACA BLOCK. In the workshop we learned to identify different structures in RUQ/LUQ, SUBCOSTAL view PLAX/PSAX VIEW ,APICAL FOUR CHAMBER VIEW OF HEART. We came to know about Ultrasound I/V guided cannulation & how to identify free fluid in traumatic patients and much more. Proud to be an LGEM candidate. Thankyou so much

FEEDBACK # 23

Dr Irfan Khan

Before this workshop I had no idea about ultrasound but Now after attending this workshop I am confident enough to do emergency ultrasound.

I am very thankful to Dr Ash who came up with this idea and delivered such kind of workshop ,which I had never even imagine that it could be done in Pakistan.

During the workshop I have learned How to do trauma FAST scan,how to look for Aorta, heart and pleural cavity.

Also ,This workshop made me confident to pass IV line and central line under Ultrasound guidance.

Being Orthopedic and Trauma Resident for the first time I had learned how to do Fascia Illiaca block under ultrasound guidance.

Thank you so much Sir Dr.Ash for making us which we never had think of.

FEEDBACK # 24

Dr Afifa Younis Raja

Greetings of the day!!

What an amazing day we had today!!

Level 1 EM Ultrasound workshop!!

Honestly at the start of the workshop I had no clue on how to even hold a probe BUT after the work shop I just want to put a probe on every patient landing in my ER.

Dr Syed Ali and Dr Ash did a marvellous job in tutoring us about such a crucial technique that will immensely benefit us and our patients.

Dr Ali started the session with amazing learning materials on eFAST, ELS, Assessing AAA, ultrasound guided vascular access, fascia iliaca block.
Dr Ash enlightened us with his Pearl's and shared his personal experiences show POCUS helped making the exact diagnosis which were earlier missed and how its absoullety critical for an EM physician to have this knowledge.
The best part was the hands on training where we were able to practice all the discussed views and apply the theoretical knowledge. I hope we keep on practicong and sharpen our skill to benefit our Patients.
A big round of applause for Dr Mukhtiar, Dr Azeem and Dr Khizir for arranging such an amazing event.
Thankyou evercare hospital and team for your collaboration.

FEEDBACK # 25

Dr Azka Shamim

Aoa respected sir
Today 11 Jan 2023 was a remarkable day in our lives as we got a chance to be part of first ever level 1 USG workshop as per RCEM guidelines ... Conducted by our great mentors Dr @Sir Ashfaque LCC UK and Dr @ALI ..
Starting from machine specifications (depth, gain ,freeze) probe handling and placements (linear, curvilinear, echo probes)
various views , M mode, CDI, PWD
and then eFAST, ELS (echo in life support) , Abdominal aorta (seagull sign, dumbbell sign) and detection of AAA , Fascia iliaca compartment block, USG guided IV cannulation (in plane and out plane) , detection of pneumothorax.....
In fact it was such a wonderful experience, really feeling to buy my own USG machine ..
Thank you so much LGEM team and thanks to organizers Dr Azeem and Dr khizer for arranging everything amazingly

FEEDBACK # 26

Dr Javeria Wali

A ground breaking Emergency Ultrasound Level 1 workshop conducted on 9th January, 2023 in Karachi. Facilitated and lead by Dr. Syed Ali Ahmed alongwith Dr. Ash, it was Brilliantly and effortlessly executed and an absolute treat to attend.
Dr. Ali started with a comprehensive presentation with the basic indications and theoretical knowledge about Emergency Ultrasound, Fast Scans, Right and Left Upper Quadrants, different views of Abdominal Aorta uptil its bifurcation, Echo in

life support, ultrasound guided IV access, in plane and out plane, PAN block, Fascia iliaca block. Dr. Ash shared extremely interesting cases managed through timely diagnosis with the help of ultrasound. Ample time and opportunity was given to each participant for hands on session with Dr. Ali and Dr. Ash supervising and correcting techniques to have best possible outcome with least discomfort to patient. Thank you london GEM for providing us this platform and giving us such workshops previously unheard of in Pakistan.

12TH JANUARY 2023

EVENT NAME:

Day 1 of 100 Emergency Medicine Procedure Workshop At Lahore Ever Care Hospital.

DOCTORS FEEDBACK

FEEDBACK # 1

Rajab Abbas

Today was the 1st day of 100EM procedures workshop, though I am attending this workshop twicely but the adrenalin rush and level of excitement is quite high. Never heard about this much learning by highly qualified teachers in this easy and comprehenble way. All credit goes to Dr Ashfaque,this project it his brain child which all LGEM candidates will propagate all across the Pakistan in soon future. Before attending this workshop we all were doing many simple procedures in wrong way.Thank You Dr Ash for teaching us the minute details and standard protocol making these procedures really simple, noone ever before put so much efforts for their trainee.

Important learning points of today's session are :

•Airway manoeuvres
•Airway adjuant :OPG/NPG
•Advance airways :ETT/IGEL
•IV cannulation,Venous sampling,
• ABGs (Hellens test)
•BLS : CPR and use of Pocket mask and BVM
•Digital nerve block
•Hematoma block in colles #
•Fascia illiaca block

•Adult choking/paediatric choking
° Helmich maneuver
°Foreign body removal
•Nail bed injury repair
•Nail re implantation>suture in shape of 8 for nail bed transplant
•Subungal hematoma drainage > Trephine
•Different techniques of suturing
•RSI
Thank you so much Dr Ash for bring this mobile workshop to Pakistan and Dr Ali and Dr Mukhtiar are amazing teachers I am learning alot from each and every tutor and as well as all GEM colleagues
Looking forward to day 2 to correct myself and learn many new things.
A proud GEM Candidate
Dr Rajab Abbas

FEEDBACK # 2

Sana Hameed

What a knowledge-full lecture on asthma, learned new terms/ objective/ management sequence,
Comparison of treatment as per NiCE and Gina guidelines. And ending of the session with a few questions by Dr. Jacob.
Really appreciate dr. Jacob and dr. Ash for taking out time from their busy routines and helping us learn new things 🙏🙏

FEEDBACK # 3

Rabiyyah Bashir

Impatient! ❤️❤️❤️

FEEDBACK # 4

Dr Afifa Younis Raja

A much-awaited workshop and I can say the wait was worth it.
Dr Ash and Dr Ali did a splendid job in teaching us such crucial procedures, the procedures that we thought we were doing right had so many flaws but now they have been rectified by our great mentors.

Grateful to dr Mukhtiar and dr Azeem for sharing their knowledge and teaching us.

We covered:

• Airway maneuvers
• Airway adjuncts
• Intubation
• I-gel
• lV cannulation
• ABG and blood sampling techniques
• Suturing
• Subungal haematoma
• Ring blocks
• Haematoma blocks
Fascia Illiaca block
• BLS
• Choking management And many more

⭕The only thing to improve I felt was to increase the timing of session where needed as few of us were not able to perform all procedures, that saddens me as we won't able to have this kind of opportunity again and to be honest we won't be able to get such awesome mentors so practicing all stations under their guidanc,e is absolutely vital.

✅Overall it was a marvellous experience, the knowledge we gained will definitely benefit our patients, it makes me content that this all will lead to safe practice. Bless our mentors and facilitators for arranging such an epic workshop.

FEEDBACK # 5

Dr Maimona Javaid

I dreamed of EM workshop by dr ash when I first read and saw his post long years back. He was conducting with dr naila. I felt blessed finally I landed in EM class. Day 1 was a new experience for me when I saw a huge table having all movable skill lab equipments. It was quite inspiring . It was a first interaction with dr ash in class and first introduction with dr mukhtiar , dr ali , and all organizer buddies and infact all gem buddies . We were taught almost 21 procedures on day 1 , all faculty was superb in teaching . Few procedures name as
ETT
OPA

IPG
IV cannulation
ABGs
Venepuncture
Fascia iliac block
Ring block
Hematoma block
BLS
Helminch maneuver
Rescue airway
I gel (the revolutionary device)
Different sutures
Nail repair
Trephine.....
And so much more.
Hands practise was available which was quite necessary .
Dr ash , dr mukhtiar , dr ali himself were observing and helping all students and were there at diff stations . And all facilitators were there too to support .
It was a wonderful day with excellent learning and new learnings .
Stay blessed all gem faculty.

FEEDBACK # 6

Dr Irfan Khan

Before attending this workshop I thought this workshop would be just like a normal activity of LGEM program,but on day first when Dr Ash started the lecture with Airway management in major trauma patient opened my eyes because whatever we have been doing were wrong and I think this is not our fault because no body has teached us these before.
Chin lift and head tilt.
Jaw thrust.
Measuring and passing oropharyngeal and Nasopharyngeal airway.
I-gel,which I found the most interesting thing to save severly injured trauma patient.
Intubation and passing ETT.
Hematoma block
Ring block

Illiaca block
Nail trephine for nail bed hematoma
How to fix nail bed injury
Helminch manoveur
Iv canulation
Abgs
Venous blood sampling
BLS
Suturing and knots tying technique.
I myself had this suturing and knots tying station in MRCS part b Osce exam,which I didn't do well although I was passed in the exam.But the way Dr.Ash taught this station was amazing.
Sir I can say you are ALLROUNDER of medical field Mashallah.
Thank you sir for giving us the opportunity to be a part this great program.
Whenever,I start writing something regarding this I become short of words because I think this is unparellel program in the history of medical field.

FEEDBACK # 7

Dr Mubashir Hussain

It's was wonderfull session .
We learn laryngoscopy and intubation
Iv cannulation
Abgs and its manure
Subungual hematoma release
Naso phyrangeal air ways
Oropharyngeal airways
Suturing techniques
CPR it's step
Interactive sessions and many more smart things I have learned today.
Tea was fantastic
Lunch was amazing
Thanks to Dr ash and LGEM
My Allah almighty keep Dr ash happy and healthy .

FEEDBACK # 8

Dr Shazia Asim

Dear L GEM,

I have no words to express my gratitude on how wonderfully Dr Ash and Dr Ali have conducted the 100 emergency procedure workshop.Although I am working as family medicine specialist but I always feel deficiency in skills which could save a life of patient.I was not confident in passing ETT, securing airway,taking blood for ABGs and other emergency procedures.Dr Ash and his team explain and teach the procedures in such a manner that now I feel that I can perform them effectively.
Hats off to hardwork of Dr Ash and his team
My suggestion is to please extend your program to GPs and family Physicians in Pakistan.

FEEDBACK # 9

Dr Mariam Nawaz

What an amazing day it was. I have been waiting for this workshop for the past 6 months, and today, the wait has finally ended. What was delivered in 7 hours exceeded my expectations. A day very well spent. I am sure I haven't learned this much in the entire year that I learned in these 7 hours. We learned 21 procedures today, and each and every candidate got the chance to perform hands-on practice. There were so many points that Dr. Ash clarified, which are missed even by our consultants. Some of the things we learnt are:

ETT
OPA
IPG
IV cannulation
ABGs
Venepuncture
Fascia iliac block
Ring block
Hematoma block
BLS
Helminch maneuver
Rescue airway
I gel (the revolutionary device)
Different sutures
Nail repair
Trephine.....
And so much more.

Dr Ash, Dr Ali, and Dr Mukhtiyar were amazing at teaching us all this. I got to meet so many amazing people.
Day 1 was amazing, waiting for Day 2. What I learned today will surely improve my practice and I will teach it to as many doctors as I can InshaAllah.

FEEDBACK # 10

Dr Shahid Ahmad

An amazing first day at 100 emergency procedure workshop.It was a hands-on workshop unlike the other conventional ones where you just listen and don't do anything . Everyone of us practiced each and every procedure. Dr Ash was very energetic and cooperative and we learned a lot from him in today's session. Some of the hand on procedures that we learned and practiced are

1) BLS
2) Air way Manures
3) Nasopharyngeal airway
4) Oropharyngeal Airway
5) I gel
6) Endotracheal intubation
7) various Sutures
8) IV cannulation
9) Heimlich Maneuver
10) Abgs
11) sub uncle hematoma drainage
12) nail bed injury and reimplantation
13) digital nerve block

And 17 other procedures as well..
Thank you Dr Ash and all the organizing team for this amazing workshop.
Looking forward to the 2nd day....

FEEDBACK # 11

Dr Rehan Khalil

It is the 1st day of the workshop and it was well organised from start to end. The session started timely with the recitation of Holy Quran (by Dr Khizar) and after that there were brief introductory remarks by Dr Ash and a professor from Evercare Hospital(i forgot his name).
After the introduction, Dr Ash formally started teaching the procedures in a very interactive way. He would first invite one of the candidates and ask them to do the

procedure with all the equipment provided there and later on he will point out mistakes and demonstrate the correct way of the procedure. Then and there i realised that many procedure/ maneuvors that i thought i was doing right were actually not correct and i need to unlearn and relearn them. After Dr Ash, the show was run by Dr Syed Ali Dr Mukhtiar Pathan and Dr Azeem.

After the initial session where things were somewhat passive, we were provided with the opportunity to hands-on practice every procedure we learnt on the manniqins. We were divided in 3 groups andstations and each group was assigned different procedures to practice and then we would switch the station.

Overall it was about 7-8 hr session with a 30 minute lunch and prayer break in between. The session went like a breeze, believe me.

Directly Observed Procedural Learning:

Here i would like to mention the procedures learnt.

1- The correct way of head tilt and chin lift.

2- When not to to head tild and chin lift - thaf is in suspected C Spine injury.

3- Jaw Thurst - airway maneuvor to keep airway patent in C spine injury.

4- Stablizing the C spine in trauma patient.

5- Intubation in a C spine injured patient

6- How to remove Cervical Collar in trauma patient.

7- Insertion of the NPA - bevelled end towards the septum and direct the NPA paralled to hard pallate

8- Insertion of OPA and when to rotate it.

9-Measuring the size of NPA and OPA.

8- Correct way of applying Bag Valve Mask

9- Correct way of squeezing the self inflating bag of Bag Valve Mask.

10- Use of the revolutionay iGEL - put lubricant on the flat surface on its lower wide end, hold it like a pen with tge numbers on it facing towards you and insert it.

11- What is Rapid Sequence Intubation and how to achieve it.

12- Induction agents and their doses - propofol, etomidate

13- NMJ Blocking agents andtheir doses - succsamethonium, rocuronium

14- How much pressure to apply on cricoid while intubation - 10 pounds i.e equal to the pressure you apply on the bridge of nose that causes discomfort.

15- Standard post intubation care.

16- Hemlich Maneuvor in a choking patient- make a fist with your right hand and apply it below the xiphoid process and and thrust upwards and backwords.

17- How to asses whether it is partial choking (making sounds) or complete choking(unable to make sounds)?
18- If choking patient collapses, start CPR.
19- How to manage choking infant?
20- When to start CPR in a collapsed patient- scene safety, assess rrsponsiveness, check pulse and breathing, call for help.
21- How to do CPR - side of the patient, ensure flat and firm surface, effective speed (100/min) and force (2 inches), 30:2 in adults and in infants when no assisstent available.
22- Do CPR for atleast 20 minutes
23- How to do IV Cannulation - preprocedure talk, prepare trolley, apply tornique, disinfe t the area, insert needle, open tornique when you see blood, apply stopper and fixomal, discard needle in sharps bin.
24- How to do ABGs - heparinzed skin and at 45 degrees rather than 90 degree.
25- Allens test when performing ABGs using radial artery.
26- Hematoma Block - ensure the needle is in hematoma by negative pressure and then push local.
27- Ring block - nerve ending are on the lateral sides of the fingers so give local in web space on each side of the finger and new technique is on the palmar surface of the base of the finger.
28- Fascia Iliaca block - in hip fractures.
29- Repair of the lacreated nail bed - always inspect nail bed if the nail is injured so you don't miss nail bed lacreation.
30- Nail Trephine.
31- How to do sutures and differenf tyoes of sutures to use.
32- How to hold forceps and the needle holder? - surgeons grip.
33- How to hold needle usingneedle holder? - from junction of anterior 2/3rd and poster 1/3rd.
34- How to pass ETT? How to use Bougies?
Staright outta Heart:
Thank you Dr Ash for taking this initiative of teaaching and training the non-trainees. I believe this project will be pioneer in helping doctors become Safe Doctors.
Special thanks to Dr Syed Ali Ahmed (loved your energy and vibe btw), Dr Mukhtiar Pathan and Dr Azeem.

FEEDBACK # 12

Dr Aqsa Yaqoob

Today was Day 1 of 100 Emergency Procedures Workshop. It was a very interesting and interactive session. We learnt so many procedures which include BLS (Adult and Pediatrics) as well as choking. Endotracheal intubation, how to pass I GEL, OPG, NPG. How to perform Head tilt ,chin lift and Jaw thrust in a right way. IV cannulation, ABG's (do Allen's test first) Suturing ,Subungual hematoma (nail trephine) Nail bed Repair via Ring Block,Fascia Illiaca block , hematoma block.Our supervisor Dr.Ash knows the art of teaching and how to deliver these skills to his trainees. Also thanks to Dr.Ali Dr.Mukhtiar and Dr.Azeem for providing hands-on for learning.

FEEDBACK # 13

Dr Azka Shamim

AOA respected sir

Today on 12th january 2023 we had a life changing experience .. We attended first day of 100 emergency procedure workshop.. It was a long session starting from 8 in morning till 5 in evening ,, still we were feeling like just keep practicing,, more than 30 procedures were introduced to us and full hands on practice was done .. we learnt procedures from following domains:

* basic airway maneuvers (head tilt chin lift, jaw thrust, OPG, NPG,BVM, **I-GEL**)
*Rapid sequence induction, intubation and ventilation
*Basic life support techniques , CPR critical components
*choking in adults and pediatrics
*removal of upper airway foreign body
*IV cannulation, IV sampling with butterfly needle, ABGs sampling
*drainage of subungal hematoma and repair of nail bed
*digital ring block, hematoma block,FICB
*various suturing techniques

in fact it was a unique and amazing experience and really looking forward for the next 3 days,, feeling blessed to be part of this one of its kind program and many thanks to dr ashfaque sorathia and Dr Ali as UK faculty to teach and train us

FEEDBACK # 14

Qaisar Shah

The first day of the 100 emergency procedure workshop at Evercare Hospital Lahore was a valuable learning experience. The workshop was led by Dr. Ash, an

Emergency Medicine consultant from NHS UK, and was assisted by Dr. Syed Ali, a Registrar from NHS UK, Dr. Mukhtiar, and Dr. Azeem Imran. The workshop covered a wide range of important procedures including airway management, use of basic and advanced airway adjuncts, bag valve mask ventilation, endo tracheal intubation, removal of foreign bodies from the upper airway, abdominal thrusts, needle cricothyroidotomy, neck immobilization and intubation, IV cannulation, venipuncture, arterial blood gases, infiltration of local anesthetics in wounds, hematoma block, fascia iliac block, femoral nerve block, digital ring block, drainage of subungal hematomas, nail bed injuries, wound closure and suturing, and basic life support for adults and pediatrics.
Overall, the workshop provided a comprehensive overview of emergency procedures
Thanks Dr. Ash, Dr. Syed Ali, Dr. Mukhtiar Pathan, Dr. Azeem Imran for this knowledgeable & valuable workshop.

13th JANUARY 2023

EVENT NAME:

Day 2 of 100 Emergency Medicine Procedure Workshop At Lahore Ever Care Hospital.

DOCTORS FEEDBACK

FEEDBACK # 1

Rajab Abbas

Today was the 2nd day of 100EM procedures workshop, Never heard about this much learning by highly qualified teachers in this easy and comprehenble way. All credit goes to Dr Ashfaque,this project it his brain child which all LGEM candidates will propagate all across the Pakistan in soon future. Before attending this workshop we all were doing many simple procedures in wrong way.Thank You Dr Ashfaque for teaching us the minute details and standard protocol making these procedures really simple, noone ever before put so much efforts for their trainee.
Important learning points of today's session are :
•Shoulder dislocation

•Elbow dislocation
•Colles fracture reduction
•Hematoma block
•Inter phalangeal joint dislocation
•TMJ dislocation
•Thomas splint
•How to apply POP
•How to apply slings
•Thumb spicca
• SVT/VT
• Chemical/ Electrical Cardioversion
• Valsalva/ modified Valsalva
• Catheterization
•Bradycardia and tachycardia algorithm
Thank you so much Dr Ash for bring this mobile workshop to Lahore Pakistan this time and Dr Ali and Dr Mukhtiar are amazing teachers I am learning alot from each and every tutor and as well as all GEM colleagues
Looking forward to day 3 to correct myself and learn many new things.
A proud GEM Candidate

FEEDBACK # 2

Imtiaz Ali Shah

Today we had day 2 of 100EM procedure workshop,yet another thrilling day full of learning and skills. Like day one first there was full explanation and demonstration of the procedure and after that handson training of every procedure.we learnt about
Ankle dislocation and reduction
Elbow relocation
Should relocation
TM JOINT dislocation and managment.
Different types of splints and their application.
Like Thomas splint,pelvic binder Thumb spika ,ulnar gutter etc.
Application of PoP and back slabs
Nail bed repair and managment of subungle haematoma.
Catheterization.
Fascia illiaca block and digital blocks,femoral vein access.

Reduction of colle,s fracture
Managment of Brady and tachy arrhythmias along with cardioversion,modified valsalva manuvars etc
Overall it was a comprehensive session avey useful and practical one.we came across many mistakes while performing these procedures and they were corrected there and then by our instructors.Dr Ash and Dr Ali along with dr mukhtir gave their hundred percent and make sure that every one should learn these procedures.
At the end I would like to thanks dr Ash,Dr Ali and the whole London GEM team for providing us such a great platform for learning.

FEEDBACK # 3

Ram Leela

Par excellent Sir!! You are true inspiration for all of us!!

FEEDBACK # 4

Rabiyyah Bashir

Day 2 included
practice of reduction methods of dislocated shoulder, elbow dislocation, colley's fracture and a pulled elbow.
beautiful demonstration of traction and reduction of fractures and dislocations.
Splints and Slings.
tachyarrythmia and bradycardia algorithm run.
Defibrillation and pacing.
Valsalva and modified valslva.
Catherterization under aseptic measures.
Fascia iliaca block , femoral venous access and block.
This is just a superficial outlook, but the way we were taught, supervised, put into practicing ... was undoubtedly THE BEST... NO ONE EVER , ANYWHERE TAUGHT US THIS WAY....
Feel blessed to be amongst the chosen ones ❤️❤️❤️
A big Thanx to **Ashfaque Ahmed** Sir, **Mukhtiar Pathan** Sir, Dr **Syed Ali Ahmed** Sir, Dr Azeem Sir, Dr Khizir and Dr Rida .....
❤️❤️❤️❤️❤️❤️❤️❤️❤️❤️
More power to
London Global Emergency Medicine Family ❤️❤️❤️

FEEDBACK # 5

Zegham Abbas

Hectic but wonderful day Dr Ash taught us so many procedures and skills and all trainee learned it by heart and I am truly grateful to Dr Ash Dr Mukhtar Dr Azeem Dr Syed Ali.
Following procedures were taught and various methods were discussed and we performed each procedure on manikin e.g
Shoulder joint dislocation
Kochers Manoeuvre
Back Slab POP
Mills and cunnighams method
Colles fracture relocation
TMJ dislocation management
Valsalva Manoeuvre
Scaphoid fracture stabilisation
Mallets Method
Modified valsalva
BLS
Bradycardia management
SVT VT management
Pelvic Open book fractures
It was an amazing session all in all very fruitful learning we also visited evercare hospital state of the art hospital indeed I would like to thanks Dr Ash for arranging wonderful workshop.

FEEDBACK # 6

Sana Hameed

Day 2 of work shop continues with more exciting and important procedures needed in emergency.
Such detailed procedures explanation done followed by proper hands ON time to do every procedure from catheterisation to musculoskeletal emergencies of joint displacement and their managements in emergency which can not only help patients to relieve pain but also save them from expensive treatments.
Today we also got to learn some important cardiac emergencies and their emergency managements bradycardias and tachycardia's. Learning these procedures has actually opened most of ours minds made us realise how much we have lacked in EM procedures for years.
GOD bless sir **Ashfaque Ahmed** and LGEM

FEEDBACK # 7

Waleed Ahmed

Another day of intense learning, I don't think my brain's big enough to remember all the procedures, will have to keep practicing

FEEDBACK # 8

Yasir Dilawar

On day 2 of this workshop sir Ashfaque Ahmed gave us a thorough overview of different traumas related to orthopedics and how to treat such cases i.e shoulder relocation,elbow and ankle relocation.we practiced these procedures on mannequins under his supervision

Subungal hematoma drainage,nail bed repair,how to apply splint to elbow,mallet finger splint,ring removal by using thread, procedure of doing backslab,fascia iliaca block,Thomas splint,femoral stab, urinary catheterization correct way,Chemical Cardioversion etc.

Special thanks to Dr Ashfaque Ahmed for arranging such a unique workshop in which we can learn so many procedures in such short time.also thanks to Syed Ali sir for helping us.

FEEDBACK # 9

Beenish Manzoor

On the 2nd day of 100EM procedures workshop, we had alot to learn and All credit goes to Dr Ashfaque.this is such a unique workshop that even after attending so many hours talk we wanted our mentor to keep on teaching us without pause. Before attending this workshop we all were doing many simple procedures in wrong way.Thank You Dr Ashfaque for teaching us the minor details and standard protocol of RCEM making these procedures really simple, and correcting us by giving us chance to do under supervision hands on procedures noone ever before put so much efforts for their trainees and i can bet that on **Ashfaque Ahmed** sir has this much patience to keep on answering our questions .

Important learning points of today's session are :

•Shoulder dislocation (anterior and posterior) their 3 manuever of reduction

•Elbow dislocation and reduction

•Colles fracture reduction

•Hematoma block

•Inter phalangeal joint dislocation and digital block

•finger strapping

•TMJ dislocation and its 2 ways of reduction
•Thomas splint
•How to apply POP
•How to apply slings
•Thumb spicca
• SVT/VT
• Chemical/ Electrical Cardioversion
• Valsalva/ modified Valsalva
• Catheterization
•Bradycardia and tachycardia algorithm
Thank you so much Dr Ash for bring this mobile workshop to Lahore this time and Dr Ali and Dr Mukhtiar are amazing teachers I am learning alot from each and every tutor and as well as all GEM colleagues
Looking forward to day 3 to correct myself and learn many new things....

FEEDBACK # 10

Qaisar Shah

Day 2nd of 100 EM Procedure Workshop at Evercare Hospital Lahore & led by Dr. Ashfaque, Dr. Ali Ahmed, and Dr. Mukhtiar and was attended by LGEM candidates. The attendees learned various procedures such as shoulder dislocation, elbow dislocation, Colles fracture reduction, Hematoma block, Inter phalangeal joint dislocation, TMJ dislocation, Thomas splint, POP and sling application, thumb spica, SVT/VT, Chemical/Electrical Cardioversion, Valsalva/modified Valsalva, Catheterization, and bradycardia and tachycardia algorithm and much more.
The workshop was praised for the comprehensive and easy-to-understand teaching method and the effort put in by Dr .Ashfaque & Dr. Ali,
Thanks alot for such an amazing,valuable & knowledgeable workshop.

FEEDBACK # 11

Khalid Khan

Really enjoyed the second day well planned and layed out, easy for all to follow.
Observed and learned about topics,
helped me understanding of the poorly followed previously techniques, maneuvers and not felt over loaded and rushed at any moment during all day long hours workshop.
Some of the cases to mention:

Shoulder dislocation reduction techniques
SVT/VT
Inter phalangeal joint dislocation
TMJ dislocation
Chemical/Electrical Cardioversion
Modified Valsalva
Colles fractures reduction
Hematoma block
Elbow dislocation reduction techniques
Thomas splint.
Thank you yet again LGEM team. it was fun but a lot of work. And it was! keep it up

FEEDBACK # 12

Annie Tahir

That's great!! Good to see you Ali!

FEEDBACK # 13

نـا صر ف اطمه

Thrilling day 2 started with our beloved mentors presentation.. all procedures were thoroughly taught and clear demonstartion was done.. Dr Ash taught us all manipulation techniques to deal with dislocations.. and i was amazed that how simple they are.. yet we were not been taught all this yet.. Cunningham technique was such a surprising technique.. Dr Ali said usually now he don't give sedation along with this procedure.. like its such a remarkable one.. and he being ST6 learned it in last workshop by Dr Ash.. how blessed we are to be known all this at this stage.. they make us capable to take away someone's pain..
These Managements were taught;
Ankle relocation
Shoulder relocation (kocher's, mille's and Cunningham method)
Elbow relocation
Management of nurse mid elbow
Reduction of colle's fracture
Phalangeal relocation
Procedure sedation
How to apply plaster.. the whole technique.. first to apply stocking.. then cotton.. then plaster of paris(10 layers).. then crape.. with full demonstartion

How to apply splints.. broad arm sling, thumb spika..
How to apply pelvic binder.. and if not available then use of bed sheet for this purpose
Nail bed repair and reimplantation of paper foil to guide the new nail
Catheterization (and while performing it on mannequin.. he taught us why the male patient should be in lying position.. its bcz of the anatomy..)
Dr Ali's favourite fascia iliaca block
Femoral stab
Management of bradycardia and tachycardia.. chemical cardioversion and electrical cardioversion, modified valsalva maneuver for SVT
Just writing this and getting all those memories.. what a wonderful days we have spent.. full of learning.. full of enthusiasm..
jazakALLAH khairan kaseera mentors.. for all this.. and Dr khizr and Dr azeem for all the facilitation😍

FEEDBACK # 14

Dr Afifa Younis Raja

I thought the bar was set yesterday, but Dr Ash proved us all wrong and delivered another superpower pack full of knowledge sessions. His passion for Emergency Medicine just amazes me. His energy and stamina are commendable MashAllah, and kudos for never compromising on quality.
Dr ALI is a true reflection of Dr Ash yet he adds his own flavor to our workshop. The way he teaches shares his clinical skills, and imparts all his experiences with us is applauded. So lucky to have you on board.
Today we covered:
Shoulder dislocation
Elbow dislocation
Colles fracture reduction
Inter phalangeal joint dislocation
TMJ dislocation
Thomas splint
How to apply POP
How to apply slings
Thumb spicca
ACLS
Bradycardia and tachycardia algorithm and many more.

Dr @Dr M A Pathan LGEM thank you soooo very much for sharing your wisdom with us, the way you make sure each and every student is involved shows your passion for teaching and improving our skills.

Dr khizir dr azeem dr yameen dr rida your facilitating skills are really appreciated.

FEEDBACK # 15

Dr Maimona Javaid

Day 2 EM class started with new enthusiasm and energy. We were looking forward to add more to our knowledge . Long list of procedures we learnt and we were taught in a detailed manner. Such as
Ankle dislocation and reduction
Elbow relocation
Should relocation
TM JOINT dislocation and managment.
Different types of splints and their application.
Like Thomas splint,pelvic binder Thumb spika ,ulnar gutter etc.
Application of PoP and back slabs
Nail bed repair and managment of subungle haematoma.
Catheterization.
Fascia illiaca block and digital blocks,femoral vein access.
Reduction of colle,s fracture
Managment of Brady and tachy arrhythmias along with cardioversion,modified valsalva manuvars etc
Dr mukhtiar , dr Azeem , dr ash dr Ali kept helping us at hands on stations .
Without getting irritated when we were continuously asking questions and wanted to revise all .
All team very humble , polite , generous and supportive .
I pray and hope I revise each and every step taught and apply in practical life and help patients in a better than .
I am getting my confidence back slowly and gradually as I forgot all medicine procedures .
Stay blessed all gem team. .

FEEDBACK # 16

Dr Ruma Mustafa

Spectacular day started with recitation of holy quran by Dr.khizir, Wonderful opening remarks by Dr. Ash and Dr.Mukhtiar and Dr.khawar
I accomplished many small things that looks like small but the way of correctly doing in an ethical way to give less harm are actually a big thing for the patient safety to avoid negligence, unremarkable efforts by Dr.Ash Dr.Mukhtiar and Dr.syed Ali all my respected faculty are truly amazing proud to be ur trainee
Today, we learnt more than 30
Theoretical discussion to Hands On practice
Procedures:
Quincy Drainage
Ankle dislocation and ankle block
Delayed ankle manipulation
Ankle dislocation reduction
Shoulder Relocation kocher's ,mille's, and cunninghan method
Elbow dislocation/nurse mid elbow
Phalangeal &metatarsal fractures
Colles fracture
Radial head subluxation
Application of Plaster cast/Application if back slabs POP
Thomas splint/Donaway splint
Pelvic binder/pelvic stabilization
Application of Slings coller/cuff/Arm slings
Thumb splint ,Mallet's finger splint
TMJ dislocation
TMJ subluxation
Abnormal nail growth
Nail bed injuries
Repair and re-implantation
Drainage of subungal hematoma
Aseptic technique of Male catheterization
Adult Brady cardia algorithm (with pulse)
Advance life support
Chemical/DC cardioversion and pacing
Valsalva maneuver
SVT/VT management and so on.

Each station was highly equipped and well organized every one getting the chance to do a practice freely and in a peaceful manner
I am really grateful and thankful to the
Dr.Ash
Dr.Syed Ali
Dr.Mukhtiar
and LGEM platform for that they organized so well with no cost for GEM candidates, all the way from UK its a huge effort for us,truly thankful
Ap nai hoty tu koi bi nai hota u gave a vision to many Alhamdulillah I am ur trainee

Bless u, Sir, always 🖤💙
ALLAH GIVE YOU MORE & more

May it bring abundant success for us n for u toOoo Sir always 😇🥰

FEEDBACK # 17

Dr Azka Shamim

Aoa respected sir
Today on 13th Jan 2023 we attended day 2 on this workshop and literally saying these are the best days of our lives when we are learning this much , which people might not have learnt in ages ... We covered procedures from the musculoskeletal, cardiac emergencies till accurate techniques of catheterization, nerve blocks, femoral stab etc, we covered following important learning points:

- Ankle dislocation reduction and outcomes of delayed management
- shoulder relocation , Kocher's maneuver, mills maneuver, cunningham maneuver
- Application of below elbow backslab
- neighbour strapping
- sling application
- Thomas/Donnaway splint
- Elbow dislocation reduction
- pelvic fracture binder
- TMJ dislocation/subluxation
- Colles reduction
- phalyngeal and metacarpal fractures management

- ACLS primary and secondary assessment
- VT and VF management
- valsalva and modified valsalva maenuvers
- male catheterization
- femoral stab
- fascia iliaca block

infact it was a wonderful experience and really learnt alot.. lookingforward to day 3 inshaAllah

FEEDBACK # 18

Dr Irfan Khan

On the first day of workshop I realize that this program is much beyond our imagination and my interest was accelerated for the next day.

Here come the day which made me speechless because the way Sir was explaining and performing the different techniques of joint relocation was wonderful
Shoulder joint relocation
Elbow joint
Distal radius fracture reduction and manipulation
Inter Phalangeal joint reduction
Patella relocation
Ankle joint relocation
Different splinting techniques
Thomas splint
Below elbow back-slab
Above elbow back slab
Below and above knee back slab
Broad arm sling
Elevated Arm sling
Cuff and collar splint
Thunk spica caste
Ulnar gutter
Pelvic binder
Nursemaid elbow
Different blocks of limbs.

I took me two years to learn the above procedures in 2 years of structured training program but All of these was taught and performed by Dr.Ash in just 3 hours. Apart from this,I also have learned how to treat Brady and tachy Arthymias and chemical cardioversion.
Sir you are just Amazing.
Lot of love and respect for you.

FEEDBACK # 19

Dr Shahid Ahmad

Hand on procedures of today's session are :
•Shoulder dislocation
•Elbow dislocation
•Colles fracture reduction
•Hematoma block
•Inter phalangeal joint dislocation
•TMJ dislocation
•Thomas splint
•How to apply POP
•How to apply slings
•Thumb spicca
• SVT/VT
• Chemical/ Electrical Cardioversion
• Valsalva/ modified Valsalva
• Catheterization
•Bradycardia and tachycardia algorithm
Thanks Dr Ash and his team for arranging such an amazing workshop

FEEDBACK # 20

Dr Mubashir Hussain

It was amazing working day we learned about chest drain . Cricothyrodocomy , needle thorocotomy , foreign body removal from nose ,ear ,eye , beyond cervix of female , ultrasound showing aorta and it's bifurcation , itraosscious approach for sampling and transfusion , pH of eye . Various hemorrhage in ratina and disc swelling , cousco speculum examination , epistaxsis and it's packing ,
London gem is all about spreading love
Thanks to whole team especially to our mentor Dr ashfaque sorathia .

14th JANUARY 2023

EVENT NAME:

Day 3 of 100 Emergency Medicine Procedure Workshop At Lahore Ever Care Hospital.

DOCTORS FEEDBACK

FEEDBACK # 1

Rajab Abbas

Such a power pack session 3rd day of 100EM procedures workshop, everyone was so enthusiastic in learning and teaching the procedure to other colleagues; this can only happen in Dr Ashfaque workshop. Before attending this workshop we all were doing many simple procedures in.Thank You Dr Ashfaque for teaching us the minute details and standard protocol making these procedures really simple, none ever before put so much efforts for their trainee.

Important learning points of today's session are :

•Foreign body from eye/nose/ear
•Bimanual examination/ pap smear/ vaginal foreign body
•Chest drain
•Tracheostomy / needle thorocotomy
• Fundoscopy/ Otoscopy
• log roll trauma Patients transfer
• helmet removal in c.spine truama
• nasal packing / tampoon/ rapid rhino / folleys
• eye irrigation in chemical injury/ eye pH / Morgan lense
• Three way occlusive dressing
• Arterial lime
• Introsseous access

Thank you so much Dr Ash for such an amazing learning workshop thanks Dr Ali and Dr Mukhtiar . I am learning alot from each and every tutor and as well as all GEM colleagues

A proud GEM Candidate

FEEDBACK # 2

Rabiyyah Bashir

Day 3

Included
Cricothyroidotomy and tracheostomy
Safe transfer of potential cervical trauma patients
Chest intubation
IO access
Fundoscopy
Otoscopy
Removal foreign body in eye, ear and nose
Use of Ultrasound in cellulitis, necrotizing fascitis, abscess, fractures, retinal detachment, pleural effusion, Pulmonary Edema, heart failure, pericardial effusion and PE
bimanual examination in gynae, speculum examination and foreign body removal...
Management of epistaxis.
Use of Peak flow meter
This is just a bird's eye view.....
The session was overwhelming! Words would fall short to express the gratitude...
It was as If God had set the stage to amaze us ❤️❤️❤️❤️❤️
A HUGE THANKUUUUUUUU Dr **Ashfaque Ahmed** Sir, Dr **Mukhtiar Pathan** Sir, Dr **Syed Ali Ahmed** Sir, Dr Azeem Sir, Dr Amini Sir, Dr Khizir and Dr Rida.... ❤️❤️❤️❤️❤️❤️❤️❤️❤️❤️❤️❤️❤️.
Lots of love for **London Global Emergency Medicine** Family ❤️
Great Regard for **Pema-Uk** ❤️❤️❤️

FEEDBACK # 3

Ghayoor Khattak

The workshop was a great success today, with a significant amount of learning accomplished without any moments of boredom. It was the most engaging workshop I have ever attended, and I am relishing every moment of it. I hope the workshop continues in this manner. We covered an extensive range of topics, including needle thoracotomy and chest intubations, needle cricothyrodotomy and surgical cricothyrodotomy, tracheostomy, anterior and posterior nasal packing, foreign body removal from the ear, nose, and eye, PV examination and speculum examination, hand-held doppler, intraosseus access, and many other procedures. I am deeply grateful to Dr. Ash, Dr. Ali, Dr. Azeem, and Dr. Mukhtiar for their guidance and expertise.

FEEDBACK # 4

Syed Suhail Ahmad

Today was a power packed day of learning some of the important ED procedures which includes

- Needle and Surgical Cricothyroidotomy
- Tracheostomy
- Chest drain insertion
- Needle decompression
- Intraosseous access
- Collar application
- Helmet removal in injured patients
- Log roll
- Checking eye pH
- Foreign body removal from eye, ear, and nose
- Epistaxis management
- Bimanual examination and alot more

The interesting part was arranging real samples of animal trachea and ribs so that everyone can get a complete hands-on experience which felt great 👍👏

Thank you LGEM, PEMA, LCC for providing us this wonderful opportunity!

👍👍👍

FEEDBACK # 5

Nouman Abdul Malik Nou Mie

The day was packed with adrenaline rush, learning so many interesting procedures in one go....

Removing foreign bodies from ear/nose/eye

Epistaxis management

Eye pH/irrigation/fundoscopy

Bimanual examination/speculum examination/high vaginal swab/pap smear

The most wonderful station by Dr Ali on various ultrasound images and FAST scan/aorta scan

Helmet removal in injured patient with safe transfer protocols and log roll

Chest drains

Arterial line insertion

Obtaining intra osseous access

Needle-cricothyroidotomy/surgucal cricothyroidotomy/tracheostomy

We feel so proud to be part of this big change that is London GEM programme. Thanks Dr Ash and Team LGEM for organizing such fantastic workshop

FEEDBACK # 6

Sana Hameed

What a jam packed session again today. When sir ash talks it's like you don't want him to stop for 1 second

It's like who cares about the food or time just let us learn more and more.

We have done 90+ procedures in just 3 days and it feels like it's just the number because when sir ash is teaching let it be 300 procedures even.

Today we did more of emergency surgical procedures starting from needle cricothyroidotomy to chest tube insertion. It's like who need to wait for general surgeon anymore for such emergencies. Management of epistaxis anterior/ posterior . Different foreign body removals from

Eye, nose and ears and even the Gynae emergencies we can face.

Sir Ashfaque everyone who has attended these procedures until now is definitely in your dept because it's only Allah who knows how many lives of patients, how much pain relief your trainees have done just because of your 100 emergency procedures. And I am really honoured to be a part of your 6th 100 Emergency Medicine Procedure Workshop Venue Lahore.

FEEDBACK # 7

Shahid Ahmad

Today's procedures that we learned and practiced on mannequins are

>Eye irrigation in chemical injury, eye pH , Morgan lense

>Three way dressing for Tension pneumothorax

>Arterial lime

>Introsseous access

>Foreign body removal from eye,nose and ear

>Bimanual examination, pap smear, vaginal foreign body

>Chest drain

>Tracheostomy and needle thorocotomy

> Fundoscopy and Otoscopy

> log roll in cervical trauma Patients

>helmet removal in c.spine truama

>nasal packing

Thank you so much Dr Ash and his team for arranging this amazing workshop....

FEEDBACK # 8

Muhammad Ibrahim

Today was a highly productive day at the workshop. I was able to learn a lot without feeling bored for even a second. I have never been so engaged in a workshop before. I am thoroughly enjoying the experience and hope it continues. We covered a wide range of topics including: needle thoracotomy and chest intubations, needle cricothyrodotomy and surgical cricothyrodotomy, tracheostomy, anterior and posterior nasal packing, foreign body removal from the ear, nose and eye, PV examination and speculum examination, hand held doppler, intraosseus access, and many other procedures. I am very grateful to Dr Ash, Dr Ali, Dr Azeem, and Dr Mukhtiar for their guidance and expertise.

FEEDBACK # 9

Mina Khan

Heartiest

congratulations

Everyone. Rida Rana Rida Rana Muhammad Yameen Muhammad Yameen Ubaid Ur Rehman Khizir Ubaid Ur Rehman Khizir Mukhtiar Pathan Mukhtiar Pathan Muhammad Azeem Imran Muhammad Azeem Imran On conducting EM 100 procedures workshop on an international platform based on an updated curriculum and providing us candidates the excellencies of Emergency Medicine.

Topics Covered were indeed extremely important and practical.

Head Tilt Chin lift/Jaw Thrust/Oropharangeal tube /Nasopharyngeal airway/BVM/IGel/LMA/BURP maneuvere /BLS/Helminch Maneuvre /Surgical crucothyroidectomy/penetrating injuries/Aspiration Pneumothorax/IV cannula /ABGS/Venupuncture/Neck immobilization/LogRoll/Helmet Trauma/Shoulder relocation/Mills Maneuvre/ER physician responsibility /Elbow dislocation/ Manipulation of wrist/Metacarpal subluxation/Hematoma Block/RingBlock/Ankle Dislocation/Thomas splint/Fascia iliaca block/Catheterization /Ulnar cutter Splint /Pelvic fracture/IO drill/peak flow metre /Epistaxis//POCUS /femoral tap/Nsil bed injuries/suprapubic bladder aspiration/priaprism/ NRP/Digital globe massage/Nasal foreign body extraction /Ear foreign body extraction/Quinsy drainage/Corneal Foreign body/ Tarsal foreign body/Eye irrigation in ED / chest drain/Saldinger chest drain/SVT/unstable svt/VT/modified vslsalva/Adult Bradycardiac Algorithm/Pacing/ Fundoscopy/ Otoscopy/Bimanual pelvic exam / Vaginal spec

exam/High vaginalswabs/ Neexle cricothyroicdectomy /Tracheostomy/antenatal e am /Ring Removal / Fish hook removal. And many more ....
We definitely owe you alot Ashfaque Ahmed Dr Ashfaque Ahmed Dr Ali and London Global Emergency Medicine team. Proud Trainee 🌹

FEEDBACK # 10

Zegham Abbas

Another amazing hectic day a lot or learning points. Dr Amini also teach us he is wonderful teacher he taught us various method chest drain PR examination.
Pneumothorax needle decompression •
Needle and surgical Cricothyroidotomy
Aspiration Pneumothorax
Tracheostomy
Sildenger chest drain
Foreign body removal from eye nose ear
Bimanual and Speculum examination
Epistaxis Management
Fundoscopy (Retinal Detachment Foreign body removal, CRVO)
Otoscaopy (TM Quadrant)
Intraosseous access
Inline immobilization
Log roll
Helmet removal in head trauma
Arterial line
Eye Irrigation
It's was amazing experience specially on chest drain in real thorax and trachea thanks to all teacher once again.

FEEDBACK # 11

Syeda Maheen Ejaz

An amazing session with each passing day I feel blessed to be a part of it thank you so much Dr Ash a lot of prayers for you. Thank you everyone for teaching training and facilitating❤️
Some of the learning reflections
Needle cricothyroidotomy
Surgical cricothyroidotomy
Tracheostomy

Collar application
Log roll
Chest drain
Intraosseous access
ENT procedures in Ed
Opth
Gynae
A whole new world of Ultrasound thank you Dr Ali for introducing ultrasound.
Amazing Bravo to the whole team👏👏

FEEDBACK # 12

Imtiaz Ali Shah

Today we attended the third day of 100 Em workshop conducted by london Gem. As usual it was a wonderful session, we learnt many new procedures and handson practice was carried out.Todays session included the following procedures.
Foreign body removal from ear ,eye and nose.
Vaginal foreign body removal
Biannual examination.
Tracheostomy/needle thorocotomy.
How to pass chest drain.
Funds copy and otoscope.
Log roll and in line immobilisation
Helmet remover in trauma patient
Ant nasal packing and post nasal packing.
Checking the pH of eye in chemical injuries.
Use of Mirgan lense.
Chest drains
Over all it was an excellent day.we picked up our deficiencies and our tutors immediately corected us .proud to be a part of this wonderful learning session. Thanks to dr Ash,Dr Ali and london Gem for providing us this wonderful platform of learning

FEEDBACK # 13

Afshan Salman

3rd day of 11 EM workshop, amazing huge bundle of skills & knowledge. We learned today: Cricothyroidotomy and tracheostomy
Safe transfer of potential cervical trauma patients

Chest intubation
IO access
Fundoscopy
Otoscopy
Removal foreign body in eye, ear and nose
Use of Ultrasound in cellulitis, necrotizing fascitis, abscess, fractures, retinal detachment, pleural effusion, Pulmonary Edema, heart failure, pericardial effusion and PE
bimanual examination in gynae, speculum examination and foreign body removal...
Management of epistaxis.
Use of Peak flow meter. Thankyou Dr. Ash, Dr. Ali & Dr. Mukhtiar for all your efforts. proud to be an LGEM candidate

FEEDBACK # 14

Qaisar Shah

Today, a variety of emergency surgical procedures were performed, including needle cricothyriodotomy and chest tube insertion. These procedures can be performed quickly and effectively without the need to wait for a general surgeon in emergency situations. Other procedures that were performed include the management of anterior and posterior epistaxis, as well as the removal of foreign bodies from the eye, nose, ears, and even gynecological emergencies. Overall, the team was able to handle a wide range of emergency surgical procedures with confidence and skill.
Resuscitation of newborn infants,
Removing fish hooks,
Examination of the retina and prenatal examination,
Emergency department treatment for priapism,
Irrigating the eyes in cases of chemical injury,
Measuring the pH of the eye,
Removing foreign objects from the vagina and much more.
Thanks Dr.Ashfaque & Dr.Ali for this wonderful, knowledgeable & skillful workshop .

FEEDBACK # 15

Yasir Dilawar

Again another very good day for us.today we learnt about FAST Scan in trauma patients and performed on one of our colleagues.We were taught per/vaginal examination,Speculum examination, foreign body removal from vagina.procedures like cricothroidotomy,chest tube insertion,intraosseous access,how to check PH of the eye, ophthalmoscopy,otoscopy,removal of foreign body from eyes and ears.Thanks to Dr Ash & all others contributing in this workshop.

FEEDBACK # 16

Dr Afifa Younis Raja

Another amazing day with our prestigious faculty Dr Ash, Dr Ali and Dr Mukhtiar. Today we had an addition of another extremely talented Dr Amini to our great team. It was great learning from you.

We covered:

• Needle and surgical cricothyroidotomy
• Tracheostomy
• Tension pneumothorax needle decompression
• Aspiration pneumothorax
• Sildenger chest drain
• Foreign body removal from eye, nose ear.
• Fundoscopy
• Otoscopy
• Epistaxis management
• Eye irrigation
• Bimanual and speculum examination
• Arterial line
• Intraosseous access
• Inline immobilization, log roll, helmet removal in head trauma and many more

The most amazing part was that we were provided with ribs and tracheas for having a real life feel that truly shows the dedication of this great team.

Truly blessed to be part of this distinguished team.

Thank You once again our facilitators Dr Azeem and Dr Khizir.

FEEDBACK # 17

Dr Ruma Mustafa

Marvellous day started with full zeal to master in each and every station.
Wonderful opening remarks by Dr.Ash and Dr.Mukhtiar and Dr.khawar
Theoretical discussion to hands-on practice

Procedure:
We practiced more than 35 procedures Mashallah
Needle Cricothyroidotomy Ind/ Contra.I
Surgical Cricothyroidotomy
Per cutaneous tracheotomy
Intubation of patien with cervical spine injury
Putting coller C-spine for protection
Log roll Safe transfer of trauma patient
Helmet Removal
Open/closed pneumothorax
Aspiration pneumothorax
Chest drain equipment trolly /insertion
Tension pneumothorax
Seldinger chest drain
EM procedures to support Circulation
Arterial line
Interosseous Access ,I/O Access
Opthalmology/ENT procedures in ED
Fundoscopy and different slides of eye
Otoscope normal tympanic membrane and slides of perforation,
Gormet,A.O.M,Bulging ,wax
FB removal Nose/Eye/Ear
Checking Eye PH
Morgan lense
Epistaxis nasal tampon,cautrization
Rapid rhino insertion
Biamanual pelvic examination
Cuscos Spaculum examination
High vaginal swab/cervical sampling/Pap Smear
FB removal from vagina(lost tampon/condom mannequin)
Peak flow meter and so on.
At the end, what I love the most is no doubt about it.....

"WE CREATED MAN IN THE BEST DESIGN"
Quran95

Each station was highly equipped and well organized every one getting the chance to do a practice freely and in a peaceful manner
I am truly blessed to have such wonderful teachers thanks to Dr.Ash, Dr.syed Ali, and Dr.mukhtiar for their utmost support thanks alot
Proud GEM trainee

FEEDBACK # 18

Dr Azka Shamim

Aoa respected sir
Today we attended the 3rd day of 100 EM workshop which was quite intense , but we felt such thrilling and exciting activities that not for a single minute we felt exhausted.. This 4 days workshop is going to be the most amazing part of our lives ... We covered alot of EM and really gained so much confidence .. following important topics were covered today :
* Abdominal thrust to remove airway foreign body
*Needle cricothyroidotomy
*Surgical cricothyroidotomy
*Percutaneous tracheostomy
*Manual in line stabilization
*Helmet removal in trauma
*Pneumothorax
*Insertion of chest drain
*Arterial line
*Intraosseous access
*Fundoscopy and various conditions associated
*Otoscopy
*POCUS related to skin and soft tissue, musculoskeletal, lungs and abdomen
*Bimanual examination
* Peak expiratory flow meter
*How to check pH of eye
*Eye irrigation for post chemical injury
*Corneal and tarsal foreign body removal
* Nasal FB removal
*Quinsy drainage
*Epistaxis, rapid rhino, cauterization

* Neonatal resuscitation
In Fact it was marvelous. Thank you so much sir Ashfaque for your mentorship, guidence and support in every aspect of our lives

FEEDBACK # 19

Dr Irfan Khan

Day 3 of 100 emergency medicine procedures workshop
This was the intense day because Dr Ash was on fire.
He taught us almost 40 procedures along with hands on on mannequin.
Ophthalmoscopy
Otoscopy
Eye Ph measuring
Tarsal FB removal
Corneal FB removal
How to wash eye after chemical injury
Removal of FB from ear
Management of epistaxis including nasal packing,Rhino pad, use of pediatric foley and cauterization.
Removal of nasal FB
Cervical collar application and
Measuring its different size
Helmet removal in trauma patient
Cervical spine stabilization and intubation in spine injury patient
Needle and surgical cricothyroidotomy
Tracheostomy
Needle thoracocentesis
Pneumothorax aspirAtion
Chest drain (open and close)
Apart from this, The interesting thing is Sir knows even gynecology more than gynaecologist because Bimanual PV examination, speculum examination
Removal of FB, high vaginal swab and pap smear was taught amazingly.
Sir Dr. Ash is Allrounder of medicine.

FEEDBACK # 20

Dr Mubashir Hussain

Today was the third day of work shop it was amazing .I have learned a lot of procedure Atls , BLS , defebrilators and cardioversion . Cardiavmc arthymias ,.

Various manoeuvres of shoulder dislocation reduction like miles , Cunningham's , kocher manoeuvre ,
I learned how to reduce proximal redius dislocation reduction , choles fractures , And it's manual reduction .how to use slings and arm slab . How to apply plaster of Paris , how to stabilize femur fracture by Thomas way .
Subungual hematoma release
Ring block
Fascia aliaca block
Suturing
Catherazatin for patients
It's hard to put all that I have learned in written . London gem is pure piece of love.
Thanks to Dr ash and it's whole team

14TH JANUARY 2023

EVENT NAME:

Lung Tumours Acute Presentations By Dr Jacob Baby consultant Resp Physicians NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Bushra Imran

The discussion and explanation in today's session on long cancer ,throwing the light on singn& symptoms, investigations,guidelines.I learnt how and why hoarseness of voice occur,laryngeal nerve palsy ,Phrenic nerve palsy and Pancoast tumor.He also explained in comprehensive way the types of lung cancer, Horner's syndrome, tumor markers ,superior venacava syndrome and much more knowledgeable stuff.
In the end case presentation by dr Shiraz was also informative.
Thank you Dr jacob and GEM team

FEEDBACK # 2

Abdul Ghaffar

This is wonderful lecture and got huge knowledge
Thx sir

FEEDBACK # 3

Rizwan Siddeq

Thanks to Dr Jacob for such a wonderful session on lung malignancies.
Dr Jacob explained lung cancer sign symptoms , investigations how to proceed for diagnosis , TNM classification treatment as per TNM classification n guidelines
Why hoarseness of voice occurs , left recurrent laryngeal nerve palsy, left phrenic nerve palsy, Pancoast tumors Types of lung ca Small Cell Carcinoma
Squamous Cell Carcinoma
Adenocarcinoma
Large Cell Carcinoma
Paraneoplastic Syndromes
In small cell Ca 1. SIADH -> Hyponatremia
2. Increased ACTH - Cushings Syndrome
3. Carcinoid -> Flushing & Diarrhea
4. Eaton Lambert Syndrome , In Squamous cell ca
PTHrp - Hypercalcemia
Horner's Syndrome - Ptosis, Miosis, & Anhidrosis Pancoast's Tumor -> 1st & 2nd thoracic nerve - shoulder pain - ulnar nerve pain
adeno carcinoma 1. Pulmonary Osteoarthropathy - pain in hands or legs (XRAY -> Periosteal Elevation)
2. Marantic Endocarditis
large cell ca 1. SVC Syndrome
2. Gynecomastia
TUMOR MARKERS IMMUNOHISTOCHEMISTRY
•Adenocarcinoma-TTF| POSITIVE,CK7,CK20, NAPSIN A POSITIVE, BerEP4 positive
• Squamous cell carcinoma- TTF I Negative, p63,CK5, CK6 POSITIVE
• Small cell carcinoma-TTF I positive, CD56,SYNAPTOPHYSIN, CHROMAGRANIN POSITIVE
• MALIGNANT MESOTHELIOMA- CALRETININ,CYTOKERATIN 5/6,WILMS TOMOUR
D240negative. MANAGEMENT
• Surgery -stage I-111

• Chemotherapy
•Radiotherapy
• Immunotherapy. Surgery in stage 1-3a , LUNG FUNCTION FOR SURGERY
• Lobectomy -post-bronchodilator FEV I is > 1.5 litres
• Pneumonectomy - post-bronchodilator FEVI is >2.0 litre
. Vo2 max min 15ml/kg/minand chemotherapy radiotherapy n rest all explained well.
Thanks Dr Ash for this wonder-full plate-form to learn from the experienced pulmonologist

FEEDBACK # 4

Nasir Hayat

This session was Amazingly presented and well organised and taught. I learned alot and all the Questions were answered.
Thanks to Dr Jacob for such a wonderful session on lung cancer.
Dr Shiraz case presentation was wonderful.
Dr Jacob explained lung cancer classification sign symptoms investigations of choice TNM classification treatment as per TNM classification n guidelines. SVC obstruction syndrome,
Silicosis n Lung TB, hoarseness of voice left recurrent laryngeal nerve palsy, left phrenic nerve palsy, Pancoast tumor syndrome all explained very well c/o CA lung reference.
Treatment Surgery in stage 1-3 n chemotherapy radiotherapy n rest all explained well.
Thanks Dr Ash n LGEM team for arranging wonderful lecture on lung cancer.I would highly recommend it for physicians and ER doctors to join it.Proud to be LGEM candidate .

FEEDBACK # 5

Muzna Ahmed

Today's lecture was on the difficult topic but Dr. Jacob explained all the important aspects of Lung tumors. He described types which includes Adenocarcinoma most common, Squamous cell carcinoma, large cell carcinoma & small cell carcinoma. Risk factors include smoking, family history, second hand smoke, beta carotene, radon gas, exposure to asbestos or other pollutants & radiation.

All type of lung cancer cause paraneoplastic syndromes & hypercalcemia. Superior vena cava syndrome is caused by local spread which blocks it & affecting recurrent laryngeal nerve results in Hoarseness of voice.
Sequence of investigation for diagnosis of lung cancer is the most important ie, chest x-ray within two weeks of unexplained symptoms then CT scan for liver, adrenals & lower neck. Tumor markers immunohistochemistry plays great role in treating lung cancer.
He explained management of lung cancer, TNM characteristics, Non-small cell cancer stages, small cell lung cancer stages, lung function for surgery, surgery or radiotherapy for people for not having lobectomy, surgery for small cell lung cancer, 19% survival rate in Non-small cell lung cancer and so on.
Thank you Dr. Jacob for such a great lecture which is very difficult to diagnose straightway and management required thorough understanding.
Thankyou LGEM and Dr Ash.

FEEDBACK # 6

Anila Zafar

Thank you for an amazing and comprehensive lecture on lung cancer.
He mentioned classification of lung cancer according to TNM classification. How to differentiate between right sided and left sided tumor, SVC obstruction syndrome.
Case presentation by Dr shiraz was also marvellous.

FEEDBACK # 7

Warda Yawar

This lecture was conducted by one of my favorite doctors Dr. Jacob this topic was so difficult but he explained it us very well
I am extremely thankful to him that starting from types of risk factors to symptoms investigation and treatments
he specifies each symptom in detail and palsy and paraneoplastic syndromes, hypercalcemia was taught in detail, then an x-ray ct scan with contrast and staging pet scan, U/s guided biopsy, and what not then treatment was suggested in each stage of lung cancer
thank you so much once again dr Jacob
and dr ASH for this lecture

FEEDBACK # 8

Dr Mishal Shan

The lecture provided a very thorough approach to investigating lung cancers as per NICE guidelines. It also taught us the various ways in which lung tumors can present, both common and rarest ways. We also learned the simplified staging process and basics of management. The case presented by Dr Shiraz was very unique and provided also alot of important learning points.
Thank you Dr Jacob Baby for such a comprehensive presentation! After taking this lecture, I'll keep in mind to think of lung tumour even with rare and unique disease presentations.

FEEDBACK # 9

Dr Ghazala Sheikh

Today's session was full of knowledge, all high yields topics were discussed
I learnt,

● Types of lung Cancer
. Adenocarcinoma which is the most common
. Squamous cell ca
. Large cell ca
. Small cell ca 15%
● Risk factors for lung CA
. Smoking
. Second hand Smoking
. Family hx
. Dietary supplements
. Radiations
. Radon gas
. Asbestos
● Symptoms
. Fatigue
. Cough with or without blood
. SOB
. Repeated chest infections
. Back, shoulder n chest pain
. Blood clots
● Paraneoplastic Syndromes
● Lambert Eaton Syndrome
● Difference bw lambert Eaton and myasthenia gravis

● Hypercalcemia
● Superior Vena Cava Syndrome
● Hoarnessnes of Voice
● Left phrenic nerve palsy
● Pancoast Syndrome
● Sequence of investigations is a must in diagnosis of lung CA
● Chest X ray indications
. Urgent x ray done to be in a 2 week period
● CT chest
● NICE guidelines in Diagnosis and staging of lung CA
● Immunohistochemistry
. Tumor markers
● Managment of lung Ca
. Depends on small and non small cell CA,
● TNM 8_ primary tumor classification
● non small cell lung ca Stages
● Lung function for surgery
● programmed cell death ligand 1
● 19% is overall survival for 5 years

At the end case by Dr shiraz was also amazing, curiosity increased with every slide that when it turns out Lung CA.

Very thanks to Dr Ashfaque Ahmed

FEEDBACK # 10

Dr Bushra Khan

A very difficult topic covered comprehensively. I learned the types if lung tumour, most common risk factors, paraneoplastic syndromes and their presentations, how to investigate and manage each type with updated NHS guidelines. Detailed Self Reflective practice note has already been sent of what I learned in detail. Dr Jacob is always very thorough and to the point. Love attending his sessions.

Brilliant case presentation by Dr Sheeraz. Very relevant to the topic and showed us the importance of all what Dr Baby taught us today

Well done London Gem 💎

FEEDBACK # 11

Dr Amash Khan

Today's topic was beautifully delivered by Dr Jacob about the lung tumors. He described about the types of lung tumors, their risk factors, the paraneoplastic syndromes they cause along with superior vena cava syndrome, investigations needed for diagnosis of lung tumors and their metastasis, their TNM staging and need for radio and chemotherapy treatment for the tumors and some of it's survival rate.
The lecture was brief and he tried to encompass every important detail needed for the diagnosis of lung cancer.
Thank you Dr. Jacob and Dr. Ash for providing this beautiful lecture.

FEEDBACK # 12

Dr Leela Ram

It was brilliant session by Dr. Jacob who explained all the important aspects of diagnosing Lung tumors. He described types which includes Adenocarcinoma most common, Squamous cell carcinoma, large cell carcinoma & small cell carcinoma. Risk factors include smoking, family history, second hand smoke, beta carotene, radon gas, exposure to asbestos or other pollutants & radiation.
All type of lung cancer cause paraneoplastic syndromes & hypercalcemia. Superior vena cava syndrome is caused by local spread which blocks it & affecting recurrent laryngeal nerve results in Hoarseness of voice.
Sequence of investigation for diagnosis of lung cancer is the most important ie, chest x-ray within two weeks of unexplained symptoms then CT scan for liver, adrenals & lower neck. Tumor markers immunohistochemistry plays great role in treating lung cancer.
He explained management of lung cancer, TNM characteristics, Non-small cell cancer stages, small cell lung cancer stages, lung function for surgery, surgery or radiotherapy for people for not having lobectomy, surgery for small cell lung cancer, 19% survival rate in Non-small cell lung cancer and so on.
Though it seemed difficult but tried to give more concentration on it & learnt so many new things. It will definitely improve our practice.
Thank you Dr. Jacob Baby for such a great lecture on lung tumors which is very difficult to diagnose straightway & thank you Dr. Shiraz for nice case & thank you Dr. Ash.

FEEDBACK # 13

Dr Ghulam Saddique

Feedback:

Name: Dr.Ghulam Saddique
Date: 14th January 2023
Tutor: Dr.Jacob Baby Respiratory Consultant NHS UK
Topic: Lung Cancers Acute Presentations
Excellent session and most difficult one discussed by Dr.Jacob in a very precise and easy way so we can assimilate it easily .
Types of lung cancers
Adenocarcinoma (most common)
Squamous cell carcinoma
large cell carcinoma
Small cell carcinoma
Risk factors are Smoking , Secondhand Smoking , Asbestosis , Dietary supplements (Beta carotene)
Symptoms are Back ach Shoulder pain, persistant cough, fatigue, Coughing up of blood, Repeated respiratory infections, unexplained weight loss and blood clot.
Paraneoplastic features are associated with these lung cancers as following
Small cell Carcinoma:

1.SIADH =Hyponatremia
2.increase ACTH= Cushing's Syndrome
3.Carcinoid = Flushing and Diahrrea
4. Eaten Lambert Syndrome
5. Superior Vena cava Obstruction

Squamous cell carcinoma:

1.PTHrp =hypercalcemia
2.Horners Syndrome =Ptosis, miosis, Anhidrosis
3.Pancoasts Tumor =1st &2nd thoracic nerve
4.Shoulder pain =ulnar nerve pain

Adenocarcinomas:

1.Pulmonary Osteodystrophy= Pain In Hands And legs Xrays (periosteal elevation)
2.Marantic Endocarditis

large cell carcinoma:

1. SVC syndrome
2.Gynaecomestatia

Proximal muscle weakness

That improves with movement

Difference between MG & LE syndrome discussed

Hypercalcemia Dehydration,RF could be due to malignancy ,Multiple myeloma

PTHrp 80% in Sq cell CA

PTH levels reduced ,Vit D is also reduced

Sodium can be low by SIADH

Superior venacaval syndrome from Local spread

Extensive network of veins on the chest

JVP dilated non pulsatile

Due to obstruction tumor on right side

Bronchogenic

Small cell

Sq cell

Lymphoma

If its emergency

Stenting of SVC

Chemotherapy can be directly effective

Hoarseness of voice due to left sided tumors

Left vocal cord due to recurrent laryngeal nerve palsy due to tumor

Left phrenic nerve palsy

Left raised hemi diaphragmatic

Pancoast syndrome

Shoulder pain

Tumor infiltrating the brachial plexusis

Hornor syndrome s/s

Paresthesia

Paresis of arm and hand

1st and 2nd rib involvement

Sequence of Investigations discussed

That gives most information with least risk to the patient

X-ray

2 or more unexplained symptoms

Cough

Fatigue

Sob
Chest pain
Weight loss not responding
Persistent RTI
Finger clubbing
Supraclavicular lymhadenopathy
CT chest contrast enhanced
Include liver adrenals
Lower neck

Algorithm for Dx and staging assessment including updates from NICE GL NG 122 DISCUSSED IN DETAIL
CXR normal low suspicion
CXR abnormal CT CHEST
REFER FOR CHEST PHYSICIAN who takes Hx examines fitness assessment, spiromtery ,basic blood tests
Choose investigations that gives max diagnostic and staging info with least risk
PT Who is having fitness status satisfactory then do chest CT if inconclusive then do PET SCAN
Pleural lesion then pleural biopsy
If PET +ve LYMPh node then EBUS IS next investigation
If there IS NO FDG +ve the CT guided biopsy
If pt is having poor performance status leave them for comfort care rather then go for extensive treatment
Tumors markers immunohistochemistry
Discussed . Differentiate different CA
MANAGEMENT
SMALL AND NON SMALL
TNM
TUMOR T1-4
NODE 1-3
METASTATIS 8TH PRIMARY TUMOR CLASSIFICATION
Tumor involving chest wall then T3
Same side of lung nodules T4
Metastatic then M1

EXplained well
Non small cell CA
STAGE O ,I,II can go for surgery ,III, A surgery III B AND C & IV No surgery
IV IS MOST advanced metastases
If tumor is >7 cm then uts T4
SMALL CELL CA
LIMITED STAGE
EXTENSIVE STAGE
MANAGEMENT
SURGERY I-III
RESECTABLE AND OPERABLE
LUNG FUNCTION FOR SURGERY discussed
POST BRONCHODILATOR FEV 1>1 .5 L
Pneumonectomy - >2.0 L
Vo2 max min 15ml/kg/min cardiopulmonary excercise testing .
Surgery and radio with curative for non small cell CA
Surgery and radio for people not having lobectomy
SABR
Surgery for small cells can only be for very early stage
Chemo and radio is 1st line
Etoposide plus cisplatin
Chemoradiotherapy is
For extensive platinum based comb chemo
Metastatic non small Ca
Management
Check for mutations
EGFR In asian non smoker and adeno
ALK mutation
Younger
Metastatic
PDLI programmed cell deatg Ligand I
Check point protein
On immune cells T cells acts as a type of off switch
TREATMENT BASED on there positivity discussed.
SURVIVAL 19% overall

And for stage 1 treated 90%
About 80% directly related to smoking
Marvellous Case presentation by Dr.Sheraz.
Thankyou Dr Jacob for such a detailed topic presentation and picked many points which normally are confusing especially regarding diagnosis and Paraneoplastic syndromes .
Proud to be a part of London GEM Programme.

FEEDBACK # 14

Dr Ahmad Tanveer

A Big topic to cover
Types of LUNG CA
•Adeno ca most common
•Squamous CA
•Large cell CA
•Small cell 15%
Small & non small cell CA
RISK FACTORS
Smoking & 2nd hand smoking
Family Hx
Dietry supllіments B carotein
Radon Gas
Asbestosis
Radiation

S/s
Fatigue
Persistent cough
sob
Coughing up blood
Repeated RTI
Blood clots
Back and shoulder pain
Unexpected weight loss
Paraneoplastic
Small cell CA

SIADH,Inc ACTH
Carcinoid
Eaton lambort
SVC Synd
Sq cell Ca
PTHrp hypercalcemia
Horners
Pancoats tumor
Shoulder pain ulnar nerve

Adenocarcinoma
Pulmonary osteoartgropathy
Marantic endocarditis
Large cell CA
SVC synd
Gynecomastia
Lambert eaton
Antibodies against presynaptic NMJ
Dec acetylcholine release
Proximal muscle weakness
That improves with movement
Difference between MG & LE syndrome discussed
Hypercalcemia Dehydration,RF could be due to malignancy ,multple myeloma
PTHrp 80% in Sq cell CA
PTH levels reduced ,Vit D is also reduced
Sodium can be low by SIADH
Superior venacaval syndrome from Local spread
So many veins on the chest
JVP dilated non pulsatile
Due to obstruction tumor on right side
Bronchogenix
Small cell
Sq cell
Lymphoma
If its emergency

Stenting of SVC
Chemo can be directly effective
Hoarseness of voice due to left sided tumors
Left vocal cord due to recurrent laryngeal nerve palsy due to tumor
Left phrenic nerve palsy
Left raised hemi diaphragmatic
Pancoast syndrome
Shoulder pain
Tumor infiltrating the brachial plexis
Hornors syndrome s/s
Paresthesias
Paresis of arm and hand
1st and 2nd rib involment
Squence of Investigations discussed
That gives most information with least risk to the patient
Xray
2 or more unexplained symptoms
Cough
Fatigue
Sob
Chestvpain
Weight loss not responding
Persistent RTI
Finger clubbing
Supraclavicular lymhadenopathy
CT chest contrast enhanced
Include liver adrenals
Lower neck
Alogrothm for Dx and staging assessment including updates from NICE GL NG 122 DISCUSSED IN DETAIL
CXR normal low suspicion
CXR abnormal CT CHEST
REFER FOR CHEST PHYSICIAN who takes Hx examines fitness assessment, spiromtery ,basic blood tests
Choose inv that gives max diagnostic and staging info with least risk

PT Who is having fitness status satisfactory then next CT chest CT is PET SCAN
Pleural lesion then pleural biopsy
If PET +ve LYMPh node then EBUS IS next investigation
If there IS NO FDG +ve the CT guided biopsy
If pt is having poor performance status leave them for comfort care rather then go for extensive treatment
Tumors markers immunohistochemistry
Discussed . Differentiate different CA
MANAGEMENT
SMALL AND NON SMALL
TNM
TUMOR T1-4
NODE 1-3
METASTATIS 8TH PRIMARY TUMOR CLASSIFICATION
Tumor involving chest wall then T3
Same side of lung nodules T4
Metastatic then M1
EXplained well
Non small cell CA
STAGE O ,I,II can go for surgery ,III, A surgery III B AND C & IV No surgery
IV IS MOST advanced metastases
If tumor is >7 cm then uts T4
SMALL CELL CA
LIMITED STAGE
EXTENSIVE STAGE
MANAGEMENT
SURGERY I-III
RESECTABLE AND OPERABLE
LUNG FUNCTION FOR SURGERY discussed
POST BRONCHODILATOR FEV 1>1 .5 L
Pneumonectomy - >2.0 L
Vo2 max min 15ml/kg/min cardiopulmonary excerxise testing .
Surgery and radio with curative for non small cell CA
Surgery and radio for people not having lobectomy
SABR

Surgery for small cell ca only for very early stage
Chemo and radio is 1st line
Etoposide plus cisplatin
Chemoradiotherapy is
For extensive platinum based comb chemo
Metastatic non small Ca
Management
Check for mutations
EGFR In asian non smoker and adeno
ALK mutation
Younger
Metastatic
PDLI programmed cell deatg Ligand I
Check point protein
On immune cells T cells acts as a type of off switch
TREATMENT BASED on there positivity discussed.
SURVIVAL 19% overall
And for stage 1 treated 90%
About 80% directly related to smoking
Dr Sheraz presented the case of 64yr old male life long smoker
With family hx of cancer
With + ve neuro ss
MRI head and CT non suggestive
Stroke consultant reviewed.
FREOM nystagmus
Ataxia
LP attempted 3 times but delayed to 2 wks
Pschy review done
All labs negative
CSF Wcc raised
WIth Flickering eyelids.
CT chest 2 LN
after 10 days of covid vaccine
Treatment continues as meningitis
Oligoclonal bands +ve

All antibodies screening negative .
PET CT done
Ext left hilar lymphadenopathy
EBUS done.
Malignant cells
2 months of admission completed
Small cell Ca with paraneoplastic syndrome diagnosed.
Single agent carboplatin and assess response 6 cycles.
Methyl pred gave good reposne but later deteriorarated.
Fast track with life expectancy less then 3 months is new term . A great detailed case presentation
Thankyou Dr Jacob for such a detailed topic presentation and picked many points which normally are confusing especially regarding diagnosis and Paraneoplastic syndromes .

FEEDBACK # 15

Dr Muhammad Saad

Today's session was on lung tumors acute presentations by Dr Jacob. He comprehensively described lung cancer, its types, most common ones, staging, clinical findings and treatment according to staging. Dr Jacob also discussed the paraneoplastic manifestations like Lambert Eaton Myasthenic syndrome. Difference between Myasthenia Gravis and Lambort Eatons myasthenic syndrome, pancoasts tumor, SVC obstruction. In the end there was a detail case presentation by Dr Shiraz. Learnt alot of new concepts.
Thanks to Dr Ash and London GEM for such valuable session.

15th JANUARY 2023

EVENT NAME:

Day 4 of 100 Emergency Medicine Procedure Workshop At Lahore Ever Care Hospital.

DOCTORS FEEDBACK

FEEDBACK # 1

Muhammad Ibrahim

Today was another great day at the workshop, full of Learning. Again so many new emergence procedures learned today like:

1. Neonatal resuscitation
2. Fish hook removal
3. Fundoscopy and antenatal examinations
4. Priapism treatment in ED
5. Eye irrigation in chemical injuries
6. How to check eye pH
7. How to remove foreign body from vagina

And much more.

Throughout the workshop 107 emergency procedures were taught, no one imagined, they would learn that much in such short time.

It was absolutely wonderful workshop, although it was a last day of workshop but we still wanted it to continue. The amazing thing about this workshop was that the tutors were so selflessly engaged with you, they were so humble and down to earth, and were spoon feeding everyone of us.

If I Compare myself before and after the workshop, I feel myself a very confident doctor now and I can surely say that I would not never stumble now if i ever see a patient in ER with whatever condition he has, and that is the beauty of LGEM, they gives you so much of confidence and will instantly polish your skills and make you an extraordinary doctor.

Thanks Dr Ashfaque, Dr Syed Ali, Dr Mukhtiar and Dr Azeem and other LGEM members for arranging this incredible workshop for us. I will be indebted to my these mentors for my whole life for doing something for us, that no one did before.

FEEDBACK # 2

Ghayoor Khattak

Today was another great day at the workshop, full of Learning. So many new emergence procedures learned again today like: 1. Neonatal resuscitation 2. Fish hook removal 3. Fundoscopy and antenatal examinations 4. Priapism treatment in ED 5. Eye irrigation in chemical injuries 6. How to check eye pH 7. How to remove foreign body from vagina And so many other Throughout the workshop 107 emergency procedures were taught, no one imagined, they would learn that much in such short time. The amazing thing about this workshop was that the tutors were so selflessly engaged with you, they were so humble and down to earth, and were spoon feeding everyone of us. If I Compare myself before and after

the workshop, I feel myself a very confident doctor now and I can surely say that I would not never stumble now if i ever see a patient in ER with whatever condition he has, and that is the beauty of LGEM, they gives you so much of confidence and will instantly polish your skills and make you an extraordinary doctor. Thanks Dr Ashfaque, Dr Syed Ali, Dr Mukhtiar and Dr Azeem and other LGEM members for arranging this incredible workshop for us. I will be indebted to my these mentors for my whole life for doing something for us, that no one did before

Today was another productive day at the workshop, where I had the opportunity to learn a wide range of new emergency procedures. This included techniques such as neonatal resuscitation, fish hook removal, fundoscopy and antenatal examinations, priapism treatment in the emergency department, and eye irrigation for chemical injuries, as well as how to check eye pH and remove foreign bodies from the vagina. The workshop covered a total of 107 emergency procedures, which was an impressive achievement given the short time frame.

The instructors were highly engaged and dedicated to our learning. They were humble and approachable, providing hands-on instruction and guidance throughout the workshop. As a result, I feel more confident in my abilities as a doctor and better equipped to handle a wide range of emergency situations.

I would like to express my sincere gratitude to Dr. Ashfaque, Dr. Syed Ali, Dr. Mukhtiar, Dr. Azeem and other members of LGEM for organizing such an incredible workshop. Their dedication to teaching and mentorship has had a profound impact on my learning and development as a doctor, and I will be forever grateful for their efforts.

FEEDBACK # 3

Dr Afifa Younis Raja

I feel sad this being our last day, but w are ending the AMAZING WORKSHOP on a great note as we exceeded 100 EM procedures, In fact we learnt 107 procedures. This kind of workshop has never been witnessed before. Today we learned some additional procedures like:

DRE

Neonatal resuscitation

Antenatal exam

Bimaual and Cuscos speculum examination

Fish hook removal
Priprsim
WET FLAG
We got a chance to do hands-on practice of all the procedures.
Certificate distribution was doneat the end.
Overall it was a very successful workshop and i can easily say i have never witnessed anything like this before.

FEEDBACK # 4

Dr Maimona Javaid

Very extensive workshop it was overall .
Really feel need of revision to grab all procedures thoroughly
Dr Ash taught many ENT and eye procedures
Dr Ali lecture was wonderful as always
Dr Azeem lecture was good too
We had good time for hands on practise
All faculty superb
Very helpful and cooperative
Day ended with lots of memories in form of pictures / group photos

Inshallah would like to revise EM workshop at any other station.
Dr Ashfaque being a director and creator of this workshop is indeed one of the best teacher . He teaches with heart and appreciates each student.
Extremely grateful to dr mukhtiar , dr ali , dr amini . They all too great teachers and gave us lot of respect and support in every aspect.
May Allah bless all team more and more ameen .
Dr Mamoona javed
London gem first batch

FEEDBACK # 5

Dr Ruma Mustafa

An other Spectacular day , wonderful opening remarks by Dr. Ash
Theoretical discussion to Hands-On practice
Procedures:
Supra pubic bladder Aspiration
Priapisam and management
Pr examination Digital rectal examination

Proctoscopy
Rectal polyp,Fistula in another
Prolapsed haemorrhoids, etc
Breast Examination
Ischaemic limb due to tight dressing
Suturing of punctured wound
Neonatal life support/RESUSSITATION
Fetal heart sound
Antenatal examination
WET FLAG and so on.
Each station was highly equipped and well organized every one getting the chance to do a practice freely and in a peaceful manner
All the procedures thought in these 4 days are just according to the RCEM CURRICULUM UK standards to have in pakistan. It is a dream come true, totally unbelievable.
Mashallah, we practised almost 107 procedures in 4 days work shop this is truly unbeatable. These practices should continue forever to be confident in good practice to follow the ethical ways internationally or nationally.
It was such an amazing experience with all loving tutors. Thanks so much for each n everything
Dr.Ash (keemiya ban!!! unforgettable speech)
Dr.syed Ali
Dr.Mukhtiar
Whole LGEM trainee

FEEDBACK # 6

Dr Azka Shamim

Aoa respected sir
So today we attended the 4th day of this workshop and literally we were having a feeling for this workshop not to have an end .. how quickly these days are passed but with full of passion and a new energy motivation and inspiration..
It is unimaginable to get ful knowledge and hands on practice of more than 100 EM procedures in just 4 days and to add on also on 4th day along with teaching of new procedures , we were given a plenty of time to revise and repeat hands on practice for all the previous procedures... And this felt amazing
Following important learning points were elaborated:

* Digital globe massage
*Wet flag calculation
*Fish hook removal
*Suprapubic bladder aspiration
*Priapism
*Neonatal life support
*Antenatal examination
*Digital rectal examination
It was a wonderful experience attending all these days and gaining so much knowledge and learning these amazing skills.. really thankful to our great mentor Dr Ash for enabling us to be part of this unique program

FEEDBACK # 7

Dr Irfan Khan

On last day of workshop, I woke up with enthusiasm of learning more and Alhamdulillah I have learned things which I have never even imagine before .
Neonatal resuscitation
Antenatal examination
WET FLAG
Fish hook removal
Management of priapism including draining and phenylephrine injection.
My overall feedback regarding this event is we are blessed to have Dr. Ash because he is a man who came all the way from UK to teach and train us. This is never happened in history before.
Here in pakistan ,when we go to our supervisor to ask regarding some procedure or seek some help we have always faced embarrassment ,bullying and even sometime abusive languague.

FEEDBACK # 8

Dr Mariam Nawaz

Wow, what a day! And we exceeded 100 EM procedures! Infact we learnt 107 procedures. This kind of workshop has never been witnessed before. Today we learned some additional procedures like
DRE
Neonatal resuscitation
Antenatal exam
Fish hook removal

Priprsim
WET FLAG (something very few Drs in Pakistan have awareness about)
We got a chance to do hands on practice of all the procedures. Certificates were distributed and MoU signed with evercare hospital.
The learning I had in past 5 days is more than what I learned in last 5 years. This was only possible because of vision, concern and determination of Dr Ash.
Thankyou so much Dr Ash, Dr Ali, Dr Mukhtiyar and Dr Amini.
Looking forward to practically apply what I learned in this workshop and teach it to others.

15TH JANUARY 2023

EVENT NAME:

High Yield Cardiology By Dr Naila Sorathia NHS UK Consultant

DOCTORS FEEDBACK

FEEDBACK # 1

Rabiyyah Bashir

An important topic , explained beautifully...
Explicit explanation of difficult and tricky SBA questions... How ACS management can change under diff senarios was informative.
Thankyou Dr Naila Ma'am for your effort and time ❤️❤️❤️

FEEDBACK # 2

Bushra Imran

Today was amazing informative session in which questions on daily practice use discussed.I learnt how to approach chest pain ,which patient will admit,who need urgent cardiologist consultation and who will discharge after treatment.ACS management,STEMI with LVF, and rescue PCI.Also discussion done on risk stratification TIMI score,GRACE ,EDAC score .We revised ECG with scenario .Thank you dr Naila for such a excellent session

FEEDBACK # 3

Yasir Dilawar

Topic was high yield cardiology.Dr Naila taught us scenarios of CVS their management.ECGs were discussed.Guidelines like TIMI score,GRACE and EDAC which are very important.such a good session.Thank you Mam

FEEDBACK # 4

Uzma Shaikh

CVS High yields were definitely high yields. Dr Naila amazingly taught us ecgs, management of various presentations of MI and multiple complications. We learnt regarding management and recognition of tachyarrythmias and bradyarrythmias, anticoagulants and their mechanism of actions.
Thankyou for these fantabulous sessions, looking forward to more SBA sessions from you.

FEEDBACK # 5

Muzna Ahmed

It was a most awaited session as it was conducted by dr Naila.
She taught us more than 15 real case based scenarios on HTN, arrythmias, Syncope,Bradycardia in pregnancy,bleeding,headache, chest pain. And How to manage them as an EM registrar. The steps to reverse and stabilize the pt's critical condition, ACS management / protocols on an updated curriculum was taught by her ,she also mentioned Newly introduced Antiplatelets medications and rectified many old usages of Unfractionated heparin/antiplatelets (that are being used blindly in our home country) she had prepared for fine management of acs ,HTn urgencies/Emergencies, chest pains rushing in to ER. Some high yield topics were: HAS-BLED /CHADVAS/ORBIT/TIMIS/HEART /Grace scores/Multifocal atrial tachycardia case/heart block type 1/3 ECgs/Nstemi/Stemi with hypotension/ Hemopericardium don'ts/ aortic dissection / best tx after managing an unstsble cvs pt =PCI, when to discharge/ whether to admit all pts/ VT/ SVT/ pt with pre syncopal symptoms bradycardic on atenolol frst line ? / cardiac first Aid 4 points Oxygen/Gtn infusion/pain killers/Beta blockers (cardio selective)/ urgent 20 mins INR before strting thrombolytics >3 contra, 2-3 assessment, ticagrelor reversible effects low risk/prasugrel irreversible high bleed risk usage.
In short span of time she excellently explained these high yield topics which will be remembered easily.
Thank you Dr Ash Dr Naila for such amazing session this will help in acing exam.

FEEDBACK # 6

Shehzad Hussain

Thanks to Dr Naila for such a wonderful session which started with patient presentations symptoms signs investigations differential diagnosis scoring and treatment all explained very well.
TIMI SCORE
GRACE SCORE
EDAC SCORE
HEART SCORE all explained well,
Ischemic chest pain n cardiac measures
Fondaparinux / Heparin indications
On Warfarin when to thrombolise in STEMI
Failure to re perfusion
Rescue PCI
Persistent n permanent Afib treatment all explained very well.
Thanks Dr Ash n LGEM team for this amazing session it's very helpful with clinically applicable knowledge, many things have been explained which only Trainees will know it's difficult to learn/ understand these things for non trainee Drs. Thanks Dr Naila for this excellent session.

FEEDBACK # 7

Ghulam Saddique Saddique

Session was conducted in a very precise and detailed way and made the session informative and interactive for the GEM participants.
It was case based discussions, topics included use of TIMI score for admission and treatment and predicts 30 days mortality
NICE recommends Grace Score predicts 6 month mortality
EDAC for low risk chest pain assesment in haemodynamically stable patients .
Includes Age ,sex,known case of CAD.
HEART (Hx,ECG,Age,Risk factors,Troponin)
Undifferentiated patients with possible ACS .
Pt. with low risk and repeat troponin after 3 hrs if negative , can be discharged with opd followup.
Initial treatment for ACS , unstable angina, STEMI,NSTEMI same for all
Include: Oxygen if required not for all patient ,GTN,Morphine,B blockers
Antiplatelet and antithrombotic treatment: remember the MOA
Fondaparinux is given in ED
High bleeding risk assessment by using ORBIT/ HASBLED score

Use of Unfractionated Heparin to be given(in case of Renal failure with Cr clearness <30 then no fondaparinux) and monitor APTT 6-hourly.
Dont give Fondaparinux if PCI planned in 24hrs.
Absolute contraindications of BBs in ACS case scenario
Hypotension,Bradycardia,Cardioselective B blockers are preferred(atenolol etc)
urgent angio,High TIMI SCORE
CP not improving within 90min of treatment, STEMI
Remember Thrombolytics contraindications
Tenecteplase and Retiplase are given if PCI facility is more then 2 hrs away.
If already on Warfarin then check INR within 20min of sample if <2 then thrombolyse if >2 but ❤️ then consider risk benefit and if >3 no thrombolytic
If Re infarction repeat ECG in 90 min then rescue PCI
ADP receptor blockers -Prasugril irreversible blockers can use in young with low risk of bleeding patients and Ticagrelor in older patients with ACS - a reversible blocker.
Scenario with STEMI AND LVF - tx is PCI
If Post MI Cardiogenic shock and LVF- give Inotropes
RV infarction with Inf. Wall STEMI
then IV fluids to be given to expand preload
HTN case scenario:
Pregnant lady with Hypertensive Urgency Labetalol and if Pre eclampsia then MgSo4
Memorize Bradycardia algorithm
Aortic Dissection scenario- coronary sinuses with STEMI changes-referral to Cardiac surgery
CP with neurological symptoms
WPW pre-excitation A.fib ECG. Tx is cardioversion
Persistent Vs permanent A.fib
CHADVASC score for stroke prediction .
Use of DOACS
It was a brilliant session. Thanks to Dr.Niala for conducting a wonderful session.

FEEDBACK # 8
Mina Khan

Todays session was very comprehensive, Dr Naila always come up with best explanations. She taught us more than 15 real case based scenarios on HTN, arrythmias, Syncope,Bradycardia in pregnsncy,bleeding,headache, chest pain. How to manage them as an EM registrar. The steps to reverse and stabilize the pt's critical condition all exam related were revealed by her. ACS management / protocols on an updated curriculum was taught by her . Moreover she also mentioned Newly introduced Antiplatelets medications and rectified many old usages of Unfractionated heparin/antiplatelets (that are being used blindly in our home country) she had prepared us for a fine management of acs ,HTn urgencies/Emergencies, chest pains rushing in to ER. Topics included were HAS-BLED /CHADVAS/ORBIT/TIMIS/HEART /Grace scores/Multifocal atrial tachycardia case/heart block type 1/3 ECgs/Nstemi/Stemi with hypotension/ Hemopericardium don'ts/ aortic dissection / best tx after managing an unstsble cvs pt =PCI, when to discharge/ whether to admit all pts/ VT/ SVT/ pt with pre syncopal symptoms bradycardic on atenolol frst line ? / cardiac first Aid 4 points Oxygen/Gtn infusion/pain killers/Beta blockers (cardio selective)/ urgent 20 mins INR before strting thrombolytics >3 contra, 2-3 assessment, ticagrelor reversible effects low risk/prasugrel irreversible high bleed risk usage. Thank you London Global Emergency Medicine for providing us such a high yield platform. Proud trainee🌹

FEEDBACK # 9

Afshan Salman

An excellent comprehensive session by Dr. Naila. We learned ECGs, STEMI, NSTEMI, arrythmias and algorithms and much more. Clinical scenarios, complications and management of various CVS ds. we were taught scores like TIMI, GRACE, HEART and EDAC useful in cardiac emergencies. Thankyou very much

FEEDBACK # 10

Faiq Uz Zaman Khan

Power Packed CVS Session by Dr Naila.
Her presentation consisted of SBAs, ECGs, Clinical Scenarios and Management of various CVS Disorders.
STEMI,NSTEMI, Afib, Bradycardia Algorithm, Tachyarrhythmias, Aortic Dissection, Tamponade ,etc, you name it , she went through the clinical management of all of these diseases in a question and answer format. Thank You

Dr Naila for your time. I will definitely go through all of the scores and algorithms you mentioned. GEM of a lecture.

FEEDBACK # 11

Dr Shahid Ahmad

Learning points of this wonderful session are
1) Timi score
2) GRACE score
3) EDAC score
4) Ischemic chest pain n cardiac measures
5)Fondaparinux / Heparin indications
6)On Warfarin when to thrombolise in STEMI
7)Failure to re perfusion
8)Rescue PCI
9)Persistent and permanent Afib treatment
Thanks Dr Naila for this excellent session

FEEDBACK # 12

Dr Mishal Shan

Like all of Dr Naila's lectures, this one was yet another delight! Loaded with information and high yield clinical pearls that have made me alot more confident in approaching cardiovascular emergencies in the clinic. These include STEMI, NSTEMI, MI with arrythmias, pulmonary edema, high BP etc. She also touched up on a number of scoring systems which help safely escalate treatment plans and also taught us when can a patient be safely discharged. The lecture was very interactive from start to finish and I'm looking forward to many more lectures by her.

FEEDBACK # 13

Dr Leela Ram

It was brainstorming session on CVS, it was interactive and very explanatory. It covered all the important cases of emergency; including TIMI Score, Risk stratification of ACS, EDAC, HEART & what's important for exam.
Many ECGs were discussed, all were important which included Atrial tachycardia, Ventricular tachycardia, WPW syndrome, STEMI, NSTEMI, Heart block & so on.
Overall it was full packed knowledge session.
I have learnt that it's not easy to work independently without proper experience and expertise and address problems with other doctors for admission.

We can't admit every patient and we can't discharge every patient, there are certain guidelines to follow upon.
Thank you so much Dr. Naila Sorathia for this brainstorming & fantastic lecture & thank you Dr. Ash for great LGEM forum.

FEEDBACK # 14

Dr Ghazala Sheikh

I learnt,
● Risk Straitification Pathways
To rule out admissions/discharge of pateint with cardiac sounding chest pain
● TIMI score
. Used for Prognosis and mortality assessment for 30 days
● Grace Score
. Used for Prognosis and mortality assessment upto 6 months
● 1st Aid to all pateints with ischaemic chest pain
. OXYGEN
. GTN
. MORPHINE
. B BLOCKERS
● Anti thrombin we use now is Fondaparinux,
. Before prescribing must access the bleeding risk through
. Orbits score
HAS BLED
● after giving Unfractioned heparin, access bleeding risk after every 6 hours
● in renal failure Fondaparinux is contraindicated
● Don't use Fondaparinux if you plan angioplasty within 24 hours
● Before giving B blockers use in cardiac pateint consider,
. Blood pressure
. Heart rate
● use cardioselective B blockers
. Bisoprolol
. Metoprolol
. Atenolol
● Conseder Urgent angiography when Timi score is high 6_7
● after thrombolysis if symptoms persist Or you repeat ECG after 90minutes but still ST elevation not resolved

. Then Go for PCI don't repeat thrombolysis
● door to balloon time for STEMI is 90 minutes
● Contraindications of thrombolysis
. Ischemic stroke in previous 6 months
. Recent surgery in 3 weeks
. Pt on warfarin
. CNS tumors
In pregnancy and PUD you can do
● if Pt successful thrombolysis,
Still they Need PCI stent in 24 hours
● STEMi with HF
. Do PCI don't waste time in managing HF
● Cardiogenic shock
. Give isotopes then consider intra Aortic balloon pump
● Inferior wall MI
. Give fluids, as they become very hypotensive
● POST MI
. you diagnose MR or VSD
. Its Ventricular wall rupture leading to Cardiac Temponade
. Don surgical correction its an acute emergency
● POST MI
. You diagnose type 1 Heart block
. Do pacing
● HTN urgency
. Don't drastically reduce the BP
. Only increase the dose of his current medication
● HTN emergency
. IV labetalol
● ACS with HTN
. Give GTN infusion
● HTN with AD
. Give labetaolo
● HTN e pregnancy
. Give labetalol
● hemopericardiun with AD

. Don't do pericardiocentesis
● new Onset A_Fib
. Stroke assessment by
. CHAD VASC
. DOCS given
. Warfarin given _ if significant valvular disease or mechanical valves
● MAT * multifocal Atrial tachycardia
. Common in COPD
Other than these points
There were alot of informational stuff

Thankyou dr naila and Dr Ashfaque for making out journey easy 💖

FEEDBACK # 15

Dr Nasir Hayat

This session was Amazing and wonderful taught. All the Questions was answered .I learned a lot.
By today lecture we learnt how to approach chest pain and which patient will admit and which we discharge
We also learnt risk stratification like TIMI score, GRACE, EDAC, HEART score and all pathways. We also refresh our mind in different ecg and we also revise different hypertension management. Besides these we also learnt where is our weak point in cardiology and how to study for MRCP. It was very nicely presented and was organised well.I would high recommend it for physicians and ER physicians to join it.Proud to LGEM candidate.

FEEDBACK # 16

Dr Amash Khan

Today's topic was seems somewhat like a mock test to recall most of the important aspect of some of Cardiovascular diseases presented in the ER by Dr. Naila. She provided with different scenarios and asked the questions related for the diagnosis, treatment and further management of the presented diseases while explained them as we move on to the next questions. These helped in re-remembering the knowledge and a guide to what the examiners ask for and expect us to know.
Thank you Dr. Naila for your guidance and lectures.

FEEDBACK # 17

Dr Muhammad Saad

Today's session was on high yield cardiology. Dr Naila extraordinarily described the gist of cardiology in such a short duration of time. It was an interactive interesting session. It was exam as well as emergency orientated. A lot of scenarios were discussed focusing on lab investigations and main treatments. It was such a wonderful session.
Thanks Dr Ash London GEM for arranging such session.

FEEDBACK # 18

Dr Ahmad Tanveer

It was a real brain storming session. Fast paced targeted for high yeild CVS topics of interest.
Exam oriented guidance at registrar level the performance RCP wants
•How tp access all chest pains who need admissiom significance of TIMI Score if its more then 4 then admission and cardiology consult.
TIMI score discussed that predicts 30day mortality
Scoring OF TIMI includes
Age>65, Already having 3 or more CAD risk factors,ASA in past 7 days,>2 episodes of angina in past 24hrs ,ST changes >0.5mm on ECG,+ ve cardiac markers.
Needed for prognosis and treatment stretegy .
Grace Score predicts 6 month mortality recommended by NICE.
EDAC for low risk chest pain assesment in haemodynamically stable patients .
Includes Age ,sex,known case of CAD.
HEART (Hx,ECG,Age,R/Factors,Troponin)
Undifferentiated patients with possible ACS .
Patient having low risk and repeat troponin after 3 hrs is -ve can be discharged with opd followup.
If high risk then admission and serial assessment.
1st scenario is all about the theme how to proceed with a Chest pain in ED ,who needs admission and treatment ,referral to cardio team.
2nd scenario Base line treatment for ACS
INCLUDES
Oxygen
GTN
Morphine
B blockers

AND THIS remains same for ACS ,USA,STEMI,NSTEMI cases.
Then Antiplatelets treatment discussed in scenario
Fondaparinux is given in ED as 1st add.
High bleeding risk assessment to be done by using ORBIT/ HASBLED score
In case Unfractionated Heparin to be given(incase of Renal failure with Cr clearness <30 then no fondaprinix)then have to monitor APTT 6hourly.
No Fondaparinux if PCI planned in 24hrs.
Mechanism of all Antiplatelets and antithrombotics to be familiar with
CONTRAINDICATION of B blockers in ACS
1- HYPOTENSION
2-Bradycardia
Cardioselective B blockers are preferred
Consideration of urgent angio
High TIMI SCORE
CP not settling with in 90min of treatment
STEMI
Door to balloon time is 90min
Thrombolytics
Tenecteplase and Retiplase are given if PCI facility is more then 2 hrs away.
Contraindications discussed.
If already on Warfarin then check INR within 20min of sample if <2 then thrombolyse if >2 but <3 then consider risk benefit and if >3 no thrombolytic
If Re infarction repeat ECG in 90 min then rescue PCI
ADP receptor blockers
Prasugril in young with low risk of bleeding patients as its irreversible blocker
While Ticagrelor in older patients with ACS and its reversible blocker.
Scenario with STEMI AND LVF
then BEST TREATMENT is PCI
If Post MI Cardiogenic shock and LVF
then INOTROPES & IABP
RV infarction with IW STEMI
then IV fluids to be given to expand preload
Several ECGS discussed
HTN scenarios were wonderful as they are common encounters and confusing

Pregnant lady with Hypwrtensive Urgency Labetalol and if Pre eclampsia then MgSo4 can also be tried
Bradycardia alogrithm to be memorized.
Aortic Dissection scenario with lower extension leading to involvement of coronary sinusis with STEMI changes then surgical emergency referrral to Cardiac surgery

CP+ neurological symptoms dissection to be focussed.
Afib with pre excitation ECG in pt having WPW TREATMENT is cardioversion
Afib Persistent permanant discussed .
CHADVASC score for stroke prediction .
Use of DOACS
In clear view Dr Naila has stormed our brains very well in such a short period of time and She is excellent teacher . Make sense of every scenario what RCP needs us to know . Thanks alot Dr Naila for such a lively and power packed session .

21ST JANUARY 2023

EVENT NAME:

Radiology Pearls for EM & Acute Physicians By Dr Muhammad Imran Consultant Radiologist NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Warda Yawar

As far as I think about this lecture that it should be a must in every setting institution training setup for a better understanding because every doctor has a right to understand between different modalities
We as a Pakistani dr is facing difficulties with every passing day's health system compromised dr Imran taught us to at least examine the diagnosis at the bed site of the emergency patient whether RTA head trauma spinal injury blood fluid in the stomach

he taught us every radiology modality in a 2.5-hour session in detail and answer every question we asked him
thank you so much dr Ash for organizing this lecture and thank you dr Imran for conducting such as extra ordinary lecture for us I will share my knowledge with my friends

FEEDBACK # 2

Qaisar Shah

Basic concepts of radiology ,Various imaging modalities ,Right imaging modality at the right time for the right patient ,How to interpret each imaging modality,Covering common and some uncommon presentation with What imaging next and how to request appropriately & How to avoid unnecessary imaging/radiation .
Dr.Imran explained epidural, subdural, and subarachnoid hemorrhage presentations on CT scans and how to look for signs of air, blood, CSF, collections, infarcts, and hemorrhage on CT scans. They were encouraged to think outside the box when making a diagnosis and considering the next steps in management. The speakers also touched on the use of MRI signal intensity for T1 and T2 . Overall, it was a comprehensive and valuable session that provided a solid foundation of knowledge and clinical correlation for the diagnosis of scenarios in the emergency department. Thank you to Dr. Ash for organizing such a beneficial session.

FEEDBACK # 3

Yasir Dilawar

It was an amazing session by Dr Imran.he taught us about the basics of X-ray, Ultrasound,CT and MRI.How to interpret CT and MRI.how the different structures like bone,blood,soft tissue look on CT and MRI.he also explained CT brain and some cases like Extradural Hematoma,Subdural Hematoma, Subarachnoid hemorrhage,intraparenchymal hemorrhage.swirl sign which indicates active bleeding.mid line shift in a CT.Aneurysm and infarct.Some learning about the anatomical structures of brain.it was amazing.i enjoyed it so much.I am waiting for another session with Dr Imran.

FEEDBACK # 4

Mina Khan

Human body isc75% water, we see densities in imaging. X rays are unidirectional beams /opacity/lucency terminologies used.CT is same as X rays but are multidirectional 360/180’ beams. Contrast X rays (IV pyelogram) are replaced by

CT-KUB. Pregnancy/Renal impairement relative contraindications. CT has attenuation/densities/shades of gray/Hounsfield unit /CT aortogram/mesentericangiogram/pulmonogram/CT contrast pelvic/abdomen.Appreciate axial/transverse scans/sagittal scan/Air1000hu/Lung 500Hu/Fat 50hu/water 0hu / soft tissue/blood 50hu /bone 1000 hu. Fluid confined by inflammatory wall /renal abcess/appendicitis/SMA Thrombosis/ if RFTs are normal/hydration is good then do contrast. MRI has signals/ intensity/ no rasiation/no X rays used.Gadolinium dye/T2 show urine/CSF white/if pt moves in scanner then alignment gets disturbed image becomes blur/Ultrasound has echogenicity/sound waves / Contrast US dye air bubbles/microbubbles/prerequisites preganancy bladder should b full/ Posterior ischemic stroke -best is MRI (not picked on CT) EDH accumulation of mid meningeal arterial blood biconvex collection/ swirl sign clotted/unclotted acute blood a life threatening sign on ct / give and urgent call to neurosurgery in that case. SDH crosses the suture/ causes elderly falls/shaken baby syndrome /boxing. Intracparenchymal bleed/ basal ganglia/pons/cerebellum HTN bleed /arteriovenous malformation/venous sinus thrombosis/posterior fossa neoplasm/CT non contrast-acute hypodense round area/hematoma (mixed/iso hyperdense/deep ICH rupture into ventricles/lobar hematoma caused by cerebral amyloid angiopathy . SAH /order CT- Angiogram/ blood in SAH /ACA bleed most common/sylvian fissure(mid cerebral artery) bifurcation. Perimesencephalic Subarachnoid Hemorrhage /non aneurysmal . Active bleed (contrast pooling) CTA spot sign . if there is dural sinus clot venous infarct noted at a distance with reperfusion injury ,then CT venogram is indicated.

FEEDBACK # 5

Warda Yawar

As far as I think about this lecture that it should be a must in every setting institution training setup for a better understanding because every doctor has a right to understand between different modalities

We as a Pakistani dr is facing difficulties with every passing day's health system compromised dr Imran taught us to at least examine the diagnosis at the bed site of the emergency patient whether RTA head trauma spinal injury blood fluid in the stomach

he taught us every radiology modality in a 2.5-hour session in detail and answer every question we asked him

thank you so much dr Ash for organizing this lecture and thank you dr Imran for conducting such as extra ordinary lecture for us I will share my knowledge with my friends

FEEDBACK # 6

Muhammad Abubakar

A wonderful session by Dr. Imran about different Radiological modalities, their differences, how to interpret, what to do when to do & how to do in a specific patient.

Xray

Ultrasound

CT

MRI

He started from basics then to the specifics of each and every modality like how the CSF and brain tissue looks in CT, how to see subdural, extradural and intra parenchymal bleed, hemorrhagic infarct, venous infarct nd much more.

The great lecture overall. Thank you Dr. Ash and LGEM for arranging such an amazing faculty and topics for us.

FEEDBACK # 7

Dr Afifa Younis Raja

Greetings of the day!!

Today we had an amazing session on Radiology for EM & Acute Physicians By Dr Imran Consultant Radiologist NHS UK

Dr Imran had a great command over the topic and it was surreal learning from such a great mentor, especially on a very difficult subject for me. The most captivating thing about Dr Imran's lecture was the humbleness and the way he slowly and gradually went through his slides making sure we all were engaged and understanding each and everything.

First we covered the basics of all radiology modalities. Then we discussed thoroughly the neuroimaging of commonly presenting ER cases.

Extradural hemorrhage

Subdural hemorrhage

Subarachnoid hemorrhage

Intraparenchymal hemorrhage

It was an amazing session and I learned a lot which will definitely reflect in the

day to day practice
Thank You so much DR Ash for bringing on board such great mentors.

FEEDBACK # 8

Dr Mishal Shan

The lecture picked up from the very basics and ended up giving us a comprehensive practice of the CT scans which we might encounter in the ER. It was also great to learn how and when to request the relevant scans even before the neurologist/ neurosurgeon receives the patient. Even though we have learned about brain hemorrhages previously, I still learned so many new things which we were never taught before. e.g identifying ongoing bleed in CT, locating venous sinus thrombosis etc. Enjoyed every bit of it!

FEEDBACK # 9

Dr Ruma Mustafa

Fantaboulus session taught by Dr.imran
he explained in a comprehensive way each n every slide was too intresting to understand
I learnt many important points
Imaging modalities
Right image... right time ... right patient
Avoid unnecessary imaging
Image interpretation
Xray...opacity vs. Lucency
CT...Attenuation/density
MRI...signal intensity
USG...Echogenicity
Nuclear...uptake
Fluoroscopy...filling defect
Contraindications... pregnancy,B.feeding,
Renal impairment
Xray..specific to place/
CT..360 view of image(axiel/coronal/sagittal) contrast/without contrast
Acute Bleed,fractures
Different densities in CT
Air <Fat<Water<Soft tissue <Bone<metal
Lung window

Bone window
Soft tissue window
MRI ..T1.. Anatomy
T2..pathology
lesion,demylinating diseases, unidentified Ischaemic stroke
DWI
FLAIR
STIR
MRA
USG waves.. reflected.. solid gas..bright
Transmitted..fluid..dark
Doppler USG..direction of bloodflow
Neuroimaging...Cerebral hemorrhage
Extradural..swirl sign(active bleed),biconvex,
unilat,fracture
Subdural..cresentric,supra tentorial convexity
Subarchnoid..
Parenchymal...
stages of hemorrhage MRI
Hyper Acute<24hrs
Acute 1-3days
Early Subacute >3days
Late Subacute >7 days
Chronic > 14 days
Venous infarct
Cerebral ischemic infarct
How to look for blood and CSF
CTA<DSA<aneurysm >coiling
Although,everything precisely explained in 2 & half hr that r not enough for the radio seems more to learn inshallah Inshallah
Highly intellectual session in a very short span. greatful learning
Thanks alot to my mentor,
Dr.Ash
Dr.imran
Whole LGEM team

FEEDBACK # 10

Dr Wajeeh Nazar

Dr. Imran's talk on the Radiology for EM and Acute Medicine was VERY Well articulated. As a matter of fact, Dr. Imran presented the material in the most effective way possible. X-rays, CTs, MRIs, fluoroscopies, and ultrasound were among the imaging modalities he covered, along with their indications and contraindications. WE LEARNED VERY IMPORTANT IDEAS AND NEW CONCEPTS 1. SUBDURAL HAEMOR. HYPERDENSE CRESENTERIC SPREAD DIFFUSELY NO SUTURES TO CROSS LESS PRESSURE ON BRAIN THAN EXTRADURAL 2. SUBDURAL GENERALLY SUPRATENTORIAL MAY CROSS THE STURES CAUSE IS MAINLY IS RAPID MOVEMENT OF HEAD, VENOUS DISTURBANCES BLEEDS SLOW SHAKING BABY SYNDROME ELDERLY PEOPLES WITH REPETITIVE INJURIES 2. LEARNED IMPORTANT POINTS OF DIAGNOSING EXTRADURAL HEM 3.SEEN CT OF VENOUS INFARCTS, METS, TUMORS AND SOL 4. CT IN ACUTE AND CHRONIC HEM. 5.DDS BY LOCATION We are all eagerly awaiting the next presentation. Many Thanks to Drs. Ash and Imran for sharing their invaluable knowledge of radiology in emergency settings with us.

FEEDBACK # 11

Dr Amash Khan

Today's lecture by Dr. Imran was beautifully explained as simply as possible. He started with the basics of imanging and guided on what, when and how many types of radiological imaging to use in ER along with the findings shown. He covered the neuroimaging in detail. He lectured about houndsfield unit, CT brain,bone and soft tissue, MRI T1 and T2 and different findings which can be found in these imagings.

Thank you Dr. Imran and Dr. Ash for this lecture.

FEEDBACK # 12

Dr Mariam Nawaz

So much discussed in 2 hours but with the main aim of ensuring that everyone exits the lecture with clear concepts. Dr Imran has an impressive way of teaching. We had a session on radiology for nonradiologists, and Sir cleared so many of our concepts.

We learned about different radiological modalities available and how they work and how their views are interpreted. Then, we learned in detail about diagnosing extradural, subdural, SAH, and interparynchymal haemorrhage, aided my multiple images to clarify the subject. I learned a lot, I. These 2 hours. I am looking forward to more amazing sessions by Dr Imran. Thankyou Dr Imran, Dr. Ash, and Lodon GEM.

FEEDBACK # 13

Dr Azka Shamim

Aoa respected sir

Today on 21st January 2023 we had an amazing session with Dr Imran (consultant radiologist) NHS UK regarding the radiology for non radiologists .. so it was a power pack of 2.5 hrs with so much interactive discussion that made this topic palatable and easy to understand.
Dr Imran started the session teaching all the radiology basics , physics of x-ray , CT scan and MRI and basic concepts .. following important points were highlighted during the session
* various imaging modalities
*How to avoid unnecessary radiation,
*What imaging to be done next
*Different windows of CT
*Interpretation of CT in ischemic and hemorrhagic infarct
* How to look for density in CT and intensity in MRI
*Active bleeding in hemorrhagic infarct _ do NECT
*Epidural/subdural and subarachnoid haemorrhage
*Thrombus/perimesencephalic infarcts
*How to look for blood or CSF and intraparenchymal bleed
*T1 and T2 sequence of MRI
Infact radiology seemed to be a little difficult to understand but thanks to our great mentor Dr Ash for arranging the best sessions for us regarding any topic and bringing the right teacher for us .. Dr Imran explained every concept amazingly and made it very easy
Thank you so much Dr Ash for this great opportunity

FEEDBACK # 14

Dr Leela Ram

Overall session was outstanding, it covered Radiology from very basic to advanced. Dr. Imran demonstrated everything in simple and digestible way, he explained Basics ie;

1. X-ray is read as opaque vs lucent
2. CT is read as attenuated/ dense
3. MRI: signal intensity
4. Ultrasound: echogenicity
5. Nuclear: uptake
6. Fluoroscopy: filling defect

Tissue density is measured in Housefield HU; it increases in this order ie; Air>Fat >Fluid>Soft tissues>Bone>Metal.

We have to see specific window for specific structures in CT scan.

While MRI has two sequence: T1 & T2

T1: Water is dark: better for anatomy (Soft tissue structures)

T2: Water is bright: better for pathology (inflammation and oedema)

While Ultrasound waves are reflected by solid and gas are bright whereas transmitted(not reflected) by fluid is dark.

CT vs MRI:

CT: Acute setting, good for acute hemorrhage, may be good for acute ischemic stroke, good for fracture

MRI: good for those cases where Ischemic stroke not clear on CT, for space occupying lesions (SOL) further, for demyelinating diseases for example Multiple sclerosis.

Types of Cerebral hemorrhage:

1. Extradural
2. Subdural
3. Subarachnoid
4. Parencymal

Extradural hemorrhage is hyperdense, biconcave, more than 95% unilateral, supratentorial, doesn't cross sutures, compress underlying brain & skull fracture is present in 90-95%.

He discussed Subdural hemorrhage, different diagnosis by location, subarachnoid hemorrhage, Intraparenchymal hemorrhage, Cerebral ischemic infarct & taught many different CT scans & other scans.

Session was interactive & understandable. I learnt many new things, it cleared my concepts and more improved my reading of radiographs.
Thank you so much Dr. Imran for wonderful session and thank you so much Dr. Ash for considering the addition of Radiology for Acute Physicians for MRCP candidates.

FEEDBACK # 15

Dr HK Danish

Radiology is the key to diagnose in emergency medicine
DR Muhammad Imran Consultant Radiologist NHS explained every thing so nice and clear
Before this session I couldn't interpret CT , now I can differentiate between hemorrhage mass and infarct .
Some of the points that I learned in this session are ..
Basic Radiology investigations , thier mechanism and how to perform them
Limitations ,Indications and contraindications of various Radiology procedures
Ct scane views , axial coronal and sagittal. Tissue density difference . Soft tissue bone and lung window
MRI in t1 water is dark in t2 water is bright , t1 is used for better anatomy, in STIR like t2 but fat is dark for edema in tissue and perianal abscess
Ultrasound, acoustic shadow and enhancement, doppler study .
Neuro imaging. CT vs MRI
Cerebral hemorrhage types,
extradural looks better in NECT , extra dural is confined in sutures , it creates extra pressure. Extra dural hemorrhage 90 to 95 % have skull fracture. Swirl sign in hematoma suggest active bleeding . Occurs in accident due to manengeal artery injury
Sbdural hemorrhage, it shows crescent appearance. Between arachnoid and inner layer . Supratentorial convexity most common, occurs in elderly due to veins problem .
Acute on chronic subdurab hemorrhage.
DDS on the on the site of bleed .
Subarachnoid hemorrhage is 80% due to anurysm . Go for CT angiogram. Most common bleed is in anterior communicating artery.
Perimesencephelic subarachnoid hemorrhage.
Thanks Dr Ash and Lgem team for providing us this amazing learning experience

FEEDBACK # 16

Dr Nasir Hayat

This session was Amazingly presented.I learned alot .All the Question was Answered.

It was an interactive lecture ,which was almost for 2.5hrs duration.It was a comprehensive lecture explaining in detail the use and diagnosis based on Xray ,CT Scan ,CT Angio ,MRI ,Ultrasound .Then He explained about how to apply the knowledge in clinical settings ,medical conditions which we encounter in daily life in ER.The difference between the diagnosis of Epidural ,Subdural and subarachnoid hemorrhage presentations on CT scan in the ER setting .How to look to for Air ,Blood ,CSF ,collection ,Infarct ,Hemorrhage on CT scan and to think out of the box during diagnosis about the next management approach.MRI signal Intensity for T1 to detect water which will be dark used better for anatomy (soft tissue) ,and T2 signal where water is bright better to detection of Pathology ie collections ,Inflammation etc.Terms like DWI,FLAIR,STIR ,MRA which helps in different clinical diagnosis of MRI.Altogether it was a power pack session to give us basic knowledge and clinical correlation for diagnosis of scenarios in ED.I would highly recommend it for ER physicians and physicians to join it .Proud to be LGEM candidate.

28TH JANUARY 2023

EVENT NAME:

High Yield EM By by Dr Saba Shiraz Registrar EM NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Hani Suhail

High yeild emergency medicine by dr saba was an amazing session where we learnt about different topics in a very short time with up to the point knowledge and it was a very much needed session. thank you very much

FEEDBACK # 2

Syed Suhail Ahmad

An excellent exam oriented session on High Yield EM By Dr Saba Shiraz Registrar EM NHS UK.
Important SBAs were discussed interactively involving topics like Pre-eclampsia, Eclampsia, Anti-D immunoglobulin, Testicular appendage torsion and Blue dot sign, and some important radiological signs on x-rays like eyebrow sign, lisfranc injury, role of wet flags etc.
Thank you LGEM, PEMA for arranging such sessions 👍👍👍

FEEDBACK # 3

Khatija J. Farooqui

Such an amazing session by dr saba on on high yield EM SBA question of Mrcem exam based topics
Mainly covering Peads , Gynae (hypertensive emergency pre eclampsia&eclampsia)CVST,ortho and X-rays.
Thrombolysis in unstable, priapism testicular torsion (blue dot)eyebrow sign in orbit fracture ,mid foot ankle fracture sedate and manipulate nt wait for X-ray, Anti B immunoglobin indication,anti D indication, TIA thrombolysis and PE management guideline, BRUE, Wet Flag ETT ,opioids naloxone indication and many more thanks to dr Ash and team LGem for this wonderful session.

FEEDBACK # 4

Rida Rana

AlhumdulliAAllah attending a super amazing session by Dr Saba Shiraz on High Yield topics commonly questioned in MRCEM Examination . It was in deed a very precise session , well focused on exam preparation and covered a wide range of topics starting from gynae and obs topic and ending with orthopedics. The best part was in that it was entirely interactive and comprised of questions and their answers. The topics were covered in the explanation of the answers and thus it grabbed the attention of every candidate . Hopeful to attend more of such session from Dr Saba . thank you so much Dr **Ashfaque Ahmed** for bringing such amazing faculty on board who teach us with the pure intention of making get through and through the exam . AlhumdulliAAllah on being part of LGEM.🌹

FEEDBACK # 5

Rajab Abbas

Such a power pack knowledgeable session by Dr Saba in which she comprehensively covered very high yield exam oriented SBA questions starting from gynae to paeds,orthopaedic and x-rays.

Important learning points of today's session are :
• Indications for Anti D
• cases of pre eclampsia
• TIA and guidelines from DVLA
• Lisfranc #
• Importance of Shelton's line
• Drugs causing Priapism
• BRUE
• Indication for Naloxon infusion
• WET FLAG
• CVST
Thank you Dr Saba for this quite interesting and engaging session.
Thank you Dr ASH for arranging this session
A proud GEM Candidate

FEEDBACK # 6

Muhammad Azeem Imran

Power pack excellent session . important learning points were
1. Pre eclampsia start in 20 weeks UpTo 6 weeks Postpartum period. .
2: Pregnant female@10 week may present with loss of consciousness , headache & vomiting Differential include venous sinus thrombosis .
3: Patient with pulmonary embolism after CTPA , with worsening hypoxia & hypotension,the most appropriate step in treatment is Thrombolysis.
4: Massive pulmonary thrombus , unstable patient, cardiac arrest - treat with thrombolysis
5: WET FLAG question for ETT size diameter in 4 years old boy
6: Any fracture with neurovascular compromise - the initial management is sedation and manipulation.
7: Anti D immunoglobulin indications - closed abdominals injury/ fall in third trimester, APH , invasive procedure, Ectopic pregnancy, therapeutic termination of pregnancy, spontaneous abortion<12 weeks , threatened miscarriage>12 weeks.
8: BRUE in Prematurity
9: Blue Dot sign - torsion of testicular appendix management with pain killer , no surgery
10: Notify DVLA in TIA , PCA
11: antipsychotics - priapism

12: Eye brow sign of orbital emphysema
13: any breach in shenton line indicate NOF
14: Lisfranc fracture - wide gap in first metatarsal space , due to injury of Lisfranc ligament between medial cuneiform and second metatarsal bone. - C/ F Plantar ecchymosis. can't walk on tip toe.
so weight bearing XRay, oblique view should be taken .
Amazing session, to impart knowledge. Thank you Dr Ash for arranging such a vibrant plateform for learning SBA MRCEM , Jaza kum Allah khair.

FEEDBACK # 7

Bushra Imran

Thank you dr Saba for today's informative session...discussion on basic ER related questions i.e on causes of eclampsia and preaclampsia with look for CVST ,appropriate treatment for pt with pulmonary embolism with thrombosis,WET FLAG and its components,also told how to calculate the size of oral ETT in 4yrs old child and then the formulas for size and length,,the pt with ankle fracture +nuerovascular compromise and need to sedate in ER ,management of OVERDOSE of opioid,high &low risk for BRUE.I learnt about testicular appendage/torsion and blue dot sign which need to treat conservatively rather than to refer for surgery +Lisfranc fracture which I doesn't know before.The drugs causing Priaprism ,x ray of facial fracture ,femur neck fracture and importance of shenton's line...though the session was interestingly excellent
Thank you dr Saba and Dr Ash

FEEDBACK # 8

Hamna Yaqub

Amazing session of high yield emergency medicine by Dr Saba
We learned that pre eclampsia can present up to 6 weeks post partum.
The first line in UNSTABE PE PATIENT is thrombolysis.
WET FLAG components.
BRUE in children.high and low risks of BRUE.
If you find neuro vascular compromise in fracture, immediately sedate and manipulate.
Anti B immunoglobulin indications.
management of opiod overdose.
Diagnosis and treatment of testicular appendage torsion(blue dot sign).
DVLA guidelines for TIA.

Shenton line importance in NOF.
Drugs causing priapism.
Eyebrow sign in orbital fracture.
Lisfranc fracture and its importance as it can cause unstable mid foot.
The whole session was interactive, Dr. Saba way of teaching was simple and explanations are very clear.
Thankyou Dr Saba.
Thank you Dr Ash for arranging thus session.

FEEDBACK # 9

Muhammad Yameen

Very productive and focused session conducted today by Dr. Saba Awan.
She covered different specialities in one hour session.
In this session we learnt about:
CVST
Pre-eclampsia
Thrombolysis in PE
ETT(oral) in pediatrics
Sedation and manipulation in deformed ankle
Anti D immunoglobulin in RH negative pregnant patient
Naloxone infusion in heroine addict
High risk BRUE
Testicular appendage torsion
Blue dot sign
Single and multiple TIA and DVLA instructions
Drugs causing Priapism
Eye brow sign in orbital emphysema
Shenton's line in NOF fracture
Lisfranc injury and it's importance.
The session was very nice that no one wanted it to end.
Thank you Dr. **Ashfaque Ahmed** for bringing such amazing tutors onboard.

FEEDBACK # 10

Amir Ashraf

It was a truly amazing session , such a power pack and informative session with wide range of Questions .
We were taught :

1) eclampsia and preeclamsia is seen after 20weeks of gestation till 6 weeks post partum , so if any pregnant pt presents before 20 weeks , look for CVST .
2) we thrombolyse the pt with PE as most appropriate management even if hemodynamically unstable .
3) WET FLAG and its components , specially how to size oral tube length .
4) it pt has ankle fracture with neuro vascular compromise , just sedate and manipulate don't wait for xray or ortho .
5) Indication for Anti B immunoglobin
6) managing opoid overdose pt , even if gcs drops after initial dose , start Naloxone infusion as its hald life is very short , intubation won't help much .
7) high and low risk for BRUE
😎 testicular appendage torsion and a blue dot sign . Manage conservatively with pain management , no need for surgery.
9) DVLA guidelines with TIAs
10) MC drugs causing priapism
11) xray of eyebrow sign in facial fracture.
12) neck of femur fracture and imp for shenton's line.
13) lisfranc fracture and how imp it is to diagnose as it can cause instable mid foot .
I will say todays session really woke me up after immediate long 8 hours duty .
Thankyouu Dr Saba 👍
Thankyou Dr Ash for arranging such an amazing lecture .
Proud LGEM trainee .

FEEDBACK # 11

Imtiaz Ali Shah

Today we had a comprehensive exam preparatory session by Dr Saba covering important emergency medicine topics.It was an interactive session with mcq,s of high yield topics and their explanation. Dr Saba did a wonderful job in this short period of time and tried her best to deliver most of important learning points.The different scenarios cover the following topics like
Pre-eclampsia..up to 6 weeks post partum .
PE and need of thrombolysis.
Paediatric life support and use of WETFLAG .
INDICATIONS of Anti-D immunoglobulin.
Role of NALOXONE in opiates overdosage.

Assessment of patient with BRUE and HIGH RISK AND LOW RISK BRUE .
TESTICULAR APPENDAGE TORSION with blue dot sign.
TIA and ĎVLA.
Drugs causing PRIAPISM
It was an excellent session by dr Saba covering most of emergency scenarios He made the things interesting and understandable for us.Overall it was a fruitful session
At the end I would like to thanks dr Saba for this wonderful presentation and also dr Ash for providing us this amazing platform of learning in the form of London GEM.

FEEDBACK # 12

Yasir Dilawar

In this session Dr Saba discussed about difference between eclampsia and seizure in antenatal period.A scenario about venous sinus thrombosis,Patient with pulmonary embolism after CTPA with hypoxia & HTN most appropriate treatment Thrombolysis,WET Flag for ETT size,BRUE in prematurity and radiology scenarios which were very useful.

FEEDBACK # 13

Qaisar Shah

Today, Dr. Saba led a session that lasted for one hour. The topic of discussion during this session was high-yield MCQs, specifically those related to emergency medicine.

> Eclampsia and preeclampsia typically occur after 20 weeks of gestation and can continue up to six weeks post-partum. Therefore, if a pregnant patient presents before 20 weeks, it is important to consider the possibility of cerebrovascular sinus thrombosis (CVST).

>The most appropriate management for a patient with a pulmonary embolism (PE) is thrombolysis, even if the patient is hemodynamically unstable.

>Indications for administering anti-B immunoglobulin.

>In managing a patient with opioid overdose, if the patient's Glasgow Coma Scale (GCS) drops after the initial dose, it is important to start a Naloxone infusion as its half-life is very short and intubation may not be as effective.

>High and low risk factors for BRUE (bronchiolitis, RSV, URI, and exacerbation of asthma/COPD).

>DVLA (Driver and Vehicle Licensing Agency) guidelines for patients with TIAs (transient ischemic attacks).
>Medications that can cause priapism.
>If a patient presents with an ankle fracture and neurovascular compromise, it is best to sedate and manipulate the fracture immediately rather than waiting for an x-ray or orthopedic consultation.
>Testicular appendage torsion and the "blue dot sign." This condition can be managed conservatively with pain management and surgery is not typically necessary.
>Neck of femur fractures and the importance of Shenton's line in diagnosis.
>Lisfranc fractures and the importance of early diagnosis as they can cause instability in the midfoot.
>WET FLAG and its components, specifically the proper technique for determining the appropriate length of an oral tube.
>The "eyebrow sign" on an x-ray in the case of a facial fracture.
The session was extremely informative and beneficial, as it was filled with discussions that covered high-yield and important information. The material covered during the session is likely to be helpful for those preparing for medical exams or for practicing emergency medicine. Overall, the session was well-structured and contributed to a deeper understanding of the topic at hand.
Thanks Dr.saba and Dr.Ash for this amazing session.

FEEDBACK # 14

Afshan Salman

Today had very informative and useful session with Dr. Saba. MRCEM SBA Questions were discussed. We learned:
. CVST needs to be considered if patient with nausea, vomiting, headache comes before 20 wks of pregnancy and its not pre-eclampsia.
. Pre-eclampsia extends from 20th wk of gestation upto 6 weeks postpartum.
. Importance of WET FLAGs and how to calculate ETT length in children,
. Management of ankle dislocation with neurovascular compromise.
. Naloxone in opioid toxicity.
. Concept of BRUE.
. BLUE-DOT sign.
. TIA & DVLA,
Priapism, Shenton's Line, Lisfranc Injury and much more.

An interactive and interesting session. Thankyou very much Dr. Saba and Dr. Ash for the wonderful session

FEEDBACK # 15

Dr Aakash

Learning points were👇👇

==> Eclampsia is common after 20 th week of gestation.

_____

==> preclampsia starts after 20 th week & can remain up to 6 th weeks postpartum.

_____

==> what is the difference between Appropriaite & next best treatment.

_____

==> formula for Length of ETT oral tube to be used in children is (age /2) +12

_____

==> Manipulation of ankle fracture.

_____

==> learnt about the indication of Anti- D immuniglobulins.

_____

==> How to use nalaxone infusion...?

==> Learnt about what is brue.? Risk factors for that.

most important risk factor is Pre-maturity

Brue is very benign disease.

_____

==> What is DVLA guidance for TIA patients..

==> what is Blue dot sign.? what does it shows.

==> Drugs causing priapism.?

_____

==> Also learnt about different x-rays,.

It was a really wonderful & fruitful session.

_____

Proud to be the part of the London gem .❤️

FEEDBACK # 16

Rana Gulraiz

The lecture was a totally interactive session which was in mcq format to demonstrate all the important topics and life case scenarios which we encounter in day to day life in the ED.It comprised of diagnosis of Eclampsia and Preeclampsia

,CVST .Management of PE ,indications for administration of Anti-B immunoglobulin, Opioid overdose and risk of withdrawal symptoms to reappear if opioid removal is done all at once.High and Low risk factors for BRUE identification and management accordingly.DVLA guidelines of dealing with patients with TIAs and to change the management according to single or multiple TIAs,Medications that cause priapism .Tension appendage torsion and the blue dot sign used for diagnostic purposes, Neck Of Femur Fractures and importance of Shenton's Sign ,WET SIGN and appropriate length of an oral tube. The Eyebrow sign on xray of a facial fracture .Lumbric sign and Management accordingly.

Thankyou very much Sir Dr Ashfaque Ahmed ❤️

FEEDBACK # 17

Mina Khan

Today's session was related to exam questions, she had put her hard earned efforts in making questions for all candidates. We were taught.
10weeks primigravida presenting with nausea /dizziness and seixures the next day , its CVDT , whereas eclampsia occurs after 20 weeks/ 40 yrs pt coming with hypoxia/sbp 80/ SOB/suspected PE , tx thrombolysis/ Pels WET FLAG/ in case of joint vascular injury tx immediate sedation/manipulation/cant hold for an Xray/ 30 wks anemic gravida hx of fall/ no injury /us normal / B negative next step simple give anti D imm as a protocol in last smester of a negative pt/ opoid posioning nalaxone given/ gcs 7 improved /but deteriorating again/ start naloxone infusion / BRUE assessment (havent seen such diqgnosis in my home country) in premature babies/ guidance regarding TIA/ 1st episode no symptoms/ no notifying dvla/ban driving fr 1 month/multiple episodes notify dvla ban fr 3 months. Drugs causing priapism tcas/antidepressants/ lisfranc xray/ shentons line /eyebrow sign Xray/plantar ecchymosis . Learned and noted ... Thank you **London Global Emergency Medicine**

FEEDBACK # 18

Beenish Manzoor

Today we had a power pack and fully exam oriented case base discussion session on Many regular based emergency medicine cases..
Imp learning points were:
1.eclampsia and preeclampsia seen after 20 weeks. cvst should be in differentials if pregnant female present before 20 week

2.eclampsia can ve present after postpartum upto 6 weeks
3.thrombolyse pt with PE if pregnant and even if hemodynamically stable
4. DVLA guidelines about when to report them and what to do in case of TIA
5. fracture,tendency to missed diagnose it,how to manage it(surgica6 intervention)
6.xray findings (eyebrow sign) in case of facial fracture and looking for shenton' s line in case of neck of femur fracture.
7. Testicular torsion- a clinical diagnosis which has similar symptoms to that of torsion but no surgical intervention required, just conservative management enough. Intervention is required only if symptoms not relieving or diagnosis is unclear.
8. case of ankle fracture with neuro vascular compression, don't wait for ortho ,simply sedate and manipulate the fracture.
9.when to give anti D Immunoglobulin to pregnant patients.
10.heroine abuse and when to give naloxone infusion, being mindful of full reversal of opioid as can lead to withdrawal symptoms.
11.high and low risk BRUE
12. Drugscausing priapism
13.how to diagnose CVST
14.west flag and how to calculate Ett size
Truly interactive session by Dr Saba .
Thanks Dr Ash
Thankyou LGEM candidate
Proud gem trainee 🙏

FEEDBACK # 19

نا صر ف اطمہ

It was really amazing and comprehensive lecture. Dr Saba disscussed really important topics and that too in very palatable way
Some of the chunks for readers that what we learned, so that reading a comment can benefit them..
1) the duration for eclampsia and preeclampsia is from 20weeks of gestation till 6 weeks post partum.. so don't miss it in postpartum patient thinking she can't have it
2)if patient with PE is unstable.. top line management is thrombolysis
3)WET flag.. its really an important thing.. its a whole chart about how to calculate different measurements

4) many of the disclocations are supposed to be dealt by ER physician.. we shouldn't bother ortho peeps for the stuff, we can do.. but obviously in case of any complication or for the stuff that is beyond your capacity.. do ask them for help 🙂
5) indications for Anti-B immunoglobin in pregnancy.. these shouldn't be miss.. read and absorb them all 🙂
6) managment of opioid overdose patient.. Dr Ash taught this in workshop.. that reversal and infusion should be maintain if patient is deteriorating again and again.. and that patient shouldn't be discharged (Nalaxone has shorter half life)
7)high and low risk BRUE.. when to labell it
😎 managment of torsion of testicular appendage causing blue dot sign. Surgery is not required.. conservative management and reassurance is needed
9) DVLA guidelines for TIA patients and importance of documentation
10)facial injury Xray showing eyebrow sign
11) priapism..
12) shentons's line importance to see fracture of neck of femur in xray
13) lisfranc fracture.. ab yeh toh google kryn na ap 😁
jazakALLAH khairan kaseera Dr Ash.. for bringing all this to us.. can't thank ALLAH pak g enough.. Alhamdulilah for being part of LGEM

FEEDBACK # 20

Saba Aslam Khan

Comprehensive, exam oriented session with Dr Saba, it was highly interactive the thing I liked the most was we were in continuously in the state of brain storming because there were continuous MCQs before every topic so we were taught academically as well as reasoning and tricks to attempt the MCQs, how to understand the stem, what examiner is actually asking …..
topics we learned were,
-HTN in pregnancy
-CVST
-Pulmonary embolism
-use of Anti-D immunoglobulin
-DVLA guidelines
-Fractures (femur,ankle)
- Xrays
-blue dot sign
-testicular torsion

- opiods overdose and management
-BRUE
-Priapism causing drugs
Thank you so much Dr Ash for arranging high yield lecture …. Really helpful..
A proud GEM trainee

FEEDBACK # 21

Zia Hayat

It was an amazing lecture for almost one hour covering all the major topics related to Emergency Medicine.The lecture was a totally interactive session which was in mcq format to demonstrate all the important topics and life case scenarios which we encounter in day to day life in the ED.It comprised of diagnosis of Eclampsia and Preeclampsia ,CVST .Management of PE ,indications for administration of Anti-B immunoglobulin, Opioid overdose and risk of withdrawal symptoms to reappear if opioid removal is done all at once.High and Low risk factors for BRUE identification and management accordingly.DVLA guidelines of dealing with patients with TIAs and to change the management according to single or multiple TIAs,Medications that cause priapism .Tension appendage torsion and the blue dot sign used for diagnostic purposes, Neck Of Femur Fractures and importance of Shenton's Sign ,WET SIGN and appropriate length of an oral tube. The Eyebrow sign on xray of a facial fracture .Lumbric sign and Management accordingly .All together it was a power pack session which was an eye-opener to study for the Exams with full confidence. Thankyou Dr.Ash for arranging the amazing session by Dr.Saba .

FEEDBACK # 22

Shehzad Hussain

Thanks to Dr Saba Today session on high yield SBA by Dr Saba was amazing she covered many topics Eclampsia Preclampsia Pulmonary Embolism BRUE DVLA Lisfrance fracture and many more topics she had done detailed discussion on Q and answers topic related. It was very good comprehensive lectures with clinical exam based knowledge. Thanks to Dr Ash n LGEM team for arranging wonderful SBA high yield session.

FEEDBACK # 23

Anila Zafar

A very comprehensive session by Dr Saba , it was amazing from the exam point of view. It had me brainstorming the whole time. She also mentioned how should we approach the MCQ questions and how to really understand what is being asked.
I learned about:
Eclampsia
Preeclampsia
CVST
Fractures of femur and ankle
Pulmonary embolism
X-rays
Blue dot sign
Torsion
Drug overdose and its management
BRUE
I would like to thank Dr ASh for keeping this lecture , it really helped.

FEEDBACK # 24

Dr Ruma Mustafa

Wonderful session Amazing experience
I have leanrt so many informative things regarding the exam
1- Pre-Eclampsia.. seizures not before than 20 weeks till 6 weeks P.P
2- CVST.....Pureperium lady with alt.sinsorium cerebral venous sinus thrombosis could be missed tx HEPARIN
3- Thrombolysis...P.E,massive thrombus,unstable patient,cardiac arrest
4- ETT length for 4 Yrs....14cm... PLS WET FLAG
5- Sedate and Manipulate....Ankle fracture neuromuscular compromised
6- Anti-D immunoglobulin...RH Incompatibility With B- blood group...avoid hemolysis of foetal blood cells...falls
7- Nalaxone infusion uptill 4mg 24 hrs... herion addict,pinpoint pupil GCS 7, no need of intubation required
8- Prematurity....high risk feature of BRUE
Infant <2months <32 weeks at birth =/>1
event
9- Testicular appendages torsion... Blue dot sign ,no surgery required (new thing, in pk its Emergency) conservative management

10- Single TIA...1 month drive cessation, no notify DVLA/ Multiple TIA...3month drive cessation, must notify DVLA
11- Sertaline Most common anti depressent causing priapisam
12- intraorbital emphysema...frontal skull xray.... Curvilinear lucency superior aspect of the right orbit showing a black eyebrow sign..orbital fracture
13- Shenton's line..Hip xray....identifying NOF /lower limb trauma..loss of contour of Shenton's line is a sign of fractured NOF
14- Lisfranc injury ... Planter ecchymosis while footballing
Very informative and intellectual session given by Dr. Saba she is mastermind Mashallah ,super brainiac . She knows very well how to tackle the exam question
Thanks soOo much Dr.saba such amazing SBA practice
Thanks a lot, Dr.Asfaque, for everything and every effort ...can't thank u enough
I am truly grateful

BLESS U AND WHOLE GEM TEAM 💚💙💜💖

FEEDBACK # 25

Dr Maimona Javaid

Good lecture on high yield SBA covered all imp topics , great learning it was though many of my Answers were incorrect . Still I learnt . Dr ash had a great start discussion . Followed by dr Saba lecture . Topics included eclampsia: preeclampsia, Thrombolysis , BRUE , high and low risk , DVLA, femur fracture. Lisfrance fracture was a new term for me . Eye brow sign in facial fracture and much more . Grateful dr Saba and dr ashfaque. Inshallah will revise it again.
Dr mamoona
London gem first batch

FEEDBACK # 26

Dr Ghayoor Khan

It was a wonderful session regarding exam.
Dr.Saba had covered all aspects very well,she prepared this session excellently.
Scenarios regarding Gynacological disorder, Poisoning(anti-dote), Drugs(side effects), X-rays(fractures and specific signs) and Paeds(wet flag formula)were discussed.
I have learnt a lot about exam that how to exactly answer the question which was asked.

I will be waiting for another session.
Thanks
Dr.Saba Shiraz and LGEM

FEEDBACK # 27

Dr Amash Khan

Today's lecture was of discussion on MCQs of different topics which are seen in the ER like anti D and tetanus admistration, orbital edema, BRUE, lisfranc fracture, testicular appendage torsion, stroke, shenton's line, etc. They were very informative and of importance in Emergency medicine.

FEEDBACK # 28

Dr Faizan Ur Rehman

Assalam o alaikum Dr Ash. I hope you are doing well. I had a lot of fun with today's session. I feel that bcqs are best form of learning. The session was really fun and interactive. Multiple topics were discussed including gynae, orthopedics, pediatrics and some diagnosis that are easily missed in the ED.
Dr Saba did an amazing job with the presentation honestly not a moment was I out of it. All focus was on the questions. I really enjoyed the x ray part. I think such lectures are really helpful to me at this stage as I am prepping for PLAB 1. In my opinion the best learning points that I thought i would miss were pre-eclampsia presents post partum 6 weeks as well so important not to miss that. Furthermore, it was nice to learn that we reduce fracture in the ED instead of calling orthopedics for all fractures. My love for emergency medicine really at it's peak rn.
Last but not the least like always I am grateful to this platform. I hope to continue learning in the future.
Thank you.

FEEDBACK # 29

Dr Afifa Younis Raja

Greetings of the day!!
Another awesome lecture arranged by Dr Ash, I am amazed how he foresees what topic to be arranged and when, arranging such a great session at the start of our exam is a mindful stroke to orient us with the format and keep us vigilant about the toughness of the exam as well.
We had a healthy discussion on High Yield Emergency Medicine By Dr Saba Shiraz Registrar EM NHS UK.

Dr Saba's way of teaching is phenomenal, selecting high yeild topics and then discussing the exam points this will definitely benefit in our exams. We covered:

- Preeclampsia
- Venous sinus thrombosis
- Opioids and Naloxone
- BRUE
- TIA and DVLA
- Testicular appendage torsion
- Priapism
- Lisfranc injury
- Orbital emphysema
- Shenton's line or NOF fracture
- PE and thrombolysis
- WET FLAG
- Anti D immunoglobulins

Thank you Dr Saba for such an informative session, I really wanted the lecture to continue for another hour as the learning process was so interactive.
Thank Dr Ash for bringing amazing faKIfacultyforward.

FEEDBACK # 30

Dr Mishal Shan

EM doctors need to quickly evaluate a situation, reach a differential diagnosis and formulate a management plan. This lecture full of SBA type questions gave us a very thorough practice of how to approach such scenarios in the exam and in real life. I got to learn about CVST in pregnancy, infant BRUE, approach to naloxone poisoning, some orthopedic injuries, and alot more in this one hour.
It was a great practice session and I am really looking forward to more of such brainstorming activities.

FEEDBACK # 31

Dr Nasir Hayat

This session was Amazing and well organised and very well taught.I learned alot. Thanks to Dr Saba Today session on high yield SBA by Dr Saba was amazing she covered many topics Eclampsia Preclampsia Pulmonary Embolism BRUE DVLA Lisfrance fracture and many more topics she had done detailed discussion on Q and answers topic related. It was very good comprehensive lectures with clinical

exam based knowledge. I would have highly recommend it for ER physicians to join it .she answerd all the Questions. Proud to be LGEM candidate

FEEDBACK # 32

Dr Aakash

Learning points were 👇👇

==> Eclampsia is common after 20 th week of gestation.

==> preclampsia starts after 20 th week & can remain up to 6 th weeks postpartum.

==> what is the difference between Appropriaite & next best treatment.

==> formula for Length of ETT oral tube to be used in children is (age /2) +12

==> Manipulation of ankle fracture.

==> learnt about the indication of Anti- D immuniglobulins.

==> How to use nalaxone infusion...?

==> Learnt about what is brue.? Risk factors for that.

most important risk factor is Pre-maturity

Brue is very benign disease.

==> What is DVLA guidance for TIA patients..

==> what is Blue dot sign.? what does it shows.

==> Drugs causing priapism.?

==> Also learnt about different x-rays,.

It was a really wonderful & fruitful session.

FEEDBACK # 33

Dr Nouman

It was an amazing session with very interesting mcqs that were discussed with a view on exam & clinical skills focus.

Dr Saba really put great effort in helping to understand the question & answers and everyone was eager to participate.

Thanks Team LGEM and Dr Saba for such informative session. Hoping to see more of this

28TH JANUARY 2023

EVENT NAME:

Renal Dysfunction In Systemic Diseases MRCP High Yield By Dr Naila Sorathia Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Rajab Abbas

Today's session was knowledgeable and exam oriented. In Two hours session she explain and elaboratd every aspect affecting renal disfunction.

• Cause of AKI (pre/intra/post renal)
• Renovascular disease
• SLE Nephropathy
• Stages of diabetic nephropathy & Role of ACE inhibitors
• New knowledge what I learned today was about Renal Screen . It was new term for us in which causes of renal dysfunction is sought out. By sending labs for related connective tissue disorders.
• She talked about Amyloidosis in detail with exam point of view.
• She also explained renal vascular disease. Its pathophysiology and systemic involvement.
•Cinical difference with multiple myeloma and MGUS
• Difference between HUS and TTP .

Thank you Dr Naila and Dr Ash for this session.
A proud LGEM candidate

FEEDBACK # 2

Mina Khan

Todays session by dr naila was very comprehensive , she taught about SLE nephropathy which has signs of proteinurea/nephrotic syndrome/progressive AKI/CKD/ drug induced sle doesnot involve kidneys/ drugs causing sle phenytoin/ hydralazine/biopsy is needed to stage disease/type 1/2 mild form no tx required/3/4 stage need high dose of steroid/cylophosphamide. Scleroderma crises (HTN/microangiopathic anemia/aki) tx ace inhibitors/Diabetic Nephropathy/microalbuminea/macroalbuminea/capillary damage protein leakage/>200mg/L proteinuria/24hr urine test not possible, do albumin-creatinine ratio test/stage 1 GFR>20% /stge 2 hypertrophied kidneys/hyperfiltratin/stgr3 microalbuminuria/stge4 macroalbuminuria/stgr 5 EKSD / tx ace inhibitors/ARBs /strict glycemic control/bp 130/80mmhg/ other causes of renal failure

HUS/TTP/Hypertensive nephrosclerosis. Learned and noted alot. Thanks London Global Emergency Medicine

FEEDBACK # 3

Yasir Dilawar

In today's lecture Dr Naila gave us a lot of valuable concepts like RAAS system,SLE nephropathy, Diabetic Nephropathy,Micro and Macro Albuminuria,Stages of Diabetic Nephropathy,Thrombotic microangiopathies,HUS, difference between HUS and TTP,Myeloma vs MGUS, Vasculitis and it's classification,Wagener Granulomatosis and much more.she also discussed the various screening tests for kidney diseases and management of these conditions.it was very good lecture.Thanks to Dr Naila mam.

FEEDBACK # 4

Suhail Ahmed

A very commonly tested topic for MRCP exam yet very volatile to remember. A hot subject in MRCP exam.
This teaching session gave me the great insight into this topic.
Dr. Naila included all the common. Systemic diseases that affects the kidneys such as Amyloidosis, Myeloma, Connective tissue diseases.
Thank you so much Dr. Nails and Dr. Ashfaaque for this great learning activity.

FEEDBACK # 5

Ghulam Saddique Saddique

Exceptional session conducted by Dr.Naila Ashfaque Full of Knowledge pearls she shaired. Exam focused targed mcq points to be asked in scenarios .
AKI mostly presents with vague symptoms
Classification
Pre Renal Causes (vascular)
Renal causes Intrinsic
Post renal Obstructive cause
Renal causes then classified as
•Glomerular -nephritis nephrotic synd Glomerulonephritis
•Intrestitial mainly by medications
•Tubular by RTA,Medications contrast, amyloidosis, Rhambdomylosis.

Then such a details discussion done by Dr Naila about the Extrinsic causes leading to RENAL Failure in AKI setting. Systemic disorders like amyloidosis,RV diseases,connective tissue diseases,Diabetes, HTN, thrombotic microangiopatheis.
Amyloidosis discussed in detail.
Presentation with Proteinurea,nephrotic syndrome renal failure.
AL Light chain with poor prognosis.
AA amyloidosis better prognosis then AL subtype.
Kidneys are the main target in AA.
Heriditary Amyloidosis
Biopsy of target organ to be done to confirm which stains congo red.
Explaination of amyloidosis pathophysiology was great as it comprisis of light chains of immunoglobulins being clumped up and deposit in kidneys leading KI, In heart leading to RCMP, Arrhythmias and LVH. Peripheral neuropathy macroglosia.
50% cases of amyloidosis have multiple myeloma
AA amyloidosis discussed secondary to
Ch suppurative disorders like TB
Ch inflammatory disorders like CTD
Rheumatological conditions .GI IBS,Whipples
Renovascular disease discussed in detail
Atherosclerosis as main pathophysiology.
Renal atery stenosis .
Fibromuscular dysplasia in young patients constitues 10% cases of renovascular with poor controlled HTN.
RAAS system explained.
For screenjng Doppler RV
Gold standard MRA / CTA
Then briefly Connective tissue diseases discussed.
Mixed CTD SLE RA
Renal screen a bunch of tests to get the confirnation about the cause of AKI explained. Heard it for 1st time.
Includes Myeloma screen
RA factor, cANCA pANCA , ANA ,anti dsDNA , Complient factors, HbA1c
Diabetes and its renal complications discussed as its #1 causes of renal failure.
Its screening

Proteinurea as micro and macro albumin urea discussed.
How to cath up with spot urinary ACR .
HTN leading to AKI
MGUS stable plasma protein disorder vs Multiple Myeloma with end organ damage discussed.
Vasculitis types affecting the kidneys discussed in details
HUP in children vs TTP in adults discussed
Whole session by Dr Naila nonstopped covered all the high yield topics with such an extreme dedication of a TECHER . Highly obliged leared alot .

FEEDBACK # 6

Dr Ahmad Tanveer

Dr Naila's todays session was as usual more then expectations. Full of Knowledge pearls she shaired. Exam focused targed mcq points to be asked in scenarios .
AKI mostly presents with vague symptoms
Classification
Pre Renal Causes (vascular)
Renal causes Intrinsic
Post renal Obstructive cause

Renal causes then classified as
•Glomerular -nephritis nephrotic synd Glomerulonephritis
•Intrestitial mainly by medications
•Tubular by RTA,Medications contrast, amyloidosis,
Rhambdomylosis.
Then such a details discussion done by Dr Naila about the Extrinsic causes leading to RENAL Failure in AKI setting. Systemic disorders like amyloidosis,RV diseases,connective tissue diseases,Diabetes, HTN, thrombotic microangiopatheis.
Amyloidosis discussed in detail.
Presentation with Proteinurea,nephrotic syndrome renal failure.
AL Light chain with poor prognosis.
AA amyloidosis better prognosis then AL subtype.
Kidneys are the main target in AA.
Heriditary Amyloidosis
Biopsy of target organ to be done to confirm which stains congo red.

Explaination of amyloidosis pathophysiology was great as it comprisis of light chains of immunoglobulins being clumped up and deposit in kidneys leading KI, In heart leading to RCMP, Arrhythmias and LVH. Peripheral neuropathy macroglosia.
50% cases of amyloidosis have multiple myeloma
AA amyloidosis discussed secondary to
Ch suppurative disorders like TB
Ch inflammatory disorders like CTD
Rheumatological conditions .GI IBS,Whipples
Renovascular disease discussed in detail
Atherosclerosis as main pathophysiology.
Renal atery stenosis .
Fibromuscular dysplasia in young patients constitues 10% cases of renovascular with poor controlled HTN.
RAAS system explained.
For screenjng Doppler RV
Gold standard MRA / CTA
Then briefly Connective tissue diseases discussed.
Mixed CTD SLE RA
Renal screen a bunch of tests to get the confirnation about the cause of AKI explained. Heard it for 1st time.
Includes Myeloma screen
RA factor, cANCA pANCA , ANA ,anti dsDNA , Complient factors, HbA1c
Diabetes and its renal complications discussed as its #1 causes of renal failure.
Its screening
Proteinurea as micro and macro albumin urea discussed.
How to cath up with spot urinary ACR .
HTN leading to AKI
MGUS stable plasma protein disorder vs Multiple Myeloma with end organ damage discussed.
Vasculitis types affecting the kidneys discussed in details
HUP in children vs TTP in adults discussed

In nutshell this lecture Dr Naila nonstopped covered all the high yield topics with such an extreme dedication of a TECHER and GURU. Highly obliged leared alot .DR ASH thanks for todays lectures pearls by you too . 

FEEDBACK # 7

Dr Ghazala Sheikh

Today's session was very useful in exam point of view, totally exam oriented, I learnt the importance of each topic related with systemic diseases impacting kidneys

● AKI
. Causes
. Classification
. Renal causes defined in detail
. Drugs causes interstitial nephritis
. Tubular nephritis by contrast, RTA etc
● Systemic disease such as SLE
. Mostly nephritic picture
. Amyloid depositions
. Sceleroderma
● Diebeties and kidney
. Stages of diebetic nephropathy
. Stages of Proteinuria
. Ace/Arbs renoprotective
● importance of renal Screening
● Thrombotic disorders and kidney
. HUS mostly in children
. Child+AKI+diarrhea. Must exclude hus
. Thrombopenic Thrombocytopenic purpura mostly in adults
● Myloma and kidney
. Difference bw multiple myeloma and MGUS
● Atherosclerosis in renal arteries
. Pathophysiology
● Fibromuscular Dysplasia

Overall lecture contained very important points, reviewing again and again will make us a better grip on Renal system

Thankyou mam naila for giving us your precious time 💖

FEEDBACK # 8

Dr Afifa Younis Raja

Greetings of the day!!
So today we got lucky and got BONUS LECTURE from DR ASH J
The topic was renal dysfunction in systemic diseases by Dr Naila Ashfaque, I love the way she teaches us and how she highlights the exam's favourite points.
Topics we covered today:

- Evaluation of AKI
- CAUSES of AKI (pre renal, renal, post renal)
- Renal causes of AKI (intrinsic and extrinsic)
- Common systemic disorders affecting kidney
- Amyloidosis classification
- AL Amyloid (light chain amyloid) can deposit everywhere in body apart from brain

o For definitive diagnosis biopsy of involved organ with Congo red stain

- AA Amyloid
- Reno vascular disease (Renal artery stenosis, firbromuscular dysplasia)
- Connective tissue disorders affecting kidney
- SLE nephropathy
- Diabetic nephropathy
- Albuminuria
- Thrombotic microangiopathy
- HUS
- TTP
- HTN in kidney
- Myeloma and kidney

It was an amazing interactive session, and this has definitely polished our clinical skills.
Thankyou Dr Naila for an incredible session and Dr Ash for the bonus session.

FEEDBACK # 9

Dr Mishal Shan

Like every lecture by Dr Naila, this one was also great and gave us alot of practical information which is relevant not only for the exam but also in routine practice. She covered a lot of causes and presentations of renal disease, told us which condition to suspect in which situation and how to proceed with further investigations and management. 2 hours of the lecture were worth each and every minute!
Thankyou very much for such useful classes!

FEEDBACK # 10

Dr Leela Ram

It was an awesome session on renal manifestations of systemic diseases by Dr. Naila Ashfaque, she explained the causes of Kidney failure:
1. Pre-renal(decreased kidney perfusion)
2. Intrarenal causes
3. Post renal causes (Obstructive uropathy)
Variety of causes affect kidney function from acute to drugs and insidious.
Amyloidosis remains one of the causes which affects kidney & causes proteinuria, nephrotic syndrome and CKD.
Biopsy reveals Congo-red staining. Classification of Amyloidosis:
1. Light chain (AL Amyloidosis) has poor prognosis
2. AA Amyloidosis: it targets heart
3. Hereditary Renal Amyloidosis
Atherosclerosis causes narrowing of renal arteries which result in activation of RAAS (Renin>Angiotensinogen>Angiotensin-I>Angiotensin-II>Aldosterone>Na+H2O retention+ ADH which causes retention of water) which increases blood pressure.
Common systemic disorders affecting kidneys are:
1. Amyloidosis
2. Renovascuar disease
3. Connective tissue disorders
4. Diabetic nephropathy
5. Thrombotic microangiopathy
6.Hypertension
7. Myeloma
8. Vasculitis
9. CCF

Some other causes include Fibromuscular dysplasia in younger patients with history of hypertension.
Entire session covered all investigations and treatment options and also side effects.
I have learned so many new things & will strive to give more and more input in studies for MRCP exam.
Thank you so much Mam for terrific session & thank so much Sir for motivating us for the best.

FEEDBACK # 11

Dr Nasir Hayat

This session was very well presented and Taught.I learned Alot.
Dr Naila's todays session was as usual more then expectations. Full of Knowledge pearls she shaired. Exam focused targed mcq points to be asked in scenarios .
AKI mostly presents with vague symptoms
Classification
Pre Renal Causes (vascular)
Renal causes Intrinsic
Post renal Obstructive cause
Renal causes then classified as
•Glomerular -nephritis nephrotic synd Glomerulonephritis
•Intrestitial mainly by medications
•Tubular by RTA,Medications contrast, amyloidosis, Rhambdomylosis.
Then such a details discussion done by Dr Naila about the Extrinsic causes leading to RENAL Failure in AKI setting. Systemic disorders like amyloidosis,RV diseases,connective tissue diseases,Diabetes, HTN, thrombotic microangiopatheis.
Amyloidosis discussed in detail.
Presentation with Proteinurea,nephrotic syndrome renal failure.
AL Light chain with poor prognosis.
AA amyloidosis better prognosis then AL subtype.
Kidneys are the main target in AA.
Heriditary Amyloidosis
Biopsy of target organ to be done to confirm which stains congo red.
Explaination of amyloidosis pathophysiology was great as it comprisis of light chains of immunoglobulins being clumped up and deposit in kidneys leading KI, In

heart leading to RCMP, Arrhythmias and LVH. Peripheral neuropathy macroglosia.
50% cases of amyloidosis have multiple myeloma
AA amyloidosis discussed secondary to
Ch suppurative disorders like TB
Ch inflammatory disorders like CTD
Rheumatological conditions .GI IBS,Whipples
Renovascular disease discussed in detail
Atherosclerosis as main pathophysiology.
Renal atery stenosis .
Fibromuscular dysplasia in young patients constitues 10% cases of renovascular with poor controlled HTN.
RAAS system explained.
For screenjng Doppler RV
Gold standard MRA / CTA
Then briefly Connective tissue diseases discussed.
Mixed CTD SLE RA
Renal screen a bunch of tests to get the confirnation about the cause of AKI explained. Heard it for 1st time.
Includes Myeloma screen
RA factor, cANCA pANCA , ANA ,anti dsDNA , Complient factors, HbA1c
Diabetes and its renal complications discussed as its #1 causes of renal failure.
Its screening
Proteinurea as micro and macro albumin urea discussed.
How to cath up with spot urinary ACR .
HTN leading to AKI
MGUS stable plasma protein disorder vs Multiple Myeloma with end organ damage discussed.
Vasculitis types affecting the kidneys discussed in details
HUP in children vs TTP in adults discussed

In nutshell this lecture Dr Naila nonstopped covered all the high yield topics .I would high recommend it for physicians to join it.Proud to be LGem candidate.

FEEDBACK # 12

Dr Faiza Arshad Baig

Today's session was an eye opener and wonderfully informative. It was based on Mrcp exam high yields.

She described all the renal manifestations of systemic disorders step by step:

Renal causes and its classification

Pre renal causes

Renal causes

Post renal causes

She told us how to classify renal causes

First micro and macro albuminuria then for diagnosis aspects

1- glomerular

2-tubular

3- interstitial

4- vascular

Then she described Amyloidosis in detail with exam point of view

It's deposition, staining and classification: light chain with poor prognosis,

A-A amyloidosis main kidney organ and cardiac involvement

Heridatory

✨peripheral neuropathy plus proteinuria and renal function deranged in amyloidosis

✨AL infiltrate any organ other than brain.

She also explained renal vascular disease. Its pathophysiology and systemic involvement.

Renal screening:

BUN , eGFR, serum creratinine, urinalysis, Microalbuminuria,, UACR(urine albumin to creatinine ratio) ,

ANCA for Vasculitis, Glomerular basement membrane antibodies for Goodpastures ds,

ANA for SLE or other connective tissue disorders, Serum urine Electrophpresis for Myeloma,

C3 C4 for immune comlex Nephritis

C3,C4, ANA, ANCA, cryoglobulins,, MPO (myeloperoxidase antibodies), IgG IgA IgM

In the end of topic she explained diabetes and its renal complications and how HTN leads to cause AKI

✨What is the clinical difference with multiple myeloma and MGUS
✨what is the clinical difference between HUS in kids and TTP in adults
To summarize, Dr Naila covered all the high yield mrcp points of renal manifestations with dedication. Thank you Dr Naila and Dr Ash

29th JANUARY 2023

EVENT NAME:

Glomerulonephritis High Yield MRCP By Dr Yasir Baig Consultant Nephrologist NHS uk

DOCTORS FEEDBACK

FEEDBACK # 1

Ahmad Tanveer

A beautifully crafted lecture very well explained by Dr Yasir. More intrestingly the slides explanation with staining, Immunofluorescence and electron microscopy images added an actual picture. Pearls of knowledge shared by Dr Yasir was excellent.

Glomerulonephritis: a group of immune- mediatead disorders characterized by inflammation of the glomeruli.I

ntrinsic cause of AKI which can lead to CKD. 3rd MCC of ESRD following HTN and diabetes.

Types of GN

(Complexity vs Simplicity) -Histopathological Lesions on Biopsies

(Crescenteric GN, FSGS, MPGN)

-Immunopathogenesis based types (newer approach for targeted treatment)

Autoimmune GN(IgA, MN, ANCA, Anti-GBM, Lupus)

Infection related GN

(PSGN, HIV, Hep B&C)

Auto inflammatory GN(Compliment over activation and C3GN)

Monoclonal gammopathy related to GN.

(AL amyloidosis,light & heavy chain DD)

Clinical Presentation:

Nephrotic Syndrome:

Edema,

Albuminuria >3.5g in 24 hrs,

Serum Albumin <30g/L

Nephritic Syndrome:

Edema,Haematuria,HTN

•Both(Nephrotic + Nephritic /RPGN)

Sign and symptoms GN:

Lethargy, tiredness ,wt. Loss, rash, swelling, hemoptysis,

nasal/oral ulcers,

hearing loss,oligoanuria, HTN,hematoproteinuria, derranged renal functions.

Lab workup:

Urine dip,uACR/uPCR,FBC,U&C, Coagulation Profile.

If heamatoproteinuria with AKI then do

•Renal screening that include ANA, dsDNA, C3,C4, Anti GBM, Myeloma Screening.

ECG

Chest X-ray and Renal US.

Renal biopsy: Gold Standard for diagnosing GN.

General measures of Management:

History & examination, investigations & respond fast for managing Fluid balance, BP control measures,

Lifestyle adjustments

smoking cessation

salt restriction,exercise & involving the Specialist

GN with Nephritic and Nephrotic /RPGN:

1.Anti GBM antibodies mediated(90% develop ESRD antibodies against alpha 3 chain of typeIV collagen ,can cross react with alveolar BM- good pasture syndrome

Tx: steroids, cyclophosphamide

2.ANCA Vasculitis(MPA, GPA, EGPA)

CRESENT GN, Proteinase 3ab +ve in GPA, MPOab +ve in MPA, Eosinophilia with GPA (churug Strass Syndrome). IF -ve, on EM no deposited are seen but break in capillary BM.

Tx : steroids, cyclophosphamide,ritux

It can overlap with anti GBM .

3.Lupus Nephritis (20% progress to ESRD in 10 years)

5 stages of as per immune complex deposit

1 & 2 is mesangial deposited

3 (focal)4 (diffuse) proliferative = subendothelial deposited, hypercellularity,with necrotising and crescent lesions

Stage 5 membranous

IF:polyclonal IgG,IgA,IgM,C3,C1q.

Tx: hydroxycholine with life style stage 1 and 2

Steroid and low dose cyclophosphamide or MMF in 3&4

GN with nephritic syndrome:

Post streptococcal GN-1-2 % to ESRD, developed after throat (1-2 wks) or skin (4-6 wks) strep. Infx.

Hypercellularity of neutrophils,granular deposited in IF and subepithelial hump like deposits

Tx : culture and treat infx.

IgA Nephropathy (10% progress to ESRD highest in Asian)IgA antibodies form immune complex with glycosylated IgA1 leading to glumerular deposite.

Tx: RAAS inhibitor use and SGLT2 inhibitor if u ACR > 22.6mg/dlwith GFR 25---75.

Ritux or cyclo if crescent and rapid progression

GN with Nephrotic Syndrome:

1.Minimal Change Disease:

MCC of Nephrotic synd. In children, normal RFTs,Podocyte foot effacement in glomeruli on EM.

Very responsive to steroids ,Hyperlipidemia management, anticoagulation if albumin <20 to 25, fluid and salt management.

2.Membranous Nephropathy.

20 to 30% progress to ESRD

Primary MN anti PLS2Rab bind to receptors on podocytes on subepithelial area.

Secondary MS due to drug , malignancy ,Hep B

Thickened capillary walls ,spikes

Tx according to risk(eGFR , proteinuria ,serum albumin value)

3.FSGS (80% develop ESRD

Types :idiopathic,Genetic (APOl genes in Africans) secondary (drugs and HIV,CMV,lithium)

Podocytes effeacment

Tx: as per presence or absence of Nephrotic syndrome

4.C3 Glumerulopathies

5.Lupus Nephritis type 5

Mcqs were exam oriented and at right time and at right place that session was extremely interesting .

At the end the two cases by Dr Ash presented

1st interesting case of Pt having SLE with B/L blindness with suspected CKD.

2nd was of a pregnant lady with loin pain who was diagnosed with emergency usg evaluation to be having hydronephrosis were discussed.

Gem of a lecture very well explained and Dr Yasir and Dr Ash thanks for such a great educational activity.

FEEDBACK 2

Faiza Baig

This session was comprehensive and well focused.

Dr.Baig explained the particular type of GN , complexity or simplicity. He first mentioned the physiology and pathology of kidney and then,

The definition and classification of GN. Clinical Presentation Based on

• Nephrotic Syndrome

- Edema

- Albuminuria >3.5g in 24 hrs

- Serum Albumin <30g/L

• Nephritic Syndrome

- Edema

- Haematuria

- Hypertension

• Nephrotic + Nephritic / RPGN

He also described microscopic picture of disease

Work Up

• Urine dip

• uACR/uPCR

• FBC, U&Es, Coagulation profile

• If haematoproteinuria with AKI then renal screening includes

ANA, dsDNA, ANCA, C3, C4, anti-GBM, Myeloma screen

• ECG

• Chest Xray

• Renal Ultra sound

Gold standard for diagnosis of GN is renal biopsy.

Always take general measures, take history and examination, think and do management quickly

Take vitals and maintain fluids.

GN with Nephrotic Syndrome

1. Minimal Change Disease

2. Membraous Nephropathy

3. FSGS

4. C3 Glomerulopathies(DDD)

5. Lupus Nephritis type5,

GN with Nephritic Syndrome

1. Post Strept Infection GN

2. IgA NephropathyLupus

Nephritis stages and treatment

• Hydroxycholine with life style in stage 1&2

• Steroids+ Low dose cyclophosphamide or MMF in

3&4

• Class V as MN mainly CNIs (cyclosporine and tacrolimus)

Mixed identifications and management GN with nephrotic plus nephritic.

In the end of lecture Dr Baig gave us 3 scenario based mcqs related to this topic, which were highly informative.

And lastly, Dr Ash told us a known case, was on renal thrombosis. How he diagnosed and managed that case.

Thank you Dr Ash and Dr Baig

FEEDBACK # 3

Anila Zafar

Dr Yasir's lecture on glomerulonephritis was amazing. He explained the different types with their distinctive points in a very comprehensive manner.

He classified them and also taught how to identify the type based on the patient's presentations, it's treatment.

He also differentiated it from nephritic.

He also explained their differences based on biopsy findings and according to their light and electron microscopy.

Thank you Dr ASH and Dr yasir.

FEEDBACK # 4

Ghulam Saddique Saddique

A wonderful session conducted by Dr Yasir he tried to clear our concepts about glomerulopathies and it's clinical presentations and what is required for workup.

Glomerulonephritis

is a term used to describe a group of immune- mediatea disorders characterized by inflammation of the filtration units of the kidney (the glomeruli).Intrinsic cause of AKI which can lead to CKD.

Types of GN (Complexity vs Simplicity) Histopathological Lesions on Biopsies Crescenteric GN, FSGS, MPGN

Immunopathogenesis based types (newer approach for targeted treatment)

Autoimmune GN(IgA, MN, ANCA, Anti-GBM, Lupus)

Infection related GN

(PSGN, HIV, Hep B&C)

Auto inflammatory GN(Compliment over activation and C3GN)

Monoclonal gammopathy related to GN.

Clinical Presentation Based

Nephrotic Syndrome

Edema

Albuminuria >3.5g in 24 hrs

Serum Albumin <30g/L

Nephritic Syndrome

Edema

Haematuria

Hypertension 1

Nephrotic + Nephritic /RPGN

Sign and symptoms GN

1.HTN, 2.Abnormal RFTS, 3.Hematoproteinuria, 4.weightloss, 5.hemoptysis, 6.lethargy, 7.tirdness.

Workup :

Urine dip

u ACR/u PCR

FBC,U&C, Coagulation Profile.

If heamatoproteinuria with AKI then do Renal screening that include ANA, dsDNA, C3,C4, Anti GBM, Myeloma Screening.

ECG

Chest X-ray and Renal USG.

Gold Standard for diagnosing GN is Renal Biopsy.

General measures of Mangement

History & examination, think and respond quickly, Fluid balance, BP control measures, Lifestyle adjustments and involving the Specialist

GN with Nephritic and Nephrotic /RPGN

1.Anti GBM antibodies mediated(90% develop ESRD antibodies against alpha 3 chain of type4 collagen also cross rear to alveolar BM.

2.ANCA Vasculitis(MPA, GPA, EGPA)

CRESENT GN, Proteinase 3ab +ve in GPA, MPOab +ve in MPA, Eosinophilia with GPA (churug Strass Syndrome). IF -ve, on EM no deposited are seen but break in capillary BM.

It can overlap with anti GBM .

3.lupus Nephritis (20% progress to ESRD)

5 stages of lupus nephritis

1 & 2 is mesangial deposited

3 focal 4 diffuse proliferative = subendothelial deposited.

Stage 5 membranous.

GN with nephritis

Post streptococcal GN (granular deposited in IF and subepithelial hump like deposite

IgA Nephropathy (10% progress to ESRD highest in Asian)IgA antibodies form immune complex with glycosylated IgA leading to glumerular deposite. RAAS inhibitor use and SGLT2 inhibitor if u ACR > 22.6mg/dlwith GFR 25---75.

GN with Nephrotic Syndrome.

1.Minimal Change Disease.(Podocyte effacement in glomeruli in children)

Very responsive to steroids ,Hyperlipidemia management, anticoagulation if albumin <20 to 25, fluid and salt management.

2.Membranous Nephropathy.

20 to 30% progress to ESRD

Primary MN anti PLS2Rab bind to receptors on podocytes on subepithelial area.

Secondary MS due to drug , malignancy ,Hep B

3.FSGS (80% develop ESRD types Genetic APOl genes in Africans secodry type due to drugs and HIV.

4.C3 Glumerulopathies

5.Lupus Nephritis type 5

Two case based discussion by Dr.Ashfaque .Thanks Dr.Ashfaque for providing us informative knowledge on LGEM platform

I am proud to be apart of LGEM programme.

FEEDBACK # 5

Beenish Naveed

Dr Yasir taught us one of the most difficult topic comprehensively. He explained what is required to know exactly about a particular type of GN. He started with explaining the definition and classification of GN.

How to identify different types according to the patient's presentation and it's specific treatment. When we classify them as nephrotic and when as nephritic. He also explained the different biopsy results related to the type of GN and it's electron microscopy presentation.

Dr Yasir explained the Mcqs as well which helped in understanding of the topic in depth.

Thank you Dr Yasir for wonderful explanation and thanks Dr Ash for providing us such knowledgeable teachers.

FEEDBACK # 6

Dr Raja Mobeen Ahmed

Another great lecture expertly delivered by Dr Yasir on a complex topic of Glomerulonephritis. He superbly taught about the types of GN, the clinical presentation, the necessary investigations, findings on histology and Immunofluorescence and the various treatment options.

He started with definition of GN as immune mediated disorders that cause inflammation of the glomerulus, leading to AKI and in some cases CKD, being the 3rd leading cause of CKD after Diabetes and HTN. He also showed how the glomerulus looks on histology slides.
He then told the classification of GN can be based upon
1) Histopathology (Cresentic, FSGS, MPGN),
2) Immunopathogenesis (Autoimmune such as IgA, ANCA, MN, anti GBM, Lupus nephritis)
3) Autoinflammatory (Complement over activation, C3GN)
4) Monoclonal Gammopathy related GN (AL amyloidosis)
The classification can also be done based on Clinical presentation such as Nephrotic (edema, hypoalbuminemia, proteinuria >3.5g/24h), Nephrotic (edema, hematuria, hypertension) and mixed Nephrotic and Nephritic (LN class III and IV, anti GBM, Cryoglobulinemic GN, ANCA vasculitis).
Dr Yasir taught about the signs and symptoms of GN which can include hypertension, hemoproteinuria, abnormal kidney functions and also S and S of the underlying disorder leading to GN e.g. vasculitis.
Then we discussed the workup required which includes Urine dipstick, uACR/uPCR, FBC U and E Coagulation profile, if hemoproteinuria with AKI to send renal screen which has ANA dsDNA ANCA C3 C4 antiGBM Myeloma screen, ECG, Chest X ray, Renal ultrasound. The gold standard test being the kidney biopsy.
Dr Yasir summarized the general management of these disorders with taking a good history and examination, to think and respond quickly, fluid balance, blood pressure control, life style modification (reduce salt, stop smoking , exercise) and to initiate specific therapy sooner than later. Then he moved onto the specifics of different GNs.
1) Anti-GBM vasculitis. 90% patients develop ESKD in weeks. Has auto antibodies to alpha-3 chain of Type IV Collagen. It can cross react with alveolar BM leading to Goodpasture's syndrome. Linear pattern on IF. Treatment options include Steroids, Cyclophosphamide and Plasma exchange.
2) ANCA vasculitis. It causes Crescentic GN/RPGN. Associated with anti-PR3 Ab in GPA, MPO Ab in EGPA. It is pauci-immune (IF is negative). On Election microscopy no deposits but breaks in BM seen. Treatment is Steroids with Cyclophosphamide or Rituximab but no PEX (PEXIVAS trial). If overlap with anti-GBM then PEX is to be done but has poor prognosis.
3) Lupus Nephritis. 20% patients progress to ESKD in 10 yrs. Can be divided into 5 stages (Class I and II has mesangial deposits, Class III Focal, IV DPGN, Class V membranous). It has "Full House" staining with polyclonal IgG IgA IgM C3 C1q. Treatment is according to the stages. For Class 1 and 2 HCQ and lifestyle

measures. For Class 3 and 4 with Steroids and Cyclophosphamide or MMF. For Class V use Calcineurin inhibitors (CNIs)
4) PSGN. 1-2% develop ESKD. Develops 1-2 weeks after URTI or 4-6 weeks after strep skin infection/impetigo. Microscopy shows hypercellularitt with neutrophils, Granular deposits on IF subepithelial humps. We have to culture and treat infection and take supportive measures.
5) IgA nephropathy. It's the most common GN in the world. 10% progress to ESKD in 10 years. Can be found in all age groups, highest in Asians. Crescents can be present/RPGN. Has mesangial expansion and proliferation. IF positive for IgA mesangial deposits. The IgA Ab forms immune complexes with Glycosylated IgA1 leading to deposition. Treatment includes supportive care (RAAS inhibitors, lifestyle), SGLT2i if uACR>22.6mg/mmol and eGFR 25-75. Trials with newer drugs like Atrasentan, Sparsentan, HCQ. If there is RPGN to give IS therapy with Rituximab or Cyclophosphamide.
Dr Yasir then discussed the GN with Nephrotic Syndrome picture which includes Minimal Change Disease, Membranous nephropathy, FSGS, C3 Glomerulopathies (Dense deposits disease), Lupus nephritis V.
1) MCD, a common cause of Nephrotic Syndrome in children. The kidney function remains preserved. Pathophysiology involves abnormal cytokines of T cells causing effacement of podocytes leading to selective proteinuria. The light microscopy is normal, on IF no deposits, on EM effacement of podocytes. The disease is very responsive to steroids. Other measures include salt restriction and fluid management, hyperlipidemia management and to Anticoagulated if serum albumin below 20-25.
2) Membranous nephropathy. 20-30 percent progress to ESKD. Can be divided into Primary MN (anti PLA2R Ab), Secondary MN (malignancy, drugs, hep B, LN Class V). Has thickened capillary walls with spikes, Granular deposits on IF, EM shows subepithelial deposits. The treatment is based on Risk classification. Low risk have normal eGFR with proteinuria<3.5 and albumin>30 and treatment is wait and see. For moderate risk treatment is Wait and see OR Rituximab OR CNRI +- steroids. For high risk treatment with Rituximab OR Cyclophosphamide OR CNRIs OR steroids. For very high risk modified Ponticelli regime with altered every month pulse steroids and Cyclophosphamide. Immunosuppression is not usually indicated in secondary MN. Remember to give prophylactic anticoagulation with warfarin if Albumin<20-25.
3) FSGS. 80% progress to ESKD. EM shows podocytes effacement. Is associated with Genetics (APOL1 in Africans), Idiopathic, Secondary (drugs, HIV, CMV, lithium). Treatment for primary FSGS is with immunosuppression. For secondary, evaluate for causes of the secondary FSGS, consider genetic testing, do not start immunosuppression.

In the end of the lecture, Dr Ashfaque discussed 02 interesting cases. The first case dealt with a patient of Lupus who had loss of vision and importance of monitoring retinal toxicity of HCQ was made. The second case had a patient with loin pain who was eventually diagnosed with Renal Vein Thrombosis.
The whole lecture, from start to finish, kept me engrossed as Dr Yasir actively involved the participants and interspersed MCQs in between. I have learned a lot in this lecture which was very efficient and to the point.
Thank you Dr Yasir, Dr Ashfaque and the London GEM team for providing this learning opportunity.

FEEDBACK # 7

Dr Ghazala Sheikh

A very exam oriented session

It included,

. Glomerulonephritis

. Types on the basis of

Histopathology

Immune complex depositions

Infectious

Autoimmunity

. Clinical presentation

. Nephritic syndrome

. Signs n symptoms of GN

. Lab investigations

. Managment options

. GN with nephritic and nephrotic syndrome

. GN with SLE

. IgA nephropathy

. Membranous Nephropathy

. Focal segmental Glomerulonephritis

. Minimal change disease

. C3 glomerulopathies

. Lupus nephritis type 5

At the end, Topic related MCQs helped alot

Dr Ash presented a very interesting case regarding renal thrombosis

Thankyou so much to both of you for giving us comprehensive understanding

FEEDBACK # 8

Dr Nasir Hayat

This session was Amazing and well presented and very well taughted.
Dr Yasir explained what is required to know exactly about a particular type of GN.
He started with explaining the definition and classification of GN. Clinical Presentation Based
• Nephrotic Syndrome
- Edema
- Albuminuria >3.5g in 24 hrs
- Serum Albumin <30g/L
• Nephritic Syndrome
- Edema
- Haematuria
- Hypertension
• Nephrotic + Nephritic / RPGN
How to identify different types according to the patient's presentation and it's specific treatment. When we classify them as nephrotic and when as nephritic. He also explained microscopic picture of disease
Work Up
• Urine dip
• uACR/uPCR
• FBC, U&Es, Coagulation profile
• If haematoproteinuria with AKI then renal screen including
ANA, dsDNA, ANCA, C3, C4, anti-GBM, Myeloma screen
• ECG
• Chest Xray
• Renal Ultra sound
He also put the Mcqs as well which helped in understanding of the topic in depth.

And realised how tough it could to grasp the real understanding of all GNs .
GN with Nephrotic Syndrome
1. Minimal Change Disease
2. Membraous Nephropathy
3. FSGS
4. C3 Glomerulopathies(DDD)
5. Lupus Nephritis type5, GN with Nephritic Syndrome
1. Post Strept Infection GN
2. IgA NephropathyLupus Nephritis stages and treatment
• Hydroxycholine with life style in stage 1&2
• Steroids+ Low dose cyclophosphamide or MMF in
3&4
• Class V as MN mainly CNIs (cyclosporine and tacrolimus)
Mixed pictures Gn, identification and management , GN with
Nephrotic+Nephritic /RPGN
1. Anti-GBM antibodies mediated
2. Lupus Nephritis(class 3&4)
3. Cryoglobulinemic GN
" Hide
4. ANCA Vasculitis (MPA,GPA, EGPA)
I would highly recommend it for physicians to join it.Proud to be LGEM candidate

FEEDBACK # 9

Dr Leela Ram

The most interactive and informative lecture conducted by Dr. Yasir Baig, he demonstrated from basic to complex including definition, types, clinical presentation, General approach, specific approach.

Types of Glomerulonephritis (Complex vs Simplicity)

• Histologic lesions on Biopsies

• Crescenteic GN

• FSGN

• MPGN

Immunopathogenesis based types (newer approach for targeted treatment)

•Autoimmune GN (IgA, MN, ANCA, Anti-GBM, Lupus GN)

• Infection related GN (PSGN, HIV, Hepatitis B & C)

• Autoinflamatory GN (compliment over activation)

• Monoclonal gammopathy related GN (Al Amyloidosis, Light and Heavy chain DD)

Clinical presentation:

Nephrotic syndrome: Edema, Albuminuria >3.5g/24h, serum albumin<30g/l

Nephritic syndrome: edema, haematuria, HTN

Signs and symptoms: lethargy, tiredness, wt loss, swelling, rash, hemoptysis, nasal/oral ulcer, hearing loss, oligoanuria, HTN, haematuria, abnormal renal function.

Work up:

Urine dipstick, uACR, uPCR, FBC, U&E, Coagulation profile if haematuria with AKI then Renal screen including ANA, dsDNA, ANCA, C3, C4, Anti-GBM, Myeloma screen), ECG CXR, Renal ultrasound. It also included several MCQs with discussion.

Overall it turned out to good learning from reading & discussing MCQs. I learnt several new things & hopefully will apply in practice.

Thank you Sir Dr. Yasir Baig for beautiful session & thank you so much Sir Ash for summarizing with cases presentation.

29TH JANUARY 2023

EVENT NAME:

High Yield Trauma By Dr Syed Ali Ahmed FRCEM

DOCTORS FEEDBACK

FEEDBACK # 1

Hani Suhail

A wonderful session by Dr Ali, very informative with a lot of precise and conceptual discussion to our daily approached cases in our routine management. Thank you for this great session regarding trauma.

FEEDBACK # 2

Farheen Naseem

It was fruitful and full of interactive session.in This sessions he more focused on exam material which is more help full for all mrcem exam like primary intermediate and osce.he taught us more about major trauma topics
First time briefly learn about canadian c spine rules
Upper and lower limb fractures
Ottawa rules for ankle fractures
Learn about blocks
Management of tetanus
More learn about montagia fracture
Shoulder dislocations
Meniscus tear presentation
All session was excellent and it's clear my concepts for primary exam most of upper limb fractures.thank u dr @Dr Ali and @Dr Ash for such nice learning platforms where we grow and polished day by day thank u again

FEEDBACK # 3

Syed Suhail Ahmad

A comprehensive and absorbing session on **High Yield Trauma By Dr Syed Ali Ahmed FRCEM**, a born teacher and presenter 👏
Excellently covered some of the most common yet important ED presentations that we encounter daily in our clinical settings, covered T&O that included
- Canadian C-Spine rules for X-Rays
- Ottawa ankle rules
- Common upper limb fractures often missed and confused like Monteggia and Galezzi
- Shoulder dislocations
- Hillsach's and Bankart's lesions
- Hematoma and Bier's blocks
- ACL and Meniscal tears, Lachman and Pivot shift tests
- TFCC and Piano key sign importance
- Tetanus-prone and high-risk would
- Tetanus vaccination and Immunoglobulin administration

Looking forward to more such interactive and interesting sessions from Dr. Ali.
Thank you LGEM, PEMA and Dr.Ash for such an outstanding LGEM faculty 👍👍👍👏👏

FEEDBACK # 4

Haider Ali

A very exam oriented session on trauma and orthopaedics was delivered Dr. Ali ahmed.

Different types of fractures of upper and lower limb were discussed in detail with their management. The best part was the discussion regarding how to read and what to look for in exam scenarios.

Candian C Spine rule and tetanus prone wound were also discussed at the end of the lecture.

Thanks Dr. **Ashfaque Ahmed** and **London Global Emergency Medicine** for arranging such amazing sessions.

FEEDBACK # 5

Nazish Nazi

One of the bestest lecture I ever attended on High yield trauma with such amazing Radiographs, i always lack motivation to read black n white radiographs but Dr Ali made those black n white radiographs so much interesting and easy to understand , he taught it very actively with interactive Question answers indeed it was a brainstorming session today ....

He taught very important stuff like Canadian C Spine rule, Upper limb fractures , unique lesions related to it like Bankart lesion , Lower limb injuries with radiographs, especially Salter Haris Classification, and most interestingly tetanus wound classification with its vaccination , it was all very useful and very interesting learning session today .

Many Thanks to Dr Ali and Sir Ash for todays session. 🙂

FEEDBACK # 6

Anila Zafar

Today's session by Dr Ali was very informative and comprehensive. He mentioned in detail the scenario, it's diagnosis, differentiating points, management. He highlighted the high yield points in relevance to exams. Amazing. Thank you very much Dr ASH and Dr Ali.

FEEDBACK # 7

Muzna Ahmed

It was an amazing knowledge pack session of orthopedics in which many ED physcians are not skilled and its investigations are mainstay to reach diagnosis as some fractures may present with symptoms with the lapse of time.

Dr Ali is an excellent arduous tutor he puts his 100% into every task whether lecture or hands on workshop and clears all the confusions of every candidate. Today we have covered high yield topics of:-

✓Canadian C spine rule

✓Supracondylar fracture of humerus

✓Galezzi fracture

✓Ant discoloration of shoulder

✓Hill sach's lesion & bankart lesion

✓Post dislocation of shoulder (rim sign and trough line sign)

✓Reverse Hill sah's & reverse Bankart lesion

✓Ottawa ankle rules

✓Exclusions of ottawa ankle rules

✓Monteggia fracture

✓SALTR classification with examples

✓Colley's fracture, complications and indication for manipulation & reduction

✓Bier's block

✓ACL tear (Lachman's test, pivot shift test)

✓Pulled elbow

✓TFCC injury and piano key sign (role of MRI)

✓Meniscal tear and cooper's sign

✓Toodler's fracture /CAST fracture

✓Barton's fracture and need of fixation

✓Tibial plateau fracture and Schatzker classification

✓ABC of tetanus prone and high risk tetanus wounds.

This is such kind of orthopedics knowledge which Majority doesnt know. I'm highly grateful to Dr Ash and Dr Ali for bringing up this.

FEEDBACK # 8

Saba Aslam Khan

Woah! What an amazing session we had today with Dr Ali, the feel of lecture was like having discussion with our kind senior, Dr Ali is exceptional speaker he has power to grasp the attention of audience and engage them.. his way of delivering

lecture is like a breeze of cool air in boring lectures … the session was not only exam oriented but also applicable to ED and had touch of legal advices …. The highlights of lecture were ,
-Canadian C-spine rules
-upper and lower limb fractures with their radiological presentation
-ottawa rules
-Regional Blocks
-tetanus management
-tetanus prone wounds classification and it's management
-*What is your name doctor* 😁
Thank you so much Dr Ash for arranging such a highyield session we never wanted this lecture to finished …
A proud GEM trainee,

FEEDBACK # 9

Muneeb Ahmed

Attended this session by one of my favourite tutor Dr. Syed Ali held a successful session on high yield trauma SBA.We learnt scenarios based learning on Canadian C-Spine Rule,Supracondylar Fracture of Humerus and its classification,Galeazzi Fracture ,Anterior and posterior dislocation of shoulder and its complications(Hill-Sachs Lesion Bankart/Reverse Hill-Sachs & Reverse Bankart Lesion,Ottawa Ankle Rules: guidelines for ankle injury assessment to determine need for radiograph,Exclusions of Ottawa Ankle Rules,Monteggia Fracture: a fracture involving forearm and elbow,SALTR Classification,Colley's Fracture, Complications & Indications for Manipulation & Reduction: a fracture near the wrist,Brief review about Bier's Block,ACL Tear (Lachman's Test & Pivot Shift Test).
Unfortunately couldn't attend last few minutes due to bad signals but it was overall very informative and we loved his teaching skills.
Thanks Dr.Ali and Dr. Ash for this amazing session.

FEEDBACK # 10

Imtiaz Ali Shah

Today Dr Ali carried out an amazing session about high yield trauma. What a session it was,a treat to listen and watch.A session full with learning and absorbable knowledge .lucky to have such an amazing and energetic teacher like dr Ali who always try to give his hundred percent.

It was an interactive session covering important points of high yield trauma including
CANADIAN C SPINE RULUES.
GALLEZI,S FRACTURE ,HILLSAC LESION.
ELBOW INJURIES
MONTEGGIA FRACTURES.
ANTERIOR/POSTERIOR DISLOCATION OF SHOULDER JOINT.,BANKART LESION.
OTTAWA ANKLE RULES.
SALTER AND HARRIS CLASSIFICATION.
KNEE INJURIES AND MENISCAL INJURIES.
TETANUS AND WOUND MANAGEMENT.
AS mentioned earlier that it was a wonderful ful session, A session jam packed with knowledge and excellent teaching skills.
I would like to thanks dr Ali for such a wonderful session and also dr Ash for providing us this wonderful platform of learning in the form of London GEM.

FEEDBACK # 11

Faiq Uz Zaman Khan

In this session Dr Ali discussed common cases that we daily see in A&E. Each scenario was presented to the participants and it's diagnosis, management and clinically significant points were discussed. Dr Ali's holistic approach towards each scenario was brilliant. On every case he discussed the high yield pointers with regard to FRCEM primary , intermediate and OSCE exam. Yes that's right, one scenario and he discussed it on 3 different levels. Along with that he was guiding us on how to improve our clinical skills. Undoubtedly a great teacher.

FEEDBACK # 12

Qaisar Shah

Dr. Syed Ali held a successful session on high yield trauma MCQs. The session was beneficial for both clinical practice and exams and covered a range of high yield points related to trauma.
•The Canadian C-Spine Rule: a set of guidelines for neck injury assessment to determine need for cervical spine x-ray
•Supracondylar Fracture of Humerus: a fracture near the elbow at the upper end of the arm bone

•Galeazzi Fracture: a fracture involving the forearm and elbow, with break in radius and wrist joint dislocation
•Ant Discoloration of Shoulder: a sign of possible shoulder dislocation, with bruised/discolored skin in joint area
•Hill-Sachs Lesion & Bankart Lesion: shoulder dislocation-related damage to humeral head and labrum, respectively
•Post-Dislocation of Shoulder (Rim Sign & Trough Line Sign): signs of shoulder dislocation, with changes in humeral head shape and position
•Reverse Hill-Sachs & Reverse Bankart Lesion: lesions due to repeated shoulder dislocations, with damage to glenoid and humeral head, respectively
•Ottawa Ankle Rules: guidelines for ankle injury assessment to determine need for radiograph
•Exclusions of Ottawa Ankle Rules: conditions requiring radiography of ankle even if rules not met (fractures, nerve/vessel injuries)
•Monteggia Fracture: a fracture involving forearm and elbow, with break in ulna and radial head dislocation
•SALTR Classification with Examples: a system to categorize and classify distal radius fractures based on location and break pattern
•Colley's Fracture, Complications & Indications for Manipulation & Reduction: a fracture near the wrist, complications can include nerve/vessel damage, reduction may be indicated for displaced fragments
•Bier's Block: a regional anesthesia for limb surgical procedures to provide pain relief
•ACL Tear (Lachman's Test & Pivot Shift Test): a knee injury with tear in anterior cruciate ligament, diagnosed with Lachman's and Pivot Shift tests
•Pulled Elbow: an injury in children involving elbow dislocation of radial head from humerus
•TFCC Injury & Piano Key Sign (Role of MRI): injury to wrist stability-providing triangular fibrocartilage complex, diagnosed with Piano Key Sign and confirmed by MRI
•Meniscal Tear & Cooper's Sign: a tear in the knee joint cushion, the meniscus, diagnosed with Cooper's Sign
•Toddler's Fracture & CAST Fracture.
Overall the session was excellent and informative, gaining valuable knowledge and skills.

Thanks Dr.Ali and Dr. Ash for this amazing session.

FEEDBACK # 13

DrKiran Feroz

Wonderful session ....as always Dr.Ali...Today's topic Canadian C spine rule.... supracondylar fracture ...fracture of radius and ulna..ant.dislocation of shoulder...post dislocation of shoulder ....interestingly Hill _Sachs lesion which is Hill of humerus....Bankart lesion .... trough line ....ankle injuries...uttawa rules of foot...John's fracture..Salta haris fracture...colles fracture... knee injuries...Barton's fracture...and last but not the least most imp tetanus wound classification all beautifuly explained....a session extremely useful for all of us....Thanku Ashfaque bhai ...Dr.Ali ....the LGEM team for bringing us closer to highly knowledgeable faculty ...God bless u all

FEEDBACK # 14

Rana Gulraiz

Today started an amazing session about high yield trauma.
What a session it was,a treat to listen and watch.A session full with learning and absorbable knowledge .
lucky to have such an amazing and energetic teacher like dr Ali who always try to give his hundred percent.
It was an interactive session covering important points of high yield trauma including
CANADIAN C SPINE RULUES.
GALLEZI,S FRACTURE ,HILLSAC LESION.
ELBOW INJURIES
MONTEGGIA FRACTURES.
ANTERIOR/POSTERIOR DISLOCATION OF SHOULDER JOINT.,BANKART LESION.
OTTAWA ANKLE RULES.
SALTER AND HARRIS CLASSIFICATION.
KNEE INJURIES AND MENISCAL INJURIES.
TETANUS AND WOUND MANAGEMENT.
AS mentioned earlier that it was a wonderful ful session, A session jam packed with knowledge and excellent teaching skills.
Special Thanks to my mentor my director My teacher **Ashfaque Ahmed**❤️

FEEDBACK # 15

Hareem Zakir

Thankyou so much Dr Ali for such an amazing session . You're definitely one of the most dedicated teachers of the team. You instil the passion in us and make us eager to learn more . The best part of the session was your quote "we learn for the patients,not for the exams only . We have to make difference in their lives "

FEEDBACK # 16

Phota Ram

Today an Excellent session by Dr Ali as we have learned a lot from from Dr Ali in Ultrasound workshop related to emergency today we have learned importants topics of upper and lower limb fractures and dislocations, that high yield and exam oriented ,all fracture and dislocations we studied many times but we forgot but the way Dr Ali has taught it will easily remembered and cleared many concepts.

Learning points :

Canadian C spine rules
Gallezi fracture
Colles fracture
Montegia fracture
Anterior and
Posterior dislocation of shoulder
Bankart lesion
Ankle Ottawa Rules
Ottawa rules for hand
Salter Haris fracture
Wound and tetanus prone wound and high-risk tetanus wound.

FEEDBACK # 17

Uzma Shaikh

Marvellous session by Dr **Syed Ali Ahmed** on orthopedic trauma and wound management.

He taught us regarding Canadian C spine rule, ottawa ankle and foot imaging rules, their indications and contraindications.

We learnt regarding glazzi, monttegia, colles, barton, supra condylar fracture, toddlers fracture, lateral tibeal plateu fracture anterior and posterior shoulder disslocations. He taught us Hill sachs leison, Bankart leison, ACL, meniscal tears.

Tetanus prone, high tetanus prone and clean wound classification.

Indications of tetanus and immunoglobulins.

I request Dr **Ashfaque Ahmed** to assign him more lecs on trauma so that we can learn and pass our exams under his guidance.

FEEDBACK # 18

Kamlesh Kumar Lilani

First of all Congratulations to you Sir for clearing FRCEM. It was a very amazing to listen you again but this time not an ultrasound but on how to recognize different cases on trauma with proper management. You explained Trauma of Limbs very very well with details and added osce scenerios and how to read questions and to get better answer for that.

FEEDBACK # 19

Bushra Imran

From where I will start about today's session ,it was interesting like to not ending long lasting, by Dr Ali with understandable concise way and beneficial descriptions of x Ray's and scenarios. The Canadian C -Spine(the most important),how to manage elbow injury,Galerzi fracture ,Hill sach's lesion,posterior and anterior shoulder dislocation with x ray description, Bankart lesion(which I dont know before),ankle fractures,Uttawa rules of foot ,Monteggia fracture,knee elbow ,wrist injuries and management ,High risk tetanus wound ,ACL tears,..in the end its was best session by Dr Ali

Thank you GEM team and Dr Ash

FEEDBACK # 20

Anila Zafar

Today’s session by Dr Ali was very informative and comprehensive. He mentioned in detail the scenario, it’s diagnosis, differentiating points, management. He highlighted the high yield points in relevance to exams. Amazing. Thank you very much Dr ASH and Dr Ali.

FEEDBACK # 21

Zia Hayat

It was an amazing lecture by Dr.Ali ,was very interactive and kept us all pumped up till the end .His way of teaching is totally extra ordinary with great impact on the mind and keeping exam focused material which enhanced our skills for preparation all together .He gave an overview of all the major topics and case based scenarios which we face on a daily day to day basis.

He spoke about the Canadian c spine rules ,upper and lower limb fractures ,Ottawa rules for ankle injury, Regional blocks ,tetanus Management, Gallezi Fracture

,Montegia Fracture ,Anterior and Posterior Dislocation of Shoulder ,Bankart lesion,Salter Haris Fracture ,knee injuries like ACL tear ,PCL tear ,Meniscus tear presentations and management, Altogether it was power pack session covering all important points and topics related to trauma and resuscitation in ED .Thankyou Dr.Ash for arranging such and amazing learning opportunity for us all .

FEEDBACK # 22

Rabiyyah Bashir

THE PERFECT LECTURE !

covered

✓Canadian C spine rule

✓Supracondylar fracture of humerus

✓Galezzi fracture

✓Ant dislocation of shoulder

✓Hill sach's lesion & bankart lesion

✓Post dislocation of shoulder (rim sign and trough line sign)

✓Reverse Hill sach's & reverse Bankart lesion

✓Ottawa ankle rules

✓Exclusions of ottawa ankle rules

✓Monteggia fracture

✓SALTR classification with examples

✓Colley's fracture, complications and indication for manipulation & reduction

✓Bier's block

✓ACL tear (Lachman's test, pivot shift test)

✓Pulled elbow

✓TFCC injury and piano key sign (role of MRI)

✓Meniscal tear and cooper's sign

✓Toodler's fracture /CAST fracture

✓Barton's fracture and need of fixation

✓Tibial plateau fracture and ✓Schatzker classification... Bumper fracture

✓ABC of tetanus prone and high risk tetanus wounds.

All this in just 1.45 hrs.... Dr Ali Sir gave 45 mins over time... We are blessed to have such dedicated Mentors..
THIS IS THE FIRST TIME I KEENLY LISTENED A LECTURE RELATED TO ORTHO!
A BIG THANKYOU Dr **Syed Ali Ahmed** Sir for a wonderful lecture and
Dr **Ashfaque Ahmed** Sir for making it possible for ppl like me.
Huge Regard for **London Global Emergency Medicine**
❤️❤️❤️❤️

FEEDBACK # 23

Dr Mariam Nawaz

> Seldom do you get to have a powerful session like the one we had
> today. Dr Ali is an exceptionally good teacher. He taught us amazing
> practice essentials and exam essentials today and taught us tausing
> exam based scenarios. It was an honor to study from him. Some of the
> imp things we learnt are
> Canadian C spine rules
> Managing elbow injury
> Gallezi fracture
> Hill Sach's lesion
> Posterior dislocation of shoulder
> Bankart lesion
> Ankle Ottawa Rules
> Ottawa rules for hand
> Montegia fracture
> Salter Haris fracture
> Colles fracture
> Biers block
> Knee injuries
> Elbow injuries
> Wrist injuries
> Accidental vs non accidental injuries in kids
> Wound management
> Thankyou Dr Ali and Dr Ash for this powerful session. Really looking
> forward to have more preparatory sessions with Dr Ali

FEEDBACK # 24

Dr Amash Khan

Today's session was on High yield Q/A
based lecture regarding some trauma and orthopedic related cases which comes in ER by Dr Ali Ahmed which was so great and helped recalling the previous topics thoroughly.
Thank you for your time and I wish to have these lectures more often.

FEEDBACK # 25

Dr Nasir Hayat

This session was Amazing and well organised and very well taught.I learned alot and all the Questions were answered.
Dr Ali is an exceptionally good teacher. He taught us amazing practice essentials and exam essentials today and taught us tausing exam based scenarios. It was an honor to study from him. Some of the imp things we learnt are
Canadian C spine rules
Managing elbow injury
Gallezi fracture
Hill Sach's lesion
Posterior dislocation of shoulder
Bankart lesion
Ankle Ottawa Rules
Ottawa rules for hand
Montegia fracture
Salter Haris fracture
Colles fracture
Biers block
Knee injuries
Elbow injuries
Wrist injuries
Accidental vs non accidental injuries in kids
Wound management.
I would highly recommend it for ER physicians and physicians to join it.Proud to be LGEM candidate.

FEEDBACK # 26

Dr Faizan Ur Rehman

Excellent presentation by Dr Saad. It was quite precise and to the point. I think the beauty of the presentation was that the concepts of ED management of trauma were cleared up. Like a lot of scenarios discussed are common that we see frequently and manage. So learning the concept behind management and presentations was really helpful.
Last but not least props to Dr Saad for his dedication to teaching. It could be seen that a lot of hard work was put into this presentation. It was really fun good from a learning perspective.
Once again thank you to Dr Ash for providing us with such an amazing platform.

FEEDBACK # 27

Dr Afifa Younis Raja

WOW what a lecture we had today, it was a marathon of knowledge. Today we discussed High Yield Trauma & Resuscitation by DR Syed Ali Ahmed FRCEM, his teaching style is great, and the way he kept us all engaged, kept it interactive, and targeted the high yiled topics that's not only clinically important but also exam favourite , is commanbible. Today we covered so many topics:

- Canadian C spine rule
- Supracondylar fracture
- Galeazzi fracture
- Anterior dislocation of shoulder
- Posterior dislocation of shoulder
- Ankle injury and Ottawa rule
- Colles fracture
- Hematoma and beis blick
- Knee (ACL) injury
- Pulled elbow
- Triangular fibrocartilage complex injury
- Meniscal tear
- Toddlers fracture
- Barton's fracture
- Right lateral tibial plateau fracture
- Wound management (tetnus-prone prone injury)

It shows Dr Ali's dedication and passion for teaching that he stayed 45 min extra, and to be honest we were happy to even continue it for another hour as the

teaching style was engaging and we learned a lot of things today that will help both our clinical practice and exam as well.
Thank dr Ash for arranging such an amazing lecture at a crucial time.

22nd JANUARY 2023

EVENT NAME:

Hypercholestrolemia & Dyslipidemias For MRCP Trainees By Dr Nahal Raza Cardiology Registrar NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Ram Leela

It was superb session on Hypercholestrolemia & Dyslipidemia with all important points & exemplary demonstration. It covered types of lipids that is; HDL Cholesterol, LDL Cholesterol & Triglycerides. Types of Dyslipidemia:
1. Primary Dyslipidemia
2. Secondary Dyslipidemia
Primary includes Familial combined hyperlipidemia, Familial Hyperapobetalipoproteinaemia,
Familial hypertriglyceridemia, homozygous familial or polygenic hypercholestrolemia.
Causes & risk factors for hyperlipidemia are obesity, sedentary lifestyle, lack of physical exercise, alcohol use, tobacco use, use of illicit or illegal drugs, STIs, type-2 diabetes & so on.
It covered Dyslipidemia types, signs and symptoms, how & when to treat, recommended lipid levels.
Treatment pointers: Offer the Atorvastatin 20mg for the primary prevention of CVD to people who have 10% or greater than 10 years risk of developing CVD while Atorvastatin 80mg to those people who have had CVD. Side effects should be born in mind while prescribing these drugs and adjust accordingly.
Follow up should be at 3 months after starting these drugs.

Lifestyle modifications include cardioprotective diet, physical activity of 150 minutes/week, weight management, alcohol consumption and smoking cessation.
The session remained fantabulous & most interactive.
I have learned reason of giving statins at night and mode of different medicines.
Many new drugs are to be in NHS guideline soon. A modern approach to Dyslipidemia.
Thank you so much Dr. Nahal Raza for exemplary demonstration and thanks Dr. Ash for commitments & hardwork for LGEM Family❤️.

FEEDBACK # 2

Ghulam Saddique Saddique

Today's session was very difficult and dry most of us have no through command on that topic so Dr.Nahal made it an interactive session by calling the names of participants and asked questions by displaying different pics regarding hyperlipdemia and dislipidemia.
Session started identifying xanthelasmas, arcus cornealis, extensor tendon xanthomas, palmar crease xanthomas, tuberous xanthomas, orange tonsil in tangier disease to name a few.
Types of Lipids in the body: LDL bad cholesterol, HDL, Triglycerides which develop when calories are not burned right away and stored in fat cells.
Types of Dyslipidemia:
Primary: Type I(LDL Or ApoC2 deficiency causing pancreatitis)
Type IIa & Type IIb (LDL receptor or Apo B100 deficiency causing Achilles tendon xanthomas and corneal Arcus)
TypeIII (Apo E Deficiency causing Palmar xanthomas)
TypeIV (LDL overproduction causing pancreatitis)
Familial combined hyperlipidemia, familial hyperapobetalipoproteinemia, familial hypertriglyceridemia and homozygous familiar or polygenic hypercholesterolemia.
Secondary: because of obesity, sedentary lifestyle, alcohol and tobacco use, T2DM, hypothyroidism, CKD or liver conditions, cushings, female sex higher LDL levels after menopause.
Symptoms can range from loose stools, depression, stomach distension, poor appetite, fatigue, weight gain. Increased risk of coronary heart disease, peripheral arterial disease, stroke.

Before starting lipid modification for primary prevention of CVD take at least 1 lipid sample include measurement of total cholesterol, HDL, non HDL, triglyceride. Most important is to note that fasting sample is not needed.
As per NICE total cholesterol level should be 5mmol/L or less for healthy adults and 4 or less for those at high risk. LDL level 3mmol/L or less for healthy adult and 2mmol/L or less for those at high risk.
An ideal HDL >1mmol/L and total cholesterol to HDL ratio should be <4.
Treatment: offer atorvastatin 20 mg for primary prevention of CVD for people with 10% or > Ten year risk of CVD. Use QRISK2 to estimate risk. Start 80 mg in people with CVD, usually continued for 1 year and the dose can be reduced in view of potential drug interaction, risk of adverse effects and patient preference. Repeat lipids at 3 months aiming for greater than 40% reduction in non HDL. If not achieved discuss adherence and timing of dose, life style and diet, consider increasing the dose based on clinical judgement.
Lifestyle modification includes: cardio protective diet, physical activity: 150 mins of moderate intensity of aerobic activity or 75 mins of vigorous intensity aerobic activity or a mix of both, weight management, alcohol consumption (14 units a week), smoking sensation.
It is important to know when to refer the patient lipid management clinic: possibility of familial hypercholesterolemia investigate if T.CHO >7.5 and family H/O premature coronary heart disease. Specialist assessment if T.CHO >9 or non-HDL >7.5, urgent specialist review if triglyceride>20mmol/L that is not due to alcohol or poor glycemic control.
<5% low risk life style modification(class I)
5%- 7.5% borderline risk, if risk enhancers present then discuss moderate intensity statin therapy(class IIb)
>7.5%-20%intermediate risk + risk enhancers initiate moderate intensity statin to reduce LDL by 30-49 % (class I) >20% high risk initiate statin to reduce LDL by 50%
Very high risk of ASCVD: give high intensity or maximal statin if still LDL >70 mg/dl or 1.8mmol/L add ezetimibe after max dose of statin and ezetimibe then PCSK9-I can be added.
Statins reduce LDL by 20%-60%, triglycerides by 10%-20% and increases HDL 10%-15%. Fibrates are not preferred as they might increase LDL.

10 mg Atorvastatin causes 33% reduction in LDL and 80 mg causes 55% reduction.
Statins with short half life are given at night as hepatic cholesterol synthesis is maximum between midnight and 2am. But atorvastatin and rosuvastatin have long half life making it safe to use in morning. Atorvastatin also has antioxidant property. Statins are HMG CoA reductase inhibitors and side effects include myopathy and increased liver enzymes. Ezetimibe cholesterol absorption inhibitor side effects headache and GI distress.
Newer drugs are PCSK9 inhibitors, apolipoprotein B synthesis inhibitor, microsomal triglyceride transfer protein inhibitor, thyromimetic, cholestryl ester transfer protein.
Overall, Dr. Nahal thoroughly covered all aspects of hypercholesterolemia and dyslipidemia.
I am proud to be a part of LGEM programme.

FEEDBACK # 3

Dr Nasir Hayat

This session was Amazing and wonderfully presented.learned alot
A very informative and engaging lecture on not so interesting topic but Dr. Nahal deserves apprecaition for her ability to engage everyone and make any topic interesting. She revisited all the basic concepts and then progressed to NICE guidelines. Her quiz on different signs was beneficial to jog our memory and will aid in identifying xanthelasmas, arcus cornealis, extensor tendon xanthomas, palmar crease xanthomas, tuberous xanthomas, orange tonsil in tangier disease to name a few.
Starting from types of Lipids in the body: LDL bad cholesterol, HDL, Triglycerides which develop when calories are not burned right away and stored in fat cells.
Types of Dyslipidemia:
Primary: Type I, IIa, IIb, III and IV
Familial combined hyperlipidemia, familial hyperapobetalipoproteinemia, familial hypertriglyceridemia and homozygous familiar or polygenic hypercholesterolemia.
Secondary: because of obesity, sedentary lifestyle, alcohol and tobacco use, T2DM, hypothyroidism, CKD or liver conditions, cushings, female sex higher LDL levels after menopause.
Symptoms can range from loose stools, depression, stomach distension, poor

appetite, fatigue, weight gain. Increased risk of coronary heart disease, peripheral arterial disease, stroke.

Before starting lipid modification for primary prevention of CVD take at least 1 lipid sample include measurement of total cholesterol, HDL, non HDL, triglyceride. Most important is to note that fasting sample is not needed.

As per NICE total cholesterol level should be 5mmol/L or less for healthy adults and 4 or less for those at high risk. LDL level 3mmol/L or less for healthy adult and 2mmol/L or less for those at high risk.

An ideal HDL >1mmol/L and total cholesterol to HDL ratio should be <4.

Treatment: offer atorvastatin 20 mg for primary prevention of CVD for people with 10% or > Ten year risk of CVD. Use QRISK2 to estimate risk. Start 80 mg in people with CVD, usually continued for 1 year and the dose can be reduced in view of potential drug interaction, risk of adverse effects and patient preference. Repeat lipids at 3 months aiming for greater than 40% reduction in non HDL. If not achieved discuss adherence and timing of dose, life style and diet, consider increasing the dose based on clinical judgement.

Lifestyle modification includes: cardio protective diet, physical activity: 150 mins of moderate intensity of aerobic activity or 75 mins of vigorous intensity aerobic activity or a mix of both, weight management, alcohol consumption (14 units a week), smoking sensation.

It is important to know when to refer the patient lipid management clinic: possibility of familial hypercholesterolemia investigate if T.CHO >7.5 and family H/O premature coronary heart disease. Specialist assessment if T.CHO >9 or non-HDL >7.5, urgent specialist review if triglyceride>20mmol/L that is not due to alcohol or poor glycemic control.

<5% low risk life style modification(class I)

5%- 7.5% borderline risk, if risk enhancers present then discuss moderate intensity statin therapy(class IIb)

>7.5%-20%intermediate risk + risk enhancers initiate moderate intensity statin to reduce LDL by 30-49 % (class I) >20% high risk initiate statin to reduce LDL by 50%

Very high risk of ASCVD: give high intensity or maximal statin if still LDL >70 mg/dl or 1.8mmol/L add ezetimibe after max dose of statin and ezetimibe then PCSK9-I can be added.

Statins reduce LDL by 20%-60%, triglycerides by 10%-20% and increases HDL

10%-15%. Fibrates are not preferred as they might increase LDL.
10 mg Atorvastatin causes 33% reduction in LDL and 80 mg causes 55% reduction.
Statins with short half life are given at night as hepatic cholesterol synthesis is maximum between midnight and 2am. But atorvastatin and rosuvastatin have long half life making it safe to use in morning. Atorvastatin also has antioxidant property. Statins are HMG CoA reductase inhibitors and side effects include myopathy and increased liver enzymes. Ezetimibe cholesterol absorption inhibitor side effects headache and GI distress.
Newer drugs are PCSK9 inhibitors, apolipoprotein B synthesis inhibitor, microsomal triglyceride transfer protein inhibitor, thyromimetic, cholestryl ester transfer protein.

Overall, Dr. Nahal extensively covered all aspects of hypercholesterolemia and dyslipidemia.I would high recommend it for physicians to join and ER physicians. Proud to be london Gem candidate.

FEEDBACK # 4

Dr Ahmad Tanveer

A very informative lecture on a dry topic but Dr. Nahal deserves apprecaition for her ability to engage everyone and make it palatable. Explained basics & NICE guidelines. Her quiz on different signs was beneficial to identify
•xanthelasmas,
•arcus cornealis,
•ext tendon xanthomas, •palmar crease xanthomas, •tuberous xanthomas, •tangier disease
Starting from types of Lipids in the body: LDL bad cholesterol
HDL healthy
Triglycerides which develop when calories are not burned right away and stored in fat cells.
Types of Dyslipidemia:
Primary: Type I, IIa, IIb, III and IV
•Familial combined hyperlipidemia
•familial hyper apobetalipoproteinemia
•familial hypertriglyceridemia & homozygous familiar
2ndary: Causes

obesity, sedentary lifestyle, alcohol and tobacco use, T2DM, hypothyroidism, CKD or liver conditions, cushings, female sex higher LDL levels after menopause. Symptoms ranging from loose stools, depression, stomach distension, poor appetite, fatigue, weight gain. Increased risk of CHD.PAD stroke.
Before starting lipid modification for primary prevention of CVD take at least 1 lipid sample include measurement of total cholesterol, HDL, non HDL, triglyceride.
•Fasting sample is not needed. MYTH cleared
As per NICE total cholesterol level should be 5mmol/L or less for healthy adults and 4 or less for those at high risk. LDL level 3mmol/L or less for healthy adult and 2mmol/L or less for those at high risk.
An ideal HDL >1mmol/L and total cholesterol to HDL ratio should be <4.
Treatment: offer atorvastatin 20 mg for primary prevention of CVD for people with 10% or > Ten year risk of CVD. Use QRISK2 to estimate risk. Start 80 mg in people with CVD, usually continued for 1 year and the dose can be reduced in view of potential drug interaction, risk of adverse effects and patient preference. Repeat lipids at 3 months aiming for greater than 40% reduction in non HDL. If not achieved discuss adherence and timing of dose, life style and diet, consider increasing the dose based on clinical judgement.
Lifestyle modification includes: cardio protective diet, physical activity: 150 mins of moderate intensity of aerobic activity or 75 mins of vigorous intensity aerobic activity or a mix of both, weight management, alcohol consumption (14 units a week), smoking sensation.
•When to refer the patient to lipid management clinic: possibility of familial hypercholesterolemia investigate if T.CHO >7.5 and family H/O premature coronary heart disease. Specialist assessment if T.CHO >9 or non-HDL >7.5, urgent specialist review if triglyceride>20mmol/L that is not due to alcohol or poor glycemic control.
<5% low risk life style modification(class I)
5%- 7.5% borderline risk, if risk enhancers present then discuss moderate intensity statin therapy(class IIb)
>7.5%-20%intermediate risk + risk enhancers initiate moderate intensity statin to reduce LDL by 30-49 % (class I) >20% high risk initiate statin to reduce LDL by 50%

Very high risk of ASCVD: give high intensity or maximal statin if still LDL >70 mg/dl or 1.8mmol/L add ezetimibe after max dose of statin and ezetimibe then PCSK9-I can be added.
Statins reduce LDL by 20%-60%, triglycerides by 10%-20% and increases HDL 10%-15%. Fibrates are not preferred as they might increase LDL.
10 mg Atorvastatin causes 33% reduction in LDL and 80 mg causes 55% reduction.
Statins with short half life are given at night as hepatic cholesterol synthesis is maximum between midnight to 2am.
Atorvastatin and rosuvastatin have long half life making it safe to use in morning.
Atorvastatin also has antioxidant property. Statins are HMG CoA reductase inhibitors and side effects include myopathy and increased liver enzymes.
Ezetimibe cholesterol absorption inhibitor side effects headache and GI distress.
Newer drugs are PCSK9 inhibitors, apolipoprotein synthesis inhibitor, microsomal triglyceride transfer protein inhibitor, thyromimetic, cholestryl ester transfer protein.
It was a great discussion
Only Dr Nahal was capable to handle such a dry topic in an interactive way Thanks alot Dr Nahal and Dr Ash for arranging this educational activity covering many MCQs . Regards