London
Breaking Barriers in EM
Global Emergency Medicine Programme
GEM

FEEDBACK FILE 3

EVENT NAME:

Infective Endocarditis MRCP1-2 & PACES by Dr Nahal Raza Cardiology Registrar NHS UK.

DOCTORS FEEDBACK

FEEDBACK # 1

Sidra Asad

Excellent lecture gave by Dr Nahal which covers all basic and clinical aspects of this topic. Her lectures are always amazing as they are interactive and she always adresses to all the questions thoroughly. I have learnt alot from her presentation from definition, patho, causes, diagnosis (modified dukes) and management of infective endocarditis. Moreover there were slides on Osler nodes and janeway lesions in real patients and flowchart in regards to the causes which were highly useful to learn this topic. In this lecture i have learnt some amazing mnemonics and peripheral stigmata of this disease. We were taught the latest guidelines of management and most important organisms in UK. 3 Case based discussions were held related to this topic and Dr Ash gave his valued feedback on them. This programme is unique and i m glad to be part of this. Thanks alot.

FEEDBACK # 2

Mehak Nabi

Informative session conducted by Dr Nahal comprising on pathophysiology causes including bacterial fungal abnormal substrate,how to diagnose starting from taking hx examination labs and imaging 3ps of oslers node and why do they get on finger tips most imp of TTE TOE , complications of I.E, why do PR progession occurs, indications for surgery. Case discussion was very interesting. Thanks Dr Ash for sharing your experience with us and how you deal with them and how you always think out of the box.

FEEDBACK # 3

Bushra Khan

Dr Nahal Raza is an amazing teacher. She is very energetic and interactive. She covered infective endocarditis very comprehensively. We studied its definition, causes, names of bacteria causing it, most common and uncommon, duke's criteria for diagnosis; she showed is pictures of Osler's nodes and Janeway lesions. The pathophysiology of these. Different presentations of IE. Its treatment that is really complicated. This topic is favourite of MRCP and it was nicely covered. Has the opportunity to present a case of infective endocarditis. Dr Faisal also presented a very good case.

Dr Ash has this quality of connecting people. Thank u Dr Ash for providing with a great bunch to study with. Amazing job⭐⭐⭐💐

Feels like Im back in my college years. Connecting with batch mates every week😊

⭐⭐

Thank

FEEDBACK # 4

Ramsha Tasnim

Very informative lecture about endocarditis, It includes definition (inflammation of heart chamber and valves that can be difficult to treat)

Its causes (bacterial, abnormal substrates)

Morphology

Infective pathogens (s.sanguinis, s aureus, s.epidermidis, fungal infections)

How to diagnose (history examination)

Peripheral stigmata of disease (osler nodes, janeway lesions,roth spot,splinter hemorrhages)

Modified dukes criteria (major and minor criteria)

Investigations (blood cultures, transthoracic echo, and transesophgeal echo)

Treatment of IE
Complications of endocarditis (congestive cardiac failure, valvular damage, prolongs fever, recurrent fever)
Surgical indication of IE (heart failure, uncontrolled infection, embolism risk)
Case base discussion by Dr Bushra and Dr Faisal was very comprehensive and informative.
Thanks Dr Ash.

FEEDBACK # 5

Ghazala Xhiekh

Dr nahal Raza has a very friendly approach she kept interactive session as always. She covered the most important topic of CVS ie infective endocarditis
I learnt,

- IE definition, causes and pathophysiology
- modified Duke's criteria
- detailed History, examination and investigations
- Treatment
- Complications
- ECG and ECHO changes in IE
- Osler's nodes and janway lesions
- ACCA/AHA guidelines
- Indication of surgery
- 3 CBDS contained very useful information as well

Grateful for Dr Ash who made this decision to improve medicine practices in pakistan. Thankyou so much sir

FEEDBACK # 6

Sadia Abbasi

I love the way of Dr Nahal Raza teaching, as always full of energy well organised session. Too many learning points and how we pick cases of infective endocarditis from different presentation I learnt today.
Infective endocarditis defination, cause (bacterial source and abnormal substrate in prosthetic valve and native vale damage) pathophysiology, morphology,how to diagnosis(history examination blood and imaging) Clinical manifestation , modified dukes criteria,how to manage. Osler's nodes and janeway lesion there importance in exame point of view excellent never forget.

In the end final words by Dr Ash are always magical giving different perspective of topic to think and approach a case always love this. Excellent cases discussed by Dr Bushra khan, Dr Shiraz and Dr Hassan with different presentation of infective endocarditis. Thanks a lot Dr Ash I learnt a lot just because of this London GEM MRCP programme.

FEEDBACK # 7

Faiza Baig

I would say that this lecture was really informative and in a precise context. I love the way of Dr Raza's teaching with full of positive energy.
It consists of definition and its causes.
Pathophysiology, causative organism and how to examine and diagnose the patient? The peripheral stigmata and Duke criteria (major and minor)for diagnosis and what are janeway and osler nodes.
What are investigations!!
-Blood cultures
-Transesophegeal echo
-Transthoracic echo
Dr Raza also explained the similarities in ESC and ACC/AHA guidelines. Both guidelines consider heart failure, uncontrolled infection and embolic risk.
She also discussed dissimilarities of these guidelines which includes
-Timing of surgery
-Large vegetation
- Vegetation size and emboli
To conclude it is better to optimize clinical practice and use of surgery in Infective Endocarditis. In the meantime also do thorough patient assessment by different endocarditis teams.
There were 3 cases presented by
Dr Bushra khan
Dr shiraz Mehmood
Dr Faisal abdulhanan
From my perspective all 3 cases were interesting and explained elaborately.
In the end Dr Ash restate the topic that history and examination is very important for infective endocarditis. Thanks Sir and Mam for stimulating and brilliantly taught lecture.

FEEDBACK # 8

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 # 9

Dr Nasir Hayat

This session was very amazing and well organized. Very informative lecture about endocarditis, It includes definition(inflammation of heart chamber and valves that can be difficult to treat)
Its causes (bacterial , abnormal substrates)
Morphology
Infective pathogens(s.sanguinis, s aureus, s.epidermidis, fungal infections)
How to diagnose (history examination)
Peripheral stigmata of disease (osler nodes, janeway lesions,roth spot,splinter hemorrhages)
Modified dukes criteria(major and minor criteria)
Investigations (blood cultures, transthoracic echo,transesophgeal echo)
Treatment of IE
Complications of endocarditis (congestive cardic failure, valvular damage , prolong fever , recurrent fever)
Surgical indication of IE(heart failure, uncontrolled infection , embolism risk)
Case base presentation was very comphrensive and informative .Highly

recommended for physicians to join it to be more knowledgeable and skillful physicians.

FEEDBACK # 10

Dr Ghulam Saddique

Dr Nahal kept the topic simple and interesting session with lots of knowledge and information was summarized in an simplest way.
She taught the definition, causes and pathophysiology of IE.
She discussed the main causative organism and the symptoms they present with.
The morphology and the diagnosis' structure were helpful in understanding. She comprehensively explains the peripheral stigmata and how to pick them from exam point of view. Modified Duke Criteria was explained in detail.The important investigations and the importance of history and examination was discussed in depth.
Treatment with antibiotics and the correct usage was taught.
Complications developed from IE and the varied range of symptoms patient can present in clinical setting.
Why the serial ECG was required? To look for the PR prolongation this develops as a result of aortic root abscess.
Many cases and learning points were shared by Dr Ash which clear all the doubts .
It is indeed an amazing power pack of knowledge.
Thanks Dr Ash for his countless efforts and energy.
I am proud to be part of London GEM programme.

FEEDBACK # 11

Dr Leela Ram

It was superb lecture, discussed definition, causes, morphology, how to diagnose using modified Duke's criteria and apart from it, several clinical diagnoses, clinical manifestations. It was interactive and interesting.
As she always tried to incorporate all important material to teach in order to make us understand the topic with long lasting memory. She made lecture interesting and worth learning.
I have learnt that Infective endocarditis is a life threatening inflammation of heart chambers and valves & can be difficult to treat. Bacterial source endocarditis is caused by infected needles (IV drug use, open wound, dental procedure, cardiac device, surgery, intravascular catheter whereas some congenital heart diseases and prosthetic valve after surgery can be cause. Aortic & mitral valves are most

common infected while tricuspid valves are infected in IV drug abusers. Most common pathogens are S. Sanguinis, S. Aureus, S. Epidermis, Enterococcus, S. Bovis & C. Burnettii. Clinical symptoms are fever most often but may not be present in some cases, new heart murmur, splinter hemorrhages & Janeway lesions. 80% is caused by bacteria and 2% is caused by fungi. Most common and virulent is Staphylococcus, 2nd most common is Streptococcus & 3rd one is Enterococcus. Fungi Candida albicans & Aspergillus causes it.
It will improve my diagnosis, I will take proper history, clinical examination and investigation & management plan according to the investigation. I will apply modified Dukes criteria: Blood cultures more than 2 times 12hours apart & Echocardiography, temperature 38C, Immunological phenomenon, microbiological evidence, Embolic phenomenon, Risk factors (congenital heart conditions and IV drug use). Therapy includes Antimicrobial agents and Surgery.
Typical cases presented were very good with lot of learning. As a usual Dr. Ash emphasized the importance of diagnosis of Infective endocarditis, he discussed that if patient has fever persistently with no obvious cause, it could be endocarditis in provisional diagnoses. Sometimes, it's not responding to antibiotics and doesn't resolve at once, it can last months to years. Thanks Dr. Bushra, Dr. Sheeraz & Dr. Faisal for case presentation. Thanks Dr. Ash for overall cocktail of special knowledge.

FEEDBACK # 12

Dr Faisal Abdul Hannan Butt

As always Dr.Nahal Raza delivered this session in an very interesting and understandable way.
It focused on following points;
Basic definition Of Infective Endocarditis (I.E) and its causes, pathophysiology, causative organisms; Staph.Aureus , Strep, Viridans, HACEK Organisms.
Culture Negative Infective Endocarditis
How to examine and diagnose the patients of I.E?
Modified Duke's Criteria(Major and Minor Criteria) 2 Major or 1 Major and 3 Minor Or 5 Minor Criteria.
Vasular and Immunologic Phenomenon in I.E; Janeway lesions,Osler nodes,Roth Spots
Investigations; CBC, ESR, Rh Factor, Urine R/E Blood cultures (Alteast 3 Samples from 3 different sitea), Transesophegeal echo,Transthoracic echo.

Similarities in ESC and ACC/AHA guidelines. Both guidelines consider heart failure, uncontrolled infection and embolic risk.
Dissimilarities of these guidelines which includes;Timing of surgery ,Large vegetation,Vegetation size and emboli.
Antiobiotic Regimen for I.E, depending on the cause of I.E.
There were 3 cases presented by
Dr.Bushra khan
Dr.Shiraz Mehmood
And Myself (Faisal Abdul Hanan)
All cases were interesting and indeed learned alot from this whole session and cases being presented.
Thanks Dr.Ashfaque Ahmed for facilitating the whole session.
Thanks Dr.Nahal Raza
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 13

Dr Muhammad Shafique

Dr Nahal is dedicated cardiologist of his time young energetic for their students always. For me it was a boring but she taught in a lovely way.
Infective endocarditis definition is inflammation of endocardium by i. V drugs user that is non sterile
Bactrrial source and abnormsl substrate with thrombi of fibrin and plates
Affected valve mostly mitral followed by aortic
Most common pathogen s. Singuinis
HACK ORGANISM
Staplococus most common most virulent
Strepcocus 2nd most common
Enterocouci 3rd most common
Opportunist candida
How to Dx. History examination blood test imaging
Duke criteria major criteria and minor criteria mnemonic BE TIMER
Oslor nodes janways lesion
Treatment with guide line and emperical treatment
Surgical sugnal. When low cardiac output. Uncontrolled infection embolism risk.
Short but clinically important case by Dr Ashfaque and two other by Dr Bushra a long case and typical case by Faisal Abdul Hannan

Thanks LONDON GEM

FEEDBACK # 14

Dr Beenish Naveed

Dr Nahal kept the topic simple and interesting with lots of knowledge and information was summarised in an easy way.
She taught the definition, causes and pathophysiology of IE.
She discussed the main causative organism and the symptoms they present with. The morphology and the diagnosis' structure were helpful in understanding. She comprehensively explain the peripheral stigmata and how to pick them from exam point of view.modified Duke criteria was explained in detail.The inportant investigations and the inportance of history and examination was discussed in depth.
Treatment with antibiotics and the correct usage was taught.
Complications developed from IE and the varied range of symptoms patient can present in clinical setting.
Why the serial ECG was required? To look for the pr prolongation which develop as a result of aortic root abscess.
Many cases and learning points were shared by Dr Ash which clear all the doubts . It is indeed and amazing powerpack of knowledge.
Thank you Dr Ash for his countless efforts and energy

FEEDBACK # 15

Dr Tooba Qadeer

I would like to praise the teaching style of Dr Nahal, it's very energetic and efficient. She explains difficult topics very easily and they become easier to absorb. Learned about the definition, aetiology, causes (iv drug abuser, rheumatic, prosthetic valves, bacterial, viral, fungal, congenital heart diseases, dental procedure) of infective endocarditis, modified dukes criteria, culture negative causes. For diagnosis always going to basic hx, exam (splinter hemorrhages, osler node, Janeway lesion, murmurs), blood culture 2 samples 12 hrs apart, strep sanguineous being most common cause now, echo (tte and toe), use of toe for small lesions and obese, copd, chest wall deformity patients, abx treatment for different gram +ve and gram -ve bacterial causes, complications of IE, doing ecg every 2 weeks to look for PR prolongation for ruling out aortic root abscess/ involvement which becomes indication for surgery, other surgical indications. I

learned important points regarding MRCP questions and stressing on the fact to rule out IE in every illness with fever present greater than 1 week.
Case presentation by Dr Bushra and Dr Faisal were also very informative. Thanks to all for today's session.

FEEDBACK # 16

Dr Erman Faroza

Very interactive and energetic session it was. Thanks to Dr Nahal the way you deliver your lecture is very admirable. Today I have learnt Infective endocarditis definition ,cause(bacterial source and abnormal substrate in prosthetic valve and native vale damage)pathophysiology, morphology, how to diagnosis (history examination blood and imaging) Clinical manifestation , modified dukes criteria Osler's nodes janeway lesion and much more...
Thank you Dr Bushra and Dr Faisal for discussing very informative case by this we are able to learn that apart from bookish knowledge how to diagnose Infective endocarditis from different scenarios.

FEEDBACK # 17

Dr Mariam Sultan Khan

Well if someone hates cardiology and find it extremely hard should attend Dr. Nahal lecture. As a teacher she really understands where her students lack and how to make the topic interesting and easy to digest.
Today's topic was no different
She started with definition of infective endocarditis i.e. life threatening inflammation of heart's chambers and valve that can be difficult to treat. She elaborated on its causes including bacterial source or abnormal substrate. Morphology of infective endocarditis. The most commonly affected aortic and mitral valve and in IV drug abusers tricuspid valve. She discussed the pathogens in great detail, bacterial being 98% and staph aureus being most common, rare tropheryma whipplei culture negative, HACEK, non HACEK, fungal that are rare but with very high mortality rate. To diagnose a patient by history, examination, bloods and imaging. Clinical examination and peripheral stigmata including pictures to remember osler's node, janeway lesion, splinter hemorrhage. She gave us an excellent pnemonic to remember modified dukes criteria for infective endocarditis. Role of TTE and TOE, phases of antibiotic treatment of infective endocarditis, antimicrobial therapy and indications of surgery.

Thank you so much for such an amazing lecture Dr. Nahal. Your efforts will go a long way.
Moreover, very insightful cases discussed by Dr.bushra, Dr. Faisal and Dr. Sheraz . The discussion gave an idea on how to actively look for infective endocarditis in real life scenario.
Dr.Ash your efforts are commendable on providing us this platform and how you own us non trainee Doctors and continue to inspire us to be better Physicians.
Thanks sir.

FEEDBACK # 18

Dr Uzaima Nighat

Todays session was very much informative. Dr Nahal kept everyone engaged throughout the session.
Today we discussed the definition of IE and patho physiology of the disease along with the important cause and causative organisms.
Approach towards the patient with IE. Keys is to always start with detailed history and examination then labs and relevant imaging. Duke's criteria for which she made excellent mnemonic to remember.Important labs include sequence blood cultures and imaging including TTE and TOE.
Treatment of IE with updated guidelines.
Dr Bushra and Dr faisal discussed some really interesting cases.
Thankyou!

FEEDBACK # 19

Dr Mohid Kannan

Interactive and up to date session today.
Covered the definition of IE,
Causes,
Morphology ,
Up to date Infective pathogens(s.sanguinis as most common pathogen in IE now, s aureus, s.epidermidis, fungal infections,
Diagnosis (history examination , imaging , blood cultures , Echo(TTE, TOE)
Peripheral stigmata of disease (osler nodes, janeway lesions,roth spot,splinter hemorrhages, splenomegaly)
Modified dukes criteria(major and minor criteria)
Treatment of IE with antibiotics and prophylactic antibiotics,

Complications of endocarditis (congestive cardic failure, valvular damage , prolonged fever , recurrent fever),
Surgical indication of IE
ACC/AHA guideline
ECG requirement for PR prolongation for aortic root abscess.
Case base discussion by dr Bushra,Dr. Ash and Dr faisal was helpful to approach IE.
Thank you Dr Ash and Dr. Nahal

FEEDBACK # 20

Dr Zeeshan Ayaz

Wonderful session .Dr Nahal kept everyone engaged throughout the session.
Today we discussed the definition of IE and patho physiology of the disease along with the important causes and causative organisms.
Diagnosis of infective endocarditis in clinical practice is very difficult, Key is to always start with detailed history and examination then labs and relevant imaging.
We learned about peripheral stigmata of IE (janeway lesions ,osler nodes , Roth spot , splinter hemorrhages) , Duke's criteria(major and minor)for which she made excellent mnemonic to remember, complications of endocarditis, ACC/AHA guidelines, Important labs include sequence blood cultures and imaging including TTE and TOE.
Treatment of IE with updated guidelines.
Dr Bushra and Dr faisal discussed some really interesting cases.

FEEDBACK # 21

Dr Omema Hilal

Dr Nahal is an amazing teacher, her methodology of teaching makes her sessions very unique to herself. The session was very useful and amazing.
She keeps our attention throughout the class she is one of my favourite teachers.
Through different cases, i got the deep understanding and confidence to deal with patients presenting with infective endocarditis.
In today's session, i have learned that infective endocarditis has typical presentation but it can also have some vague presentations
I learnt about the causative organisms which is sanguinis and HACEK group and aureus

Transthoracic echo not always sufficient to rule out the INFECTIVE ENDOCARDITIS, if suspected we should opt for transesophageal echo if available.
Antimicrobials has important role in treatment.
Signs includes 4Ps
Pink painful pulps and peripheries
Can present with peripheral thromboembolic symptoms
Complication includes, prolonged fever,
Congestive heart failure vulvular hear disease uncontrolled infection risk, needs antibiotics for lond periods
Three cultures from three different sites 12 hours apart.
Osler nodes are at tips of fingers and toes
Janeway lesions are at palm and soles.
The antimicrobials has to be learnt by heart.
Thank you Dr Nehal for your exceptional teaching. We have retained the topic fully.
Special thanks to Dr Ashfaque who made it possible for all of us to provide world class training platform to all of you, in our own comfort zones.
Though it is very uncomfortable for you and your family to dedicate each and every weekend on us, even after completion of training and exams, you dedicate it for us who were non trainee doctors and their potential was never acknowledged.
You are bringing best in us.
There would be no second Dr Ash coming.
I don't have words to thank you enough.

3rd DECEMBER 2022

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 summarized 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. Thanks 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 treatment 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 wonderful platform for learning .thanks all LGEM team also

FEEDBACK # 17

Aleena Rahman

A wonderful lecture presented 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 we must 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. Thanks Dr Michael for this amazing lecture.

FEEDBACK # 18

Hira Nehal

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

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 taking: 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 gave 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

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.
Thanks 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 starts 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

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!

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.
Thanks Dr Nahal for an amazing session.
Thanks 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

Today’s 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. Thanks 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 loved 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. Truly a fully loaded informative session, Thanks so much Dr Nahal and Dr Ashfaque.
Alhamdulillah 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. 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 bring 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

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, especially 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.
Thanks Dr Ash and Dr Nahal.

FEEDBACK # 17

Hani Suhail

A wonderful session about valvular heart disease, this seesion omprehensively 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.
Thanks Dr. Nahal and Dr. Ash for those pearls and wonderful points to correlate and connect with.

FEEDBACK # 18

Aqsa Yaqoob

Outstanding session gave 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 Nahal 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 interests 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 very energetic 1 hour with alot of knowledge. Nicely done gem team especially Dr Nehal. Thanks to you and the whole team of GEM and especially our mentor Dr Ash, wouldn't be possible without their 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... Mashallah what a confidence ...a gr8 grip over the subject... from basics to high tech knowledge.... everything explained soooo 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 Allah will 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 it's 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 reached the diagnosis and winning 50 pounds.

The knowledge we get through this platform is beyond words. Thank 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 its 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 you 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 flows 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. Thanks sir for your endeavors to make all of us a successful story and proving wonderful platform.
Proud to be a part of LGEM program

FEEDBACK # 31

Syed Suhail Ahmad

In this session Covered
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
➡ Difference 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 allowed to attending this lecture.
Thanks Dr Nahal for wonderful teaching.
Bless 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 management
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 management
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

Excellent session on valvular heart disease presented 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 lesions 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 and Dr. Imran was good enough to diagnose it straightaway. Thanks 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

It’s 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 PO INT(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.
OSCE session by Dr Kamran and Dr Ash excellent and so many learning points from exam side.

FEEDBACK # 43

Muhammad Abubakar

An outstanding lecture gave 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 cause 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.

Thanks 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 covered 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.

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.

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.
Thanks Dr **Nahal Raza** for excellent teaching.
Many thanks Sir Dr **Ashfaque** for your continuous guidance, help and support.
Truly bless 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. Love 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.
Started from the pathophysiology to their management in emergency without needed to got 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. Learn the bundles of new concept.
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 MCQ's 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

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 development 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 ventricularm 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 important are that how to examine certain heart diseases were also diacussed. One of the new things for me was the Erb's Point.

At the end there was a lovely OSCE Session by Dr Ash and Dr Imran Farooqa.

FEEDBACK # 60

Dr Mishal Shan

Genuinely love each and every minute of the 1.5 hour 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 interesting 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… Thanks 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.

10th DECEMBER 2022

EVENT NAME:

Asthma Diagnosis & Management for EM & Acute Physicians By Dr Jacob Baby Respiratory Consultant UK

DOCTORS FEEDBACK

FEEDBACK # 1

Babar Hussain

A lot of learning points for me especially
~I heard the first time about the role of FeNo in investigation of asthma.
~IgE level.
~ Eosinophil count.
~ Spirometry.

In management
~difference between NICE guidelines and GINA guidelines,
~ Role of preventor and releiver
~ Role of SABA, ICS, LAMA, LABA, theophylline and MgSO4.
Over all it was a wonderful session.
I am really grateful to Dr **Ashfaque Ahmed** and **London Global Emergency Medicine** for arranging such an amazing session.
Thank you very much Dr Ash and Dr Jacob.
Proud LGEM candidate

FEEDBACK # 2

Sadia Khan

Very informative lecture by Dr Jacob! Was confused with management of Asthmatic patients in ED after lecture much concepts cleared about diagnosis and management specially FENO test… thank you Dr Ash and LGEM

FEEDBACK # 3

Shehzad Hussain

Thanks to Dr Jacob n Dr Ash for wonderful session on Asthma management.
It was a comprehensive lecture which covered presentation, History, PE, precipitating factors, testing for asthma, Spirometry, reversibility with bronchodilators n FENO, Principles of pharmacotherapy, definition of controlled asthma.
Step wise management of asthma, asthma classification and complete treatment as per NICE and GENA guidelines. It was comprehensive lecture which practically covered each aspect of asthma management as per latest guidelines.
Thanks alot Dr Ash n LGEM team for wonderful session.

FEEDBACK # 4

Hani Suhail

A wonderful session on asthma with alot of clearance of the presentation, approach, management and the different guidelines
Thank you Dr. Jacob and Dr. Ash for making it easier to understand and more relatable to our daily experiences.

FEEDBACK # 5

Rabiyyah Bashir

It was interesting to know how exactly you label someone asthmatic.. detail of guidelines for management...and the practical implications of the stepwise management... The clinical relevance of this lecture was awesome ❤️❤️❤️... Thanku Dr Jacob ❤️… We feel grateful to be a part of this platform ❤️... God bless you Dr **Ashfaque Ahmed** Sir ❤️. Thanks **London Global Emergency Medicine** ❤️

FEEDBACK # 6

Sana Hameed

What a knowledge-full lecture on asthma, learned new terms/ objective/ management sequence, Comparison of treatment as per NiCE and Gina guidelines. The session ended 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 # 7

Noman Ahsan

Today's session was expertly covered with detailed explanation.I must say that Dr.Jacob has a firm grip on this topic and he his way of teaching is very good...Learned lots of new things but highlited points are Role of FeNo in investigation of asthma.
He comprehensively explained Asthma management and the difference between NICE and GINA guidelines..
When to prescribe SABA along with steroids and different combinations of SABA , LAMA, Theophylline...
Brilliantly explained this topic and learned alot...Thanks Dr.Jacob and Dr.Ash for this great session...

FEEDBACK # 8

Bushra Imran

In today's session very clearly and comprehensively described the guidelines ,history taking important points,how to diagnose,spirometry and its usage ,FeNO in investigation, with Gena classification ,NICE classification differences for treatment,stepwise plotted on diagrmatic tables ,Risk factor and fatal signs of severe asthma.Acute Astma and its management.Then in the end Questions discussion for our understanding about the topic was superb...Thank you Dr Jacob and Dr AsH for this session.

FEEDBACK # 9

Mohid Kanan

It was an interactive session today by Dr. Jacob
Covered the topic comprehensively, started with brief description of asthma, overview of the NICE approach diagnosis, initial clinical assessment (clinical hx, occupational asthma,physical examination,testing for asthma), Objective tests recommended in guidlines(spirometry, BDR, FeNO,PEF variability,direct bronchial challenge test with histamine and methacholine).
Diagnosis of Asthma in order of tests:
Measure FeNO first followed by spirometry and factors affected the FeNO level ,
Principle of pharmacological treatment
Definition of controlled Asthma,
NICE, GINA ,BTS guidelines
Monitoring asthma control
Types of Acute asthma
*Moderate * severe *life-threatening *near fatal active Asthma and risks
Criteria of admission
* Management and investigations of acute asthma in hospital.
Overall, it was a wonderful session with a lot of learning today and Dr. Jacob explained everything very well.
Thank you Dr. Jacob and Dr. Ash

FEEDBACK # 10

Yasir Dilawar

Today was a very important lecture about Asthma.we learnt quite a lot about the diagnosis, symptoms and different tests to know about Asthma.Eosonophil count for allergic asthma and it's treatment with corticosteroids.Neutrophilic Asthma.
FeNo in Investigation of Asthma
Fev1/Fvc this concept
Patient feels better after SABA is reversible Asthma
Occupation
Spirometry measurements
Nice Guidelines
Management of Asthma.
Special thanks to Dr Jacob.your lecture was so good.we learnt so much from you.

FEEDBACK # 11

Imtiaz Ali Shah

Today we had another excellent session by dr Jacob regarding Asthma .It was an excellent session covering various aspects of the disease. Important learning points were,
Definition of Asthma.
NICE APPROACH to Asthma including Structured history,examination, objective tests
INITICAL CLINICAL ASSESSMENT including
History,occupation and symptoms.
PEAK FLOWER monitoring at least 4 times in a day for occupational Asthma.
PHYSICAL EXAMINATION.
DIAGNOSIS OF ASTHMA..Concept of FENO and BD REVERSIBILITY were new learning points for us while diagnosing Asthma.
TREATMENT OF ASTHMA. A very detailed discussion about treatment options were carried out including use of SABA,ICS LRTA and LABA was excellent .
Overall it was an amazing session by dr Jacob covering all aspects of the disease, the way he shared his knowledge was brilliant and he made the things easy to understand which shows his professional strength.
At the end I would like to thanks dr Jacob for this wonderful presentation and also dr Ash for providing us this wonderful platform of learning in the form of London GEM.

FEEDBACK # 12

Syed Suhail Ahmad

Couldn't have been any better session on Asthma than this accordingly to NICE Uk Guidelines
Included
- Asthma and its dignosis
- Importantce of FEV1/FVC ration and FeNO in diagnosis
- Importance of detailed history and clinical examination
- Difference between acute, moderate, severe, life threatening, near fatal, and fatal asthma
- Controlled asthma
- Management according to NICE and GINA guidelines and difference between them
- When to start SABA, LABA, LTRAs, ICS in asthmatic patients
- Dose management of ICS and its potential side effects

- Management of acute asthmatic attack which includes Oxygen, Nebs with Salbutamol, Steriods, Mg Sulfate and Aminophylinne
- Monitoring etc

Lots of new learning points and take home messages.

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

FEEDBACK # 13

Sidra Asad

It was an amazing lecture by Dr Jacob Baby which comprehensively covered this topic. We were taught the basic definition of asthma, overview of NICE approach for diagnosis, initial clinical assessment including disgnostic and objective tests. I have also learnt new things which were not clear in my mind before like the the concept of FENO (>40 with BD reversibility or peak flow variability for diagnosis of asthma)., factors increasing and decreasing Feno,This presentation mainly covered updated NICE guidelines for management(explained step by step by algorithm) and also explained GINA guidelines (worldwide guidelines); moreover when to refer to the specialist, admission criteria, in hospital and outpatient management, intubation criteria, only esinophilic asthma responds well to steroids, ICS doses and classifiaction of asthma according to severity. It was an excellent presentation and i have never been taught this topic before the way Dr Jacob has explained. Lastly, the session was ended with some exam oriented MCQs. I m blessed to be part of this programme. Thanks a million!

FEEDBACK # 14

Aurangzaib Ahmed

First ever lecture by Dr Jacob, he is actually faculty for Mrcp but it was a special arrangement by the great Dr Ash so that we also get a flavour of MRCP and also apply the knowledge in our ER setup.

It was non other than an eye opener for all of us. The things that Dr Jacob mentioned in his presentation were just outstanding. It made us realize how far we are from the current practice of asthma.

The concept of FENO in the diagnosis of asthma is brand new for us and most of have not even heard of The role of FENO in the diagnosis of asthma. Usually here we use FVC and FEV1ratio to label pt as asthmatic.

The concept was beautifully explained and put in a very easy and teaching friendly manner to make it look easy.

Once the pt is labelled as asthmatic he needs to be categorised properly so that proper treatment can be started
Then differentiate pt and his symptoms on the basis of symptom resolution as reversible or not
Explaining the difference and use of NICE vs Gins guidelines.
The lecture ended with a summary of the whole class by asking 4 questions and summarizing the whole class in those 4 questions.
All in all an amazing class with alot of information and he made it look very simple. Thank you Dr Jacob and Dr Ash for such an amazing lecture.

FEEDBACK # 15

Kamlesh Kumar Lilani

It was informative lecture on Management of Asthma learned IgE level and eosinophil count. Sir showed spirometry techniques. FeNO which was very first to know for Asthma and also different guidelines to know Asthma Management.
Thanks Dr. Jacob and Dr. Ash for wonderful session .

FEEDBACK # 16

Imran Khan

It was a wonderful presentation by Dr Jacob , explained Asthma and its management by adding FeNO test .

FEEDBACK # 17

Phota Ram

Excellent session by Dr Jacob about asthma how to diagnosis and step wise management of asthma.started with how to approach and clinical history taking and clinical assessment of patient and different tests
>skin prick test
>IGE level, raised esinophills,
>peak expiratory flow rate >reversible bronchodilator test improvement FEV1 >12% after after bronchodilator , >spirometry FEV1/FVC,<70% >Fena >40 positive . step wise management of asthma
SABA used as reliever therapy and for mantaince therapy low dose of steroids low steroids+LTRA,
low steroids+ LABA
MART and high dose steroids
Acute severe Asthma
Peak flow predicted 33-50%

Respiratory rate>25
Heart rate>110
Unable to complete a sentence.
Management of acute severe Asthma
>Oxygen to maintain o2 saturation 94_98%
>B2 bronchodilator (sulbutamol 5mg) via nebuliser
>Ipratropium bromide
>prednisolone tab 40-50 mg or iv hydrocortisone 100mg
Repeat 3 time for 30 minutes
Life threatening asthma
PEF<33%
O2 <92%
Silent chest,cyanosis
Hypotension
Arrythemia,LOC
Management of life threatening asthma
Discuss with senior clinician and ICU team
IV mgso4 1.2-2gm for 20 minutes
Near Fatal asthma
Raised Paco2
Require mechanical ventilation with high pressure

FEEDBACK # 18

Muzna Ahmed

First interaction with Dr Jacob Consultant NHS UK today and he delivered very comprehensively an effective outlook and management of Asthma. This session was extremely helpful regarding diagnosing treatment and post treatment managements of this very commonly encountering disease.
Today's highlights were:-
*To establish well structured history, ask about triggers i.e pets, smoking any food that tiggers allery etc, ask about wheeze, breathlessness, daily/seasonal variation, hx of atopic disorders, if new onset ask about occupation for example bakery.
*Examination is very important part in the series of diagnosis and if no wheese, ronchi heard asthma is not excluded.
*Asthma cant be out-ruled only on symptoms or hx of atopy without objective tests

*Don't rule out other diagnosis if other symptoms control continues to remain poor after rx.
*skin prick tests to aeroallergens
*serum total and specific IgE
*peripheral blood eosinophil count
*exercise challenge (to adults aged 17 and over)
#FOLLOWING ARE DIAGNOSTIC TESTS FOR ASTHMA:-
*Spirometery for age above 5yrs(less than 70% obstructive disease)
*bronchodilator reversibility (BDR Improvement in FEV1 of >12% and >200 ml increase in volume)
*Fractional exhaled Nitric oxide(FeNO) for 17 and above (above 40% is positive)
*Peak expiratory flow variability(above 20% variability monitored twice daily for 2-4 weeks is considered positive)
*Direct bronchial challenge test with histamine or methacholine for FEV1>60% predicted
#Moderate acute asthma:
Increasing symptoms;
Peak flow > 50-75% best or predicted;
No features of acute severe asthma.
#Severe acute asthma
Any one of the following:
Peak flow 33-50% best or predicted;
Respiratory rate > 25/min;
Heart rate ≥ 110/min;
Inability to complete sentences in one breath.
#LIFE THREATENING ASTHMA
Any one of the following in a patient with severe asthma:
Peak flow <33% best or predicted; Arterial oxygen saturation (Sp02) <92
Partial arterial pressure of oxygen (Pa02) <8 kPa,
Normal partial arterial pressure of carbon dioxide (PaCO2) (4.6-6.0 kPa):
Silent chest
Cyanosis
Foor respiratory effort
Arrhythmia
Exhaustion

Altered conscious level
#Near-fatal acute asthma:
Raised PaCO2 and/or the need for mechanical ventilation with raised inflation pressures.
Rx:
NICE guideline
BTS
GINA guideline
A/c to NICE guidelines:
Treatment line for Asthma
1. Newly diagnosed or intermittent attacks give SABA inhaler
2. Persistent attacks, symptoms onset requring maintanence therapy give Low dose ICS,
3. If asthma is uncontrolled with low dose ICS as maintainence therapy offer LRTA in addition to ICS and observe for 4-8 weeks
5. If uncontrolled on Low dose ICS and LRTA add LABA with ICS, with or without LRTA
6. If uncontrolled by Low dose ICS with LABA, with or without LRTA, than add MART (maintainence and Reliving therapy)
7.If asthma is uncontrolled in adults on a moderate maintenance ICS dose with a LABA (either as MART or a fixed-dose regimen), with or without an LTRA, consider:
Increasing the ICS to a high maintenance dose (this should only be offered as part of a fixed-dose regimen, with a SABA used as a reliever therapy).
A trial of an additional drug (for example, a LAMA or theophylline).
Seeking advice from a healthcare professional with expertise in asthma
LIFE THREATENING TREATMENT:
1 I/V MgSO4 1.2mg-2g
2 ITU Admission
3 Nebulized more frequently with beta bronchodilator.
It was very handful information on such complicated topic. Thank you Dr Ash and Dr Jacob.

FEEDBACK # 19

Ghazala Xhiekh

Dr jacobs teaching style is unique and shares his knowledge whole heartedly

Today's session was amazing overall
I learnt,
● Definition of Asthma
● Overview of NICE approach to diagnosis ie structured Hx, Examination and objective tests
◇ Don't rule out other diagnosis if symptom control continues to remain poor after treatment
● Initial clinical assessment, Ask for
• wheeze
• cough
• breathlessness
• daily or seasonal variation in these symptoms
• any trigger that makes symptoms worse
• a personal or family hx of atopic disorders
◇ Don't use symptoms alone without an objective test to diagnose Asthma
◇ Don't use hx of atopic disorders alone to diagnose Asthma
● Occupational Asthma
● Peak flow monitoring atleast 4 times a day
● Be aware that even if examination results are normal, the person may still have Asthma
● Testing for Asthma
• don't offer the following as diagnostic tests for Asthma
- skin prick test to aeroallergins
- serum total and specific IgE
- peripheral blood eosinophilic count
- exercise challenge to adults at 17 and over
● Objective tests recommended in guidelines are
• Spirometry (offer everyone aged 5 and over)
• BDR (bronchodilator reversibility)
• FeNO (fractional exhaled nitric oxide)
• Peak expiratory flow variability
• Direct bronchial challenge test with histamine or methacholine
● Diagnosis of Asthma
• FeNO>40+positive bd reversibility or Peak flow variability/PCO2<8mcg
• FeNO 25-39+PCO2<8mcg

• BD reversibility+Peak flow variability>20%
● Confounding factors that may increase or decrease FeNO level
● if Eosinophils are high, will respond to steroids otherwise Not
● Positive test thresholds for objective tests
● principles of pharmacological treatment
● Definition of controlled Asthma
● NICE guidelines for inhaled corticosteroids dosage
● Treatment pathway according to NICE approach Initially SABA is used, then ICS if still symptoms persist add LTRA ie montelukast along with ICS
But, other than NICE, other guidelines use LABA instead of LTRA
● the Royal college of physicians 3 questions
• Difficulty sleeping because of Asthma
• Asthma symptoms during the day
• Asthma interfered with usual activities
● Moderate Acute Asthma
● Severe Acute Asthma
● life threatening Asthma
● Near fatal active Asthma
● Criteria for admission
Thanks to dr Ash who made this possibility for us that we can learn from such great teachers ❤️

FEEDBACK # 20

Zegham Abbas

Today we have lecture on asthma delivered by Dr Jacob he explains the topic wonderfully and comprehensively the core knowledge of asthma how to diagnose and manage it. Today we had different key learning points like
>Clinical history taking it key points like cough wheezing and asthma related to occupation.
>peak Flow monitoring
> Physical examination auscultation of high pitch sound on expiration
> Different modalities for diagnosing asthma like
Skin prick test
Serum IgE
Exercise Challenge test
Peripheral eosinophil count

Spirometry
> FENO (fractional exhales nitric oxide) > 40 % & reversible bronchial asthma
> Bronchodilator reversibility
> PFT FEV1/FVC less then 70% obstructive pattern
>FACTOR Increase of DecreaseFENO
Gender, height,allergic rhinitis,smoking
>Stepwise management of asthma according to patient's condition
>Doses of ICS
*(Ciclesonide)
Low 80-160mcg
Medium 240-320mcg
High 400-640mcg
* Budesonide
Low 200-400mcg
Medium 600-800mcg
High 1000-1600 mcg
Difference between the guidelines for the management of asthma like NICE ,GINA ,SCOTTISH and other guidelines
Thanks Dr Ash and Dr Jacob for wonderful learning session.

FEEDBACK # 21

Muhammad Abubakar

Great session on Asthma by Dr. Jacob. Very well explained each topic included:
=> Tests for Asthma
* Spirometry = Age >5
* Bronchodilator Reversibility (BDR) = offered to pt. with obstructive spirometry
* Functional Exhaled Nitric Oxide (FeNO) = Age >17
* Peak Expiratory Flow Variability
* Direct Bronchial Challenge Test with Histamine or Methacholine (if there is diagnostic uncertainty)
=> Diagnosis of Asthma
=> Positive test threshold for objective tests
=> Treatment Pathway
* SABA > ICS > LTRA
* LABA
* MART Regimen

* Increase dose of ICS
* Anticholinergic drug
* Oral Corticosteroids
=> Questions of Asthma Control
=> Acute Asthma
=> Moderate Acute Asthma
=> Acute Severe Asthma
=> Life Threatening Asthma
=> Near-Fatal Acute Asthma
=> Risk of Fatal Asthma
=> NICE Guideline
=> GINA Guideline
And much more presented very greatly by Dr. Jacob. Thank You Dr. Ash and LGEM Team for all the work you are doing.

FEEDBACK # 22

Beenish Manzoor

It was Excellent session by Dr Jacob about very important and common presentation in A&E asthma about how to diagnose and step wise management of asthma.started with how to approach and clinical history taking :about how it starred ,allergies ,pets occupational hx i e bakery etc
Family history
*clinical assessment of patient
*Physical examination:
Wheeze and rohnci doesn't excluded other causes
Investigation :
*skin prick test
*IGE level, raised esinophills count
*Exercise challenge test
*peak expiratory flow rate
*Reversible bronchodilator test improvement FEV1 >12% after after bronchodilator ,
*Spirometry FEV1/FVC,<70%
*Feno >40 positive
*direct bronchial challange test with histamine and methacholine for FEV1>60%.
Step wise management of asthma

SABA used as reliever therapy and for mantaince therapy
*low dose of steroids
* low steroids+LTRA,
*low steroids+ LABA
*MART and high dose steroids
Acute severe Asthma
Peak flow predicted 33-50%
Respiratory rate>25
Heart rate>110
Unable to complete a sentence.
°Management of acute severe Asthma include
°maintain o2 saturation 94_98%
°B2 bronchodilator (sulbutamol 5mg) via nebuliser
°Ipratropium bromide
°prednisolone tab 40-50 mg or iv hydrocortisone 100mg
Repeat 3 time for 30 minutes
Life threatening asthma
°PEF<33%
°O2 <92%
°Silent chest,
°cyanosis
°Hypotension
°LOC
Management of life threatening asthma include
Discuss with senior and ICU team
°IV mgso4 1.2-2gm for 20 minutes
Near Fatal asthma
°Raised Paco2
°Require mechanical ventilation with high pressure
It was quite a phenomenal session .
Thanks alot Dr Ash
Thanks LGEM team
Proud Gem candidate

FEEDBACK # 23

Rajab Abbas

It was a comprehensive lecture on the management of Asthma as well as exam orientated SBA were pointed out.
Imp learning points of today's session :
• Diagnosis of asthma by
° IgE levels and Eosinophil count
° Spirometry
° FEV1/ FVC < 0.7
° FENO
• Difference b/w Asthma and COPD
• Occupational Asthma
° ask about newly onset Asthma and relation with holidays like off from work
• Extensive Management plan = Immediate
treatment > subsequent treatment>> Monitoring>> discharge
• Preventive n control management
•
• PFER should be 20% n 200ml
• Usage of SABA LABA LAMA ICS THEOPHYLLINE n MgSO4
• Importance of NICE/ GINA guidelines
• Difference b/w severity of asthma and there management.
It was quite a phenomenal session. Thanks alot Dr Jacob for this wonderful teaching.
Thank you Dr ASH.
A proud GEM candidates
Happy learning.

FEEDBACK # 24

Amir Ashraf

Today the lecture delivered was very comprehensive and based in true understanding of asthma , Dr jacob taught very delightfully and made sure we understood each and every point that is important for practice as well as exam orientated .
- steroids will only help if high eosinophils
-FeNo in invesgation of Asthma
- basics of fev1/fvc
- how asthma is can be diagnosed on differently .
- if after SABA , pt feels better its reversible Asthma , if not think about copd

- question a person about occupation with new onset presentation (baker's asthma very common in bakery workers)
-spirometry measurements
- Nice guidlines step by step
- Gina guidelines step by step
- diff btw nice and gina guidelines
-the perfect step wise management of acute asthma .
- diff b/w acute , moderate , severe and fatal asthma .
And much much more . Its was beautifully presented , there were questions at the end and he made sure everyone understood the topic well and honestly everyone answered all questioms correctly. We would love to see Dr Jacob again with come other respiratory topic .
Many many thanks to My supervisor Dr Ash for always bringing up the best for us ❤️
Proud LGEMian .

FEEDBACK # 25

Muhammad Azeem Imran

Another excellent session from LGEM plateform on Asthma
Learning point:
asthma confirmation by spirometry
PEFR variability more than 20 %
Direct bronchial challenge variability more than 20%
1.*FENO* more than 40%& reversibility - bronchial asthma
so FENO more than 40 ppb%
followed by positive bronchodilator reversibility &
2. *spirometry*
two test for diagnosis of bronchial asthma
if FENO high eosinophilic inflammation and it respond to steroid very well
obstructive spirometry FEV 1/ FVC < 70 %
Before starting treatment always consider reasons , alternative diagnosis,
lack of adherence, suboptimal inhaler technique ,
smoking
occupational exposure, depression,
environment factors
**~I *learnt what is

controlled asthma FEV1 / FVC more than 80 %**~*
ICS
budesonides 200-400low dose
600-800moderate
How to start treatment of asthma
appropriate step according to condition of patient
preventive & controller
steroid treat inflammation
bronchodilator treat spasm
5 steps management of asthma
start with SABA alone with intermittent asthma
1. *low dose ICS* first line maintenance therapy manifested nocturnal attack , more than 3 times a week attacks
eg budesonides twice a day & salbutamol
after 4-8 weeks
if uncontrolled
2. ****second step
offer *LTRA* -* montelucast*** in addition ICS
but LABA according to other guide lines
3. next step
ICS & LABA not improving
then go for MART regimen (formeterol& budesonides or salmeterol & fluticasone) with low dose ICS
4. if uncontrolled UpTo 8 weeks
increase dose steroid - 400 / same inhaler UpTo 8 times
if not improving start
additional drug *LAMA* (ipratropium , tiotropium , glycopyronium) or theophylline
thephylline in low resource conutries
.5 *oral steroids*
if uncontrolled then referr for biologic treatment
3 things
review, assess & adjust is personalized 3 steps of GINA guidelines
low dose ICS & formeterol in mild asthma decrease exacerbation 60- 64%
GINA guidelines

track 1-2Low dose ICS ,& formeterol in step 2
how to monitor asthma controle
ACT test (day time & night time symptoms, nocturnal attacks , need for releiver
Lung FunctionTest
Acute Asthma
peak flow 33-50%
R/R > 25 / min
HR >110
cannot complete sentence
life threatening asthma
peak flow < 33
spot <92
paco2 <8 kpa
hpotension
acute confusion
Near fatal asthma
need ITU admission
How to menage acute sever asthma
3 things
1. oxygen spo2 -94-98%
2.salbutamol 5mg via oxygen driven nebulizer
3.ipratropium 0.5 mg repeat 3 timesx
4.prednisolone 40-50 mg dailyor IV corticosteroids
100 mg 6 hrly
after every 15-30mnts
5.iv mg sulfate 1.2- 2 gm & 6.ventilator support
not NIV
monitor , spo2 ,HR, ABG , Serum K
I am thankful to Dr Ash for arranging such a excellent speaker Dr Jacob for delivering his presentation on this routine A& E problem.

FEEDBACK # 26

Afshan Salman

Learned NICE as well as GINA guidelines for asthma treatment.

Never knew about FeNO fractional exhaled Nitrous Oxide and its importance before, in diagnosing the disease. Learned peak flow variability, eosinophilic and non eosinophilic asthma and its relation to steroid response and much more. Thankyou Dr. Jacob, Dr. Ash and team LGEM. ❣️

FEEDBACK # 27

Hamna Yaqub

Dr Jacob covered all aspects of asthma definition, NICE approach to asthma,clinical assessment, interpretation of PFTs ,examination, diagnosis , lab interpretation and treatment(steroid only useful in eosinophil asthma).
The concept of FENO in diagnosing asthma was really interesting to learn.
Thank you Dr Jacob for explaining the topic in an easy manner.
Thank you Dr Ash for arranging this session.

FEEDBACK # 28

Khatija J. Farooqui

Another excellent session by Dr.Jacob on management of Asthma in EM. From history taking to managements acute to severe asthma treatments guidelines classifications spirometry usage ,FeNO investigation in diagnosis(new learning point). Overall wonderfull lecture .Thanks to Dr Ash & team LGEM.

FEEDBACK # 29

Abid Marwat

Aoa . It's was indeed an excellent asthma session with dr Jacob. Many old concepts cleared and much to update oneself with contemporary guidelines and treatment plans. Thank Dr Jacob and Dr Ashfaque Ahmed

FEEDBACK # 30

Farheen Naseem

Today lecture delivered by Dr Jacob which ia comprehensive and detailed about asthma he taught us asthma which we never learn before as he like taught us .more focused point are
Usage of steroids
Steroid more responsive in esinophilic asthma not in neutrophilic asthma
A new investigation knows as FeNo which is more predictable
Correct Usage of SABA LABA Ics
1st time know about Gina.and bts .Nice guideline about asthma how they applied step by step

Over all full lecture was comprehensive and after taking this lecture we are more confidently deal with asthma pt in A&E
Thank u dr Jacob dr Ash and lgem team

FEEDBACK # 31

Zia Hayat

It was an amazing talk by Dr.Jacob who is and excellent teacher ,he briefly first explained the definition of Asthma and also how we can label patients who are real asthmatics from other having dust or atopic allergies.He explained clearly the workup criteria with detailed explanation about the FEV1 AND FVC and the ratio to rule out obstructive and Restrictive Asthma types.NICE guidelines for the management of Asthma in ED according to its level of severity .He gave us an idea about the difference in management approach between the NICE and BTS ,GINA /WHO criteria for treatment options.Overall it was a wrap with different guidelines and management skills taught . Thankyou so much dr.Ash for this really comprehensive talk

FEEDBACK # 32

Dr Mariam Nawaz

We were taught asthma and its management by Respiratory consultant from NHS and it was a very enlightening session. Getting in this LGEM program is the best decision Pakistani doctors can make. We learned in detail about asthma, its classification and its detailed management in the light of latest guidelines. Some of the pearls i gatherd are
> While taking the history always keep occupational asthma in mind and ask relevant questions like; are symptoms better in days away from work?
> Record all the answers for later review
> Recommended tests are spirometry, BDR, FeNo, peak expiratory flow variability and direct bronchial challenge
> Asthma can be Acute, moderate acute, severe acute, life threatening and near fatal. All of these need to be identified and treated accordingly
> We learned about FeNO
> Treatment options for asthma were discussed in detail including SABA, LABA, ICS, Theophylline, MgSO4
It was a wonderful session
Thankyou Dr Jacob and Dr Ash

FEEDBACK # 33

Bushra Khan

It was indeed a very informative session. I learned

1. Diagnosis of Asthma - use of Feno
2. Obstructive pathology- FEV1/ FVC < 70%, bronchodilator reversibility >12%
3. Principles of Treatment
4. Definition of controlled asthma
5. ICS doses
6. Treatment pathways in NICE, BTS and GINA guidelines
7. Monitoring of Asthma control.
8. Management of Acute Severe Asthma- when to intubate and ventilate, no role of NIV in asthma.

Overall a great session with so much knowledge. Thank you Dr Jacob and London GEM 💎

FEEDBACK # 34

Nasir Hayat

This session was amazing, comprehensive taught and based on understanding of asthma , Dr jacob taught very wonderfully and understood each and every point that is important for practice as well as exam.

- steroids will only help if high eosinophils

-FeNo in invesgation of Asthma

- basics of fev1/fvc
- how asthma is can be diagnosed on differently .
- if after SABA , pt feels better its reversible Asthma , if not think about copd
- question a person about occupation with new onset presentation (baker's asthma very common in bakery workers)

-spirometry measurements

- Nice guidlines step by step
- Gina guidelines step by step
- diff btw nice and gina guidelines

-the perfect step wise management of acute asthma .

- diff b/w acute , moderate , severe and fatal asthma .

Its was beautifully presented , there were questions at the end and he made sure everyone understood the topic well and honestly everyone answered all questioms correctly.Highly recommended for physician to join it to get the deepth of practical knowledge and be skillful in future.Proud to be LGEM candidate.

FEEDBACK # 35

Hira Nehal

Asthma : chronic inflammation disorder of airway resulting in variable airflow obstruction .

Diagnosis of asthma :based on characteristics pattern of signs and symptoms along with a brief history

Family hx of allergy

Diurnal variation in symptoms and severity associated with stress anxiety exercise or exposure of specific allergin

Occupational hx very important .ask about work or home or holiday association during attacks or exerbation .

Examine pt .as all asthmatic don't have wheeze some have silent chest too

Investigation for asthma ..

Skin prick test

IgE levels

Spirometry (aged 5 or above)

BDR

FeNO

FEV1:

FVC

CRITERIA FOR DIAGNOSIS

>70% OBSTRUCTIVE LUNG DISEASE

COPD and ASTHMA can be differentiated if BDR FEV1 ll improve to 1.2 or there is 200ml change reversibility that is not present in copd

On basis of severity asthma is devided into

Moderate / intermittent

Night symptoms

Increasing symptoms or no feature of acute exerbation

PEF>50%TO 75%

SEVERE ASTHMA

inability to complete sentences in one breath

PEF :33 TO 50

RR >25

PR>110

LIFE THRETHNING ASTHMA

PEF<30 SpO2 <90 PaO2<8kPa
Normal PaCO2
SILENT CHEST CYANISOS ARYTHMIAS HYPOTENSION .EXHAUSTION OR ALTERED LEVEL OF CONCIOUSNESS
NEAR FATAL .RESPORATORY ACIDOSIS PaCO2
Management of asthma stepwise .
SABA + ICS[occasional)
SABA+LOW DOSE ICS(MAINTANANCE)
SABA+LOW DOSE ICS +LRTA
SABA+LOWDOSE ICS+LRTA+LABA
IF NOT WORK START
MART REGIME
If this fails increase dose of steroid oral prednisone 40 to 50mg for 5 days or iv 100 mg every 6 hrly.
MgSo4 1.2 to 2 gram in 20 mints slow infusion
Aminophyline is used with consultation of senior staff .
Sedatives are contraindicated .
Importance of review assist and adjust
Overview of GINA guideline along with NICE guideline .
Admission criteria (pt doesn't settle in 120 mints) or live threatening or near fatal asthma
Discharge criteria :PEF>75%
Intensive care referral.
Chk avalibility of medicine and technique to use inhaler
Issue PEF meter
F/u in GP clinic .
Very nice lecture with many learning points. Thank you dr jac and dr ash .

FEEDBACK # 36

فاطمہ ناصر

It was such an excellent lecture.. every detail.. diagnostic points.. management.. different guidelines..
Dr Jacob did it amazingly.. he was so keen to teach us.. even after time he offered himself to disscuss mcqs.. such a passionate team..
jazakALLAH khairan kaseera Dr Ash.. you are such a blessing for all of us

FEEDBACK # 37

Ayesha Mushtaq

It was a very comprehensive session regarding Asthma it's investigations and management plans specially management of Acute Asthma explained very interestingly.. alot of learning points and all were addressed in a an easiet way..thanku Dr Jacob and Dr **Ashfaque Ahmed** for such an informative session..

FEEDBACK # 38

Ghulam Saddique Saddique

It was a comprehensive session gave the complete understanding of asthma , Dr jacob made us understood each and every point that is important for practice as well as exam.

- steroids will only help if high eosinophils
-FeNo in invesgation of Asthma
- basics of FEV1/FVC
- how asthma is can be diagnosed on differently .
- if after SABA , pt feels better its reversible Asthma , if not think about COPD
- question a person about occupation with new onset presentation (baker's asthma very common in bakery workers)
-spirometry measurements
- Nice guidlines step by step
- Gina guidelines step by step
- diff btw nice and gina guidelines
-the perfect step wise management of acute asthma .
- diff b/w acute , moderate , severe and fatal asthma .

It was beautifully presented , there were questions at the end and he made sure everyone understood the topic well and honestly everyone answered all questions correctly.Highly recommended for physicians to join it to get the deepth of practical knowledge and be skillful in future.

Proud to be a part of lGEM candidate.

FEEDBACK # 39

Ahmad Bin Khalid

Today's session was on asthma and it's management by Dr Jacob it was brilliant and comprehensive teaching session alot of learning points taken like feno ,role of SABA ,LABA,MGSO4,NICE GUIDELINES,GINA GUIDELINES,ETC.

Thank you so much **London Global Emergency Medicine** AND DR ASH

FEEDBACK # 40

Dr Nouman

Once again, an amazing wonderful topic taught under the unmbrella of LGEM. As a note of appreciation I am really amazed at the topics seleted for EMFP session. Asthma is a condition most commonly encountered and most "lazily" diagnosed with a wheeze or a superficial examination....with patients started on medications that they do not really need and hence missing out their definitive diagnosis. Its a dilemma most oft encountered in the clinical settings of Pakistan.

This session however has really pointed out and revised all the important points regarding the diagnosis and management of Asthma meanwhile mentioning the NICE guidelines... We ll remember now that "every wheeze is not Asthma"

Thanks Dr Ash and Team LGEM, Dr Jacob for this important session

FEEDBACK # 41

Dr Hira Nisar

Dr. Jacob gave an excellent comprehensive lecture on Asthma, its diagnosis and management. He described the utility of FeNO, Peak flow variability, FEV1/FVC ratio along with history in diagnosing asthma. All wheezes are not due to asthma, was a concept new to me. I learned that a trial period of 4 to 8 weeks should be given before adjusting or changing an asthma regimen.

I learnt that NO is an inflammatory marker, therefore FeNO is increased in Asthma patients but it only supports the diagnosis. Dr. Jacob wonderfully explained step by step control of Asthma by NICE and other guidelines along with the concept of MART regimen. I learnt management of acute asthma attack in ED and indications of intubation in such patients. Usage of IV Magnesium sulphate in acute asthma attack was also a new concept for me.

Thank you.

Foundation program trainee, London GEM.

FEEDBACK # 42

Dr Muhammad Amash Khan

Today's session was important because one becomes easily confused
when prescribing treatment for asthma on basis of occuring sign and symptoms. Dr Jacob beautifully explained the clinical diagnosis and tests for asthma and the treatment criteria like NICE and GINA guidelines and MART regimen.

Thank you Dr Jacob amd Dr Ash for the lecture.

FEEDBACK # 43

Dr Aiman Nazir

It was really wonderful to attend today's session which was so comprehensive and up-to-date with guidelines. Topic was wisely chosen as Asthma is the most common obstructive airway disease encountered in ED and can be fatal if not diagnosed and managed early.
Dr Jacob's way of delivering the knowledge , teaching and explaining all the details was beyond excellent. Explanation of asthma , relevant history , objective tests according to guidelines (like FeNO, spirometry,BDR , peak flow variability) was explained in detail .
What's more challenging than diagnosing asthma is its treatment and a lot of acute physicians struggle to manage asthma in ED . All the management was explained in simple ways , according to guidelines , stressed on factors that should be done by an ED physician and after that the whole management plan was discussed and repeated so that it was retained in our minds was really beneficial. It was indeed one of the best lectures on asthma and so beautifully explained that no confusion regarding its diagnosis, investigations and treatment was left behind.
Dr jacob was a great teacher and his way of teaching was really excellent. Would like to learn again from Dr Jacob Baby. Thank you so much Dr ASH for arranging this wonderful session .

FEEDBACK # 44

Dr Ahmad Tanveer

Dr Jacob is a great teacher, expert in his specialty and got all the respiratory

medicine on his finger tips
Today's session was amazing overall
I learnt,
● Definition of Asthma
● Overview of the NICE Guidelines for diagnosis ie. Structured Hx, Examination, objective tests and MRCP examination points
⚡ Initial clinical assessment ask for,
• wheeze
• cough
• breathlessness
• daily or seasonal variation in these symptoms
• any trigger that makes symptoms worse
• a personal or family hx of atopic disorders

⚡ Don't use symptoms alone without an objective test to diagnose Asthma
⚡ Don't use hx of atopic disorders alone to diagnose Asthma
● Occupational Asthma
● Peak flow monitoring atleast 4 times a day
● Be aware that even if examination results are normal, the person may still have Asthma
● Testing for Asthma
• don't offer the following as diagnostic tests for Asthma
- skin prick test to aeroallergins
- serum total and specific IgE
- peripheral blood eosinophilic count
- exercise challenge to adults at 17 and over
● Objective tests recommended in guidelines are
• Spirometry
•BDR
• FeNO Heard for the first time
• Peak expiratory flow variability
• Direct bronchial challenge test with histamine or methacholine that if not available than go with treatment and review if there sign symptoms improvment.
● Diagnosis of Asthma
• FeNO>40+positive bd reversibility or Peak flow variability/PCO2<8mcg
• FeNO 25-39+PCO2<8mcg
• BD reversibility+Peak flow variability>20%
● Confounding factors that may increase or decrease FeNO level
● If Eosinophils are high, will respond to steroids otherwise Not.
● Positive test thresholds for objective tests
● principles of pharmacological treatment
● Definition of controlled Asthma
● NICE guidelines for inhaled corticosteroids dosage shared and explained
● Treatment pathway according to NICE approach Initially SABA is used, then ICS if still symptoms persist add LTRA ie montelukast along with ICS.
But other than NICE, other guidelines use LABA instead of LTRA
● the Royal college of physicians 3 questions
• difficulty sleeping because of Asthma
• Asthma symptoms during the day

• Asthma interfered with usual activities
● Moderate Acute Asthma
● Severe Acute Asthma
● Life threatening Asthma
● Near fatal active Asthma
● Criteria of Admission
All well explained.
Also the SIGN AND BTS asthma guidelines discussed and explained the common and differ points.
Power pack lecture all together really enjoyed this learning activity and understanding management algorithms

Thankyou Sir Dr Jacob and Dr Ash who made this possibility for us that we can

learn from such great teachers

FEEDBACK # 45

Dr Shahid Ahmad

It was informative lecture on Management of Asthma learned IgE level and eosinophil count, spirometry techniques. FeNO, i heard of it for the first time, and lastly various guidelines to know Asthma Management.

FEEDBACK # 46

Dr Muhammad Ghayoor Khan

It was a very comprehensive and excellent teaching session.
A lot of learning points for me i:e the role of FeNo in investigation of asthma,IgE level, eosinophil count, spirometry.
In management role of preventor and releiver,role of SABA, ICS, LAMA, LABA , theophylline and MgSO4.
We would love to see Dr.Jacob again with other respiratory sessions.
Thanks Dr Jacob And Dr.Ash

FEEDBACK # 47

Dr Qaisar Shah

Dr JACOB Discussed:
ASTHMA
• Heterogenous disease characterised by chronic airway inflammation.Defined by history of respiratory symptoms ,such as

wheeze,shortness of breath, chest tightness and cough,that vary over time and in intensity,together with variable expiratory airflow limitation.

OVERVIEW OF THE NICE APPROACH TO DIAGNOSIS

INITIAL CLINICAL ASSESSMENT:

Clinical history

Take a structured clinical history in people with suspected asthma. Specifically, check for:

• Wheeze, cough or breathlessness, and any daily or seasonal variation in these symptoms

• Any triggers that make symptoms worse

• A personal or family history of atopic disorders

• Do not use symptoms alone without an objective test to diagnose asthma

• Do not use a history of atopic disorders alone to diagnose asthma.

Occupational asthma

• Check for possible occupational asthma by asking employed people with suspected new-onset asthma, or established asthma that is poorly controlled:

• Are symptoms better on days away from work?

• Are symptoms better when on holiday?

Refer people with suspected occupational asthma to an occupational asthma specialist

•Peak Flow monitoring at least 4 times in a day

PHYSICAL EXAMINATION:

• Examine people with suspected asthma to identify expiratory polyphonic wheeze and signs of other causes of respiratory symptoms, but be aware that even if examination results are normal the person may still have asthma

TESTING FOR ASTHMA:

• Do not offer the following as diagnostic tests for asthma:

• skin prick tests to aeroallergens

• serum total and specific IgE

peripheral blood eosinophil count

• exercise challenge (to adults aged 17 and over)

Use skin prick tests to aeroallergens or specific IgE tests to identify triggers after a formal diagnosis of asthma has been made.

OBJECTIVE TESTS RECOMMENDED IN THE GUIDELINE:

SPIROMETRY

• BRONCHODILATOR REVERSIBILITY (BDR)

FRACTIONAL EXHALED NITRIC OXIDE (FeNO)

.PEAK EXPIRATORY FLOW VARIABILITY

• DIRECT BRONCHIAL CHALLENGE TEST WITH HISTAMINE OR METHACHOLINE

DIAGNOSIS OF ASTHMA

FENO >40 + POSITIVE BD REVERSIBILITY OR PEAK FLON VARIABILITY /PC20 < 8 mcg

FENO 25-39 + PC20 <8 mcg

BD REVERSIBILITY +PEAK FLOW VARIABILITY > 20%

OBJECTIVE TESTS:

FENO (+ve Test):

Adults ➜ 40 ppb or more

:Children and young people➜35 ppb or more

OBSTRUCTIVE SPIROMETRY:(+ve test)

Adults, children and young people ➜FEV1/FVC ratio<70% (or below lower limit of normal if this value is available)

Bronchodilator reversibility (+ve test):

Adults➜Improvement in FEV1 of ≥12% and ≥ 200 ml inerease in volume

Children and young people➜Improvement in FEV1 of ≥ 12%

Peak flow variability(+ve test):

Adults, children and young people➜Variability >20%

Direct bronchial challenge test(+ve test):

Adults➜PCO2 ≤8mg/ml

Children and young people➜Not Applicable

Principles of pharmacological treatment (
• Take into account the possible reasons for uncontrolled asthma before starting or adjusting medicines for asthma in adults, young people and children. These may include:
alternative diagnoses
lack of adherence
•suboptimal inhaler technique
• smoking (active or passive)
• occupational exposures
• psychosocial factors
seasonal or environmental factors
Definition of controlled asthma
Complete control of asthma is defined as:
• no daytime symptoms
• no night-time awakening due to asthma
• no need for rescue medication
• no asthma attacks
• no limitations on activity including exercise
• normal lung function
• in practical terms FEV1 and/or PEF>80% predicted or best
• minimal side effects from medication
TREATMENT PATHWAY FOR ADULTS AGED 17 AND OVER:
Offer a SABA as reliever therapy to adults with newly diagnosed asthma
• For adults with asthma who have infrequent, short-lived wheeze and normal lung function, consider treatment with SABA reliever therapy alone
Offer a low dose of an ICS as the first-line maintenance therapy to adults with:
Symptoms at presentation that clearly indicate the need for maintenance therapy (for example, asthma-related symptoms
3 times a week or
more, or causing waking at night) or
Asthma that is uncontrolled with a SABA alone

Treatment pathway for adults aged 17 and
Over

• If asthma is uncontrolled in adults on a moderate maintenance ICS dose with a LABA (either as MART or a fixed-dose regimen), with or without an LTRA, consider:

• Increasing the ICS to a high maintenance dose (this should only be offered as part of a fixed-dose regimen, with a SABA used as a reliever therapy) or

• A trial of an additional drug (for example, a LAMA or theophyline) or

• Seeking advice from a healthcare professional with expertise in asthma

Personalized asthma management:

Assess+Adjust+Review .

LIFE THREATENING ASTHMA

• Any one of the following in a patient with severe asthma:

• Peak flow < 33% best or predicted;

• Arterial oxygen saturation (Sp02) < 92%;

• Partial arterial pressure of oxygen (Pa02) <8 KPa;

• Normal partial arterial pressure of carbon dioxide (PaCO2) (4.6-6.0 KPa);

• Silent chest

• Cyanosis

• Poor respiratory effort

• Arrhythmia

• Exhaustion

Altered conscious level

Hypotension

Near-fatal acute asthma

Raised PaCO2 and/or the netd for mechanical ventilation with raised inflation pressures

CRITERIA FOR ADMISSION:

Admit patients with any feature of a life-threatening or near-fatal asthma attack.

Admit patients with any feature of a severe asthma attack persisting after initial treatment.

Patients whose peak flow is greater than 75% best or predicted one hour after initial treatment may be discharged from ED Unless they meet any of the following criteria, when admission may be appropriate:

• still have significant symptoms
• concerns about adherence
• living alone/socially isolated
psychological problems
. physical disability or learning difficulties
• previous near-fatal asthma attack
• asthma attack despite adequate dose of oral corticosteroid prior to presentation
presentation at night
• pregnancy

OXYGEN ADMINISTRATION:

Give controlled supplementary oxygen to all hypoxaemic patients with acute severe asthma titrated to maintain an Sp02 level of 94-98%. Do not delay oxygen administration in the absence of pulse oximetry but commence monitoring of SpO2, as soon as it becomes available

Steroid therapy

Steroids reduce mortality, relapses, subsequent hospital admission and requirement for Beta2 agonist therapy. The earlier they are given in the acute attack the better the outcome

Give steroids in adequate doses to all patients with an acute asthma attack

Continue prednisolone (40-50 mg daily) until recovery (minimum 5 days)

Do not stop inhaled corticosteroids during prescription of oral corticosteroids

Consider giving a single dose of intravenous magnesium sulphate to PATIENTS WITH ACUTE SEVERE ASTHMA (PEF <50% best or predicted) who have not had a good initial response to inhaled bronchodilator therapy.

Magnesium sulphate (1.2-2 g IV infusion over 20 minutes) should only be Used following consultation with senior medical staff

Use IV aminophylline only after consultation with senior medical staff

MONITORING

• Record oxygen saturation by oximetry and maintain arterial SpO2, at 94-98%

Measure the serum theophylíne concentration if aminophylline is continued for more than 24 hours (aim for a concentration of 10-20 mg/L or 55-110 micromol/L)

MANAGEMENT OF ACUTE ASTHMA IN ADULTS IN HOSPITAL: IMMEDIATE TREATMENT

Oxygen to maintain Spo2 :94-98%

B2- bronchodilator (salbutamol 5 mg) via an oxygen-driven nebulizer

Ipratropium bromide 0.5 mg via an oxygen-driven nebulizer

Prednisolone tablets 40-50 mg or IV hydrocortisone 100 mg

No sedatives of any kind

Chest X-ray if pneumothorax or consolidation are suspected or patient requires mechanical ventilation

IF LIFE-THREATENING FEATURES ARE PRESENT:

• Discuss with senior clinician and ICU team

Consider IV magnesium sulphate 1.2-2 g infusion over 20 minutes (unless already given)

Give nebulized B2- bronchodilator more frequently e.g salbutamol 5mg up to every 15-30 mninutes or 10 mg per hour via continuous nebulization (requires special nebulizer)

SUBSEQUENT MANAGEMENT

IF PATIENT IS IMPROVING continue:

O2 to maintain SPO2 94-98%

Prednisolone 40-50mg daily or iv hydrocortisone 100mg/6hour

Nebulised B2-bronchodilator with ipratropium 4-6 hourly

IF PATIENT NOT IMPROVING AFTER 15-30 MINUTES:

• Continue oxygen and steroids

. Use continuous nebulization of salbutamol at 5-10 mg/hour if an appropriate nebulizer is available. Otherwise give nebulized salbutamol 5 mg every 15-3o minutes

Continue ipratropium 0.5 mg 4-6 hourly untill patient is improving

IF PATIENT IS STILL NOT IMPROVING:

Discuss patient with senior clinician and ICU team

Consider IV magnesium sulphate 1.2-2g over 20 minutes (unless already given)

Senior clinician may consider IV B2-bronchodilator or IV Aminophylline or progression to mechanical ventilation

MONITORING:

Repeat measurement of PEF 15-30 minutes after starting treatment

Oximetry: Maintain SpO2 >94-98%

Repeat blood gas measurements within 1 hour of starting treatment if:
- initial PaO2 <8 kPa (60 mmHg) unless subsequent SpO2>92% or
- PaCO2 normal or raised or patient deteriorates.
Chart PEF before and after giving B2-bronchodilator and at least 4 times daily throughout hospital stay
Transfer to ICU accompanied by a doctor prepared to intubate if:
- Deteriorating PEF, Worsening or persisting hypoxia, or hypercapnia
- Exhaustion, altered consciousness
. Poor respiratory effort or respiratory arrest
DISCHARGE:
When discharged from hospital: patients should have:
Been on discharge medication for 12-24 hours and have had inhaler technique checked and recorded
Thanks Dr Jacob & Dr Ash for this comprehensive session.

FEEDBACK # 48

Dr Raja Mobeen Ahmed

It was a highly potent lecture covering major aspects of Asthma, covering both its acute presentation in the Emergency and its chronic management in the clinic. Dr Baby started with the important points to ask in history, focused on Occupational Asthma and the physical findings in such patients. I especially appreciated his point that not all wheeze is equal to asthma and he told important differentials such as COPD, Heart Failure and Lung Malignancy.
He emphasized the Objective tests to diagnose asthma. I knew a little about these tests but was always a bit confused about the use and sequence of these tests. Now I know the importance of FeNO testing, the cutoffs used, the use of Spirometry and Bronchodilator Reversibility Testing, Peak Expiratory Flow variability and if required, the Methacholine challenge.
Then there was a discussion about what constitutes Controlled asthma and the NICE guidelines for management of Asthma were discussed in detail including the drugs and doses of corticosteroids. The GINA guidelines were briefly also discussed. Dr Baby also told about what objective questions to ask and monitor in Asthmatic patients on follow-up to know whether they have controlled, partially controlled and uncontrolled asthma.
Furthermore, the important Emergency management of Acute Asthma was taught. I learnt about the criteria of Severe Acute Asthma, when it becomes Life-

Threatening Asthma and Near-Fatal Asthma. Dr Baby explained what drugs to use, how to escalate therapy and when to approach the ITU and when to go for Invasive Mechanical Ventilation.
Overall, every minute of this lecture was filled with pearls of knowledge about Asthma. My knowledge of Asthma has been expanded and I now have more confidence in approaching patients with this problem.

FEEDBACK # 49

Dr Afifa Younas

The session covered:
• Important history points and not to miss occupational history.
• How to do physical examination and be mindful that asthma patients can present without wheeze and normal chest findings on auscultation.
• Objective tests recommended for asthma:
1. Fractional exhaled nitric oxide (equal or more then 40ppb)
2. Spirometry
3. Bronchodiator Reversibility (improvement of FEV1 of 12 % and 200 ml)
4. Peak expiratory flow variability
5. Direct bronchial challenge test with histamine or methacholine
• Principals of pharmacological treatment
• Step wise management of stable patient according to NICE and GINA guidelines
• How to classify acute asthma into moderate, severe, life threatening and near fatal categories
• Approach to acute exacerbations of asthma in ED
• Criteria of admission.
Over all it was an excellent and comprehensive session learned alot of new things that will definitely reflect in my clinical practice.
Thanks Dr Ash for brining bringing phenomenal mentors on board.

FEEDBACK # 50

Dr Rehan Khalil

Just attend a detailed session on Asthma by Dr Jacob.
A lot of things were learnt and some of these are as follows:
1- When do we call it to be asthma?
2- Every wheeze is not asthma.
3- How to differentiate between Asthma nad COPD?

4- Diagnostic Tests in asthma like FeNO, Spirometry, Reversibility, Challenge Test etc.
5- Management ofdifferent stages of asthma.
6- NICE, BTS and GINA guidelines.
Its was anextensive session ineed.
Regards,
Dr Rehan Khalil, EMFP

FEEDBACK # 51

Dr Muhammad Saad

Today's session was on one of the most important presentation in ED, Asthma. Dr Jacob comprehensively described the asthma. Starting from the basics of asthma, he discussed pathophysiology, symptomatology, laboratory investigations need to be done, drugs that are used in its Management, step wise management according to international guidelines and the emergency condition associated with it. Such a valuable session it was. Thanks Dr Ash and London GEM for such valuable session.
Yours sincerely
Dr Muhammad Saad

FEEDBACK # 52

Dr Leela Ram

It was super lecture which included Overview of NICE approach to Diagnosis of Asthma, initial clinical assessment, objective tests recommended in the guideline, the FeNO test, principles of pharmacological treatment, Review, Reassess, Readjust strategic plan, Monitoring Asthma control, Moderate acute Asthma, Severe acute asthma, life threatening asthma, near -fatal acute asthma, risk of fatal asthma, Criteria for admission, Acute severe asthma management.
Dr. Jacob gently covered entire lecture & made us understand every single point wherever needed. His delivery of lecture is amazing, we just stuck to it effortlessly.
I have learnt that Asthma is not diagnosed on base of signs and symptoms but rather we have to diagnose it with detailed history, clinical examination and relevant tests. Occupational asthma is assessed on off-work that's; patient gets better on holidays or days away from work.

Recommended tests are Spirometry, Bronchodilator Reversibilty, Fractional exhaled Nitric oxide (FeNO), Peak expiratory flow variability, Histamine or Methacholine challenge tests.
FeNO test is new one which diagnoses Asthma in different ways, order of test in adults is Feno first then Spirometry, if there is obstruction, Bronchodilator Reversibilty test is performed afterwards. Regarding Feno test, Nitric oxide is produced in lungs and is present in exhaled air, it acts bronchodilator, vasodilator, Neurotransmitter & inflammatory mediators in lungs and airways.
Neutrophilic asthma doesn't respond to Corticosteroid. Pharmacological treatment includes SABA, ICS, LABA, Leukotriene receptor antagonist, Theophylline, and lastly Oral corticosteroid but new guidelines for asthma are BTS, Genas guidelines. Genas guidelines includes inhaled corticosteroid+ Formoterol as first line in management of Asthma because severe exacerbations reduced by 60-64%.
Our practice will significantly change with new investigations, new guidelines and new drugs. We will change treatment plan ahead. We will be able to manage severe acute asthma with new drugs.
Thank you so much for wonderful knowledge from Dr. Jacob & thank you Dr. Ash for summary & encouraging us to comment online with our tutor. Thanks London GEM Administration and London GEM platform.

11th DECEMBER 2022

EVENT NAME:

Cardiomyopathies For Acute & EM Physicians By Dr Nahal Raza Registrar Cardiology NHS UK

DOCTORS FEEDBACK
FEEDBACK # 1
Noman Ahsan
Yet another energetic session by Dr.Nahal....Today's lecture was all about Cardiomyopathies and its types...Comprehensively explained the topic and clearing concepts regarding pathophysiology and how to differentiat them...
Learned lots of new points...
ARCV, DCMP, RCMP , HOCM explained in detail along with its etiologies , pathophysiology investigation and management..

Thanks Dr.Nahal for such an amazing lecture...

FEEDBACK # 2

Imtiaz Ali Shah

Yet another excellent lecture by Dr Nahal regarding cardiomyopathies,an important topic which should be known by every physician. Important learning points were,

DEFINATON.

A Group of conditions whose final,common pathway is myocardial dysfunction.

CLASSIFICATION.

Arrthmogenic Right ventricular myopaty.

DILATED CM.

HYPERTROPHIC CM.

RESTRICTIVE CM.

UNCLASSIFIED CM.

Arrythmogenic R ventricular CM....Replacement of muscle by fibrous scar and fatty tissue.

DILATED CM...Ef less than 40% in the presence of increased dimensions.

Important causes includes electrolyte imbalance

Endocrine,hypertension, infiltrated diseases, ischemia, nutritional etc

MANAGEMENT...Salt restriction,vasodilator,ACEi,ARBs Beta Blockers

Cardio version pace makers. AntiArrythmic drugs.

HYPERTROPHIC CARDIOMYOPATY.

Stiffness of the LV with resultant impaired ventricular filling,fibrosis,myocardial disarray.

RESTRICTIVE CARDIOMYOPATHIES.

Myocardium becomes rigid,noncompliance.

TREATMENT..DIURETICS,VASODILATORS,

CALCIMUM CHANEL BLOCKERS. DIGITALIS.

It was a wonderful session and we learnt a lot.Dr Nahal presented it in a very professional way,she made the things understand able and absorbing for us.i really like the style of her presentation. At the end I would like to thanks dr Nahal for for this wonderful presentation and also to dr Ash for making it possible for us.

FEEDBACK # 3

Yasir Dilawar

Wow what a lecture.i learnt so much concept from Dr Nahal Raza. Dilated Cardiomyopathy
Hypertrophic Cardiomyopathy
Restrictive cardiomyopathy
Systolic dysfunction
Diastolic Dysfunction
Causes of all these conditions.some chest x-rays,echo cardiography,ecgs.
So happy for myself to have attended this lecture.Thank you Dr Ash

FEEDBACK # 4

Shehzad Hussain

Thanks to Dr Nahal n Dr Ash for amazing session on Cardiomyopathy, it covered cardiomyopathy n it's classification Etiology,
Arrythmogenic RV cardiomyopathy = fibrous fatty tissue replaces normal tissue,
Dilated cardiomyopathy
EF less then 40% with increased LV dimension n normal wall thickness with systolic dysfunction etiology n treatment.
Hypertrophic cardiomyopathy= increased ventricular wall thickness n disarray of muscle tissue.
Types 1: Symmetrical concentric hypertrophy
2: Asymmetric septal hypertrophy without obstruction
3: Asymmetric septal hypertrophy with obstruction
4: Apical hypertrophy
HOCM
Classification
Restrictive Cardiomyopathy etiology n treatment limited
Alcoholism n cardiomyopathy
Difference between Hypertrophic Dilated n Restrictive Cardiomyopathy
ECG signs
All this covered up comprehensively in short time session thank you Dr Nahal.
Thanks Dr Ash n LGEM team for arranging an amazing session.

FEEDBACK # 5

Qaisar Shah

CASE PRESENTATION by Dr NAHAL (F/24➞
ARVC)
Dr Nahal Discussed:

☞CARDIOMYOPATHY➞A diverse group of conditions whose final ,common pathway is myocardial dysfunction.

☞ CAUSES:

Remodeling+ Infectious+Toxins+Nutritional+Infiltrative/Proliferative Diseases+Systemic Connective Tissue Diseases+Idiopathic.

☞CLASSIFICATION:

ARVC+Dilated CM+Hypertrophic CM+Restrictive CM+Unclassified CM

☞SYMPTOMS OF ARVC:

(Palpitations+Fainting+Dizziness+Fatigue+Lightheadedness+Swollen Ankles,Legs & Abdominal region+Abnormal Heartbeats+Sudden Arrest to Exertion.

IN ECG➞Premature Ventricular Complexes

TREATMENT:

(Antiarrhythmics+ACEi+Anticoagulant+Digoxin+Diuretics+Cardioversion+Ablation+Pacemaker+ICD+Cardiac Transplant)

☞DILATED CARDIOMYOPATHY:

Increase in ventricular diameter but not in Muscle of the Heart+ EF less than 40% while increased LV Dimensions

DILATION leads to Impaired Systolic function & Impaired Contraction

☞CAUSES:

PRIMARY ➞IDIOPATHIC

SECONDARY ➞ (HTN+Vulvular heart disease+Tachyarrythmias+Toxins+Infectious+Ischemia+Rheumatological, Endocrine, Nutritional, Infiltrative, Neuromuscular & Electrolyte Abnormalities)

☞ALCOHLIC CM(DCM):

CAUSES:

CHF,HTN,CVA etc

1/3 of all cases is major cause of secondary non-ischemic CM

THREE MECHANISMS

(Direct toxic effect+Thaimine+Cobalt)

Men with more than 10 year consumption aged 30-55 Years.

TESTS:

CXR+EKG+ECHO+CATHETERIZATION

MANAGEMENT:

Na Restrictions+Vasodilators+ACEi+ARB+Beta-Blockers+Cardioversion+Pacemakers+Diuretics+Anticoagulant+Antiarrhythmics+Heart Transplant.

☞HYPERTROPIC CM:

Enlargement of Heart muscle➞Stiffness of LV➞

Impaired Ventricular Filling

Note in ECG if:

R-Wave in AVL is more 11mm .

LEAD 1 R-Wave Height & LEAD 111 S-Wave Depth is more than 25 mm.

LEAD V1 Depth of S-Wave PLUS Height in V5 more than 35mm.

TREATMENT:

No treatment with no symptoms

Drug treatment for Mild symptoms

Moderate/Severe symptoms:

NON-OBSTRUCTIVE➞(Beta-Blockers+Ca-antagonists+Diuretics)

OBSTRUCTIVE ➞(Drug Treatment+Alcohol Ablation+Myectomy+Pacemaker)

☞RESTRICTIVE CM:

Resembles Constrictive Pericarditis+Non-compliant Myocardium+Diastolic Dysfunction

CAUSES:

(Idiopathic+Infiltrative+Non-Infiltrative+Storage disease+Endomyocardial)

TREATMENT:

No treatment but can use:

Diuretics+Vasodilators+CCBs.

The session was really amazing

Thanks Dr Nahal & Dr Ash for this session.

FEEDBACK # 6

Bushra Imran

Today Dr Nahal explained in easy concept making way about definition, causes ,types of cardiomyopaties(i,e dilated,restrictive and hypertrophic),what is Arrythmogenic right ventricular cardiomyopathy ARVC , its causes,pathophysiology and treatment.She also given overview on alcoholic and smoking related cardiomyopathy, HOCM(here she told us example of people died

of this).Despite the whole session was excellent with information and revision of topic
Thank you Dr Nahal and Dr Ashfaque

FEEDBACK # 7

Saba Aslam Khan

Dr Nahal is phenomenal teacher , her lectures are therapy for the students. Cardiac System is like the nightmare for me but Dr Nahals' lecture delivering style is like we are just discussing topic with our senior and by the end of lecture you have command of the topic .. She is such a lively teacher who can make difficult topic easy … lecture started with the definition of cardiomyopathy and it proceed with the aetiology and then difference between Dilated CM, HOCM, and restrictive CM, management of cardiomyopathies.
Thank you so much for this comprehensive lecture Dr Nahal and Thank you so much for arranging this for us .. learned alot .
A proud GEM trainee,

FEEDBACK # 8

Hani Suhail

Cardiomyopathies a wonderful presentation that started with an interesting rare condition arrhythmogenic right ventricular cardiomyopathy and all through the rest of the cardiomyopathies where topics were explained in a very simple manner with great discussion and understanding. Thank you Dr Nahal and Dr. Ash for making us excited for the next topic to come.

FEEDBACK # 9

فاطمہ ناصر

What a comprehensive lecture with such an energetic tutor.. she make us all awake.. literally.. almost every slide was so interactive.. learned so much..
That case she discussed about ARCV was so heart touching..
All types were comprehensively taught..
And guys every hypertrophic cardiomyopathy is not HOCM.. 😁
jazakALLAH khair Dr Nahal and Dr Ashfaque
Stay blessed in both worlds🌹

FEEDBACK # 10

Muhammad Abubakar

Excellent session by such an enthusiastic and energetic tutor. She explained very well about all the types of Cardiomyopathies - arrthymogenic, dilated,

hypertrophied, restrictive. How to differentiate b/w them, findings in each of them, their management plan. Excellent.

FEEDBACK # 11

Kamlesh Kumar Lilani

It was amazing to listen her again and her interactive session. It was good to recall all basic and than more managements tactics for A&E dr when comes to Cardiology. She explained very thing very well. That smokers Heart good to remember that.

Thanks Dr Nahal and Dr. Ash for amazing session.

FEEDBACK # 12

Warda Yawar

Very informative practical session with examples of real life kind of case based discussion

Enjoyed the whole hour learning each and every slide

Thanks to Dr Nahal n Dr Ash for amazing session on Cardiomyopathy, it covered cardiomyopathy n it's classification Etiology,

Arrythmogenic RV cardiomyopathy = fibrous fatty tissue replaces normal tissue,

Dilated cardiomyopathy

EF less then 40% with increased LV dimension n normal wall thickness with systolic dysfunction etiology n treatment.

Hypertrophic cardiomyopathy= increased ventricular wall thickness n disarray of muscle tissue.

HOCM

Classification

Restrictive Cardiomyopathy etiology n treatment limited

Alcoholism n cardiomyopathy

Difference between Hypertrophic Dilated n Restrictive Cardiomyopathy

ECG signs

All this covered up comprehensively in short time session thank you Dr Nahal.

Thanks Dr Ash n LGEM team for arranging an amazing session.

FEEDBACK # 13

Muhammad Azeem Imran

She discussed about different cardiomyopathy, pathophysiology and treatment

Definition of cardiomyopathy

irreversible , primary , progressive disease of heart muscle , final common pathway is myocardial dysfunction
Aetiology
cardiovascular
infectious
toxin
infiltrative
endocrine
Arrythmogenic right ventricular CM , ARVC -
Dilated CM , HOCM , Restrictive CM
ARVC
replacement of muscle by fibrous scar and fatty tissue RV most effected .
sign& symptoms
PVC , cardiac arrest , asystole
treatment- antiarrhythmic
ACE I
anticoagulant
digoxin
diuretics
cardioversion
ablation
pacemaker
ICD
surgery
Dilated cardiomyopathy
EF < 40%in presence of increased LV dimensions
So _dilation_ of one or both ventricles , _impaired systolic_ function of ventricle either one or both
account for 25%of heart failure
causes of DCM
primary,, secondary ,
alcohol is the most important cause of DCM
CHF , HTN , arrythmia, are presentation
diagnosis by
CXR -enlargement

ECG- tachyarrythmia, Q wave , R wave
Echo -global dysfunction
Management
salt restrictions
vasodilator
ACEI
ARB
beta blockers
cardioversion
pacemaker, diuretics, anticoagulant, antiarrhythmic-amoidarone , heart transplant
Hypertrophic cardiomyopathy
stiffness of LV with resultant ventricular filling is Hallmark of HOCM
Restrive cardiomyopathy
idiopathic, non infiltrative, infiltrative , storage diseases,
endomyocardial eg metastatic
No treatment for restrictive CM as preserved EF , only treatment diuretics
valsartan , saqributril combination
Thank you so much Dr Nahal for comprehensive session, very well elabotive discussion . Thank you Sir Ash for arranging such a vibrant plateform to teach us . proud to be a part of LGEM program

FEEDBACK # 14

Bushra Khan

Dr Nahal did and a really informative session on cardiomyopathy. She explains everything in so much detail and the concepts are really clear. I learned
1. Aetiology and classification of cardiomyopathy
2. Arythmogenic Right Ventricular tachycardia- replacement of heart muscles by fibrous scar and fatty tissue.
Signs and symptoms of heart failure and arrhythmias and its treatment.
3. Dilated cardiomyopathy- dilated heart ventricles. LV function is reduced,
4. Alcoholic cardiomyopathy - entity of dilated cardiomyopathy , its presentation and treatment.
5. Difference between dilated and hypertrophic cardiomyopathy. Symmetrical and asymmetrical hypertrophic cardiomyopathy.
6. Systolic dysfunction in dilated cardiomyopathy and diastolic in restrictive cardiomyopathies.

7. ECG recognition of HOCM
8.Restrictive cardiomyopathy
This lecture cleared alot of concepts of cardiomyopathy and will definitely help me in my exam as well as medical practice ❤️‍🔥

FEEDBACK # 15

Khatija J. Farooqui

Yet another interesting session with lots if learning points differentiate dilated, restricted,cardiomyopathies ventricular CM,ARVC CM,HOCM teplace cardiac tissue by fibro fatty tissue there sign /symptoms treatments including systemic and surgical intervention . Thanks to team LGEM and Dr Ash.

FEEDBACK # 16

Hamna Yaqub

Another interactive session with Dr Nahal clearing our concepts about cardiomyopathies.ARCV HOCM DCMP RCMP how to differentiate diagnose manage these conditions.
Thank you Dr Nahal for this comprehensive session.

FEEDBACK # 17

Javeria Wali

A very detailed lecture on the topic 'Cardiomyopathies" was taken by Dr. Nahal Raza, an extremely lively and energetic teacher! She makes Cardiology a piece of cake with her power packed sessions taught in an easy to remember way. She started with the basic definition and WHO definition of Cardiomyopathies and moved on to the pathophysiology and classification. Dilated Cardiomyopathy, Hypertrophic Cardiomyopathy and Restrictive Cardiomyopathy were each explained and well elaborated with case discussions. Causes, Signs and Symptoms (palpitations, dizziness, chest pain, arrythmias, fatigue, swollen ankles, abdomen etc), Diagnosis, ECG and Echo findings, management and Treatment options of each were discussed and understood. Basic difference between Dilated (increased chamber size with reduced ejection fraction) and Hypertrophic cardiomyopathy (increased thickness of walls with preserved ejection fraction) was explained. Arrythmogenic Right Ventricular Cardiomyopathy in which cardiac muscle is replaced by fibrofatty tissue causing arrythmias and death was elaborated comprehensively. Really learned a lot in this very useful session

FEEDBACK # 18

Abid Marwat

Aoa. Cardiomyopathy is certainly a difficult topic but this session beautifully cleared all those concepts which one would have spent hours to learn. Than you Dr Nahal, Dr **Ashfaque Ahmed**

FEEDBACK # 19

Zia Hayat

Dr.Nahal is an amazing tutor ,she started off with a brief overview about the definition and different types of cardiomyopathies like Dilated,Hypertrophic or Restrictive .She explained beautifully about the concept of ARVC i.e Arrythmogenic Right Ventricular Cardiomyopathy in which a hear muscle is replaced by a fibrous scar and fatty tissue .We learned about the Arrythmias ,CHF ,Dilated Cardimyopathy pathophysiology ,Alcoholic cardiomyopathy which is a major cause of non-ischemic cardiomyopathy .She also gave us an overview about the diagnosis ,evaluation and management plan for HOCM ,and its complications .She also explained about the Restrictive Cardiomyopathy .All together it was an excellent session with lots of new information and comprehensively covered all the topics.Thankyou Dr.Ash for arranging such a wonderful talk

FEEDBACK # 20

Dr Mariam Nawaz

Dr Nahal is an amazing teacher, her last session about vavlular heart disease was also phenominal just likie todays session. mIt was our second session for the day but jer style of teaching doesn't lets you wander off in thoughts. We learned about Cardio myopathies and learned a lot in 1 hour.

Some of the pearl i gathered are as follows:

> Cardiomyopathies can be dilated, hypertrophic or restrictive

> Arryrthmogenic Right Ventricular Cardiomyopathy is a disease where heart muscle is replacedby fibrous scar and fatty tissue

Right ventricle is most commonly affected

Symptoms present in early teens or in20s

Arrythmia is a prominant feature

CHF or tricuspid regurg can also occur

PVCs can be seen on ECG

> Dilated Cardiomyopathy:

Diameter of the heart is increased but muscle mass is unaffected

EF is less tahn 40%

Leads to impaired systolic fuction of both ventricles

Can be ofvprimary or secondary etiology
Alcogolic cardiomyopathy is a major cause of secondary non ischemic CM
Heart will be enlarged, which can be visualized on X ray
Treatment: incl;udes salt restriction, ACEi, ARBs, BB or diuretics, Antiarrythmics, definitive management is heart transplant
> Hypertrophic cardiomyopathy:
Thickening of heart muscles with myocardial disarray due to abnormal collagen deposition and altered contractile proteins in the myocytes
Diastolic dysfunction is prominent
Hypertrophy can be symetric or asymetric, asymetric hypertrophy is more dangerous as it can cause outflow obstruction during systole
ECG findings: R wave in avL>11mm
R wave in lead 1 plus S wave depth in lead 3>25mm
S wave depth inV1 plus height in V5 that exceeds 35mm
>Restrictive cardiomyopathy
Thankyou Dr Nahal for thuis amazing session. Looking forward to having more sessions by you

FEEDBACK # 21

Hira Nehal

It's starts from
basic definition of cardiomyopathies
AIETOLOGY
•infection •toxins •infiltrative•endocrine
ARRYTHMIA RIGHT VENTRICULAR CM(ARVCM)
replacement of muscle by fibrofatty sxar tissue. RV is mostly affected
●IN a young adult PVCs should not be missed and ARVC should be rule out .
Types of cardiomyopathies according to WHO
●Dilated DCM:EF <40 %EF.
M.c cause of DCM In UK is Alcoholic CM
●Restricted RCM(LEAST COMMON VARIETY MOSTLY DUE TO SARCIDOSIS AMYLODOSIS HAEMOCHROMATOSIS)
●Hypertrophic HCM(ISCHEMIC VALVULAR)
THANK YOU DR NAHAL AND THANK YOU DR ASH FOR AN AMAXING SESSION.

FEEDBACK # 22

DrKiran Feroz

Today's topic cardiomyopathies .....beautiful presentation by Dr.Nehal..... each and every detail was xplained beautifully....I enjoyed the session from the start till the end.....the good thing about Dr.Nahal is that she always starts from the basic and her sessions are interacive...thanku London 💎

FEEDBACK # 23

Remal Noor

The session was comprehensively and beautifully presented .
Learned different types of cardiomyopathies pathophysiology and treatment
Arrythmogenic right ventricular CM , ARVC -
Dilated CM , HOCM , Restrictive CM
sign& symptoms and management.Cleared alot of misconceptions and elaborated the precise management of A&E cardiac presentations.
Learned a lot and realy feeling proud to be part of LGEM ....stay blessed our mentor Dr ashfaque

FEEDBACK # 24

Ram Leela

It was very comprehensive session, good explanation, picturesque learning & questioning & answering interaction.
Dr. Nahal is very good & mode of delivery of lecture is always outstanding. She described Cardiomyopathies, its types, causes, management plan. Types include Dilated Cardiomyopathy, Hypertrophic Cardiomyopathy, Restrictive Cardiomyopathy & Arrhythmogenic right ventricular Cardiomyopathy. Dilated Cardiomyopathy has ejection fraction (EF) less than 40%. Dilated Cardiomyopathy is characterized by heart enlargement, increased muscle mass & impaired systolic function of either ventricle or both ventricles. Dilated Cardiomyopathy is most prominent disease. Dilated can be primary and secondary.
➡ people who consume alcohol/wine over more than 10 years develop Alcoholic Cardiomyopathy (DCM).
All Cardiomyopathy produces almost same signs and symptoms so can't diagnose entirely on this parameter. Detailed history, physical examination and related investigations will reveal cause & its type.
➡ Hypertrophic Cardiomyopathy is increased muscle mass with disarray of Myocardium. symmetrical & asymmetrical depending on chambers, diastolic function is impaired. Hypertrophic Cardiomyopathy is usually asymptomatic but

sometimes presents with mild, moderate or severe symptoms. People suddenly dies because of hypertrophic Cardiomyopathy. Treatment depends on non-obstructive & obstructive symptoms. Non-obstructive treatment is Beta-blockers & calcium antagonists while obstructive includes drug treatment, alcoholic ablation, myomectomy & pacemaker.
I have learnt that cardiac signs and symptoms almost same so can't diagnose its type of Cardiomyopathy.
Restrictive Cardiomyopathy has no satisfactory treatment, we have to treat secondary causes.
Drug therapy must be used with caution.
Our practice of cardiology will definitely change with such amazing training. We will be able to diagnose different Cardiomyopathy on the basis of best history & timely referral to cardiac department for intervention and further management.
Thanks Dr. Nahal Raza & Dr. Ash for great teaching platform.

FEEDBACK # 25

Nasir Hayat

This session was Amazingly presented ,smoothy runned and answered all the Questions.
Learned alot different cardiomyopathy, pathophysiology and treatment ,Defination of cardiomyopathy
irreversible , primary , progressive disease of heart muscle , final common pathway is myocardial dysfunction.
Cardiovascular
infectious
toxin
infiltrative
endocrine
Arrythmogenic right ventricular CM , ARVC -
Dilated CM , HOCM , Restrictive CM .
Replacement of muscle by fibrous scar and fatty tissue RV most effected .
sign& symptoms
PVC , cardiac arrest , asystole
treatment- antiarrhythmic
ACE I
anticoagulant

digoxin
diuretics
cardioversion
ablation
pacemaker
ICD
surgery
Dilated cardiomyopathy
EF < 40%in presence of increased LV dimensions
So _dilation_ of one or both ventricles , _impaired systolic_ function of ventricle
either one or both
account for 25%of heart failure
causes of DCM
primary,, secondary ,
alcohol is the most important cause of DCM
CHF , HTN , arrythmia, are presentation
diagnosis by
CXR -enlargement
ECG- tachyarrythmia, Q wave , R wave
Echo -global dysfunction
Management
salt restrictions
vasodilator
ACEI
ARB
beta blockers
cardioversion
pacemaker, diuretics, anticoagulant, antiarrhythmic-amoidarone , heart transplant
Hypertrophic cardiomyopathy
stiffness of LV with resultant ventricular filling is Hallmark of HOCM
Restrive cardiomyopathy
idiopathic, non infiltrative, infiltrative , storage diseases,
endomyocardial eg metastatic
No treatment for restrictive CM as preserved EF , only treatment diuretics
valsartan , saqributril combination

This was very nice and wonderful presentation learned many things ,I would highly recommend for physicians to join it and be best Doctors on future.Proud to be LGEM candidate undersupervision of my mentor Sir.Dr.Ash All these are possible only and only by one man The SIR Dr.Ash The Great.

FEEDBACK # 26

Dr Ghazala Sheikh

Thanks alot Dr nahal Raza covering whole cardiac session enthusiastically.
Today I learnt,

- Cardiomayopathies their different types, pathophysiology, management plans
- Arythmogenic Right Ventricular tachycardia
- difference between HCOM and DCM
- importance of BNP
- types of hypertrophic Cardiomayopathy
- Restrictive Cardiomyopathy
- Alcoholic Cardiomyopathy

Very thankful to our mentor Dr Ashfaque Ahmed

FEEDBACK # 27

Dr Nouman

Attended quite an interesting learning session on Dec 11/12/22 by Dr Nahal Raza.
Many important points were taught following a basic outline of clinical teaching.
The topic was defined highlighting its various types i.e Hypertrophic, Dilated.....
The different investigative modalities to rule out/in the diagnosis were taught.
I can definitely use this knowledge for better clinical outcomes in my patients.
Thanks Dr Ash and Team LGEM to keep inspring us

FEEDBACK # 28

Dr Rehan Khalil

Just attended a comprehensive session on Cardiomyopathies. Dr Nahal discussed about cardiomyopathies and their pathophysiology.
Some of the learning points are mentioned below:
1- What is a cardiomyopathy?
2- Different types of Cardiomyopathies like Restrictiv, Dialted, Hypertrophic etc
3- Pathophysiology if each type
4- Causes of cardiomyopathies
5- ARVC
6- Alcohol is the common cause of Dilated Cardiomyopathy

7- HOCM etc.
8- Diagnosis and Management.
Indeed it was a comprehensive session that covered everything.

FEEDBACK # 29

Dr Ahmad Tanveer

Todays lecture as always was a Gem lecture ,outstanding clarification precise and to the point clearing many confusions about pathophysiology of cardiomyopathies
Echo is gold standard investigation for most of CMP
ARVC
Arrhythmogenic RV cardiomyopathy is very severe as apical fibrosis dirupts normal condution pathways and leads to ectopic focus. CARDIAC MRI is the definate investigation if have any doubt on echo
DCMP
Increase in diameter of chambers
1 or both ventricular chamber dilatation with Impaired systolic function due to Apoptosis necrosis fibrosis,the cardiac muscukature Not retaining stretch as a result
DCMP MOST COMMON
of cardiomyopathies and also in Middle aged African males
Hypertension can cause hypertrophic and ischemic
Alcoholic most common ischemic cmp in UK
Hypertrophic LV occurs in HCMP not in DCMP Discussed 2 cases
24 yr old girl with ARVC
2ND DCMP
BNP has only got role in CMP with preserved EF HF
Every HCM IS NOT HAVING HOCM
2 types of Symmetric or asymmetric Hypertrophic cardiomyopathy.
Apical or ventricle wall Asymmetrical HCM Asymmetrical is without obstruction and with obstruction with septal hypetrophy and SAM of anterior mitral leaflet obstructing LVOT,got poor prognosis with sudden death
Causes
myocyte hypertrophy
Dynamic lv outflow obstruction
Hypertrophic cmp got preserved EF
& Diastolic dysfunction

Heart cavity is reduced in size as per size due to HCM . Stiff ventricle and low vol CO but normal % as on echo
BNP is very helpful to rule out HF in such cases.
DCMP smoker heart
Smoking causes DCMP
Waping is more dangerous then smoking alone cause Wet lung disease not reversible
Dilated LA with AFIB is not DCMP but with dilated LV leading to dilated LA
ECG criteria for HCM
R wave 1 + s wave lead 3 more then 25mm
But in Thin or young people . Can have such ECG but there lead 3 is not fulfilling the criteria.
Restrictive CMP
LESS THEN 5% Prevalence
Diastolic
Causes
Infiltrative
Storage haemichromatosis
Endomyocardtis ,radiation ,
Uperio or entresto tablet
Valsartan + sacubatril HF with preseved EF
HF With reduced EF THEN SGLT2 inhibitors like EMPAGLIFLOZIN or DAPAGLIFLOZIN is very useful in dynamjc treatment.
In all cardiomyopathies treatment of heart failure is the main stay. Along with possible treatment of underlying cause if possible for reversible cardiomyopathies
Such a detailed lecture in such a short period of time is a wonderful teacher's capability .
Thankyou Dr Nahal and Dr Ash for arranging such a detailed lecture activity it upgarded my knowledge and understanding of cardiomyopathies to a new level .

FEEDBACK # 30

Dr Ghulam Saddique

Marvellous session conducted by
Dr nehal ,outstanding clarification precise and to the point clearing many confusions about pathophysiology of cardiomyopathies
Echo is gold standard investigation for most of CMP

ARVC
Arrhythmogenic RV cardiomyopathy is very severe as apical fibrosis dirupts normal condution pathways and leads to ectopic focus. CARDIAC MRI is the definate investigation if have any doubt on echo
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ECG criteria for HCM
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Storage haemichromatosis
Endomyocardtis ,radiation ,
Uperio or entresto tablet
Valsartan + sacubatril HF with preseved EF
HF With reduced EF
In all cardiomyopathies treatment of heart failure is the main stay. Along with possible treatment of underlying cause if possible for reversible cardiomyopathies
Such a detailed session in such a short period of time is a wonderful teacher's capability .
Thankyou Dr Nahal and Dr Ash for arranging such a detailed interactive session it upgarded my knowledge and understanding of cardiomyopathies to a level which is required for the professional health workers.

FEEDBACK # 31

Dr Faiq uz Zaman Khan

As always Dr Nahal structured her lecture in such a way that it made difficult concepts relating to Cardiomyopathy pathophysiology easily palatable.
Her description of ARVCM was spot on .
And the classification of Cardiomyopathies and their relation with heart failure is something that confuses alot of people but Dr Nahal made it very easy for the participants to understand
Great lecture

FEEDBACK # 32

Dr Aiman Nazir

I am really thankful to Dr ASH for choosing the topics wisely and arranging wonderful sessions .

Cardiomyopathies is indeed an important topic which all of us should be aware of. And for me I find it a little difficult to retain it but it was taught by Dr Raza in such a beautiful way that cleared all of the concepts and made it easier to retain for knowledge and exams .
Starting it concisely with book definitions and further explaining it in simple terms , discussion about its pathophysiology,etiologies , types and management was covered in detail.
Dr Nahal keeps the session interactive and interesting by asking questions , answering queries, and tells about real life scenarios / patients and their outcome .
Her presentation slides have diagrams for better understanding , flow charts , comparing diagrams to instill everything in mind .
Explaining each of the cardiomyopathy(Dilated , Hypertrophic , Restrictive), including their causes, their presentations , diagnostic tests , ECG findings , and their management in detail was precisely covered in one hour lecture. Further discussions about HFpEF and HFrEF were done and explained .Alcoholic cardiomyopathy was also discussed.
Thank you so much Dr Raza for making it easier for us to learn and retain information.Thank you Dr ASH .

FEEDBACK # 33

Dr Memoona Arif

The session took me back to my pathology lecture when I was in my 4th year of MBBS.
.The cardinal definition of CMP.
.Aetiology
.Pathophysiology
.Classifications
Particularly the classification of hypertrophic cardiomyopathy
1. Obstructive HCM in which there is thickening of interventricular septum leading to LVOT obstruction.
2. NON Obstructive HCM
. Differentiation points discussed regarding systolic and diastolic dysfunction in DCM and HoCM respectively.
.Investigations especially BNP test and it's significance.
.Treatment and Management

It was beneficial for me as my concepts were revised and I acquired new information.
Especially the enthusiasm of DR. NAHAL RAZA is unparrallel. May ALLAH bless her.
Thank you

FEEDBACK # 34

Dr Muhammad Ghayoor Khan

It was again a wonderful session conducted by Dr.Nehal on most important topic which was Cardiomyopathies.
She delivered it in a very understandable way,as by starting with cardiomyopathies,its types(Arrythmogenic right ventricular cardiomyopathy,Dilated cardiomyopathy, Hypertrophic cardiomyopathy and Restrictive cardiomyopathy)then their differences and management.
Thanks
Dr.Nehal And Team LGEM

FEEDBACK # 35

Dr Raja Mobeen Ahmed

It was another informative lecture by Dr Nahal. All of her lectures have been excellent mainly because she involves the audience by frequent questions so we never lose our interest during the talk and this lecture continues the trend .
I learnt the definition of Cardiomyopathy as an irreversible primary progressive disease of the heart muscle and also learnt about the classification systems, the first dividing them into Primary or Secondary and the second system classifying them into Dilated, Restrictive, Hypertrophic,ARVC.
Dr Nahal discussed a case where a 24 year female was brought to her initially in Ventricular fibrillation and she ran the code for a very long time. Unfortunately, that patient passed away and the autopsy revealed diagnosis of ARVC and I understood the importance of this rare but important diagnosis, which can lead to dangerous arrhythmias and cause sudden cardiac death. The other things discussed later on included:
• Further details on ARVC, the fibrofatty replacement of the right ventricle, its presentation, , ECG findings especially frequent premature ventricular contractions, Echocardiographic finding and use of Cardiac MRI. The genetic association and its treatment with anti-arrythmic, ablation, Pacemaker/ICD.

• Dilated Cardiomyopathy, the most common Cardiomyopathy. The principle of eccentric hypertrophy and Laplace's Law was discussed, explaining mathematically how LV stress is increased with more cavity pressure, increased chamber size and decreased wall thickness. Causes of DCMP were discussed especially Alcoholic Cardiomyopathy and 3 mechanisms by which Alcohol causes damage to heart muscle. The management of DCMP being similar to that of HFrEF with heart transplant being the final and definite cure.
• Hypertrophic Cardiomyopathy, its ECG findings, the different criteria to diagnose LVH on the ECG (Sokolov Lyon, R wave>11mm in aVL, the height of R in lead 1 plus S in lead III>25mm), echo findings of HCM, the management of non obstructive and obstructive HCM.
• Restrictive Cardiomyopathy, the different causes especially Infiltrative diseases, non-infiltrative disease like Scleroderma, storage disorders, etc.
Overall, an excellent lecture which gave an overview on the different cardiomyopathies.

11th DECEMBER 2022

EVENT NAME:

Comprehensive Geriartic Assessment By Dr Naila Ashfaque Lead Consultant NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Hamna Yaqub

First class with Dr Naila on Comprehensive Geriatric Assessment and she won our hearts. The lecture was Comprehensive, interactive and interesting. Learned lots of new concepts and tools. How by using simple tools we can avoid the future incidents and help the Geriatric population to live a better life. Thank you Dr Naila this was an amazing session.
8 elements of CGA
Geriatric giants
AMT SCORE
MUST SCORE
BEER CRITERIA

FRAX SCORE
COGNITIVE ASSESSMENT
DELIRIUM 4AT
MMSE MOCA
15 QUESTIONS DEPRESSION ASSESSMENT

FEEDBACK # 2

Muhammad Azeem Imran

what is CGA?
It comprise holistic assessment of old health, well being to formulate plan& order issues .
Where it is done ?
Home , GP surgery, community, franility clinic, frality unit hospital, front door ED hospital
why elderly people fall?
medicine, medical condition,
gaiter & balance impairment, vision & hearing loss , cognitive impairment, muscle weakness, inadequate diet , alcohol, risk talking behavior, environment hazards
why CGA important?
reducing
mortality & morbidity,
hospital admissions
cost
Causes & effects
multiple
who does it
doctor, physiotherapist, occupational therapist, social worker, pharmacist, nurse
Extended MDT
Multi specialty involvement
old age psychiatrist
tissue viability nurses
delirium team, diabetic specialist nurse , podiatrist, opticians & audiologist,
Geriatric Giants
immobity, instability, incontinence, intellectual impairment, iatrogenic
8 Element of CGA

medical problem, geriatric giants , cognition, functional status , social, affect, nutrition, medications
Make Problem list based on assessment
Medical assessment need
5 things , (physical exam , medicine, nutrition
what aspects are commonly missed in exam
from top to bottom
finger counting , hearing assessment , examine oral hygiene , footwear, exam of legs & foot , weight , postural hypotension, CVS exam - (aortic stenosis), PR exam - constipation leading urinary retention , always rule out chronic retainer , so do bladder scan
joint Exam , sarcopenia ,
we will do **Some additional test*
BMI , TUG test , gait speed test , chair stand test , whisper test , hearing & vision test
Medication review
1. look for anticholinergic burden especially
antihistamine, TCA , , oxybutanin, - urinary retention, constipation, causing fall , delirium ,
Stopp- start criteria
assessment tool for prescription & treatment respectively
BEER,S criteria
to avoid common problems in prescribing for old people
Key medicine in BEER,s criteria
caution regarding use of
Tramadol , - SSRI - serotonin syndrome
SSRI- SIADH - hyponatremia, increased risk of fall
opioid s- inc risk of fall & SIADH ,
NSAIDS - renal failure
anticholinergic burden - antihistamine, TCA , tolteridine
Sedative - Diazepam
**Nutritional assessment*
calculate BMI - underweight risk is 10- 40%
MUST SCORE
tool for over nutrition & under nutrition

5 must steps
BMI ,
weight loss , acute disease effect score
add all 3 score
Bone Health Assessment
by FRAX score
moreover we look into medication- steroid, smoking , alcohol , caffeine use
FRAX score consist of 12 factors , that increase risk of fractures
low -
intermediate - do BMD and start Bisphosphonate
high- start bisphosphonate
pain assessment
huge factor causing delirium
pain is assessed by *Abbey* pain scale for dementia patient
Psychological assessment
5 checks
cognition
- AMTS , three items recalls test clock drawing, mini cog test three steps , 3 words ask to remember, give clock , ask recall
if AMT score is low then do delirium score
, *delirium*- 4 AT tool test - alertness, AMT 4 , attention test , acute change / fluctuating course
if AMT score is low do detailed assessment MOCA superior than MMSE by physiotherapist and done in A& E , *dementia* , *depression* count 5-10%in old people, always under reported
depression is assessed by Tool -Geriatric depression scale -comprise 15questions for assessing severity & monitoring treatment
score > 5 means depression is present
Barthel index tool for Functional assessment done by physiotherapist. this tool include continence assessment too .
Moreover
Look for Environmental hazards
Excellent session by Dr Naila , learnt a lot about assessment tools in Geriatrics, Honestly to say we need more sessions by Dr Naila - she is mirror image of Dr Ash

FEEDBACK # 3

فاطمہ ناصر

Starting from presentation, it was really very good.. then Dr Naila's session.. even though she had really bad infection which was quite obvious, she delievered the session so nicely.. she was so dedicated..

Geriatric Giants

Stop-Start tool

BEers criteria

Frax score

Barthel index

And many more..

Learned so many new teminologies.. jazakALLAH khair Dr Naila and Dr Ashfaque.. really

FEEDBACK # 4

Zegham Abbas

Amazing session by Dr Naila(MRCP MRCEM FRCEM NHS Consultant) on comprehensive geriatric assessment of elderly patient basically it's a multiple holistic approach for the assessment of health in elderly patients and to plan the management.

Most common factors of fall in elderly patient are Age , gait , medicine, balance impairments , vision and hearing loss ,muscular weakness Alcohol and cognitive impairment.

CGA GAINTS

immobility

instability

incontinence

Intellectual impairment

Iatrogenic

Elements of CGA

Geriatric giants

Medical problem

Cognition

Functional status

Social affect

Nutrition

Medication

Medical Assessment
1 Physical examination
2 Medication
3 Nutrition
4 Pain Assessment
5 BMI TUG Test
BEER'S Criterion
Multiple dimensional approach for the management of the elderly patients like dietitian Nutrition opticians audiologist podiatrist.
Nutritional Assessment
MUST score
1 Measurement of weight and height
2 Unplanned weight loss
3 Acute disease's effect
4 Add all 3 scores
5 Use management guidelines
Assessment of bone health
1 Medication
2 smoking
3 FRAX scores
4 Medical conditions like RA
What is FRAX'S score
Calculation of risk for getting bone fractures in 10 years
Factors of FRAX score Age,weight height,sex,smoking, history of fractures, RA , bone mineral density
ABBEY'S pain scale for the elderly patients with dementia
Psychological Assessment
Cognition
Delirium
Dementia
Depression
Geriatric depression scale
BARTHEL'S INDEX
AMT score
Environmental Hazards

Thanks mini Dr Ash (Dr Naila) for such a informative lecture.

FEEDBACK # 5

Qaisar Shah

CASE PRESENTATION by Dr Shiraz Mehmood (Pneumococcal pneumonia+small bowel obstruction ➜Ileus)

Dr.Naila Discussed:

☞ What is CGA➜Multidimensional Assessment of an older person regarding health & wellbeing leading a plan to sort out issues related to older person.

☞ CGA is done at:

Person own home+Gp Surgery+In community+Frailty clinic+Units in Hospital+Front door ED

☞ RISK FACTORS FOR FALLS IN ELDERLY PEOPLE:

Age more than 80, Medication+Females+Alcohol use+Muscle weakness+Poor nutrition+Environmental+Impairment in Gait/Balance,hearing/Vision

☞ CGA is Important in:

REDUCING➜Mortality+Hospital Admission+Frailty Impact

PREVENTING ➜Fragility Fractures

IMPROVING➜Life Quality

CGA mostly done by:

Geriatrician+Physiotherapist+Occupational therapist+Social worker+Pharmacist+Nurse

☞ 5 Geriatric Giants are:

Immobility+Instability+Incontinence+Intellectual Impairment+Iatrogenic

☞ 8 ELEMENTS OF CGA:

MEDICAL ASSESSMENT

P/E➜Head to Toe Examination+

Additional Test like➜BMI+TUG+GAIT SPEED+CHAIR STAND+FINGER COUNTING+WHISPER TEST

MEDICATION➜Review prescribed Medication & Check correlation with Frailty+Falls+Admissions & also check for Anticholinergic burden.

Use STOPP-START CRITERIA & BEERS CRITERIA

NUTRITION:

Check for malnutrition (Low BMI➜Hospital Admission)+Use MUST SCORE for Malnutrition
BONE HEALTH:
Review medication (steroids)+Conditions like CKD,R.A etc+Access about Exercise,Smoking,Alcohol, caffeine & FRAX SCORE.
PAIN ASSESSMENT :
Use PAIN SCALE+Initial Pain Assessment record & ABBEY PAIN SCALE for Dementia Patients.
PSYCHOLOGICAL ASSESSMENT:
COGNITION: ➜Screening Tests➜AMTS+THREE ITEM RECALL TEST+CLOCK DRAWING TEST+MINI COG TEST
DELIRIUM :➜4AT TEST (Alertness+AMT4+Attention Test+Acute change /Fluctuating Course)
ADDITIONAL TESTS :(MOCA for Dementia+MMSE)
DEPRESSION:
Assess Cause like Chronic Condition+Weakness+Loneliness etc by GDS-15 & GDS-30
After Assessment PHYSIOTHERAPIST will do FUNCTIONAL ASSESSMENT & OCCUPATIONAL THERAPIST will do their work.
At last Dr.Ash gave us HOMEWORK of CGA on OLD AGE PARENTS in our own house
The session was amazing.
Thanks Dr.Naila & Dr.Ash for this wonderful session.

FEEDBACK # 6

Amir Ashraf

This lecture was the very helpful , as the care of elderly is often neglected in Pakistan and Maldives where I work , and after today's session , I can confidently assess elderly patients presenting to ED under my care .
The following topics were discussed in detail :

- What is CGA ?
- Where is CGA done?
- Why elderly people fall ?
- Why CGA Important ?
- Causes and Effects of fall

• Who does it ?
• Extended MDT ?
• 5 Giants of geriatrics
• Elements of CGA
• Medical Assessment
• Physical examination and aspect missed commonly
• Some additional test
• Medication review
• STOPP-START
• BEER'S Criteria
• Nutrition assessment
• MUST SCORE
• Assessing bone health
• Pain assessment
. How pain is assessed
. Psychological Assessment (5 checks)
. Cognition screening test
. Delirium 4 AT test
. Cognitive Assessment further tests
. Depression
. Geriatric depression scale

Thankyou so much Dr @Naila. You have taught this lecture in very detail and made very easy to understand .

Thankyou @Dr Ash for arranging this wonderful topic for us , its so great knowing about this topic and also its newly added in Curriculum makes a bigger impact on our learning .

Thankyou Dr shiraz for very details case presentation

FEEDBACK # 7

Rajab Abbas

It was a super session conducted by doctor Naila Ashfaque on comprehensive gireatric assessment, the session started with a power pack presentation of Dr Sheraz followed by a detailed view of CGA by Dr Naila.

She covered all aspects of geriatric evaluation in a really beautiful manner,

She talked about:

• A multi dimensional holistic approach of elderly patient and divising a plan after assessment to decrease the morbidity and mortality.
• CGA can be assessed at home of the patient, at Frailty clinic, @ gp clinic and frailty unit of the hospital.
• Risk factors of fall and their effect
• Importance of CGA for well being of patient
• 5 Geriatric giants
• 8 elements of CGA
• MEDICAL assessment and physical examination
• STOPP _ START Tool / Beer's criteria for medications.
• MUST score for malnutrition
• Assessment of bone health • FRAX score
• Pain assessment
• 5 checks of psychological assessment
• Cognitive assessment
• Delirium 4 AT test
• MOCA / MMSE
• Geriatric depression score (15 questions)
It was a wholesome lecture on CGA which is the need of our and really Greatful to doctor Naila she delivered the lecture in best possible way having fever and cough. Hats off to you mam.
Thank you doctor ASH for for providing us opportunity to attend such amazing session.

FEEDBACK # 8

Beenish Manzoor

Today's session starts with amazing presentation by Dr sheraz a wonderful comprehensive case beautifully explained by Dr sheraz
It was very unique and new topic with a alot of learning points by Dr Naila
Learning objectives of todays lec were
* CGA is assessment of old health, well being to formulate plan& order issues
MDT Approch in CGA
° Home
°GP surgery
°community
° franility clinic

° frality unit hospital
°front door ED hospital
Causes of fall in elderly patients and
Risk factors include
*medicine
*medical condition
* impairment,
* cognitive impairmen
*behavior, environment hazards
mortality & morbidity,
hospital admissions
cost
Geriatric Giants
°immobity,
°nstability,
°incontinence
° intellectual impairment
° iatrogenic
8 Element of CGA
Make Problem list based on assessment
Medical assessment need
5 things , (physical exam , medicine, nutrition
what aspects are commonly missed in exam
Medication review
Different scores and scles
*Stopp- start criteria
*Must score
*Frax score
*BEER,S criteria
*Abbey pain scale
*Amts scre
*Delirium 4At test
*Moca
*Mmse
**Nutritional assessment*

Most imp and interesting 👉
if AMT score is low do detailed assessment MOCA superior than MMSE by physiotherapist and done in A& E , *dementia* , *depression* count 5-10%in old people, always under reported
depression is assessed by Tool -Geriatric depression scale -comprise 15questions for assessing severity & monitoring treatment
score > 5 means depression is present
Barthel index tool for Functional assessment done by physiotherapist. this tool include continence assessment too .
Moreover
Look for Environmental hazards
Excellent session by Dr Naila , learnt a lot about assessment tools in Geriatrics....thankyou Dr ash for everything truly blessed simply he is the best supervisor
And we need more sessions by Dr Naila ❤️
Thanks to LGEm team

FEEDBACK # 9

Kamlesh Kumar Lilani

When i heard about GM through Ashfaque Ahmed posts and i get to know it is very interesting to deal and treating elderly ones when they have diseases involving multiple systems in the Body and Dr. Naila made it more knowledgeable easy to learn more about GM. Although it's not currently at our level but we have more knowledge about it now.
Thanks Dr. Naila and Dr. Ash for another amazing session.

FEEDBACK # 10

Muhammad Abubakar

An amazing session on Comprehensive Geriatric Assessment by Dr. Naila. I must say it was a great experience on the 1st lecture by Dr. Naila on such an important topic which is neglected by many in our country. Topics discussed today included;
=> Where CGA Dona
* Older Person's home
* At GP Surgery and more
=> Risk Factors for Fall
=> Why CGA Important
* Reducing

* Prevention
* Improvement
=> Causes & Effects
=> Who Does It
* Doctor
* Physiotherapist
* Occupational Therapist
* Social Worker
* Nurse
* Pharmacist
=> Extended MDT
=> Physical Examination
* Gailt
* Bedside Vision and Hearing Assessment
* Oral Cavity
* Footwear
* Examination of Legs and Feet - sensation, power, presence of ulcers
* Weight
* Postural Hypotension
* Cardiovascular-aortic stenosis causing cardiogenic syncope
* PR Examination including Bladder scan
* Joint Examination
* Overlooking Sarcopenia
=> Elements of CGA
=> Geriatric Giants
=> STOPP-START Criteria
=> BEER's Criteria
* Tramadol
* Opioids
* NSAIDs
* Anticholinergic Burden
* Sedatives - Diazepam
* SSRI
=> The 5 'MUST' Steps
=> Bone Health Assessment

* History & FRAX Score (12 factors)
=> Pain Assessment
* Pain scale
* Abbey pain scale
=> Psychological Assessment
* Cognition
* Delirium
* Demantia
* Depression
=> Cognition Screening Tests
* 4 AT Score
* AMTs Test
* Three item recall test
* Clock drawing test
* Mini Cog test - three steps - give three words ask to remember
* Give clock to draw
* Ask to recall
=> Cognitive Assessment Further tests
* MMSE
* MOCA
=> Depression
=> Geriatric Depression Scale - GDS 15 & GDS 30
=> Barthel Index
Whole lecture was very great from start to end. A very well organised and thoroughly Case was presented by Dr. Shiraz which was very informative and well managed. At the end teaching of Dr. Ash was very heart touching about giving time to our elders. This topic surely will make a huge impact on our daily practice towards elderly patients. Thank You LGEM, day by day we are feeling much proud by having this course led by such a great personality Dr. Ashfaque.

FEEDBACK # 11

Syed Suhail Ahmad

A completely new topic with lots of learning points 👏
- What is CGA?
- Who are involved in MDT of CGA?
- Risk factors & Causes

- 5 Geriatric Giants
- 8 Elements of CGA
- Medical assessment and its components
- Different scores and scales of assessment i.e STOPP-START, FRAX Score, MUST Score, BEERS Criteria, ABBEY Pain Scale, AMTS Score, Delirium 4 AT Test, MOCA, MMSE and Depression Scale

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

FEEDBACK # 12

Muzna Ahmed

Today's session is conducted on a very unique topic on COMPREHENSIVE GERIATRIC ASSESSMENT by very learned, excellent tutor Dr Naila. It was a first interaction and she spell-bound every listener by her amazing talk.

She beautifully skimmed the topic in following headings:-

1.What is CGA?, where is it done? Why is it important?

2.Who does it?

3.Risk factors,causes and effects of fall.

4.Extended MDT i.e► Old age psychiatrist

‣ Tissue viability nurses

‣ Delirium team

► Diabetic specialist nurse

► Podiatrist

‣ Optician/audiologist

‣ Can include multi specialities as required

5.Geriatric Giants i.e ► Immobility

► Instability

► Incontinence

► Intellectual impairment

‣ iatrogenic

6.Different elements of CGA i.e medical, nutritional,social, cognitive etc

7.Medical assessment of geris

8.Physical examination and what points are usually missed

9.Investigations

10.Medication reciew which includes very important anticholinergic burden.

11.Screening Tool Of Older People's Prescriptions (STOPP)

12.Screening Tool to Alert to Right Treatment (START)

13.Beer's criteria (tramadol, SSRI,Opiods, NSAIDs, sedative)
14.MUST SCORE for Malnutrition
15.BONE HEALTH: FRAX SCORE.
16.PAIN ASSESSMENT :
Pain scale+Initial Pain Assessment record & ABBEY PAIN SCALE for Dementia Patients.
17.Psychological assessment :
19.Cognition ➜Screening Tests➜AMTS+THREE ITEM RECALL TEST+CLOCK DRAWING TEST+MINI COG TEST
20.Delirium :➜4AT TEST (Alertness+AMT4+Attention Test+Acute change /Fluctuating Course)
21.MOCA for Dementia+MMSE.
22.Depression:
Assess Cause like Chronic Condition+Weakness+Loneliness etc by GDS-15 & GDS-30
23.Physiotherapy
24.Occupation therapy.
Lastly Dr ASH added his points by encouraging us to conduct this holistic methodological assessment to our parents, grandparents at our home and spread awareness of this knowledge.
Thank you Dr Ash and Dr Naila

FEEDBACK # 13

Aurangzaib Ahmed

Today we had an amazing session with Dr Naila Ash regarding a topic that is ignored by even the biggest tertiary care hospital in Pakistan. Comprehensive Geriatric Assessment and treatment.
The class began with case presentation by Dr Shiraz, who presented an amazing and a very comprehensive case of a geriatric patient that was presented to the ER with history of ALOC, vomiting of fecal matter and G.weakness.
The patient was evaluated using the CGA tools that will be discussed later in the class and the patient was then treated accordingly.
After the case presentation Dr Naila begain with the most amazing class that really made most of us bit our fingers. As for us before this class, if any geriatric patient presented to ER he or she was evaluated on 3 lines that is and a diagnosis was

made with 3 DDs in mind either RTI, UTI or electrolyte imbalance. We has no idea that the UK government was investing so much in the care of geriatric patients and that those poor souls have so much in them when it comes to evaluation and diagnosis.

Comprehensive Geriatric assessment:

Initially a holistic assessment of the elderly patient and then design a treatment plan which best suits the needs of that patient.

5 Geriatric giants:

Immobility

Instability

Incontinence

Intellectual impairment

Iatrogenic

Elements of CGA:

Medical problems

Geriatric Giants

Cognition

Functional status

Social

Nutrition

Medication

Medical Assessment:

Physical examination

Medication review

Nutritional assessment

Bone Health

Pain assessment

Medication Review:

Anticholinergic burden

Who is administering the medication

How is the medication dispensed.

STOPP-START mechanism:

STOPP--> Screening tool of older people's prescriptions

START--> Screening tool to alert to right treatment.

Beer's criteria:

Consists of a list of medication that is considered high risk for geriatric patients and if prescribed need to be monitored and stopped immediately. Some of the drugs in this list include:
Tramadol
Opioids
SSRIs
NSAIDS
Antihistamines and TCAs
Sedatives and Diazepam.
Nutritional status:
Use the tool Must score: it includes 5 steps.
Bone health assessment:
FRAX score (assesses risk of fractures)
Pain assessment:
Pain scale
Abbey pain scale for patients with dementia.
Psychological assessment: 5 checks
Cognition
Delirium
Dementia
Depression
Cognition:
AMTS- abbreviated mental test score 10 points
MOCA Montreal cognitive assessment for dementia
MMSE Mini mental state examination
Delirium 4 AT test:
Depression:
Geriatric depression scale, .
Barthel index of activities of daily living.
Amazing session really an eye opener, we all have geriatric patients at our houses and they were being ignored as we were not being guided properly regarding their assessment and treatment. Using these tools it will help us evaluate and give the best treatment to our geriatric patients that they really deserve. Thank you Dr Naila for such an amazing lecture and thank you Dr Ash for giving us the opportunity to be part of such an amazing program.

FEEDBACK # 14

Noman Ahsan

Today's session was very special as it was conducted by non other than our Dr.Naila...I heard lots about her from Dr.Ash and no doubt she is one of the best teacher ..She knows how to communicate and engage students and make sure that students memorise important points during the lecture...Today's lecture got me back in school times where teacher made u to learn and memorise each n every single point...JAZAKALLAH..

Today's session started with great presentation by Dr.Sheraz...

Dr.Naila Comprehensively and expertly covered very important and most neglected field in pakistan...In pakistan , we don't hav Geriatric departments and its a shame that we neglect very important people of our life...This lecture completely changed my mind on how to take history and assess old age pts along with lots of different criteria and scores that Dr.Naila pushed us to memorise and implant in our hospital system and give time to take detail history and use these specific criteria and scores....An eye opener lecture for me ...Thanks Dr.Ash for bringing in Dr.Naila into faculty ..We are blessed to hav u guys to teach n guide us to make our and pakistan future safe ,healthy and bright...Thanks alot

FEEDBACK # 15

Bushra Khan

What an amazing power pack presentation by Dr Naila. Even working in geriatrics for sometime in UK, I still learned alot in this session. I learned about

1. Geriatric giants (immobility, instability, incontinence, intellectual impairment, iatrogenic)
2. What aspects are commonly missed during physical examination of the elderly e.g gait, oral cavity, footwear, weight, postural hypotension, PR examination, joint examination.
3. Stop start criteria
4. Beer’s Criteria - the ill affects of tramadol, opoids, NSAIDs, SSRIs, sedatives.
5. Nutritional assessment 5 steps of MUST score.
6 How to assess bone health including FRAX score. Frax score has 12 factors to look at.
7. Pain assessment using Abbey’s pain scale
8. Psychological assessment including cognition, dementia, delerium, depression.

9 cognition screening test like AMT's(age, DOB, place, year) How to do clock drawing test.
10. 4 AT for delerium (alertness, AMT4, attention by doing months backwards, acute ir fluctuating course)
11. Geriatric depression scale
Score >5 signifies depression
Lovely to meet you Dr Naila, indeed ur very sweet at the same time strict. You both make a lovely couple. May Allah bless you in both worlds❤️

FEEDBACK # 16

Abid Marwat

Aoa , Geriatrics medicine is completely new concept for me . I have never ever thought that this department has so much so learn and most importantly how to channelise and categorise different diseases in old aged population . We never bring the age of patient there capacity and mental health into account when dealing with them where it's the core of management . Thank you for Introducing us to this topic and would love to learn more in sessions coming forth . Thank you Dr Naila and Dr **Ashfaque Ahmed**

FEEDBACK # 17

Warda Yawar

Mind opening session and learned to deal with old people during my training period how to assess treat diagnose and manage the patient
Wonderful sub speciality and will grow soon
This session was Amazing and wonderful taught.It was runned very smoothly.
i learnt soo many interesting points in Geriatrics,
Geriatric giants
Anticholinergic burden
STOPP and START screening tool
MUST score
BEERs Criteria
Bone Assessment fall fracture
Abbys pain scale
AMT score
4AT score
Moca and MMSC
GDS

Barthel
This is highly recommended for ER physicians to join it and get more skillful and get practical grib on it .Proud to be LGem candidate
Thank you so much dr naila and ASH
You have been truly teaching us with all your remarkable efforts

FEEDBACK # 18

Shehzad Hussain

Thanks Dr Naila n Dr Ash it was amazing session on geriatric assessment in ED, plenty of practical knowledge delivered,
I think we never examined elderly like this, the way Dr Naila explained is wonderful…
CGA, extended MDT,
Geriatric giants
Immobility, Instability, Incontinence , Intellectual Impairment and Iatrogenic.
Elements of CGA like medical problems, geriatric giants, Cognition, functional status, social, affect, nutrition n medication
Further physical examination medication review nutritional review bone review n pain assessment. Hospital admission,
STOPP-START TOOLS
BEERS CRITERIA
MUST SCORE 5 steps BMI unexplained weight loss acute illness, Malnutrition n management.
Bone health assessment and FRAX score
Psychological assessment with Cognition Delirium Dementian Depression
AMTS SCORE
DELIRIUM VS DEMENTIA
4AT score of Delirium
MOCA AND MMSE BARTHEL index. All this explained in a wonderful way.
Thank you Dr Naila and Dr Ash for this amazing learning session. It definitely changed my vision towards elderly patients.
Thank you Dr Shiraz for wonderful presentation.
Thanks LGEM team for amazing session.

FEEDBACK # 19

Zia Hayat

It was an amazing talk started off with the presentation by Dr.shiraz which was really informative about the Assessment of Elderly in the ED, later Dr.Naila explained the meaning if this term CGA ,where it should be done ,learned a lot of new terms like Head to Toe Assessment with whisper counting ,STOPP-START Criteria ,BIERS Criteria ,MUST score for malnutrition Assessment, FRAX score for Bone Health ,ABBEY PAIN SCALE for Dementia Patients, Cognition screening using AMTS,THREE ITEM RECALL TEST,CLOCK DRAWING TEST AND MINI COGNITION TEST,Assessment for Delirium using 4AT TEST,Assessment of Depression in the Elderly by GDS-15 and GDS-30 .After Assessment physiotherapist for functional assessment and occupational therapist assessment. It was all together a new concept for us about the assessment, management, treatment and diagnosis of medical practice with the Geriatric group.She is an excellent teacher and gave us basic knowledge and skills to manage Elderly in the ED.Thankyou dr.Ash for arranging this talk for us.

FEEDBACK # 20

Bushra Imran

Today Dr Naila discussed and given very important topic on Geriatric Assessment, covered all aspects in best way possible .She showered her precious knowledge so we as health care providers should improve both home + hospital geriatrics assessments and then can treat accordingly.I learnt through this session The basic concepts of CGA ,where it does,why to important, 5 geriatic Giants,causes,Who does it,Elements of CGA ,the 5 MUST steps ,when and how bone health assessment in elderly people,FRAX score, pain Assessment and pain score,Psychological assessment and cognitive screen score,what is dementia +delirium 4AT,STOPP -START criteria.Rhis session was comprehensive and informative for me in which in lacking ,not aware of many aspects in my daily practice related to CGA....Thank you Dr Naila and Dr Ashfaque

FEEDBACK # 21

Dr Mariam Nawaz

The session was breath takingly good. Geriatric assessment....a topic scarcely ever talked about in Pakistan....and we were lucky enough to learn it from NHS consultant. Just like paeds population, geriatric population needs an entirely different examination, there is so much that we need to keep in mind while dealing with geriatrics.

Some of the things we learned are as follows:

> Risk factors that may cause fall in elderly: Age>80, Medications, Medical conditions, Gait balance and impairment,Vision and hearing impairment, Cognitive impairment and confusion, muscle weakness, lack of diet and exercises, Alcohol use, Risk taking behaviors, female gender, Environmental hazards.

> The geriatric support team includes

Geriatric Doctor
Physiotherapist
Pharmacist
Nurse
Occupational therapist
Social worker
Tissue viability nurses
Delirium team
Diabetic specialist nurses
Podiatrist
Optician and audiologist

>5 geriatric giants

Immobility
Instability
Incontinence
Intellectual impairment
Iatrogenic

> CGA:

Nutrition, Medications, affect, social, functional status, cognition, geriatric giants, medical problems

>Medical assessment:

Physical examination, medications review, nutritional assessment, bone health assessment, pain assessment

>STOPP-START SCREENING TOOL:

STOPP is screening tool for older people prescriptions
START is screening tool to alert the right treatment.

>BEER'S CRITERIA

It is list of medications that should be avioded common problems in geriatric people

>Tramadol causing SIADH and hyponatremia

>Opoids to be avoided in people with risk of falls, and people on benzodiazipine and gabapentin.
>Avoid Nsaids in people with renal failure
>Anti cholinergic burden
>Sedatives such as Diazepam
>Screening tool for malnutrition is
MUST score- Malnutrition Universal screening tool
>Access Bone health with FRAX score which access probability of having fracture in next 10 years
>Pain Assessment by
Pain scale
Iitial pain assessment score
Abbey pain scale in people with dementia
Cognition screening test
AAMT- Abbreviated mental test score
Clock drawing test
Mini Cog test
>Delirium 4AT test
1. Alertness 2. Abbreviated mental test
3. Attention test- month of year backwards
4. Acute change or fluctuating course
5. Montreal cognitive test for dementia (MOCA)
6.MMSE- Mini mental state examination
Importance of using various diagnostic tools should not be under estimated.
Thankyou Dr NAila and Dr Ash, looking forward to having more sessions with you

FEEDBACK # 22

Syeda Maheen Ejaz

An amazing session. I must say there are not only new learnings but the whole session is very unique and new for me. Alot of scores and tools to asses which are really simple and easy with no cost on patients pocket and alot of benefits of quick real time assesment, mangagement. A huge thanks to Dr Naila ❤️we are really blessed to have you. A very detailed lecture on comprehensive Geriatric assement started with a very nice case presentation by Dr Shiraz how a multidisciplinary team involved for a geriatric patient.

Some highlight of the session
Risk of fall
Geriatric giants
Stopp- start tool
Beer,s crieteria
Must score
Frax score
Pain assesment
AMTS
Delirium 4AT
Barthel index
Geriatric depression scale and alot more.
Thank you so muc Dr Naila and Dr Ash for arranging such session❤️

FEEDBACK # 23

Imtiaz Ali Shah

First of all we welcome dr Naila on the platform of London GEM. Today was her first lecture about CGS.It was a detailed and comprehensive lecture covering all aspects of geriatric assesment and we realize the importance of this important topic which is totally ignored in our setup because there is no planning and infrastructure available.
Dr Naila discussed in detail that
WHERE CGS IS DONE.
RISK FACTORS FOR FALLS.
WHO DOES CGS.
5 GERIATRIC GIANTS these are
Immobility
Instability.
Incontinence.
Intellectual impairment.
Iatrogenic.
She discussed components of CGA
The importance of physical examination.
The concepts of STOPP--STAR and BEER'S CRITERIA and their importance was totally new for us.

FRAX SCORE which calculate the probability of osteoprotic fractures in ten years was a new tool for us.
At last she explained the importance of
PAIN ASSESMENT.
PSYCHOLOGICAL ASSESSMENT
DELIRIUM and DEPRESSION ASSESSMENT.
IN short this was a totally new learning for us and today we realize the importance of this subject.
Dr Nala delivered her lecture in a professional way she explained each component in a very comprehensive way and we are looking forward for more sessions by her in future.
At the end I would like to thanks dr Naila for sparing her valuable time and dr Ash for providing us this wonderful opportunity for learning.

FEEDBACK # 24

Remal Noor

An amazing worth attended lecture by DR NAILA... who covered the topic very precisely n thoroughly .she told about the importance of MDT
5 geriatric giants:
1 immobility
2 instability
3 incontinence
4 intellectual impairment
5 iatrogenic
Elements of CGA
I got to learn about geriatric assessment tools like
FRAX score . AMTS and delirium 4AT test
MOCA , MMSE
Thank you Dr Naila and Dr Ash for helping us to achieve our desired milestones

FEEDBACK # 25

DrKiran Feroz

Wow wow wonderful session....it was pleasure having quality education from our one and only senior Naila baji.....geriatric assessment is one of the difficult topics to cover....but how beautifully she covered each aspect of it was commendable ....from initial physical assessment to complete assessment whether the pt is in delirium or dementia ...various assessment tools were discussed which were new to

us....simply loved it 💞thanks London Gem...and yes Ashfaque bhai u r lucky to have her as ur partner ...May Alah keep u both away from evil eyes Ameen

FEEDBACK # 26

Khatija J. Farooqui

What an amazing lecture on comprehensive Geriatric Assessment by dr Naila Ashfaque new topic with lots of learning tools like different scores i.e MUST&FRAX score, CGA elements, Geriatric giants,pain scale depression scale.fall Risk , bone assesment,stop-start criteria and many more.Thank you dr Naila dr Ashfaque and team LGem.

FEEDBACK # 27

Faiza Baig

It was an Amazing session and beautifully explained by Dr Naila.
It was started by what is CGA and how to assess elderly falls!!
✨There were 5 Geriatric Giants:
1- immobility
2- instability
3- incontinence
4- intellectual impairment
5-iatrogenic
✨What are the 8 elements of CGA:
It includes medical problems, geriatric giants,cognition,functional and social status, affect,nutrition and medications.
✨Medical assessment :-
~ physical examination
~medication review
~nutrition assessment
~bone health assessment
~pain assessment
DO NOT use NSAIDS and anticholinergic drugs above 60. They will cause renal failure and severe effects.
STOPP-START TOOL 🛑
BEER'S criteria ⭕
MUST score for malnutrition🌞
FRAX score for bone assessment 🦴

✨Fuctional assessment for cognition. How to differentiate between dementia and delirium!!
✨Cognitive assessment includes
1- open questions
2- mini cog
3- chair stand up test
4- gait test
5- finger test
6- draw clock test
✨delirium 4AT test
✨MOCA
✨geriatric depression scale (GDS-30)
✨physiotherapist and occupational therapist should practice barthel index scale to measure daily activities performance.
** Dr Naila also explained that stop using TRAMADOL or use with caution in older people due to increased risk of hyponatremia or SIADH.
I have learned new assessments and tools in this vast subject which were all new to me. It was a great and phenomenal learning opportunity.
I love her way of teaching. 🎀Thank you Dr Ash and Dr Naila.

FEEDBACK # 28

Javeria Wali

Date: 11th Dec 2022

Brilliant session conducted on Comprehensive Geriatric Assessment (CGA) by Dr. Naila Ashfaque. It was a topic which has never been discussed before in Pakistan and the frail elderly patients we encounter in our medical practice need exactly this to manage their never ending ailments and pains. These are largely ignored and brushed off as a part of the normal ageing process putting them at risk of fractures and further deteriorating their quality of life. Dr. Naila discussed
What is CGA,
Why is it important
Where the CGA should be conducted,
Who should be involved (Doctor, Nurse, pHysiotherapist, occupational therapist, optician, podiatrist, tissue viability nurse, delirium team, diabetic specialist nurse, audiologist, social worker)

5 Geriartic Giants (Immobility, Instability, Incontinence, Intellectual impairment, Iatrogenic), Risk factors that may cause fall in elderly: Age>80, Medications, Medical conditions, Gait balance and impairment,Vision and hearing impairment, Cognitive impairment and confusion, muscle weakness, lack of diet and exercises, Alcohol use, Risk taking behaviors etc
Elements of CGA including Medical, Geriartic Giants, Nutrition, Medications, affect, social, functional status, cognition
Medical assessment (Physical examination, medications review, nutritional assessment, bone health assessment, pain assessment)
Medication Review (STOPP-START Screening Tool, Beer's Criteria (Tramadol causing SIADH and hyponatremia, Opoids avoided in fall hx, NSAIDs, Anti cholinergic burden, Sedatives)
Nutrition Assessment (MUST score- Malnutrition Universal screening tool having 5 steps),
Bone health Assessment (FRAX score which access probability of having fracture in next 10 years with 12 factors),
Pain Assessment (Pain scale, initial pain assessment tool, Abbey pain scale in people with dementia),
Psychological Assessment (Cognition-AMTS Abbreviated mental test score, Delirium- 4AT test, Dementia and Depression/Geriartic Depression Scale)
Further Cognition Tests include Montreal cognitive Assessment for dementia (MOCA) and MMSE- Mini mental state examination
All in all, a comprehensive and wonderful session opening up a whole new world in front of us in terms of elderly patient care.

FEEDBACK # 29

Afshan Salman

A very comprehensive and excellent session by Dr. Naila Ashfaque.✨
I always get confused dealing an elderly patient as we were never taught before specifically as how to assess and treat a geriatric patient. Now after this session I feel confident as how to approach an elderly patient and what to avoid here, like ♦️ NSAIDs and anticholinergics (TCA, antipsychotics, antihistamines etc) are not good choice for patient above 60yrs of age, considering their more pronounced adverse effect in this age group. Like wise, ♦️Tramadol carries risk of SIADH & hyponatremia whereas ♦️SSRIs can cause serotonin syndrome in elderly patients.

Its a whole process of care that we were taught today, including 8 elements of 🎗 Comprehensive Geritric Assessment CGA namely:
Medical problem,
Geriatric giants,
Cognition,
Functional status,
Social,
Affect,
Nutrition,
Medications.
We learned 🎗Beer's criteria, 🎗MUST score for detection of nutrition status. 🎗 FRAX score to assess bone health, 🎗pain scale & Abbeys pain scale for patient with Dementia,
Psychological assessment & cognition screening tests (♦AMTS, ♦Clock drawing, ♦Mini-cog test),♦ 4 AT test, ♦MoCA, ♦MMSE and ♦Geriatric depression scale.
This huge bundle of knowledge we got today in such a short period of time. Thank you so much Dr. Naila, Dr. Ash & team LGEM. ❣

FEEDBACK # 30

Javeria Siraj

Amazing session by Dr. Naila on comprehensive geriatric assessment. In this session, we learned how to assess an elderly patient in the ED, got to know about 5 geriatric giants and 8 elements of CGA were discussed in detail. Also got to know about START STOP criteria. Ovarall this was an amazing session, thanks to Dr. Naila.

FEEDBACK # 31

Hani Suhail

A wonderful session regarding geriatric and the importance of care for our older generation is a must.
Todays session was about the importance of care, assessment and treatment and support for the our older population in society
the Geriatric giants which included Immobility, instability, incontinence, intellectual impairment, iatrogenic and how each point was explained in a way that kept us engaged to realise how deficient we are in alot of aspects in our self and medical aspects. STOPP-START criteria was introduced to us.

Thank you so much Dr. Naila and Dr. Ash.

FEEDBACK # 32

Saba Aslam Khan

Before having this lecture I believed that patients are classified into two classes i.e paediatrics and adults …. But now I believe oyr elderly patients are different from normal adults aswell , so from now on I will classify patients into three categories…

It was so engaging and amazing lecture, I learned many new things and I was amazed that most of the critical patients landing in ER are elderly patients and what we were doing with them …!! Many misconceptions are corrected and now I believe Managing a geriatric patients is not a job of single person it should have multidisciplinary approach. I learned about stopp-start mechanism,beer's criteria, and effect of drugs on eldery

Patients .. their nutritional status and Use if MUST score to manage it.

Acute disease and it's scoring, FRAX scoring for Bone assessment and much more…

Thank you @Dr Naila for introducing us to whole new world of geriatric medicine I learned alot..

A proud GEM trainee

FEEDBACK # 33

Liz Beggs

Lovely to read new learnings, teaching & care for the elderly. So much appreciated 💓

FEEDBACK # 34

Uzma Shaikh

Geriatric medicine is an alien concept in Pakistan, I bet many of people including medical fraternity are not even aware of word "geriatric" mean. But, here we bunch of doctors learnt basics yet detailed screening tools to access geriatric health by Dr Naila and Dr Ashfaq.

We learnt regrading comprehensive geriatric assessment which is multidisciplinary holistic approach to access health and well being of older population, factors affecting it and execution of plan to support their health and well being.

It is done in older person's home, at GP clinic and Surgery, frailty clinics and hospital.

Risk factors of fall among elderly

1. Age>80, 2. Medications, 3. Medical conditions. 4, Gait balance and impairment, 5. Vision and hearing impairment, 6. Cognitive impairment and confusion. 7, muscle weakness. 8, lack of diet and exercises, 9. Alcohol, 10, Risk taking behaviors. 11, female gender, 12. Environmental hazards.

People involved in geriatric support are

Geriatric Doctor

Physiotherapist

Pharmacist

Nurse

Occupational therapist

Social worker.

Tissue viability nurses

Delirium team

Diabetic specialist nurses

Podiatrist

Optician and audiologist

5 geriatric giants

Immobility

Instability

Incontinence

Intellectual impairment

Iatrogenic

Elements of GCA

Nutrition, Medications, affect, social, functional status, cognition, geriatric giants, medical problems

Medical assessment

Physical examination, medications review, nutritional assessment, bone health assessment, pain assessment

STOPP-START SCREENING TOOL

STOPP is screening tool for older people prescriptions

START is screening tool to alert the right treatment.

BEER'S CRITERIA

It is list of medications that is needed to aviod prescribing for common problems in geriatric people with medical conditions

Some common medications are

Tramadol causing SIADH and hyponatremia
Opoids to be avoided in people with risk of falls, and people on benzodiazipine and gabapentin.
Nsaids in people with renal failure
Anti cholinergic burden
Sedatives such as Diazepam
Screening tool for malnutrition is
MUST score- Malnutrition Universal screening tool
Access Bone health with
FRAX score which access probability of having fracture in next 10 years
Pain Assessment by
Pain scale, initial pain assessment score
Abbey pain scale in people with dementia who can't speak
Cognition screening test.
AAMT- Abbreviated mental test score
Clock drawing test
Mini Cog test
Delirium 4AT test
1. Alertness 2. Abbreviated mental test
3. Attention test- month of year backwards
4. Acute change or fluctuating course
5. Montreal cognitive test for dementia (MOCA)
6.MMSE- Mini mental state examination
Depression is assessed by Geriatric Depression scale comprising of 15 questions and score >5 denotes depression

FEEDBACK # 35

Maimona Javaid

It was one of the most wonderful lecture and topic was totally new to us as their is no dr or deptt of geriatrics here . I would love to conduct lecture on it here. Dr naila took and conducted one of the most imp topic of life for us being a dr . It's so imp to learn about it . Geriatric giants , so many scores like stopp , stalk , depression scores , detailed assessment points like nutrition , medical history , physiotherapy involvement, Psychistry involvement , detail fast score , and a new index score , so much to learn and so many scores I would revise all again and

would love to help my parents first . Extremely grateful to dr naila and dr ash both for arranging this lecture for us.
Stay blessed

FEEDBACK # 36

Aleena Rahman

There are few lectures that leave you spellbound with the depth of their knowledge and the scoring systems used, and this lecture was one of such few ones. Dr Naila is an extremely dedicated and detail oriented tutor who gave a holistic view in assessing geriatric patients. We were taught that assessment and evaluation comes first, before rushing to treat them.
Starting from risk factors leading to falls, and the MDT approach required to assess and evaluate these patients. Geriatric giants was a very unique concept and the head to toe Medical Assessment was detailed and focused and covered every bit of aspect of geriatric examination. Assessment of oral cavity for instance,was explained so well
We studied about STOPP START CRITERIA and the Beer's Criteria, including the medication that needs to be avoided.
Some aspects of this lecture so unique and different in our context such as the depression scale, the nutrional assessment, the MUST score, Pain Assessment (including Abbey Pain scale), and the Psychological assessment tools.
Undoubtedly, I will be using many of these scores to evaluate geriatric patients from now on, and I understand that giving them time and treating them with a multidisciplinary approach is the actual wya to treat them.
Thank you so much Dr Naila, for delivering this exemplary lecture even when you were unwell. Much appreciated, and all the details of scoring systems and evaluation methods were clinically relevant, targeted and focused! Thank you again.

FEEDBACK # 37

Haider Ali

Todays lecture by Dr. Naila was one of the best lectures of this programme. Never imagined that Geriatric would be that interesting. Geriatric giants and different scoring system were very new thing for me to learn in this session.
Most probably, will change my practice assessing geriatric patients from now.
In the end, would like to request Dr. Ash and **London Global Emergency Medicine** to arrange more sessions with Dr. Naila. 😊

FEEDBACK # 38

Dr Nouman

Wondeful session attended on the emerging discipline of Geriartics.
The importance of catering our examination to the need of a "Gerri" patients was discussed. G-Giants, Stop-start tools were mentioned. How to score malnutrition in elderly patients. How to perform a neurological assessment and always check for oral hygeine.
This lecture has provided us with useful information that can be used to furthure expand our clinical acumen for the benefit of elderly patients.

FEEDBACK # 39

Dr Ghazala Sheikh

Today's session was very interesting though its most neglected subject in our setup but Dr naila Ashfaque added charm in the topic 👌 we came to know the importance of geriatric care.
Very thanks to Dr naila
Today I learnt ,

- CGA Definition
- Where its done
- Risk factors of fall in elderly
- importance of CGA
- impact of fall in elderly
- Extended MDA
- Beer Criteria
- nutrition assessment
- MUST score
- Abbey's Pain scale
- Cognitive Assessment
- Delirium Assessment
- Geriatric Assessment scale

Thankyou so much dr Ash for this programme.

FEEDBACK # 40

Dr Muhammad Saad

Today's seesion was on rarely discussed topic Geriatic assessment. For the first we were taught in detail about Comprehensive Geriatic Assessment by Dr Naila Ashfaque. The session commenced with a case presentation by Dr Sheraz, then the

session was lead by Dr Naila Ashfaque. She comprehensively discussed the importance of Geriatics, main presentations related to Geriatics and reason related to those presentations , how can it be approved and role of multidisciplinary team approach in Geriatics.

She comprehensively discussed Geriatic assessment. In the session alot of topics were discussed:

》 Geriatic Giants:
- -Immobility
- -Instability
- -Intellectual impairement
- -Incontinence
- -Iatrogenic

》 Elements of Geriatic Assessment:
- -Medical problems
- -Geriatic giants
- -Cognition
- -Functional status
- -Socail
- -Affect
- -Nutrition
- -Medications

》 Nutritional assessment

》 Bone assessment

》 Pain assessment

》 Psychological assessment

》 Geriatic Depression Scale

》 Scoring systems e.g MUST score

》 Barthel Index

This was one of the best session I ever attended. Thanks Dr Ash and London GEM for such valuable session.

FEEDBACK # 41

Dr Nasir Hayat

This session was Amazing and wonderful taught.It was runned very smoothly.
i learnt soo many interesting points in Geriatrics,
Geriatric giants
Anticholinergic burden
STOPP and START screening tool
MUST score
BEERs Criteria
Bone Assessment fall fracture
Abbys pain scale
AMT score
4AT score
Moca and MMSC
GDS
Barthel
This is highly recommended for ER physicians to join it and get more skillful and get practical grib on it .Proud to be LGem candidate

FEEDBACK # 42

Dr Leela Ram

What a beautiful session it was!! It was all about medicine of Older people who are either not cared or ignored altogether among families, friends and other people. Who will look after them at last journey of life?
Dr. Naila demonstrated every point in view of care, assessment and treatment and support from medical team.
I have learnt so many new concepts, criteria and different score for different bodily systems.
CGA is important with a view to reduce mortality and improving independence, reducing hospital admission & readmission, reducing impact of frailty, preventing complications like reconditioning & fragility fracture & improving quality of life.
5 Geriatric giants
Immobility, instability, incontinence, intellectual impairment, iatrogenic.
Elements of CGA:
1. Medical problems
2. Geriatric giants
3. Cognition
4. Functional status

5. Social
6. Affect
7. Nutrition
8. Medication

Medical assessment includes physical examination, medication review, nutrition assessment, bone health assessment, pain assessment.

Tests recommended are BMI, TUG test, Gait speed test, chair stand test, whisper test, finger counting test.

Regarding medication and polypharmacy STOPP-START criteria is used & so many new things/stuff.

Our practice of geriatric medicine is poor & ignored. After this energetic and fully packed session will greatly improve.

We will examine older people from head to toe, ie eyes, hair, nose, ears, oral cavity & etc.

I will assess my parents and older patients with all due criteria, score & tests.

Thank you so much Dr. Naila Ashfaque for terrific lecture & welcome again.

Thank you Dr. Ashfaque for your support & commitments to London GEM platform.

FEEDBACK # 43

Dr Ahmad Tanveer

Great session

Dr Shiraz first presented a detailed geriatric medicine case of elderly female which later on revelaed community aquired Pneumonia with secondry bowel ileus and partial small intestinal obstruction. How the case was managed as a team effort with consultations from surgical nephro medicine ,physiotherapy, nutritionist inputs of the team.

It was an Amazing session and beautifully explained by Dr Naila Ashfaque

It was started by what is CGA and how to assess elderly falls!!

⚡ 5 Geriatric Giants:

1- immobility
2- instability
3- incontinence
4- intellectual impairment

5-iatrogenic

⭐What are the 8 elements of CGA:

medical problems, geriatric giants,cognition,functional and social status, affect,nutrition & medications. Well explained in detail.

Medical assessment includes

GPE

medication review

nutrition assessment

bone health assessment

pain assessment

DO NOT use NSAIDS and anticholinergic drugs above 60. They will cause renal failure and severe effects.

STOPP-START TOOL was extremely new term

BEER'S criteria

MUST score for malnutrition

FRAX score for bone assessment all these i have heard for very first time and it also amazed how important they are in CGA.

Fuctional assessment for cognition. How to differentiate between dementia and delirium!!

Cognitive assessment includes

1- open questions

2- mini cog

3- chair stand up test

4- gait test

5- finger test

6- draw clock test

FOR Delirium 4AT test

MOCA & MINIMENTAL Scoring

geriatric depression scale (GDS-30)

physiotherapist and occupational therapist should practice barthel index scale to measure daily activities performance.

Dr Naila also explained that stop using TRAMADOL or use with caution in older people due to increased risk of hyponatremia or SIADH and strictly contraindicated in acute abdomen.

Such a comprehensive view of this subject which were all new to me. Power packed lecture with so much updates and full of knowledge boastup
Thank you Dr Ash and Dr Naila and Dr Sheraz for case presentation .

FEEDBACK # 44

Dr Raja Mobeen Ahmed

I believe this was one of the finest lecture of the GEM MRCP program. This is a very neglected topic in Pakistan and I'm sure 99.9% of doctors working here would have no idea about Geriatric Assessment and I have learned so much from this talk. It started with an excellent case presented by Dr Shiraz about an elderly lady who had Pneumonia and sub-acute intestinal obstruction. The case gave an overview on how to assess such patients from Head to Toe and how to manage these problems. I was astonished to learn about the role of Occupational Therapist and Social Care especially the part about the home adjustments, arranging the safe/key system and having plan of 8 carers visiting the patient at home to make sure she stays well. This shows the Comprehensive health care system developed by the NHS and I wish we can develop similar standard of care in Pakistan.
Then, the wonderful Dr Naila Ashfaque presented the details of Geriatric Assessment. I learnt about many new tools, scoring systems and gained knowledge on the following

• The places where CGA is done and by whom
• Risk factors for Falls (age,female gender, drugs, medical conditions, alcohol, sarcopenia, gait/vision/hearing problems)
• Importance of CGA in reducing admissions, lowering mortality and morbidity, improving quality of life
• The 5 Geriatric Giants of Immobility, Instability, Incontinence, Intellectual impairment, Iatrogenic
• Components of Physical examination in Geriatrics including tests stuff as Time to get up and go TUG test, finger counting, etc
• Medication review including anticholinergic burden
• Using STOPP/START to assess medication for the elderly
• Beers Criteria to check important drug effects e.g. opioids causing constipation, dizziness
• Nutrition Assessment with the MUST tool and its 5 steps
• Bone health assessment with FRAX/use of NOGG to help make treatment decision

• Pain assessment and the use of Abbey pain scale in patients with dementia
• Psychological assessment. For Cognition use of the Abbreviated Mental Test score, three item recall and how to do Clock drawing test
• For delirium, using 4AT (Alertness, AMT4, Attention, Acute Change)
• Use of Montreal cognitive assessment and Mini Mental state examination to check Cognition in detail
• Functional assessment for activities of daily living (ADL) with Barthel Index . In the case presented by Dr Shiraz, he had introduced another scale, Rockwood frailty score as well.

Most of this stuff was new for me. I plan to share these Gems with my colleagues at the hospital so we can start implementing these steps at our setup and I'm sure, countless patients will gain significant benefit with these measures. A thousand times thanks to Dr Naila Ashfaque and the GEM team for providing this golden learning opportunity.

FEEDBACK # 45

Dr Shahid Ahmad

A very detailed lecture on comprehensive Geriatric assement started with a very nice case presentation by Dr Shiraz how a multidisciplinary team involved for a geriatric patient.

Main points of today's lecture are
Risk of fall
Geriatric giants
Stopp- start tool
Beer,s crieteria
Must score
Frax score
Pain assesment
AMTS
Delirium 4AT
Barthel index
Thanks Dr Naila

FEEDBACK # 46

Dr Aiman Nazir

Today's session on geriatric assessment was totally a new concept and entirely different thing to learn. Have never studied or done a geriatric assessment which

basically is an holistic assessment of older people to address their concerns and issues and formulate intervention according to concerns identified.
Each and every detail was covered and explained beautifully by Dr Naila. Stating its Importance , its etiologies , which team / team members are involved in this plan ,extended MDT.
Learned some really new terminologies and ideas like 5 geriatric giants (immobility,instability,iatrogenic ,incontinence , intellectual impairment), elements of CGA, how to assess, what factors should be assessed, highlighting the commonly missed points during assessment , tests to order for CGA ,.
A lot of new criterias , tools and guidelines were discussed like STOPP-START, Beers criteria, MUST score(including 5 must steps), FRAX score etc .Assessment of cognitive function by various tests like 4AT , MOCA, MMSE, Barthel index etc .
Overall it was really something new and interesting for me to study this in such a detailed session . Dr Naila kept the session interactive for better understanding and learning.
Thank you so much Dr. Naila and Dr ASH for arranging a wonderful session and making us familiarise with new topics/concepts that will definitely improve our practices.

FEEDBACK # 47

Dr Muhammad Ghayoor Khan

Today's session was on rarely discussed topic Geriatic assessment.
The session starts with a brilliant case presentation by Dr .Sheraz, then the session was lead by Dr Naila Ashfaque.
She comprehensively discussed the importance of Geriatics, main presentations related to Geriatics and reason related to those presentations,how can it be approved and role of multidisciplinary team approach in Geriatics.
She comprehensively discussed Geriatic assessment.I have learned alot about Geriatric by attending this session which are;
Geriatric Giant,Nutritional assessment,Bone assessment,Pain assessment,Psychological assessment,Geriatic Depression Scale,MUST score,Stop,Start,Beer criteria,Must score,FRAX score.
Special thanks to Dr.Naila for giving this lecture in spite of being unwell.
Thanks
Dr.Naila And Team LGEM

FEEDBACK # 48

Dr Muhammad Umair Khalil

It was a complete and comprehensive session on Geriatric assesment (CGS) by Dr Naila Ashfaque

CGS is a interdisciplinary diagnostic process to determine the physical, psychological and functional capability of elderly to devise a management plan for their treatment and reduce their visits to the hospitals.

In todays lecture, dr naila explained the risk factors in old people, the Geriatric Giants (immobility, inability, incontinence, intellectual impairment and iatrogenic) and Elements of CGA which includes

Medical problems, Geriatric Giants, Cognition, Functional status, social prob. Nutritional problems and medications.

Medical assessment includes:

Physical assessment

Medication assessment

Nutritional assessment

Bone health

Pain assessment

We also discussed some imp criterias like STOP-STARTT Criteria as screen tool to check polypharmacy, BEER criteria, MUST Score as Malnutrition universal screening tool and Bone Health Assessment tools like FRAX Score & ABBEY Pain Scale.

Important points in psychological assessment includes Cognition assessment, Delirium, Dementia and Depression assessment.

The idea of Minimal mental score Examination(MME), 4AT Score for delirium assessment, Abnormal Mental test score (AMT score) was new for me.

Todays session was a wholesome package on Geriatric assessment by Dr Naila.

Thanks & regards.

FEEDBACK # 49

Dr Afifa Younas

Greetings of the day!!

Today we had an amazing session on **Comprehensive geriatric assessment by Dr Naila Ashfaque Consultant NHS UK**

It’s an innovative domain for us as we don’t commonly come across a proper well established geriatric setup, but today I came to realize how critical it is to have a well-established geriatric assessment for our elderly population.

Today we covered:

· How to assess risk factors for falls, as the elderly are poor historians so we have to involve their careers as well.

· The multidisciplinary team includes (a geriatrician, physiotherapist, occupational therapist, social worker, pharmacist, and nurse)

· Extended MDT (Old age psychiatrist, Tissue viability nurses, Delirium team, Diabetic specialist nurse, Podiatrist, Optician/audiologist, Other multi specialties)

· Understanding of **Geriatric Giants** that pertains:

1. Immobility
2. Instability
3. Incontinence
4. Intellectual impairment
5. Iatrogenic

· **8 elements of CGA**

1. Medical problems
2. Geriatric giants
3. Cognition
4. Functional status
5. Social
6. Affect (mood, screen for depression)
7. Nutrition
8. Medications

Ø Make a problem list and make a plan based on assessment.

5 important steps of Medical assessment:

1. Physical examination (gait, bedside vision and hearing assessment, oral cavity, footwear, examination of leg and foot, weight, postural hypotension, CVS , PR examination and bladder scan, joint examination, overlooking sarcopenia)
2. Medication review
3. Nutrition assessment (**MUST score)**
4. Bone health assessment (**FRAX score)**
5. Pain assessment (**ABBEY PAIN SCALE)**

Psychological assessment

1. Cognition **(AMTS score)**
2. Delirium **(4AT score)**
3. Dementia (MOCA/MMSE)
4. Depression (geriatric depression scale

Overall it was a brilliant session and has initiated a thought process in all of us to actively lead in this new domain, and given us a wake-up call that it's about time our country understands the need for this crucial domain of GERIATRIC MEDICINE.

Thank you Dr. Ash for always bringing great mentors onboard and picking such enlightening topics for us.

FEEDBACK # 50

Dr Faiq uz Zaman Khan

Geriatric Medicine is one of the most under rated speciality in Pakistan.
And Dr Naila's lecture showed us the difference how geriatric population is treated in UK and Pakistan .
She introduced us to different scoring systems that would help us assess the severity of different diseases.
This lecture was a real eye opener for all of us.

FEEDBACK # 51

Dr Ghulam Saddique

It was a superb session conducted by Dr.
Naila Ashfaque on comprehensive gireatric assessment, the session started with a presentation of Dr Sheraz followed by a detailed view of CGA by Dr Naila.
She covered all aspects of geriatric evaluation in a really asthetic manner,
She talked about:

• A multi dimensional holistic approach of elderly patient and divising a plan after assessment to decrease the morbidity and mortality.
• CGA can be assessed at home of the patient, at Frailty clinic, gp clinic and frailty unit of the hospital.
• Risk factors of fall and their effect
• Importance of CGA for well being of patient
• 5 Geriatric giants (Immobility, Instability, Incontinence , Intellectual Impairment and Iatrogenic).
• 8 elements of CGA like (medical problems, geriatric giants, Cognition, functional

status, social, affect, nutrition n medication).
• MEDICAL assessment and physical examination
• STOPP _ START Tool / Beer's criteria for medications.
• MUST score for malnutrition
• Assessment of bone health • FRAX score
• Pain assessment
• 5 checks of psychological assessment
. ATM'S score
• Cognitive assessment
• Delirium 4 AT test
• MOCA / MMSE
• Geriatric depression score (15 questions)
Thank you Dr Naila and Dr Ash for this marvelous teaching session. It definitely changed my vision towards elderly patients.
Thank you Dr Shiraz for wonderful presentation.
I am proud to be a part of London GEM Programme.

FEEDBACK # 52

Dr Mishal Shan Siddiqui

The session delivered by Dr Naila was incredible and one of the best sessions we've had in this programme. It was a very new concept for most of us Pakistani doctors to assess the elderly patients so comprehensively in the emergency department.
I learned a lot today and will hopefully try to incorporate this in my practice. From revamping our physical examination in the elderly to teaching us new assessment tools catered to this population, addressing commonly missed problems of nutrition, balance, oral cavity hygiene, we got a new insight into geriatric medicine.
It was also amazing to learn how the occupational and physiotherapy services can be involved in elderly care to improve their quality of life.
Really looking forward to having more sessions with Dr Naila!

FEEDBACK # 53

Dr Rehan Khalil

Just attended a very unique lecture on Comprehensive Geriatric Assessment. After attending this lecture i realized that Geriatrics is a whole world and it is need of the day for elderly patients to provide them with care they need.

Alot of new things were there that i learnt today and some of themare mentioned below:
1-Geritric Giants
2-Elements of Geriatric Assessment
3- Anticholinergic Burden
4- STOPP-START Tool
5- MUST Score for malnutrition
6- BEER's tool
7- How to do Bone Health Assessment?
8- Abbey's Pain Scale to assess pain in people who have got dementia.
9-:Congnitive assessment - AMTS Score
10- Delirirum assessment - 4AT Score
11- Geriatric Assessment Scale (GDS)
In the start of the lecture there was an amazing case presentation on an Elderly Fall.

17th DECEMBER 2022

EVENT NAME:

Congestive Cardiac Failure By Dr Nahal Raza Cardiology Registrar NHS UK.

DOCTORS FEEDBACK

FEEDBACK # 1

Saba Aslam Khan

Dr Nahal as capability to actively engage the audience, other superpower she has is to convert the complex topic to the easiest one …
Today we had comprehensive yet detailed session on heart failure she unveiled the concepts in step wise manner started from defination, pathophysiology , difference between R and L heart failure, Diagnosis on the clinical basis than on lab investigations and radiological findings, difference between HFpEF and HFrF… 4 pillars of HF in management..

Thank you so much Dr Ash and LCC for arranging such high yields sessions for us … I learned alot…
A proud GEM trainee

FEEDBACK # 2

Nasir Hayat

This session was Amazing and wonderful presented. discussion and explanation regarding Definition of heart failure
Sign symptoms of LHF AND RHF
CAUSES EXPLAINED well
NYHA classification of HF
DIAGNOSIS
History Examination
Blood tests RFTS LFTS CBC
ECG ECHO
HF r EF VS HFp EF
HFrEF have systolic dysfunction ,DCMP
HFpEF with diastolic dysfunction
Either with HCM,RCM Higher volume to mass ratio
Eccentric randomised cardiac myocytes vdconcentric properly arranged cardiac myocytes hypertrophy LV remodelling explained.
Aging ,obesity and high BNP related to both preserved and reduced EF HF .
4 PILLERS OF HF Treatment
ACEI OR ARNI
(Valsartan + sacubatril)
B blockers
MRA (SPIRONOLACTONE EPLERINON)
SGLT2i (EMPAGLIFLOZIN DAPAGLIFLOZIN)
frusamide & nitrates for symtomatic improvements no impact on mortality improvement
RFTS to be monitored
Cardiorenal failure is caution.
Primary care PCN
HF nurses and pharmacist in community reduce hospital admissions
Ivabredin as secondary rate controling drug sinus rhythm in HFrEF
Inducations of CRT & ICD

Excellent session with detailed discussion on the topic.The session was organised well and taught so nicely and enjoyed the session.I would highly recommend it to physicians to join it .Proud to LGEM candidate

FEEDBACK # 3

Sadia Abbasi

Excellent session ,well organised ,interactive and full of energy by dr Nahal Raza
Learning points:Definition of heart failure, Sign symptoms of LHF and RHF ,NYHA classification of HF, DIAGNOSIS History, Examination,Blood tests RFTS LFTS CBC ,ECG ECHO,HFrEF vs HFpEF,
4 PILLERS OF HF Treatment
ACEI OR ARNI (Valsartan + sacubatril)
B blockers
MRA (SPIRONOLACTONE EPLERINON)
SGLT2i (EMPAGLIFLOZIN DAPAGLIFLOZIN)
frusamide & nitrates for symtomatic improvements no impact on mortality improvement
RFTS to be monitored
Cardiorenal failure is caution.
Primary care PCN
Thanks dr Ash and dr Nahal Raza for wonderful session.

FEEDBACK # 4

Muhammad Abubakar

Another great session of cardiology by Dr. Nahal. The way of her teaching is good. Today almost all the aspects of heart failure especially chronic heart failure discussed including; diagnosis, investigations, difference between HFrEF & HFpEF and management most importantly the management of HFpEF.
She comprehensively covered the topic in almost 1.5 hour. Thank you Dr. Ash and LGEM for the great faculty.

FEEDBACK # 5

Muhammad Azeem Imran

Important Learning points of today's session were,
Heart failure is structure cardiac abnormality to provide adequate oxygenation. Which is syndrome of symptoms SOB, DOE, orthopnea, pedal Edema , raised JVP.
Causes :

MI (IHD),CAD, HTN, valuvalar diseases, CMP,Myocarditis, thyroid disease, Pregnancy.
Risk factor :
HTN, Dyslipedemia, Diabetes, Smoking, Family Hx.
To differentiate btw right and left heart Failure .
RHF: raised JVP, Pedal Edema , cor Pulmonale, ascites, fatigue.
Due to : pulmonary disease CF, COPD, pul HTN, ILD, Infection chronic, PE, ARDS.
LHF: SOB, poor exercise tolerance , orthopnea, PND, Tachycardia, Tachypnea, Fatigue, restlessness.
Due to : impaired contractility , Mi, DCMP, MR, AR , HTN.
MS, Tamponade, LVH.
*Severity of *HF:
NYHA (class 1 to class 4) .
Diagnosis:
History
Examination (JVP, Edema, rales,periphery cold)
ECG, Echo,BNP, BLis , CXR.
HFrF EF <40 , low vol mass to vol ration
HFpEF diastolic HF , EF >= 50 , 41-49 borderline
High Lv mass to vol ratio.
Risk factor : HFrF (MI, smoking , Men, aging, obesity.
HFpEF : (AF, Aging, Renal Dysfunction,Proteinuria.
Pillars of HF:
ACEi/ ARNI, BB(Bisoprolal,
Carvidalol, Metoprolol)MRA, Sglt2 (diuretics effect, metabolic effect)
Above are class 1 recommendation.
Where as
Diuretics, Ivabradin, Vasodilator, omercative (low EF with Low BP), vericiguat of low eGFR
Are class 2 recommendation.
And also to keep the HCT/ Ferritin to normal level .
Response of treatment:
exercise tolerance improves, EF improves, symptoms improve.
Echo to repeat depends on structure of heart abnormalities, EF.

CRT -P
CRT-D
ICD(120-140 ms eout LBBB)
Only ICD has three wire shows on X-ray
All depend on QRS interval and NYHA class despite the medication trial has no or less effect .
COPD vs CHF
Cough
Wheeze
Sputum
PND
Smoking , JVP, bp, arythemia, crackles .
Thank you Dr Nehal for a wonderful presentation and Dr Ash for leadership to teach us from excellent speaker.
Proud to be part of LGEM program

FEEDBACK # 6

Yasir Dilawar

It was a very important topic for us as Dr Nahal explained a lot of things about Heart Failure.Definition of heart failure
S/S of LHF & RHF.NYHA classification.How to make a diagnosis,what are the important investigations.HFrEF vs HFpE was a very good learning point for us.4 pillars of HF RX And Role of Ivabridin and digoxin.it was so much for us to learn each slide was important.thank you Dr Nahal and Dr Ash.

FEEDBACK # 7

Muzna Ahmed

The topic chronic heart failure is as wide as sky and as deep as sea and our tutor Dr Nahal is a professional teacher and guide to transcend this topic.
She covered following headings:-
Definition of heart failure
S/S of LHF/RHF
NYHA classification
H ow to make diagnosis
Investigations
HFrEF vs HFpEF
4 pillars of HF rx(acei, arni, beta blocker,mra,sglt2i

Indications of echo and its repetition
CRT-D CRT-P ICD
Role of ivabradin and digoxin
Traditional vs vasodilating beta blockers.
She comprehensively explained every treatment option and all drugs with their specific roles in HF
It was a roller coaster session many new things were discussed as per cardiology point of view.
Thank you so much dr Nahal and Dr Ash for giving us this opportunity.

FEEDBACK # 8

Hamna Yaqub

Another extraordinary session with Dr Nahal on Heart failure. She covered the subject in its entirety with ease.
Causes,signs and symptoms of left and right heart failure, diastolic systolic dysfunction,HFrEF and HFpEF, Eccentric and concentric LV remodelling,NYHA functional classification,4 pillars of HF(ACEi beta blockers MRA SGLT2i) diagnosis,phenotype specific treatments,CRT P CRT D and ICD.

FEEDBACK # 9

Kamlesh Kumar Lilani

It was more interactive session in which everything regarding CHF cleared very well. Like 4 pillars of HF treatment, HfrEF vs HFpEF and DD among CHF, COPD and Pneumonia differentiated well.
Thanks Dr. Nahal and Dr. Ash for amazing us again.

FEEDBACK # 10

Suhail Ahmed

Dr nahal explained the CHF in a great way.
From Definition of heart failure, sign and symptoms than how to differentiate right heart failure and left heart failure by sign and symptom.
ACC/AHA STAGES OF HEART FAILURE
Diagnosis of heart failure
HFrEF (<40% EF)
HFpEF (>50% EF)
4 pillar of heart failure
1) ACEI
2) BB

3) MRA
4) SGLT2 INHIBITORS
when and how to use ivabradine in heart failure.
Primary / PCN
Management of HFrEF and HFpEF
On optimal medical therapy of LVEF <35% go to ICD
SGLT2 inhibitors role in the heart failure
Role of CRT-P, CRT-D VS ICD
Thanks Dr. Ash and Dr. Nahal.

FEEDBACK # 11

Haider Ali

The most detailed session on congestive heart failure was delivered by Dr. Nahal raza. She literally did justice to this topic by covering all aspects in such a short period of time.
CRT-P, CRT-D & ICD was very new for me to learn and that was amazing.
Thank you so much London GEM and Dr. Ash for his continous efforts.

FEEDBACK # 12

Afshan Salman

Session on Heart Failure by Dr. Nahal Raza was an interactive and informative session. She had full command of the topic and answered each & every query. Session covered HFrEF, HFpEF, 4 pillars of HF, Differential diagnosis, management and much more. Thanks Dr. Nahal & Dr. Ash. ✨✨

FEEDBACK # 13

Hareem Zakir

Once again an amazing lecture by Dr Nahal on chronic heart failure, starting from the scratch from basics to physiology then the ways patients present with the different types of chronic heart failure to their management in detail, she covered every single bit in suchan amazing way that not a single moment was dull. The most interesting part was how to rule out the other differential diagnosis which makes the life of an emergency physician as well as an acute physician easy.
Thank you for your time. Looking forward to more sessions with you ❤️

FEEDBACK # 14

Rida Rana

Attending a super amazing lecture by Dr Nahal Raza on the topic of Chronic Heart Failure which in deed we have studied many times in our medical college days ,

yet today it was taught in the best way possible . No one could have done this job better than Dr Nahal. She has an art of grasping the attention of the entire audiences by her interactive way of teaching . Especially the tabulated form, pictorial presentations makes the session an easy to learn one . From the commonest causes of Chronic Heart Failure , to the patho physiology of Right & Left sided heart failure , diagnosis on basis of clinical and investigation , management especially the 4 pillars of Heart Failure , indication of CRD, CRT , ICD ; NYHA classification of the stages , HFrEF & HEpEF , and last but not the least - how to quickly differentiate and diagnose COPD , Pneumonia and Chronic Heart Failure based on history and examination - was one of the best points taught during the session .
Thanks Dr Ashfaque Ahmed for providing us with such an outstanding faculty. Alhamdulillah on being a part of LGEM 🌹

FEEDBACK # 15

Javeria Wali

A great session on Congestive Cardiac Failure by Dr. Nahal Raza. She delivered a detailed, thorough and extremely informative lecture with latest guidelines and medications currently available to manage CHF. She is brilliant in a way that she answers each and every question in such a comprehensive manner that it is clear that she has a complete command on her subject. She started with definition of heart failure and moved on to right and left heart failure, their difference, their etiology, signs and symptoms, diagnosis and treatment. She emphasized the differences between heart failure with reduced ejection fraction and heart failure with preserved ejection fraction beautifully and the concept was understood perfectly. 4 pillars of HF (ACEI, ARNI/MRA/ SGLTi/ Beta blockers), Continuum of HF, vasodilating Beta blockers, CRT-P, CRT-D and ICD, NYHA classification of HF, sacubutril and valsartan combination were new to us and discussed to everyones satisfaction. Differential diagnosis of CHF, CAP and COPD was explained with the help of excellent tables. Really enjoyed todays lecture as a proud LGEM trainee

FEEDBACK # 16

Syed Suhail Ahmad

Comprehensively covering the A to Z of CHF, from definition, causes, types, features, diagnostic tests, and detailed management according to NICE/NHS guidelines

Most important were the 4 pillars of CHF - ACEi, b-Blockers, SGLT2i and MRA, the mainstay in the treatment of CHF
Thank you **London Global Emergency Medicine** and **Pema-Uk** 👍👍👍

FEEDBACK # 17

Mina Khan

Today's session was very comprehensive and detailed. The tutor covered all majors, she very well demonstrated clinical management and updated tx guidelines.she has been a very enthusiastic teacher always. She started with basics and then advanced eventually.
Heart failure definition- pumping insufficiency of the heart. Right sided heart failure cor pulmonale inc peripheral venous pressure / fatigue / more prominent pedal edema /acites/hepatomegaly/ sec to chronic pulmonary disease/ git upset/ distended jugular vein / weight gain. LHF: paroxymal dysnea/ inc pulmonary wedge pressure / pulmonary congestion / crackles/wheezes/tachy/orthopnea/fatigue/cyanosis NYHA class I/II/III/IV AHA stages Stage ABCD / Hx Examination/CXR/hemodynamic studies/Echo/BNP testing / HF rEF : systolic dysfunction / EF<40% /eccentric remodeling /LoW LV mass to volume ratio .HFpEF : diastolic dys/EF>50% /concentric remodeling /High LV mass to vol ratio 4 pillars of HF ACEI/MRA/SGLT2/ARNI/B blocker .. treatment strategies in HFpEF. Proud LGEM trainee.. Thank you **London Global Emergency Medicine**

FEEDBACK # 18

Zegham Abbas

Excellent session presented by Dr. Nahal.The way of her teaching is good.
Today almost all the aspects of heart failure especially chronic heart failure discussed including;
diagnosis,
investigations,
difference between HFrEF & HFpEF management
management of HFpEF.
She comprehensively covered the topic in almost 1.5 hour.
Thanks Dr Ash and Dr Nahal for wonderful teaching session.

FEEDBACK # 19

Ghulam Saddique Saddique

Session was full of informative and we learnt so many things . Dr.Nahal teaching and slides are unique and informative..
What I learnt today? CCF, with preserved EF and reduced EF , INTRODUCTION
Heart failure with preserved ejection fraction (HFpEF) is a clinical syndrome in which patients have signs and symptoms of HF as the result of high left ventricular (LV) filling pressure despite normal or near normal LV ejection fraction (LVEF; ≥50 percent) heart failure with reduced ejection fraction (HFrEF) ejection fraction ≤ 40% also called systolic heart failure
Most randomized trial evidence is specific to patients with HFrEF
heart failure with preserved ejection fraction (HFpEF) typically ejection fraction ≥ 50% also called diastolic heart failure
Important to consider and exclude other potential noncardiac causes of symptoms suggestive of heart failure
Most common causes Ischemic heart diseases, Hypertension, valvular heart disease, restrictive and obstructive cardiomyopathy, investigations , manegemnet plan management
ACCF/AHA guidelines specify treatment according to HFrEF guidelines
continuation of heart failure medications after recovery of ejection fraction suggested, specifically beta blockers, ACE inhibitors, and angiotensin receptor blockers, Entresto Sacubitril/valsartan(ARNi) , MRA, SGlT2 inhibitors ,
periodic follow-up including echocardiography required, especially if cessation of medication is considered, role of ivabradin and digoxin and when to use them, traditional vs vasodilating beta blockers , usage of CRT-d vs CRT-p, ICD accorrding to classification and s/s ,
Thank u so much for Dr nahal and Dr Ash
I am proud to be a part of London GEM Programme.

FEEDBACK # 20

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 # 21

Muneeb Ahmed

Sorry for the late response.Attended this amazing session and being cardiology resident helped me a lot in understanding pathophysiology and latest guidelines.Dr.Nahal being very kind in answering all the queries and covered the topic in 1and half hour.

She discussed in detail revised definition,difference between right and left sided heart failure,clinical signs and symptoms ,relevant investigations,classification ,difference between systolic and diastolic dysfunction.In the management she discussed in details four basic pillars of HF and stepwise approach in treating such patients.She also discussed empirical antihypertensive strategies,difference between various devices as treatment modalities.

In the last slide she discussed how to differentiate weather it is COPD/AHF/pneumonia.

Before the presentation we had a case discussion by Dr.**#Ash** 65yr old lady admitted LRTI/HF supposed to be treated on diuretics and antibiotics probed to be having OSA/Cor-pulmonale and GI malignancy on basis of through clinical Hx and examination.

Bless to be learning from legends in their fields.

FEEDBACK # 22

Remal Noor

An amazing session conducted by a marvellous teacher Dr nahal on CCF with beautiful presentation explained with latest guidelines and thoroughly explained the complex topic in an interesting mind grasping ways in tabulated and pictorial help reinforced by DR ASHFAQUE interesresting case presentation....

FEEDBACK # 23

Khalid Khan

Heart failure by Dr Nahal. Thanks for thorough explanation. Initiated from basic definition to a detailed coverage of this important topic included all risk factors ,causes, presentations to ER, ECG, Echo findings and pharmacology step by step in accordance to NHS guidelines. Hope to see more such lecture from you soon

FEEDBACK # 24

Ahmad Tanveer

A big topic covered in a short time very detailed discussion and explanation regarding Definition of heart failure

Sign symptoms of LHF AND RHF
CAUSES EXPLAINED well
NYHA classification of HF
DIAGNOSIS
History Examination
Blood tests RFTS LFTS CBC
ECG ECHO
HF r EF VS HFp EF
HFrEF have systolic dysfunction ,DCMP
HFpEF with diastolic dysfunction
Either with HCM,RCM Higher volume to mass ratio
Eccentric randomised cardiac myocytes vdconcentric properly arranged cardiac myocytes hypertrophy LV remodelling explained.
Aging ,obesity and high BNP related to both preserved and reduced EF HF .
4 PILLERS OF HF Treatment
ACEI OR ARNI
(Valsartan + sacubatril)
B blockers
MRA (SPIRONOLACTONE EPLERINON)
SGLT2i (EMPAGLIFLOZIN DAPAGLIFLOZIN)
frusamide & nitrates for symtomatic improvements no impact on mortality improvement
RFTS to be monitored
Cardiorenal failure is caution.
Primary care PCN
HF nurses and pharmacist in community reduce hospital admissions
Ivabredin as secondary rate controling drug sinus rhythm in HFrEF
Inducations of CRT & ICD
Excellent session with detailed discussion on the topic
Thanks DR NAHAL
DR ASH . Regards

FEEDBACK # 25

Sana Hameed

As expected another great session arranged by the great mentor dr. **Ashfaque Ahmed** really really greatful to attend Dr. Nahal on such a wet topic of heart failure and she made it like it's a basic topic to cover
What great differentiation done of LHF and RHF their diagnosis on basis of symptoms to their investigations and management.
Management pillars. Eccentric and concentric remodelling. Treatment and differentials done cleanly. Thank you soo much dr. Nahal and sir ash for this session.

FEEDBACK # 26

Dr Ghazala Sheikh

As always Dr nahal Raza covered comprehensively CVS, mandatory for MRCP as well. She had a interactive session maintaining interest with her lectures
I learnt,

- Heart failure, Types (right and left)
- Causes of HF
- Signs and symptoms of right and left cardiac failure
- Diastolic Dysfunction
- Systolic Dysfunction
- ACC/AHA Stages of heart failure
- Diagnosis of CHF
- HFrEF
- HFpEF
- Concentric Eccentric hypertrophy
- 4_pillars of HF (ACEI, B blockers, MRA, SGLT2i)
- Specialist education and support
- Treatment strategies in HFpEF amining at arterial stiffness
- SGLT2I in pateints with HF without diebeties
- CRT-P vs CRT-D vs ICD
- the dilemma of diagnosis

COPD vs CHF vs CAP
Thanks to dr nahal Raza and big thanks to Dr Ash for the session

FEEDBACK # 27

Dr Shahid Ahmad

Dr Nahal lecture on chronic heart failure was the best one i ever attended on CHF
Main points i learned in in this session are

Diagnosis of CHF based on
>history and examination
>BNP
>Echo
Treatment
>beta blockers
>Ace inhibitors
>Spironolactones
>Sglt2
Types of heart failure
HFrEF and HFpRF
Overall it was an amazing lecture.....

FEEDBACK # 28

Dr Muhammad Amash Khan

Today's lecture on heart failure was given by Dr Nahal which she started with the definition of heart failure and h causes and diagnostic sign and symptoms of Left and Right heart failure and classification of heart failure then we went towards the Pharmacological management in which we learned about the four pillars of heart failure and their indications then at the end we learned about the surgerical intervention.
It was magnificently described in a way that we can learn easily.
Thank you Dr Nahal and Dr Ash for this lecture.

FEEDBACK # 29

Dr Muhammad Ghayoor Khan

Again a wonderful session by Dr Nahal on congestive cardiac failure.
Thanks for thorough explanation. Initiated from basic definition to a detailed coverage of this important topic included all risk factors ,causes, presentations to ER, ECG, Echo findings and pharmacology step by step in accordance to NHS guidelines.
Learning points:
Definition of heart failure, sign symptoms of LHF and RHF ,NYHA classification of HF, History, Examination,Blood tests RFTS LFTS CBC ,ECG ECHO,HFrEF vs HFpEF,
4 PILLERS OF HF Treatment
ACEI OR ARNI.

Thanks
Dr.Nahal And Team LGEM

FEEDBACK # 30

Dr Aiman Nazir

It was a very comprehensive lecture in accordance with the latest guidelines and up to date knowledge. This one hour was not only just book knowledge but also the years of experience of Dr Raza that she shared with us and I truly consider myself privileged .

Heart Failure is basically a structural and functional cardiac abnormality which can have various signs and symptoms . Further explaining about the types : 1-Right heart failure and 2- Left Heart Failure . Explaining their causes, their signs and symptoms , how to differentiate between the two with history , examinations and investigations .

Also taught about NYHA classification(I,II,III,IV) to assess severity .

Furthermore now Heart Failure has to be classified/diagnosed as either HFpEF or HFrEF. Dr Raza explained both with differentiating points and explained them in detail.

Heart Failure pillars(4 pillars) were explained and its significance was discussed in detail. These 4 pillars are ACEi, B-blocker, MRA and SGLT2i. .Apart from their class I and class II indications, the symptomatic management was also discussed in detail. Dr Raza also emphasized about the role of other healthcare workers(heart failure nurses, pharmacist etc) who manage these patients in the community to prevent hospital admissions and ED visits.

Management was taught in detail for HFrEF and HFpEF supported by the latest guidelines and research. Also emphasized upon the SGLT2i therapy outcomes if they are introduced in the patients with Heart Failure. Lastly the treatment plan after all the medical therapy fails i.e CRT-P vs CRT-D vs ICD was discussed along with their indications . Never had this clear knowledge of such devices and their indications before this lecture.

Thank you so much Dr Nahal for making this complicated topic easy for me and sharing the latest information available in terms of treatment strategies .

The entire session was interactive which made it more interesting and beneficial.

Thank you.

FEEDBACK # 31

Dr Faiq uz Zaman Khan

An indepth Lecture on Chronic Heart failure. Dr Nahal beautifully defined the the difference between Chronic and Acute HF , HFrEF & HFpEF , L sided and R sided HF , CRT P & CRT D and clearfield how the management of these entities differ from each other.
Furthermore she explained the new advancements in managing HF and how the treatment modalities will change over time.
Nonetheless, her great way of teaching is what makes these complex concepts palatable.
Thank u for this lecture.

FEEDBACK # 32

Dr Qaisar Shah

What is Heart Failure?
A structural cardiac abnormality leading to failure
of the heart to provide adequate oxygen to
metabolising tissues despite normal filling
pressures..
GENERAL CAUSES OF HF;
Coronary artery disease
Myocardial infarction
Valve disease
ldiopathic cardiomyopathy
Hypertension
Myocarditis/ pericarditis
Arrhythmias
o Thyroid disease
D Pregnancy
D Toxins (alchohol, chemotherapy)
a Inherited cardiomyopathies
Right Heart Failure
RIGHT SIDED FAILURE
(Cor Pulmonale)
•Fatigue
•Peripheral
Venous Pressure
• Ascites

•Enlarged
Liver & Spleen
• May be secondary to
chronic pulmonary
problems
• Distended
Jugular
Veins
• Anorexia &
Complaints of
GI Distress
• Weight Gain
• Dependent Edema
Cardiac Causes
Left sided HF
Pulmonary stenosis
Right ventricular infarction
Right Sided HF
Parenchymal pulmonary disease
-COPD
Interstitial lung disease
Chronic infections
•Adult respiratory distress syndrome
Pulmonary Vascular Disease
•Pulmonary emobolism
•Pulmonary HTN
-Right ventricular infarction
LEFT SIDED FAILURE
•Paroxysmal Nocturnal
Dyspnea
• Elevated Pulmonary
Capillary Wedge
Pressure
•Pulmonary Congestion
- Cough

- Crackles
-
Wheezes
- Blood-Tinged
Sputum
Tachypnea
• Restlessness
•Confusion
•Orthopnea
• Tachycardia
• Exertional
Dyspnea
• Fatigue
• Cyanosis
ACC/AHA

STAGES OF HEART FAILURE

NYHA FUNCTIONAL
CLASSIFICATION

DIAGNOSIS;

There is no single diagnostic test that can confirm
the diagnosis of heart failure
Constellation of symptoms and signs
CXR findings
Confirmation of cardiac abnormality
Invasive hemodynamic studies
Echocardiogram
Serum BNP testing

FOUR PILLARS OF HEART FAILURE;

ACEi
Ramipril 10mg OD
or
B-Blocker
Bisoprolol 10mg
OD
(Alternatives

Carvedilol 25mg BD
or Nebivolol 10mg
OD)
AMBERI: Specialist recommendation, can be
initiated and optimised in Primary Care
MRA
Spironolactone or
Eplerenone 50mg
oD
SGLT2i
Empagliflozin or
Dapagliflozin 10mg

TREATMENT STRATEGIES IN HF p EF AIMING AT ARTERIAL

STIFFNESS
COMORBIDITIES
CONTROL:
• Hypertension
• Diabetes
• Others like
obesity, renal
dysfunction,
etc.
CONVENTIONAL
DRUG THERAPIES:
• Beta blockers
• Diuretics
• Statins
• Add-on
agents like
LCZ696, MRA,•
ivabradine
LIFE STYLE
MODIFICATION:
.Diet
• Exercise

FUTURE DIRECTIONS
IN PHARMACOLOGY;:
• NO system
• NO donors
• MGP pathway
• MMP9 inhibitors
•STAT3 inhibitors etc.
IT WAS AN AMAZING SESSION COVERED ALL ABOUT CCF.
THANK YOU DR.NAHAL AND DR.ASH FOR THIS NICE SESSION.

17th DECEMBER 2022

EVENT NAME:

Pneumonia & its 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

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

Today , Dr Jacob taught us pneumonia as he was actually preparing us for our exam
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

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
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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
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Legionella from air conditioning and Chlamydia discussed.
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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 temperature 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 much 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
- A typical pneumonia (mycoplasma pneumonia, chlamydophila pneumonia, legionella pneumophila)
- A typical 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

Thanks 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 occurs 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 Bashar Hassan

It was amazing session delivered by Dr Jacob about pneumonia
He thoroughly classifies pneumonia.
Will explained its all features. All it's investigation and management.
Thanks to Dr Ash thanks to Doctor Jacob

FEEDBACK # 43

Dr Mariam Nawaz

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 attend 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.

18th DECEMBER 2022

EVENT NAME:

Congenital Heart Diseases By Dr Nahal Raza Cardiology Registrar NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Hamna Yaqub

Another excellent session with Dr Nahal , her way of teaching is just amazing. She covers all bases starting with anatomy pathophysiology presentation sign and symptoms complications treatment and prognosis.
Today's topic Adult Congenital heart disease by Dr Nahal.
ASD (4 types) most common secundum
Coarctation of aorta (radio femoral delay, blood pressure, rib notching)
Tetralogy of falot(VSD overriding of aorta right ventricular hypertrophy pulmonary stenosis)

Transposition of great arteries(d and l type)
The fontan patient(Congenital anomaly having single or common ventricle leading to fontan procedure)(arrhythmia sick sinus syndrome heart failure)
Ebsteins anomaly(atrialization of RV, sail like TV)(pulmonary plethora murmur cyanosis r to l shunt exercise intolerant)(globular heart on x ray)
Eisenmenger's syndrome(reversal of shunt from r to l)(complications; pulmonary hypertension dyspnoea brain abscesses(because of cerebral microemboli) hemoptysis).
Case discussion at the end was very interesting.
Thank you so much Dr Nahal
Thank you Dr Ash for selecting such a gem for teaching. She is absolutely amazing.

FEEDBACK # 2

Saba Aslam Khan

Woah …!! What an amazing lecture we had today on Congenital heart disease , Dr nahal is magical teacher coming right from the disney land of medical world 🤔 She knows how to engage each and every audience and I enjoy her lectures alot … we learned many new things about TOC,VSD,ASD, valve diseases, Ebstein anamoly , Eisenmenger syndrome right from scratch to their management, lecture was exam oriented as well as practically applied ,
Thank you so much dr nahal for this amazing lecture and Thank you so much dr ash for arranging this lecture for us, Dr ash is such a dedicated mentor that he kept attending lectures with us and actively participates and give us his practical pearls to us even on weekend and even during his family time .. we are so in debt to his kindness… !!
A proud GEM trainee

FEEDBACK # 3

Hk Danish

I am a huge fan of DR Nahal Raza's teaching . Mam explained Congenital Heart Diseases in such amazing way that it revised few point that i knew and A lot of point which i never even heard of before . A few point if i quickly mention were 1.ASD . Clinic finding, auscultation, therapy 2.Coarctation of aorta . Clinical finding -> radio femoral delay , rib notching. Coarctation surgical repair , survival after coarctation repair . Tests for recurrence 3. Tetralogy of Fallot4. Transposition of great arteries. L type & D type 5. Fontan patient complications: tachy brady

syndrome , 6. Ebsteins Anomaly : clinical presentation 7. Eisenmenger syndrome: complications, treatment
Mam gave us MCQS to solve in the end and explained Their answers in detail .
Thanks Dr Nahal Raza , Dr Ash and Lgem team for this amazing learning experience.

FEEDBACK # 4

Khalid Khan

Discussed & covered TOF, CHD , VSD, TOF, Bicuspid aortic valve disease, Coarctation of aorta, Eisenmenger syndrome, Ebesteins anomaly, Pulmanry stenosis, RVH. Presentations & diagnosis criteria, management plan, +/- surgical intervention with success rate, types of anomalies, supplementation of oxygen support & diuretics in various cases, mumurs, Fontain patient, Cyanosis, Arrythmias, CXR fidnings all well explained. Thanks Dr Nahal & Dr Ash. Happy new year and joyful break ahead to all!

FEEDBACK # 5

Muzna Ahmed

Dr Nahal delivered a very energetic powerpack talk today on CHD. We have learned so many new things and refreshed our old concepts the core content of the session is as follows:-
1. ASD its anatomy and prevalance
2. Coarctation of aorta:- definition,prognosis clinical presentation rx, and follow up protocol (rib notching on CXR is pathognomonic)
3. Tetralogy of fallot
4. Transposition D type and its complications
5. L type transposition and its complications
6. Fontan patient
7. Ebstein anomaly
8. Eisenmenger

Lastly she did a mind drill with BCQs that is helpful for mrcp and mrcem candidates.
She cleared all above concepts magnificently.
Thankyou so much for instilling this valuable knowledge.

FEEDBACK # 6

Soura Jawed

Amazing session by Dr nahal on congenital heart disease very thoroughly described each one of them with definition its anatomy, pathology she tremendously covered clinical aspect of every disease and even covered the treatment plan for each of it. At last the 3 mcqs were cherry on top
Thank you for the great lecture dr nahal and dr **Ashfaque Ahmed**

FEEDBACK # 7

Amash Khan

As usual concise and upto the point lecture by Dr Nahal which covered the whole congenital heart diseases their pathophysiology, signs, symptoms, life expectancy and treatment and at the end few mcqs were asked which were really helpful.
Thank you Dr nahal and Dr Ash for the lecture.

FEEDBACK # 8

Rida Rana

Attended a well elaborative ,interactive session on Congenital Heart Disease by one of my most favourite tutor Dr Nahal Raza . She makes the session entirely focused with respect to what is being asked in examination . Especially love the pictorial presentations and tabulated forms used by Dr Nahal to teach the topic in the most easy to learn pattern . Each and every congenital heart disease ASD , TOF , TGA , Eisenmengers Syndrome ,Coarctation of Aorta , Fontan Patient - along with. the treatment and complications was taught in the best way possible .
Thankyou Dr Ashfaque for bringing up such amazing faculty on board .AlhumdulliAllah on being part of LGEM 🌹🎊🎉

FEEDBACK # 9

Hareem Zakir

And Dr nahal continues to impress us with her knowledge 😊 Adult congenital heart diseases are kinda new to us as this isn't taught to us mostly but the way she covered all of this in such few time was amazing. The clinical presentation was taught so patients could be easily picked up and not missed . One most improved thing we were taught was the complications patient develop even after surgeries so we know what to look for in the patients even after they have undergone surgical procedures. Thankyou Dr nahal and looking forward for more energetic sessions with you 💔

FEEDBACK # 10

Rana Gulraiz

Today was the sum up about the first batch MRCEM with Dr Ash the program director for this 2 years course .
He discussed about the GEM program for MRCEM Explain the ARCP how and when to complete detailed discussion about the feedback, SRL, CBDs and the most important about the DOPs .The time period of submission of paper work.Thankyou verymuch sir ❤️

FEEDBACK # 11

Ghulam Saddique Saddique

Dr .Nahal once again bubbling with knowledge,what an amazing and marvellous session conducted by Dr.Nahal she discussed
CONGENITAL HEART DISEASE (Problems with the heart's structure that exist since birth)
Congenital heart Disease may be:
ATRIAL SEPTAL DEFECT
Types (secundum 75%, Primum 15%,Sinis venosus 10%, Cor sinus is rare.
C/P: may be SYMPTOMATIC+ ASYMPTOMATIC
℞ : Percutanous Closure & Surgical Closure
COARCTATION OF AORTA (Narrowing in proximal Descending aorta)
RIB NOTCHING on CXR
℞ : PATCH AORTOPLASTY & BYPASS TUBE GRAFTING around segment
TETRALOGY OF FALLOT
It refers to a combination of four related heart defects that commonly occur together. The four defects are: (VSD , Overriding Aorta , Pulmonic Stenosis , RVH
Survival rate (86%)
℞ :valve replacement for regurgitation.
TRANSPOSITION OF GREAT ARTERIES
TYPES:
D-Type & L-Type
℞ : Arterial switch operation
COMPLICATIONS
D-TYPE (Arrythmia, Sys.ventricular failure, Baffle obstruction)
L-TYPE (Progressive Heart Failure, Arrythmia, Severe AV functional regurge)
COMMON VENTRICLE/FONTAN
PROCEDURE

Congenital anomaly with effectice "single" or "Common" ventricle (Tricuspid atresia,Double inlet LV,Hypoplastic Lt Heart,Double out RV Variations)
STAGED PROCEDURE (To bypass the systemic flow into P.A)Baffle
COMPLICATIONS: (Arrythmia,Heart failure,Enlarged RA,Polycythemia)
EBSTIENS ANOMALY
(Atrialization of RV,50% ASD/PFO,50% ECG evidence of WPW)
Enlarged RA on CXR
EISENMENGER SYNDROME (Reversal of shunt from Lt to Rt)
Survival (not good)
For Polycythemia (PHLEBOTOMY) & Aviod extensive CV Procedures.
Amazing session by Amazing Dr Nahal Raza
Thanks Dr Ash & Dr Nahal for this brilliant session .
I am proud to be a part of the London GEM Programme.

FEEDBACK # 12

Bushra Imran

Before mostly I learnt about Congenital heart diseases in children but today an excellent session on adult congenital heart diseases was delivered by dr Nahal Raza.A comprehensive discussion on TOF,corrected VSD ,valvular heart disease,TGA, ASD ,Eisenmenger syndrome,causes, treatment,clinical aspect,4 defect of TOF ,L type transportation Arterial switch operation ,Baffle obstruction,coarctation of aorta Fontan patient...I gained informative points and learnt fruitful knowledge
Thank you dr Nahal and Dr Ash

FEEDBACK # 13

Kamlesh Kumar Lilani

She is very keen in teaching and always delivers an interactive session despite of any situation, more power to you Madam.
Her anatomy description, pictorials and management plans are always best to learn.
Thanks Dr. Nahal.

FEEDBACK # 14

Qaisar Shah

Dr.Nahal Disussed:
oCONGENITAL HEART DISEASE (Problems with the heart's structure that exist since birth)
oCongenital heart Disease may be:

o ATRIAL SEPTAL DEFECT
Types (secundum 75%, Primum 15%,Sinis venosus 10%, Cor sinus is rare.
C/P: may be SYMPTOMATIC+ ASYMPTOMATIC
℞ : Percutanous Closure & Surgical Closure
o COARCTATION OF AORTA (Narrowing in proximal Descending aorta)
RIB NOTCHING on CXR
℞ : PATCH AORTOPLASTY & BYPASS TUBE GRAFTING around segment
o TETRALOGY OF FALLOT
It refers to a combination of four related heart defects that commonly occur together. The four defects are: (VSD , Overriding Aorta , Pulmonic Stenosis , RVH
Survival rate (86%)
℞ :valve replacement for regurgitation.
o TRANSPOSITION OF GREAT ARTERIES
TYPES:
D-Type & L-Type
℞ : Arterial switch operation
COMPLICATIONS
D-TYPE (Arrythmia,Sys.ventricular failure,Baffle obstruction)
L-TYPE (Progressive Heart Failure,Arrythmia,Severe AV functional regurge)
o COMMON VENTRICLE/FONTAN
PROCEDURE
Congenital anomaly with effectice "single" or "Common" ventricle (Tricuspid atresia,Double inlet LV,Hypoplastic Lt Heart,Double out RV Variations)
STAGED PROCEDURE (To bypass the systemic flow into P.A)Baffle
COMPLICATIONS: (Arrythmia,Heart failure,Enlarged RA,Polycythemia)
o EBSTIENS ANOMALY
(Atrialization of RV,50% ASD/PFO,50% ECG evidence of WPW)
Enlarged RA on CXR
o EISENMENGER SYNDROME (Reversal of shunt from Lt to Rt)
Survival (not good)
For Polycythemia (PHLEBOTOMY) & Aviod extensive CV Procedures.
Amazing session by Amazing Dr Nahal Raza
Thanks Dr Ash & Dr Nahal for this nice session .

FEEDBACK # 15

Aqsa Yaqoob

A very much informative and interactive session by NHS Cardiology Registrar Dr.Nahal Raza.

Key points of the lecture :

ASD its 4 types.

Secundum (most common ASD) 75% prevalence.

Septum Primum

Sinus venosus (uncommon)

Coronary sinus(rare)

ASD clinical features and therapy

Coarctation of Aorta and its Repair

Features, Radiological findings(Rib notching).

Tetralogy of Fallot: Risk / follow up

Transposition D- type and its complications

L-Type Transposition (congenitally corrected Transposition) ,its complications.

The Fontan , Patient, Procedure and its complications, Ebstein Anomaly, Clinical Presentation, Eisenmenger syndrome .In the last MCQ's to assess our knowledge.

Thank you very much to Dr.Nahal and Dr.Ash for such an amazing lecture.

FEEDBACK # 16

Muhammad Azeem Imran

Todays lecture was about Adult congenital heart disease.

Learning points were

1. This topic was non exsistent 20 years back,

2. TOF has best survival rate following CHD surgery

Adult congenital heart diseases:

• VSD, ASD,TOF,Bicuspid aortic valve disease with coarctation of aorta , TGA

• Ebesteins anomaly

• Eisenmenger syndrome

• Coarctation of aorta

*Atrial Septal defect 😘

• Secundum: most common type 75%

Either septum primum or septum secundum doenot develop well

• Primum: septum primum is not attached to the endocardial tissue

• Sinus venosus: Rare 10%

• Cor Sinus: rare

ASD clinical aspect
Auscultation: fixed splitting of 2nd heart sound and ejection systolic murmur
• Older pt lose pulm ejection murmur as shunt becomes bidirectional
Treatment of ASD
• Percutaneous closure: only for secundum, contraindicated in others
• Surgical closure: good prognosis, closure age <25, PA pressure < 40
If age >25 and PA pressure > 40 decreased survival rate
• Adult population normally comes with secundum and may cause complications like stroke
Coarctation of aorta:
• Narrowing of proximal descending aorta
notable points are
1.Poor prognosis if unrepaired
2.Radio femoral delay
3. murmur is radiating to interscapular region it is co arctation
4.Rib notching (pathognomic)
Treatment
Repair is mainly surgical: Patch aortoplasty or bypass tube grafting
Despite surgery
• Recurrance - 8 to 54%
•aortic aneurysm/ rupture
• coronary artery disease
Follow up
every 1 to 2 years: ECHO
TOF :
4 points
1.• VSD
2 • Over riding of aorta
3 • Pulmonary stenosis
4 • RVH
May cause right outflow obstruction
• Risk of sudden cardiac death
follow-up with ECGs is done.
(Atrial arrhythmia -fatal)
• Review with ECHO / cardiac MRI

Transposition of great arteries
• D type: lethal
• L type:
• D transposition _complications_
Arrythmis
Sick sinus syndrome,
atrial flutter, A Fib, CCF- heart transplants
L type transposition:
• Progressive heart failure
• Arrythmias
• Severe AV regurgitations
Fontan Patient
any congenital anomaly with single or common ventricle
Complications
Arrythmis
HF
RA may become enlarged and source for thrombus
Treatment
Contain procedure
Ebsteins anomaly
Atrealization of right ventricle
WPW -50% ECGs
Presentation
• Murmur
• Cyanosis
• Atrial arrythmisa
• Exercise intolerance
• CXR: huge globular heart
Eisenmengers syndrome
Reversal of shunt from right to left,
Cyanosis will be there
High mortality
Complications:
• Coagulopathy/ platelet consumption
• Brain abscesses

• Airway hemorrhag @ high altitude
Treatment
• Phlebotomy for polycythemis
• Heart lung transplant is definitive treatment
• Diuretics, prn, oxygen
It was a wonderful session . thank you Dr Ash for arranging such a vibrant plateform to teach us. Jaza kum Allah khair

FEEDBACK # 17

Dr mariam Nawaz

Lectures by Dr Nahal is always amazing just like todays lecture. You cannot get bored in her lecture and she constantly involves us by asking questions. Todays lecture was no different, we got to learn so much about a topic that was not even taught 20 years back, Adult congenital heart disease. Here is a summary of what i learned
1. This topic was non exsistent 20 years back,
2. TOF has best survival rate following CHD surgery
3. Adult congenital heart diseases:
• VSD: corrected earlier in life, mostly asymptomatic and don't cause clots
• ASD
• TOF
• Bicuspid aortic valve disease with coarctation of aorta
• TGA
• Ebesteins anomaly
• Eisenmenger syndrome
• Coarctation of aorta
4. Atrial Septal defect :
• Secundum: most common, 75%
Either septum primum or septum secundum doenot develop well
• Primum: septum primum is not attached to the endocardial tissue
• Sinus venosus: Rare 10%
• Cor Sinus: rare
5. ASD clinical aspect:
• Majority repaired in childhood
• Mostly asymptomatic with machinery murmur
• Auscultation: fixed splitting of 2nd heart sound and ejection systolic murmur

• Older pt lose pulm ejection murmur as shunt becomes bidirectional
6. ASD Theray:
• Percutaneous closure: only for secundum, contraindicated in others
• Surgical closure: good prognosis, closure age <25, PA pressure < 40
If age >25 and PA pressure > 40 decreased survival rate
• Adult population normally comes with secundum and may cause complications like stroke
7. Coarctation of aorta:
• Narrowing of proximal descending aorta
• Poor prognosis if unrepaired
• Radio femoral delay
• If murmur is radiating to interscapular region it is co arctation
• Rib notching (pathognomic)
• Repair is mainly surgical: Patch aortoplasty or bypass tube grafting
• Even after surgery some patients may still present with symptoms
• Recurrance can occur in8 to 54% of people
• Can develop aortic aneurysm/ rupture
• If these patients present with heart ache in A and E think of problem with coronary arteries
• Check for radio femoral delay
• Follow uo every 1 to 2 years: ECHO
8. TOF:
• VSD
• Over riding of aorta
• Pulmonary stenosis
• RVH
• Its imp to know whether there is right outflow obstruction
• Risk of sudden cardiac death is huge because the qrs duration in these patients starts increasing and their follow-up with ECGs is done.
• Atrial arrhythmias are common in these patients and can be fatal
• Review with ECHO or cardiac MRI
9. Transposition of great arteries
• D type: lethal
• L type:
• D transposition complications

¬ Arrythmis
¬ Sick sinus syndrome, atrial flutter, afic
¬ Present with congestive heart failure with treatment with heart transplant
¬ Baffle obstruction: suspect if patient has upper extremity edema
10. L type transposition:
• Most present in adult hood
• Congenitally corrected transposition
• Progressive heart failure
• Arrythmias
• Severe AV regurgitations
11. The Fontan Patient: any congenital anomaly with single or common ventricle may lead to a fontan procedure
These patients are mainly a presentation to cardiology and very well followed up and mostly don't come to ER
Thankyou so much Dr Nahal and Dr Ash for this amazing session

FEEDBACK # 18

Ahmad Tanveer

Wonderful session today explaining all major adult congenital Heart Disease
ASD TYPES
Secundum most common followed by primum.
Clinical significance as paradoxical embolus
Percutaneous closure best for secundum
Surgical closure under 40
Coarctation of Aorta
Narrowing in proximal descending aorta . If unrepaired aneurysm & dissection ,CHF, Premature CAD.
Clinically
Difference in BP AND PULSES. Radiofemoral delay
Systolic murmur
RIB notching on x-ray pathognomonic for coarctation. Treatment surgical repair but still can have symptoms,HTN. Recurrence rate is high. 8-54%
Aortic aneurysms and can also rupture even after repair.
FOllowup after 1-2 years for re-evaluate
TOF

VSD,over riding of Aorta,PS,RVH.
Variability with degree of RVOT obstruction and size anatomy of PA .Survival after surgery 86%
Risk followup
SCD 25-100 fold.
Risk can occur 2 decades after correction. Related with QRS more then 180ms due to RV conduction atrial arrhythmias. Can be fatal in these patients. PVR can decrease QRS duration . FOllowup Cardiac MRI and Echo
TGA
D type lethal
PA Lv and AO from RV .
Cyanotic HD
Surgical repair earlier in life
Arrhythmias/SCD as complications
Systemic
L type better prognosis.
RV LV Change over
mostly present in adulthood.
TV on left side on RV side
MV on Right side on LV side
Complications
RV anatomy is not supposed to work as LV progressive Heart failure, arrhythmias severe AV regurgitation as function .
Fontan Patient effective single common ventricle lead to a fontan procedure.
Tricuspid Atresia.
Double inlet LV
Hypoplastic LH
Some variations of double outlet RV.
STAGED procedure. Systemic venous return directly to PA AND bypass ventricle .
Complications
Arrhythmias
SSS/ tachy Brady
HF
RA enlarged and source of embolus .

Ebteins anomaly
Atrialization of RV
50% ASD PFO
50% ECG WPW
Atrial arrhythmias
Murmur
Cyanosis
Exercise intolerance
Surgery has to be done
Big globular heart on x-ray
Eisenmenger Syndrome .
Shunt reversal R TO L
cyanotic heart disease
Coagulopathy
Brain abcess
Cerebral microemboli
Treatment
Ploycythemia phlebotomy
Rule out correctable disease.
Heart failure and oxygen treatment
Cardiac lung transplantation
At last 3 MCQs are knowledge check injection
Really enjoyed.
Thanks Dr Nahal for such a great teaching
And Dr Ash for your great effort for us .

FEEDBACK # 19

Zia Hayat

It was an amazing lecture as usual by Dr.Nahal ,she is an excellent teacher and the way she explains with the help of diagrams and tables they are extremely remarkable.She started with the incidence of congenital heart diseases seen in Adult population which presents later in life.She discussed in details about the VSD,ASD,TOF ,Biscuspid Aortic Valve disease ,Coarctation of Aorta ,TGA ,Ebesteins anomaly ,Eisenmenger Syndrome ,Coarctation of Aorta .She explained all the topics in details with its clinical correlation in real case scenarios with the help of xray and echo findings .There were lots of learning points with explanation

during the lecture about management of such congenital anamolies, role of Cardiac MRI in the diagnosis ,need for cardiac catherization as well as importance of electrophysiological studies in diagnosis of such cases.Then she presented with 3 case based questions related to the topics which gave an outline for diagnosis and proper management according to clinical symptoms of patients with these conditions. Thankyou Dr.Nahal for the amazing lecture and Thankyou Dr.Ash for arranging such an excellent lecture for all of us.

FEEDBACK # 20

Nasir Hayat

This session was Amazing full of knowledge and very practical session.I learned alot and explaining all major adult congenital Heart Disease .

ASD TYPES

Secundum most common followed by primum.

Clinical significance as paradoxical embolus

Percutaneous closure best for secundum

Surgical closure under 40

Coarctation of Aorta

Narrowing in proximal descending aorta . If unrepaired aneurysm & dissection ,CHF, Premature CAD.

Clinically

Difference in BP AND PULSES. Radiofemoral delay

Systolic murmur

RIB notching on x-ray pathognomonic for coarctation. Treatment surgical repair but still can have symptoms,HTN. Recurrence rate is high. 8-54%

Aortic aneurysms and can also rupture even after repair.

FOllowup after 1-2 years for re-evaluate

TOF

VSD,over riding of Aorta,PS,RVH.

Variability with degree of RVOT obstruction and size anatomy of PA .Survival after surgery 86%

Risk followup

SCD 25-100 fold.

Risk can occur 2 decades after correction. Related with QRS more then 180ms due to RV conduction atrial arrhythmias. Can be fatal in these patients. PVR can decrease QRS duration . FOllowup Cardiac MRI and Echo

TGA
D type lethal
PA Lv and AO from RV .
Cyanotic HD
Surgical repair earlier in life
Arrhythmias/SCD as complications
Systemic
L type better prognosis.
RV LV Change over
mostly present in adulthood.
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Fontan Patient effective single common ventricle lead to a fontan procedure.
Tricuspid Atresia.
Double inlet LV
Hypoplastic LH
Some variations of double outlet RV.
STAGED procedure. Systemic venous return directly to PA AND bypass ventricle.
Complications
Arrhythmias
SSS/ tachy Brady
HF
RA enlarged and source of embolus .
Ebteins anomaly
Atrialization of RV
50% ASD PFO
50% ECG WPW
Atrial arrhythmias
Murmur
Cyanosis
Exercise intolerance
Surgery has to be done

Big globular heart on x-ray
Eisenmenger Syndrome .
Shunt reversal R TO L
cyanotic heart disease
Coagulopathy
Brain abcess
Cerebral microemboli
Treatment
Ploycythemia phlebotomy
Rule out correctable disease.
Heart failure and oxygen treatment
Cardiac lung transplantation.Enjoyed the session alot.I would high recommend it for physicians to join it.Proud to be LGEM candidate.

FEEDBACK # 21

Muneeb Ahmed

Attended this lecture delivered by senior registrar in cardiology Dr.Nahal.Being cardiology resident these lectures are very useful and most awaited.She discussed in details about the VSD,ASD,TOF ,Biscuspid Aortic Valve disease ,Coarctation of Aorta ,TGA ,Ebesteins anomaly ,Eisenmenger Syndrome ,Coarctation of Aorta .She briefly discussed clinical implications,relevant investigations and treatment modalities .At the end of session she had a quiz(3 case)based questions related to the topics to asses understanding of topic.
Thankyou Dr.Nahal and Dr.Ash for your efforts.

FEEDBACK # 22

Beenish Manzoor

Like always such a power packed session by dr nahal she is such an amazing and energetic tutor just love the way she has an art of making lecture so interesting ..
oCONGENITAL HEART DISEASE Defination (Problems with the heart's structure that exist since birth)
oTYPES of CHD
1.ATRIAL SEPTAL DEFECT
Types (secundum 75%, Primum 15%,Sinis venosus 10%, Cor sinus is rare.
*Clinical presentation : may be SYMPTOMATIC+ ASYMPTOMATIC
Treatment Option: Percutanous Closure & Surgical Closure
2.COARCTATION OF AORTA:

Treatment : PA & BYPASS TG around segment
3. TETRALOGY OF FALLOT
The four defects of tof are: (VSD , Overriding Aorta , Pulmonic Stenosis , RVH
Survival rate (86%) Treatment :valve replacement for regurgitation.
4.TRANSPOSITION OF GREAT ARTERIES
TYPES:
D-Type & L-Type and complications
Treatment: Arterial switch operat
5. EBSTIENS ANOMALY
(Atrialization of RV,50% ASD/PFO,50% ECG evidence of WPW)
Enlarged RA on CXR
6. EISENMENGER SYNDROME (Reversal of shunt from Lt to Rt)
Survival rate is less
For Polycythemia (PHLEBOTOMY)
Amazing session by Amazing Dr Nahal Raza fully exam oriented session.
Dr Ash pearls as always is cherry on top of cake
Thanks Dr Ash for always being there for us and sacrificing his weekends for us.you are truly a mentor.we are so blessed to have such a dedicated Tutor.Alhamdullilah.
Thankyou LGEm team
Proud GEM candidate

FEEDBACK # 23

Farheen Naseem

Today she gave us details lecture about classification of congenital heart defect in adults
Dr nehal briefly tell us every expect of congenital heart defects and its treatment its complications
Her lecture was beautifully designed not much lengthy and not much short we understand it easily
More focused on
And
Coarctstion of aorta tof and tga
Most common asd defects
Eastern anatomy
Eisenmanger

I really amaize from her way of teaching she taught every point with details
Thank u dr nehal for wonder full lecture I really enjoyed and learned alot from ur today lectures thank u dr Ash our mentor and thank u to LGEM team

FEEDBACK # 24

Dr Ghazala Sheikh

Today's topic was full of knowledge, although before it seemed unimportant but after attending this session I came to know the importance of this topic
Very thanks to Dr nahal and Dr Ash for sharing your knowledge
I learnt,

- Atrial Septal Defect
- Coarctation of aorta
- Tetralogy of fallot
- Transposition of great vessels
- Tricuspid atresia
- Ebstein anomaly
- Essenmengers Syndrome
- Fontan pateint/ procedure

Thanks for your positive energy ✨

FEEDBACK # 25

Dr Shahid Ahmad

Todays lecture on congenital heart disease by Dr Nahal was really good.
We have learned Various types of congenital anomalies like
Tetrology of Fallot
Transposition of aorta
Coarctation of aorta
Ebstein anomaly
Fanton patiet,
Their clinical presentation, what to do next in their management and all that stuff
Overall it was an interactive session with alot of questions answered by dr nahal
Thanks dr nahal for this amazing presentation.

FEEDBACK # 26

Dr Muhammad Ghayoor Khan

Again a great session of cardiology by Dr.Nahal Raza on one of the most important topic i:e congenital heart diseases.

I had learned about TOF, CHD,VSD,TOF,bicuspid aortic valve disease, coarctation of aorta, Eisenmengers syndrome, Ebesteins anomaly,pulmonary stenosis, RVH.
Presentations & diagnosis criteria, management plan,surgical intervention with success rate, types of anomalies, supplementation of oxygen support & diuretics in various cases, mumurs, Fontan patient,cyanosis, arrythmias, CXR fidnings all well explained.
Thanks
Dr Nahal & Dr Ash

FEEDBACK # 27

Dr Faiq uz Zaman Khan

Dr Nahal Raza is one of the best teachers in the LGEM faculty.
Her lectures beautifully incorporate basic sciences and the clinical aspects of cardiology.
In this lecture she specifically focused on congenital heart diseases that present in adulthood.
She helped participants understand about some of the surgical corrections that adults with CHD would have gone through.
She introduced us to many terms and procedures that most of us were not aware of , the Fontan Patient being a typical example.
The MCQs at the end were a great addition and I hope to see more of them
All in all,her lively way of teaching is what really makes her lectures amazing.
Waiting for the lecture on HTN disorders.

FEEDBACK # 28

Dr Mubashir Hussain

It was an amazing experience and was a amazing lecture delivers by one of our all time favourite teacher and cardiologist Dr Nehal raza .how thoroughly she deliver heart failure aspect it's classification into hfref and hfpef .she also discussed the diagnosis criteria for heart failure it's sign symptoms .
Lgem is not only learning platform but also pure love .thanks to Dr ash and Dr Nehal raza.

FEEDBACK # 29

Dr Aiman Nazir

It was a wonderful session conducted by Dr Raza on congenital Heart Diseases.

Lecture objectives and overview was given in the beginning which i believe is the most essential thing to highlight, also stating the incidences of these diseases and role of cardiologists. Whole session was interactive and lecture slides contained graphs , pictures and animation. That is really good for pictorial memory and retaining information .

starting with the types

1-ASD , its prevalence (1/1500live births), its 4 types (Primum , Secundum(mc), Sinus Venosus and Cor Sinus(rare). explanation about their anatomical defect , their clinical presentations, and its management(percutaneous closure(best) and surgical closure).

2-Coarctation of Aorta : narrowing in prox descending aorta, clinical presentation, xray and MRI findings , what to look for in clinical examination of patient , its treatment(surgical correction), prognosis , recurrence rate despite repair (8-54%), its complications (HTN , aneurysm) . Also not to miss the importance of followup after every 1-2 years and what to look for in followup cases. all the things were so organised and fluent and comprehensive .

3-TOF : beautiful explanation including anatomical pictures, clinical features, survival rates following complete repair, discussion about the increased risk of sudden cardiac death in these patients and also how important it is to regularly follow up the patient with necessary investigations.

4-TGA : again beautiful diagrams for explanation, its types (D type(more lethal) and L type), explanation of both types and their complications (like SCD , Arrhythmias etc) survival chances and prognosis of patients .

5- The Fontan Patient : never heard of this before but because of today's session I am thankful to Dr Raza for increasing my knowledge .,it is a congenital anomaly with an effective single or common ventricle . Further explaining with pictures and discussing the complications(arrhythmias, Heart Failure thrombi etc) and its management.

6- Ebstein Anomaly: atrialization of RV , explaining its presentation according to age of presentation, signs and symptoms to look for in a child or adult patient, a very good c xray image shown that could never be slipped out of my mind .

7- Eisenmenger Syndrome : reversal of shunt, its clinical features, complication (coagulopathy, brain abscesses, airwayy hemorrhage and cerebral microemboli), beautifully explained the pathophysiology of each complication , alos

comprehensively discussed the management of complication as well as definitive treatment.
the MCQ discussion with explanation was excellent to make our concepts clear and to check our knowledge acquired during the lecture .
I must say that Dr Raza has really made a difference by her teaching skills in knowledge and made things so clear that just a quick read of these topics will be enough to retain info in our minds for any exams and for professional life .
Thank you so much Dr Raza and Dr ASH .

FEEDBACK # 30

Dr Javeria Wali

Today's session on Adult Congenital Heart disease by Dr. Nahal Raza was a really comprehensive and power packed session. Dr. Nahal teaches in such an interesting and energetic way that it grips our attention till the very last moment. All the topics were covered brilliantly including Atrial Septal Defects, coarctation of aorta, tetrology of Fallot, Transposition of the great Arteries, The fontan patient, Ebstein's anamoly and Eisenmanger's syndrome. The signs and symptoms, pathophysiology, auscultation findings, murmers, CXR findings, treatment and repair were discussed alongwith interesting case discussions at the end. Cardiology has really been made easy by these sessions.

FEEDBACK # 31

Dr Noman Ahsan

Dr.Nahal Raza lectures are always full of energy ...she keeps asking questions during the lecture to make it more interesting and everyone listen to her with full attention...Today's lecture as always was very fruitful and very informative ..It was a good repetition of the topic...
Lectures include all the Congenital heart diseases and she tried her best to make it easy to understand the difference ....TOF , VSD, ASD , Bicuspid aortic valve disease , Coarctation of aorta, Ebestein's anamoly and Eisenmenger syndrome...
Never seen and never heard of Rib notching and it was a highlighted point for me in this lecture.....
Too much learning in a very short period of time ...Thanks Dr.Nahal for this wonderful Lecture

FEEDBACK # 32

Dr Muhammad Saad

Attended today's session on Adult congenital heart diseases. Dr Nahal comprehensively explained the topic. The adult congenital heart diseases like ASD, VSD, Coarctation of aorta, Tetrology of fallot, Transposition of great vessels etc were precisely explained along pathophysiology, symptomatology, clinical findings, laboratory findings,relevant surgical and medical interventions needed to be done. It was quite a valuable session , learnt alot of new concepts from exam and clinical point of view. Thanks Dr Ash and London GEM for arranging such precious session.

FEEDBACK # 33

Dr Leela Ram

That was an excellent session of 1.5 hour on Adult Congenital heart diseases. It comprises of ASD, Coarctation of Aorta, Tetralogy of Fallot, Transposition of Great arteries, Common ventricle, Ebstein anomaly, Eisenmenger syndrome.

➡️ Coarctation of Aorta: It's narrowing of proximal part of descending aorta

➡️ Treatment: Surgery and Balloon Angioplasty

➡️ Follow-up: 1-2 year

➡️ Tetralogy of Fallot:

1. VSD
2. Overriding of Aorta
3. Pulmonic stenosis
4. RVH

➡️ Transposition of D-type:

Complications: Arrhythmias, Systemic ventricular failure,

➡️ Fontan patient: congenital anomaly with single or common ventricle

➡️ Ebstein anomaly: Atrialization of Right ventricle

She lectured fanstically, it was good to learn more about such anomalies.

I learnt that adults with congenital anomaly should undergo surgery without delay. Patient of Ebstein anomaly usually has bigger heart size encompassing almost whole of Chest X-ray. L-type transposition, 25% patients die by the mean age 38. We should always do clinical examination of cardiovascular system in order to diagnose congenital heart diseases and refer such patients immediately to Cardiology department for rapid investigation & treatment.

Dr. Nahal Raza is excellent Cardiologist with clear concepts of cardiology & thanks Dr. Ash for providing us great opportunity of learning from every lecture.

18th DECEMBER 2022

EVENT NAME:

End of Year Supervisor Meeting With Programme Director Dr Ash

DOCTORS FEEDBACK

FEEDBACK # 1

Babar Hussain

Today's session conducted by Dr Ashfaque Ahmed was full power packed and full of adrenaline dose.
It was full of energy, very interacting.
I have never seen any supervisor to be involved with such dedication.
Thank you very much for guiding us about the importance of this program, ARCPs, SRLs and CPDs.
InshaAllah we will do our best to complete all the paper works.
The best part was the last session which was very spiritual. Thanks a lot for giving us the key to success, and reminding us to always ask for barakaat in life time and work.
This program has really changed my life and you are my ideal **Ashfaque Ahmed** ❤️ and I am very grateful to you for that sir.
Proud LGEM candidate.

FEEDBACK # 2

Shehzad Hussain

It was an excellent meeting with our dearest mentor Dr Ash, we have been guided how to prepare for ARCP, what's required documents paper work, SLR CBD and feed backs presentations. What's worth of ARCP and how it will help further in career growth all was discussed thoroughly.
Specially further guidance on career growth how to go for it how Dr Ash LGEM will help us to go for beyond in the field is amazing, definitely Dr Ash you always helped us move us to come out of our comfort zone and you always motivate us to learn n teach others that's amazing part of Dr Ash,s mentorship learn n teach others.
At the end of meeting Dr. Iqbal's poetry to motivate us is excellent. Negotiation before exam was great part I like it I love it.

Thanks Dr Ash N LGEM team for amazing end of year meeting.

FEEDBACK # 3

Amir Ashraf

-Today we had a meeting about our Arcp to be help in early 2023 , we were explained about the impotance of Arcps , 4 main credentials to complete (attendance , feedbacks , cbds and srls) , all the queries were discussed and sorted out , Dr Ash motivated us how to make a difference , he made everything so easy like a piece of cake on plate . We were encouraged to Appear in exams and be fearless . At the end were allowed to tell and discuss our aims in life , a very integral part of development is social life and how to manage mid life crises .
It was great session and an amazing talk . Thankyou sir for your precious time . No supervisor has ever done this not even close . ❤️

FEEDBACK # 4

Aqsa Yaqoob

An excellent and eye opener session with Sir.Ashfaque in which he explained about upcoming ARCP which is in the month of April/May next year and how we should prepare ourselves and complete paper work for this(CBD's, SRL's and DOP's) and to progress further in this programme . He is the true supervisor who continues to guide and motivates his trainees and concerned about their progress. Many things about ARCP have been cleared. It was a very moral boosting session. Thank you Dr. Ash for this wonderful session.

FEEDBACK # 5

Ahmad Bin Khalid

A thoughtful session by Dr. ASH on "year mandatory
meeting" it's a motivational and spiritual session indeed. Detail discussions on ARCPS, CBDS, SRLS, how to complete paperwork, and all that.
Finally, the "PEARLS OF DR **Ashfaque Ahmed** WAS JUST
THOUGHT PROVOKING AND BIND BLOWING
Goals of life
Aim of life
Iqbal philosophy
Most importantly, the secret of success (ash)
Thank you so much for your precious time and inspiration.
Thank you **London Global Emergency Medicine** for organizing such sessions.

FEEDBACK # 6

Dr Aakash

It was one great session today as usual.
Today I actually learnt the theme of dr ash dreams. what he expects from us.
Not just passing the exams is the goal but to be a competent EMERGENCY CONSULTANT is the goal.
He has planned each & every thing for April Intermediate candidates.
we openly asked many questions in the session that were in our mind .
So in short it is not just an Online course but a real our life changing program❤️

FEEDBACK # 7

Mehak Nabi

I have never seen such a supervisor who is more concerned and worried for his students more then us. It was a much needed session in fact a wake-up call for us to buckle up and start preparing your CBD,SRLS,DOPS. Get yourself ready for the ARCP which is all the paperwork that we need to do. I will always remember your words sir regarding lahasil ki justuju...will keep following your path and will help others in every possible way like you do. Thank you Dr Ash.

FEEDBACK # 8

Rajab Abbas

It was end of year meet up session of the great mentor Dr ash with all LGEM candidates from MRCEM, MRCP and Foundation program (EMFP).
It was a two hour session in which doctor ASH talked about ARCP; how to complete it,how to complete paper work about feedbacks CBD SRL and Exams given.
Many quries were addressed regarding ARCP and exam preparation.
It was Indeed A power pack motivation session by the doctor ASH .
Besides educational activities the doctor ASH had discussion about the aim of life and midlife crisis. It was the best part of the session we learn giving within our sources.
Thank you great mentor for training us educationally as well as spiritually.
A proud LGEM candidate.

FEEDBACK # 9

Naveed Memon

Today's session was 2 hours long discussion where Dr Ash motivated and shared great ideas to improve academically.
Summary of today’s meeting

Detailed discussion about progression in program.
ARCP will held in April/May
ARCP includes Attendance (Feedbacks) CPDS, SRLS and DOBs.
Must appear in upcoming exam ie MRCEM intermediate.
For exam study strategy, 4 components Foundation> targeted>MCQs> Recalls.
Aim of Life (La Hasil ki Talash).

FEEDBACK # 10

Abdul Ghaffar

Give a boostor dose and told us hqow much important this program and values of it
We should complete the paper work (cbd srls Dops 1) and progress the further program
Its totaly true
Thanks Dr ASH

FEEDBACK # 11

Mina Khan

It has been a wonderful session with Dr Ashfaque.
He very well discussed our status in this programme. How to complete portfolios, cbds, srls. He also mentioned timelines regarding course and exams. When we will be getting our final ARCPs. Immensely motivated us regarding aim in life and how to proceed in life so that to avoid any kind of mid life crises , where he fully explained it, I had never heard of it before. It wasnt an ordinary meeting. But a really serious one for a crude mind like mine I guess Thank you London Global Emergency Medicine Proud LGEM trainee

FEEDBACK # 12

Imtiaz Ali Shah

Today's session was different from the previous ones as it was not purely academic but it was end of the year meeting with our consultant dr Ash.i was an interactive session in which he addressed the minor issues faced by us.Dr Ash also discussed about the upcoming ARCP in March/April and discussed with us how we are going to proceed for it.He again gave reminder for SRLs and CBDS and advise to complete them in time.He answered various queries from us in detail.
The second half of the meting was more motivational as this is the trade mark of Dr Ash. He always motivates you and encourages you and never let your moral to go down and he did the same today.He enlighten the importance of London GEM for us and ensured us that we are equally respectable and important for London

GEM as this is our programme and we own it , Dr Ash added the colour of IQBAL POETRY in his motivational address and know our moral is sky high after his discussion.
It is very hard to write a few words for a person like Dr Ash,s caliber

FEEDBACK # 13

Rida Rana

Alhamdulillah attended the much needed meeting by my mentor Dr Ashfaque Ahmed on how to prepare for ARCP , how to cope up with the challenges , each and every point was highlighted and every question by each candidate was well answered by the supervisor of the Programme . It was in deed an eye opening session - a wakeup call - a booster dose by Dr Ash to motivate the.candidates on completing the paper work properly . I havent seen any supervisor so much concerned about the candidate's portfolio . Truely blessed on having Dr Ashfaque as my Supervisor . May Allah give us the strength to make our supervisor proud in the upcoming ARCP meeting. Alhamdullillah on being part of LGEM 🌹

FEEDBACK # 14

فاطمہ ناصر

It was so nice to have this meeting.. so much we have learned.. and so much yet to be learn.. my heartiest prayer for u is that may ALLAH pak g bless u immensely in both worlds.. stay bless bless bless and bless sir g.. can't imagine we
the unsupervised people are blessed to have supervisor like.. I don't know what we have done good.. or what ALLAH pak g has seen in us.. we are literally the luckiest one.. its ALLAH PAK g's pure fazal on us💙

FEEDBACK # 15

Abrar N. Syed

An Excellent in depth Versatile session for Academia but More Importantly Life as a Whole.....This session was an eye opener for all the Gem Members as well as led to a Different n Beautiful Perspective to all Challenges one faces in life n what one wants to Achieve.....
Dr Ash Keeps on setting the bar higher n higher, WoW.
Those inputs of Iqbals Philosophy not only makes us Pakistanis Realise what we have been ignoring in the formation of our Beloved Country but also what Milestones one can achieve just By Understanding n Following em as Dr Ash did.
Hats off Sir Ash, Such an Eye opener,
With Immense Gratitude💯👏🏻💯

FEEDBACK # 16

Muhammad Abubakar

It was very necessary session, it boosted our moral & efforts. Excellent and much needed session. Many important things discussed including; Feedbacks, CBDs, SRLs, what to do and how to prepare for ARCP. The motivation Dr. Ash always provide is beyond imagination. Thank you Dr. Ash you are love. "Proud LGEM Trainee"

FEEDBACK # 17

Rana Gulraiz

Started again sunday with good vibes i had my mantor session which was about our Arcp to be help in early 2023 , we were explained about the impotance of Arcps , 4 main credentials to complete (attendance , feedbacks , cbds and srls) , all the queries were discussed and sorted out , Dr Ash motivated us how to make a difference , he made everything so easy like a piece of cake on plate . We were encouraged to Appear in exams and be fearless. At the end were allowed to tell and discuss our aims in life, a very integral part of development is social life and how to manage mid life crisis.

It was great session and an amazing talk. Jazakallah Sir ❤️

FEEDBACK # 18

Warda Yawar

Todays meeting was conducted by our honourable dr Ashfaque Ahmed

This session will always be remembered because it was beautifully delivered by you i thought once that it seems like scripted😅

Because there was a lot of queries which you sorted out at the end of the year it was a rewarded lecture for us thank you so much for giving your time and listen to every participants of your program their aims and the advices you provided was an eye opener

Definitely i recommend your program

You taught us to avoid mid life crisis so there we should always have an aim in life it was an extra ordinary discussion

And turning point and the quote by Iqbal was amazing and we should focus and stick to whatever you said and i really enjoyed that 2 hour session

FEEDBACK # 19

Syed Suhail Ahmad

A comprehensive and interactive yearly meet-up session between LGEM trainees and their supervisor, how often do we see that 😊
"A trainee should be a reflection of his supervisor" Dr.Ash is living up to that, and grooming us educationally, mentally, and financially 👏👏👏
Today we were briefed about
- Role of LGEM programme in our life and how it can benefit us by actively participating and giving
- Importance of ARCPs and their worth in any future trainings we opt for
- Importance of CBDs, SRLs and DOPs forms
- Importance of feedbacks
- When to appear for RCEM exams
- Last but not the least the issues faced by each one of us and their possible solutions

Thank you @🇫🇸Dr.Ash LGEM🇵🇩, much needed, future is definitely LGEM InshAllah! 👍👍👍

FEEDBACK # 20

Ghulam Saddique Saddique

A very detailed session regarding whole vision of the program ,all detailed discussion for CBDs,SLRs,DOBs,Attendance and feedbacks. Its a very vast comprehensive structured program and today's discussion with Mentor Dr Ashfaque depicts his Aim and broader vision.
That Worthy question about the Aim in life is the most difficult to answer Obviously there is no ambiguity that Dr Ashfaque has a very obvious optimistic vision about that program and is definitely going to inculcate that vision in our thoughts and practically in the near future.The Inputs of Iqbal's philosophy an eye opener for us what we are doing,what we can do and what we should do to deliver what we are learning. Hats off to You Sir Dr Ash,its just a matter of time your vision will make a strong imprint in the form of your GEM candidates changing the entire portfolio of emergemcy and acute medicine where ever your trainees are INSHALLAH .

FEEDBACK # 21

Mohid Kanan

End of year mandatory meeting with our program director and supervisor Dr. Ash Sir, You have been inspiring and motivating us from the beginning of the LGEM program.

The meeting was about each program to finish
all the CBDs,SLRs,DOBs on time and feedback after every session.
Discussed the Aim of life to achieve everything which should not be possible and we should strive for it till we get a better outcome.Dr. ash has a vision of making this program successful which will do wonders in future Insha'Allah.This program was started for non trainee Pakistani doctors who are struggling for post graduation.
Our future is in safe hands and we are learning from the best. Happy to be a part of the LGEM program. Thank you Dr. Ash for this wonderful program.

FEEDBACK # 22

Qaisar Shah

Dr.Ash discussed :
°The detailed discussion about ARCP
°Attendance+Feedbacks+CBDs+SRL+DOPs
°Timeline for Submission
°Aim in Future? (I think so every LGEM Candidate want to be like Dr.Ash in Future)
The meeting was so amazing.
Thanks Dr.Ash & Thanks LGEM whole Team.

FEEDBACK # 23

Bushra Imran

Today dr Ash discussed about the GEM program, about ARCP and when to complete paper work before yearly assessment. He explained in detail about feedbacks SRL,CBDs and DOPs which are mandatory to pass MRCEM .He gave an overview that hiw this program helps us in developing portfolio for future goal and objectives.Also in the end he told us great vision of our success which make me proud as a part of LGEM .
Thank you Dr Ash

FEEDBACK # 24

Zegham Abbas

A man without a vision is nothing. Detailed 2nd meeting of this year.Dr Ash whole vision of this program is discussed his future plan regarding GEM candidate all detailed discussion for CBDs,SLRs,DOBs,Attendance ,ARCPand feedbacks. Its a very vast comprehensive structured program and today's discussion is based on it.

There is no ambiguity that Dr Ashfaque has a very clear and optimistic vision about GEM program and is definitely going to inculcate that vision in our thoughts and practically in the near future.DR Ash discuss Iqbal's philosophy regarding self assessment, goals and to opt realistic approach towards success is really inspiring for me. Hats off to You Sir Dr Ash,its just a matter of time your vision will spread all over the globe through your trainees. Now your are not alone whole non trainees doctors are standing with you and your vision. May ALLAH give us strength and courage so we can achieve the goals that you set for us.

FEEDBACK # 25

Obaid Ur Rehman

Dr Ash emphasized on the importance of our program and how it's going to change the future of EM in Pakistan and all abroad.He mentioned the things we were lacking in and how to improve them, answered the individual queries,How's been the performance of us,what he expects from us and what he has plans for us in the future and how should we prepare for it.He also shared Iqbal's philosophy ,what's should be our purpose of life and why has Allah created us.He taught us like a parent to not just succeed academically but also be a better person in every aspect of life. He really gave us a motivational booster to push hard and always dream the impossible.Thank you Dr Ash for this sincerity and dedication .

FEEDBACK # 26

Kamlesh Kumar Lilani

It is always informative to listen Our Guru who is very fond of Knowledge of A & E medicine. He added importance of portfolio of GEM candidate and ARCP. He added how he succeeded in his journey and that's our inspiration.
Thanks Guru for motivating us.

FEEDBACK # 27

Muzna Ahmed

This session is close to every trainee's heart as our great beloved mentor Dr Ash in 1st hour gave us a wakeup call to keep pace with paperwork complete before deadline and importance of feedbacks how they are mandatory for trainees and their programs.
Dr Ash has let us all come out of anxiety of upcoming ArCP And get prepared for it as it is not so unachievable and everyone who puts effort, done with their paperwork nicely can pull it out. Personaly im very thankful to him to show us ways to succeed.

In the next hour Sir has depicted a life's coach role, dicussed with us the importance of a great aim of life,whatever you give to others comes other way around to you be it knowledge, wealth,comfort,any helping hand etc.
Sir has spell-bound us with his mesmerizing talk and i feel myself encouraged and confident for upcoming future challenges tasks and aims to achieve
Highly thanks to you Dr Ash.

FEEDBACK # 28

Muhammad Wajeeh Labar

When we learn how much time and care Dr. Ash puts into caring for us all, words fail us. A good workout was had. It is very outstanding and unmatched by any standards what you are doing, Sir. The program's goals and requirements for applicants were succinctly stated. You have addressed all of our crucial questions and have expertly led us all, so now all of the candidates—whether they are MRCP, MRCEM, or EMFP—know they are not in this alone. Academics, learning objectives, methodology, and a plan for the EMFP, MRCP, and MRCEM batches were all topics of discussion during the conference. In a two-way conversation, applicants posed questions, and Sir addressed each one individually while also discussing goals for the future. In a two-way conversation, applicants posed questions, and Sir addressed each one individually while also discussing goals for the future. They are encouraged and inspired by a powerful figure. our compass. Our brilliant light Congratulations, Dr. Ash. We won't let you down.We appreciate you setting up such a remarkable programme for Pakistan as LGEM and for making it adaptable for us.

FEEDBACK # 29

Saba Aslam Khan

The beauty of LGEM program is that we get to talk to our supervisor 24/7… our supervisor is treating us like our own kids and no one of us ever felt left alone, despite being all the time available Dr Ash time to time arrange meetings for us , where he talks one to one with us and motivate us and guide us,today was one of it’s kind meeting where Dr Ash prepared us for ARCPs, CBDs and SRLs…!!
Dr ash is great supervisor and best leader, he is not only making us future EM leader but also brightening our innerselves, we have grown alot in professionally as well as spiritually….!!
Thank you so much Dr Ash for arranging this meeting and bring LGEM platform for us… ✨🌻

A proud GEM trainee

FEEDBACK # 30

Syed Muhammad Zeeshan Hashmi

Todays session was our end of yr supervisor meeting with all of his trainees who are under training in dr Ash's unique Global Emergency Medicine Foundation program , he himself conducted this lecture and cleared multiple queries among his students, about their attendance, its importance, the self reflective forms of every lecture , DOPS forms of 100 EM procedure workshop, and how important are CBDs for us and what actually case based learning is , how will it help us in future and also what Our respected teacher and his team are doing and what they actually want from us , the discussion about midlife crisis was very very important for us and all youngsters,for all those of our age group that we should have a broader aim in our life not a very materialistic or easily achievable one but something far that at least if we "shoot for the moon ,if you miss you will land among the stars "
That was a push up call by Dr Ash to just push and pump us all once again that just go on .you have completed half a yr and other half is remaining, just complete it with properly and on time .....
Thanks Dr Ash

FEEDBACK # 31

Afshan Salman

We had end of year meeting today with our supervisor, one & only Dr. Ash. We all feel a professional & spiritual bond with our mentor. He knows very well where we stand and what we are capable of, always motivating and guiding us to give our best and achieve the best. No doubt he cares about our career and personal development.
Session involved discussion on CBDs, SRL, DOPs and all paper work that needs to be updated till the end of this year, then we have to go through mandatory ARCP. He asked us about our aim of life and gave it a new direction.
Getting inspiration from Iqbal's poetry our mentor showed us the true meaning & purpose of life. The session enlightened our mind & soul. I am grateful to my Allah for choosing this path for me and giving us a genius mentor. Thank you Dr. Ash for inspiring us to work hard and dream big!!✨✨

FEEDBACK # 32

Javeria Wali

Today's Mandatory End of the year meeting with our Supervisor Dr. Ashfaque turned out to be the most inspiring and thought provoking talk I have ever attended.. Such dedication is truly phenomenal and awe inspiring. Dr. Ash discussed our goals for this program, importance of feedbacks, SRLs, CPDs, DOPs and all paperwork for our RCEM portfolio, timeline for MRCEM exam and ARCPs. He invited everyone to share their difficulties and offered solutions. Extremely helpful and motivating us all to give our best efforts to this program in order to be recognized and reap the maximum benefits. Thank you Dr. Ash for this session.

FEEDBACK # 33

Zia Hayat

Today we had an amazing lecture from Dr.Ash about the end of year programme ,he discussed with us in detail the role of ARCP ,CBDs,SRLs and the required paperwork which should be completed by all candidates in order to pass this programme .He gave us an overview about how this programme will help us develop our portfolio for future goal and objectives . He explained in detail on how this will have a positive impact on our career as an EM physician and also will help us get training post in the UK on the basis of performance and competencies signed off by him.In the End he gave us a very unique flavour about what should be our aim in life and how we can give back to people and help them in whatever way we can ,add value to people's life which noone has ever taught us in life.I am really proud to be under his supervision, his ideas and support is more than a blessing.Thanks a lot Dr.Ash for taking out time for us.

FEEDBACK # 34

Hamna Yaqub

Today's end of year meeting session with Dr Ash was very inspiring and motivating. He thoroughly discussed what he wants from us and where he wants to see us in future , how we can make the most of this program by just following his advice. How to clear ARCP. How to mange our portfolios. This session was a booster to our morale and motivated us all to work our best.

Thank you Dr Ash for this amazing session.

FEEDBACK # 35

DrKiran Feroz

Today's session was actually a motivation for all of us Gem trainees ...Ashfaque bhai not only guided us motivated us but on top explained how imp is to have

CBDs ,SRLs and DOPs completed on time....the importance of paper work is a requirement to work in UK....100 procedural workshops has its own importance which will help us in future...future will IA b of Emergency medicine IA....lots of prayers for the entire team

FEEDBACK # 36

Faizan Ur Rehman

It was a good session. The purpose of program and expectations from the candidates was very well summed up. Starting with the academic part and then talking about our aims in general. Dr.Ash gave a really good perspective over pursuit of happiness.

Overall, I felt that the focus was more on MRCEM candidates. However, the session was really motivating and loved the way Dr.Ash dealt with one of the candidate who was a bit anxious regarding upcoming exams. It takes a great teacher to deal and confront like this upfront.

Furthermore, it was really comforting to know that we have a cushion in form of LGEM to lean back upon.

FEEDBACK # 37

Phota Ram

Today we have an interactive session with our mentor Dr Ash and have discussed about the academic of LGEM and future perspectives. discussion about the feedback, SRL, CBDs , DOPs ,ARCP and portfolio.All these are very important required RCEM curriculum and NHS job.Last session about Goal of life and Dr ash always Inspire and Motivate has students,I feel proud to be the part of LGEM.

FEEDBACK # 38

Sana Hameed

Sir you are real GEM not only the director of London GEM but also a rare gem of Pakistan who is just priceless. I can say with guarantee there is no consultant or supervisor who has ever dealt with all the questions/ difficulties or issue of their trainees have not only professionally but personally. A two hour packed session addressing all the aims and professional growth you expect from us and will be leading us. InshaAllah sir we all will be your pilot batch and will make you proud. All the prayers for you and PEMA and London GEM team.

FEEDBACK # 39

Khalid Khan

Discuss so far progress started from March & upcmoing ARCP. Requirements barriers, feedbacks. Documentations of CBD, DOPs, SRL and +/- exams plan. All Questions concerns were well listened & answered. A time line and guidance were provided. Thank you Dr always pleasure listening you.

FEEDBACK # 40

Muneeb Ahmed

A much needed , thought provoking and motivational session with Dr.Ash.
The purpose of meeting was to address queries related to this programme.
What we are supposed to do...time frame for exam/learning outcomes..paperwork /feedbacks/attendances.Dr.Ash addressed all our queries and asked everyone about their goals and motivated all of us.Never seen a mentor giving individually attention and addressing their fears related to exam and financial aspects.
Blessing indeed..Thank you Dr.Ash and London GEM team.

FEEDBACK # 41

Hk Danish

A wonderful session with our mentor Dr Ash . It is always inspirational and raise our spirits. He thought us all the steps required a trainee in NHS and he also encouraged us alot for future exams . I can not be thankful enough to Dr Ash and Lgem team.

FEEDBACK # 42

Muhammad Azeem Imran

I am amazed to attend todays session , what a wonderful 360 supervision by great mentor by Dr Ash .
I have never seen such a vibrant mentor in my life.
He gave Detailed discussion about progression in program.
ARCP will held in March 2023
ARCP will includes Attendance (Feedbacks) CPDS, SRLS and DOP.
so one part is wake up call to get paperwork completed by March.
Second part of today's session was advice and how to ACE exam
Must appear in upcoming exam ie MRCEM intermediate.
For exam study strategy, 4 components Foundation from OHEM, targeted revision,MCQs & Recalls.
Last part was a conclusions
Aim of Life & Motivation narrating Great poetry Of Allama Iqbal

FEEDBACK # 43

Ahmad Tanveer

A very detailed session regarding whole view of the program ,all detailed discussion for CBDs,SLRs,DOBs,Attendance and feedbacks. Its a very vast structured program and todays discussion with Mentor Dr Ash reflected that Aim and his superb vision.

The beautiful question about the Aim in life,No doubt Dr Ash has set a very high standard for the program ,The Inputs of Iqbal's philosophy an eye opener for us what we are doing,what we can do and what we should do to deliver what we are learning. Hats off to You Sir Dr Ash,its just a matter of time your vision will make a strong imprint in the form of your GEM candidates changing the entire portfolio of emergemcy and acute medicine where ever your trainees are INSHALLAH .

FEEDBACK # 44

Remal Noor

It was an excellent meet up with an outstanding mentor who really knows well abt his students and realy concerned about their success n learning more than anything else.....the way he addressed exam fear today was amazing...money nt matters bt his way to encourage me to appear in exam realy touched me and nw its high time for me to not let him down InshAllah....I m feeling proud and honoured to be part of LGEM -a unique prog which is matchless in training to train doctors to be the best out of thm....stay blessed DR ASHFAQUE .....a shout out for LGEM

FEEDBACK # 45

Amash Khan

An amazing and detailed session taken by the mentor himself which further cleared the perspective and the aim of the program and the discussion on CBDs, SLRs, attendence and DOPs was done and some of questions were answered regarding them.Aim in life was asked and some guidance was given and at the end some motivational speech was given by Dr Ash which further boosted the moral.

FEEDBACK # 46

Umair Khalil

It was a end of the year meeting of program director Dr Ash with all GEM Candidates (MRCP, MRCEM & EMFP).

Session continued for 2 Hrs where Dr Ash told the candidates about ARCPs, their importance in the program and how beneficial they are in professional career in UK and how to make CBDs, SRLs etc. Dr Ash also highlighted the importance of

GEM program, currents ED Conditions in Pakistan and Role of PEMA & LGEM in revolutionizing the emergency medicine in Pakistan.
Dr Ashfaque individually asked the participants about their aim in life and also highlighted the moral aspects of doctors in society. The ideology of Barakah and Hazrat Allama Iqbal's concept of true and practical Muslim was also discussed.
All the queries of participants were also answered. It was a life changing session.
Thankyou dr Ash for such wonderful session and such session should be arranged frequently.
Thankyou Dr **Ashfaque Ahmed** and **London Global Emergency Medicine**.

FEEDBACK # 47

Dr Ghazala Sheikh

Dr Ashfaque Ahmed explained the whole MRCP programme and its purpose, we always needed that motivation and guidance which is provided by our mentor.
We are very blessed sir that you are supervising us although you have a very busy schedule but still you make effort.
Very grateful for your precious time and support 💕

FEEDBACK # 48

Dr Muhammad Ghayoor Khan

It was again an informative session by Dr.Ash on the LGEM program.
I was completely awared about LGEM program after taking this session.
CBDs, Feedbacks,SRLs and DOPs are mandatory for completion of the program.
Also I am awared of the aim and future of LGEM and it's candidates.
I'm very thankful to Dr.Ash for making me as a part of the program.
Insha'Allah I will do my best to complete this program like CBDs,SRLs, Feedback etc and will also help LGEM to achieve the Goal of Dr.Ash in the future.
Thanks
Dr.Ash

FEEDBACK # 49

Dr Maimoona Javed

Mandatory meeting with dr Ash and ARCP and general discussion on goals and expected outcomes of students of gem and how they going to Persue further
Talk was excellent. Dr ash answered almost all questions regarding ARCP and made understand all trainees to grab it properly.
Benefit of ARCP was discussed in detail.
Importance of paper work and portfolio was highlighted in so much detail.

It helped me understand all clear concepts of ARCP.
It motivated me a lot to finish my work on time.
Dr Ashfaque is the lead hero of Mrcem training first batch by London gem .
And we totally trust him he gonna take all of us to heights of success in national and international forums.

Stay blessed dr Ash 👍

FEEDBACK # 50

Dr Nasir Hayat

This session was Amazing, very well organised and very well taught.learned alot
Gave Detailed discussion about progression in program.
ARCP will held in March 2023
ARCP will includes Attendance (Feedbacks) CPDS, SRLS and DOP.
so one part is wake up call to get paperwork completed by March.
Second part of today's session was advice and how to ACE exam
Must appear in upcoming exam ie MRCEM intermediate.
For exam study strategy, 4 components Foundation from OHEM, targeted revision,MCQs & Recalls.
Last part was a conclusions
Aim of Life & Motivation narrating Great poetry Of Allama Iqbal.Proud to be LGEM candidate MRCEM.

FEEDBACK # 51

Dr Leela Ram

Sir Ash said that every year, there's to be meeting about objectives, ideas & plans & so for New Year and to revise what to do & where are we during course?
He reiterated the importance of feebacks, SRL, CBD, DOPS & else other than that for promising portfolio. Our paper work should be ready within prescribed time period so as expedite process for issuing ARC number much like GMC or PMC.
Undoubtedly, entire process is time consuming and requires great efforts to accomplish all of it until said months.
The LGEM programs are not only about MRCP & MRCEM exams but also more than that. Anyone can hardly imagine beyond that.
Apart from that, we were asked about aim of life, everyone has different aim of life. Some of them achieve while some of them still in struggle & so many give up pursuing their dreams.

Thank you so much Dr. Ash for telling about great vision and aim of life and to set different goals at different stages of life in order to avoid mid life crises & so on.
❤️🙏

FEEDBACK # 52

Dr Faiq uz Zaman Khan

This session showed us the dedication and efforts Dr Ash has put in the LGEM program.
This was a much needed session as we were briefed about how the LGEM program will proceed further next year .
The LGEM FP candidates got a wake up call, and that was much needed .
In the end Dr Ash shared his views about life and quoted beautiful verses from Iqbal's poetry , which is always boosts the moral of the candidates.
He also shared his secret of passing so many postgraduate exams.
Wonderful and heart warming session

FEEDBACK # 53

Dr Azka Shamim

AOA respected sir
Today we had end of year mandatory meeting with our supervisor *__Dr Ashfaque sorathia (consultant NHS UK)__ *, and it was literally a power pack of 2 hours full of energy, motivation and positive vibes.
We as LGEM trainees can proudly say that there is no other supervisor in whole faculty of any organization who is so much into his trainees. The way Dr Ash is taking us to the higher levels day by day ... This is remarkable
It was a 2 hour session, with first hour mainly academic and following points were highlighted by our mentor :
appraisal of MRCEM batch for their good work , which boosted our energy and enthusiasm to do much better next time
##To work in a dedicated ER , to gain hands on practice of clinical skills ... We can't just move forward by clearing exams and without any skills
ARCPs to be held in upcoming months and for that the must things are -- CBDs, SRLs, Feedbacks, DOPS and Attendance
Regarding preparation of any exam the steps should be -- make foundation strong, study from targeted books, solve mcqs and then do recalls

To be vigilant regarding maintenance of portfolios , as this will have a huge impact on our future

Regarding 2nd half of the session Dr Ash asked us about our Aim in life and we had a wonderful and totally unique conversation with our supervisor.. it included the following points :

Always aim for something unachievable, to avoid midlife crisis , as you will not loose purpose and will not deviate

Intention does matter, you just have to work on your dreams and money will follow

Any project you start it should be self sustainable

And we all are deputy of our Creator - Almight Allah , sent in this world to show His reflection... So we should have aim in life for which Allah has sent us in this world

Countless thanks to our great mentor

A proud GEM trainee

FEEDBACK # 54

Dr Noman Ahsan

A detailed discussion regarding our on going programme...Dr.Ash thoroughly explained and advised to complete our SRLs, CBDs, DOPs , Feedbacks in time and to b regular in attending every single lecture ..Attendance is mandatory as well...plus he advised to work on QIPs and arrange workshops to hav a better ARCP portfolio....Session was very helpful and will try to complete all this in time...Thanks Dr.Ash for the session..

FEEDBACK # 55

Dr Muhammad Saad

Today we had end of year meeting with Dr Ash. During the meeting Sir discussed about academics, learning outcomes, methodology, Plan for EMFP, MRCP and MRCEM batches. It was active 2 way meeting in which candidates asked queries and Sir answered all of them one by one and discussed future plans and ambitions. We are so lucky to have supervisor like Dr Ash. Thanks for arranging such an extraordinary program like LGEM for Pakistan and making this program flexible for us.

FEEDBACK # 56

Dr Nouman

Words give out when we get to know how much effort and concern Dr Ash has for us all. What you are doing Sir is quite extraordinary and unmatcheable by any standards. You have guided us all so well....answered all our important queries and now all the candidates, be it MRCP, MRCEM or EMFP know that they are not alone. They have the support and inspiration of a tall icon. Our beacon. Our shining light.
Hats off to you Dr Ash
We will not disappoint you.
We will carry and spread the message of patriotism, professionalism and achievement that You want to instill in us.
Thanks a lot for this much needed one on one interaction

27th NOVEMBER 2022

EVENT NAME:

Chronic Renal Failure MRCP1-2 & PACES BY DR Yasir Baig

DOCTORS FEEDBACK

FEEDBACK # 1

Mehak Nabi

Comprehensive session conducted by Dr Yasir today learnt detailed mechanism of ckd according to kidgo guidelines markers of ckd imp of modifiable and non modifiable risk factors for diagnosis what should be the targeted hb,bp according to egfr in ckd patients MBD various management plan modalities for RRT. Case based discussion was interesting. Today's session will influence my clinical approach stronger and also highlighted exam based stuff. Thank you Dr Ash for all your efforts.

FEEDBACK # 2

Bushra Khan

Dr Yasar covered a very important topic interms of exams as well as clinical practice. Its a very common presentation in the hospitals therefore it’s necessary to have the knowledge. Dr Yasar covered the basic pathophysiology of CKD along with its classification. The clinical complications of such as anemia, secondary

hyperparathyroidism, vit D management, blood pressure n diabetes management. Different modalities of Renal replacement therapies such as haemodialysis, peritoneal dialysis.
The highlight of the session was differentiating between acute n chronic renal failure. Huge learning through an amazing case was presented. It will surely stick to our head for life.
Thank you Dr Yasir n London Gem.

FEEDBACK # 3

Suhail Ahmed

A comprehensive teaching session delivered by Dr. Yasir Baig on CKD. He explained the KDIKO CKD staging together with albumin level.
Various causes of CKD and their management were also discussed such as DM, HTN.
CKD management discussed including Anaemia, Bone disease, Secondary and tertiary hyperparathyroidism and hyperphosphatemia.
Different modalities of RRT were explained.
In the last, the OSCE was great that showed that how to differentiate between CKD and AKI in the first presentation of the patient to the hospital with no previous record.
Thank you Dr. Yasir and Dr. Ashfaaque.

FEEDBACK # 4

Sadia Abbasi

It was a amazing and well organised session learnt so many things including KDIGO Guidline ,mechanism of CKD (raised intra glomerular pressure, glomerular damage and tubulointerstitial scarring) importance of proteinuria in diagnosis and prognosis,stages of ckd explained by giving example make it easy to understand, Factors influencing ckd progression(modifiable and non modifiable),detail of ckd and anemia,ckd and MBD (role of vit d use of phosphate binder ,cinacalcet) CKD and BP (bp targets)CKD and Diabetes(anti diabetic drugs relation to eGFR) role of SGLT2 in ckd,CKD and Diet which is always neglected part in management plan,CKD AND LIPIDS,Modalities for RRT,importance of continuous accessment and pt education whichis most important part in management .when to start dialysis ,indication of RRT,dialysis(hemo occur by diffusion process and peritoneal occur by osmosis)

And finally a case discussion which is highly important for clinically as well exam purpose.
Thank you very much dr Yasir and Dr Ash for providing us a opportunity to learn and improve our practice. Thanks alot.

FEEDBACK # 5

Sidra Asad

This lecture was about chronic kidney disease and Dr Yasir has thoroughly covered all basic and clinical aspects of this topic which is highly important. Case based discussions by Dr Leela and Dr Yasir were structured and relative to the topic and it has covered the correct format of history taking, examination and doing relevant investigations to reach the diagnosis and how to rule out the differentials (how to differentiated between AKI and CKD). Dr Yasir has focused not only on the basic mechanism, definition and stages of CKD, but also we were taught about relation of CKD with BP, DM(target BP with and without proteinuria), anemia, lipids ;and role of proteinuria(prognosis, monitoring tool and marker of CKD). Also, updated guidelines on management of CKD with DM were extensively covered like role of SGLT2 inhibitors and Metformin, modalities for RRT and indications of dialysis. Moreover, he has explained the difficult topic of dialysis in an understandable way that how it actually works (also explained by a diagram).This was a wonderul session. Thanks alot

FEEDBACK # 6

Faisal Butt

This Session was very interesting , delivered by Dr.Yasir Baig. It comprehensively covered all important clincial aspects regarding CKD and also according to Mrcp Exam.
Dr.Yasir's teaching focuses on main concepts of a topic. He taught following points ;
CKD Definition
KIDIGO Stages of CKD
Causes(tubular, interstitial disease, Race(Black patient)
(BP, proteinuria, exposure to nephrotoxic agents, renal obstruction, UTI, dyslipidemia, anemia, smoking.Management CKD and anemia
CKD & DM, CKD &BMD, CKD & HTN
Activated Vit D replacement, phosphate Binders,Modalities For RRT (transpant, Hemodialysis, peritoneal Dialysis, CRRT), How to prepare patient for

hemodialysis and when to start Hemodialysis.sIndication of Hemodialysis (Uremia, metabolic acidosis, fluid overload, hyperkalemia),Hemodialysis mechanisms of diffusion
Case presentation By Dr.Leela Ram was Good , as how our practice in pakistan is way behind and how it was a preventable death, as told by Dr.Ash.
Osce was done by Dr.beenish.Learned alot indeed.
Thanks Dr.Yasir Baig
Thanks Dr.Ashfaque Ahmed for facilitating the whole session,
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 7

Ghulam Saddique Saddique

Today's session was amazing and Dr Yasar delivered a lecture on CKD in a more elaborated and detailed manner which would guide us in management of CKD patients. what he taught us in session is as under
1) Definition of ckd
2) Stages of CKD (KIDIGO)
3) non modifiable causes(tubular interstitial disease, RACE(Black patient)
Modifiable causes (BP, proteinuria, Exposure to nephrotoxic agents, renal obstruction, UTI, dyslipidemia, anemia, smoking,
4) Management CKD and anemia
CKD and DM, CKD and BMD, CKd and BP
Dietary restrictions, activated Vit D replacement, phosphate Binders
5) Modalities For RRT (transpant, Hemodialysis, peritoneal Dialysis, CRRT)
5) How to access and educate you to confirm your diagnosis and prepare patients for hemodialysis.
6) when to start Hemodialysis (Ideal Study)
7) Indication of Hemodialysis (Uremia, metabolic acidosis, fluid overload, hyperkalemia)
😎 Hemodialysis mechanisms of diffusion by showing Images.
In the end Dr.Yasar Baig presented a very good case of a CKD pt and dr beenish did Osce.
Dr.lella Ram did a case presentation on CKD
Overall it was a nice presentation and I am going to apply today's knowledge in real patients in future. Really looking forward to learning more from you Dr yasir baig.

Also thankful to Dr.Aahfaque who facilitated us on every step of learning and professional carrier.
I am proud to be a part of London GEM programme.

FEEDBACK # 8

DrShafik Zaid

Disease progression stages. Ckd in diabetes and its management drugs of choice target bp with ckd and dm with protenuria egfr stages role of metformin on progressive ckd. Pathophysiology of glomerular dises.
Diffrentiation between acute and chronic. The vary nee term crash Lander..
Amzing dr ash dr yasir thank i very much

FEEDBACK # 9

Ram Leela

It was terrific lecture which included Mechanism, importance of proteinuria, CKD stages based on KIDGO Nomenclature, factors influencing CKD progression, CKD+Anemia, CKD+ Metabolic disorders, CKD+BP, CKD+Diabetes, CKD+Lipids.
Dr. Yasar delivered his lecture with utmost dedication, he tried his best to input our brain. He smoothly demonstrated each point.
I have learned that CKD is a progressive loss of function of Kidneys, it's diagnosed through first Proteins in urine. It has prognostic value in the progression in the CKD & important monitoring tool for treatment target. There are some non-modifiable factors such as Race & Tubulointersitial disease.
It has taught to take proper history, clinical examination and management.
According to the KDIGO, abnormalities of kidney structure or function present for 3 months. Classification of CKD is based on cause, GFR & Albuminuria.
Persistent albuminuria category is A1 A2 A3 and GRR category is G1... Normal or high, G2: Mildly decreased, G3a: mildly to moderately decreased, G3b: Mildly to severely decreased, G4: Severely decreased, G5: Kidney failure when GFR is < 15ml/min. After CKD, several complications ensues such as Anemia, Metabolic disorders such Secondary hyperparathyroidism, Hypertension & Dyslipidemia.
There's a much association between Diabetes and CKD ie CKD is the complication of DM. I also learnt modalities of treatment which includes Hemodialysis, Peritoneal dialysis, RRT, Conservative management & life style modifications.
Thanks Dr. Yasar Baig & Dr. Ash for outstanding teaching & made us understand complicated topics in a simple way.

FEEDBACK # 10

Ramsha Tasnim

Very informative and comprehensive lecture
On chronic kidney disease its include definition mechanism of kidney injury
Importance of proteinuria. i.e maker of kidney damage , prognostic value and monitoring tool for treatment target .
Stages of chronic kidney disease according to KDIGO guidelines
Factors influence the CKD progression
Management
Diet restriction low salt and protein
Anemia correction
Correct Bone mineral disorders
Control of B.P and glycemic control
Modalities for renal replacement therapy
Indication of dialysis .
Types of dialysis
And case base discussion by Dr Leela Ram
And osce by Dr Beenish Naveed
Thanku Dr Ash
Regards Dr Ramsha tasnim

FEEDBACK # 11

Dr Ghazala Sheikh

Very thanks to Dr Yasir Baig for taking such an amazing session on CKD one of my favourite topics. Specially those associations like
CkD with diebeties (canagliflozin and dapagliflozin)
CKD and diet (restriction for phosphate, potassium diet, salt and fluids)
CKD and lipids (statins and ezetimibe)
Stages of CKD according to KDIGO guidelines.
Modalities of renal replacement therapy
Types and indications of dialysis .
CBD by Dr leela ram
And OSCE by Dr beenish was also worth
Thanks to dr Ash for such a informative platform 👍

FEEDBACK # 12

Dr Nasir Hayat

This session was amazing and very informative and comprehensive lecture
On chronic kidney disease its include definition mechanism of kidney injury
Importance of proteinuria. i.e maker of kidney damage , prognostic value and monitoring tool for treatment target .
Stages of chronic kidney disease according to KDIGO guidelines
Factors influence the CKD progression
Management
Diet restriction low salt and protein
Anemia correction
Correct Bone mineral disorders
Control of B.P and glycemic control
Modalities for renal replacement therapy
Indication of dialysis .
Types of dialysis
And case base discussion.The osce done was wonderful .i would highly recommend it for physicians to join it to have bright future.Proud to be LGEM MRCP candidate.

FEEDBACK # 13

Dr Mohid Kannan

Explained CKD well in this session with concepts and covered all the important topics related to CKD.
Starting from definition (KDIGO) along with CKD stages , types of causes(non modifiable and modifiable),race.
Importance of Proteinuria and BP in CKD patients.
Investigations needs to be done
Treatment options for CKD with or without DM or anemia
correction of BMD
Diet modification
Indications of dialysis.
Case discussion / OSCE was great by Dr. Beenish Naveed.
Learnt a lot today.
Thank you Dr. Yasar ,Dr. Ash.

FEEDBACK # 14

Dr Syed Kamran Hussain

It was very comprehensive and interesting session delivered by Dr.Yasir Baig. It covered all important learning, examination, osce and clincial aspects regarding CKD. He started with.
Definition CKD
Stages of CKD (KIDIGO)
Causes like
Tubular interstitial disease Race(Black patient)
BP
DM
Proteinuria
How to differentiate b/w AKI & CKD
Nephrotoxic agents
Renal obstruction
UTI
Dyslipidemia
Anemia causes , Managment
Hazards of smoking
Managementof CKD
Deficiency of Vit D Replacement of Active vit D
phosphate Binders
Modalities For RRT (transpant, Hemodialysis, peritoneal Dialysis, CRRT), Patient preperation for hemodialysis
Hemodialysis.Indication of Hemodialysis (Uremia, metabolic acidosis, fluid overload,hyperkalemia mechanism of hemodialysis.
Case presentation and osce By Dr.Leela Ram and Dr Beenish was excellent , and in the end Dr ashfaque just want to say you are great.
Thanks Dr.Ashfaque, DR YASIR BAIG
Thanks tO LGEM TEAM

FEEDBACK # 15

Dr Arshad Ali Khan

Lecture was so informative and full of huge knowledge
Let me tell u what I learnt from today lecture
1) Define of ckd and factor influencing CKD progression
2) Stages of CKD (ckd by GFR and albunuria)
3) CKD AND ANEMIA (when to start iron transfusion and erthropoitein)

4) CKD AND MBD (When to use phosphate binder especially calcium containing and sevelamer)
5) CKD and BP
6) CKD AND DIABETES (roles of SGLTS , METFORMIN AND INSULIN)
7) CKD AND DIET
8) CKD AND LIPIDS (WHEN TO START STATIN)
9) MODALITIES FOR RRT
10: WHEN to start dialysis and how to work
And at last case presentation we learnt how to manage ckd by stepwise and how to differiate from AKI
THANK SO MUCH TO DR. YASIR BAIG AND DR. ASH

13th AUGUST 2022

EVENT NAME:

Headache HX & MX in ED with PLAB OSCE Session by DR Shum Dev

DOCTORS FEEDBACK

FEEDBACK # 1

Ali Kazim

It was a comprehensive and informative session on headache . I learned a lot about history taking , examination, D/D'S , and management plan . It will surely help us in the future.
Thank you Dr Ash and Dr Shumontha Dev .

FEEDBACK # 2

Hani Suhail

A quick and comprehensive way of dealing with a patient with headache with setting a main diagnosis without being scatterred around is what we should focus on and what was taught today. Everyday we learn something that we miss and need to re visit . Thank you it was a great session.

FEEDBACK # 3

Javeria Siraj

Thanks to Dr. Shumonatha and Dr. Ash got to learn a lot about history taking, diagnosis, and management plan of headaches in the ER. and also about the importance of time management in clinical and OSCE settings... Looking forward to applying these in practice.

FEEDBACK # 4

Muhammad Wajeeh Labar

Amazing session where I learned the right history and treatment for the main headache reasons. For example, subarachnoid haemorrhage brain tumours, clusturs, and migraine I was shocked to learn about headache warning signs. learned how to use an examination to make a diagnosis. Thank you Dr. Ash and Dr. Shumontha Dev for today's wonderful session on how to avoid performing unneeded tests and providing appropriate treatments

FEEDBACK # 5

Sadia Khan

Very focused yet compherensive approach to patient presenting with headache 👍 ..learned differential diagnosis..nice session it was thank you Dr shum and Dr ash and nice presentation by Dr sawaira..

FEEDBACK # 6

Hamna Kirn

Todays session was very well organized.
Everything was explained in detail and it made it easier to understand. learned how to differentiate between the type of headache, how to make diagnosis on the basis of history and then do only relevant investigation to confirm our diagnosis.
Thanks alot for this amazing session

FEEDBACK # 7

Warda Yawar

Very informative session by our beloved presenters
Approach to reach the diagnosis made easy learned alot.
Thank you dr ash and dr shum dev

FEEDBACK # 8

Yasir Dilawar

A very good approach to headaches.it was a nice session by Dr Shum.he gave us very valuable advices on how to approach a headache case and it's management.thank you Dr Ash for arranging such a nice session.presentation and osce part was also good.👏

FEEDBACK # 9

Fatima Asad

Dr Shum Dev's lecture on headache history and management was very elucidative. He not only went through basic history- taking skills, but also taught common causes of headache presentations in the ER and how to manage them. These lectures are very eye opening as the way we take histories here and manage cases is so different and needs a lot of improvement. I am very grateful for Dr Ash to have organized this course, it is very much needed!

FEEDBACK # 10

Muhammad Ibrahim

It was a wonderful teaching session with Dr shum Dhev about headache. How to rule out primary and secondary causes of headache in ER, and red flag symptoms which can help us in ruling out serious causes of headache, everything was comprehensively taught by Dr Shum. Thanks Dr shum Dhev.

FEEDBACK # 11

Sawaira Gul

It was a very informative and Interactive session. All the major History points were discussed in detailed in such a short period of time. It made all of the possible differentials very clear. Very Thankful to Dr.Ash for giving me the opportunity to present the case on Headache and Giving me constructive feedback. Looking forward to such amazing future sessions as well. keep👍🏻

FEEDBACK # 12

Faiq Uz Zaman Khan

Great session on headaches , Dr Shum gave us a structured approach to a symptom with a pretty diverse etiology ... Indeed a great teacher

FEEDBACK # 13

Dr. Muhammad Amash Khan

Today’s topic was on headache in ED by Dr. Shum dev which he briefly described the history, types, causes, red flags and investigations related to headache.

FEEDBACK # 14

Umair Khalil

Had a comprehensive discussion about headache cases in ED. Learnt how to approach the case of Headache, what points might need to be covered in history taking. Discussion started with case presentation by Dr Swaira followed by case discussion and presentation by Dr Shum.

An osce station was performed by Dr Mina and Dr Shum and whole fiscussion was summarised comprehensively by Dr Ash.
Overall it was an informative session with good studying points.

FEEDBACK # 15

Muhammad Saad

Had a brilliant session. Quite informative and made a precise track for diagnosing headache emergencies in ER. Class started with a case discussion, approach to the patient's concern, ruling out the differentials via history were comprehensively discussed. Thanks alot Dr Ashfaque and Dr Shum Dev for this informative session.

FEEDBACK # 16

Dr Muhammad Ghayoor Khan

It was a comprehensive session on one of the most common case in ED i:e Headache.
We have a lot of patients with complaint of headache in our ED/OPD of our hospital,after this case base discussion,I am able to take history also to rule-out different causes of headache and their mangement .Also to look for Red Flag sign first then further management.I will avoid unnecessary ordering of investigations like CT brain which will expose my patient to unneeded radiations.
Thanks
Dr.Shum Dev and Dr.Ash

FEEDBACK # 17

Dr Faizan Ur Rehman

So starting with a brilliant presentation by Dr.Sawaira. A great case presentation on migraine really set the right tone for the rest of lecture. Her case was really precise and to the point and I've never understood concept of migraine better.
Moving on to the presentation by Dr.Shum. Words can't express how easy it was to understand clinical presentation, management plan and how to perform in an OSCE. Absolutely amazing he really set the standard high for all the upcoming lectures.
I learned how to rule out the red flags which I think is very important for someone like me who wants to pursue emergency medicine in the future.
It very well summed up. I would really struggle when ruling out secondary causes of headache. Now I'm bit more comfortable in that regards. Especially now I classify it as mild, moderate and severe and this classification is working wonders.

20th AUGUST 2022

EVENT NAME:

Abdominal Pain HX & MX Plan with PLAB OSCE by DR Michael Traur & DR Ash

DOCTORS FEEDBACK

FEEDBACK # 1

Hani Suhail

A directed approach to our minds with a simple breakdown of sophisticated pointers to help us redirect our path to a better way towards understanding Abdominal Pain with all the high yield points regarding approach, management and ED dealings.
And a simplified OSCE session. With what areas we keep missing on.
Thank you Dr. Michael Traur and Dr. Ash.
Every session is a step towards better management.

FEEDBACK # 2

Saba Asghar

Abdominal pain from surgical perspective was summarized very well in the lecture today by Dr. Michael Traur. The osce station on Abdominal Pain also helped us clarifying what is expected from us as foundation doctors. And how to lead the history in that direction. Really helpful. Thank you Dr. Ash

FEEDBACK # 3

Abdul Ghaffar

Thanks dr Ash and Michael traus , I leard today how take history of abdominal pain what is relevant questions asked from patients..... I admired to doc Michael traus, when a pregnant lady [9 month] came to hospital with appendicitis how to identify this pain of appendix vs cholecystitis ... and management. Thx doc Michal

FEEDBACK # 4

Ali Kazim

It was an Amazing session On abdominal Pain . I learned allot about the differentials and current methods of treatment .
OSCE presentation was wonderful learned allot from it .
Thank you Dr Micheal and Dr Ash !

FEEDBACK # 5

Aiman Nazir

Thank you to such amazing doctors Dr Traur and Dr ASH for conducting a very comprehensive lecture /session.

The golden rules, categorizing the abdominal pain in different domains and easily differentiating different types of abdominal pain on basis of history is the most unique and simple approach. And not just treating the symptom and disease but to manage the patient as whole is the real key. Indeed a confidence boosting session to manage patients with abdominal pain.

Thankyou so much.

FEEDBACK # 6

Marryam Masood

Thanks Dr Ash and Dr Michael, attended today's lecture on Abdominal pain Hx taking and Mx in Ed teaching us precise, to the point approach towards pt. Not only this lecture but previously all of the lectures I have attended are making my clinical practice better. This course is exceptional 👏

FEEDBACK # 7

Javeria Siraj

Thanks Dr. Michael Traur. It was an informative and insightful session about abdominal pain... Learned about various differentials, their presentation and treatment plan.

FEEDBACK # 8

Muhammad Saad

An amazing session. Sir Micheal did really hard work on the presentation. Learned alot of differentials and the most important rule of three of not to miss in elderly, young males and females. The Osce station was very good. Dr Ash the reasons of failing the OSCE station and how to overcome them.👍👍

FEEDBACK # 9

Areeba Shahid

Indeed very helpful session with so much to learn. Thankyou Dr Ash and team. You're doing such a great job. Today's session was on abdominal pain and Dr Micheal Micheal nicely explained all the acute presentations, differentials with management plan. Last but not least the Osce presentation was an amazing insight.

FEEDBACK # 10

Muneeb Jawed

Thanks dr michael! The session taught me how to deal with abdominal pain in an organized way!. Very informative

FEEDBACK # 11

Warda Yawar

Legendary man dr micheal traur you explained and summarized everything in an hour

You describe almost every region of abdomen

Thank you so much

It will help us alot in our surgery and medicine rotation 💯

FEEDBACK # 12

Muhammad Ibrahim

A very focused and comprehensive session By Respected Dr Michael Traur and Dr Ash on the topic of abdominal pain diagnosis and management. With this 1 hour session, every case with abdominal pain presenting in ER can be confidently assessed and managed properly. Thanks Dr Michael and Dr Ash.

FEEDBACK # 13

Sadia Khan

Wonderful session it was with Dr Michael!Learnt Causes of Abdominal pain and how to rule differential diagnosis with help of history.. He taught "Golden rules of Belly" never heard before..and much more! Thank you Dr ash and Dr Micheal and London GEM team for the session..

FEEDBACK # 14

Sadia Anwar

Great session with Dr Michael.The way he divided the Abdominal pain into 5 main causes(Vascular,Urological,Gyane,Medical,Surgical)was a new thing for me as we always studied on quadrant basis. Thankyou Dr **Ashfaque Ahmed** ,Dr Michael .

FEEDBACK # 15

Obaid Ur Rehman

An absolute masterclass of a lecture by Dr. Michael Trauer .The way he categorized the abdo pain in various specialities (vascular ,urological, gynaecological etc made it so much easier,and included every possible condition that can present with abdo pain.Renal colic admission criteria,golden rule of belly,sonographic murphy sign,twist score of testicular torsion,permissive hypotension in ruptured AAA were some of very interesting and high yield things that i learned.Hoping to learn more from Dr.Michael ,he has a nice way of

teaching,simple ,on point and interesting.Thanks Dr Ash for arranging this session and many many **congratulations** for London college of EM.Hoping to be a part of it too.InshaAllah

FEEDBACK # 16

Dr. Muhammad Amash Khan

Beautiful lecture given by Dr. Michael on abdominal pain in which he divided it into systemic causes like vascular, urological, gynecological, medical and surgical, and further explained the key findings for the diagnosis of different diseases causing abdominal pain.

FEEDBACK # 17

Yasir Dilawar

Today we had a live session with Dr Michael Traur and Dr Ash.it was about abdominal pain and how to diagnose and manage different cases.so much to learn from this experience.Thank u to Dr Michael.

FEEDBACK # 18

Wajiha Mughal

Thanks dr Ash and team for this amazing session on abdominal pain with dr. Michael. Learned many things today.

FEEDBACK # 19

Wardah Hasan

Thanks dr ash and michael traus i learned different ways to take history of abdominal pain . This lecture has greatly helped me in enhancing my knowledge esp related to designing a management plan.

FEEDBACK # 20

Salman Wazir

It was a great session a good revision of key medical issues seen frequently in ED and clinical pearls that will prove beneficial in triaging and prioritising treatment for patients seeking care. It is a good programme for anyone who wants to up their game in ED. Thank you for the opportunity Londom GEM, Dr Ashfaque and Dr Micheal. Looking forward to working with you someday soon.

FEEDBACK # 21

Umair Khalil

A comprehensive 1hr of learning on abdominal pain in ED was done in this session with Dr Michael Traur m, EM Consultant St.Thomas Hospital, London.

Dr Michael told a systemic approach to Abdominal pain, categorization of the pain and followed by step by step discussion of each group of complain.
After presentation, there was case discussion on abdominal pain according to mock PLAB 2 osce pattern by a GEM Candidate. Later the session was concluded by Dr Ash.

FEEDBACK # 22

Mina Ali Shaikh

The systemic way to approach the abdominal pain was very comprehensive. Going by this method, it's unlikely to miss any serious or life threatening cause. Dr. Michael is a good teacher who subliminally teaches to have a holistic approach towards the patient. Dr. Ashfaque, despite not taking the lecture himself, was actively present and is always encouraging to further our post-graduate learning.

FEEDBACK # 23

Dr Muhammad Ghayoor Khan

It was a wonderful session on abdominal pain by Dr.Micheal Trauer.
I have learnt a lot of learning points fron this session such as ;
1. Make your patient comfortable first, and show empathy
2. Blood in the stool of 70 year old male doesn't always means that it is a colorectal carcinoma, first you have to rule out other causes as well.
3. Before jumping directly to the investigations in management, go with examination first.
4. Never declare the diagnosis of cancer during exam, if you have it in mind, just keep it last in your differentials.
Dr Fatima Asad presnted the case on abdominal pain brillliantly.
Thanks
Dr.Micheal and Dr.Ash

9th OCTOBER 2022

EVENT NAME:

FRCEM PRIMARY RAPID REVEIW WITH DR ASH SESSION 2

DOCTORS FEEDBACK

FEEDBACK # 1

Abrar N. Syed

Back to Back Sessions on one of d Most Complex subject in Med School, yet made so easy n Exam Oriented by none other than DR Ash Himself.....Taking These sessions not only lead to loads of academic learning but also gave an in-depth insight about how to skim n skip certain things when studying for an exam.....It basically lead to awareness about how to approach the material when preparing for exams instead of decades old methodology of Cramming Things up.....Thank You So DR Ash !!!

FEEDBACK # 2

Dr. Afifa

Greetings of the day!!

Dr. Ash you will make us all fall in love with pharmacology.

Pharmacology was always a daunting and dry subject for me and very volatile, but after attending Dr. Ash's lecture of pharmacology my opinion has changed, the way he teaches us with clinical references and highlights the AnE related important points is commendable.

We covered vasodilators,ACE inhibitors, statins, sodium nitroprusside, alpha blockers, calcium channel blockers, sympathomimetics, anticoagulants, beta 2 agonist, antimuscarinics, corticosteroids, dexamethasone, hypnotic and anxiolytics, antipsychotics, lithium, tricyclic antidepressants .

Few pearls from the lecture:

1. Nitrates are contraindicated in RV infarct
2. Keep in mind methemoglobinemia and cyanide poisoning due to sodium nitroprusside
3. Alpha blockers can cause postural hypotension
4. ACE Inhibitors can cause hyperkalemia
5. APTT monitoring for heparin initially 3 hourly than 6 hourly than once daily
6. Role of protamine sulfate in heparin reversal
7. Aspirin should be discounted if tinnitus develops
8. Role of dexamethasone in cauda equina
9. Diazepam can cause neutropenia
10. Antipsychotics and QT interval prolongation relationship

Thanks Dr. Ash for your time and hard work.

FEEDBACK # 3

Dr. Aleena Rahman

It was indeed a rapid review session. In 2.5 hours, Dr. Ash covered more than half of the pharmacology. As always, he delivered an immaculate lecture, filled with clinically and exam relevant knowledge. We studied about medicines of heart failure, ACEIs, Beta blockers, CCBs, Adrenaline/Epinephrine, Anticoagulants, CNS medications, TCAs, Aspirin and many more. Important take home messages were:

Muscle twitching, bradyarrythmias, headaches due to cerebral vasodilation, somnolence are some side effects. Decreased platelet aggregation, methmoglobinemia and cyanide poisoning is a serious side effect.

ACE Inhibitors are contraindicated in pregnancy and bilateral renal artery stenosis. Sodium nitroprusside drug reservoir needs to be protected from light source and sunlight. Do not use verapamil for wide complex tachycardia. Nifedipine should not be used in cardiogenic shock. All CCBs cause headaches and dizziness. Atropine is not effective for MOBITZ TYPE II block and 3rd degree block. Adrenaline is the primary drug in resuscitation. In pregnant women with mechanical heart valves, warfarin should be given otherwise pregnancy is a contraindication for warfarin. Statins cause rhabdomyolysis and statin induced muscle breakdown. Salbutamol causes tremors, tachycardia and transient hypokalemia causing muscle twitching. Atypical antipsychotics have a higher rate of metabolic adverse effects and weight gain. Amitriptyline also has anticholinergic effect (urinary retention, dry mouth, glaucoma).

Thanks Dr. Ash for teaching us pharmacology in the best way possible.

FEEDBACK # 4

HK Danish

These days due to dry weather and recent pandemic we face a lot of patients with respiratory symptoms and in older patients and trauma CNS symptoms are also presented . This lecture helped me a lot in understanding drugs related to respiratory and CNS .I learned how to administer drugs in a proper doze for a symptom , all the contra indications and adverse effects regarding CNS and respiratory system .

Respiratory system :

l Always check serum K before giving regular salbutamol nebolization .

l Role and mechanism of action of dexamethasone in edema and inflammation .
l Ipratropium Bromide causes glaucoma .
l Aminophyline causes headache , tachycardia and tremors .
l Hydrocortisone causes hyperglycemia , delirium and hypokalemic alkalosis .
l Beclomethasone are used chronic asthma .

CNS :

l Hypnotics and anxiolytics : diazepam causes neutropenia & jaundice in long term use . They act on GABA receptors .

l Chlordiazepoxide : Used in alcohol withdrawal . Starting doze 40mg/day then lowering the doze gradually .

l Lorazipam : Quick action , sedative , 1 to 2 mg as anxiolytics and 4mg in seizures.

l Anti-Psychotic : Dopamine D2 antagonist . They cause tardine dyskinesia , neurolyptic malignant syndrome . They prolong QT interval . Safest injection to calm the patient Fluphenazine .

l Atypical Anti-Psychotic : Olanzapine , Chozapine , Quetiapine

l Anti manic Drugs : lithium toxicity should be monitored if the patient is of anti psychotics . Range of Li toxicity is 1 to 1.5meq/Lit . Lithium causes hand tremors.

l Tricyclic Antidepressants : Amitriptyline can cause divergent squint techi arythmia . Most sensitive tool for **TCA overdoze** is ECG and VBGs are also helpful . Brugada patren is noted in ECG (ST elivation in lead V1--V3) . Management includes gastric levage with activated charcol , reduces absorbtion of TCA . second management Bicarbonates replacement .

12th NOVEMBER 2022

EVENT NAME:

Brady Arrhythmia for MRCP1-2 & PACES by Dr Nahal Raza Cardiology Registrar NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Bushra Khan

Dr Nahal Raza is a very energetic and interactive speaker. All the cardiology lectures I have attended from her is always worthy of my time. Today's topic Brady Arrhythmias, she covered very comprehensively. She included main important topics which would be relevant for MRCP and clinic practice like different heart block ECGs their symptoms as well as management. Different types of Pacemakers and Defibrillators.

A very good lecture overall and look forward to more from her. Thank you so much Dr Ashfaque and team for all the hard work.

FEEDBACK # 2

Faiza Baig

It was an extensive, energetic and effective interactive communication.

First of all she told about Martin Brady who holds the world record for the slowest heart rate.

She included main topics:

- Classification and causes of Brady arrhythmias (transient, persistent, permanent)
- Different types of ECG's which includes

1st degree, 2nd degree and 3rd degree heart block

- RBBB, LBBB
- Trifasicular and bifasicular axis deviation
- Types of Pacemakers and Defibrillators.
- Management of Brady arrhythmias i.e.

Transcutaneous pacing

I learned clear and consistent information with skillful objectives.

Thanks Dr Ashfaque and Dr Nahal for such an organized and detailed discussion.

FEEDBACK # 3

Sidra Asad

Excellent presentation which comprises of a variety of ECG's which are truly important not only for the exams but for daily clinical practice.

Dr Nahal interactive way of teaching and putting so many graphic figures and flow charts makes her lectures unique and understandable. I have always learnt immensely from her lectures and always make me go back to her slides while making my own notes. All points in this ppt were up to the mark which meets current NICE guidelines expected to be learnt in exam. The classification of brady arrhythmias according to anatomy (above ventricles, Av nodes…) and according to

duration of symptoms (transient, persistent...)+ explaining all ECGs step by step and indications of pacemaker were explained in detail.
She has explained the real life scenarios with these ECG's and has emphasized on how to diagnose on the basis of ECG's.
Thank you much for always giving outstanding lectures.

FEEDBACK # 4

Sadia Abbasi

Thanks Dr Nahal Raza for a great, energetic and interactive session.
I learnt a lot, Classification of Brady arrhythmias, heart blocks, bifasicular , trifasicular, axis deviation, RBBB, LBBB how to identify these in ECG which is always confusing for me😇. I learnt so many new things especially about pacemaker's types, codes and their use according to NYHA Classification.
Amazing session all credit goes to Dr Ash and his team. Thank you very much Sir.

FEEDBACK # 5

Beenish Naveed

Powers pack session with a lot of explanation on ECG and identify the types of heart block. Starting with the classification of bradycardia and the underlying pathophysiology and its explanation and treatment was all up to the mark. Clear many doubts about the ECG and how to approach the patient. Explanation of NYHA classification and detailed criteria of which patient requires what is amazing. Dr Nahal has got an amazing talent of teaching with keeping audience engage all the time. I cannot imagine this session could be so interesting because of her way of teaching, such an amazing teacher.
Big thanks to Dr Ashfaque who provide the opportunity for us to learn in this way.
Thank you Sir and thank you LGEM Team

FEEDBACK # 6

Faisal Butt

Today's Session was delivered by Dr. Nahal Raza, Brady arrhythmias and its related ECG findings always confused me ,but after today's session, my concepts were cleared and learned a lot of new things and important stuff regarding Brady-arrhythmias. A lot of ECG's were shared which were very helpful in understanding the main concepts. I learned following points from today's lecture; Brady-arrhythmias and classification: sinus node disease (sinus Brady cardia, sinus pauses, tachy-brady syndrome and chronitropic incompetence)
Sinus Arrest (absence of P-wave for >3sec)

AV node and His purkenjie system disease (1st degree, 2nd degree mobitz type 1 and 2, 3rd degree heart block) RBBB, LBBB,
Bifasicular (Axsis deviation + BBB), trifasicular (Axsis deviation + BBB+1st degree heart block)
Red flags Of Brady-arrhythmias
Management of Brady-arrhythmias, transcutaneous pacing including indications of pacemaker and PPM nomenclature .
Use of single chamber ICD, dual chamber ICD and biventricular device
Thanks Dr Nahal Raza
Thanks Dr. Ashfaque Ahmed for facilitating the whole session,
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 7

Dr. Nasir Hayat

Wow this was very well presented session i liked it the most Amazing session. I learned a lot and enjoyed the session. The session was very well taught, well organized, practical session and full of medical knowledge. The ECG's was fantastic. I high recommended for doctors and physicians to join it to have the depth of knowledge and be very skillful. This is the unique style of Teaching of LGEM MRCP and SIR Dr. Ash.

FEEDBACK # 8

Dr. Ghulam Saddique

From the start whole of the session was full of enthusiasm and immense knowledge. It started with symptoms of brady-arrhythmias and classification: sinus node disease(sinus brady cardia, sinus pauses, tachy-brady syndrome and chronitropic incompetence)
Sinus Arrest (absence of P-wave for >3sec)
AV node and His purkenjie system disease (1st degree, 2nd degree mobitz type 1 and 2, 3rd degree heart block) RBBB, LBBB,
Bifasicula (Axis deviation + BBB), trifasicular (Axis deviation + BBB+1st degree heart block)
All the common and rare causes were discussed along with insight on red flags.
Management of Brady-arrhythmias, transcutaneous pacing including indications of pacemaker and PPM nomenclature, also discussed about single chamber ICD, dual chamber ICD and biventricular device.

Thanks to Dr Ash and Dr Nahal for conducting that session. I am proud to be a part of London GEM Programme.

FEEDBACK # 9

Dr. Abubakar

Today i learned about presentation, causes, classifications of brady arrhythmias
I also learned about different ECG presentations
Mobitz type 1&2, right and left bundle branch blocks, complete heart block and many more, learned about pacemaker use and its indications, pacemaker code
Explanation of NYHA classification
Thanks Dr Nahal and sir ash.

FEEDBACK # 10

Dr. Leela Ram

It was full of knowledge with several new points, pictures and ECGs. It was outstanding session.
As a usual, she delivered her lecture with full pack of knowledge & added several pictures to demonstrate very well.
I have learned that Bradycardia isn't necessarily meant to have heart rate less than 60/min unless it presents with signs and symptoms . Some people in world may have genetically low heart rate ie, below 60/min despite that they live their life normally. Regarding Heart block, it may be transient, persistent and partial. Transient heart block is associated with thyroid dysfunction, Lyme disease or drug toxicity which is to be treated & rarely needs pacemaker while Persistent heart block is associated with some genetic diseases such as Sarcoidosis or Amyloidosis that will definitely be treated with pacemaker. Partial hear block is associated with fault with conducting systems so this similarly will need per cutaneous pacemaker. Red flags are hemodynamically unstable, abnormal ECG, Heart failure, ongoing syncope with Bradycardia, genetic disease, heart block.
This will enable me to take proper history of patients who present with lightheadedness, giddiness, short of breath, fatigue & sometimes fall. ECG, Holter monitor, Loop recorder & Electro physiological studies are required to diagnose such disorders. Treatment includes artificial pacemaker, dual chamber pacemaker, atropine, adrenaline, dopamine & warfarin.
The lecture was phenomenal with several different ECGs.
Thank you Dr. Nahal Raza for wonderful lecture & thank you so much Dr. Ash for guiding us on each step of this fantastic course & tireless dedication to us.

FEEDBACK # 11

Dr. Rizwan Siddiq

A wonderful session on brady arrhythmias by Dr Nahal , all types of bradycardias taught well, specially bifasciular and trifascicular blocks and all reasons needed, another important thing was pacemakers knowledge , how to classify them . Really informative, all management with practical approach and gone be applicable immediately. This program is going to be massive hit. Dr Nahal really worked hard for all slides and her presentation skills were so good, totally satisfied 👏👏👏

FEEDBACK # 12

Dr. Tooba Qadeer

Amazing learning experience, learned about types of Brady arrhythmias, chronotropic incompetence - diagnosed by a treadmill test not ECG, tachy-brady syndrome, referring urgently to cardiologist for mobitz type 2, 3rd degree HB, tri-fascicular block for pacemaker, types of ICD, CRT, a lot of ECGs. A lot of new concepts develop that previous unknown to me. Dr Nahal teaching style is very interactive and fun as always and it was a great lecture. Thanks.

FEEDBACK # 13

Dr. Mariam Sultan Khan

Another power-packed session by very energetic Dr. Nahal, It started with symptoms of brady-arrhythmias and classification: sinus node disease (sinus bradycardia, sinus pauses, tachy-brady syndrome and chronitropic incompetence) AV node and His purkenjie system disease (1st degree, 2nd degree mobitz type 1 and 2, 3rd degree heart block) RBBB, LBBB, Bifasicular, trifasicular.

All the common and rare causes were discussed along with insight on red flags. Management of Brady-arrhythmias, transcutaneous pacing including indications of pacemaker and nomenclature everything was discussed in great deal. Dr. Nahal has a talent to stimulate interest, explain concepts with exhaustive knowledge on the subject area. Her approach assists in digesting the topic.

Thanks to Dr Ash and Dr Nahal for this fruitful session. Looking forward to a power packed session tomorrow!

Regards Dr. Mariam Sultan khan

FEEDBACK # 14

Dr. Zeeshan Ayaz

An excellent session on Brady arrhythmias which covered a lot of things from types of Brady arrhythmias to identifying them on ECG and their management as well .I really like her interactive way of teaching. Today I learned different types of heart blocks, including trifasicular and bifasicular blocks .In the end she explained so well about pacemakers that it cleared all my doubts regarding their types, Codes and their use according to NYHA classification.

FEEDBACK # 15

Dr. Ahmad Tanveer

Superb lecture comprehensive detailed well explained, Types discussed and ECG quiz with explanations. Causes and then assessment in management approach. AV blocks were well explained with management options in ACLS setting and then PPM type's Interactive teaching at best as everyone has to engage. Again Thankyou Dr Nahal and Dr Ash for such a detailed and to the point with lots of confusion clearing aspects of Brady Arrhythmias discussed.

FEEDBACK # 16

Dr. Muhammad Akber

A wonderful session with much of explanation on ECG and heart block and explanation of each ECG, classification of bradycardia and its pathophysiology and treatment with new guidelines . Clearing much of doubts on types of blocks, Brady arrhythmia topic was very difficult for me Dr Nahal made it very easy along with ECG explanations.

Much thanks to Dr Ashfaque that's all is possible for us in Pakistan because of him for us to learn in this way. Thank you Sir and thank you LGEM Team

FEEDBACK # 17

Dr. Muhammad

Dr Nahal cleared my concept on tachy brady syndrome, trifascicular and bifascicular block, sinus arrest, sinus pauses, Av Node and his purkinjie disease by showing ECG and explained everything step by step with management including indications of pacemaker with their types. Her way of teaching is amazing and she delivers a lecture really well.

Thankyou Dr Ash and Dr Nahal

Alhamdulillah proud to be a part of London gem programme

FEEDBACK # 18

Dr. Aiman Saeed

As always today's session by Dr. Nahal was also very wonderful and interactive.

I learned a lot from today lecture.
From definition to management Of brady arrhythmias, pacemakers and it's types, the ECG's everything was well organized and the way she delivered was amazing
Thanks Dr Ash and Dr Nahal
Proud to be part of LGEM TEAM

FEEDBACK # 19

Dr. Shiraz Mehmood

Amazing session by ever so energetic Dr. Raza took us back to medical school and refreshed our knowledge starting with anatomy of heart, cardiac conductive system, classification and type of HB leading to actual ECG readings to identify types of blocks. Engraved causes, clinical presentation, red flags and then management of blocks into our heads, made teaching so much simpler with her interactive approach and encouraging people to participate in the discussion.
It was a pleasure attending her session today. This is definitely enhancing my clinical knowledge to manage my patients with more confidence.
Thanks Dr. Raza for an amazing teaching session and thanks to Dr. Sorathia for finding a gem to teach us such a common yet important topic.

FEEDBACK # 20

Dr. Arshad Ali Khan

Lecture was so amazing and informative. We learnt in this Lecture
1) Causes of Brady arrhythmia
2) Sick sinus syndrome sub types
3) All types of heart block and by ECG we can differentiate which type are heart block and its management
4) Updated management Protocol of Brady arrhythmia
5) PPM indication
6) CRT subtypes
Overall Lecture was so interesting and piece of cake of Brady arrhythmia
Thanks Dr. NAHAL RAZA AND DR. ASH

FEEDBACK # 21

Dr. Emmanuel Qammar

A great learning experience no stone left unturned conceptually and clinically.
Refreshing session covering
Symptoms of brady-arrhythmias and classification: sinus node disease(sinus bradycardia,sinus pauses, tachy-brady syndrome and chronitropic incompetence)

AV node and His purkenjie system disease (1st degree, 2nd degree mobitz type 1 and 2, 3rd degree heart block) RBBB, LBBB, Bifasicular, trifasicular.
Grateful to both the tutors for these conceptual lectures.
Especially for providing records for review and study :)

FEEDBACK # 22

Dr. Syed Kamran Hussain

Dr Nahal presentation was excellent and she discused the topic, Bradyarrythmias
Causes
Classifications of brady arrhythmias
Sinus bradycardia
Sinus pauses
Tachy_brady syndrome
Chronitropic incompetence
Av node
His purkinjee system
1st degree
2nd degree
Bifasicular
Trifasicular(causes n treatment)
Different ecg presentations
Mobitz type 1
Mobitz type2
RBBB
LBBB
Complete heart block pacemaker
Indication
Uses
Pacemaker code
ICD
Single chamber,Dual chamber
Discusion on Ecgs,(examination point of view)
Explanation of NYHA classification.
Thank you dr Nahal and Dr Ashfaque and Adm team👍👍👍

FEEDBACK # 23

Dr. Ghazala Sheikh

Session was amazing overall A very complicated case Of ECG is covered by Dr nahal Raza
Explanation of each ECG along with causes, management's all were discussed.
Pathophysiology of bradycardia its causes and management along with that
Heart block was discussed in detail
1st degree HB
2nd degree HB (mobietz type1 and 2)
3rd degree HB
RBBB LBBB

Dr nahal Raza and Dr ash made this comprehensive learning 🙌
Very grateful for the efforts of London.gem team inshallah these efforts will bring fruit someday

FEEDBACK # 24

Dr. Raja Mobeen Ahmed

Again, quite a comprehensive lecture on bradyarrhythmias by Dr. Nahal. I learnt about the causes of bradycardia and the ways a patient might present with if suffering from bradyarrhythmias.
There were some excellent ECGs interspersed during the lecture showing different pathologies like Sinus pauses, Tachy brady syndrome, different Heart blocks. I also learnt about a new term called chronotropic incompetence. The indications for insertion of Pacemaker were also discussed including Mobitz II, Complete Heart Block, Trifascicular block, Symptomatic Mobitz I.
The most important thing in this lecture, I believe, was the ALS algorithm for Bradycardia. A brief discussion regarding use of a Temporary/Transcutaneous pacemaker was also done. I also learnt about different transvenous pacemakers (the single and dual chamber ICD, Biventricular/CRT) and the use of CRT in Heart Failure and its indications depending on QRS width and NYHA class of patient.
Briefly, the nomenclature of the Pacemakers was also touched upon.
In conclusion, a very useful and important lecture which alongwith the previous lecture on Tachyarrythmias, has taught me a lot and will surely help me and my fellow students in saving patients suffering from these emergencies.

The lectures given by Dr. Nahal have been my most favorite in this MRCP course because she involves the students with frequent questions and her lectures are so well-made.

FEEDBACK # 25

Dr. Mohid Kannan

It was an interactive session by Dr. Nahal.

Main topics covered:

* Classification and causes of brady arrhythmias(transient, persistent, permanent)

*Different types of ecgs interpretation which includes

-1st degree, 2nd degree and 3rd degree heart block

- RBBB, LBBB, axis deviation

* Types of Pacemakers and Defibrillators.

*Management of brady arrhythmias i.e;

Transcutaneous pacing

I learnt a lot today with better understanding.

Thanks Dr Ashfaque and Dr Nahal for this session.

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

Dr Ramsha Tasnim

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 Mohid Kannan

Today's lecture covered anatomy of pericardium and related diseases.
Started from pericardial effusion *difference between acute and choric sign and symptoms
*echo finding of RA and Rv collapse with management.
*cardiac temponade
*becks traid and

* Indication for pericardiocentesis very well. *Pericarditis. Difference between constrictive pericarditis restrictive pericarditis and cardiac temponade,
*Xrays and ECG interpretation
Over all it was a very informative session differentiate between STEMI and pericarditis ecg.
Thanks Dr Ash and Dr Nehal for this wonderful session.

19th NOVEMBER 2022

EVENT NAME:

Elderly Fall A Challenge for Physicians by Dr Abinas Gurung ST6 Geriatric Registrar NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Bushra Khan

Very good Lecture, I build up on my previous knowledge of how to approach an elderly with a fall. What are the common causes, how to get to the actual problem of the fall because mostly elderly aren't very good historians. Our clinic knowledge will help us identify and manage the patient appropriately.
Dr Sheeraz presented a very good case.
Thank you London GEM team

FEEDBACK # 2

Hani Suhail

Today's session was regarding elderly falls and how to assess the patient. We learnt regarding the causes of falls and their impact on the elderly population and what are the most common causes including sarcopenia, gait and balance and postural hypotension other than that we learnt about the tests related to these condition and how to evaluate postural hypotension. Education has the major impact on the prevention and the management of the condition a person could suffer from. After that we learnt about how to be able to assess the patient from the history so we don't miss any part of their fall with a pre-incidental/ incidental/ post-incidental approach. Thanks Dr. Abinas and Dr. Ash for giving us this much of a needed enlightenment regarding geriatric assessment.

FEEDBACK # 3

Muhammad Abubakar

Very informative lecture about geriatric fall, how to manage and diagnose the cause. Dr. Ash's way of taking history and examination is fantastic which we also learnt today. Thanks Dr. Sheraz for the great case. The roll of educating patients in preventing further damage is also very important. Thanks Dr. Ash to give us the time during vacation. Enjoy Milan. Thank you LCC Team.

FEEDBACK # 4

Rana Gulraiz

Attended one of the great lectures indeed, Thanks Sir Abinas and Dr Ash to teach the best approach to take history and evaluate the causes. ❤️ Always feel bliss to have lectures from LGEM team.

FEEDBACK # 5

Ali Kazim

They beautifully explained the History taking, How to Examine manage and diagnose the Cause . We learned about different Scoring systems like sarc-f and frax . Its was an excellent session .
Thank you Dr Abinas and Dr Ash !

FEEDBACK # 6

Amash Khan

Todays lecture was a great one by Dr abinas started with the etiology then causes their clinical presentation and management and was taught about different scoring systems like sarc-f and frax and at the end Dr sheraz presented a case and Dr Ash taught himself how to manage geriatric fall case in ER.Thank you Dr. Abinas, Dr.Sheraz and Dr. Ash for this lecture

FEEDBACK # 7

Mukhtiar Pathan

Falls are marker of frailty, & acute or chronic health impairment in elderly people. Falls in turn diminish function by causing injury, activity limitations, fear of fall and loss of mobility.
Falls are a common, but often overlooked, cause of injury, and therefore is a challenge for Physicians.
Many Falls do not result in serious injury. But there is always a risk of Head injury, or bony injury which should never be missed.

And Today's Session on Elderly Falls by Dr Abinas & Dr Ash was conducted to educate we Physicians about the Falls, about assessment of patients with history of fall, and about management strategies.
Truly it was a superb session, and in the last Dr Ash beautifully defined pre-incidence, Incidence, and post-incidence assessment of patients, which no doubt will make us all able to appropriately assess and will make us capable to treat the patients accordingly.
Thank you Dr Abinas
Thank you Dr Ash
Thank you London Global Emergency Medicine (LGEM) Program
Thank you Pakistan Emergency Medicine Association (PEMA)

FEEDBACK # 8

Yasir Dilawar

It was pleasure for me to attend this lecture from Dr Abinas who is a senior geriatrician.we learnt causes of fall in injury.sarcopenia was new word for me and it is the most common cause of fall.risk factors.how to manage such patients.learnt about orthostatic hypotension and it's diagnosing method.And in the end a good case Presentation by Dr Shiraz.And of course Dr Ash doing his way of managing such patients.amazing thank you sir.stay blessed and enjoy.

FEEDBACK # 9

Imtiaz Ali Shah

Today we had an important session regarding elderly falls and approach towards their management by dr Abinash. It was an excellent session .During the session we learnt a bout
THE CAUSES of elderly fall including
1..MENTAL HEALTH (Alzhimers, confusion weaknesses etc)
2..VISION DEFECTS.
3...MUSCULOSKELETAL including SARCOPENIA
4...NEUROLOGICAL (Epilepsy stroke etc)
ENVIRONMENTAL .
Secondly we learnt about the imp effects of falls including
1..PHYSICAL (Brusing ,fractures, brain haemorrhages,Dehydration, death.)
2..IMMOBILITY.
3...MENTAL..(Depression, loss of confidence, Fear,)
4...SOCIAL (Inability lo leave home,Inability to travel.)

The last part of lecture was about the mangment of the falls which includes
EDUCATION
HYDRATION
SALT INTAKE 4...10MG/DAY.
HEAD UP....10 DEGREE.
LIFE STYLE MODIFICATION.
MEDICATION.
REVIEW...reduce polypharmacy.
It was a wonderful session by dr Abinash, he covered the whole topic in a very comprehensive manner and make the things easier to understand. At the end Dr Ash summarised the whole topic in his own style.
I would like to thanks dr Abinash for this wonderful presentation and also dr Ash for providing us such a great platform of learning in the form of London GEM.

FEEDBACK # 10

Qaisar Shah

Today's an excellent 1.5 hour session about FALL IN ELDERLY PATIENTS conducted by Dr Abinas ST6 Geriatric Registrat NHS UK,
Case presentation by Dr Sheraz & summarized by Dr Ash Consultant EM NHS UK
Dr Abinas covered the possible causes of FALL IN ELDERLY PATIENTS,Sarcopenia, Postural Hypotension its causes , proper method to monitor B.P & Management
Preventing Falls in elderly patients,Case Risk Identification,FRAX Score & Treatment, Multifactorial Interventions
Dr Sheraz presented a case of 84 years old female with Hx of fall covering all asepects from good Hx till Assessment & Plan
At last Dr Ash well summarized the whole topic & added that "Do not miss any serious Medical problem"
:Rule out the cause whether Medical/Mechanical
: Take good Pre-incident, Incident & Post-incident History
:Check for Major systemic problems then for minor systemic problems
Look for A,B,C
Orientation, movement,Gait
Important investigations (ECG,Blood sugar,CBC)
:Examine each system deeply

:Look for BONE HEALTH
: Rule out ➜Manage➜Referall
Such an amazing session & i learned alot
Thanks Dr Abinas, Dr Sheraz & Dr Ash for this nice session

FEEDBACK # 11

Faiza Baig

This topic included causes and effects of falls in the elderly.
How to set a plan and scoring for its management and how to assess these patients by different methods including retropulsive method.
Dr Shiraz presented a comprehensive case that was highly informative.
In the end Dr Ash summarized the details and how to approach these patients by doing major examinations and investigations.
Had a very instructive discussion.
Thankyou Dr Ash and Dr Gurung

FEEDBACK # 12

Nousherwan Soomro

Learned lot of new things, treating elderly require completely different holistic approach, Bravo Abinas 👏🏻 and as always **Ashfaque** never forgets to put icing on the cake 🎂 with cherry 🍒 on top

FEEDBACK # 13

Aqsa Yaqoob

An excellent session delivered by Dr.Abhinas gurung ST6 geriatric registrar on Elderly fall.we learnt 3 most common causes of fall in elderly: sarcopenia, postural hypotension and age related balance and gait problems. Causes of sarcopenia.How to check for postural instability.test for postural hypotension and many more new points.Dr.Ash taught us how to do complete assessment and stratify the risk of fall.
Thank you LGEM faculty for providing such an informative lecture.

FEEDBACK # 14

DrMaryam Iqbal

Maryam iqbal @ ...very informative and interesting lecture by Dr Abhinas...presenting fall in the elderly!!

FEEDBACK # 15

Hareem Zakir

Dr Ash always come out with something new from an overlooked topic.

Dr Abinas' lecture was phenomenal. fall is one of the most common problem with which elderly patients come in ed . The lecture beautifully covered the causes , risk factors,proper evaluation and history taking with pre incident, incident and post Incident questions, management of the patients. It also covered the quick tests which need to be done for the safe discharge of the Patient . It will definitely help us to treat the elderly falls and also save them from the risk of future falls.
Thankyou for the detailed descriptions. Already looking forward to tomorrow's lecture 😊
Thankyou Dr Abinas and Dr Ash.

FEEDBACK # 16

Faisal Butt

Todays Session was delivered by Dr.Abinas.Dr. Abinas is nice tutor, he kept the whole session simple and friendly.Learned alot
Importance of falls in elderly
Visual , Vestibular , somatosensory Causes of falls & Physical , mental and social effects of fall.
Sarcopenia, Causes of Sarcopenia,
Retropulsion Test
Pathophysiology & Management Of Postural Hypotension
Strength & balance Training.
Case presentation by Dr.Shiraz was very Comprehensive and good.
At the end , Dr.Ash gave his input and review about how to take history , examine and investigations for elderly fall case.
Also the Pre incident , incident , post incident history of fall.
Evaluate Major then Minor Organ system. ABC approach initially then check for orientation ,gait and movement
Risk assessment of fall.Time Up and Go Test.
Thanks Dr.Ashfaque Ahmed for facilitating the whole session,.
Thanks Dr.Abinas.
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 17

Muneeb Ahmed

Attended this an amazing lecture by Dr.Abinas and Dr.Ash on Elderly fall and approach to such patients.

Dr.Abinas gave a comprehensive review of the topic focusing on various causes of falls in elderly patients like sarcopenia,gait,visual,vestibular,postural hypotension and then he discussed multifactorial assessment using retro pulsion, and plan.
Dr.Shiraz presented an excellent case followed by Dr.**Ashfaque Ahmed** golden points in assessing such patients,especially history points (pre-post and incidental situation),Risk startification and system wise findings(major & minor) and management plan.
Thank you London Gem team for such amazing lecture.

FEEDBACK # 18

Amir Ashraf

It was a wonderful presentation which covered all the possible causes of fall in elderly , the new cause that i learned today Sarcopenia (age related muscle loss) .
Everything was briefly covered , learned a pattern to check postural hypotension and many others things .
Unfortunately iam on duty right now and was continuously involve in seeing pts so i couldn't concentrate much but the fractuon of lecture which is listened with concentration was amazing and Dr abhinas has always been a champ in delivering lectures 👍
Dr shiraz presented a very nice presentation , covered many parts from what Dr Abhinas talked and he presented very well .
And lastly the summary by our beloved @🇫🇸Dr Ash 🇵🇩 was super amazing , sir the way you give your way of assessing a patient is really intellectual , it really teach us how not to miss anything and reach on perfect diagnosis . Very well done 👏👏

FEEDBACK # 19

Warda Yawar

Today's an excellent 1.5 hour session about FALL IN ELDERLY PATIENTS conducted by london gem
Dr Abinas covered the possible causes of FALL IN ELDERLY PATIENTS,Sarcopenia, Postural Hypotension its causes , proper method to monitor B.P & Management
Preventing Falls in elderly patients,Case Risk Identification,FRAX Score & Treatment, Multifactorial Interventions
Dr Sheraz presented a case of 84 years old female with Hx of fall covering all asepects from good Hx till Assessment & Plan

At last Dr Ash well summarized the whole topic & added that "Do not miss any serious Medical problem"
:Rule out the cause whether Medical/Mechanical cause
Take hx
:Check for Major systemic problems then for minor systemic problems
Orientation, movement,Gait
Important investigations (ECG,Blood sugar,CBC)
:Examine each system deeply
Such an amazing session & i learned alot
Thanks Dr Abinas, Dr Sheraz & Dr Ash

FEEDBACK # 20

Dr. Mishal Shan Siddiqui

The session by Dr Abinas on "falls in the elderly" was indeed an eye opener for me as it provided me with a whole new insight of not only how to approach an elderly person experiencing a fall but also taking measures on my end to prevent future falls.
It beautifully taught us to keep in mind the factors which we often neglect while in an AnE setting such as assessment of postural instability and correctly doing the supine-standing BP. It also gave us some very simple yet effective tips on how to prevent falls. The session ended with Dr Ash providing an excellent summary of how to do history taking and examination of such a patient so we do not miss anything.
Really looking forward to more sessions such as these!

FEEDBACK # 21

Dr. Leela Ram

It was a wonderful session, gave an account of importance of Geriatric Medicine. It included all causes of fall in older people, prevention and timely treatment.
Dr. Abinas conducted session effortlessly, described all that one doctor should know about older people's unstable and deteriorating health.
I have learnt that Geriatric medicine is the most important specialty & such Geriatrics should be introduced in all medical related fields such as Biochemistry, physiology, microbiology & etc as a single subject. Government should ensure some investigations after age of 50 & management and prevention in Pakistan.
This session will improve my practices in view of geriatric medicine. I will see general health, mental health, all risk factors, nutrition and physical activities. I

will consider most cause that's, Postural hypotension & measure blood pressure in lying & standing up posture in 1 minute and 3 minutes apart. I will check eyes, ears, IQ, mouth, neck, chest and rest of body for holistic approach.
Our beloved Dr. Ash is always enthusiastic about teaching & learning at each moment of Medicine practice. He summarized includes head to toe approach, discussed risk assessment of older people who are under treatment and how to evaluate such patients. Pre-incidental, incidental & post incidental history and evaluation. He said that such patients should stand up & walk upto 3 meter, walk around 180° & ensure safe discharge after treatment. In the end, I must thank you Dr. Abinas & Dr. Ash for overall assessment & management of elderly people who are always prone to developing injuries and fall.

FEEDBACK # 22

Dr. Yasir Dilawar

It was very interesting lecture by Dr Abinas.we learnt so many new things like sarcopenia as the most common cause of fall in old age.orthostatic hypotension and how to check whether a person has orthostatic hypotension.some talk about the scoring system.what investigation can we do.and when to refer.Dr Abinas told that educating such patients is the most important aspect in managing such patients.a presentation by Dr Rizwan was very good.and in the end Dr Ash simplified things by his own style.pre incident.during incident,post incident.how to safely discharge a patient so a very comprehensive lecture.

FEEDBACK # 23

Dr. Ghulam Saddique

Falls in elderly are quite common, and we don't know as this fall is whether environmental or due to some underlying disease yet we don't know how to properly, approach such cases .Today I learnt about the causes of Elderly fall ,how to do risk assessment, FRAX score, AT4 score ,retropulsion test for postural instability .
Dr Shiraz presented a very good case which included almost all the ingredient which dr abinas taught us .
In the end dr ash summarised the whole lecture and shared his experience of how he handles cases of elderly fall in stepwise approach. This lecture will enable us to appropriately assess and manage elderly patients presenting with fall .
Thanks u dr Ash for providing such platform for not only furthering our careers but

also helping patients along the way .
I am proud to be a part of London GEM programme

FEEDBACK # 24

Dr. Nasir Hayat

This session was Amazing. It was taught well and organised well.Learned alot.It was excellently presented.I enjoyed the session it was runned smoothly.The case presentation was very wondeful.I would high recommend it for physicians to join to get skill ful and get the deepth of knowledge to be best physicians in future.

FEEDBACK # 25

Dr. Abubakar Tariq

Today was a Very good Lecture, because this topic is not discussed commonly
I learned today regarding common cause of elderly fall, how to do risk assessment, FRAX score, AT4 score, how to approach patients of fall.
Retropulsive method
And in the end how sir ash told his own way of approaching patients of elderly fall.
It developed a very deep understanding.

Thanks sir ash and sir Abinas
Thank you london GEM team

FEEDBACK # 26

Dr. Rehan Khalil

Greetings,
Just attended the zoom session by Dr Abinas on Falls in elderly. It was a very unique session im many ways. Previously i used to refer these falls in elderly to general body weakness but there are many other things to take into accoung as well.
Some of the new learning points are as mentiined below:
1-Sarcopenia - INVOLUNTARY muscle loss in elderly as one of the common causes of falls
2- SARC FC - tool used to assess the sarcopenia
3-Correct way of testing Postural Hypotension
4- Educations is the key to prevent falls. And it includes Hydration, Salt intake if 4-10gs daily, Head up atleast 10 degrees
It was amazing hiw Dr Ash summarized his way of approaching Elderly with Falls.
And tge most important thing he mentioned is:

How to Risk Stratify whether a patient is going to fall again or not by following 3 tests:
1- Ask patient to stand up from sitting position
2- TUG Test - Turn Up and Go test
3- 180 degrees Rotation test
At the end there was a case presentation by Dr Shiraz Mehmood.
Thanks for a wonderful session.

FEEDBACK # 27

Dr. Muhammad Saad

Today's session was based on one of the rarely addressed topic in clinical settings, assessment of falls in elderly. Dr Abinas Gurung did his best in explaining the whole session. He described common causes of falls in elderly, assessment and their management. Learnt about new concept of sarcopenia. Dr Sheraz presented the case at the end of session. In the end Dr Ash summarized the session brilliantly about assessing the fall, like whether the fall was medical or environmental, what the patient was doing during fall, where was the patient during the fall and ruling out systemic causes etc. It was brilliant session. Thanks Dr Ash and London GEM for such amazing session.

FEEDBACK # 28

Dr. Ghazala Nazeer

The session was quite helpful in preventing and managing elderly pateints in whom falls and fractures is a very common case. Thankyou dr Abinas gurung for such a informative session and much more Thanks to dr Ash who complied the whole scenario in such a wonderful way.
Proud to be a part of London gem

FEEDBACK # 29

Dr. Nouman

Another amazing session delivered by Dr Abinas Gurung. Many important things were taught from the point of view of a Geriartics Physician. We discussed the causes of fall in elderly population mentioning sarcopenia, postural instability, postural hypotension as a few of its notable causes. Every point was explained thoroughly such as testing for postural hypotension/somatosenory system, emphasis on history and management of the related riskfactors.

The case presentation by Dr Shiraz was a wonderful piece. It really was inclusive of the topic and as a whole reflected the approach of a geriartician towards such cases.
Dr Ash closed the session with his special remarks about his very own personal approach in dealing with such cases.
In short, it was the of the best sessions attended so far. We did a learn a lot of new and valuable information that we can use to furthur advance our clinical approach.
Thanks Dr Ash, Dr Abinas and Team LGEM
Regards : Dr Nouman

FEEDBACK # 30

Dr. Zeeshan Ayaz

Falls in elderly are quite common, yet we don't know how to properly approach such cases .Today I learnt about the causes of Elderly fall ,how to do risk assessment, FRAX score, AT4 score ,retropulsion test for postural instability .
Dr Shiraz presented a very good case which included almost all the things which dr abinas taught us .
In the end dr ash summarised the whole lecture and shared his experience of how he handles cases of elderly fall. This lecture will enable us to appropriately assess and manage elderly patients presenting with fall .
Thanks u dr Ash for providing such platform for not only furthering our careers but also helping patients along the way .

FEEDBACK # 31

Dr. Mariam Sultan Khan

Excellent lecture on elderly fall by Dr Abinas highlighting most common causes of fall in the elderly 1- age related loss of muscle mass(sarcopenia)
2- age related problems with balance and gait
3 - postural hypotension. All three causes were discussed in great detail along with causes, tests and management. He further elaborated on multifactorial assessment (cognitive impairment, continence problems, falls history, assessment of gait and balance, assessment of visual impairment) and lastly discussed multifactorial interventions.
Case presentation by Dr Shiraz was really significantly helpful in understanding Dr Abinas lecture in a clinical scenario.
Lastly, I cant be grateful enough to Dr Ash for summarising falls in elderly and tips to avoid errors in assessing elderly falls, the importance of history and to

justify medical fall or environment fall. Pre- incident, incident and post incident history questions. If its medical fall then major or minor system involvement. Examination and investigations to assess systemic causes. Risk assessment to avoid future fall. I have never seen such dedicated teacher and mentor as Dr. Ash

FEEDBACK # 32

Dr. Shiraz Mehmood

Amazing comprehensive topic. Started with burden on elderly fall and discussed pathological and non-pathological causes of fall with its management and lifestyle modifications.

Being a geriatric registrar, Dr. Gurung's command on the topic was amazing. Learnt retropulsion test, gait abnormalities and approaches to address those issues.

Dr. Sorathia closed the remarks by incorporating his own way of history taking, clinical examination and management ideas including risk assessments.

Thanks for the wonderful session.

FEEDBACK # 33

Dr. Shafiq

A well comprehensive lecture covering geriatric fall

We came to know who are eledely people by definition

Common cause of death over age 65.

Most common age related fall

Sarcopenia and its definition

Neurological dec muscle use

Settelite cell count decreased

Harmonal poor nutrition or any chronic disease

, 📌➡ sorcpopenic scoring system

➡ Posturinstability involve

Balencining due to vestibule cause

Somatosensation lost

Vusual impairment

📌Hoe to test post hypotension (test of retropulsion)

➡ Also decreased sensitivity in elder baroreceptor polymarphacy

🩹Mangment

Education hydration , salt balencing, headup while sleeping

Prevention involve multi factorial assessment bone health

Pont bt Dr ash
Pre incident incendenta and post incidental assessment
Systemic over view of cvc and cns
Bed side bp echo ecg cbc electolyte
Minor assessment
And risk assessment with particular test of walk

FEEDBACK # 34

Dr. Muhammad

Dr Abinas presentation was ver nice and simple. Topic he covered in his presentation was Importance of elderly fall, causes and management. Causes of sacropenia. Test we should perform in pt of elderly fall. Postural hypotension and its management. Overall he made things very clear. In the end Dr ash also had a talk in which he told his way of categorizing patient with fall in pre incident, incident and post incident. Also he told us about major and minor systemic review so that nothing can be missed. bedside examination by doing ech vbgs vitals and blood glucose. He talked about 3 meter walk test which was new for me. I must say Dr ash way of teaching is wonderful. Thankyou sir for initiating this program for non trainee doctors.

FEEDBACK # 35

Dr. Ahmad Tanveer

Most common causes of fall
Sarcopenia,age related problems with balance and gait ,postural hypotension. All three causes were discussed in great detail along with causes, tests and management. Mever heard of multifactorial assessment (cognitive impairment, continence problems, falls history, assessment of gait and balance, assessment of visual impairment)beautifuly explaonee and lastly discussed interventions.
Case presentation by Dr Shiraz was targeted helpful in understanding Dr Abinas lecture.
Thanks Dr Abhinas & Dr Ash for summarising falls in elderly and tips to avoid errors in assessing elderly falls, the importance of history and to justify medical fall or environment fall. Pre- incident, incident and post incident history questions. If its medical fall then major or minor system involvement. Examination and investigations to assess systemic causes. Risk assessment to avoid future fall.Great respect and love for my dedicated teacher and mentor Dr Ash .

FEEDBACK # 36

Dr. Tehmina Jamali

We studied that falls are common in elderly nearly 1 in 3 got fall.
Fall costs the NHS more than 2b/yr.
Ask elderly folks if they have H/O fallen ? Due to weaken/slipped/fraility/vision defect/mental health/musculoskeletal/neurological & epileptical/stroke/Parkinsonism...
Most common causes:
1)Age related loss of muscle mass "Sarcopenia"
2)Age related problems e balance & gait
3)Postural Hypotension
Sarcopenia means "Poverty of Flesh"
Age related involuntary loss of muscle mass.
Causes of sarcopenia
Neurological
Neuromuscular
Satellite cell content is reduced
Hormonal changes
Inflammatory pathway activation
Decline in activity
Ch.illness
Poor nutrition
Last 3& sarcopenia are vice versa.
There is difference in scans of young active & old sedentary pts scans.Loss of muscle mass seen in elderly.
Postural instability
-Inability to integrate sensory information & determine body oscillations in the upright position
-A disruption in any of these circuits lead to postural diaability
Visual
Presbyopia
Cataract
Macular degeneration
Vestibular
Testing
Retropulsion

Management is targeted at individual component
Postural Hypotension
When we stand 500-1000ml of blood drops to the lower half of our body
.Baroreceptors are triggered.Activation of the sympathetic system
Vaso constriction
Rise in BP & HR
Seen > in elderly < in young.
How to test:
Lying flat for 10mins
X3BP Readings
Standing for 1 min
Causes
Impaired baroreceptors in elderly .
Atherosclerosis/prolong rest/drugs/hypovolemia/Anemia(Iron deficiency anemia)/DM.
e.g.Astronauts.
Management
Education
Hydration(when wake up in the mornings & also don't jump up from bed just go slow)
Head up at least 10 degrees(when sleep flat barocereptors doesn't stimulate better)
Salt intake 4-10g/day
Life style modifications
Meds
Review-Reduce polypharmacy
Introduce volume expanders or sympathomemitics
Clinch your buttocks it increases venous return & improves cardiac output.
Advice stockings(ECS) for postural hypotension in elderly pts'.
Take with caution :
Flurocortisone
Tamsolin
Preventing falls in older pts
Case/risk identification
(Ask all pts >65 yrs if they had H/O Fall.
Mutifactorial Assessment

Cognitive impairement(forgetting)
Continence problems(rushing to toilet)
Falls history
Foot wear unstable(missing/have hazard/as lot of clutter at home one trips at home)
Advice never to wear heels & look to this also.
Assessment of gait/balance
Assessment of impairement
Should have medication review.
Bone health assessment
FRAX scoring & treatment
Multifactorial Intervention
Strength & balance training
Reduce falls by 42%
Home hazard assessment & intervention
Vision assessment & referral
Medication review with modification/with drawal
Take history of pt.in case of fall
Preincident & after
How & where it happened
Who came 1st/Help
LOC
Was ambulance called? etc
Is the cause medical?
Neuro/cardio/weakness/powerloss/warning sign/palpitation/blackouts/anemia/blood loss/drug history/big nails/.
Check ABC.
Check vital signs/all systems
Bedside test:ABG's /ECG/Blood sugar levels/SpO2
Think what the cause may be?
Sepsis/infection
Is the cause medical or else.
If pt.can walk or not may be #,or is he in pain & cannot walk admit him then less responsibility as will be looked after in hospital care.The pt.who walks is of more concern as risk of fall & re-visit with trauma.
If pt is alert then assess him.

Ask him to walk for 3m;go & come back.Time is 30 secs.
Then ask the pt to rotate for 180 degrees.They can't take more then 4 steps.
Then this is high risk case.
Stop Anti-HTN in postural drop.
Cortisol test at 9am for postural drop .
TED
ECS
stockings.
See the difference b/w Environmental & medical fall.
For Aortic stenosis bruit auscultate aortic area.
It was a learning session.
Minute to major points were highlighted.If followed timely& properly we can improve our pt's health status.
Thanks Dr. Ash for facilitating us to attend this important lecture by Dr.Abinas.

FEEDBACK # 37

Dr. Mohid Kannan

A Good lecture on elderly fall by Dr Abinas.
Discussed most common causes of fall in the elderly i.e
- age related loss of muscle mass(sarcopenia)
- age related problems with balance and gait
- postural hypotension. All three causes were discussed in detail along with tests and management. He further related on multifactorial assessment (cognitive impairment, continence problems, falls history, assessment of gait and balance, assessment of visual impairment and multifactorial interventions.
Case presentation by Dr Shiraz was helpful in understanding Dr Abinas lecture in a clinical scenario.
In the end dr ash summarised well and shared his clinical experience of handling cases with elderly fall. This lecture will help us to assess and manage elderly patients presenting with fall . Thank you d.r ash and Dr. Abinas

FEEDBACK # 38

Dr. Sadia Naveed

Greeting Sir
It was a good learning day by dr Abinas starting with elderly age 65 y and over ,causes and effects of Fall which r not only physically but mentally as well as socially.most common cause is sarcopenia in elderly apart from postural drop and

poly pharmacy . I learnt alot new things like testing of postural instability,how to test postural hypotension ,multifactorial assesment and intervention. FRAX Score. Dr shiraz present a case which is relevant to topic cleared more concepts regarding fall in elderly

Finally Dr Ash as usual gives his plan how he is approaching towards Fall in elderly which is very very comprehensive and systematic which i m going to apply in my clinical practice. Bundle of thanks for providing such platform for not only furthering our careers but also helping patients along the way .

I am proud to be a part of London GEM programme

Best regards

Dr sadia naveed abbasi

FEEDBACK # 39

HK Danish

ED is the first place for the patients any age with hx of fall . So it is very important for us the ED physicians to learn how to deal with them

I learned causes of fall in elderly

1. neurological / Neuromuscular decline
2. Sarcopenia (gradual loss of muscle mass , strength and function)
3. Hormonal changes (like in females may damage bone health)
4. Decline in activity
5. Chronic illness
6. Poor nutrition

Visual impairment :

A. Pres byopia

B. Cataract

C. Macular degeneration

Vestibular causes :

In 9th decade of life 40% of vestibular sensory cells are lost . Vestibular hair cells are also lost .

Somato sensory causes

Loss of touch , pro prioception and interoception .

I learned investigations related to fall in elderly

Management of the patients is related to the cause found

Postural hypotention :

I learned why postural hypotention occurs . when a person suddenly stand 500 to 1000 ml of blood drops to the lower half of the body , which results in hypotension.
I learned how to monitor BP in postural hypotension
Causes of postural hypotesion includes impaired baro receptors in elderly , atherosclerosis , Prolong rest
Drugs (Alpha blockers and muscle relaxants)
hypovolemia , anaemia
Management of hypovolemia , manage according to cause **, salt intake 4 to 10 g daily , hydration , head up at least 10% . Life style and medication review .**
I learned how to prevent fall in older people . case and risk identification . **History and assessment Frax scoring**

FEEDBACK # 40

Dr Shahid Ahmad

It was an amazing session by well known geriatrician Dr. Abinas.The things we learned in today's lecture are
1: Causes of fall, Sarcopenia the word i heard for the first time.
2: Orthostatic hypotension and it's diagnosing method
3: How to manage such patients
And in the end a good case Presentation by Dr Shiraz
Thanks Dr Ash

FEEDBACK # 41

Dr Muhammad Ghayoor Khan

It was again a wonderful session arranged by LGEM delivered by Dr Abinas,who is a senior geriatrician. He described common causes of falls in elderly, assessment and their management,Sarcopenia(gradual loss of muscle mass, strength and function) was new word for me and it is the most common cause of fall.
Also learnt about orthostatic hypotension and it's diagnosing method.Case presentation was good by Dr Shiraz.
In the end Dr.Ash summarized the session excellently about assessing the fall like whether the fall was environmental or medical,where was the patient,what was he doing during fall and rule out cause etc.
Thanks
Dr.Abinas,Dr.Ash and Team LGEM

FEEDBACK # 42

Dr Sadia Anwar

The lecture was regarding Falls in elderly which was delivered by Dr Abinas in a v efficient way.

There were many new learning points for me.

1)Sarcopenia as a common cause of falls in elderly.

2)Retropulsion test

3)Sarc F score

4)Educating the patient is the most important step in avoiding falls.

5)FRAX score

6)Balance and gait problems

7)Postural hypotension :how to correctly perform the test

Dr Shiraz did case presentation which was also v good.

In the last Dr Ashfaque told us his way of taking the history and managing such patients which made this topic even more easy.He told us how to address such patients by dividing the history into certain headings.

1) Medical vs Environmental cause

2)Pre incident ,incident,Post incident

3)Systemic examination of major and minor systems

4)Gross major system exam(Pronator drift,hip pelvis examination ,TUG test)

Thanks Dr Ashfaque,Dr Abinas for such a wonderful session.

FEEDBACK # 43

Dr Aiman Nazir

Today's session, delivered by Dr Abinas , an ST6 geriatric trainee, was a very comprehensive and excellent source of learning about elderly falls . Indeed these falls have been a great challenge for physicians and the healthcare system. Defining the age of elderly people and percentage of the admissions because of falls, Listing down the most common causes (like sarcopenia , postural instability and postural hypotension) and explaining each of them individually in terms of causes , tests and assessment and management was beautifully explained in much simpler terms and easy language with real life scenarios ad experience .Few new things I leant are SARC FC and Retropulsion test etc.

The best thing is that it not only increases our knowledge but also teaches us practical approaches to tackle the problems like by preventing falls doing risk identification)by FRAX scoring , assessment of gait/balance, footwear and visual assessment, medications review)and timely intervention(strength and balance

training, home hazard assessment and intervention , vision assessment and referral and medication review/withdrawal) to reduce these elederly falls and admissions . Very precisely every detail was mentioned and explained by Dr Abinas.
In the End DrASH summed up beautifully how to identify the cause of falls and how to assess it whether it's a medical or environmental fall by asking pre-incident and post incident questions in history , systemic history question , past medical and drug history . Careful examination starting with ABCDE and moving towards systemic and specialised tests not to miss strokes and other neurological causes.
Overall a very informative session and beautifully explained topic making it easy for us to approach elederly people with falls with confidence.
Thank you so much .

FEEDBACK # 44

Dr Muhammad Umair Khalil

Just attended this beautiful session of Fall in elderly by Dr Abinas. Session started with the clarity of concept that ppl aged 65 & above are considered in elderly age group bcz pension age in UK is 65. He beautifully explained various causes of Fall in elderly like Sarcopenia, postural instability and postural hypotension. Many detailed things like causes of sarcopenia whether neurological, hormonal, chronic illness or inflammation and causes of postural instability like visual, vestibular somatosensory were discussed. Retropulsion test and how to take BP readings to assess lostural hypotension were also discussed. Lastly he explained that we can manage such cases by education and of course medications using multifactorial intervention technique.
There was also a case base discussion by Dr Sheraz where he tried to cover maximum points taught by dr Abinas in his case
Lastly, Dr Ash summed up the whole lecture and also shared his own way of approaching such patients by dividing history into pre-incident, incident and post-incident parts.
This whole lecture was important because 1 in every 3 elderly patient has history of fall in a year and 14% of emergency admissions are of elderly patients with history of fall.
it was a very less discussed topic and we learnt significant things in todays session.
Thanks and regards.

26th NOVEMBER 2022

EVENT NAME:

Acute Renal Failure MRCP 1-2 & PACES By Dr Yasir Baig Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Sadia Abbasi

Excellent session by Dr Yasir Baig a quick review of basic anatomy,histology and physiology before discussing disease is Excellent approach. I learnt alot AKI definition, causes pre renal ,renal ,TMA and TTP,post renal causes,Approach towards AKI clinically (history, examination, investigation importance of urine dip importance of low platelets in FBC),how timely save a kidney (STOP for causes/risk),Prevention:4Ms monitor pt,maintan circulation, minimise kidney insult,manage acute illness,detail treatment for every cause.

Over all very much organised session covered from clinical side as well exame point of view 👌. Case scenario and case by Dr Ash excellent learning .Thanks dr Ash for London GEM MRCP programme.

FEEDBACK # 2

Sidra Asad

This lecture is the most amazing lecture i have ever attended. Dr Yasir has covered acute kidney injury and ARF in the best possible way.

In this lecture we were given 3 different cases related to 3 different causes of AKI and this topic was covered thoroughly from basic introduction to causes, patho and an extensive clinical approach in regards to history examination investigations and management.

Through this lecture, i have learnt new things, how to deal a patient of AKI when it comes to history and examination and proceeding from basic tests (urine dip, CXR, FBC, ECG, Urea and electrolytes) to special tests (immunological, renal U/S).

After attending this lecture,all my concepts are now clear regarding AKI basic anatomy, histology, causes, and clinical approach). 4 Ms of prevention (monitor, maintain, minimize and manage) and STOP(sepsis, toxins/drugs, obstruction and

parenchymal cause) for examination pointers were 2 very interesting things in this lecture.
Dr Ashfaque has also presented very interesting case highlighting the obstructive cause of AKI (case of hydronephrosis) and he has emphasized on the importance of bedside U/S to rule out some important causes.
Thank you so much for this amazing lecture.

FEEDBACK # 3

Mehak Nabi

Awesome session conducted by Dr yasir. Detailed session regarding basics of kidney along with pre renal post renal causes importance of urine dip 4Ms prevention baselines along with treatment plan and how good hx will lead towards ultimate diagnosis..osce station in end are always interesting with new cases...thank you Dr Ash for providing such platform and bringing best for us...

FEEDBACK # 4

Bushra Khan

Really good and simple slides. The way Dr Baig presented was really good. I really liked the histology slides along with each condition because MRCP 2 asks the diagnosis on the basis of histology so it was really well covered.
Pre renal, renal and post renal causes were covered comprehensivly along with management of each.
The osce session was really interesting and fun to do it myself. Still lots to learn how to speak to the examiner at the end and chalk out my management plan comprehensively.
The CBD by Dr Ashfaque was really good .
1.5 hrs well spent. Thank you London Gem

FEEDBACK # 5

Faiza Baig

Today's session was wonderfully explained and organized.
Dr Baig first described the anatomy and physiology of Kidney. Then what is AKI, its causes and contributing factors.
SAFE KIDNEY
- Approach towards AKI
- History and examination are important.
- Stop for causes and risks
-Prevention 4Ms

1-Monitor
2-Maintain circulation
3-Minimize kidney insult
4-Manage acute illness
- All the Investigations
- Treatment for pre renal and post renal
-Use the Resources for further management and plan
*NICE GUIDELINES
*KDIGO
*OHNH
Case discussion and OSCE done by Dr Bushra khan was amazing
In the end Dr Ash concluded the main points. It covered all the clinical side in a coordinated manner.
Thankyou Dr Sorathia and Dr Baig

FEEDBACK # 6

Mohid Kanan

Concisely explained and covered AKI by Dr Yasir Baig with a short review of anatomy,histology and physiology.AKI definition, pre renal causes, and post renal causes,history, examinations, investigation importance of urine dip and low platelets in FBC , mnemonic STOP. Prevention:4Ms
Treating the underlying causes
Thank you Dr. Yasar and dr. Ash

FEEDBACK # 7

Suhail Ahmed

Dr. Yasir has just provided great knowledge regarding AKI in a very short time.
From brief anatomy, histology and physiology to the practical management.
AKI definition, Causes, initial and advanced investigations.
He emphasized regarding Hx taking and examination by keeping important causes in the mind.
In the end the osce was superb highlighting all the important aspects of the lecture.
Thank you so much Dr. Yasir Baig and Dr. Ashfaaque.

FEEDBACK # 8

Beenish Naveed

Amazing session which starts eith giving us the background anatomy and physiology of kidney. Moving towards to identify the causes which are

Pre renal
Renal
Post renal
In depth knowledge of how to approach a patient and what to focus if the patient presents with wide range if symptoms specially in the emergency setting.
Picking the most vulnarable cause at right time safe the patient's life.
The 4 M approach to prevent the worst outcome :
Monitor
Maintain circulation
Minimize kidney demage
Manage acutely
In depth understanding of the definition and think from all the presprective given an edge after learning this topic.
Thank you Dr Ashfaque for arranging the top notch teacher and mentors for LGEM.
Thank you 🙏

FEEDBACK # 9

Faisal Butt

Todays Session was delivered by Dr.Yasir Baig on acute kidney injury in a very understandable way.
3 different cases related to 3 different causes of AKI were presented.Brief Anatomy and physiology of Renal function, Glomerulus and Nephron ,causes of AKI,Pre Renal , Renal And Post Renal were discussed in detail.AKI was also discussed according to Mrcp Station 5, history examination investigations and management plan.
Investigations (urine dip, CXR, FBC, ECG, Urea and electrolytes) and specific Investigations (immunological, renal U/S). 4 Ms of prevention (monitor, maintain, minimize and manage) and STOP(sepsis, toxins/drugs, obstruction and parenchymal cause) for clinical point of view.
Dr Ashfaque presented a very good case of obstructive cause of AKI (case of hydronephrosis).
Clinical Scenario disccusion by Dr.Yasir and Dr.Bushra was very interesting.
Indeed learnt alot of new stuff from this session
Thanks Dr.Yasir Baig
Thanks Dr.Ashfaque Ahmed for facilitating the whole session,

Thanks LGEM MRCP PROGRAMME

FEEDBACK # 10

Ram Leela

The session was comprehensive with anatomy, physiology, pathology of renal medicine.

He delivered his lecture amazingly, he demonstrated all with histology slides.

I have learned that Acute Kidney injury can be reversed with all essential quick management such as if patient develops Diarrhoea & Vomiting, quick rehydration therapy with crystalloid solution can reverse dehydrated state and thus saves Acute Kidney injury. So, many conditions which may cause Acute kidney injury can prevent. Urine dipstick test is the first test which will reveal blood cells, protein, infection, red cell cast, urine creatinine level

It will change my practice of renal medicine, I will always take proper history, do clinical examination and lastly management according to the case. I will oder urine dipstick test at the first visit & then subsequent investigation according to the need.

Dr. Ashaque presented hydroureter stone case, we learnt so much from it. ANCA associated Vasculitis case was an amazing discussion. Autoimmune diseases are mostly missed or undiagnosed in Pakistan. Thank you Dr. Yasar Baig, Dr. Ash, Dr. Bushra & Dr. Sheeraz for overall discussion. Thanks Dr Ash for your dedication to LGEM forum.

FEEDBACK # 11

Hassan Bugti

Excellent session by Dr Yasir ,

Thank you Dr **Ashfaque Ahmed**

FEEDBACK # 12

Dr Ghulam Saddique

Wonderful session which starts with giving us the background of anatomy and physiology of kidney. Moving towards to identify the causes which are

Pre renal

Renal

Post renal

In depth knowledge of how to approach a patient and what to focus if the patient presents with wide range of symptoms specially in the emergency setting.

Picking the most vulnarable cause at right time safe the patient’s life.

The 4 M approach to prevent the worst outcome :

Monitor
Maintain circulation
Minimize kidney demage
Manage acutely
List the KDIGO (Kidney Disease: Improving Global Outcomes) criteria for diagnosing acute kidney injury.
Investigation initially urine dip, ABGs ECG,Chest-Xray
If AKI along with low platelets then think of TTP.
Treatment; for post renal and prerenal treatment: start from Hx examination and initial management.
Renal/intrinsic needs more specific treatment.
The history pattern taken by Dr bushra was really good and I really learned alot from the presented case.
Dr Ash, presented the case of obstructive renal failure leads to significant hydronephrosis was unique and made us think out of the box and make Ultrasound as an initial approach as it helps in making diagnosis.
Once again thanks to Dr.Yasir Baig and Dr.Ashfaq.
I am proud to be a part of the London GEM Programme.

FEEDBACK # 13

Dr Nasir Hayat

This session was amazing and very well presented .I learned alot and enjoyed the session.The cases very wonderful.I learned about the AKI in very detail how to approach the patient investigation and treatment.I would highly recommend it to physicians to join it and get the deepth of knowledge and be more skillful and be best physicians.Proud to be candidate LGEM MRCP.

FEEDBACK # 14

Dr Ghazala Sheikh

It was a very comprehensive learning experience on Acute kidney Injury.
The lecture started on Anatomy, physiology and histopathology of kidney.
AKI definition, causes i.e Renal, pre renal and post renal along with TTP, TMA.
Importance of History and detailed examination of AKI pt.
Prevention (4Ms) i.e
M= monitoring pateint
M= maintenance of circulation
M= minimising kidney insult

M= managing Acute illness
Reference of,
NICE guidelines
KDIGO
OHNH were given.
Thanks to dr yasir baig who made our concepts very clear and elaborated each term.
CBD and OSCE by dr bushra was very amazing i learnt alot.
At the end dr. Ash our mentor elaborated hydronephrosis in detail and Importance of Ultrasound in diagnosis
Proud to be a part of London.gem

FEEDBACK # 15

Dr Syed Kamran Hussain

The session was well explained and well organized.
Dr yasir described the, Anatomy
physiology
Defunition ofAKI
Causes
Contributing factors
HOW TO SAFE KIDNEY
Approach towards AKI
History taking
Examination are important.
Precautions
Risks
4Ms
Monitor
Maintain circulation
Minimize kidney insult
Manage acute illness
Investigations
Treatment of pre renal
Post renal
Resources & management plan
International guidelines

NICE GUIDELINES
KDIGO
OHNH
In the end case discussion and OSCE done by Dr Bushra khan.Dr Ashfaque summarize the whoke session which covered all the clinical side in a excellent manner.
Thankyou Dr Ashfaque and Dr yasir

27th NOVEMBER 2022

EVENT NAME:

Lower Limb Injuries & Role of ED physicians by Dr Ehsan Riyaz Consultant EM NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Babar Hussain

Another marvelous session again on lower limb injuries conducted by Dr Ehsan. It again started with an excellent presentation by Dr Mishal.
Over all It was an Excellent and comprehensive session, everything in lower limb injuries including
~pelvic joint Injuries
~Fracture of bone of lower limb.
~Neurovascular injuries
~Foot injuries
~And management plans discussed in detail.
A lot of learning points and many new things like Weber classification, Lisfranc injury.
Thank you very much Dr Ehsan for the Excellent presentation and especially I really want to appreciate and learn how to cover such an extensive topic in a limited time and you have done it wonderfully.

I'm really thankful to Dr **Ashfaque Ahmed** for arranging such an important session.
So Thank you very much Dr Ash, Dr Ehsan, Dr Mishal and **London Global Emergency Medicine** .
Proud LGEM candidate.

FEEDBACK # 2

Syed Suhail Ahmad

Covering wide range of different ED presentations and their management that included fractures and dislocations of the Pelvis, Femur, Knee, Patella and all the way down to Ankle and torsal bones
Interesting and new learning points were
LISFRANC injury of the foot and its importance
Angiogram importance in knee dislocations to prevent ischemia and much more.
Thank you **London Global Emergency Medicine** and **Pema-Uk** 👍👍👍

FEEDBACK # 3

Rabiyyah Bashir

Indeed an interesting lecture with intricate details simplified.... ❤️
For me lisfranc injury and maisonneuve fracture were totally new.... Something i could have very easily missed.....
Thanku so much Dr. Ehsan for your precious time ❤️ and Dr **Ashfaque Ahmed** sir.... Thanku **London Global Emergency Medicine** ❤️

FEEDBACK # 4

Javeria Siraj

Amazing session by Dr. Ehsan on lower limb injuries... Learned quite a lot about injuries, from pelvis to phalanges... It was a comprehensive session which included everything from basic anatomy and xrays to the management... Thank you Dr. Ehsan for this great session

FEEDBACK # 5

Shehzad Hussain

Thanks to Dr Ehsaan n Dr Ash for a wonderful session on lower limb injuries, it’s a huge topic but covered up comprehensively.
As Pelvic fractures n classification of fractures investigation n management,
Use of pelvic binders, REBOVA, angiographic embolization.
Anterior posterior Hip dislocations and management,

Femoral head fractures 4 types garden classification of femoral neck fractures, intertrochanteric greater n lesser trochanteric n sub trochenteric fractures, femoral shaft fractures,
Knee n patellar dislocation tibial / fibial fractures,
Ankle joint and feet fractures investigation n management all this covered in a short time that's awesome.
Thanks to dr Mishal for wonderful presentation on lower limb injury.
Thanks dr Ash n LGEM team for amazing session.

FEEDBACK # 6

Abid Marwat

Aoa, lower limb injuries session today was extraordinary. I have learned many new fracture types and also grading classification along management in ED . Those X-rays with targeted findings are worth to save and refer back when in need . Thank you LGEM and Dr **Ashfaque Ahmed**

FEEDBACK # 7

Hani Suhail

Today's session on lower limb injuries was undoubtedly one of the most informative lectures taken as we covered alot of points in a short time with wonderful understanding regarding lower limb fractures dislocations and minute injuries which could be difficult for anyone to see. Role of x-rays, CT scan and maneuvers as well as basic anatomy with the different angles and the size and minor points to figure out the possibilities of fractures. It was a very interesting lecture to attend with the massive load of information in it. Thank you Dr Ehsan and Dr. Ash you have added alot of knowledge to enlighten us.

FEEDBACK # 8

فاطمہ ناصر

Another amazing session by Respected Dr Ehsan and Dr Ash
All lower limb fractures starting from pelvis to last bone of foot were taught.. it was amazing comprehensive lecture.. role of x rays, ct.. what we should expect in case of knew involvement.. bohlers sign were disscussed.. team pointed out so many important mcqs for intermediate exam too..

FEEDBACK # 9

Umair Khalil

A well elaborated session on lower limb injuries was presented today by Dr Ehsan, ED consultant NHS. Session started with a case presentation by Dr Mishal on

bullet injury puncturing the femoral artery followed by 1.5 hr discussion by Dr Ehsan. He separately elaborated pelvic, femoral, knee, leg and foot injuries ranging from common ones to the rare ones. Lots of classifications like Young Burgess classification, pipkin classification, introduction to REBOVA, how to apply pelvic binder,ER management of femoral, knee and foot fractures, when to refer patient to orthopedic team and when to send to home , all were discussed in detail. Lisfranc injury calcaneal fracture, how to see bohler angle and criteria for Xray of the limb (Ottawa rule) were also discussed. It was a wonderful session indeed.

FEEDBACK # 10

Noman Ahsan

Yet another great session by Dr.Ehsan... Covered all the joints and Injuries with comprehensive explanation and wonderfully explained how to diangnose fractures and how to manage them with they help of X rays...Learned new points regarding Bohler angle and Lisfranc injury...Weber classification was beautifully explained.. Thanks Dr.Ash and Dr.Ehsan for this wonderful session..it was very helpful ...

FEEDBACK # 11

Muhammad Wajeeh Labar

A fantastic presentation on lower limb injuries in the ED was given by Dr. Ehsaan Riaz.

He covered a wide range of novel ideas, from the fundamentals to radiological treatments. At the beginning of the session, a case study was also presented. Dr. Ehsaan spoke about a variety of topics, including: >Basic anatomy of the lower limbs >Pelvic ring fractures eg acetabular,single bone , Young Burgess classification: AP Compression fracturesm,Lateral compression fractures, vertical shear fractures,

All management protocols pelvic binder protocol, use of reboa.

Young Burgess classification: AP Compression fractures,Lateral compression fractures, vertical shear fractures,femoral shaft and distal femur fracture,knee disloaction and tibial fractures,ankle fracture and the last but not the least the management and diagnosing plan of rupture achiles tendon

Thank you to Dr. Ash and London GEM for organising such an excellent session.

FEEDBACK # 12

Rida Rana

Attended a super amazing and much much comprehensive session on Injuries related to Lower Limb . Cant believe that in just 1.5 hours Dr Ehsan presented the

enitre lower limb associated injuries including tje commonly missed out fractures and dislocations , the management options , normal anatomy, how to examine and look for associated injuries , role of ct in identifying the missed out fracture , classification of each fracture which are relevant and commonly questioned in RCEM examination . From pelvis till foot each and every point was highlited , explained and stressed upon in the most easy to learn method that it could be done . Thankyou Dr **Ashfaque** for arranging such faculty who delivers the lecture in the best way possible that it could be done . Webers Classification , Lisfranc Injury , Bohler Angle were one the most important pointers highlighted during the session. In a nutshell , i must say AlhumdulliAAllah om beinh part of LGEM🌹

FEEDBACK # 13

Zegham Abbas

Another amazing session with Dr Ehsan in the management and evaluation of lower limbs injuries in ED. Dr Mishal has excellent presentation. Today we learned about different fractures types and different approach of management like
>Acctebular Fracture and it's more common part of fracture (Posterior part)
>Young Burgess Classification
>T- Bone MVC fracture
> Management X ray CT SCAN Fast Scan
> Pelvic Binders
> Importance of REBOA in ER
> Allis Manoeuvre
>Pipkin classification
> Tibial pilon fracture
> Ottawa rules of knee fracture injury
> Lisfranc Fracture
And importance of CT SCAN in miss fractures
Amazing comprehensive session by DR Ehsan thanks Dr Ash for providing amazing opportunities.

FEEDBACK # 14

Muhammad Abubakar

Amazing session went on the lower limb injuries. Dr. Ehsan comprehensively covered a large topic in 1.5 hour including presentation of Dr. Mishal which was also an interesting case and well managed & presented. He discussed different fractures of Pelvic Bones, Femur, Tibia, Fibula and the foot, also including

different dislocations, mechanism of injuries, different classifications and especially missed fractures which can be lethal. It was very important lecture which enable us to deal such injuries in ED as a ED Physician.
Thank You LGEM Team to arrange such important lectures for us. Thank You Dr. ASH, Dr. Ehsan Riyaz and Dr. Mishal.

FEEDBACK # 15

Bushra Imran

Today again started with case presentation of 8yrs old boy with gunshot injury in lower limb
Then Detailed highlights by dr Ehsan on lower limb injuries started with pelvis fracture with xray and treatment ,tibial fractures ,ankle fractures,(1st time heard about REBOLA) in hip dislocation treatment,intertrocjanteric ,sub tronchantrric fractures and also the different classifications discussed with related fractures are mind thinking lecture
Thank you Dr Ehsan for amazing session

FEEDBACK # 16

Haider Ali

1.5 hours online session was conducted by Dr. Ehsaan and Dr. Ash which was made very interesting and easy to understand all those injuries and fractures. Starting from pelvis and ending till the phalnages of the toes, Dr. Ehsaan comprehensively covered all aspect of injuries and the role of an emergency physician in managing them.
Thanks LGEM programme.

FEEDBACK # 17

Warda Yawar

Pelvic fracture
Knee injury
Leg injury
Foot fracture was excellently taught by the doctor ehsan and very well delivered
All details was mentioned in it including anatomy upto management of fractures and telling us the importance of this in emergency department
In pakistan we should not miss any minor injury and should put our efforts to safe a life and do examination before and after management so we could not miss any pathology
Once again thank you so much dr ash for organising it

FEEDBACK # 18

Qaisar Shah

Dr Ehsan Riaz discussed:

☞ LOWER EXTREMITY TRAUMA

◉ PELVIS ANATOMY

◉PELVIC FRACTURE & their TYPES

❶ ACETABULAR FRACTURES ➳Common Location is Posterior wall ➳Due to MVC

℞ Surgical open reduction+internal fixation

❷ SINGAL BONE FRACTURES

◉PUBIC RAMI FRACTURES

◉SACRAL FRACTURES➳ DENIS CLASSIFICATION

❸ILIUM FRACTURES

☞ PELVIC RING FRACTURES ➳ Severe Fracture type with two breaks in circular pelvic ring➳ highest rate of major hemorrhage

◉ THE YOUNG BURGESS CLASSIFICATION

❶ LAT-COMPRESSION FRACTURE

❷ ANT-POST COMPRESSION FRACTURE

◉Type 1 ◉ Type 2 ◉ Type 3

❸ VERTICAL SHEAR FRACTURE

☞MANAGING INJURY

◉Pelvic Binder

◉X-ray ◉CT-Scan◉FAST Scan◉Associated Injury◉Tranxamic Acid◉Blood Transfusion

◉REBOA (Resuscitative endovascular balloon occlusion of the aorta) ➳ indicated for traumatic life-threatening hemorrhage

◉ Angiographic Embolization

☞HIP DISLOCATION

◉90% are Posterior Hip Dislocation

℞ Closed Reduction (Allis Maneuver)

◉ANT- HIP DISLOCATION (10%) May need Neuro-Vascular Assessment

℞ is Closed Reduction

☞FEMORAL HEAD FRACTURE

◉Pipkin Classification (1,2,3,4)

☞FEMORAL NECK FRACTURE

◉Garden Classification (1,2,3,4)

◉Functional Classification ➳Stable (1,2)+Unstable (3,4)

☞INTERTROCHANTERIC FRACTURE

☞SUBTROCHANTERIC FRACTURE

☞FEMORAL SHAFT FRACTURE

◉TYPES(0,1,2,3,4)

☞DISTAL FEMUR FRACTURE

☞KNEE DISLOCATION ➳Due to high energy Mechanism+ Mostly Posterior Dislocation+Ligament Injury+Vascular Injury+Peroneal & Tibial Nerve Injury

☞PATELLA FRACTURE

☞TIBIA FRACTURE (Proximal+Shaft+ Distal Fractures)➳Causes (MVA+Fall from height+Sporting Injury)

☞TIBIAL PLATEAU FRACTURE

◉ SCHATZKER Classification (Type 1,2,3➳Lower energy & 4,5,6➳ Higher Energy)

☞TIBIAL SHAFT FRACTURE

◉Johner & wruh's Classification

☞OPEN TIBIA FRACTURE

◉Gustilo & Anderson Classification (Grade 1,2,3)

℞ Maintain ABC+Associated Injuries+ TT+Antibiotics+Fixation

☞MAISONNEUVE FRACTURE

☞TIBIAL PILON FRACTURE➳ High Energy Fracture ➳ Need surgical Fixation

☞ANKLE FRACTURE

◉WEBER DANIS Classification

☞ANKLE DISLOCATION

☞RUPTURED ACHILLES TENDON

◉SIMMONDS Test (no deflection of Lt Ankle)

℞ is Surgical Fixation

☞FOOT

◉Foot Anatomy (Forefoot,Midfoot & Hindfoot +28 bones)
☞CALCANEUM FRACTURE➳Due to fall from Height➳BOHLER ANGLE on X-RAY
☞ THE OTTAWA ANKLE RULES
☞OTTAWA RULES FOR KNEE
At last Dr Ash discussed a case with history of fall➳ CALCANEUM FRACTURE ➳Confirmed by CT
This session was Amazing as usual
Thanks Dr Ehsan & Dr Ashfaque for this wonderful session.

FEEDBACK # 19

Rajab Abbas

It was a comprehensive session on standard approach towards Lower limb injuries in A& E department.
Session was commenced by the concise presentation of a gunshot Injury to the boy who presented in vascular n trauma department, by Dr Mishal followed by a comprehensive session by Dr Ehsan consult. EM NHS.
Imp learning points Dr Ehsan taught Today:
•Detailed Anatomy of Pelvis
• Pelvic fracture , dislocations and management
• Assessment of Pelvic joint Injuries; examination, investigation and management
• Classification of different fracture
• Lateral compression #
• Application of Pelvic Binder
• Significance of REBOA
• Hip dislocation>> Allis Manuever
• Femoral head # (Pipkin Classification)
• Femoral Neck # (Gardens Classification)
• Femoral Shaft # n types
• Knee dislocation n significance of angiogram
• Patellar #/ dislocation/ reduction/ Bipartite/Tripartite
• Tibial # (Jonner & Wruh / Gustilo n Anderson Classification)
• Maisoneuve #
• Ankle # Uni/Bi/Trimalleolar
• Ruptured TA (Simmond Test) , Management

• Foot Injuries and it's approach plus management
° Significance of Bohlar angle
• Ottawa Ankle Rules
This is Astonishing How come These Comprehensive Knowledge about such a vast subject can be transferred to juniors in such a short period it's like *He caught the wind with a net*
THANK you Dr ASH for these knowledgeable weekly sessions
Thank you Dr Ehsan for today's session.
This will help us alot to do standard practice while doing duty in A& E department.

FEEDBACK # 20

Muzna Ahmed

Amazing session conducted by dr Ehsan on lowerlimb injuries. He briefly elaborate anatomy of lower limb regions, pelvis, thigh, leg, ankle and foot their important anatomical points prone to fracture or damage, ligamental arrangements and main support they provide in stabilizing joints and lower limb.
Some important pearls were:-
•Detailed Anatomy of Pelvis
• Pelvic fracture , dislocations and management
• Lateral compression #
• Application of Pelvic Binder
• Significance of REBOA
• Hip dislocation>> Allis Manuever
• Femoral head # (Pipkin Classification)
• Femoral Neck # (Gardens Classification)
• Femoral Shaft # n types
• Knee dislocation n significance of angiogram
• Patellar #/ dislocation/ reduction/ Bipartite/Tripartite
• Tibial # (Jonner & Wruh / Gustilo n Anderson Classification)
• Maisoneuve #
• Ankle # Uni/Bi/Trimalleolar
• Ruptured TA (Simmond Test) , Management
• Foot Injuries
° Significance of Bohlar angle
• Ottawa Ankle Rules

Thank you so much Dr Ash and Dr Ehsan for enlightening us with this level of knowledge and giving opportunity.
Proud lgem trainee.

FEEDBACK # 21

Aakash

=> It was a very good lecture on lower limb injuries conducted by dr ehsan.
Lecture was started again today with presentation by Dr Mishal Khan.
it was a very wonderful presentation presented by her.
==> very new things we learnt today, regarding trauma management
Highlighted learnt things were 👇👇👇👇👇
==> It started with Pelvic anatomy, learning objectives were
1. how is the pelvic joint made.?
2. Stability of pelvic joint
➡️ types of pelvic fractures were discused i-e
1. sacrum fracture
2. single bone fractures.
➡️ Single bone fracture ..involving one part of joint.
most commonly seen in elderly patients.
➡️ classification for sacrum fractures.
➡️ ileum fractures were learnt .
➡️ pelvic ring fractures are most severe types of fractures. Multiple classification for this. but young bergress classification most easily used.
& much more new things were learnt.
It was very tuf to compile the whole lower limb injuries in one hour lecture but Dr ehsan did it in a very good &, comprehensive way.
Once again thanku dr ash for providing us this platform❤️

FEEDBACK # 22

Imtiaz Ali Shah

Today we had an excellent session by dr Ehsan regarding lower limb injuries .During this session we had a comprehensive review of important lower limb injuries which includes
PELVIC INJURY.
Pelvic fractures including (a)ACETABULAR#)
(B)SINGLE BONE #.(PELVIC RING#)
VERTICAL SHEAR# along with management.

Use of PELVIC binder AND REBOA .
HIP FRACTURES including
Dislocation
Femoral head fractures.
Femoral neck fractures
Intertrochanteric fractures.
Sub trochanteric fractures.
HIP DISLOCATION along with ALLIS MANEUVR
FEMORAL HEAD FRACTURES with PIPKIN classification.
FEMORAL NECK FRACTURES..
INTERTROCHANTERIC HIP FRACTURES.
SUBTROCHANTERIC FRACTURES along with managment.
PATELLA FRACTURES and SUN RISE View .
TIBIA FRACTURES .
a..Proximal tibia#(TIBIAL PLATEAU #)
b..Tibial shaft # distal tibial# with schatzker classification.
ANKLE FRACTURES withLauge-Hansen and
Weber Danis classification.
Ruptured Achilles tendon.
FOOT # Along with calcanium fractures and LISFRANC INJURY.
Over all this was a very comprehensive and detailed session.Dr Ehsan conducted it in a very professional way and made the things easier to understand.
Thanks to dr Ehsan for this wonderful presentation and also dr Ash for providing us this great appertunity for learning.

FEEDBACK # 23

Mariam Nawaz

Yet another amazing session by Dr Ehsan. Entire lower limb injuries covered in 1 hour, a saturated session with learning points embedded in every second of the lecture. Lesson started with a case presentation by Dr Mashal followed by Dr Ehsan's lecture. We covered entire lower limb starting from hip joint to pelvis to Thigh, knee, leg, ankle and foot injuries. Role of X rays and ct scan was discussed and great emphasis was laid on the fact that we should always examine the joint above and the joint below. Thankyou Dr Ehsan and Dr Ash for such an amazing session

FEEDBACK # 24

Khatija J. Farooqui

Best lecture on lower limb injuries by dr Ehsan and excellent presentation by dr Mishal.very precisely explained on fractured , injuries management plans. Thanks to team GEM & Dr Ash

FEEDBACK # 25

Phota Ram

Excellent session by Dr Ehsan covered most common injuries of lower limb pelvic fracture,hip dislocation, femoral head and neck injury, shaft,tibia,febula,patela injuries and ankle joint fractures and dislocation ankle.very usefull session on lower limb injuries, different classification,manuvers to reduce dislocation, important signs on xray of lower limb fractures and management of lower limb injuries

FEEDBACK # 26

Mina Khan

Todays lec on lower limb delivered by Dr Ehsan had been very knowledgeable, conprehensive and updated, Dr Ehsan elaborated many classifications where we werent aware of , and made us capable of having vast knowledge about a single organ. His explanations were precise but to the point. Dr ash in the end always contribute his value-added pearls and case scenarios for better conprehension of the topic . THANK YOU **London Global Emergency Medicine** 🌹

FEEDBACK # 27

Ayesha Mushtaq

Lower limb injuries managements were in fact the backbone of Emergency cases in daily practice of any ER physician practicing anywhere in the world and this topics were covered in the most easiest and comprehensive way... really appreciable and worth listening sessions..

FEEDBACK # 28

Ruma Bajwa

Fantaboulus session..very precisely and superbly explained each and every aspect of lower limb injuries with their managment in a very short time dr.ehsaan always put a lot of hard work in slides to make the whole lecture super easy i leanrt alot today with soOo many new things.

Thanks alot Dr.Ehsaan ,Dr.Ash

And the whole Gem team

Proud GEM trainee

FEEDBACK # 29

Zia Hayat

It was an excellent presentation starting with a case presentation by Dr.Mishal a real life case of bullet injury managed in the ED.Later Dr .Ehsan explained about the details of the lower limb injuries seen in the ED like pelvic joint injuries, fracture of knee,tibia,ankle along with different classifications used for diagnosis and management. It was a really great experience to hear about the new technologies being used for the management of these cases.Thankyou Dr.ash for arranging such an amazing talk.

FEEDBACK # 30

Beenish Manzoor

Another amazing session with vast knowledge delivered in such a short period of time

It was very comprehensive session started with dr mashal concise presentation of a gunshot injury to boy.

Then we had Dr ehsan session in which we learnt very important points

We studied :

*Anatomy of pelvis

*Pelvic Fracture /dislocation and management

*Assessment of pelic joint fracture investigation and management

*Acetabular fracture

*Pelvic ring fracture

The Young Burgess classification

*Lateral Compression

*T-bone fracture (3 types)

*AP Compression (2nd type)

*Vertical Shear#(3rd type)

Management of pelvic fracture

X-Rays/C.T.Scan/Fast Scan/look for ass.injuries

Pelvic Binder(bring bony structures in form to avoid bleeding place it over greater trochanter & it should be tight)

*Significance of REBOA(Resuscitative endovascular balloon occulusion of the aorta)

Angiograhic embolization

Always look for assess.injuries

*Hipfracture/Dislocation (Allis manuever
*Femur fracture /dislocation
*Femoral Head fracture very important and very complicated never understand it like today before include:
Pipkin classification
*Femoral Neck fracture
(Garden classification)
*Femoral Shaft Fracture (n types)
*Distal Femur fracture
*Knee Dislocations ant and post acl and pcl injury and angiogram significance
*Patellar fracture and dislocation (reduction)
*Tibial fracture (jonner and wruth classifications
*Plateau fracture
* Ankle dislocations
*Ankle fracture Uni/Bi/Trimalleolar
* Ruptured TA (Simmond Test) and Management
• Foot Injuries LISFRANC its importance and its management
*Very important;Significance of Bohlar angle
*Weber classifications was explained very comprehensively
• Ottawa Ankle Rules
Thank you so much Dr Ash and Dr Ehsan for enlightening us with this level of knowledgea
Thankyou dr ash for last mint talk and enlightening how to prepare for exam.thanks to LGEM team

FEEDBACK # 31

Hasil Khan

Great information 🌹

FEEDBACK # 32

Muhammad Azeem Imran

To me I had a feel to be once again doing orthopedic rotation of FCPS Surgery . A Rapid Review of Pelvic & lower limb trauma. At that time there was no Man to teach us , we read books and hand on experience from seniors . Learning goes from heart to heart but mismatching with standard practice. Today Dr Ehsan taught standards of orthopedic trauma management.

Today,s Session started by the concise presentation of a gunshot Injury to the boy who presented in vascular n trauma department, by Dr Mishal followed by a comprehensive session by Dr Ehsan consult. EM NHS.

**`~_Imp learning points Dr Ehsan taught Today__~```*

•Detailed Anatomy of Pelvis
• Pelvic fracture , dislocations and management
• Assessment of Pelvic joint Injuries; examination, investigation and management
• Classification of different fracture
• Lateral compression #
• Application of Pelvic Binder
• Significance of REBOA
• Hip dislocation>> Allis Manuever
• Femoral head # (Pipkin Classification)
• Femoral Neck # (Gardens Classification)
• Femoral Shaft # n types
• Knee dislocation n significance of angiogram
• Patellar #/ dislocation/ reduction/ Bipartite/Tripartite
• Tibial # (Jonner & Wruh / Gustilo n Anderson Classification)
• Maisoneuve #
• Ankle # Uni/Bi/Trimalleolar
• Ruptured TA (Simmond Test) , Management
• Foot Injuries and it's approach plus management
° Significance of Bohlar angle
• Ottawa Ankle Rules

He emphasize the importance of CT scan in missed injuries . Concise approach to menage these injuries . Recent trends & advances in picking & menagement of these injuries .

THANK you Dr ASH for arranging such a comprehensive session by Dr Ehsan .

Very Humbly saying Thank to you

FEEDBACK # 33

Mina Ali Shaikh

A detailed session by Dr. Ehsaan on lower limb injuries explained systemically from top to bottom. He taught about fracture classifications, tendon injuries and few things that were previously unheard of such as bohler's angle and lisfranc fractures. Everything explained side by side with radiological presentation.

Grateful for LGEM

FEEDBACK # 34

Zaid Ansari

Absolutely blown away by the extensive details by Dr Ehsan. Hard to believe we covered almost every major fracture and injury of lower limb in such a short time, while answering all queries and with detailed explanations. Lots of new things discussed that we had not heard of or seen in the floors of our wards, but will surely be implementing through our shared knowledge through LGEM.

FEEDBACK # 35

DrKiran Feroz

A power pack session which included all the lower limb injuries....minute fractures which could be easily missed are well xplained .....hard work by Dr Ehsan which made things easy for our understanding...I simply luved the lecture...hats off to the entire team of London Gem.....

FEEDBACK # 36

Dr Javeria Wali

Session on Lower Limb Injuries & Role Of ED Physician By Dr Ehsaan Riaz was amazing and really comprehensive. Every slide was brilliantly explained with many learning points we never heard before including Anatomy of Pelvis, Pelvic fracture , dislocations, Assessment of Pelvic joint injuries, Lateral compression fractures, Pelvic Binder, REBOA, Hip dislocation and Allis Manuever, Femoral head, neck and shaft fractures (Pipkin Classification), Knee dislocation with importance of angiogram to assess popliteal artery injury even in presence of distal pulses, Patellar dislocation and reduction, Tibial fractures (Jonner & Wruh and Anderson Classification), Maisoneuve fracture, Ruptured Achilles Tendon (Simmond Test) Foot Injuries and its management, bohlars angle, Ottawa Ankle Rules and lisfranc injury. Thankyou so much for this great session.

FEEDBACK # 37

Dr Nouman

Another wonderful session with many many many xrays and the untiring enthusiasm of Dr Ehsan to go through each of them very specifically and thoroughly. Many topics were discussee such as pelvic fractures, hip dislocation, shoulder fractures alongwith REBOVA, ottawa rule and the way to apply pelvic binder..... Gordon classification, radiological anatomy of the foot were also one among many.

Thanks Team LGEM, Dr Ehsaan and Dr Ash for an amazing learning experience
Regards: Dr Nouman

FEEDBACK # 38

Dr Mominah Furqan

Respected Sir,
thankyou Dr.Ehsan , Dr.Ash
starting from pelvic anatomy ,pelvic fractures ,dislocations and managemsnt..
classification of different fracture.type of hip dislocations,
usage and advantage of pelvic binder,
femoral head , femoral necj and femoral haft fracture .
patellar dslocation , knee joint injuries ,
ankle and foot injuries
thanks for teaching us so much in so little time so effeciently .

FEEDBACK # 39

Dr Wajiha Khan

Another excellent lecture by Dr. Ehsan where he highlighted all the important lower limb fractures esp some very important injuries like lisfranc fractures, depressed bohler angles and other fractures that can be easily missed on x-rays. Thank you Dr Ehsan and the LGEM team for this informative session.

FEEDBACK # 40

Dr Muhammad Saad

Dr Ehsaan Riaz delivered a brilliant session on lower limb injuries in ED. He discussed alot of new concepts from basics to treatment along radiology. There was also a case presentation at the start of session. Dr Ehsaan discussed alot of things some of which are:
>Basic anatomy of lower limb
>Pelvic ring fractures
>Young Burgess classification
>Lateral compression fractures
>Vertical shear fractures
>Hip dislocation
>Femoral neck fractures
>Gordon classification
>Intertrochanteric hip fractures
>Ankle fractures

>Weber Danis classification
>Tendon Ruptures
>Radiological anatomy of foot
>Lisfranc injury
>The Ottawa ankle rule
It was a brilliant session, thank you Dr Ash and London GEM for arranging such valuable session.

FEEDBACK # 41

Dr Muhammad Ghayoor khan

It was a wonderful session on lower limb injuries by Dr.Ehsan Riyaz.
I had learned alot regarding Lower limb injuries and their management at ED.
The Dr.Ehsan start the lecture from basic Anatomy of the region then their Fractures, classification of fractures, investigations(X-RAYS and Ct-scan etc) and their management was amazing.
The case presentation was excellent by Dr.Mishal Siddiqui.
Thanks
Dr.Ehsan and Team LGEM

FEEDBACK # 42

Dr Maryam Khalid

Respected Sir,
Today's session by Dr Ehsaan on lower limb injuries was very well delivered.
Though it was a very huge topic still he managed to touch every important point that should be known to an EM physician.
The case presented by Dr Mishal was also good and well presented.
Dr Ehsaan taught us about:
Basic anatomy of lower limb
Pelvic ring fractures
Hip dislocation
Femoral neck fractures
Intertrochanteric hip fractures
Ankle fractures > Weber Dani's classification
Radiological anatomy of foot
Lisfranc injury.
It was a lecture must to attend.
I learned a lot in this 1.5 hour.

Thank You Dr Ehsan and Dr Ash for your support for your time.
We are very grateful to you!!

FEEDBACK # 43

Dr Sadia Anwar

In the start of lecture was case presentation by Dr Mishal on lower limb injury which she presented v efficiently.
Dr Ehsan wonderfully covered all the important lower limb injuries in a v short span of time.
There were many learning points.
1) Different type of lower limb fractures with their classification
2) Pelvic fracture classification
3) The correct position for applying pelvic binder on greater trochanter
4) REBOA
5) Examine Abdomen in hip injury as well
6) In Knee injury after joint reduction go for angiogram to rule out vessel injury in popliteal area.
7) Ruptured Achilles tendon (Simmond sign)
8) Foot fractures
9) Lisfranc injury
10) Bohler angle
The take home message was
1) Always check joint above and below
2) Neurovascular status before and after reduction
3) Other associated injuries
4) Mechanism of injury
Thanks alot Dr Ehsan for teaching us in a v easy method and thanks Dr Ash for arranging the lecture.

FEEDBACK # 44

Dr Mishal Shan

The 1.5hour lecture by Dr Riaz on Lower limb injuries in the ED was an elaborate discussion on the commonly presenting fractures, dislocations and soft tissue injuries in any ED. He highlighted the importance and role of an ED physician in properly picking them up and managing them. We were also taught the frequently missed injuries and ways to catch them on time. Dr Riaz delivered a great deal of information in an extremely practical and clinically relevant manner which will

surely help everyone practising in the ED. Assessment of x rays of the lower limb to look for occult fractures was a very interesting part of the session. Really looking forward to more of these lectures!

FEEDBACK # 45

Dr Azka Shamim

AOA respected sir

Today we had another great session with Dr Ehsan (consultant NHS UK) regarding presentation of lower limb injuries and infact Dr Ehsan gave a detailed comprehensive overview of whole topic .. He started with overview of anatomy and covered very important classifications of injuries form pelvis to foot.

Following important points were elaborated:

Pelvic anatomy, fractures, dislocations and management

#Assessment of Pelvic joint Injuries; examination, investigation and management

#Classification of different fracture

#Lateral compression

#Application of Pelvic Binder

#Significance of REBOA

#Hip dislocation--- Allis Manuever

* Femoral head fx(Pipkin Classification)

* Femoral Neck fx (Gardens Classification)

*Femoral Shaft fx n types

*Knee dislocation n significance of angiogram

*Patellar fx dislocation, reduction, BipartiteTripartite

* Tibial fx (Jonner & Wruh / Gustilo n Anderson Classification)

* Maisoneuve fx

* Ankle fx Uni,Bi,Trimalleolar

* Ruptured TA (Simmond Test) , Management

* Foot Injuries and it's approach plus management

*Significance of Bohlar angle

*Ottawa Ankle Rules

role of CT scan and recent trends and advances in picking up missed injuries and proper approach to the management

Thank you so much Dr Ash for arranging these important sessions for the trainees of L-GEM program..

A proud GEM trainee

FEEDBACK # 46

Dr Rehan Khalil

Today we attended a comprehensive session on lower limb injuries in ED by Dr Ehsan. It was a lovely session and following points were discussed:

1- if a patient deteriorates suddenly after bone fracture, think of Fat Embolism.

2- Types of Pelvic Fractures

3- REBOA - Resuscitative Endovascular Baloon Occlusion of Aorta

4- Hip Disclocation

5- Femoral Fractures

6- After knee dislocation you must get Angiogram whether you have pulse ir not becasue an intimal tear may have normal pulses so you must rule out vascular injury.

There was case of Firearm Injury presented by Dr Mishal.

FEEDBACK # 47

Dr Afifa Raja

Salutations of the day!

Today we had another excellent session with dr Ehsan on lower limb injuries, a vast topic covered splendidly by Dr. Ehsan and we learned so many high-yield topics.

At first, Dr. Mishal presented an excellent case that was followed by Dr. Ehsan's lecture, we covered:

• Anatomy of the Pelvis
• Pelvic fractures and dislocations
• Femur head fracture (pipkin classification)
• Femoral Neck fracture
• Intertrochenteric fracture
• Femoral Shaft fractures and their types
• Knee dislocation
• Patellar fracture and dislocation
• Tibial plateau and shaft fractures
• Maisonneuve fracture
• Ruptured TA and its Management
• Foot Injuries and management
° Significance of Bohler angle
• Ottawa Ankle Rules

Thank you Dr.Ash for arranging such marvelous sessions.

FEEDBACK # 48

Dr HK Danish

Sir made it very Easy to understand with presentation including X rays and CT scan images . I learned all about examination , investigations & management of injures from pelvis all the way to foot .

A few of the new points I learned are :

1.Types of pelvis fracture , pelvic ring fracture is the most complicated because major vessels are involved (**Young Burgess** classification of pelvic ring fractures--> 1 Lateral compression *most common , 2 AP compression *pelvic diastasis occurs, Vertical shear fracture) . **Managements: highly unstable fractures so needs to be managed ASAP**

2. Hip dislocations almost 90% are posterior dislocations . time sensitive because it compresses of sciatic nerve . Goal is to reduce hip to avoid necrosis and nerve damage . always check for fracture in CT in case of anterior dislocation.

3. Femoral head fracture : Pipkin Classification

4. Femoral neck fracture : Garden Classification & functional classification .

5. **Knee Dislocation**

6. Patella fractures & dislocation : Dislocations are usually be as a result if of sports injury . Sunrise view X Ray , bipartite patella & Tipartite patella are incidental findings .

7. Tibial fracture : can present with compartment syndrome and are easily missed . So need cairfull examination . **Schatzker classification of plateau fracture , Gustilo and Anderson classification of tibial shaft , Maisonneuve Fracture is most commonly missed and are unstable fractures , needs operative measures (** results in force from medial to lateral **)**

8. **Ankle Fractures :** Tri malleolar fracture , Weber Classification of ankle fracture .

9. **Ankle Dislocation :** Almost always associated with fracture .

10 . Simmonds Test for ruptured Achilles tendon . In partial tendon rupture the test may be negative so U/S is advised

11. Foot : Divide foot into 3 --> Fore foot , mid foot and hind foot to make X ray reading easier . Most common injury that is missed is **Lisfranc injury .**

This was an amazing session and All thanks to Dr ASH for giving us this opportunity .

FEEDBACK # 49

Dr Nasir Hayat

This session was wonderful session and very well organised and presented on lower limb injuries, it covered up comprehensively every thing .
Pelvic fractures and classification of fractures investigation and management, Use of pelvic binders, REBOVA, angiographic embolization.
Anterior posterior Hip dislocations and management,
Femoral head fractures 4 types garden classification of femoral neck fractures, intertrochanteric greater n lesser trochanteric n sub trochenteric fractures, femoral shaft fractures,
Knee n patellar dislocation tibial / fibial fractures,
Ankle joint and feet fractures investigation n management.The case presentation was very nice.I would highly recommend it for ER physicians to join and get skillful and have bright future.Proud to be LGEM MRCEM candidates.

FEEDBACK # 50

Dr Shahid Ahmad

Today's session on lower limb injuries was undoubtedly one of the most informative lectures taken as we covered alot of points with wonderful understanding regarding lower limb which could be difficult otherwise.
We learned Role of x-rays, CT scan and Maneuvers as well as basic anatomy. It was a very interesting lecture to attend with the massive load of information in it.
Thanks

8th OCTOBER 2022

EVENT NAME:

FRCEM PRIMARY RAPID REVIEW WITH DR ASH CLINICAL PHARMACOLOGY SESSION 1

DOCTORS FEEDBACK

FEEDBACK # 1

Abrar N. Syed

An Excellent Session yet Again but the best part was that it covered so much of that Golden Stuff which you need to know in Exams but especially in Practical Clinical Sessions.
Both Gastro n Cardio Pharmacology was done with so in depth analysis that it will definitely change the thought process when prescribing meds in ER
Thank u Dr Ash

FEEDBACK # 2

Rabia Humayun

What an amazing and truly appreciable session by our beloved Mentor..
Thanks Dr Ash for letting us in on the ways you prepared for your exams and how you go through the basic books.
Thanks for this information packed session; it gave us a true insight of the areas we lack and how to effectively work on them.
Your guidance as to how to study, in pharmacology, what is important and what will be asked is indeed a huge deal for candidates like us who want to give the exam.
All the important stuff you discussed today; let it be antiemetics and their receptors, PPIs, the use of adenosine, calcium chloride vs calcium carbonate and their use in cardiac arrest or the use of labetolol in type B aortic dissection, each point was delivered in a manner that I for one won't be able to forget it all my life.
Thanks for the hard work and the all the early mornings you put in for us..
A true mentor in every way possible..
Thanks!!

FEEDBACK # 3

Syeda Maheen Ejaz

Amazing session a lot of new learnings for me take home is Ppi, how commonly we prescribed without realizing its adverse outcome, amiodarone, adenosine, calcium chloride, and calcium gluconate. Story is also v amazing enjoyed every bit. Thank you so much Dr. Ash for conducting a beautiful session❤️

FEEDBACK # 4

Mina Khan

Attended todays lecture on important drugs used in A & E, sir has never taken short sessions, despite he has always thought of his students... Today’s session was more lengthy and comprehensive. I can only say Alhamdullilah being the part of this program

Thanks London Global Emergency Medicine

FEEDBACK # 5

Saba Aslam Khan

Today we had 2 hours lecture by DR Ash on Pharmacology lecture was completely exam oriented as well as tips were applicable on ED department…
Some highlights of the lecture were,
—>Drug metabolism Phase 1 and 2
—>NT and Receptors for Antiemetics
—>metoclopramide double efficacy
—>PPIs and use of caution
—>Digoxin and its interactions
—>Digoxin antidote and when to use it
This was the most fastest 2 hours of my life I wanted to listen more and more from Dr Ash, His lectures are always so engaging full of real life examples , which help us remember the imp points and Full of exam tips …!!
Thank You so much for this session sir...

FEEDBACK # 6

Syed Suhail Ahmad

Today's marathon was about PHARMACOLOGY, which was comprehensive, interesting and very exam oriented. Importance was given by Dr. Ash on how to read it from an exam perspective, what to read and what not to read. Important topics like General Pharmacology, MOAs, Indications, Contraindications, Interactions, SIs etc were dissolved both from an exam and clinical POV stressing on the minute and tricky things that are often missed and can be life-saving for the patient. Thank you **London Global Emergency Medicine** and **Pema-Uk** 👍👍👍

FEEDBACK # 7

Zegham Abbas

Today we have amazing session with DR Ash the whole point of the lecture was how to pick up MCQS during your single read of text book. General Pharma drug metabolism their phases side effects of cyclizine in old male and young female, PPI side effects hypomagnesemia can lead to various disease digoxin toxicity uses of labetalol in eclampsia pre-eclampsia and in aortic dissection was golden point which we never know until today’s session. I hope we will cover whole MECEM PRIMARY like this fruitful study technique.

FEEDBACK # 8

DrKiran Feroz

Wonderful session today...as usual...pharmacology explained in a manner which is easy to remember and with detailed explanation ....cases discussed along with the explanation ...how to manage the most critical patients and what are the deadly drug interactions were taught nicely....the knowledge I received today was mind blowing and I was completely unaware of it ...thanks Ashfaque bhai and team for sharing so much knowledge which is highly useful for our future....God bless u and the entire team Always Ameen..

FEEDBACK # 9

Hassan Tariq

Listening lectures is always my favorite but Dr Ash lecture is tremendous make the topic easy to learn and then to do MCQ's
Today Dr Ash told about the pharmacology of
GIT CVS
PPI should only where indicated
Dogoxin mechanism & its toxicity
Global ST elevation on ECG
What antibody used for toxicity
Doses of adenosine
How adenosine should use in precaution with amiadarone
Where its dose should be decreased and increased
Use of diuretics
Their mechanism of action
Use of acetazolamide in glaucoma
Potassium sparing cause acidosis
Use of amiadarone for arrythmias
It's contraindications
Use of cacl2 and calcium gluconate
It's was an amazing session which revised half of pharma in just 2 hours and also learn many things regarding **clinical** practice.
Many of us always prescribe PPI randomly.
This lecture made changes in prescribing medicine
Thanks Dr Ash 😍

FEEDBACK # 10

Muhammed Aamir Ayoub

Thanks Dr. Ashfaque for the amazing lecture on Pharmacology. Learn about clinical pharmacology needed for ER physician and for exam purpose as well.
JAZAKALLAH KHAIR

FEEDBACK # 11

Hassan Tariq

Pharmacology
CNS
Anticoagulants
Respiration
Ca channel blockers
Anti-hypertensive
Antipsychotics
Details of each and its applications/safe use in ER
Dr Ash way of presentation was superb. Always new things I learnt.
Take home message for me
Was tab capoten not take or give on very high BP which is a very common practice in Pakistan and people do self-medications too.
It's great to receive new info always.
I was surprised to learn such a great new things about antipsychotics side effects and much more .
This is much for clinical practice and also for exam .
Thanks London GEM, many Thanks
Dr Ashfaque Sorathia
(MBBS, MRCP, MRCEM, FRCEM, EBEEM).

FEEDBACK # 12

Maimona Javaid

CNS
Anticoagulants
Respiration
Ca channel blockers
Anti-hypertensive
Antipsychotics
And much more
Lecture of Dr ash was superb . Always new things I learnt.
Take home message for me

Was tab capoten not take or give on very high BP which is a very common practice in Pakistan and people do self-medications too.
It's great to receive new info always.
I was surprised to learn such a great new things about antipsychotics side effects and much more.
Stay blessed Dr ash
You are a star and a future celebrity in Pakistan and world.
Soon will see you on national TV channels
Keep rising and growing 👍

FEEDBACK # 13

Dr. Afifa Younas

Greetings of the day!
Today we had an amazing session on pharmacology for
MRCEM primary preparation, we covered GI and CVS pharmacology and the session was taken by our favorite Dr. Ash, who always chooses a tough topic and makes it so interestingly comprehensive and keeps things interesting and engaging that we end up loving that topic.
His teaching approach was in an exam oriented manner along with its clinical application and significance. It will definitely help in our daily practice. Few pearl from today's lecture:

1. Drug metabolism Phase 1 and 2
2. First pass metabolism
3. Neurotransmitters and Receptors of emesis
4. Most common presentation of digoxin toxicity is unexplained tiredness/lethargy, and decreased appetite.
5. Digi fab to be given if K levels are above 5.
6. Adenosine dosage should be decreased to 3mg if the patient is on carbamazepine and dipyridamole, while increased if on theophylline and caffeine.
7. Patients receiving adenosine should be informed about its effect of impending doom.
8. Adenosine should not be given in WPW, as it will lead to VT.
9. Risk of hypomagnesemia with PPIs
10. Digoxin - Amiodarone interaction
11. Calcium chloride - in cardiac arrest and peri arrest with hyperkalemia

12. Amiodarone S/E photosensitivity
13. Cyclizine shouldn't be given to the elderly
14. .Promethazine can be given on pregnancy

It was a great session overall, and 2 hours passed by like a breeze and we were immersed in a sea of knowledge and in awe of our mentor's caliber and honestly we all were so eager to continue the session as long as possible.
Look forward to another amazing session tomorrow.
Thank you once again

FEEDBACK # 14

Dr. Aleena Rahman

Dr. Ash has a special way of teaching. His style is unmatched. He can a subject as dry and challenging as pharmacology appear so easy and digestible. We had a 2 hour long lecture on pharmacology of drugs. Though the session was exam relevant, Dr. Ash pointed out many important clinically relevant points that would serve to be very helpful in our practice. His interactive manner of teaching makes it fun. Furthermore, he teaches in a way that you remember even the most complicated of drugs. Important points learnt were: Antiemetic agents exert their action via various neurotransmitters. Due to cyclizine's anticholinergic effects like urinary retention, blurred vision, drowsiness it is not given in motion sickness. Promethazine can be given to pregnant women. Hyoscine is an antimuscarinic drug used for the treatment of motion sickness. Metochlorpramide also has prokinetic effects and that is useful in patients with diabetic gastroparesis. Prochlorperazine is used in various vestibular disorders and motion sickness. Dangerous side effect of prolonged PPI use is hypomagnesemia. Digoxin is given to slow ventricular response in atrial fibrillation or atrial flutter Adenosine should be avoided in WPW syndrome. A side effect of amiodarone is photosensitivity (sunburns). Propranolol is contraindicated in cocaine induced ACS.
Thank you Dr. Ash for a brilliant lecture!

FEEDBACK # 15

Dr. Ayesha Mushtaq

Well a lot of things to learn but I really loved the concept to learn a topic from an examiner point of view rather than an exam candidate... This concept really changed my approach about preparation... moreover; a lot of clinical points were explained so beautifully and in easiest way... Thank you Dr Ashfaque Ahmed for all your efforts...

FEEDBACK # 16

HK Danish

The topics discussed included important about GIT and CVS pharmacology related to emergency medicine practice and exams

I learned about the following drugs.

Vasodilators: patients presenting with chest pain should not be administered blindly with Nitroglycerine because it reduces preload and afterload.

In Right heart MI it causes Rt ventricular infraction. Should not be given in severe bradycardia & tachycardia.

Other complications of GTN include cyanide poisoning and metho globinemia .

GTN causes increased intracranial pressure and should not be given to patients with head trauma .

Alpha blocker : Cardura is a selective alpha 1 receptor blocker . indicated in hypertension .

ACE Inhibitors: Captopril , Enalapril etc should be advised with care because it worsen renal failure , RFTS should always be advised before giving ace inhibitors . It causes angio oedema and hemi tongue swelling . ACE Inhibitors are contra indicated in pregnancy .

Calcium channel Blocker :

Verapamil do not use in wide QRS complex

Should not be used with Beta blocker

All calcium channel blocker can cause head ach

Amlodipine5mg is the first drug of choice for high BP

After administration of amlodipine, GTN IV titration fluid is given with regular BP monitoring .

Nimodipine is used specially in traumatic bleed

Sympathomimetic drug : Dopamine lower doze medium doze and higher doze have different effects, side effects include increase intra ocular pressure , it can also cause blindness . Dobutamine is indicated in cardiac failure , side effect include myocarditis and increase in troponin levels .

Vaso-constrictors: Atropine used in bradycardia initial doze 0.5 to 3 mg , can pe repeated upto 6 times after every 5 minutes . Then go for pacing. Adverse effect is dry mouth .

Drugs used in resuscitation : Epinephrine/Adrenaline increases heart rate and AV nodal contractility . In cardiac arrest doze in 1:10000 , in anaphylaxis doze in 1:

1000.
Metaraminol increases the force of myocardial contractions as well as having a peripheral vasoconstrictor action.It is given when BP is very low during anaesthesia .
Anti coagulants : Heparin mechanism of action , indication and dosage . At lower doze it deactivated factor Xa , and prevents pro thrombin to thrombin . In higher doze it deactivate factor IX , factor X , factor XI factor XII , thrombin and prevents fibrinogen to fibrin . It is used in low doze in MI and high doze in Pulmonary embolism , It reduces platelets count so APTT must be advised before heparin infusion .
Cyclizine should not be given in elderly (neuroleptic malignant syndrome)
Promethazine can be used in pregnancy.
Metoclopramide should not be used in young patients.(risk of extra pyramidal reaction increases)
Domperidone dose not have anti muscarinic effect, there for ineffective in motion sickness.
PPI causes irreversible inhibition of H/K atipase in the parital cell of the stomach which results in hypo magnesemia which inturn causes muscle spasms and arythmeas and convulsions.Risk of pneumonia is 25% higher in patients using PPIs.
I thoroughly enjoyed this lecture and Dr Ash is my all time fav teacher

5th NOVEMBER 2022

EVENT NAME:

Pleural Lung Pathologies MRCP1-2 & PACES by Dr. Syed Wasib Consultant Respiratory NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Mehak Nabi

Awesome session conducted by Dr Syed Wasib. Session of 1:30 hour was a roller coaster of knowledge types of pneumothorax complications BTS guidelines

management pleural effusion pleural tap findings ADA levels lent score significance of bed side u/s triad of CCF CLD CKD for pleural effusion and much more which was later summarized by our dear Dr Ash in a min was so fruitful. Dr Ash started the session with a very interesting case of pneumothorax. Dr Bushra performed so well in OSCE session. Proud to be the part of this amazing journey of MRCP conducting by Dr Ash and his team thank you Sir for your efforts and devotion for bringing change in our education. I would like to thank Dr Wasib for taking out time for us in the middle of his journey.

FEEDBACK # 2

Faisal Butt

Today's lecture was a comprehensively brilliant learning session and covered a lot of practical learning points about Plerual Lung Diseases.

Dr. Syed Wasib discussed latest guidelines about Pneumothorax, causes, its etiology and how management of pneumothorax has evolved according to new guidelines.

How USG Chest can pick up pneumothorax. Importance of Alpha 1 Anti-trypsin Level, Complications of Pneumothorax

Pleural effusion ,its causes, Exudative ,Transudative. Dresslers Syndrome. How pleural tap lab findings will be different in chylothorax and pseudochylothoax . Significance of Serum LDH,ADA Levels.

Interesting OSCE session was done. Dr. Bushra Performed very well, took a detailed history of the given case.

Dr. Ash intermittently kept giving his input and kept summarizing what Dr. Syed Wasib was teaching. Also at the end Dr. Ash gave his review about the whole session and about case presented for OSCE.

Thanks Dr Syed Wasib

Thanks Dr. Ashfaque Ahmed for facilitating the whole session, Thanks LGEM MRCP PROGRAMME

FEEDBACK # 3

DrMuhammad Akber

Today's lecture was an amazing learning session and covered a lot of learning points about Plerual Lung Diseases.

Dr Syed Wasib has discussed about Pneumothorax its etiology and management of pneumothorax according to new guidelines

Significance of Alpha 1 Anti-trypsin.

Pleural effusion its causes Exudative and Transudative. Dresslers Syndrome, and difference of chylothorax and pseudochylothorax in pleural tap.
Importance of Serum LDH and ADA in TB diagnosis
Dr Bushra Performed very well took a detailed history of the given case.
Thanks Dr Syed Wasib Dr. Ashfaque Ahmed

FEEDBACK # 4

Sadia Abbasi

It was a great and comprehensive session delivered by Dr .Wasib about Pneumothorax and Pleural diseases.
Although he had no resource to go through topic but had very good command on it.
OSCE session was great. Dr bushra did an excellent job. Dr Ash Thank you for giving us this platform to learn from the best .
I am proud to ba a part of London GEM Programme.

FEEDBACK # 5

Faiza Baig

Feedback
It was a comprehensive talk and covered all main points of pleural diseases. Dr Wasib knowledge was going in a smoothly effortless manner.
Dr Bushra did a wonderful OSCE session, learned a lot, yet there is more to learn at this platform.
Thankyou Dr Ash to summarize the article and has shown great dedication.

FEEDBACK # 6

Beenish Naveed

First of all a big thank to Dr Ash who has arranged such dedicated tutors for us. Dr Wasib teaching is full of information and loads with knowledge; he is just fluently explaining every single cause behind all the pleural diseases. He does not need to look on any PPT or book to explain. He is experienced and giving the examples of real scenarios makes the session more interesting. Dr Wasib explanation about the different approaches was commendable. To begin with different types of Pneumothorax, pleural effusion, types of effusion, importance of bedside ultrasound the barcode and seashore signs
The OSCE case in aspect of MRCP was helpful for me to understand they underlying cause behind the patient's presentation.

I am thankful to Dr Ashfaque who attends all the lectures with us with all the dedication and devotion and summarize all the golden points of lecture at the end Thank you

FEEDBACK # 7

Sidra Asad

It was an amazing session which mainly covered 2 topics (Pneumothorax and Pleural effusion). Through this lecture, i have learnt a lot of new things and its more about practical knowledge like how to evaluate a person with simple pneumothorax and how to identify different causes of chest pain while taking history. Dr Wasib has discussed some very important topics related to MRCP exam and has covered almost all aspects of these topics in regards to clinical settings and hospital admission. (How to proceed in A&E and when to admit)? Case presentations were organized and all points were discussed step by step. This presentation was more clinical and at the end of the session, Dr Ashfaque has summarized all important points once again. Thank you so much.

FEEDBACK # 8

Bushra Khan

It was a very important topic covered in terms of MRCP as well as clinical practice. Dr Wasib delivered it with so much passion. He didn't have proper resources for the talk because of unforeseen situation but still he delivered his commitment n given us an excellent talk. He knew his stuff on his fingertips. very professional and profound, inspired to attend this lecture. Every single minute was worthy👏⭐

FEEDBACK # 9

DrShafik Zaid

Such an outstanding lecture delivered by Dr wasib on pleuratic chest disease its outcome acute management and correlation with ca lungs particularly on pneumothorax how to work on outpatient and further understanding. Dr ash hints point on post lecture mind blowing. Even a single lecture covered so much i don't know how wonderful will be after complete pulmonary session. Feel so much excitement about it. Pakistan really demands for such platform and almost every med professional is eagerly waiting for mentor like Dr Ash hats off.

FEEDBACK # 10

Suhail Ahmed

Dr. Wasib delivered this lecture in a beautiful way and touched all the points. I learned a lot such as USG use in pneumothorax and its related signs and the new BTS guidelines. Dr. Wasib showed his great dedication with this course by delivering this lecture while he was traveling with his family.
Dr. Bushra did remarkably well in the OSCE. And in the last Dr. Ashfaaque gave his input and summarizing everything.
Thanks Dr. Ashfaque and Dr. Wasib.

FEEDBACK # 11

Dr. Mariam Sultan Khan

Indeed an amazing session yet again. Dr Wasib lecture depicts his deep knowledge and insight on the subject. The whole session was so fluid, no hiccups at all.
Starting from pneumothorax its types and new BTS guidelines on management of pneumothorax. Significance of bedside ultrasound chest in pneumothorax
He also discussed Pleural effusion in great detail including transudative, exudative, Pleural tap findings.
Hepatic hydrothorax, 3 C's,
Importance of detailed history, dresslers syndrome post CABG, LENT score for malignant Pleural effusion. It was simply brilliant. Then, the osce session was great Dr bushra did an excellent job. Once again, Dr Ash Thank-you for giving us this platform to learn from the best - giving us a new beginning. Appreciate it!

FEEDBACK # 12

Dr. Abubakar Tariq

Sir today was a very comprehensive lecture on pleural diseases
I learned the types of pneumothorax, its presentation, when to suspect this and the use of chest drain
Regarding pleural effusion
The 3Cs CCF CRF CLD
Main difference between trans and exudative effusion
And many things more
Thanks Dr Syed Wasib and sir ash

FEEDBACK # 13

Dr. Uzaima Nighat

Today’s session by Dr Wasib was amazing. He very well explained pneumothorax, pleural effusion. Difference btw exudative and transudative fluid. Mesothelioma was explained very well.

Thank you Dr Ash for always adding useful points related to the topic and exam.

FEEDBACK # 14

Dr. Ramsha Tasnim

Today a wonderful session of 1 hour and 30 mint
Very well and precise explanation of pneumothorax its classification
Investigations and treatment acc tou BTS guidelines and also plueral effusion causes and treatment of underlying diseases
Dr Bushra osce session was very well and detailed history of case
Dr ash give over view of all the lecture and also discuss case about pneumothorax .
Thank you Dr Ash for this amazing lecture session

FEEDBACK # 15

Dr. Nasir Hayat

This session was wonderful and nicely taughted.I learned alot .This session was runned very smoothly. The osce was examine focus i real enjoyed it.The pleural diseases and pnemothorax approach was wonderful.Its highly recommended for Doctors to join it to have hold on it and get grib on it and be very skillful doctors.

FEEDBACK # 16

Dr. Arshad Ali Khan

today session was so informative nd sea of knowledge..by today lecture we knew how to approach pleural effusion and management specially we learnt lent score in pleural effusion and well scrore in pulmonary embolism.. today osce was so interesting and full of informative..besides these well explanation of pneumothorax..
Thanks Dr wasib and Dr Ash

FEEDBACK # 17

Dr. Ghulam Saddique

It was a very Comprehensive and compact session delivered by Dr .Wasib about the over view of Pneumothorax and Pleural diseases.
First classified the pneumothorax into Primary Spontaneous & secondary spontaneous .Then management plan according to BTS guideline .
Told the significance of chest Ultrasonography at bedside to indentify Pneumothorax and Pleural effusion.
Sometime after putting chest drain lungs don't expand so this means it could be bronchopulmonary fistula formation.

He discussed Pleural fluid that can be exudative or transudative ,what is the role of lights criteria . pH less than 7.2 or LDH more than 1000 indicate empyema thoracis, Hepatohydrothorax in liver cirrhosis, Chylothoracic (high Triglycerides in pleural fluid) and Pseudo chylothorax (high cholesterol in pleural fluid).
Malignancy of pleural membrane mesothelioma and it's types
Epithelioid good prognosis while sarcomatoid has worse prognosis.
The most importance of LENT scoring on which all treatment depend .
Then, the osce session was great Dr bushra did an excellent job. Once again, Dr Ash Thank-you for giving us this platform to learn from the best - giving us a new beginning.
I am proud to ba a part of London GEM Programme.

FEEDBACK # 18

Dr. Neelam Zehra

A great session today. I am amazed how he grasped our attention for the whole span without even using any presentation. He was teaching us cases like cases being discussed in rounds covering all details and step by step management. I always found pneumothorax and pleural effusion identification and management very difficult but he explained it like a piece of cake and step by step management according guidelines was commendable.
The way he taught it gave us confidence in treating a patient and owning them for proper care which is not very common among teachers here. The way he gave us doctors time in between his family time is highly appreciated. Thank you Dr. Wasib.
Special thanks to Dr. Ash who keep organizing sessions like that every week. He truly owns us like no one else does and I'm glad to be a part of this program. They way you summarized the whole session in few minutes is exemplary.

FEEDBACK # 19

Dr. Aiman Saeed

This was a wonderful session and well precised
It taught me how to approach a pt with pneumothorax , pleural effusion
How to classify pneumothorax , differenciate between trasudative and exudative fluid, difference between chylothorax and pseudochylothorax , lent score which i did knew before.
Management of different pleural diseases
Overall i learned alot of things today .

Once again Thanks Dr wasib and Dr Ash for ✨

FEEDBACK # 20

Dr. Ahmad Tanveer

It was a very great comprehensive And compact power pack session by Dr Wasib about the Types of Pneumothorax and its management options .
Primary,secondary and itrogenic. Management plans axcording to BTS guidelines.
For the 1st time came to know that USG chest is fastest way to identify Pneumothorax and pleural effusions. As previosuly chest drain management seem to be the 1st thing to do but after your explanation the needle aspiration and chest drain came for complicated cases and for most of the Pneumothorax observation is first line and only symptomatic.
Then pleural fluid types exudative and transudative types how to manage them and what to go for cytology in tap examination
Then Mesothalioma was explained in detailed its great to understand so easily by you .
Osce part was refreshing too by Dr Bushra and Dr Wasib very informative . DR ASH Thanks alot for arranging such a session and taking personal interest in our training . I am really obliged to be part of LGEM MRCP group

FEEDBACK # 21

Dr. Tariq Farhad

It was an amazing one hour of learning in which dr was
It taught us about pneumothorax and its classification, pleural effusion, the difference between transudate and exudative fluid, difference between chylothorax and pseudochylothorax. There was also a discussion about the LENT score which was a new thing for me.
One of the suggestions is to have a PPT is very important to keep the audience concentrated and it will be helpful to revise also.
Dr. Bushra did an excellent OSCE, I learned a lot from that mock pace.

FEEDBACK # 22

Dr. Ghazala Sheikh

This session was outstanding; hats off to Dr Wasib who left his family in midway just to conduct this class. Absolutely we regard you sir.
Lecture was so informative I learnt,

● most of primary pneumothorax which we are facing in middle ages specially in Talls, and another risk is use of Cannabis, marfans syndrome and family history of homocystenemia.
● BTS guidelines are changed from last 1 year in which pateints are managed without intervention until there is hemodynamical unstability
We send them home after 48 hours we repeat chest x Ray
Usually pneumothorax resolves in a 7 day period or in 2 weeks so we observe them and send them home with pulse oximeter.
Irrespective of size of pneumothorax, hemodynamic stability is the main focus.
● At start only simple aspirations e 16G or 18G cannula or 6 French catheter, pleural aspiration kit, and then if pneumothorax improves send home if Not improves put chest drain and admit him.
● U/S chest is a very useful tool to pick pneumothorax, if you are in emergency you can perform U/S chest (bar coat and sea shore sign) .
● if its a 1st episode do simple chest xray if it's a 2nd episode do HRCT chest to rule out any other lung pathology
● LAMP (lymphangiomayomatosis) a rare cystic lung disease which can rupture and cause pneumothorax Bilaterally.
● in immunocompromised pateints do HRCT. Rarely we send alpha 1 anti trypsin and do spirometry to access lung function.
● followups should be for 2 weeks,
Exertions avoided
Air travel is not allowed
Extreme sports such as diving etc is restricted
● chemical pleurodesis with TALC if pneumothorax is Reoccurring (28% e psp 45% e ssp)
Other than that BTS pleural algorithm was discussed. Pleural effusion, empyma, pulmonary embolism were cleared in a comprehensive way.
2 cases were discussed by Dr Ash.
Thanks to London.gem for making these complicated topics much easier and easily absorbable.
All credit goes to @Ash Bhai for creating such a nice platform that we can directly connect with UK consultants
FEEDBACK # 23

Today's lecture was a great learning session and covered a lot of learning points about Plerual Lung Diseases.

He discussed about pneumothorax, classification of Pneumothorax, pleural effusion, causes, its etiology and management of pneumothorax,pleural effusion according to latest guidelines(BTS), difference between transudative and exudative fluid.

How USG Chestpain pick up pneumothorax(Barcode and seashore). Importance of Alpha 1 Anti-trypsin Level. Complications of Pneumothorax.

Dresslers Syndrome. How pleural tap lab findings will be different in chylothorax and pseudochylothoax . Significance of Serum LDH,ADA Levels.

Interesting OSCE session was done. Dr.Bushra done very well.

Dr.Ash gave his review about the whole session and concise the whole session very well.

Thanks Dr.Ashfaque and Dr wasib

FEEDBACK # 24

Dr. Leela Ram

It was extraordinary session by Dr. Syed Wasib, he was much dedicated to his profession because he delivered his lecture without help of slides. I felt that this session might not be so much informative. On the contrary, it evolved the most wonderful. He explained types of Pneumothorax ie, Primary spontaneous pneumothorax, Secondary pneumothorax, Traumatic pneumothorax & Iatrogenic pneumothorax. Each pneumothorax has different management depends on presentation along with age, underlying causes, the detailed history and co-morbiditiess. Spontaneous pneumothorax is suspected in COPD, Asthma patient while secondary Pneumothorax is also COPD & Asthmatic patients after 50 or 60 years. X-ray is indicated to see how much it is. Usually small air pneumothorax doesn't require intervention unless patient is hemodynamically unstable ie, low blood pressure, tachycardia, tachypnoea as well as disoriented. Needle aspirations and chest drainage is the treatment of pneumothorax however, advancement in Medicine, management is changing.

His delivery of lecture was extraordinary, he described everything in detail, he remained energetic till the end. He is the really extremely great consultant.

I have learnt that primary and secondary spontaneous pneumothorax can be managed at home Irrespective of its size according to new guidelines 2022. Such patients are closely monitored with pulse oximeter and asked the patient to come

after 48 years to repeat chest X-ray. Moreover, differential diagnosis of pneumothorax is MI, Pulmonary embolism, Aortic dissection should not be ignored. Ultrasound can be undertaken if patient can not get up or move.
This lecture will significantly change my practice of handling such patients who present with shortness of breath, chest pain, tachycardia, tachypnoea and low blood pressure. I will consider pneumothorax and examine them physically to confirm tracheal deviation & absent breath sounds.
Dr. Ashfaque summarised everything in the end right away and in the beginning he shared an interesting scenario of pneumothorax.
Thank you Dr. Syed Wasib & Dr. Ash for such a nice presentation and entire discussion.

FEEDBACK # 25

Dr. Emmanuel Qammar

Excellent lecture again
Emphasis on important key aspects for mrcp exam was spot on :) really liked it
Pneumothorax its etiology and management of pneumothorax according to new guidelines
Significance of Alpha 1 Anti-trypsin.
Pleural effusion its causes Exudative and Transudative.
Dresslers Syndrome and difference of chylothorax and pseudochylothorax in pleural tap
Importance of Serum LDH and ADA in TB diagnosis.
The History taking case question given to DrBushra (welldone) was a learning experience too

FEEDBACK # 26

Dr. Raja Mobeen Ahmed

It started with quite an interesting case by Dr. Ashfaque, which had an easy-to-miss Pneumothorax unless the clinician kept a high degree of suspicion and went for the X-ray. Dr Wasib taught about the types of Pneumothorax, the new BTS updates regarding management (depending on hemodynamic stability and not on size), about cocaine abuse leading to pneumothoraces, the ‘bar-code and loss of sea-shore sign” on Ultrasound to detect pneumothorax. I also learnt about what to do in case the lungs do not expand following insertion of a chest drain and about bronchopleural fistulas, and about pleurodesis.

Next, there was a discussion about Pleural effusions, causes of transudative and exudative effusions, use of Light's criteria, criteria to differentiate empyema vs uncomplicated parapneumonic effusion, importance of ADA levels to help in diagnosis of Tuberculous pleural effusion, the 3 types of Mesotheliomas, the LENT score to determine prognosis with Malignant pleural effusion.
Dr. Wasib was able to deliver all of this in an effective manner despite no availability of a Powerpoint and I enjoyed the lecture.
The OSCE at the end was excellent with the possibility of a Pulmonary Embolism and also of Ovarian malignancy in the patient.
Overall, regarding the whole talk I give it a 10/10.

FEEDBACK # 27

Dr. Mohid Kannan

It was a concise and comprehensive session delivered by Dr .Wasib about Pneumothorax and Pleural diseases without proper resources to go through the topic.
How to classify pneumothorax , differentiate between trasudative and exudative fluid, difference between chylothorax and pseudochylothorax , lent score and management of different pleural diseases was explained very well.
Osce session was good. Dr Bushra did great. Dr Ash Thank you ,we all are learning from the best.
Overall i learned a lot of things today.

6th NOVEMBER 2022

EVENT NAME:

Tachy-Arrhythmias MRCP 1-2 & PACES by Dr. Nahal Raza Cardiology SPR UK

DOCTORS FEEDBACK

FEEDBACK # 1

Mehak Nabi

Amazing session conducted by Dr Nahal and summarised by Dr Ash. Learnt classification of tachyarrhyhthmia Svt Atrial tachycardia atrial flutter atrial

fibrillation VT management plan valsalva maneuver and so on...thank you Dr Ash for providing such platform.

FEEDBACK # 2

Sadia Abbasi

Cardiology chapter always remains tough for me especially Tachy-Arrhythmias Dr Nahal Raza did wonderful session and in organised manner i learnt alot .I always like her pictorial presentation now i will never forget types of AF by her slide show Classification of tachyarrhyhthmia, pathophysiology ,Svt, Vt, types of vt and difference between avrt and avnrt and management, when to give electrical cardioversion and pharmacological cardioversion. Ecgs slides at the end cleared futher concepts.

Dr ash talk on tachyarrhythmias and its management plan including modified valsalva maneuver ,4 points to remember before treating pt excellent . Dr mukhtia also presented a nice case. Thank you very much Sir for bringing London GEM Programme.

FEEDBACK # 3

Nasir Hayat

This session was amazingly presented it was full of knowledge and very practical session .I learned alot how to approach, diagnosis and treatment. It was runned very smoothly and all the questions was answered.I enjoyed the session.It was exam focus.I would highly recommend it for doctors to join it to become more skillful and get the grib on topics and understand the deepth of medical knowledge.The ECG learning was wonderful session.Proud to be London Gem MRCP candidate.

FEEDBACK # 4

Faiza Baig

Learning something everyday, and everyday is different. I love the way of dr Nahal's teaching with passionate and as an art,

Learned amazing basic skills and differences.

Types of tachyarrhymias and differences.

Dr mukhtiyar presented the case very well.

In the end of session Dr Ash gives review of the topic and how he manage the case of tachyarrhymias plus he told us about the maneuvers and guide lines

Thank you so much for this amazing lecture

Thankyou Dr Ash

FEEDBACK # 5

Ahmad Tanveer

Its a very informative MRCP oriented session started with
Classification of Supraventricular tachy arrhythmias ATRIAL FIB AND FLUTTER then Nodal AVNRT AND AVRT WPW Then Ventricular VT Torsades and Vfib .
Pathophysiology of all types discussed very detailed. Then management plan of each type depending on stable and unstable hemodynamic status discussed and cleared. Resuscitation protocol algorithm discussed clearing many confusions .
Then its was great to see the trial ECGs of all tachy arrhythmias shared by Dr Nahal. A very informative and detailed session .
At last Dr Mukhtiat gave the case presentation on SVT case and his approach in treatment of SVT .
DR ASH discussed his approach 4 point based in treatment of all arrhythmias .
Thanks Dr Nahal Dr Ash for such a great session and Dr Mukhtiar for his case presentation.

FEEDBACK # 6

Ghulam Saddique Saddique

Dr Nehal cleared many concept with her presentation. Things I learned from today's session : Classification of tachyarrhyhthmia,
SVT with heart rate 100-180Bpm
Atrial tachycardia atria rate > 100
Atrial flutter
Atrial fibrillation (1.proxysmal <7days, 2.persistant > 7days, 3.longstanding >1 year, 4. Long standing accepted AFib)
Permanent .
Then classification of Atrial fibrillation
(EHRA) .
CHA2DS2 VASc estimate stroke risk
AVNRT (only restricted to nodal area)
AVRT (there is a accessory pathway)it include orthodromic and antidromic tachycardia).
VT
Types
Non sustained (3 or more ventricular beats of < 30sec)

Sustained VT (> 30sec)
Monophasic VT (it has same configuration)
Polymorphic VT (it has changing configuration).
Biphasic VT.
Then talked about medication causing torsade de point all antipsychotics.
Narrow complex tachycardia QRS <120msec while wide complex tachycardia is > 120msec.
Cardioversion Rules :
1. QRS narrow & regular cardiovert at 50 to 100 j.
2. QRS narrow & irregular cardiovert at 120 to 200 j.
3.QRS wide& regular cardiovert at 100j.
4. QRS wide & irregular defib.
Ecgs at the end of session cleared our concepts. Overall its was an excellent session.
Dr ash talk on tachyarrhythmias and management including modified valsalva maneuver was great and I am definitely going to practice this on my patients in future . Thankyou so much sir for you time and kind efforts.
Dr mukhtiar also presented a good case which was perfect presentation of SVT.
I am proud to be a part of London GEM Programme .

FEEDBACK # 7

Faisal Butt

Today's lecture was a great learning session and covered a lot of conceptual and clinical learning points about Tachy-Arrhythmias. It taught following points:
Svt-Atrial Arrhythmias, Sinus Tachycardia , Atrial Tachycardia ,Atrial Flutter.
SVT, VT. AVNRT. Typical AVNRT, Atypical AVNRT.
Pathophysiology of Atrial Fibrillation. EHRA classification of Atrial Fibrillation.
CHA_2DS_2-VASc Score for Atrial Fibrillation Stroke Risk.
Narrow complex Tachycardia , Broad Complex Tachycardia.
Management of Adult Tachaycardia(with Pulse) According to Resusication Council UK
A lot of practice ECGs were shared by Dr.Nahal. And the flowcharts/algorithms kept the whole lecture very interesting.Dr.Nahal indeed has very good grip on the subject, she gave a fantastic lecture.
Dr.Mukhtiar presented a case on Paroxymal Supraventricular Tachycardia, It was very detailed case , from history till management, it was great.

At the end ,Dr.Ashfaque gave his review about tachyarrhythmias and how he manages such cases and summarized the whole session in few minutes.Great Job.
Thanks Dr Nahal Raza
Thanks Dr.Ashfaque Ahmed for facilitating the whole session,
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 8

Dr. Muhammad

Dr Nehal cleared many concept with her presentation. Things I learned from today's session : Classification of tachyarrhyhthmia, difference between svt and vt and management regarding when to give electrical cardioversion and pharmacological cardioversion. She also explained types of vt and difference between avrt and avnrt very well. Ecgs at the end of session cleared our concepts. Overall its was an excellent session.
Dr ash talk on tachyarrhythmias and management including modified valsalva maneuver was great and I am definitely going to practice this on my patients in future . Thankyou so much sir for you time and kind efforts.
Dr Mukhtiar also presented a good case.

FEEDBACK # 9

Dr. Uzaima Nighat

Such an informative session conducted very well by Dr Nahal. Tachyarrhythmias is a complex topic which was made understandable by the efforts of dr nahal. SVT and its classification all complied in one chart and discussing each and every classification in detailed. A little quick ECG quiz which made very easy for me to differentiate btw polymorphic and monomorphic and torsade pointes.
Dr mukhtiar presented the case very well. Helped alot to corelate with what we discussed in the topic.
Lastly, Dr Ash always has something to add valuable. The difference of seconds btw wide and narrow QRS complex and the 4 signs to consider before starting treatment.
Thank you all the three drs for giving such a wonderful session today!!

FEEDBACK # 10

Dr. Ghazala Sheikh

I always like to be taught by Dr nahal a very friendly approach by her. The way she teaches is incredible
I learnt,

● classification of tachyarrhythmias
● Atrial flutter
● Atrial fibrillation it's classification ie. EHRA
● Ventricular tachyarrhythmias and its types ie. Sustainable, monophasic, polymorphic, biphasic.
● Cardioversion Rules
● ECGs
● torsads de points e Drugs like antipsychotics, macrolides etc

CBD by Dr. Mukhtiar on paroxysmal supraventricular tachycardia was amazing
At the end Dr Ash, emphasised tachyarrhythmias in a very comprehensive way
Thanks to dr Nahal Raza Dr Ashfaque Ahmed for such a informative session 👏

FEEDBACK # 11

Dr. Zeeshan Ayaz

A very informative session. It was a very complex topic but dr Nahal tried to make it understandable .Things I learned from today's session are : Basic mechanisms of different types of tachyarrythmias, SVT and VT differences and their management, Types of Attial fibrillation and its management, pharmacological and electrical cardioversion and when to use them. ECG's quiz at the end was very helpful as well.
Dr Ash summarised everything at the end and gave his valuable input on 4 things to consider to differentiate between hemodynaamicall stable and unstable patient.
DR Mukhtyar presented a very detailed case and helped us in correlating the topic.

FEEDBACK # 12

Dr. Ramsha Tasnim

Wonderful lecture of l hour 30 mint about tachyarrthmias . important points tou differentiate b/w Vt and Svt ..types of svt and vt
Ecg findings and management.
Dr Ash summarized the lecture at the end 4 things to differentiate b/w hemodynamically stable and unstable patient.
Dr Mukhtar give the precise presentation /case discussion on proxymal svt .

FEEDBACK # 13

Dr. Mariam Sultan Khan

The lecture started with immense energy followed by avalanche of information. I really appreciate Dr. Nahal how she concised a vast topic. I felt, even a little bit of distraction will result in missing out on information. She started by normal

electrical conduction of heart then classification of tachyarrhythmias SVT Atrial fib (paroxysmal, persistent, long standing persistent, permanent). Typical and atypical atrial flutter, nodal AVNRT and AVRT WPW then VT including monomorphic, polymorphic and torsades de pointes. Moreover, Ket differences between VT and SVT and how VT can be life threatening. Finally, Management plan based on patient's hemodynamic status was discussed in great detail. All the algorithms shared were extremely helpful. Really enjoyed quiz on ecg slides. Today's case presentation by Dr mukhtiar on SVT was also great to understand real scenario.
And I cant thank Dr Ash enough. The way he summarised the lecture in the end and give us his approach its really commendable.
Definitely will go through the lecture multiple times to grasp every bit of it
Hope everyone has a good week ahead

FEEDBACK # 14

Dr. Muhammad Shafiq

It was no doubt a wonderful lecture organized by dr Nahal thanks for her dedicated lecture. We learned the main crux of tacchyarrthmia. The pathophysiology of it. Its essy understanding its clinical understanding. I only know Af Atrial flutter by ecg but now with such immense lecture i wish i can b voultererly stand on ccu or emergency ground to rescue the pts. Tacchyarrthmia is sucha technical topic i came to know it today. I learned the basic Abc of it tacchyarrthmia mangnnt on finger tips amazing. Torsade wpw vt vf I enjoyed it. Thanks dr Ash Dr nahal

FEEDBACK # 15

Dr. Abubakar Tariq

Sir today's lecture was very interesting and at the same time a little hectic because arrhythmias are tough to understand but dr Nahal made it look very interesting and easy to understand with her flowcharts
I learned about classification of tachy arrythmias
Score of risk assessment for stroke
Different ecgs
Learned about cardiovesrion
And about doses of anti arrythmic drugs
And the most of all sir ash how you summarize
It makes the whole lec easy to digest.
Thanks

Dr Nahal and sir ash

FEEDBACK # 16

Dr. Arshad Ali Khan

Today session was so informative and productive. Today we learnt how to manage tachyarrhythemia especially sinus tachy , SVT , AF , VT, AVRNT , VF .
We also learnt how to defferiate arrhythmia in ECG..
We also learnt which patient will cardiovert and how to stablize.
In the end of this session Dr.ash summarise all lecture in 5 min with example
Thank Dr Ash and Dr nahal

FEEDBACK # 17

Dr. Beenish Naveed

Amazing explanation and teaching by Dr Nahal, once again she nailed it with her unique way of teaching.A very important topic from exam point of view as well as clinically, the differnt types of arrythmia with management wad amazing. It includes VT SVT AVNRT and its sub types, Atrial Fibrillation and its management according to the Resuscitation Council UK. Everything was explained so well and clear many doubts , first time got to know the background physiology.
The cherry on the top was Dr Ashfaque's learning gems 💎 which sums up the whole session in few key points.
Thank you so much Sir and LGEM team for another important and interesting topic.

FEEDBACK # 18

Dr. Neelam Zehra

She's wonderful at teaching. How simply she classified Tachy-arrhythmias.
When to label SVT, VT, monomorphic VT, polymorphic VT, AF, EHRA classification, CHA2DS2-VASc score for risk stratification. Narrow complex and wide complex tachycardia.
After developing all concepts she cleared it everything by discussing different ECGs. It was a wonderful session. I really like the ways she delivers a lecture filling all the gaps and making sure everyone is on the same page at the end.
Like always Dr. Ashfaque's summarized the whole lecture in the end beautifully. Covering up all the important things.
Thank you all for the efforts you put on the weekend. Highly appreciated.

FEEDBACK # 19

Dr. Syed Kamran Hussain

She gave an amazing presentation. I cleared my concept with her presentation.she told us about

Sa node

Av node

Tachyarrhyhthmia,

SVT

Atrial tachycardia

Atrial flutter

Atrial fibrillation

proxysmal

persistant

Permanent

classification of Atrial fibrillation

(EHRA) .

CHA2DS2 VASc with stroke risk

AVNRT

orthodromic

antidromic

Non sustained

Sustained VT

Monophasic VT

Polymorphic VT

Biphasic

antipsychotics(side effects)

Narrow complex tachycardia QRS <120msec while wide complex tachycardia is > 120msec.

Cardioversion Rules :

QRS narrow & regular cardiovert at 50 to 100 j.

QRS narrow & irregular cardiovert at 120 to 200 j.

QRS wide& regular cardiovert at 100j.

QRS wide & irregular defib.

Ecgs

Antiarrythmic drugs.

Like always

Dr ash concise tachyarrhythmias and management including modified valsalva maneuver and side effects of old valsalva maneuver . It will help us in our fiture practice
Dr mukhtiar presented a nice case on svt
Thank you Dr Nahal and Dr Ashfaque.

FEEDBACK # 20

Dr. Leela Ram

It remained outstanding lecture with lot of knowledge. Our basic knowledge revised, got to know many more about arrhythmias. SVT arises in atria or AV node, firing rate 100-180. Atrial arrhythmias are Sinus tachycardia, atrial tachycardia, atrial flutter, AVNRT & AVRT.
Her delivery of lecture was fantastic with lot of energy. She used more and more figures & graphs which enhances learning with rapid pace.
I learned many new points regarding arrhythmias & difference amongst Paroxymal atrial fibrillation, persistent atrial fibrillation, long standing persistent atrial fibrillation & permanent atrial fibrillation. The classification on Atrial fibrillation was entirely new to me. Furthermore, Non-sustained VT, sustained VT, Monomorphic VT, polymorphic VT & Biphasic VT were known but uncleared concepts.
Our practice continually changes as we forego with this training.
Dr. Ashfaque summarized in the last, he explained his ways to tackle such arrhythmias patients in Acute and Emergency setting. He said that patient is put in propped up position to slap atria so that it may revert into normal rhythm. Always ABC approach, need to be careful while giving electric shock & etc.
Dr. Nahal & Dr. Ash remained outstanding till the end. Thanks both of you for such a nice lecture.

FEEDBACK # 21

Dr. Emmanuel Qammar

A great learning experience no stone left unturned conceptually and clinically.
All significant topics were covered : Tachy-Arrhythmias.
This session was refreshing and improved our in-depth knowledge of the following points:
Svt-Atrial Arrhythmias, Sinus Tachycardia , Atrial Tachycardia ,Atrial Flutter.
SVT, VT. AVNRT. Typical AVNRT, Atypical AVNRT.
Pathophysiology of Atrial Fibrillation. EHRA classification of Atrial Fibrillation.

CHA_2DS_2-VASc Score for Atrial Fibrillation Stroke Risk.
Narrow complex Tachycardia , Broad Complex Tachycardia.
Management of Adult Tachycardia(with Pulse) According to Resuscitation Council England.
The Qs and As session for ECG was excellent and stimulating
Usage of flowcharts and algorithms was well explained.
Case presentation on Paroxysmal Supraventricular Tachycardia by Dr.Mukhtiar was well structured,from History details and management.
Gold nuggets from Dr Ashfaque Ahmed Sorathia are awesome! :)
Grateful and thankyou to Dr Nahal Raza and Dr.Ashfaque Ahmed for both informative and pleasant lectures

FEEDBACK # 22

Dr. Raja Mobeen Ahmed

It was a well-structured lecture, starting from the very basics of anatomy and electrophysiology and later on covered the tachyarrhthmias with their diagnosis and management in detail. Dr Nahal kept all of us engaged throughout the lecture with her questions and interesting ECGs. I learnt about the differentials in Supraventricular Tachycardias, the use of CHA_2DS_2VASc to determine anticoagulation strategy in Atrial Fibrillation, and the pathophysiology of AVRT and AVNRT and a beautiful algorithm to help differentiate between these tachyarrythmias.
I learnt about new terminologies regarding types of Atrial Fibrillation, types of Ventricular Tachycardias, the drug classes which prolong the QT interval, and the ALS algorithms for management of these conditions. Overall, a feature-packed lecture.
The Case discussed at the end by Dr Mukhtiar was also interesting and well-presented. Dr Ashfaque also taught about the Modified Valsalva maneuver in hemodynamically stable SVT and the disadvantage of using the carotid massage with the possibility of causing a stroke.
All the learning points in this lecture are golden life-saving points which every doctor should know and I am glad I am now aware of them.

FEEDBACK # 23

Dr. Mohid Kannan

Wonderful presentation. Cleared all the concepts related to topic.started from Normal electric supply of the heart,

Classification of Tachy-Arrhthmias with key points of SVT Vs VT ,A.fibb, , A.flutter, CHA2DS2 VASC score with stroke risk, psychotics drugs effect,ECG interpretation and antiarrhythmic drugs management. At the end Dr. Ash summarized the the topics.
Thanks Dr Nahal and Dr Ashfaque.

20th NOVEMBER 2022

EVENT NAME:

Fragility Fractures, Osteoporosis & Bone Protection by Pam Trang Mar & Dr Ash

DOCTORS FEEDBACK

FEEDBACK # 1

Rabiyyah Bashir

Very interesting lecture on osteoporosis and osteoporotic fractures... Much needed information on how and when to manage. Even in endocrinology department i didn't get this much information about how exactly do we replace vitamin D. Thankuuuu so much DR PAM and Dr **Ashfaque Ahmed** Sir for the session. ❤️❤️❤️ Thanku **London Global Emergency Medicine** ❤️

FEEDBACK # 2

Qaisar Shah

Case 1 Presentation (FRACTURE OF DISTAL END OF RADIUS) by Dr Abubakar tariQ
Case 2 Presentation (INTER-TROCANTER FRACTURE OF FEMUR) by Dr Neelam
PAM covered:

☞ Explained Osteoporosis & its causes
☞ Metabolic Bone Disease
☞ Pathophysiology
☞ Causes in female
☞ Causes in male
☞ Common Clinical Features
☞ Indications for DEXA SCAN

☞ FRAX SCORE

☞ NOGG

☞ T- SCORE

☞ Non- Pharmacological & Pharmacological Treatment

At last Dr Ash Summarized & add important points as Usual (new word ➜ VERTEBROPLASTY)

The session was amazing & i learned alot of new things regarding FRAGILITY FRACTURE,BONE PROTECTION & OSTEOPOROSIS

FEEDBACK # 3

Mehak Nabi

comprehensive and amazing session by Dr Ash and Pam Trangmar. Detailed discussion regarding osteoporosis causes risk factors frax score T score NOGG guidelines indication of dexa scan treatment plan. Dr Neelam and Dr Abubakar presented case very well. Thank you Dr Ash for summarizing the discussion.

FEEDBACK # 4

Bushra Khan

Amazingly informative session it was. Dr Pam is been managing osteoporotic patients actively in UK and its very authentic to learn from her. He covered the common causes in males as well as females, pathophysiology, steroid induced, indication for dexa scan, when to scan, T score interpretation, Frax score, treatment with bisphosphonates, duration of treatment and holiday period which was new to me, xrays of patients on treatment which was again new to me.

The case of haemachromatosis discussed by Dr Ashfaque was very interesting.

2 CBDS by Dr Neelam and Dr Abubakar Tariq was good as well.

Many thanks London Gem

FEEDBACK # 5

Hani Suhail

Today's lecture was about how important our physiology is for us and any mishap can be chaotic if not given with the right amount needed. Fragility fractures and osteoporosis with the importance of vit D and calcium for our bones to stay firm and strong against stress and forces as well as how fragile and brittle can they become if not provided with the necessary factors can affect them. FRAX score and the management of these conditions were given in a very simplified manner.

Thank you Pam and Dr. Ash for always providing us with our daily life experience conditions and how to always be better at what we do.

FEEDBACK # 6

DrKiran Feroz

Special lecture designed for elderly.... experiencing osteoporosis....we all luv our elders ...specially our parents and grand parents.....so this special lecture was designed for them ...Dr.Pam today's lecture made me realize how imp is to get dexa scan ....bone density for this age grp....causes of osteoporosis.. precautions..identification and treatment beautifully explained....the correct loading doses ....mantainence and how to check CA and vit D all clearly explained....thanks Dr.Pam and Ashfaque bhai for today's lecture .

Thanku Dr.Abubakar and Dr.Neelam for sharing cases today....we are thankful to u both ....no doubt both cases were quite interesting ....

FEEDBACK # 7

Syed Suhail Ahmad

A comprehensive lecture on one of the most common presentation in geriatrics especially females by Pam Trangmar,

Learned so many new things about OSTEOPOROSIS

Causes and Pathophysiology

T-Score

FRAX Score

DEXA Scan

Treatment modalities and duration

Bisphosponates and its importance

Vitamin D deficiency and loading dose etc etc

Summed up beautifully by the case presentations of LGEM colleagues and Dr. Ash's interesting pearls and clinical case.

Thank you LGEM 👍👍👍

FEEDBACK # 8

Sidra Asad

Very interesting lecture by Dr Pam. In this lefture she has briefly covered all aspects of osteoporosis like definition, causes, pathophysio and management. She has highlighted some very important points regarding treatment of osteoporosis with bisphosphonates and the correct doses of vitamin D levels. Also she explained when to do dexa and when not to, plus frax score for risk assessment and NOGG

osteoporosis guidelines, atypical fractures, T bone density chart were all well explained.
Moreover bisphosphonate role in management and how to correctly prescribe it (can cause side effects) was also taught.
At the end of session, some interesting case base discussions were held and Dr Ashfaque gave his valued review on the cases. Thank you for delivering this amazing lecture.

FEEDBACK # 9

Faiza Baig

The session attended was entirely wonderful.It was regarding osteoporosis and its causes,clinical features,DEXA scan, T scoring chart,FRAX,Bisphosphonates duration and its holiday treatment.
Miss Pam also emphasized the treatment guidelines, steroidal and renal effects on calcuim metabolism and bones density.
Also discussed atypical fractures and fragility, how to protect and prevent it.
The two CBDs by Dr Neelum and Dr Abubakar were good.
In the end Dr Sorathia summarized useful points like vertebral compression and new intervention vertebroplasty
Thankyou Dr Ash and all your team.

FEEDBACK # 10

Zia Hayat

It was an amazing session ,really enjoyed every bit of it .Really helped gain a lot of knowledge to manage elderly patients and the tutor Miss Pam was very professional and kind during her lecture.Thankyou dr.ash for arranging such a great lecture

FEEDBACK # 11

Javeria Wali

20th November 2022
Today's session on Fragility fractures, bone health and osteoporosis by Pam trangmar and Dr. Ash was really amazing. Discussion on this topic was much needed as this is a commonly encountered problem in elderly and post menopausal women. Pam gave a detailed talk on Osteoporosis, its Pathophysiology, Causes in female and males, Common Clinical Features, Indications for DEXA Scan, FRAX Score and its importance, NOGG, T- SCORE, Non- Pharmacological & Pharmacological Treatment (Maintenance of calcium, vitamin d levels,

bisphosphonates and emphasis being on intricacies of prescribing them, time, precautions, what to avoid, discuss with drs.). Dr Ash added important points with case discussions, vitamin D loading and maintenance dose and vertebroplasty as a possible intervention.

FEEDBACK # 12

Faisal Butt

Pam Trangmar delivered a comprehensive session on Osteoporosis & its causes. Metabolic Bone Disease.Pathophysiology.Causes of Osteoporotic Fractures in males and females. When to do DEXA SCAN,FRAX Scoring System,NOGG,T-SCORE, Non- Pharmacological & Pharmacological Treatment of Osteoporosis.
2 cases were Presented by Dr.Neelam And Dr.Abu Bakr ,which were insightful.
At last Dr Ash Summarized the whole session and transferred his clinical knowledge about osteoporosis and discussed a case of hemochromatosis, hypogonadism and osteoporotic fracture.
It was amazing session.
Thanks Dr.Ashfaque Ahmed for facilitating the whole session,.
Thanks Pam Trangmar
Thanks LGEM MRCP PROGRAMME

FEEDBACK # 13

Muneeb Ahmed

Attended this wonderful session by PAM and Dr.Ash on "Fragility fracture due to osteoporosis"
She discussed various causes,pathophysiology ,clinical features various assessment methods (FRAX SCORE/T-Score/indications of DEXA scan)
She also briefly discussed pharmacological and non pharmacological treatment options.
Indications of oral and parental bisphosphonates and their protocols.
Then 2 clinical cases were discussed by participants Dr.abubakar and Dr.neelam.
In the end Dr.Ash discussed a very interesting clinical case of osteoporotic fracture and underlying cause was hemochromatosis.
Learnt a lot from this session.Thank you London Gem team for such an amazing lecture

FEEDBACK # 14

Dr. Nasir Hayat

This session was Amazing .it was runned smoothly and all the questions was answered.It was taught nicely and organized very well.I learned alot osteoporosis clinical feature,Vitamin D , BMI , Bisposphate and the case presentation was wonderful.I enjoyed the session.I would highly recommend it for physicians to join for their bright future and be skillful physicians.

FEEDBACK # 15

Dr. Mohid Kannan

It was a wonderful session , covering almost everything including causes , pathophysiology, steroid induced, T score, Frax diagnostic tool and treatment duration guidelines.xray images interpretation, Nice case presentation by Dr. Abubakar and Dr. Neelam and Hemochromatosis case discussion by Dr. Ash.

FEEDBACK # 16

Dr. Abubakar Tariq

Today i learned about

1-What is osteoporosis, clinical features, its patho physiology, its causes

2-Most common causes of osteoporosis include hormonal changes, lifelong calcium deficiency, vitamin D deficiency, hyperparathyroidism, history of parental fracture, medications, lifestyle

3-Steroids 7.5mg more than 3 months can cause impaired calcium metabolism and can effect bones.

4. t-score tells us how prone you are for fragility, guides us to start bone protection. Indications of Dexa scan.

WHO Frax fracture risk assessment tool.

5-The need to maintain normal BMI.

6- Bisphosphate use and its duration.

Thank you LGEM

FEEDBACK # 17

Dr. Ghazala Nazeer

Like other sessions today's session was also worth listening attentively.

I learnt,

•Osteoporosis in detail

•vit D supplementation and their dosage

•Bisphosphonate it's method of intake and cautions

•T_score, FraX, DEXA scan

Thanks to the London.gem for all the guidance and supporting us to achieve our dream

FEEDBACK # 18

Dr. Ghulam Saddique

Today is a great learning session regarding osteoporosis and its management what I learnt is as under

1-What is osteoporosis, clinical features, its patho physiology, its causes

2-Most common causes of osteoporosis include hormonal changes, lifelong calcium deficiency, vitamin D deficiency, hyperparathyroidism, history of parental fracture

, medications, lifestyle

3-Steroids 7.5mg more than 3 months can cause impaired calcium metabolism and can effect bones.

4. t-score tells us how prone you are for fragility, guides us to start bone protection. Indications of Dexa scan.

WHO Frax fracture risk assessment tool.

5-The need to maintain normal BMI.

6- Bisphosphate use and its duration.

I am proud to be a part of the London GEM programme.

FEEDBACK # 19

Dr. Shafiq

Much stuff to learn really enjoyed. Again wil say it honour to me and proud to b trainee of GEM LONDON

LEARNING TODAY

what is osteoporosis its pathophysiology osteoblast vs osteoclast imabalence role

Most common cause Harmon deficiency of estrogn and other secondary causes

Clinical feature

Indication for Dexa scan when to scan or not high fracture RISK FRAx ANALYSIS

NOGG National osteoporosis guidelines group threshold from green-0.1 yellow2. 5 to red below 2.5 up to 3 tscan bone density chart

Treatment to prevent fragity fracture in osteoporosis life style change advise

Young female pt HRT Tibolone

Postmenopausal osteoporosis and male 1st line bisphosponate alandronic acid m/f resdrinate sodium M/F

Drugd intolerance
Glucocorticoid induced
Bisphonate duration and its important information
Atypical fracture xrays
Take home message
Thanks london Gem team thanks Dr ash

FEEDBACK # 20

Dr. Ahmad Tanveer

Very informative comprehensive to the point session on osteoporosis ,its causes ,features ,
pathophysiology
Most common treatable causes of osteoporosis include hormonal changes, lifelong calcium deficiency, vitamin D deficiency, hyperparathyroidism.
Importance of history,
, drug history, lifestyle modifications . Effect of steroids in worsening the disease
Importance of t-score tells us how prone you are for fragility, guides us to start bone protection.
Indications of Dexa scan.
WHO Frax fracture risk assessment tool.The need to maintain normal BMI.
Bisphosphate use and its duration. At the end case presentations were excellent
Thanks Dr Ash and Ms Pam
I am proud to be a part of the London GEM programme.

FEEDBACK # 21

Dr. Leela Ram

It was an outstanding session, she described Osteoporosis & management.
She delivered it smoothly and described that osteoporosis is a reflection of age related bone density decline. Skeletal growth peaks between 20-40 years. Causes include Changes in hormone especially post menopause, lifelong calcium deficiency, Vitamin D deficiency, Hyperparathyroidism & medicines.
I learnt that elderly people are at risk of fracture especially women after menopause. Hypogonadism, steroids usage. It's asymptomatic until fracture occurs, acute back pain or decrease in height. I will take good history, advise Dexa scan & FRAX tool & treatment includes Bisphosphonates: Alendronic

acid, Risedronate sodium, HRT, Tibolone in young female. Parental Bisphosphonates ie, Denosumab in intolerant cases

Encourage Life style change, check calcium and vit D deficiency & monitor treatment. Thank you Mam Dr. Pam and Dr Ash.

FEEDBACK # 22

Dr. Faiq Khan

A detailed discussion on bone health, osteoporosis, Fragility Fractures and it's management.

Ms Pam has her own compassionate way of teaching . Her description of osteoporosis and it's management was very rational and was based on frax score,t score and the dexa scan .

This approach seems to be far more effective at preventing fragility fractures in the elderly than our conventional approach.

Great learning as always

FEEDBACK # 23

Dr. Nouman

The session attended today was entirely a piece of beauty. Many great details were discussed regarding osteoporosis, its causes, indications of DEXA scan, T-scoring chart. Miss PAM went to great lengths to talk about different treatment strategies, keeping in view the different causative factors. The important of counselling was emphasized

The case discussions were nice. Dr Ash did add a few fine points such as vertebral compression fracture and vertebroplasty.

I think this clinical teaching session has definitely helped us realize the often neglected & most important aspect of care for elderly (or at risk) population. We are now more aware of the topic and more determined to perfect our clinical approach.

Thanks Team LGEM, PAM & our great mentor Dr Ash

FEEDBACK # 24

Just attended a very comprehensive lecture on Osteoporosis. It was a lecture full of new learning points along with revision of my previous knowledge.

For the first time learned about:

1- FRAX Score

2- How to diagnose Osteoporosis and Osteopenia using T-score.

3- Use of Bisphosphonates

4- the correct method of using Bisphosphonates
5- Role of Vitamin D and Calcium replacement before starting Bisphosphonates
At the end there were two case presentations and discussion on them by Dr Abubakar and Dr Neelum Zahra.

FEEDBACK # 25

Dr. Muhammad Saad

Today's session on osteoporosis and bone protection was the best one. A lot of concepts were discussed comprehensively in the session about Bone protection, Different scoring systems like FRAX, T score and DEXA scan. Medications,their indications ,when and how they should be administered. There was also discussion on orthopedic x-rays, NOGG etc. There was also a case presentation by Dr Abubakar Tariq and Dr Neelam.
Thanks Dr Ash and London GEM for arranging such brilliant session.

FEEDBACK # 26

Ayesha Mushtaq

Very important and usually not well addressed topic of Osteoporosis and Vitamin Deficiency was explained today.. Worth attending lecture and very crucial topic for every Physician which will help him or her during daily practice.. Thanku Dr **Ashfaque Ahmed** for your all efforts..

FEEDBACK # 27

Dr. Mariam Sultan Khan

Very informative session that comprehensively covered Osteoporosis its causes, treatment and prophylaxis, effects of steroids on calcium metabolism and bone cell function. Indication of Dexa scan followed by a very important slide of when to do dexa scan and when not to do, T- score and its clinical significance, FRAX score. Fragility and atypical fractures .
Case presentations by Dr abubaker and Dr neelam were insightful.
I always look forward to Dr. Ash's final words in every lecture. That's the essence of an hour's class
Thank you so much Dr Ash- an epitome of academic knowledge and clinical practice

FEEDBACK # 28

Dr. Imtiaz Ali Shah

Today we had an excellent session about FRAGILITY FRACTURES, bone health and OSTEOPOROSIS by Pam Trangnar. It was very informative session and covered lot of important aspects of the topic which include
PATHOPHYSIOLOGY.
CAUSES(Early menopause.,vit D deficiency,history ofparental hip fracture hyperparathyrodism,
MEDICATIONS..(Glucocorticoids)
LIFE STYLE.
INDICATIONS FOR DEXA SCAN.
CLINICAL FEATURES (FRACTURES, acute back pain,kyphosis with pain,osteopenia.)
FRAX TOOL.
TREATMENT(Life style changes,harmony replacement, TIBOLONE,ORAL BISPHOSPHONATES.
Important information regarding bisphonates uses include
Once wekly____same day----first thing in morning 30. .40 minutes before food....large amount of water. ..stay upright.....inform your dentist about the drug.
Overall it was an amazing session. Lots of new knowledge was absorbed especially FRAX TOOL and BISPHOSPHONATES THERAPY.Pam really delivered it in a very professional way. Excellent case presentation at the end by Dr Neelam zehra and Dr Abubakr.As usual dr ASH summarised the things in their own way of practice .
Thanks dr Pam for this wonderful presentation and also dr Ash for providing us this great appertunity of learning.

FEEDBACK # 29

Dr. Tehmina Jamali

We studied:
Learning the term Osteoporosis
Causes
Consider bone density
Treatment & prophylaxis
Fragility
Osteoporosis
Reduced bone density

Deterioration & weakness of bones.In this bones becomes so brittle & fragile that easy to break silently.
Most affectees are hip/spine/wrist ...
Symptoms:Fragility of wrist/back/hip bones etc,Ht.loss 2",Receding of gums,A curved ,stooped shape to the spine(dowagers hump)
Pathophysiology
Causes
Hormonal changes-Early menopause
Ca def(Anorexia,Crohn's disease)
Vit D def
H/O parental Hip #
Hyperparathyroid disease excess PTH -Ca release from bone.
Drugs.Glucocorticoids long term high dose.
RA
Life style low body mass,index,lack of ex.
ETOH excess,smoking
In Men
Hypogonadism-decrease levels of testosterone
ETOH Excess
Steroids
Steroids if taken in high dose like 7.5mg -3 mths
They have adverse effects on Calcium metabolism & bone cell function.They also affect intestinal Ca absorption & can cause a renal leak of calcium.
Clinical Features:
Normally asymptomatic untill #occurs or pt.comes with C/O acute back ache or gradual loss of ht.or becomes tiny.
Kyphosis e ch.pain
Pt's C/O incidental osteoporosis requires investigations.
Indications for DEXA Scan
& To scan or not to scan:
It's bone density scan uses low dose x-rays to see how dense your bones are.Used to assess risk of osteoporosis.
T-score are usually in the negative or minus range.The lower the bone density T-score the greater the risk of fracture.
Normal bone density pt.《75 yrs

+1.0
0.0
Osteopenia (low bone density)
-1.0
-2.5
Osteoporosis
Aims to prevent fragility # in pts' e osteoporosis
Life style changes
Increase activity(walking/cycling/dancing/stair climbing/aerobics/gardening)etc
Stop smoking & reduce ETOH
Maintain normal BMI-20-25Kg/m2
Adequate intake of ca & vit D
As vit D def very prevalent in elderly pts esp in house bound.Also no sunlight from the mth of Nov-March(in UK)
Healthy dietary habit
Also important is weight be it lean or obese.e.g.Victoria Beckham'(lean but had c/o osteopenia/osteoporosis)
Drugs
Female pt.(HRT)
Tibolone
Oral bisphosphonates
Alendronic acid
Risedronate
If intolerant of oral preparation parenteral bisphosphonate
Denosumab
Glucocorticoid
Zoledronic acid
Teriparatide
Bisphosphonates duration
It's better to stop after 5yrs of use then hold them on Rx Holiday for how much time needs evidence.Then get the pt's bone markers done before re-start of dose.
Aldendronic acid,Risedronate sodium & ibandroic acid are reviewed after 3 yrs.
Zoledronic acid is review after 3 yrs with Dexa scan done.
Important information
Always inform your pt.upon starting Bisphosphonate

Take once a wk on the same day;1s thing in the morning.
Take before 30-45 mins before meals
Take with a large glass of water
Stay up right
Inform their dentist that they are taking this medication
To come back if there is a problem with reflux,heartburn,a jaw pain(think necrosis)
Provide your pt.with a medication leaflet highlighting the rules
Atypical Femoral Fractures(AFF)
Occurs in stress or insufficiency # complicated by the use of Bisphosphonates or other bone turnover inhibitors.
CI:Biphosphonates
Take home message:
Encourage lifestyle changes
Stop smoking
Stop alcohol
Walk
Take calcium & Vit D
Physio/occupational therapy
Monitor Rx(with help of attendent at home)
Compliance
Need to maintain 4 wks' of drug taking.Next time pt is coming b/c they haven't taken medicine needs check & make sure he/she is taking Rx.
WHO Fracture Risk Assessment Tool(FRAX) we came to know how to do it's calculations like H/O of previous #/parent history of hip #/smoking/steroid therapy/alcohol intake/gender/wt/DEXA Scan
NOGG (National Osteoporosis Guidelines Gp Intervention Threshold
Guidelines website was shared.
2 presentations were presented one by Dr.Abubakar # of distal end of Radius & other case by Dr.Neelum on Inter-trocanter#neck of femur.
A case was shared by Dr.Ash on haemochromatosis & how he reached to the relevant diagnosis.
The tip he said that a Dr.has to dig the disease become a detective.

Dr.Ash also told us about the latest treatment for #of vertebra that is vertebroplasty in which a special cement is injected into the fractured vertebra to relieve spinal pain.
The lecture was learning & interesting to gain updated knowledge of what is happening in the medical world.
Thankyou Dr.Ash
Thankyou Mrs.Trangmar

FEEDBACK # 30

Dr. Sadia Naveed

Pam Trangmar delivered a comprehensive session on Osteoporosis and I learnt with lots of new things including understand the term osteoporosis, causes,consider bone density throughout a lifetime ,treatment and prophylaxis and fragility fracture vs atypical fracture. How to prescribed Bisphosphnote with pt education, Indi ation of dexa scan ,FRAX score,NOGG intervention threshold and T score bone density chart.
3 cases was presented by dr Abubakar ,Dr Neelem and Dr Ash with good learning points especially vertebroplasty .
Thanks Dr Ash for providing such a nice platform.

FEEDBACK # 31

HK Danish

Fragility fractures are one of the most leading causes of fall in elderly .
After attending this session I learned how to assess bone health and manage them .
l **I learned osteoporosis in detail (** reduced bone density , increase risk of fracture with age)
l I learned metabolic bone disease and its patho physiology
l Causes of osteoporosis in females
1. Hormonal changes (early menopause <45 years , Ca and VitD deficiency)
2. History of parental Hip fracture
3. Hyper Parathyroid
4. Medication : Long term use of glucocorticoids
5. R.A
6. Life style : Low BMI , smoking , lack of exercise Excess alcohol .
l Causes of osteoporosis in male
Is uncommon in males . hypothyroidism , Excess alcohol & long term steroids . Sedentary life style and low BMI .

l Use of steroids 7.5mg / days for more than 3 months is long term use

l Clinical features of osteoporosis and fragility fractures : may be asymptomatic , symptoms include Acute back pain , gradual loss of height , kyphosis with chronic pain , incidental osteopenia while investigation for some other reason .

l Indication for DEXA scan

l FRAX score

l National osteoporosis Guideline Group (NOGG)

l T-Score bone density chart

l Aims and treatment plan of osteoporosis .

l Medications : In young female hormone replacement and tibolone , In post menopausal and males first line of treatment is **oral bisphosphonates ,** alendronic acid **,** Rise Dronate sodium . If intolerant of oral treatment BIsphosphonate IV , Denosumab .

l Glucocorticoid induced osteoporosis first line is alendronic acid/Rise Dronate sodium. If intolerant **Zolendronic acid ,** Denosumab , periparatide .

l Always educate your patiens on while taking**bisphosphonates**

l Take home message is better life style

FEEDBACK # 32

Dr Muhammad Amash Khan

Today's session was a great one by Dr. Pam in which she taught about the assessment of the fractures and bone demineralization disease like osteoporosis and osteopenia in which the use of Franx and T- scoring, NOGG guidelines and use of dexa scan was discussed, thier medical treatment like bisphosphonates, vit-D and calcium supplements along with prevention of such diseases were thoroughly explained.

At the end case was presented by Dr abubakar and Dr. neelum.

Thank you Dr Pam your lectures are always amazing to watch.

FEEDBACK # 33

Dr Shahid Ahmad

It was such a wonderful and informative session by Dr pam. She covered the common causes in males as well as females, pathophysiology, steroid induced.

T score interpretation, Frax score i heard about it for the first time.

Treatment with bisphosphonates, duration of treatment and instructions to the patient using it.

Overall it was great.

FEEDBACK # 34

Dr Muhammad Ghayoor Khan

Again Best session arranged by LGEM on one of the important topic i:e Osteoporosis,Bone Protection and Fragility Fractures.

It was the best session, alot of concepts were discussed comprehensively about bone protection,different scoring systems like T-score,FRAX and Dexa scan. History taking, management,how to diagnose osteoporosis and osteopenia,medications(such as Bisphosphonates,Vit-D and Calcium)their indications,when and how they should be administered were discussed.

There was also case presentation by Dr.Abubakar and Dr.Neelam

Thanks

Dr.Pam,Dr.Ash and Team LGEM

FEEDBACK # 35

Dr Sadia Anwar

Todays topic was on Osteoporosis it was delivered by Pam,her way of teaching is v unique and one doesn't get bored .

There were many new learning points.

1) It is uncommon in men to have Osteoporosis rather they have osteopenia and if the former is present it is secondary to a disease process.

2) Indication of Dexa scan

3) NOGG guidelines

4) TX of Osteoporosis

5) The term of "Treatment holiday"

6) Atypical fractures

7) Loading dose of Vit D

DR ASHFAQUE told us about a real life case scenario regarding a man having Osteoporosis with dec testosterone, lh, fsh.And after doing iron studies he was found to have hemochromatosis which caused Osteoporosis.

DR Abubakar and Dr Neelum did case presentations which were informative as well.

Thanks Dr Ashfaque and London Gem for arranging these lectures.

FEEDBACK # 36

Dr Muhammad Umair Khalil

Today's session was in Osteoporosis with 2 CBDs and one Case of Hemochromatosis in an elderly pt who presented with multiple fractures (by Dr Ash).
Pam comprehensively told the definition pf Osteoporosis, its pathophysiology, causes of osteoporosis, osteo in Men, Association with steroid use (dose of 7.5 mg or more for period of 3 months can cause osteo) and clinical features of Osteo.
We also studied indications for DEXA scan, FRAX Analysis and NOGG guidelines with T-Scoring. Finally treatment options with lifestyle and medications were discussed.
2 cases were discussed. One by Dr Abubakar oof fract of distal radius and 2nd by Dr Neelum on intra-trochanteric fracture of femur.
Thanks & regards.

2nd OCTOBER 2022

EVENT NAME:

Acute Heart Failure & MRCP PACES OSCE by DR NAHAL RAZA Cardiology Registrar UK

DOCTORS FEEDBACK

FEEDBACK # 1

Gdmas Malik

Today was out first red-letter day of initiation of MRCP course by our great honorable sir prof Ashfaque Ahmad who cherished such a great programme for our Pakistani doctors. We seated here in Pakistan and has joined such a great accredited post graduate specialty training which seems a dream and unbelievable. Our great sir made unattainable things easily achievable. It up to us how we can perform and avail this golden opportunity
Today was an amazing session contemplated by Dr. Nahal Raza who delivered her compendium regarding acute heart failure and interpreted in a very handsome way. She took in all the aspects of acute heart failure. She taught us in very absorbing way .we learnt a lot about aetiology , presentation, investigation, and management of acute heart failure.

Our great prof Ashfaque Ahmad re-enforced at the end the important inter relationship of the case scenario which instilled in minds the essence idea of OSCE and case interpretation I learnt that how one should introduce oneself e.g. I am senior doctor working as a registrar would you please, tell me your name and age then proceed further . It was very handsome presentation. We learnt a lot.
I am very thankful to our honorable sir professor Ashfaque Ahmad for his great endeavors and unprecedented contribution.

FEEDBACK # 2

Gdmas Malik

Respected sir, the lecture delivered by Dr. Nahal Raza was very engrossing and attractive. She explained the topic and took in all aspects of the acute heart failure and inculcated us the full complete picture .She defined acute heart failure aetiology e,g ischemia, postpartum cardiomyopathy. Hypertension, arrhthmia. myocarditis, endocarditis, viral and bacterial causes She also delineated the systolic and diastolic heart failure she also talked about right and left heart failure. . Right heart is mainly affected by tricuspid stenosis, pulmonary stenosis, TR, and PR ,copd interstial lunge diseases ,sarcoidosis, Amyloidosis, Dilated cardiomyopathy, Reumatic fever ,that cause Tr ,TS,PR and PS . She also talked about left heart failure ,what causes it she enumerated the list. E.g. ischemic cardiomyopathy, Dilated cardiomyopathy, Reumatic heart disease, Hypertensive cardiomyopathy, Amyloidosis, sarcoidosis, constrictive pericarditis,, myocarditis, endocarditis, connective tissue diseases, Ehlar Danlos syndrome, MARFAN SYNDROME, REUMATOID DISEASE, .
DR NAHAL RAZA elaborated the clinical picture, e.g. fatigue, dyspnoea, orthopnea, cough, Ankles oedema, acites, jugular veinus destention and liver congestion especially in Rt heart failure, cyanosis , pump failure may also cause pulmonary oedema, and chest congestion, that cause cough ,
Investigation that should be undertaken are ECG, X-RAY chest, Echocardiography, angiography and viability scan for ischemia.
Treatment plan should be sort out to ameliorate the conditions e.g. Diuretics, Ace inhibitors, B,blockers, Nitroglycerin, and treatment of the underlying cause , prevention, salt restrictions. Water restrictions if excessive chest congestion,.
She taught in comprehensive way .we learnt much more regarding Acute heart failure.
I am very thankful to respected Dr. Nahal Raza for her comprehensive lecture.

Our great respected professor Ashfaque Ahmad at the end presented a very conspicuous case scenario, which instilled in our minds a new spirits and idea how to perform during viva voce in MRCP exam, I learnt how to introduce myself e.g. my name is Dr. Abdullah and I am senior registrar, and would you please tell me your good name and age .and then proceed further.
Our honorable mentor cleared the complexity and imparted us the knowledge how to perform properly .I am Very thankful to my great mentor professor Ashfaque Ahmad for his dazzling delivery of compendium regarding exam .

FEEDBACK # 3

Bushra Khan

So my feedback!
The first weekend with London Gem
Dr. Nahal's both lectures very spot on.
Love the acute cardiac failure lecture. The slides were so comprehensive. She made a difficult topic into a very easy to understand topic. As a non-emergency doctor and having experience of Haematology, Geriatrics and Rehab, I don't get to deal with most emergencies like Aortic Dissection and acute heart failure and this course is giving me that opportunity. Thank you so much for that⭐
Dr. Ashfaque experience speaks for itself ⭐

FEEDBACK # 4

Dr.Faisal Abdul Hanan Butt ·

Dr. Nahal taught very precisely. Her way of presenting a lecture is very interesting by making use of figures and tables. She keeps the lecture very interactive and answers our questions very kindly.
Dr. Ashfaque gave a brief OSCE Scenario (Infective Endocarditis) and emphasis on proper history taking and importance of basics. He always gives us a right direction to follow.
Thankyou Dr. Ashfaque, Dr. Nahal, LGEM Team.

FEEDBACK # 5

Sidra Asad

I am glad to be part of the 2nd lecture by Dr. Nahal
Overall, i have learned a lot by this lecture. Although acute heart failure is a vast and a very difficult topic, but this lecture has cleared all my concepts. There were some new points in the lecture like role of NIV for HF which was well explained. Moreover, the case presentation at the end of session was not only very

informative but was well explained by Dr. Ashfaque. He has highlighted the common mistakes we do while taking history and the most important things we miss in history

FEEDBACK # 6

Ghulam Saddique Saddique

Wonderful presentation delivered by Dr. Nahal on acute heart failure and OSCE scenario conducted by Dr. Ashfaque was really amazing.

FEEDBACK # 7

Beenish Naveed

Another high yield topic done by Dr. Nahal in her super style of teaching, and she helped us understand the core of heart failure with not only its treatment but its causes to understand and treat the underlying cause as well. It will help me in making decision in clinical setting in future, the lecture clear all doubts about how to approach the patient of heart failure and understand the underlying condition which is actually causing symptoms to patient.

Case discussion done by Dr. **Ashfaque Ahmed** was cherry on top and he discussed the diversity and real scenario based approach which opens the new ways of learning. Indeed his knowledge is helping us with every passing learning session. God bless you sir

FEEDBACK # 8

DR Erman faroza

I have got the idea that how important to have a good history skills and even a single missed question can lead you towards wrong diagnosis. Lecture were really informative the way you explained details through tables and figures were easy to learn and thanks a ton to DR Ash that in spite of his busy schedule he remained online in every session and guide us OSCEs/Case Based Discussions as well. Thank you so much

FEEDBACK # 9

DR Neelam zehra

Acute heart failure was taught so beautifully that she made its diagnosis and management so easy that I can confidently do it now. The lecture was brilliantly delivered.

FEEDBACK # 10

DR Sidra imdad

Attended your lecture on heart failure, what an amazing speaker u r.... Making the most difficult topics so easy... She kept on engaging us so we don't get distracted.... Lecture were very well organized and to the point. Thank you for putting so much efforts and making things so understandable to us.

FEEDBACK # 11

DR Zeeshan ayaz

Feedback for DR NAHAL:

DR Nahal lecture were very well organized and she made it sure to keep everyone interactive. Her lectures were very precise and to the point and can easily be co-related clinically.

Feedback for DR ASH

I am surprised and pleased to see that DR ash is attending every session from start to finish even though other tutors are teaching. The end OSCE session is like cherry on top because DR ash summarizes everything and also adds some points that we missed.

FEEDBACK # 12

DR Uzaima nighat

Acute heart failure is another lengthy topic which she delivered so smoothly and made it so understandable is such short time.

And the end OSCE interacting session by Dr. Ash was amazing.

Thank you to both the Doctors for putting on so much effort!

FEEDBACK # 13

DR Muhammad

I must say Dr. Nahal way of teaching has ability to make everything understand so smoothly and quickly. Especially flow charts have made learning so much easier and easy to memories. She made our concepts clear and concise. And everything she made us learn was according to the updated guidelines of NICE. I really appreciate her efforts she made on slides and everything was updated according to new guidelines.

The end OSCE session I feel like is the best part because it summarizes everything and Dr. Ash always added some important targeted points that we usually miss.

Discussed OSCE regarding history taking and it was something I've never thought of adding it to a point of history so it was very knowledgeable.

FEEDBACK # 14

DR Ghazala sheikh

Dr. Nahal Raza taught us all the aspects regarding heart failure covering in a precise time with a lot of the information/guidelines. Very thankful to our mentor @Ash Bhai under his supervision I feel MRCP journey much more productive and programmed. Someday inshallah our dreams to work in UK will be completed. Thanks a lot Dr. Ash for initiating such a great work for Pakistani doctors

FEEDBACK # 15

DR Ayesha siddiqa

Amazing lectures by Dr. Nahal on acute heart failure precisely explained and covered all important aspects of topics
Thanks Dr. Ash for OSCE preparation at the end and your amazing way of teaching!!!

FEEDBACK # 16

DR Sonia syed

Feedback for DR NAHAL:

Dr. Nahal's method of elucidating the topics of acute heart failure is highly commendable. The emphasis of her taking patient's history will prevent diagnostic medical errors unequivocally. The slides on topic were comprehensive and formatted in an eye catching way. I appreciate her diligent work and utilization of verbatim report of NICE guidelines.
Well done!

Feedback for Dr ASH:

I am amazed by the ability of Dr. Ash to construe logic from a typical presentation of patients and treat the patients accordingly. Your scrupulous attitude is highly appreciated as it will benefit us in the preparation for MRCP exams. I look forward to learning new skills under your supervision.
Highly appreciated work!

FEEDBACK # 17

Dr. Mohid Kannan

Dr. Nahal:

Your teaching methods are great and good quality. Very clear and concise, and you've shown your commitment and put in so much of your time and effort.
You made this topic easy by distinguishing from cardiomyopathy, acute or chronic and its management. The session covered almost all the high yield points related to acute heart failure as per NICE guidelines.

Dr. Ash:

At the end of session, scenario based History taking interaction b/w Dr. Ash and dr. Sohail was great and what we can expect in the real exam.
All over it's a good experience and very helpful. Very informative session and a lot of learning from their clinical experiences as well

FEEDBACK # 18

Dr. ARSHAD ALI KHAN

Wonderful presentation on acute heart failure by Dr. Nahal, especially by flow charts in presentation, she hided sea of knowledge in there flow charts. With help of these charts we can learn so many things in short time..
Once again thanks to our respected @Dr. Ash MRCP Programme that they enable to teach us UK pattern new knowledge and ideas by online lecture. Sir we are expecting more than this.
SIR we will be very thankful if u provided us recorded lecture and PPT.

FEEDBACK # 19

DR. SYED KAMRAN HUSSAIN

Your teaching methods were great and concise. Very clear and smooth. Flow charts,updated guide lines (NICE). Acute heart failure topic required further time to be more clear. Although i learned alot.
Dr. Ashfaque
Thank you for conducting the osce at the end of each session.Its's a good experience and very helpful.

FEEDBACK # 20

DR. DURSHI AHMED

Hi , I am very sorry to send my feedback so late , but I watched the lecture twice and it was very comprehensive and informative. I feel like I read a book on heart failure and my concepts are much more clear now . I really liked the OSCE case discussion done in the end by Dr Ash , Its such a good practice and these OSCE case discussions are so amazing that I am forced to watch these lectures twice whenever I start a new lecture . Thank you so much Dr Nahal and Dr Ash .

FEEDBACK # 21

DR. EMMANUEL CHARLES

=> How do you feel ...?
Grateful to Sir Dr. Ashfaque Ahmed for this opportunity :)
While mind-blowing Dr. Nahal delivered her lecture on Acute Heart failure flawlessly , she was attentive to queries to :)

=> How the tutor delivered the lecture.?
Ans. Dr. Nahal and Dr.Dr. Ashfaque Ahmed both lectures delivery was excellent :)
=> What you learnt. ?
Ans. I learnt a lot in this lecture and ocse :) sadly I was at work and missed a few PEARLS :(
Extremely refreshing lecture and a concept clearing one :)
Humbly request for recorded lectures please :)
=> Will it change your practise.?
It will change my current practice surprisingly because I want to constantly improve myself as a person and professional.
=> Other compliments.?
Only a big bear hug and a big thanks to Dr. Ashfaque , Dr Nahal and LONDON GEMS for taking me on board :)
Apologies for late submission kindly forgive
Dr Emmanuel Qammar Charles

FEEDBACK # 22

Hassan Aziz

very interesting informative session it was.. highly conceptual lecture delivered by dr Nahal . my all confusions are resolved regarding acute heart failure. thanks dr Ashfaque Ahmed ..

FEEDBACK # 23

Abubakar Tariq

Very interesting lecture sir
It cleard the basic concepts how to manage a pt with AHF
And when to use and not use vasodilators.

FEEDBACK # 24

Suhail Ahmed

Another remarkable session by Dr. Nahal which was to the point and I learned many things today.

FEEDBACK # 25

DrShafik Zaid

Thank u dr ash dr Nahal after attending ur session on yoday Acute heart failure feel so great with sponging the target point knowledge on it. Before it was a bookish topic but now its a disease where we can easily get the pt for rekieve feeling like a

physician as well ur academics speech blended with ethic every single words can bring the change for us and to the pt

FEEDBACK # 26

Remal Noor

Wonderful interactive session n presentation of ACUTE HEART FAILURE wd precisely explained every detail of d topic n cleared many misconceptions by dr nahal ...n tips for osce history station by dr ash...thank u to such wonderful dedicated mentors

FEEDBACK # 27

Ahmad Tanveer

Interesting session by Dr Nahal. Acute heart failure managememt strategy and focus on the cause. Investigations prospective was well discussed. At the end OSCE by Dr Ashfaque was as always power pack delivered in short time. Good session indeed

FEEDBACK # 28

Dr Sadia Naveed

Excellent session by Dr Nahal Raza I learn alot what is heart Failure, distinguish from cardiomyopath ,distinguish between Acute and chronic HF,pathophysiology, causes ,mechanism of HF,functional classification of HF,why Na and water rention in HF,NIV in HF and management according to NICE guidelines. So many concepts were cleared it was a wonderful session Thank you very much dr Nahal Raza.Osce session by Dr Ash was excellent .Thank you Dr Ash for bringing London GEM MRCP programme.

7th AUGUST 2022

EVENT NAME:

EM History Taking and Management Plan Session 2 by DR ASH for EMFP

DOCTORS FEEDBACK

FEEDBACK # 1

Rehan Khalil

Attended this wonderful session on history taking and realized that knowledge put in a systemized way can do wonders in managing your patients successfully.

FEEDBACK # 2

Anila Zafar

Today's session was amazing as expected. I learned a great deal about how to take relevant history to reach a diagnosis and give a management plan. I am really grateful.

FEEDBACK # 3

Ali Kazim

It was really good session! Learned a lot about history taking
Thank you DR Ash!

FEEDBACK # 4

Haider Ali

Second session conducted by Dr. Ash today on focused and relevant history in ED was just amazing.
Learned many new things today and identified my lackness in some area of history taking and made a whole new format for history taking.

FEEDBACK # 5

Sawaira Gul

It was a Great Session. Unique in its way of interaction and Engaging all those whole are attending. Letting everyone showcase their knowledge and ask questions. DR Ash is an amazing teacher and Mentor indeed.

FEEDBACK # 6

Hafsa Lodhi

Attended todays' lecture by DR Ash about history taking ,the format he taught was really precise that will help us to take relevant history and making the correct diagnosis and ruling out other differentials .we surely will be applying this while taking history.

FEEDBACK # 7

Zaid Ansari

Very precise session today and our way of approaching patients will never be the same again. What I noticed most of all is that none of these things can be found in the textbooks, what we're learning is from decades of experience and it's well worth it!

FEEDBACK # 8

Muhammad Wajeeh Labar

The second session exceeded my expectations. After that, ALHAMDULILAH, I can honestly assert that I have received adequate instruction in history taking in an acute environment. I would like to thank Dr. Ash for his efforts in emergency medicine for Pakistan.

FEEDBACK # 9

Umair Khalil

Today's session with DR Ash was very informative. We studied structured & detailed history taking techniques in short time. Most commonly presented cases in ER were discussed along with differentials. This session gave me a pattern to practice and improve my history taking skills.

Dr Ash is a great teacher.

FEEDBACK # 10

Warda Yawar

The session taught by DR ash was very informative such sessions are gateway towards success.

I learned how to deal with the patients and to reach a proper diagnosis dr ash your efforts are really appreciated.

The format you taught (💯) and how you open our minds were beyond 👌 perfect.

Thank you so much and please doing your work with the same hard work😍😍

FEEDBACK # 11

Maryam Gul

The format of history taking which DR Ash successfully taught us in just two lectures is very practical, concise and easy to use. I have never used such a systematic way of history taking previously but after today I'm going to use it Inshallah, all thanks to a very good teacher. I'm looking forward to more such sessions.

FEEDBACK # 12

Yasir Dilawar

DR Ash Sir we are proud of you 👏.in such a busy schedule you take time for us and helping to improve us. The lecture was very good.no one has taught us to take history, but after this session we have a lot of idea now. Thanks

FEEDBACK # 13

Hani Suhail

Today’s session had its own flavor, knowing about the different patterns and the ways the history works was delivered in a great way. Thank you

FEEDBACK # 14

Muneeb Jawed

Very informative. Thank you DR Ash!

FEEDBACK # 15

Hafsa Fayyaz

Thank you so much for today’s session DR Ash. The session was quite helpful in the sense that I understood the importance of taking history and the way it should be done. I learned new things today.

FEEDBACK # 16

Soura Jawed

Today's session was incredibly helpful in learning history taking! Glad to know my lacking while approaching patients. DR Ash mentioned the method of data gathering in such simple way that one can practice easily. It won’t be just helpful for exams but will definitely help us out during clinical rotations.

Thank you Dr **Ashfaque Ahmed**

FEEDBACK # 17

M Tanzeel Ul Haque

Today’s class was about history taking. DR Ash very concisely taught us a great method of data gathering. So much to learn from him

Thank you for helping us out!!

FEEDBACK # 18

Wajiha Mughal

I had the chance to attend 100EM procedures by Dr. Ash and took the recorded lecture on history taking skills (because of my job commitment). One thing I must admit is Dr. Ash's dedication to quality teaching. This dedication was depicted in the "History taking skills" lecture also where he taught precise and relevant history taking skills.

FEEDBACK # 19

Abdul Ghaffar

I learned that how to take proper history today , step by step ask the questions most important was +ve medical approach with D/D , the way of this take history is best....

Thanks DR ash

FEEDBACK # 20

Muhammad Wajeeh Labar

Amazing session where I learned the right history and treatment for the main headache reasons For example, subarachnoid hemorrhage brain tumors, cluster's, and migraine and I was shocked to learn about headache warning signs and learned how to use an examination to make a diagnosis. Thank you DR Ash and DR Shumontha Dev for today's wonderful session on how to avoid performing unneeded tests and providing appropriate treatments

FEEDBACK # 21

Warda Yawar

Very informative session by our beloved presenters
Approach to reach the diagnosis made easy learned a lot
Thank you DR Ash

FEEDBACK # 22

Muhammad Wajeeh Labar

The second session exceeded my expectations. After that, ALHAMDULILAH, I can honestly assert that I have received adequate instruction in history taking in an acute environment. I would like to thank Dr. Ash for his efforts in emergency medicine for Pakistan.

FEEDBACK # 23

Dr Muhammad Ghayoor Khan

It was again a wonderful session on history taking and management in ED by Dr.Ash.
Dr.Ash delivered it brilliantly to us and I understand it quite well.
The history pattern is:
-Introduction
-Comfortable
-Relief
-ODPARA
-Positive history
-Risk factors
-Negative history
-P3 MAFTOSA
-ICE
Then

Managemant plan like;
Vitals,GPE,relevant systemic examination and base line Investigation etc
Thanks
Dr.Ash