London Global Emergency Medicine Programme GEM
Breaking Barriers in EM

EVENT NAME:

Acute Liver Failure By Dr Naila Ashfaque Sorathia Consultant NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Amir Ashraf

This lecture today was so interesting that it opened my eyes and taught me how wrong we were dealing Acute liver failure all this time . it was presented in such a beautiful way that everything made sense when I correlated it why we should do this, everything was explained with proper reasoning and updated guideline and how can we prevent huge complications if we have a proper plan in hand . Dr Ash's last 10 mins, the golden 10 mins . He gave us the proper pathway on how to lead Acute liver failure, how to writes proper orders as a Reg so that you and your SHO donot have to struggle , because if you don't write it , it won't be done as simple as that .

We learned :

-Major and minor causes of ALF (paracetamol in UK and Viral in rest of the world)

- Triad to Dx ALF (Jaundice, INR > 1.5 , and hepatic encaph) in pt with no prior liver disease .

- Pathophysiology of ALF

- Clinical presentation and how to exclude chronic liver failure

-Risk stratification

-Poor prognostic features

-Management (recognise , resus , Refer)

- Acute Liver failure Bundle
- Who will you refer (regional transplant team , gastro ,ITU)
- The kings college criteria for Paracetamol and Non Paracetamol failure
- Critical care management
-Grades of hepatic enceph
- Complications
-Ischemic hepatitis
- Hepatic venous outflow tract Obstruction.

This was such a power pack session, and Alhumdulilah i got the opportunity to learn ,

Thankyou Dr Naila and Dr Ash ❤️

- Proud LGEM Trainee

Dr Muhammad Amir Ashraf .

FEEDBACK # 2

Babar Hussain

Today's session on Acute liver failure Excellently conducted by Dr Naila Ashfaque. It was a comprehensive lecture. Started with

~Definition of Acute liver failure
~thier Causes
~how to make Diagnosis,
~Treatment plan and how to deal in ER and Especially the learning points are
~When to give Pletelets and when to give FFPs
~3 R protocol
~Acute liver failure bundle
~How to do Referal and which team to involve
~complete management plan

So overall it was a complete comprehensive session. Dr Naila made the foundation and in the end,

Dr Ashfaque sir your last 10 min comprehensive management plan I would say the golden pearls elevate the bar so high.

So thank you so much Dr **Naila Ashfaque** and Dr **Ashfaque Ahmed**. A lot of love and prayers for you both ❤️.

Proud LGEM candidate.

FEEDBACK # 3

Rida Rana

Alhamdulillah attended a super amazing session by Dr Naila on one of the most commonly encountered and frequently questioned topic of Acute Liver Failure . Dr Naila taught it in the most easy to learn pattern , starting with incidence , definition , pathophysiology , 3Rs in terms of management (Recognise, Resucitate, Refer) , Acute Liver Failure Bundle , Complications and its

management ,Indication of FFP and Platelet Transfusion and how to discuss the patient with ITU and Gastroenterology Teams while referring. I haven't attended such a well elaboratives lecture on Acute Liver Failure before. Thankyou Dr **Ashfaque Ahmed** for bringing Dr Naila as a faculty on board . You are certainly providing us with the best knowledge which is taught by the best faculty which anyone would dream of. The last 10 mins by Dr Ashfaque regarding how to write a proper plan with respect to management of such patients-- were indeed the golden minutes of the lecture. Inshallah now EM management of such patients will be done with much more planning and with a holistic approach. Alhamdulillah on being part of LGEM 😊

FEEDBACK # 4

Syed Suhail Ahmad

- Starting from the most common cause in UK and Worldwide i.e Paracetamol and Viral hepatitis respectively
- Definition i.e jaundice, coagulopathy and hepatic encephalopathy
- Pathophysiology
- Clinical presentation
- Acute liver bundle
- Kings College Criteria
- 3 Rs of Management i.e Recognise, Resuscitate and Refer
- Important Complications
- Risk stratification and Prognosis
- Role of FFPs, Platlets and when to transfuse

And a quick management plan in the end by Dr. Ash was all worth listening to. Thank you **London Global Emergency Medicine**, **Pema-Uk**, and **London Clinical Courses** for arranging these sessions 👍👍👍

FEEDBACK # 5

Imtiaz Ali Shah

Today we had an amazing lecture by dr Naila regarding Acute Liver Failure .It was a comprehensive lecture covering all important aspects of this condition which includes

Definition of acute liver Failure and Decompensated liver disease.

Pathophysiology of liver failure.

Signs of CLD including juindice, as it's, coma, spider nevi, palmar erythema, varices.

Risk stratification

Poor prognostic features.

Management with the help of 3 R,s. that is Recognise, Resuscitation and Refer Acute Liver Failure bundle.

The King's college criteria to evaluate the degree of multiorgan dysfunction from Acetaminophen induced liver Failure .
Hepatitis encephalopathy with signs/ symptoms and Grade1-----Grades 4.
HELLP syndrome, Hepatic Arterial Thrombosis.
BUDd-CHIARI syndrome.
It was an excellent session with full of absorbable knowledge and many new learning points. The session was a pure reflection of dr Nailas teaching skills which were excellent. Last ten minutes sum up by dr Ash was amazing and covered the whole topic.
At the end I would like to thanks to dr Naila for this wonderful presentation and also thanks to dr Ash and london Gem for providing this wonderful opportunity for learning.

FEEDBACK # 6

Zia Hayat

It was an amazing session with lots of clinical pearls ,it was an interactive session she explained and elaborated every aspect of APPROACH to Liver Failure starting from front door to proper management and referral to the concerned team with a multi disciplinary approach.
We discussed about many important points during the lecture ,definition of liver failure ,causes ,pathophysiology ,clinical presentation of Acute Liver Failure ,Differentiation between Acute and decompensated liver disease ,poor prognostic factors, Management including 3 Rs Recognise, Resuscitate, Refer. Kings college criteria for liver transplant, Indications for FFP and Platelets transfusion, How to refer, Involvement of ITU &Gastroenterology Team.
It was a comprehensive session and she explained all the points to manage stepwise and decide management skills accordingly. Dr.Ash explained in the last part about how to decide the management and to put the plan to decide the stepwise orders which were to be followed .Altogether it was an eye opener session for management of cases of Acute liver disease.
Thankyou Dr.Naila and Dr.Ash for this amazing session.

FEEDBACK # 7

Ubaid Ur Rehman Khizir

It was an amazing session on acute liver conducted by Dr Naila ashfaque
Dr Naila makes every session easily understandable
I learned
Acute liver failure*
Paracetamol is the most common cause in UK
Acute liver failure is decline in hepatic function characterjzed by cogaulpathy
INR > 1.5
With no prior liver disease

If occur in pre-existing liver disease then it's called decompensated liver disease
Causes
Drugs paracetamol
Viral
Metabolic Wilson
Pregnancy
HELLP
Vascular
Budd chiari syndrome
Autoimmune
Infiltrative
Melanoma
TB
Hepatic encephalopathy
Triad
Bilirubin raised
INR raised
AST ALT raised >1000
Encaphlopathy occur due to release of NH3
Differentiation b/w acute liver failure and decompensated liver failure
Look for signs of CLD
Risk stratification
King college criteria
Management
Recognize
Resuscitation
Refer
Poor prognostic factors
Admission comma
INR >6.5
aetiology
Recognize
Resuscitation
Consider intubation
Give oxygen to correct hypoxia
Give fluids for hypotension
Maintain normoglycemia
Grades of hepatic encephalopathy
Grade 2
Consider listing for transplant

CT scan to rule out causes
Avoid stimulation
Monitor and treat any infection
Consider lactulose
Complications
Sepsis
Coagulopathy
When will we give FFP
If patient is actively bleeding and INR >1.5 or INR >7
When will we give platelets <10000
Other complications
Gi bleeding need ppi in ventilated patients
Thanks Dr ash for arranging such an amazing lecture which cleared many misconceptions of our clinical management of acute failure

FEEDBACK # 8

Suhail Ahmed

A great lecture by Dr Naila. She started lecture from simple definition, explanation of all the lab tests and pathophysiology.
She beautifully explained the King's college Criteria for Paracetamol Poisoning and non Paracetamol poisoning.
How to resuscitate tue pt and how to risk stratify a patient.
She explained the treatment and which dept the pt should be ref to.
At the end Dr Ash gave the full management plan.
Thank you Dr. Ashfaque and Dr. Naila.

FEEDBACK # 9

Muzna Ahmed

It was an amazing session on liver failure by dr naila she comprehensively covers major headings of topic starting from definition of acute failure for recognition of failure there should be traid of jaundice, coagulopathy, and hepatic enceph in previously healthy individual, what is acute on chronic failure, causes most important organism are CMV, Ebstein bar Herpes virus in UK. Pathophysiology, ammonia toxification, portal HTN, Management key points are resuscitation, and early referral, how to treat hepatic encephalopathy CT head is important investigation. FFP and Platelet transfusion, HELLP syndrome.
Last 10 golden minutes by Dr Ash he told his approach of treatment which was exceptionally good and applicable.
Thank you Dr Naila and Dr Ash for such an amazing session 🙂

FEEDBACK # 10

Shehzad Hussain

Thanks to Dr Naila for a wonderful lecture on acute liver failure rapid decline in liver function characterized by Jaundice Coagulopathy INR >1.5 n hepatic encephalopathy with no evidence of prior Liver disease.
Increase of NH3, bilirubin, INR ALT/AST >1000, portal hypertension n Ascites.
Presentation of Acute liver failure n chronic, high risk stratification
Kings College criteria PCM overdose ALF as arterial PH <7.25 after adequate fluid resuscitation, NAC, 24 Hrs. Or
PT > 100 seconds (INR>6.5)
Creatinine >300 or Anuric
Grade 3-4 encephalopathy
Kings college criteria for Non PCM over dose ALF
PT>100(INR>6.5) or
1: PT>50sec(INR>3.5)
2: Bilirubin >300 mmol
3: Jaundice to Encephalopathy >7days
4: Age <10yrs or >40yrs
5: unfavorable etiology sero negative or drugs.
Management of ALF 3 R
Recognize Resuscitate n Referral
Hepatic encephalopathy Grades 1-4 , sepsis, Coagulopathy, when to give FFPs n when to give PLT
FFPs if INR>7 or Active bleeding +INR >1.5
PLT if Platelet <10000 or >50000+active bleeding or invasive procedure.
HELLP syndrome management
Ischemic Hepatitis, Hepatic artery thrombosis n Bud chiary syndrome n classic triad n management all explained very well by Dr Naila and in last 10 minutes Dr Ash discussion about plan for Acute liver failure patient was amazing it covered almost each n every step of management. Thanks to dr Naila and Dr Ash n LGEM team for such a wonderful lecture on acute liver failure.

FEEDBACK # 11

Dr Gul Nawaz Khan Wazir / Gdmas Malik

Today session regarding acute liver failure was spectacular .Dr Naila sahiba astoundingly interpreted and competently interplayed that evoked a broad sketch in our mind . This season invoked our attention on call for deeper learning and instigated our thoughts for keeping pace with the updated version and guidelines. It was exceedingly an interceding clinical contour of acute liver failure inculcated us that purged our enigmatic concept and smothered the clumsiness of our minds. This inclusive and encompassed session heralds a prompt initiative to alleviate our pitfall and surmounted the knotiness that we

had heaved in our redundant environment .The lecture was scrutinising and scrolled through the modern standard .

Madam Dr Naila sahiba conspicuously elucidated and compounded , etiology ,clinical picture ,presentation , investigations , and management .She also emphasized that it is not suffice enough but a broad demeanour is essential for competitive progress .she further elucidated the importance of risk stratifications and specific clinical presentation and its management . A king college criteria was discussed . Eg, ph less than 7.3 ,pt more than 100 s ,creatinin more than 300 micro mol/l and grade 11 and IV Encephalopathy or non paracetamol liver failure that is pt more than 100 s ,or 3 out if the 5 of the following,

1) drug induced liver failure
2) age less than 10 or more than 40 years old.
3) pt more than 50s
4) Bilirubin more than 300 micro mole/l
5) More than 1 week from first jaundice to encephalopathy .

If the above criteria met the the transplant surgeon and Gastroenterology should be involved .

Etiological causes and diseases were mentioned eg, Ischemic hepatitis due to cardiogenic shock ,septic shock and hypovolemic shock . Budd chiari syndrome was discussed which is the hepatic vein thrombosis that impede the venous drainage of liver and forge the insult ensued in this regard. Its evaluation was sketched up that Doppler study is essential to pick it up and plan the proper management . Hepatic artery thrombosis was discussed as it is rare but entail in this devastating picture of liver failure that should be evaluated to stitch in time if evolve there .all other viral hepatitis were also discussed eg, Hbv ,hcv,Ebv Cmv and herpes virus,

I have the pleasure to adduce that Madam Dr Naila lecture was strikingly uncalculated, unanticipated, recognisably distinct, readily discernible and intelligibly pervasive and erudite.

I am very thankful for such impressive delivery of lecture.

In the last 5 minutes Sir professor Dr Ashfaque Ahmad sb gleamed lika a moon light and cherished the session by his sagacious re-enforcement and glittering abstractness. He streamlined our turbulence of concept how to forge strategy for management of acute liver failure .A subtle organised approach was delineated by our honorable mentor that would be treadmill for us for future . It was one of the collocative and juxtaposed interpretation enumerated by our great mentor .sir presented with a combination of pith and exactitude to raise us to tread upon Really ,I am thankful with heartfelt feelings and emotions and praying that Allah may sprout over him the eternal consolation and delightfulness.

FEEDBACK # 12

Aqsa Yaqoob

An excellent session delivered by Dr. Naila on acute liver failure.
Key points of the lecture were:
*Definition: (Jaundice, coagulopathy (INR>1.5) and hepatic encephalopathy).
*Causes and pathophysiology of acute liver failure,
*Difference between acute liver failure and chronic liver disease.
*Risk stratification,
* Management: Recognize, Resuscitate, Refer.
*Acute Liver Failure Bundle,
*King' College Criteria for POD and non- POD.
*Hepatic Encephalopathy and its complete management.
Coagulopathy, when to give FFP's and Platelets, how to manage other
*complications for e.g: sepsis, GI bleeding, Nutritional decline.
*HELLP Syndrome,
* Ischemic Hepatitis: its causes and diagnosis.
*Hepatic venous outflow tract obstruction (Budd Chiari Syndrome),its etiology, clinical presentation: Right upper quadrant pain, tender hepatomegaly and ascites.
*Diagnosis and treatment.
In the last Dr. Ash gave a complete strategic plan of how to manage acute liver failure was just amazing.
Thank you Dr. Ash and Dr. Naila for such a wonderful lecture.

FEEDBACK # 13

Yasir Dilawar

Today's session was about acute liver failure. we learnt from Dr Naila how to diagnose Acute Liver Failure, which is the most important thing. then what investigations we must do in such patients. have to monitor patients for Hepatic Encephalopathy. look for ammonia levels.do PT/INR to look for coagulopathy. resuscitate such patients. monitor their oxygen Saturation. then we have to refer such patients to a proper setup for further management and write a detailed management according to our knowledge. then we learnt about ischemic liver disease as well, and hepatic vein thrombosis.at the end Dr Ashfaque also gave us a complete management plan for such patients.it was a very useful learning experience.

FEEDBACK # 14

Zegham Abbas

Amazing lecture on acute liver failure comprehensive discussion started with definition of Acute liver failure characterized by rapid decline in liver function

e.g. Coagulopathy, hepatic encephalopathy Grade 2/3 and Jaundice with no evidence of chronic Liver disease.
UK most common cause of acute fever is Acetaminophen toxicity
Increase of bilirubin Ammonia Aminotransaminases portal hypertension Heptic Encephalopathy Ascites.
Kings College criteria PCM overdose
ALF as arterial
1) PH les then 7.25 after giving adequate fluid resuscitation and N-Acetylcystene in 24 Hrs. Or
*PT > 100 seconds (INR>6.5)
*Creatinine >300 or Anuria
*Grade 3-4 Hepatic Encaph
Management of Acute Liver failure
*Recognize
*Resuscitate
* Refer
when to give FFPs n when to give PLT
*FFPs if INR>7
*PLT if Platelet <10000 or >50000
Different aetiologies of Acute Liver Failure
*Ischemic Hepatitis
*Hepatic artery thrombosis
* Bud chiary syndrome
Dr Ash discussion about plan for Acute liver failure was amazing he give his golden points thanks to Dr Ash and Dr Naila.

FEEDBACK # 15

Qaisar Shah

Dr. Naila discussed:
Acute Liver Failure: rapid onset of liver dysfunction leading to severe hepatic insufficiency
Pathophysiology:
Rapid damage to liver cells, leading to liver cell death and release of toxins into the bloodstream. Impaired liver function causing a build-up of toxic substances in the blood, leading to metabolic derangements and liver failure.
Clinical presentation:
Nausea, vomiting, abdominal pain, fatigue, jaundice, confusion, and coagulopathy.
Signs of Chronic Liver Disease (CLD):
Cirrhosis, hepatomegaly, spider angiomas, ascites, jaundice, peripheral edema, and other signs of liver dysfunction.

Risk stratification:
Based on underlying cause of liver failure, severity of liver dysfunction, presence of CLD, and other factors.
Poor prognostic features:
Severe encephalopathy, high serum bilirubin, low prothrombin time, high INR, high ammonia, and other factors.
Management by 3R in Emergency Department (ED):
Recognize: identify signs of acute liver failure and assess severity.
Resuscitate: manage complications such as bleeding, electrolyte imbalance, and cerebral edema.
Referral: transfer patient to specialized center for further management.
Acute Liver Failure Bundle:
Standardized approach to managing patients with acute liver failure, including early assessment and intervention, supportive care, and rapid transfer to a specialized center if needed.
Kings College Criteria for Acute Liver Failure:
A scoring system used to predict the outcome of patients with acute liver failure based on several clinical and laboratory parameters.
Critical Care Management of Acute Liver Failure:
Management of complications such as encephalopathy, sepsis, coagulopathy, and metabolic derangements.
Hepatic Encephalopathy:
A neurological complication of liver failure characterized by confusion, disorientation, and other cognitive and behavioral changes.
4 grades of encephalopathy, ranging from mild confusion to coma.
Management: treat underlying cause, control electrolyte and fluid balance, reduce production of toxic substances, and provide supportive care.
Complications:
Sepsis, coagulopathy, and others
When to give Fresh Frozen Plasma (FFP) and platelets: based on patient's coagulation status and severity of bleeding.
HELLP Syndrome:
A serious pregnancy-related complication characterized by hemolysis, elevated liver enzymes, and low platelets.
Ischemic Hepatitis:
Acute liver injury caused by decreased blood flow to the liver, leading to liver cell death.
Budd-Chiari Syndrome:
Obstruction of the hepatic veins, leading to liver congestion and portal hypertension.

The last "GOLDEN MINUTES OF Dr.Ash" summarizes the whole session & describe how to properly make a management plane for ACUTE LIVER FAILURE patient in ED.
The session was amazing & learnt a lot.
thanks Dr. Naila & Dr. Ash for this comprehensive lecture.

FEEDBACK # 16

Rajab Abbas

Today's session was knowledgeable and exam oriented. In this session Dr Naila explained and elaboratd every aspect of APPROACH to Liver Failure and it's management .
The summary of what we learn today is:
• Definition of Liver Failure
• Causes ; Most common being paracetamol poisoning
• Pathophysiology of Hepatic encephalopathy
• Clinical presentation of Acute liver failure
• Differentiation b/w ALD / DCLD
• Poor prognostic factors
• Management (3R: Recognise, Ressusitate, Refer)
• Kings College Criteria for liver transplant
• Indications for FFP & Platelets transfusion
• How to refer
• Involvement of ITU & Gastro team
It was a comprehensive session and she delivered in a really easy way to apprehend the topic.
In the End Dr ASH taught about how to manage stepwise and write prospers orders to be followed. It was a power pack knowledgeable session of this week.
Really excited to learn tomorrows sessions on Trauma and CLD.
Thank you Dr Naila and Dr Ash for this session.
A proud LGEM candidate
Dr Rajab Abbas.

FEEDBACK # 17

Bushra Imran

In today's session comprehensively covered how to approach acute liver failure to chronic liver failure to HEPATIC encephalopathy. The definition, causes of ALF, pathophysiology and treatment. When to refer and where to refer, summarized the grades of encephalopathy, she explained the 3 R's. Dr Naila beautifully taught the King's College criteria for liver transplant, HELP syndrome, Ischemic hepatitis, Budd Chiari syndrome, paracetamol poisoning, viral hepatitis causing HE and the involvement of nutritionists, When to

transfuse FFP and when to transfuse platelets at which level.. the complication of ALF though all are learning golden points..
In the end Dr Ash scenario for treatment plan was mind opening immediate lesson for us.
Thank you dr Naila and Dr Ash ..

FEEDBACK # 18

Anila Zafar

Very amazing lecture. She taught the paracetamol and viral hepatitis are the leading causes of liver failure.
She very comprehensively explained when we use the term liver failure with jaundice, coagulopathy and hepatic encephalopathy.
How it presents.
The Acute liver bundle.
Kings College criteria.
The 3Rs
Recognise
Resuscitate
Refer
The complications of ALF
How we can use FFPs, Platelets and when to decide transfusions.
Thank you Dr naila and Dr Ashfaque.

FEEDBACK # 19

Ghulam Saddique Saddique

Today a Brilliant session conducted by Dr. Naila totally reconstructed our ideology about Acute Liver failure, Indeed she patched our missing part of our clinical aspect and why it's needed for the benefit of patients. She prioritizes our Management plan about Acute Liver failure. Important pearls of session are as under:
In the UK the most common cause for Acute Liver failure is paracetamol overdose but worldwide common cause is viral hepatitis.
Definition
Acute liver failure (ALF) is a rapid decline in hepatic function characterised by jaundice, coagulopathy (INR >1.5), and hepatic encephalopathy in patients with no evidence of prior liver disease
If these symptoms occur in a patient with pre-existing liver disease, the term acute-on-chronic liver failure or decompensated liver disease is used.
Causes; Drugs, Toxins, Pregnancy, Autoimmune, infiltrative, vascular and viral.
It's a Triad of
hepatic Encephalopathy
AST/ALT >1000IU

INR equal to or > 1.5
If there is no clinical sign of Chronic Liver failure then it's Acute liver failure.
Poor prognostic sign of Acute liver failure is Increased lactate level and hypophosphatemia
acute liver failure should be checked for hypoglycemia.
RISK STRATIFICATION
High mortality exists amongst all patients
Which are Factors Associated with a poor outcome?
PROGNOSTIC FEATURES
IR >6.5
Admission comma (Grade3-4 encephalopathy)
Aetiology
Viral hepatitis Wilsons disease Autoimmune hepatitis Budd-Chiari Syndrome mushroom.
poisoning
Management
ER/ Acute medical unit always remember 3 Rs
Recognize (unexplained acidosis, confusion shock, hypoglycemia, coagulopathy and deranged LFTs)
Resuscitate (intubate patient, proper Oxygenation to correct hypoxia, give proper fluid to maintain organ perfusion to maintain MAP > 60, maintain normoglycemia
Refer to regional transplant team, Gastroenterology team and intensive care team.
Kings College Criteria
The Kings College Criteria has been developed to evaluate the degree of multiorgan dysfunction from acetaminophen-induced liver failure, and so to help with predicting positive or poor prognosis in case of liver transplantation, in the case of patients with fulminant hepatic failure (FHF)
Kings criteria alone or with serum lactate and phosphate can predict patients with poor prognosis
Criteria for POD:
Arterial pH<7.25 after adequate fluid resus, NAC,+24 hrs
Or all 3 of
PT >100sec(INR>6.5)
Cr. >300 mmol/l or anuric
Grade 3/4 encephalopathy
Criteria for Non -POD:
PT> 100(INR>6.5)
Or 3 of 5:

PT> 50sec(INR>3.5)
Bilirubin 300mmol
Jaundice to encephalopathy>7daysage <10 or > 40
Sero-ve, drugs
Critical care Mx: for
If required transplant, fluids and electrolyte monitoring ,GI bleeding, nutrition support monitor coagulation, infection, ICP (Intracranial HTN, cerebral edema)
Hepatic encephalopathy:
Grade with symptoms and management:
I: behaviour change with change in level of consciousness
II: gross disorientation, drowsiness, asterixis, inappropriate behaviour
Manage: list for transplant and transfer to tertiary centre
CT r/o other causes
Avoid stimulation
Sedatives
Monitor and tx infection
Lactulose - to reduce ammonia load ,prevent worsening of encephalopathy
III: marked confusion, incoherent speech, sleeping mostly but responsive to vocal stimuli
IV: comatose , no response to pain, decerebrate posturing
Manage: Intubation and sedation
Head elevation
Seizure prophylaxis - mannitol
Complications :
Sepsis- culture for occult or frank sepsis surveillance
Occasional Prophylactic Abx or antifungal
Coagulopathy: when to give FFPs: active bleeding and INR>1.5 or >7
When to give platelets :<10000 or <50000 or need invasive procedures or bleeding
GI bleeding- give PPI in vent. Pt.
Hemodynamic unstable: vasopressors to keep MAP>60-65
Nutritional decline: hypo- Mg, K, P - need early nutritional support (prefer enteral)
HELLP synd.: Pathophysiology
Ischemic hepatitis: shock liver (acute liver injury by insufficient blood flow/O2 delivery to liver.
Dec. Blood flow(perfusion) due to shock or low BP
Hepatic artery thrombosis(cloth in hepatic a.),MC complication of liver transplant
Causes: arrythmia,HF, infx, hypovol.shock, blood clot

Tx: the cause, tx hypotension,Abx if sepsis
Hepatic artery thrombosis(clot in hepatic a.),MC complication of liver transplant
Causes:
Primary Bud chiari syndrome75%(hepatic venous outflow tract obstruction):
5P- Pills, Pregnancy, Postpartum,Procoagulation conditions(Nephrotic synd,cancer, protein C and S Def., Factor 5leiden mutation and SLE) and polycythemia rubra Vera.
Secondary : 25%
Compression of hepatic vein(tumor)
C.presentation: triad
RUQ pain, tender hepatomegaly, ascites
ALF
Tx: thrombolysis
Marvellous session conducted by Dr.Naila Ashfaque but last golden 10mins was the real spirit of the session by Dr.Ashfaque emphasis on the comprehensive management plan .
I am once again Thankfully to both Dr.Ashfaque and Dr.Naila Ashfaque for conducting such a brilliant session to polish our skills.

FEEDBACK # 20

Mina Khan

Dr Naila delivers best sessions , which are exam related and include brain storming points.
She define acute liver failure as rapid decline in liver function/ occurring within 26weeks span having INR >1.5/ hepatic complications. Differentiate from chronic liver disease signs palmar erythema gynecomastia spider nevi(hyper estrogenimia)portal htn/melena/hypoalbuminea/hypokalemia/hyponatremia/hyperammonimea/hypoglycemia/ascites/HE/IPVD.
Kings College Criteria for paracetamol induced LF (acetaminophen poison is Most common in UK)Poor prognosis with serum lactate/ Hypophosphatemia .
Paracetamol
PH <7.25
NAC 24 hrs
OR
PT>100/INR >6.5
CR >300 mmol
Coma 3/4 grade
NON paraceta
PT>50 /INR >3.5

OR
Bili > 300 mmol
Age<10 >40
Jaundice/Enceph >7 days
Ventilated pts >GI bleed risk>H2 blockers
Keep MAP 60-65
Adjust nutritional intake
Hemolysis
Elevated
Liver enzymes
Low
Platelets= preeclamptic /placental hypoperfusion/tx prompt delivery
Hepatic artery thrombosis
Ischemic hdpatitis [Shock Liver] MC hypotension
Venous obstruction [budd chiari synd]
pregnancy/pills/procoagulants/polycythemia vera
Secondary budd chiari 25% tumor compression
Thank you Dr Naila for giving us such an important session.🌹Proud traineee

FEEDBACK # 21

Aymen Bashir

The session on Acute Liver failure was power pack and interactive. We learnt that it is defined as a rapid decline in hepatic function characterized by jaundice, coagulopathy (INR >1.5) and hepatic encephalopathy in patients with no evidence of prior liver disease.
*Causes of Acute Liver failure are drugs, viral(HAv, Hbv/HDv, non A and E), metabolic, vascular (budd- chiari, ischemia), pregnancy, Autoimmune.
*Pathophysiology of ALF
*Symptoms of Acute Liver failure
* How to differentiate between CLD and Acute liver failure.
* Risk stratification associated with poor outcome ex(grade 3,4 encephalopathy, INR >1.6)
* 3R's (Recognize, Resuscitate and Refer)
* King's College Criteria
(To evaluate the degree of multi organ dysfunction from acetaminophen induced liver failure)
Arterial PH <7.25 after adequate fluid resuscitation. NAC +24 hours.
Prothrombin>100 sec
Creatinine>300 mmol/sec
Grade 3/4 encephalopathy
* Acute liver failure bundle

* Symptom of hepatic encephalopathy
* Grading and management
* Indication of FFP if there is active bleeding and INR>1.5 or INR >7
* Platelets if <10,000 or 50,000 and need invasive procedure and bleeding.
*HELLP
*Ischemic hepatitis
*Hepatic artery thrombosis.
We are privileged to learn a lot from Dr Naila and Dr Ashfaque. Proud to be an LGEM candidate.

FEEDBACK # 22

Beenish Manzoor

Today's session was very phenomenal and extremely important topic and exam oriented session exam. In this session Dr Naila explained and elaborated every aspect of APPROACH to Liver Failure and it's management.
She has art of making topic very simple and understandable… starting from very basic.
Today's important learning points are
• Definition of Liver Failure
1.INR>1.5
2.hepatic encaph
3.derrange LFT with no previous hx of liver disease
• Causes; Most common in UK paracetamol poisoning and in Pakistan its viral hepatitis
• Pathophysiology: liver not function properly cause increased in ammonia with further cause hepatic encephalopathy. increased in billirubi. AST and alt >1000 and INR cause acute injury band liver enlarged.
• Clinical presentation of Acute liver failure
• Differentiation b/w ALD / DCLD
•symptoms ALD
Fatigue
Lethargy
Nausea
Vomiting
RUQ pain
DCLD present with
Telangectasia
Palmar erythema
Ascities
Spider nevi
Gynaecomastia

• Poor prognostic factors.
• Management (3R: Recognise, Ressusitate, Refer)
• Kings College Criteria for liver transplant +lactate +phosphate level
1.paracetamole poisoning
°arterial ph <7.25
°NAC 24 hour plus
°PT >100
°grade 3/4 encaph
2.non PCM
•pT >100 ,INR >6..5
•Billirubin >300
•Jaundice
•Age <10>40
*GRAdes of HEPATIC ENCAPH and treatment
Grade 1 change in behaviour
Grade 2 confuse delerium aggetated drowsy and tremmors
Grade 3 marked confusion with speech problem etc
Grade 4. Comatose unresponsive
•complication
Sepsis
Peritonitis
*Coagulopathy
• Indications for FFP & Platelets transfusion
FFP when
Active bleeding plus inr greater than 1.5 or alone inr is. >7
Platelets
Count of plt is <10000or 50000when need surgical intervention
Half life of plt is 2 hour aprox
• How to refer
Multidisciplinary approach
Gastro
Icu
ITU
Nutritionist
•HELLP syndrome etiology cause and management
•ischemic hepatitis
•Hepatic artery occlusion
Hepattic vein occlusion
Hepatic vein obstruction

Lastly Dr Ash scenario base discussion and how to manage stepwise and write detailed orders to be followed. It was a power pack knowledgeable session of this week.
Thank you Dr Naila and Dr Ash for this session.
A proud LGEM candidate

FEEDBACK # 23

Dr Afifa Younis Raja

Greetings of the day!!
Tremendous session by Dr Naila Ashfaque on a very critical topic ACUTE LIVER FAILURE:
We covered:

- Definition and etiology of acute liver diseases
- Clinical presentation and pathophysiology
- How to differentiate between acute and chronic CLD
- Risk Stratification
- Management 3 R (recognise, resuscitate, referral)
- King's college criteria
- Hepatic encephalopathy (grading)
- Complications sepsis, coagulopathy, nutritional decline
- HELLP syndrome
- Ischemic hepatitis
- Hepatic artery thrombosis
- Hepatic venous outflow tract obstruction

The lecture was amazing as Dr. Naila always approaches the topic with such incredible grip, targeted, interactive session, and very clear concepts that will help our exam and clinical practice.
The session ended by DR ASH's 10 min review on management plan, it was an amazing comprehensive review on how to write a plan (INCREDIBLE).
Thank You the dynamic duo DR NAILA AND DR ASH.
Kind Regards,

FEEDBACK # 24

Dr Emmanuel Charles

MRCP targeted interactive sessions with rapid review of vitals topics. All the important points were well summarized and explained.
From initial presentation of Liver anomalies ,management, treatment and life-style modifications
The lecture was case-based discussion covering the following points :
1) Different causes and pathophysiology of acute liver failure.
2) Clinical presenting signs(fatigue, malaise, lethargy, anorexia, nausea and vomiting, jaundice, pruritus, abdomen distention from ascites

3) Various Chronic liver Disease signs like(caput medusae, spider nevi, gynecomastia, testicular atrophy, ascites).
4) Explanation of King's college Criteria for Paracetamol Poisoning and non Paracetamol poisoning
5) Management - 3Rs (recognize, resuscitate, refer)
6) Type of multidisciplinary team involved and transplant criteria: regional organ-transplant, Gastroenterology and Intensive care teams.
7) HELLP Syndrome.
In the end Dr Ashfaque invaluable guidance and summarizing the whole session emphasis proper management plan were excellent as always.
Thankyou Dr. Ashfaque Ahmed for facilitating the whole session.
Thankyou Dr Naila Ashfaque Sorathia
Thankyou LGEM MRCP PROGRAMME TEAM

FEEDBACK # 25

Dr Azka Shamim

Aoa respected sir
Today we had an opportunity to learn from our favourite Dr Naila Ashfaque (consultant NHS UK) regarding Acute liver failure and Dr Naila covered the whole topic in such an amazing way that totally changed our perspective and approach to manage such patients... Dr Naila explains each and every concept in such a simple and easy to learn way and it enables us to get a full command on the topic ..
Following important learning points were discussed:
*Definition of Acute Liver Failure
INR>1.5, hepatic encephalopathy and deranged LFTs with no previous hx of liver disease
*Various causes of ALF (also in relation to regions)
Pathophysiology related to a rise in NH3 level
*Clinical presentation of Acute liver failure
*Differentiation b/w ALD / decompensated LD
*Symptoms of ALF
*Poor prognostic factors.
*Management (3R: Recognise, Resuscitate, Refer)
*Kings College Criteria for liver transplant +lactate +phosphate level
1.paracetamole poisoning
arterial ph <7.25
NAC 24 hour plus
PT >100
grade 3/4 encaph
2.non PCM

•pT >100 ,INR >6..5
•Billirubin >300
•Jaundice
•Age <10>40
*Grades of Hepatic Encephalopathy and treatment
*complications of Acute liver failure
* Multidisciplinary approach regarding how to refer
*HELLP syndrome etiology cause and management
And then came the golden session with Dr Ash for which we always wait at then end of each session... we had scenario base discussion regarding stepwise management and how to write detailed orders to be followed. It was a power pack knowledgeable session of this week.
Thank you so much Dr Naila and Dr Ash for owning us and taking us under your educational and clinical supervision.. we are really blessed..
Proud LGEM trainee

Dr Azka ✨

FEEDBACK # 26

Dr Faiza Baig

This session was amazing according to exam point of view and she focused on management plan in a systematic manner. The topic was easy to understand ,how to approach Acute liver failure.
It was defined as rapid decline in hepatic function characterised by jaundice , coagulopathy (INR>1.5), vit k decreased 2,7,10,11 coagulation factors and hepatic encephalopathy with no prior liver disease.
If occurs in pre-existing liver disease-- acute on chronic liver failure or decompensated liver disease
Causes:
Drugs/toxins: Tylenol, prescription meds, ecstasy etc
Viral: HAV,HBV/HDV, Non A-E
Vascular: budd-chiari, ischemic
Metabolic: Wilson,
Pregnancy: HELLP syndrome, fatty liver
Autoimmune:
Infiltrative: cancers, melanoma, lymphoma, TB
In UK, most common cause of liver failure is paracetamol toxicity
In Asian countries, most common cause is viral hepatitis
In China, most common cause of liver failure is mushroom poisoning.
Pathophysiology includes
hypoglycemia

Protein metabolism: hyper ammonemia, hyperbilirubinemia,
clotting factor deficiency, coagulopathy, hypoalbuminemia
systemic infection lead to sepsis
Sodium, water imbalance.
Presentation of Acute liver failure:~
Fatigue , malaise, lethargy, anorexia, RUQ pain ,pruritus, jaundice, and.
Distension- ascites
Differentiate ALD with decompensated LD clinically:
check signs of CLD:-
Esophageal varices
Portal hypertension
Caput medusae
Spider nevi
Palmar erthyema
Gynecomastia
Hepatic encephalopathy
Hepatice renal syndrome
Risk stratification: factors with poor outcomes.
Management : in ED 3-Rs
Recognise: unexplained acidosis, confusion, shock, hypoglycemia,
coagulopathy, deranged LFTs
Resuscitate:
A: consider intubation if unable to maintain airway or ventilation ,
B: Give O2 - if hypoxia
C: Fluids for hypotension - poor end organ perfusion MAP>60 or systolic> 90
D: Maintain normoglycemia
CXR, ECG,ABG, wx large bore IV ,urinary catheter
Consider invasive monitoring
Refer : regional transplant teams
Gastroenterology teams
Intensive care teams

📌Kings college criteria for liver transplantation
kings criteria alone or with Serum lactate and phosphate can predict patients with poor prognosis

✨Criteria for Paracetamol induced liver failure:
Arterial pH<7.25 after adequate fluid resus, NAC,+24 hrs
Or all 3 of
PT >100sec(INR>6.5)

Cr. >300 mmol/l or anuric
Grade 3/4 encephalopathy

✨Criteria for Non -Paracetamol liver failure:
PT> 100(INR>6.5)
Or 3 of 5:
PT> 50sec(INR>3.5)
Bilirubin 300mmol
Jaundice to encephalopathy>7daysage <10 or > 40
Sero -ve, drugs
Critical care Management:
If required transplant, fluids and electrolyte monitoring ,GI bleeding, nutrition support monitor coagulation, infection, ICP(Intracranial HTN, cerebral edema)
Hepatic encephalopathy:
Grade with symptoms and management:
I: behaviour change with change in level of consciousness
II: gross disorientation, drowsiness, asterixis, inappropriate behaviour
Manage: list for transplant and transfer to tertiary centre
CT r/o other causes
Avoid stimulation
Sedatives
Monitor and tx infection
Lactulose - to reduce ammonia load ,prevent worsening of encephalopathy
III: marked confusion, incoherent speech, sleeping mostly but responsive to vocal stimuli
IV: comatose , no response to pain, decerebrate posturing
Manage: Intubation and sedation
Head elevation
Seizure prophylaxis - mannitol
Complications :
Sepsis- culture for occult or frank sepsis surveillance
Occasional Prophylactic Abx or antifungal
Coagulopathy: when to give FFPs: active bleeding and INR>1.5 or >7
When to give platelets :<10000 or <50000 or need invasive procedures or bleeding
GI bleeding- give PPI in vent. Pt.
Hemodynamic unstable: vasopressors to keep MAP>60-65
Nutritional decline:-
Hypomagnesemia
Hypokalemia

Hypophosphatemia
HELLP syndrome
Ischemic hepatitis causes
Heart
Infection
Hypovolumic shock
Blood clots
Hepatic artery thrombosis
complication of liver transplant
Causes:
Primary Bud chiari syndrome75%(hepatic venous outflow tract obstruction):
5P- Pills, Pregnancy, Post partum, Procoagulation conditions (Nephrotic synd, cancer, protein C and S Def., Factor 5leiden mutation and SLE) and polycythemia rubra Vera.
Secondary : 25%
Compression of hepatic vein(tumor)
Clinical presentation: triad
RUQ pain, tender hepatomegaly, ascites
ALF
Tx: thrombolysis
A wonderful session, learnt alot and as usual
Last 10 min golden words of Dr. Ash summarized the whole lecture and focused how to approach proper management plan of acute liver disease 👏
✨Thank you Dr. Naila and Dr. Ash. ✨

FEEDBACK # 27

Dr Amash Khan

Today's lecture by Dr. Naila started by Definition of Acute liver failure, causes, recognizing factors, pathophysiology, prognosis, kings criteria for liver failure, it's complication like encephalopathy, sepsis, ischemic hepatitis and obstructive complications.
It was a detailed and informative lecture.
Thank you Dr. Naila for your guidance.

FEEDBACK # 28

Dr Bushra Khan

A very interesting lecture by Dr Naila on ALF.
Very important topic for exam. Patients presents as acutely unwell, recognition and management in a systemic manner is very crucial.
Thank you Dr Naila and Dr Ashfaque for keeping us right as always.

5th FEBRUARY 2023

EVENT NAME:

Chronic Decompensated Liver Disease High Yield Mrcp By Dr Anjum Gurdezi Gastroenterologist NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Rabiyyah Bashir

Dr Anjum Sir delivered a smooth lecture and nicely explained

✓ pathophysiology of decompensation in CLD

✓ Complications of Cirrhosis

✓ General management of dCLD

✓ Specific management of its complications:

✓ Ascites (loop and K sparing diuretics, large volume paracentesis & TIPSS)

✓ Variceal bleed

✓ Encephalopathy (ppt factors, role of lactulose and rifaxamine)

✓ Spontaneous bacterial peritonitis

✓ Differentiating AKI and HRS in cirrhotic patients, ICA diagnostic criteria and Management

✓ Decompensated cirrhosis care bundle

✓ Role of albumin replacement

✓ choice and dosage of diuretics

Then he patiently and skillfully answered the queries of audience.

Lastly Dr Ash shared his smart protocol of managing dCLD.

Highly Obliged to Dr Anjum Sir, Dr **Ashfaque Ahmed** Sir and team **London Global Emergency Medicine**

❤️❤️❤️

FEEDBACK # 2

Yasir Dilawar

It was a great lecture by Dr Anjum he explained in a very good way the difference between compensated and Decompensated Liver disease. how to manage it. what are it's complications. management of ascites. he also explained about the doses of spironolactone and furosemide in cases of chronic liver diseases. Dr Faiza also presented a case.

FEEDBACK # 3

Suhail Ahmed

The session was great as always well presented.

Dr. Anjum discussed the management of Decompensated CLD.
He discussed terminology first than came towards the clinical signs, management, complications and prognosis of decompensated liver disease.
HRS and hyponatraemia management was discussed amazingly in a simple way.
In the last as always Dr. Ash gave his own management plan for decompensated CLD and that was amazing.
Thank you LGEM.

FEEDBACK # 4

Gdmas Malik

The session was appealing one that strikingly encompassed the topic. The term compensated cirrhosis and decompensated cirrhosis and acute liver failure and chronic liver failure, clinical course of cirrhosis and transition from compensated to decompensated cirrhosis were delineated . Decompensation is a system disease with multiple organs dysfunctions with overt clinical presentation eg, variceal bleeding, encephalopathy, ascites and jaundice. The compensated cirrhosis survival is 12 years. The stages were discussed from 0 upto 6 stage ,pathophysiology ,and complications of decompensation , hypovolemia and hyperdynamic circulation were elaborated. Treatment of decompensated disease was discussed, which was albumin, rifaxamine , ascites , sbp hepatic encephalopathy, Gi bleeding , renal impairment and acute on chronic liver failure sarcopenia, nutritional problems, hepatic hydrothorax, hyponatremia adrenal insufficiency, and cardiopulmonary complications were clearly mentioned. Management of complications, eg ascites, large paracentesis, diuretics aldactone dose from 100 to 600mg and addition of furosemide in case of peripheral oedema, management of variceal bleeding like terlipressin, endoscopic ligation/sclerotherapy Tipps ,fluid resuscitation, Hb maintenance up to 7---9 g/dl and antibiotic prophylaxis and non specific beta blocker balloon temponad and esophageal stunts all these were clarified well
Lastly our great mentor professor Sir Ashfaque Ahmad sb re-enforced the session by adding a new thrill of an organised and well calculated management of decompensated liver failure and cultivated our minds for high level practical approach and orderly fashion performance in future .
I am excited enough to thank our great mentor for his memorable guidance and perpetual sprouting of knowledge over us .May Allah grant him glittering blissfulness and consolation.

FEEDBACK # 5

Faiq Uz Zaman Khan

Dr Gardezi simplified such a complex topic. So many patients suffer from DCLD in Pakistan and we need senior clinicians like him to guide junior

doctors on how to manage such cases. Sir Thank you so much for your time. Your lecture definitely improved our understanding of the disease and it's management.

FEEDBACK # 6

Bushra Imran

Dr Anjum lecture was marvelous, understandable easily and nicely delivered on pathophysiology of decompensated chronic liver disease, complication and treatment of cirrhosis, Ascites and how to tap ascetic fluid, treatment with antibiotics after ruling out sepsis, usage if diuretics, TIPSS, vareceal bleeding ,treatment of encephalopathy, role of albumin replacement, when to give transfusion, SBP ,AKI with HRS with differentiating points, ICA diagnostic criteria

And in the end golden discussion by DR Ash was always fruitful

Thank you Dr Anjum and Dr Ash +GEM team

FEEDBACK # 7

Mina Khan

Dr Anjum has vast clinical knowledge and great expertise on gastroenterology/hepatology. He delivered a very updated session on decompensated liver disease.

Compensated asymptomatic survival 12 years/Decompensated symptomatic 2 years /Late decompensation refractory ascites/end organ dysfunction>AcLF>Death.

Cirrhosis>portal hypertension>SBP>splanchnic vasodilation>cardiac dysfunction>Sec aldosteronism/Hepatorenal/Hepatopulmonary dysfunctions.

Tx: restrict salt intake 5-6.5gm/day/ vegan-diet/ strt on spironolactone 100-400/add furosemide 40-160 if pedal edema, 1kg wt reduction on edema/0.5kg in NoN edema/ if improvement then taper dosages/

Portal HTN: intrahepatic resistance/ backward load> inc CO> inc HRT>Systemic vasodilation>dec arterial pressure> ascites /fluid retention Tx: Sclerotherapy/band ligation/ TIPPS

Variceal Bleed: octreotide/terlipressin/fluids resus/ target Hb 7-9g/Tx sclerotherapy/band ligation/TIPPS [varices and Portal HTN are related]

Life savers : ceftrioxone if prophylaxis needed/PCVs

HepatoEnceph: Biomes form ammonia/ convert sulfur containing amino acids >mercaptans>fetor hepaticus.metabolism bypasses liver. CNS depression.

HepatoEnceph Risk F: infections/hypoxemia/hypercapnia/GI bleed/AKI/hypokalemia/Porta venous thrombosis

Tx: target precipitant/lactulose/rifaximin semi synthetic antibio to dec Biomes

Ascites leading to SBP, PMN >250cells/ml/ +gramstain / cefotaxime

ICA-AKI type 1 HRS= HRS-AKI/type 2 HRS=Non AKI-HRS

Tx: Terlipressin 1mg 6 hrly + Albumin.
Thank you London Global Emergency Medicine for such an important session.

FEEDBACK # 8

Ghulam Saddique Saddique

High yield session conducted by Dr. Anjum Gardezi. First time clearing the management concept of Decompensated CLD patients despite of dealing these patients in hospitals frequently.
Session started with the commonly used terms in chronic liver disease which are
Compensated cirrhosis
Decompensated cirrhosis
Acute liver failure
Chronic liver Failure
Clinical course of cirrhosis--> Decompensation
• Transition from compensated cirrhosis to DC occurs at a rate of ~5-7% per year • DC is a systemic disease, with multi-organ/system dysfunction
• Overt clinical signs, the most frequent of which are ascites, bleeding, encephalopathy, and jaundice.
Compensated Phase patient survival 12yrs
Stage-0 no varices with mild Portal HTN
Stage-1 no varices with clinically significant Portal HTN.
Stage-2 Varices with Clinically significant Portal HTN.
Decompensated Phase patient survival 2yrs
Stage-3 bleeding
Stage-4 Non bleeding decompensation
Stage-5 second Decompensating event
Stage-6 late decompensation
Pathophysiology of Decompensated CLD
Complication of Decompensation
Portal hypertension
varcies
hypovolumia
hyperdynamic circulation
Management of Decompensated Liver disease
Albumin, Rifaxamine and statin
Specific complication
Aspite Gastrorkestinal bleeding Bacterial infections SBP Renal impairment
Hepatic Encephalopathy
Acute-on-chronic liver failure
Sarcopenia/Nutrition Hepatic hydrothorax
Hyponatrenia

Relative adrenal insufficiency
Cardiopulmonary complications
Pathophysiology of Ascites discussed
For management Diuretics, Large paracentesis and TIPPS.
Treatment of Acute variceal bleeding
For suspected variceal bleed give vasoactive drugs (octeriotide, vaspopressin, terlipressin), fluid resuscitation, restrict transfusion with target Hb 7---9mg and antibiotic prophylaxsis. then do Endoscopy (diagnostic / ligation/sclerotherapy)
If bleeding gets control then drugs for 5-7days, Nonspecific Beta-Blockers and EVL.
If failure occurs bleeding continues then balloon temponate, esphageal stunt and finally TIPPS procedure.
Hepatic encephalopathy discussed.
Major risk factors of hepatic enceph
1.portal vein thrombosis, 2.infections, 3.electrolyte imbalance, 4.GI Bleed, 5.hypoxemia/hypercapnia
Management of HE
1.Treat the precipitant ,2.lactulose, 3.Rifixamine
Spontaneous bacterial peritonitis (SBP)
Fever, chills and abdominal pain
Ascitic tap shows neutrophil count >250cell /ml and positive gram staining /culture
Treatment 3rd generation cephalosporin (cefotaxime)
Different types of AKI in cirrhoses
All kinds of AKI can occur in cirrhotic patients
1.pre renal, 2. HRS, 3.intrinsic, 4. ATN, 5.Post renal
Not every AkI in cirrhosis is HRS
ICA diagnostic criteria for HRS-AKI
Cirrhosis and ascites
Diagnosis of AKI according to ICA-AKI criteria
No response after 2 consecutive days of diuretic withdrawal and plasma volume expansion with albumin 1 g per kg of body weight
Absence of shock
No current or recent use of nephrotoxic drugs (NSAIDs, aminoglycosides, iodinated contrast media, etc.)
No macroscopic signs of structural kidney injury, defined as:
• Absence of proteinuria (>500 mg/day)
• Absence of microhaematuria (>50 RBCs per high power field)
• Normal findings on renal ultrasonography
Management of HRS-AKI treatment

• First-line therapy is terlipressin plus albumin
Recommendation
All patients meeting the current definition of HRS-AKI stage >1A should be expeditiously treated with vasoconstrictors and albumin
Terlipressin can be administered by IV boluses (1 mg every 4-6 hours) or by continuous IV infusion (2 mg/day)
In case of non-response (decrease in SCr <25% from the peak value) after 2 days, the dose of terlipressin should be increased in a stepwise manner to a maximum of 12 mg/day
Albumin solution (20%) should be used at 20-40 g/day
Serial measures assessing central blood volume can help to titrate the dose of albumin to prevent circulatory overload
Noradrenaline can be an alternative to terlipressin
Requires a central venous line often in an ICU
+ octreotide can be an option when terlipressin or noradrenaline are unavailable
A very important point discussed is that sprinolactone is started when there is Ascites starting from low dose 100mg to maximum 400mg/day and Furosemide is started when there is a pedal eodema
Secondly we can reduce or stop the diuretic dose when there is a drastic change in serum Na+ level
If there is no drastic change in Na+level no need to stop diuretics.
Lastly one Case discussed and very comprehensive management plan of Decompensated cirrhosis patient explained in very elaborated points by Dr. Ashfaque .
Once again thanks to all the respectable teacher and Mentor to polish our skills .
I am proud to be a part of London GEM programme.

FEEDBACK # 9

Dr Afifa Younis Raja

Greetings of the day!!
Today we had a healthy discussion on Decompensated Liver Disease CLD By Dr Anjum Gardezi Consultant Gastroenterologist NHS UK, this was the first lecture I attended by Dr Anjum and he is already my favorite, the command he had over the topic, the way he delivered such targeted lecture just amazing. We covered:

- Definition, etiology and pathophysiology of CLD and the complications
- Ascites pathophysiology and management
- Variceal bleed
- Lifesavers (antibiotics, blood transfusion)
- Hepatic encephalopathy (risk factors, management)
- Spontaneous bacterial peritonitis

· Hepatorenal syndrome

The best part was the question-answer session where Dr Anjum addressed all queries thoroughly, overall an excellent session.

Kind Regards,

Dr Afifa

FEEDBACK # 10

Dr Emmanuel Charles

Mrcp targeted interactive sessions with rapid review of vitals topics. All the important points were well summarized and explained.

From initial presentation of Compensated and Decompensated Liver anomalies , management, treatment and life-style modifications

The lecture was case-based discussion covering the following points :

1)The commonly used terms compensated and decompensated cirrhosis.

2) Signs of portal hypertension like ascites, bleeding encephalopathy, jaundice.

3)Decompensated and Compensated Cirrhosis : Their difference, management and stage of disease progression.

4) Pathophysiology of Ascites and Treatment of Acute variceal bleeding was discussed.

5)Liver Encephalopathy was discussed

6)Transudate AND Exudate infection was discussed.

7)High SAAG value and Low SAAG value

In end Dr Ashfaque invaluable guidance and medical tips were excellent as always

Thankyou Dr. Ashfaque Ahmed for facilitating the whole session.

Thankyou Anjum Gardezi Consultant Gastroenterologist NHS UK

Thankyou LGEM MRCP PROGRAMME TEAM

FEEDBACK # 11

Dr Ruma Mustafa

Superb session by Dr. anjum with comprehensive explanation of each point on Decompensated liver disease. Dr. Anjum Gardezi made understandable every single point although it's very complex topic regarding clinical practice

His way of describing various important points was great & it is discussed as below:

1. Compensated Cirrhosis
2. Decompensated Cirrhosis
3. Acute Liver failure
4. Acute on chronic liver failure

Clinical course of Cirrhosis:

Decompensated transition from compensated cirrhosis occurs at a rate 5-7% per year.

Clinical signs:
Ascites, bleeding, encephalopathy & jaundice
cirrhosis stages:
Compensated (Asymptomatic) survival 12 yrs
Stage0: no varices mild PH
Stage 1: no varices, CSPH
Stage 2: varices (CSPH)
Decompensated: (symptomatic) survival 2 yrs
Stage 3: bleeding
Stage 4: first non-bleeding decompensation
Stage 5: second decompensating event
Stage 6(End-stage) refractory Ascities persistent jaundice, infection, renal and organ dysfunction
ACLF+ Death.
Pathophysiology of Decompensation:
Liver injury...Cirrhosis...portal hypertension
Specific COMPLICATION:
Ascities
GI bleed
Bacterial SBP
Renal impairment
HEncephalopathy
Acute on Chronic Liver
Sarcopenia
Hepatic hydrothorax
Hyponatremia
Relative adrenal insufficiency
Cardiopulmonary complications
ASCITES:
portal hypertension + fluid overload
MANAGMENT:
Diuretic therapy
Large volume paracentesis Ascitic drain
TiPSS Transjugular intrahepatic portosystemic shunt (a life saving radiological procedure) Ascitic Tap
VARICEAL BLEED:
Esophagus, gastric, duodenal, rectal most common are stomach and lower Esophagus
MANAGMENT:
Vasopressin active drugs

Octerotide (commonly used in pk)
Vasopressin / Telipressin
FLUID RESUSCITATION
Patient should heamodynamically stable
Restrictive Transfusion target hgb 7-9g/dl
Patient should not consider for FFP Transfusion if PPT 20/30 becoz patien will bleed more
Antibiotic propaphylaxis
Endoscopy (diagnostic + ligation/ Sclerotherpy) if control...
Non Selective Bets Blockers + EVI 2_5D
If fail...
BALLON TAMPONADE ESOPHAGEAL STENT ...TIPS
HEPATIC ENCEPHALOPATHY:
NH3..toxins to brain
MAJOR RISK FACTORS:
TIPS
Hypoxemia
Hypercapnia
GI bleed
AKI/Electrolyte imbalance deck + Infection SBP
MANAGMENT:
Treat Precipitant factors first
Lactulose
Rifaxamine
BACTERIAL SBP:
advanced cirrhosis
Portal hypertension...bowl edema..Bacterial migration from GI tract
Fever chills, ab.pain ,PMN>250cell/ ml
G+S/C
3rd generation cephalosporine cefotaxime
AKI IN CIRHOSIS:
HRS (hepatorenal syndrome)
All types of AKI
Pre Renal,HRS,Intrinsic,particularly ATN
Post Renal
ICA diagnostic criteria for HRS AKi:
Cirrhosis & Ascities
Aki according to ICA AKi criteria
No response of after 2 conecutive days of Diuretic withdrawal &plasma vol.expansion with Albumin 1g/kg/wt

No shock
Do not have nephrotoxic drugs
No sign of protinemia>500
No microheamaturia>50RBC
Normal USG KUB
CLASSIFICATION:
TYPE 1 HRS: HRS AKI (Acute)
TYPE 2 HRS: Renal impairment no AKI or NAKi (chronic)
MANAGMENT:
Precipitants
Terlipressin first line...IV bolus(1mg 4-6 hr)
Albumin 20% 20-40g/d
HRS-AKI stage>1A
Non responsive; Dec SCr<25%after 2 d12 mg /dl
Noradrenaline alt to terlipressin
CV LINe...useed in ICU
Midodrine+Octereotide can be used with lower afficacy
Little more intellects
If donot have lower limb Edema...
Spironolactone dosage:
Tab.aldactone 100mg
once /daily max to 400mg and if restrictive(Electrolyte and BLood pressure abnormal) 50mg once/ daily
If Aki ,hyponatremia, hyperkalemia, then reduce dose or stop dose
In CCF can give Spironolactone 12.5mg for mortality
If pedal edma present...add furosamide 40 mg ...200mg
Simvastatins are safe
avoid NSAiD in DCLD
Thank you so much, Dr. Anjum Gardezi & Dr. Ashfaque for training us at a consultant level.
Bless u Sir ur truly inspirational Mashallah
Proud GEM trainee

FEEDBACK # 12

Dr Ahmad Tanveer

This session was Amazing and very well presented.
The new systematic management concept of Decompensated CLD patients despite of dealing these patients in hospitals frequently. Many new pearls of knowledge update got from this lecture never heard or read in books before.
Session started with the commonly used terms in chronic liver disease which are

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Decompensated cirrhosis
Acute liver failure
Chronic liver Failure
Clinical course of cirrhosis--> Decompensation
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Stage-3 bleeding
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Stage-6 late decompensation
Pathophysiology of Decompensated CLD
Complication of Decompensation
•Portal hypertension
•varcies
•hypovolumia
•hyperdynamic circulation
Management of Decompensated Liver disease
Albumin, Rifaxamine and statin
Specific complication
Gastrorintestinal bleeding
Bacterial infections SBP
Renal impairment
Hepatic Encephalopathy
Acute-on-chronic liver failure
Sarcopenia/Nutrition Hepatic hydrothorax
Hyponatrenia
Relative adrenal insufficiency
Cardiopulmonary complications
Pathophysiology of Ascites discussed
For management
Diuretics,
Large paracentesis and TIPPS.

Treatment of Acute variceal bleeding
For suspected variceal bleed give vasoactive drugs (octeriotide, vaspopressin, terlipressin)
fluid resuscitation
restrict transfusion with target Hb 7---9mg and antibiotic prophylaxsis
Then do Endoscopy (diagnostic / ligation/sclerotherapy)
If bleeding gets control then drugs for 5-7days
Nonspecific Beta-Blockers and EVL.
If failure occurs bleeding continues then balloon temponate ,esphageal stunt and finally TIPPS procedure.
Hepatic encephalopathy discussed.
Major risk factors of hepatic enceph
1.portal vein thrombosis
2.infections
3.electrolyte imbalance
4. GI Bleed
5.hypoxemia/hypercapnia
Management of HE
1.Treat the precipitant
2.lactulose
3.Rifixamine
Spontaneous bacterial peritonitis (SBP)
Fever, chills and abdominal pain
Ascitic tap shows neutrophil count >250cell /ml and positive gram staining /culture
Treatment
3rd generation cephalosporin (cefotaxime)
Different types of AKI in cirrhoses
All kinds of AKI can occur in cirrhotic patients
1.pre renal,
2. HRS,
3.intrinsic
4. ATN
5.Post renal
Not every AkI in cirrhosis is HRS
ICA diagnostic criteria for HRS-AKI
Cirrhosis and ascites
Diagnosis of AKI according to ICA-AKI criteria
No response after 2 consecutive days of diuretic withdrawal and plasma volume expansion with albumin 1 g per kg of body weight

Provided there is Absence of shock
No current or recent use of nephrotoxic drugs (NSAIDs, aminoglycosides, iodinated contrast media, etc.)
No macroscopic signs of structural kidney injury, defined as:
• Absence of proteinuria (>500 mg/day)
• Absence of microhaematuria (>50 RBCs per high power field)
• Normal findings on renal ultrasonography
Management of HRS-AKI treatment
• First-line therapy is terlipressin plus albumin
Recommendation
All patients meeting the current definition of HRS-AKI stage >1A should be expeditiously treated with vasoconstrictors and albumin
Terlipressin can be administered as IV
boluses(1mg every
4-6 hours) or
by continuous IV infusion (2 mg/day)
In case of non-response (decrease in SCr <25% from the peak value) after 2 days, the dose of terlipressin should be increased in a stepwise manner to a maximum of 12 mg/day
Albumin solution (20%) should be used at 20-40 g/day
Serial measures assessing central blood volume can help to titrate the dose of albumin to prevent circulatory overload
Noradrenaline can be an alternative to terlipressin
Requires a central venous line often in an ICU + octreotide can be an option when terlipressin or noradrenaline are unavailable
A very important point discussed is that sprinolactone is started at 100mg OD dose to max of 400mg as it has long half life and when there is Ascites 2-Furosemide is started when there is a pedal edema at dose of 40 BD and can go upto 200mg/ day dose
Secondly we can reduce or stop the diuretic dose when there is a rapid change in serum Na+ level
If there is no drastic change in Na+level no need to stop diuretics.
Lastly one Case discussed and very comprehensive management plan of Decompensated cirrhosis patient explained in very elaborated points by Dr. Ashfaque.Proud to be LGem candidate.
Superb session a lot of incoming knowledge updates got. Thanks again Dr Ash and Dr Anjum Gardezi . Regards

FEEDBACK # 13

Dr Leela Ram

The session was superb with transparent explanation of each point on Decompensated liver disease. Dr. Anjum Gardezi made us understand every single point after completing lecture. His way of describing various important points was great & it is discussed as below:

1. Compensated Cirrhosis
2. Decompensated Cirrhosis
3. Acute Liver failure
4. Acute on chronic liver failure

Clinical course of Cirrhosis: Decompensated transition from compensated cirrhosis occurs at a rate 5-7% per year.

Clinical signs: Ascites, bleeding, encephalopathy & jaundice

Compensated cirrhosis stages:

Stage 1: no varices, CSPH

Stage 2: varices

Decompensated stages:

Stage 3: bleeding

Stage 4: first non-bleeding compensation

Stage 5: second decompensating agent

Compensated + Decompensated = stage 6(End-stage) = ACLF+ Death.

• Pathophysiology of Decompensation:

Management:

1. Suppression of aetiologic factors
2. Treating of pathogenic factors

Specific complications:

Ascites, GI bleeding, Renal impairment, H. Encephalopathy, ACLF, Sarcopenia, hepatic hydrothorax, hyponatremia, relative adrenal insufficiency, cardiopulmonary complications

Managing Ascites: Diuretics+ large volume paracentesis+ TIPPS

Life savers: Antibiotics, blood transfusion

Managing H. Encephalopathy: treat the precipitant + lactulose + Rifaxamine

Differentiating types of AKI: All types of AKI can occur in patients with cirrhosis.

This session will have massive impact on management of all types of complications ensued from decompensated liver disease.

I learned several new things, for example Albumin management, Spironalactone doses in CCF & Decompensated liver disease.

Thank you so much Dr. Anjum Gardezi & Dr. Ashfaque for training us at a consultant level.

5th FEBRUARY 2023

EVENT NAME:

High Yield Minor Trauma By Dr Syed Ali Ahmed FRCEM

DOCTORS FEEDBACK

FEEDBACK # 1

Amir Ashraf

Today the second session for high yield trauma was delivered by out most fav lovely teacher Dr Syed Ali , his teaching style , his delivery of words is so impactful that it goes straight to mind and heart , everything he teaches becomes so easy to memories . mostly after his session when I study those topics I just move on fast because he has taught it so well with such amazing reasoning and concepts behind it that I don't have to put extra efforts it reading it again ,Great skill boss ❤️

the topics we learned :

- Flexor tenosynovitis and Kanavel's criteria .
- Garden's classification
- Gas gangrene
- salter harris classification
- Spiral femur fracture and it significance with osteomyelitis
- Calcaneal fracture and Bohler's Angle
- Fibular fracture and weber classification
- peri tibial laceration and the use of steristrips in elderly
- Avulsion of superior and inferior iliac spice and muscle attachment
- Toddler's fracture
- sub capital neck of femur fracture
- Slipped upper femoral epiphysis

-scaphoid fracture

-ACL and MCL injury

NOTE : ALL THESE TOPICS WERE TAUGHT WITH RADIOLOGY EVIDENCE

It was an amazing learning day , really enjoyed alot . Thankyou @Dr ALI St4 Trainee EM UK for teaching us being post call and staying with us for 2 hours ❤️

Thankyou @Dr Ash for everything , now the blessing are uncountable ❤️

FEEDBACK # 2

Syed Suhail Ahmad

Today’s session covered

- NICE guidelines on when to go for CT C-Spine in head injury patients

- Dangerous mechanism of injuries
- Important fracture classification like Gardener and Weber and Bohlers's angle
- Commonly missed fractures like scaphoid, mallet, lisfranc, calcaneal etc
- Cruciate ligament injuries
- Femur and Tibial fractures etc

Thank you LGEM, PEMA 👍👍👍

FEEDBACK # 3

Imtiaz Ali Shah

Another high yield session by dr Ali regarding minor trauma. It was an interactive session based on clinical scenarios and discussion. Dr Ali carried out an amazing session with full of learning points and knowledge. The scenarios were related to.

Head injury investigations.
CT Head and CT spine guidelines.
Shoulder dislocation
Smith fracture.
Scaphoid Fracture.
Limping child
Lisfranc injury.
Calcaneal fracture.
Un happy triad.
Mallet finger.
Bohlers angle.
Tenosynovitis
Gas Gangrene.

Dr Ali have amazing teaching skills and he utilize them very well.His friendly attitude has a great impact on the out come of his every session .

At the end I would like to thanks dr Ali for this wonderful presentation and also dr Ash for providing us such a great platform for learning in the form of London GEM.

FEEDBACK # 4

Dr Mariam Nawaz

Dr Ali seriously take the game of teaching to next level. Today's session was as amazing and interesting as the previous one. With teachers like Dr Al8 teaching us, Inshallah there is hope that we will a0ss our SBA in first attempt

Some of the topics we learnt today are as follows

. Criteria for c spine CT in head trauma patient
.Scaphoid fracture
. Anatomical snuff box
. Lis franc injury

. Shoulder dislocation
. Hip pain in children
. Pre Tibial laceration
. MCL injury
. Elbow dislocation
. ACL injury
. Webber's fracture
. Femur fracture
. Gardener's classification
. Gas gangrene
. Limping child (SUFE)
. Mallet's finger
. Heel pain
. Bohler's angle
It was a saturated session, yet very interesting
Thankyou Dr Ali and Dr Ash for this amazing session. Looking forward to have more sessions with Dr Ali

FEEDBACK # 5

Muzna Ahmed

This session comprises of high yield FRCEM topics heavily tested in primary, Sba and osce.
Dr Ali explained everything in detail through pictures and Q/As and made the session interestingly interactive.
Today we learned:-
•Indication of CT head in trauma (in different age groups, scenarios)
•Dangerous mechanism of injuries
•scaphoid #
•lisfranc injury
•shoulder dislocation
•ASIS
•tibial lacerations
•MCL
•ACL
•ankle
•weber classification
•garderner classification (how to describe and interpret these xrays to ortho)
•Soft tissue injury like gas gangrene
•Limping child (SUFE)
•mallet finger
•tenosynovitis

These sessions reimbursed the required knowledge and preparation and helps in improving clinical practices.
Thankyou LGEM and Dr ASHFAQUE for always been keen and dedicated for trainees.

FEEDBACK # 6

Babar Hussain

Today's session on Minor Trauma excellently conducted by Dr Syed Ali Ahmed, One of our most Favorite in the LGEM Faculty.
It was an amazing interactive session of 2 hours . A lot of learning points for me especially
~ investigation for Head injuries.
~Criteria for CT head and C spine.
~Scaphoid fracture
~Smith Fracture
~Shoulder dislocation.
~SUFI (Limping child)
~Lisfranc injury
~unhappy triad
~Mallet Finger
~Calcaneal Fracture
~Bohler's angle
~Gas Gangrene
~Tenosynovitis
~ACL and PCL injuries mechanic
~What are Weber A, B and C fractures
I love Dr Ali's teaching way, very unique and interactive and everyone is so much involved.
Thank you very much Dr **Syed Ali Ahmed** for the wonderful lecture ❤️.
Thanks a lot Dr **Ashfaque Ahmed** and **London Global Emergency Medicine** for giving us this opportunity.
Proud LGEM candidate.

FEEDBACK # 7

Rajab Abbas

Today's session on Trauma by Dr Ali was really a package of new learnings about orthopaedic trauma, radiological findings regarding fractures and thier classification as well as management.
It was an interactive session and MashAllah every LGEM CANDIDATE is so enthusiastic in learning and is getting equipped with standard medicine practices and knowledge day by day.
Gist of topics which we learned today is:

• Criteria for C spine CT in head trauma
• Scaphoid #
•Anatomical snuff box
• SUFI
•Lis franc injury
•MCL injury (DEADLY TRIAD OF Donoghue
• Elbow dislocation
• ACL injury
• Femur #
• Gardener's classification
• Intertrochanteric#
• Gas gangrene (causes, management)
• Mallet's finger
• Calcaneal #(Bohler's angle
Thankyou Dr Ali and Dr Ash for this exam orientated session. Looking forward to have more sessions with Dr Ali
A proud LGEM candidate
Dr Rajab Abbas

FEEDBACK # 8

Rabiyyah Bashir

Sadly i missed the starting portion, due to duty
thereafter Dr Ali Sir broadly covered:

✓ Scaphoid fracture, diagnosis and management, role of xray and MRI.
✓ TFCC tear and piano key sign
✓ Review of shoulder and elbow dislocation.
✓ Review of Lisfranc injury
✓ Avulsion fractures of ASIS and AIIS
✓ Toddler's fracture
✓ MCL injury and unhappy triad of Odonahue
✓ ACL injury
✓ pretibial laceration in elderly and use of steri strips
✓ Calcaneal fractures and Bohler's angle
✓ Fibular fracture and weber classification
✓ Ottawa rules for foot and ankle
✓ Spiral fracture of femur and imp examination points
✓ subcapital neck of femur fracture and its complications
✓ Garden's classification of intracapsular neck of femur fractures

✓ gas gangrene case senario and management protocol.

✓ Review of Salter Harris classification

✓ Smiths fracture

✓ Intertrochanteric neck of femur fracture and Jenson classification

✓ Review of Galaezzi fracture.

✓ Slipped upper femoral epiphysis in frog lateral view and it's risk factors and complications.

✓ Suppurative flexor tenosynovitis, Kanavels cardinal signs and its management & complications.

As usual Dr **Syed Ali Ahmed** Sir had mesmerizing & energetic teaching style, he beautifully explained all the complex relevant details... And in the end our Session Supervisor Dr Asfaque Sir had to request him to stop 🙈 and relax, as he was post call. No one in the audience wanted his session to end ❤️❤️❤️

A big thanks to Dr **Ashfaque Ahmed** Sir for the making of this wonderful platform❤️

Thanks to Dr **Muhammad Azeem Imran** Sir for his enthusiastic participation ❤️

Huge regard for **London Global Emergency Medicine** ❤️❤️❤️

FEEDBACK # 9

Yasir Dilawar

It was another brilliant session by Dr Ali has explained to us a lot of x-rays and how to identify fractures. scaphoid, radial, tibial, femoral head, fibular etc. he gave us the management plan of such conditions and some classifications like webber, Gardener classifications and bohler angle. I am really thankful to Dr Ali for teaching so many things to us in these 2 hours.

FEEDBACK # 10

Shehzad Hussain

Thanks to Dr Ali once again delivered a superb lecture on High yield Trauma, the way he explain is wonderful it's mind blowing. Allah SWT have blessed him with the special art of teaching.

Multiple clinical cases were discussed like

Tenosynovitis , Gardens classification Spiral fracture of femur, SALTR HARRIS classification, calcaneal fractures , Osteomyelitis, laceration n steri strips, scaphoid fractures X-ray and indication for MRI, Limping Kid, ACL MCL injury , communication and documentation and many more explained very well. Thanks to Dr Ali for amazing lecture. Thanks to Dr Ash as always there is not even a single lecture we attended where Dr Ash have not given additional clinical information. Thanks to Dr Ash n LGEM team for arranging wonderful session.

FEEDBACK # 11

Bushra Imran

Today's another amazing 2nd session by dr Ali with learning points and scenarios related to head injury, Smith fracture, shoulder dislocation, elbow posterior dislocation, scaphoid fracture, Lisfranc injury ,Mallet finger, tenosynovitis with management ,calcaneal fracture, Bohlers angle very well explained, spiral fracture ,pretibial laceration in elderly and treatment with stristrips, fibula fracture ,review of seltzer Harris classification, SUFE in frog lateral view.. means lots of teaching and managing approaching scenarios
Thank you dr Ali and Dr Ash for this session

FEEDBACK # 12

Saad Aslam

A commendable approach by Dr Syed Ali, in teaching the bits and pieces of trauma/orthopedic questions that are often missed/misinterpreted. However the little time we have in the exam it is pertinent to be aware of comparative differences of each condition, which were explained very well.
Following are the topics that were discussed in the session:

- SUFE (slipped upper femoral Epiphysis)
- Tenosynovitis
- elbow, scaphoid fracture
- gas gangrene
- ethical counselling regarding sedation for shoulder fracture dislocation
- illustrative anatomy and blood supply of the femoral neck
- anatomical snuff box
- Gardener's classification
- Bohler's angle
- Mallet finger
- Webbers fractures (reporting level of fracture-symphysis)

FEEDBACK # 13

Hamna Kirn

Attended session on high Yield Minor Trauma By Dr Syed Ali Ahmed. one of the best session by one of the best mentor.
Topics discussed today.
-->when to do CT Spine?
if someone is unstable. don't do Ct do fast scan
nice guidelines for doing Ct spine
-->scaphoid lower half fracture aka proximal fracture. lateral and distal radial artery branches are passing. can cause a vascular necrosis(osteoarthritis) because of retrograde blood supply to distal part of the bone. if fracture doesn't

show in xray. wrist sprint and we are going asked pt to come back after 2 weeks and do MRI. we are going to look for accumulation of fluid.
-->advice for recovery from conscious sedation. don't drive, not to make any major decision. Opperate machinary
no abduction beyond 90°
-->Lisfranc injury-- pain and swelling. won't be able to bear weight.
painokey test-- elict pain.
ligment and dorsal pedis artery damage.
Mx- back slab. Ct and referring to ortho
-->unable to dorsiflex foot - common peronealnerve damage.
xray of knee need to be done.
-->unhappy triad of O'donoghue'
-->MCL 3 grades
valgus stress test. look at face
-->posterior dislocation of elbow-- ulnar nerve damage
most common fracture associated with it, medical epicondylar
-->weber fracture- fracture of fibula.
A or B or C
-->open fracture- can lead to osteomyeltis
-->neck of femur fracture--retinacular vessel and foval vessel.. avascular necrosis.
-->SUFI(slipped upper femoral epiphysis) show as not aligned or smooth. 10-15year child .
frog lateral view xray.
rf- male, overweight, GH deficiency.
-->calcaneal fracture
lumbar spine xray
xray both foot
bohler angle. how to calculate
Thank you for this amazing session.

FEEDBACK # 14

Nazish Nazi

It was again awesome lecture on High yield Trauma part 2 by Dr Syed Ali Ahmed , expert of radiology taught very well today also and delivered the lecture in such a beautiful manner that we understood every bit of lecture really well.
He is one of the bestest teachers among LGEM Faculty.
He highlighted many high yield points with interactive questions and pictorial presentations as following:
LIS FRANC fracture

LIMPING CHILD
ACL INJURY
Importance of CT cervical spine in Head injury
Shoulder dislocation
McL injury
Bohlers angle
Mallet fracture
Calcaneal fracture
Tenosynovitis
Scapgoid fracture
Gardeners classification
Gas gangrene
Femur fracture
Heel pain
At the end many thanks to sir Ash for his presence through out the lecture and giving us the oppurtunity to learn from such an amazing teacher Dr Syed Ali Ahmed.

FEEDBACK # 15

Qaisar Shah

Today Dr Ali discussed:

• CT criteria for C-Spine in head injury
• Dangerous mechanism of injury (NICE Guidelines)
• Scaphoid fracture and anatomical snuff box
• Lis franc injury
• Shoulder dislocation (post-conscious sedation advice, positions to avoid)
• Hip pain in children (ASIS)
• Pre Tibial laceration (STERISTRIP)
• MCL injury (three grades)
• Elbow dislocation (common in children, mostly posterolateral)
• ACL injury (pivoting injury, forced flexion/hyperextension)
• Weber's fracture
• Ankle injury (three types)
• Femur fracture
• Garden classification (stages 1-4)
• Gas gangrene (causative agent, investigations, management)
• Salter-Harris classification system
• Limping child (SUFE)
• Mallet's finger
• Heel pain
• Wrist pain

• Bohler's angle
• Tenosynovitis
The session was amazing .i learnt a lot.
Thanks Dr ali and Dr Ash for arranging this nice session.

FEEDBACK # 16

Beenish Manzoor

This session was Amazing and wonderfully presented.
Dr Ali seriously his way of teaching is outclass . Today's session was the continuation of previous part amazing and interesting as the previous one. He us one if the most fav facultyand whe teacher is so humble and brilliant how can possibly we not learn ..he phenomenally explain a lot of xrays and how to identify xrays
Some of the topics we learnt today are:
. Criteria for c spine CT in head trauma patient very important*
•scaphoid fracture
•smith fracture
• Anatomical snuff box
• Lis franc injury
•Shoulder dislocation
• Pre Tibial laceration
•hip pain in children
•MCL injury
•Elbow dislocation
• ACL injury
•Webber's fracture
•Femur fracture A B And C
• Gardener's classification
•Gas gangrene
• Limping child(SUFE)
•Mallet's finger
•Heel pain
•Bohler's angle
•calcanial fracture
•unhappy triad
•Tenosynovitis
I would highly recommend people to join this program as you will be in top physician after learning from such an amazing faculty who impart knowledge like no one ever could Dr Ashfaque Ahmed thankyou for everything you are doing for you trainees no supervisor would ever be able to meet your standard of teaching Thankyou Syed Ali Ahmed .Proud to be london Gem candidate

FEEDBACK # 17

Mina Khan

We were taught about Minor trauma injuries :
Potential criteria for performing c spine scan
GCS less than 13 /intubation/definitive diagnosis needed within 1 hr /Danger Mechanism of injury : Axial load on head/ height>1m/high speed RTA/Rollover accidents/scaphoid fracture (proximal borrows blood supply hence avascular necrosis)20% missed images repeat after 2 weeks/most common/any age/outstretched hyperextension wrist/normal xray /swollen area/colles cast/wrist splint/repeat MRI after 14 dys fu/
Borders of Snuff box: brevis b/w 2 longus
Avoid positioning at 90 palm facing upwards
Winged scapula/serratus ant/long thoracic n
Twisted foot injury >lisfranc fracture
14 yr old hip fracture> avulsion type ASIS
79 yr old multiple co morbids lady /laceration / dressing applied with steri strips only and admission to decision unit overnight advice aporopriate positioning /toe-knee pressure bandage to avoid blood thinners hematoma.
Foot Drop > common peroneal n/deep peroneal
MCL injuries Grades 1 mild/integrity/2 minimum laxity valgus/3 gross laxity/ACL injuries unhappy triad of o donoghue/ elbow dislocation>ulnar nerve injuri/ Ankle injury/unable to bear wt> weber system A> below syndesmosis/B at syndesmosis/C above syndesmosis
Spiral fracture of distal 3rd of femur watch distal pulses/sensory deficits/skin breaks
Garden's classification(intracapsular neck fracture femur) type 1 undisplaced+ incomplete frac type2 displaced + incomplete frac type 3 undisplaced complete frac type 4 displaced complete frac
Suppurative flexor tenosynovitis / staph. aureus tx / anagesia elevate limb/ antibiotics / on call hand surgeon .
Kanavals four signs pain on extension /flexed finger, sausage finger, tenderness of tendon sheath (late sign)
2. Wrist fracture/ capitate proximally move between scaphoid n lunate equals to SLAC wrist (scapholunate advanced collapsed)/ association with radial styloid frac / scaphoid frac / terry thomas sign (inc gap bw scaphoid n lunate equals to scapholunate difficulty.
3.severe pain in left heel / bohlers angle, (intersection of two lines from calcaneal tuberosity and highest point of subtalar joint post. facet / normal range is 20 to 40 degree)

No extension of DIP / flexed DIP./ Tx mallet splint in full extension/ follow up in 7 to 10 days
5. Sufe slipped epiphysis / frog lateral view / avascular necrosis / coxa vara / sec osteoarthritis /
galeazzi frac / anterior interosseous nerve
Hip injury / right leg shortened/ external rotation/ jenson classification (intertrochanteric neck of femur)
Salter Harris classification type 1, 2, 3, 4 / frykman classification/ Fernandez classification/ Muller classification
(smith's type 2, smith's type 3).

FEEDBACK # 18

Dr Afifa Younis Raja

Greetings of the day!!
ANOTHER AMAZING SESSION BY DR ALI AS ALWAYS. It was a TWO HOUR long session, but I was not tired at all and I can say it for all that we wouldn't have minded if it went on for another hour. Dr Ali was phenomenal as always and the amazing part was he was post-call and still delivered an amazing lecture with full dedication and energy. We covered so many topics few as below:

- Head and neck injury
- NICE guidelines for dangerous mechanism of injury
- Scaphoid fracture
- Anatomical snuff box contents and borders
- Ant shoulder dislocation
- Winged scapula
- Lisfranc injury
- Avulsion fracture of ASIS
- Medial collateral ligament of knee joint injury
- Elbow dislocation
- Spiral fractures of femur
- Garden criteria of fracture NOF
- Salter harris classification
- Smith's fracture
- Intertrochanteric fracture of femur
- Galeazzi fracture
- Toddlers fracture
- SUFE
- Mallet finger
- Calcaneal fractures
- Bohler's angle

· Terry thomus sign

I don't have words to describe how awesome his lecture was, felt like dipping in a sea of knowledge.

The best part was when D Ash imaorted
his knowledge and highlighted the clinical importance of a particular injury.

Thankyou Dr Ali AND Dr Ash
.Kind Regards,
Dr Afifa

FEEDBACK # 19

Dr Amash Khan

Today's topic by Dr Ali ahmed was of high yield and Question based on various topics like head trauma, and minor hand fractures etc.
Thank you Dr Ali for this session.

FEEDBACK # 20

Dr Azka Shamim

Aoa respected sir
Today we had an amazing session by Dr Ali (ST 6 NHS UK) regarding high yield questions covering minor trauma .. it was second session by Dr Ali and similar to previous session it was full of energy and interactive learning.. Dr Ali covered majority of minor trauma and elaborated every single point in a wonderful way ...
We covered following important learning points:
*CT criteria for C-Spine in head injury
*Dangerous mechanism of injury (NICE Guidelines)
*Scaphoid fracture and anatomical snuff box
*Lis franc injury
*Shoulder dislocation (post-conscious sedation advice)
*Hip pain in children (ASIS avulsion)
*Pre Tibial laceration (STERISTRIP)
*MCL injury (three grades)
*Elbow dislocation (common in children, mostly posterolateral)
*ACL injury (pivoting injury, forced flexion/hyperextension)
*Weber's fracture
*Ankle injury (three types)
*Femur fracture
*Garden classification (stages 1-4)
*Gas gangrene (causative agent, investigations, management)
*Salter-Harris classification system
*Limping child (SUFE)
*Mallet's finger

*Heel pain
*Wrist pain
*Bohler's angle
*Tenosynovitis
Infact it was a wonderful experience to learn all this in a 2.5 hour session.. thank you so much Dr Ash for arranging these amazing sessions for our learning, for our preparation regarding exams and for improvement of our skills .. really blessed to be part of this great platform
Proud LGEM trainee

Dr Azka ✨

11th FEBRUARY 2023

EVENT NAME:

High Yield Gastro Session 1 With Dr Ash Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Syed Suhail Ahmad

A powerpack 1.5 hours session on **High Yield Gastro Session 1 With Dr Ash Consultant NHS UK** covering the some of the most common pathologies, their causes, clinical presentation, diagnosis and management.
Included
- Oesophageal diseases
- Diseases of the stomach
Diseases of the small and large Intestine
- GI bleeding disorders
- Motility disorders
- Carcinomas
- Diverticular disease
- Hiatal hernia
- PUD
- Malabsorption and Lactose intolerance

Looking forward to the next session with Dr. Ash
Thank you LGEM and PEMA 👍👍👍

FEEDBACK # 2

Amir Ashraf

It was such a power pack session starting the day of with Dr Ash when he teaches personally , its like something that makes our day really beautiful

because the level of knowledge we get Dr ASH (a man of experience) , he knows what to teach and how to teach he knows what his students know and what they don't . He is an incredible teacher and supervisor .
Most importantly here's one thing , the level of commitment the passion and hard work of teaching it is unmatchable . He had flight for Dubai in 2 hours but he choose to deliver the teachings rather than himself packing and arranging this , he left that with family and started teaching us , I mean who even thinks of doing this ? right no one , Thats why NO ONE CAN BE DR ASH 🙂
Topics we learned :
Oesophageal disease
Disorders of the stomach and duodenum
Disorders of the small intestine
Disorders of the large intestine
GI Bleeding
Biliary disease
Every topics was brilliantly covered with details and proper understanding was ensured . Thankyou Dr Ash for this lecture .
Proud LGEM Trainee
- Dr Muhammad Amir Ashraf .

FEEDBACK # 3

Mukhtiar Pathan

Can someone believe that there is someone who has every topic of any specialty on his fingertips ?
Can someone believe that there is someone who can answer all your questions & queries which even any search engine like Google may not answer ?
Can you believe that there is someone who can tach complete Gastroenterology in just one session of 90 minutes ?
Can you believe that there is someone who is not going to skip teaching his students on weekend while his family is ready to leave for Airport?
Yes there is someone 😊
Who has complete,, infact,, advanced knowledge of every specialty of Clinical Sciences.
Who can teach Gastroenterology or any subject of Clinical Sciences in hours, which no other can teach even in days
There is someone who can answer all your questions & queries which even any search engine like Google etc nay not be able to
Who can afford to miss his flight, but can't afford missing a teaching session for his students
And That Great Great Personality is none other than Dr **Ashfaque**

Today he conducted a Session on High Yield Gastroenterology in which all topics including Esophagitis, Achalasia, Diffuse Esophageal Spasm, Esophageal Diverticulua, Hiatal Hernia, Esophageal Carcinoma, Gastric Carcinoma, Colonic Carcinoma, Zollinger Ellison Syndrome, Acute and Chronic Diarrhea, Ulcerative Colitis, Crohn's Disease, IBD, Small Bowel Obstruction, Large Bowel Obstruction, Gut Ischemia, Mesenteric Ischemia, Malabsorption, Diverticular Disease, Diverticulitis, Hepatitis, Chronic Liver Disease, Gastritis, Acid Peptic Disease, Upper GI Bleed, Lower GI Bleed, Primary Sclerosing Cholangitis, and lot lot more were taught
This is what Dr Ash is doing from the platform of London Global Emergency Medicine in Pakistan and abroad.
He is promoting right practices of Internal Medicine and Emergency Medicine.
He is training his Trainees for upcoming exams to become Consultants by clearing MRCEM & MRCP to fulfil the demand of large number of EM Consultants in Pakistan
Really proud of you Sir Dr Ash
Truly proud to be part of **London Global Emergency Medicine** (LGEM)

FEEDBACK # 4

Bushra Khan

Dr Ash covered most of the important topics in terms of MRCP exam. 1 hour session with huge knowledge and in terms of exam as well as clinical practice. Its a great commitment to conduct the session even when he's to get his flight in few hrs. Hats off to Dr Ash and Family. More power to you⭐

FEEDBACK # 5

Bushra Imran

In today's session Dr Ash covered all aspects both theoretically and clinically the whole Gastroenterology in 1.5 hr in comprehensive way that I revised all topics including esophagitis, Achalasia, Diffuse esophageal spasm, colonic carcinoma, Zollinger Ellison syndrome, acute and chronic Diarrhea, IBD, small and large bowel obstruction, ischemic gut, malabsorption, Diverticulosis disease, diverticulitis, acute cholecystitis, PSC ...It was fruitful amazing session for me ..Thank you Dr Ash

FEEDBACK # 6

Suhail Ahmed

An amazing lecture by Dr Ash , who covered almost all of the important topics in Gastro in an hours time.
This session is not only very helpful for the MRCP examination but also for our practice.
Although it's his family time but he managed to do this amazing session, that's amazing.

Thank you Dr. Ash.

FEEDBACK # 7

Beenish Manzoor

Today we had power back Session on High Yield Gastroenterology in which all topics including gastrointestinal pathologies and prompt treatment was discussed in an elaborated way ...Most importantly sir had family trip still he prefers to conduct seasion for his traineer even when his family is waiting for the flight None other than our mentor Ashfaque Ahmed can do this..Hatts of to You Sir jee. salute you:)

Important points that we discussed today was

*Difference between dysphagia and odynophagia as later one involve liquid more than solids

*Esophageal spasm (corkscrew spasm)

*Esophagitis, (barret esophagus)

*Achalasia,

*Esophageal Diverticulua,

*Hiatal Hernia, and its types

*Esophageal Carcinoma, diagnose by barrium swallow studies

*Gastric Carcinoma,

*Colonic Carcinoma,

*Zollinger Ellison Syndrome, and management

*Acute and Chronic Diarrhea,

*Ulcerative Colitis,

"Crohn's Disease,

*IBD,

*Small Bowel Obstruction,

*Large Bowel Obstruction,

*Gut Ischemia,

*Mesenteric Ischemia,

*Malabsorption,

*Diverticular Disease,

*Diverticulitis,

*Hepatitis, Chronic Liver Disease,

Gastritis,

*Acid Peptic Disease,

*Upper GI Bleed,

*Lower GI Bleed,

*Primary Sclerosing Cholangitis, and

*Lactulose intolerance

It was such a phenomenal session no one can teach in such a magical way the whole gastrointestinal pathologies in just 1.5 hour yes!!!its one and only our supervisor. none can be this much humble who allowed mrcem students to attend bonus lecture of mrcp group free of cost sir you are amazing and true leader. Ap murshid ha sir Sometimes i feel we should keep on listening to you all day long as it keeps morale high ..
Truly proud to be part of London Global Emergency Medicine (LGEM)
Thankyou Dr Ash
Thankyou LGEM team.👍

FEEDBACK # 8

Aymen Bashir

Today's session was a bonus lecture for us taken by Dr Ash despite his commitments. We learnt about oesophageal dysphagia
*Infectious esophagitis caused by Candida Albicans, HSV ,CMV and their treatment respectively.
* Diffuse oesophageal spam (nut cracker esphagus) it's presentation, diagnosis (cork - screw esophagus) and treatment (nitrates and ccb)
* Achalasia (characterized by impaired relaxation of lower esophageal sphincter)
Monometry shows- increase LES pressure, incomplete LES relaxation upon swallowing.
* Oesophageal diverticula
*Oesophageal cancer
*Hiatal hernia
*Type A gastritis associated with pernicious anemia due to lack of instrinsic factor
*Gastric cancer
*Disorders of small bowel
*Malabsorption
*Carcinoid syndrome
Presentation (cutaneous flushing, diarrhea, wheezing ,abdominal cramps)
Diagnosis - high urine levels of serotonin metabolite 5HIAA.
* Irritable bowel syndrome
* Mesenteric ischemia
* Diverticular disease
* Large bowel obstruction
* Colon and rectal cancer (Dukes classification)
* Biliary disease

In short we covered the whole high yield Gastroenterology in a short span of time. The efforts Dr **Ashfaque Ahmed** is making for his students are extraordinary. Proud to be a part of LGEM.

FEEDBACK # 9

Mohid Kanan

It was a rapid review and high yield session on Gastrointestinal disorders. Dr. Ash summarized the most important topics and exam focused points in a limited time period and was ready to attend another session and ready to go to the airport after finishing the sessions on time.

Topic Included: exam focused Findings, Dx Tx

Oesophageal diseases:

dysphagia, odynophagia

infx esophagitis- agents involved

Diffuse esophageal spasm

Achalasia

Esophageal adenocarcinoma

lactose intolerence

Carcinoid syndrome

Malabsorption

Hiatal hernia

Gastric Carcinoma

Colonic Carcinoma

Zollinger Ellison Syndrome

Acute and Chronic Diarrhea

Ulcerative Colitis

Crohn's Disease

IBD

Small Bowel Obstruction

Large Bowel Obstruction

Gut Ischemia

Mesenteric Ischemia

Malabsorption

Diverticular Disease

Diverticulitis

Gastritis

Acid Peptic Disease

Upper GI Bleed

Lower GI Bleed

Primary Sclerosing Cholangitis

Sir, I have no words to describe your dedication.

Thank you Dr. Ash.
Looking forward for the next session.
I hope, we will meet in Maldives.

FEEDBACK # 10

Mina Khan

Dr Ashfaque's teachings have always been top-notch and brain storming. He covers every aspect of context and never misses important points related to curriculum. Being the Director of LGEM he is very profound of his dedication towards us.

We were taught about:

Esophageal disorders/dynophagia/odynophagia/most common with liquids/obstructive schatzi rings/strictures/webs[plummer vinson]/ motility: achalasia birds beak/manometery/Nitrates/therapeutic endoscopy/hellers myotomy/nutcracker/scleroderma/ HSV/CMV/candida causes/Esophageal diverticula /cricopharygeus muscle/zenkers/foul smelling halithosis/regurgitation/SCC /Baretts columnar chnging to Squamous dysplasia/Hiatal hernia sliding most comon/paraesophageal

Gastritis Type A (pernicious anemia intrinsic factor B12 deficinecy)Type B (Nsaids/H pylori)

Zollinger ellison/gastrinomas/Intractable ulcers/ MEN1 /gastric levels fasting/octreotide scan/

Differentiating osmotic vs secretory diarhoeas /VIPOMAS/carcinoid/malabsorption.

Resolution of diarhoea on fasting osmotic diarhoea.

Campylobacter bloody diarheas complication(GBS/ascending paralysis)

Clostridium difficile/ Ecoli/salmonella/shigella

Lactose intolerance/avoidance of loading test/

Diverticular diseases/diverticulitis/ diverticula outpouching terminal ileum/mucosa/submucosa only/

Mesenteric ichemia(SMA mc) hypercoagulable states./ Low CO/severe pain after eating mainly.

Crohns disease/ulcerative colitis

HNPCC/Gardeners disease / sessile/pedunculated poplys /sessiles are despicable.

Dukes classification/NHS bowel screening programme 2 yrs men women age 60 above

Biliary diseases Raised ALP female fat forty fertile, ascending cholangitis infection sec to obstruction/PSC idiopathic fibrotic/ MRCP/ERCP/ Charqot's triad RUQ important pearl

Thank You London Global Emergency Medicine and Dr Ashfaque (Director Pema-Uk) 🌹

FEEDBACK # 11

DrShafik Zaid

Today Dr Ashfaq surathya the mentor of Lgem took an extensive class regarding mrcp 1 crash topics of Gastrointestinal system
This was really superb and important one. All the topics not only related to prep for MRCP1 but also much fruitful for the clinical study in our daily hospital life as an emergency or general medical physician.
How to differentiate btwen dysphagia odonophagia what is esophagus related dysphagia as well esophageal spasm stricture obstruction achalasia esphoge infection and its clinical presentation and its clinical correlation.he also explained barret esphoges how its change from gerd to barret and adenocarcinoma. Types of hiates hernia. Disorder of thevstomach and dudenum. Acute vs chronic gastritis. Type A gastritis and its cirrelation with prenecious anemia and carcinoma. Gastric ca and its risk factors. Zollinger ellison how to diagnose whats are its mangmnt. Mal absorption its causes like from gi to pancreas to billiary involvement. Acute vs chronic dirrhea. Gi infection like echoli sheggela salmonella and its clinical presentation and treatment. Clostriudium diffficile its presentation treatment from normal to life threatening. Primry billarry cirrhodis its diagnostic plan and treatment.. Sclerosing cholangitis. Lactose intolerance small bowel large bowl obstruction. Charcot triade. Mesenteric ischemia. Diverticulitis its patho physiology. Colorectal cancer inflamattory bowel disease. Irritible bowel syndrome. Each and every topic has its own weightage not for exame but for general understanding of all GI related topics. All slides were prepared for all the naive candidates who are going to garb the Mrcp 1 diet in a first go inshallah. Thanks u Dr ash for ur such commitments and dedication to all Gem candidates.
Regard Dr shafiq

FEEDBACK # 12

Imran Khan

Sir thanks for such a wonderful session.

FEEDBACK # 13

Javeria Wali

A power packed 1.5 hour session was conducted today on high yield Gastroenterology by Dr. Ash. A huge amount of topics were covered in an extremely short time including Oesophageal diseases (motility disorders, dysphagia, odynophagia, achalasia, Oesophageal carcinoma, diffuse Oesophageal spasm, diverticula, hiatal hernia), diseases of stomach (peptic ulcer disease, gastritis, gastric carcinoma), disorders of small and large bowel

(inflammatory bowel disease, IBD, small and large bowel obstruction, gut ischemia, mesenteric ischemia, malabsorption, diverticular disorders, colonic carcinoma), biliary disorders (cholelithiasis, primary sclerosing cholangitis). It's hard to believe that every topic was discussed rapidly but covering all the most high yield points including the causes, presentation, diagnosis and treatment. It is an Absolute treat to attend these lectures. Thank you LGEM and Dr. Ash

FEEDBACK # 14

Faiza Baig

Today was a extensive and rapid high yield session. It was focused on gastrointestinal pathologies related to daily life emergencies.

✨differentiate between dysphagia and odonophagia

Dysphagua is difficulty ın swallowing

Odonophagia is pain ın swallowing

Exam point of view main question of typical clinical feature of odonophagia is it involves liquid more than solids.

✨Diffuse Esophageal spasm that is CORKSCREW esophagus characterized by severe chest pain, throat pain,heart burn, trouble swallowing.

He also explained barret esophagus how its change from gerd to barret and adenocarcinoma.

✨Esophageal adenocarcinoma is diagnosed by BARRIUM SWALLOW STUDY and xrays. Types of hiates hernia. Disorder of the stomach and dudenum. Acute vs chronic gastritis. Type A gastritis and its cirrelation with prenecious anemia and carcinoma. Gastric ca and its risk factors. Zollinger ellison how to diagnose what is the management.

✨LACTOSE Intolerance and its diagnosis by nitrogen breath test

✨Carcinoid syndrome symptoms flushing, wheezing, diarrhea.

✨Malabsorption its causes like from gi to pancreas to billiary involvement. Acute vs chronic dirrhea. Gi infection like E coli shigella salmonella and its clinical presentation and treatment. Clostriudium diffficile its presentation treatment from normal to life threatening. Primry billarry cirrhodis its diagnostic plan and treatment.. Sclerosing cholangitis.

Mesenteric ischemia. Diverticulitis its patho physiology. Colorectal cancer inflamattory bowel disease. Irritible bowel syndrome.

All topics covered , easy to read and grasp.

Thank you Dr Ash for your dedication and a wonderful lecture 🤩

FEEDBACK # 15

Ghulam Saddique Saddique

Session conducted by Dr. Ashfaque has its own flavour and its own kind not comparable to others in terms of delivering the session to GEM participants

Today's session is a power pack of Gastroenterology MRCP exam covering all the relevant aspects of topics which are very important in exams and helpful in clinical practice .
Dr. Ashfaque is himself a precious GEM anyone who is near to him is definitely going to become GEM.

FEEDBACK # 16

Muzna Ahmed

This was one of the amazing sessions by one and only Dr. Ashfaque Ahmed without any doubts or perplexity.
Despite a busy and compact daily schedule and flight to put up with family he dedicated his precious time for his trainees and in span of hour he gave a comprehensive insight of Gastroenterology.
Starting from types of dysphagia, esophagitis, diffuse spasm of esophagus, diveriticulas, esophageal CA, Barret's esophagus, carcinoid syndrome, IBS, acute and chronic diarrhea, small and large bowel obstruction, APD, UGIB, primary sclerosing cholangitis, malabsorption.
With bullet points of investigations
Mainstay management protocol, risk factors and presenting features.
Dr. Ash always emphasizes on right practice in favour of patient and health care resource burden.
He is indeed a role model figure for all his trainees
Thank you LGEM and Dr Ash for these lectures and excellent training infrastructure.

FEEDBACK # 17

Sana Shaikh

Dr **Ashfaque Ahmed** sir can you plzz tell me how much chances are there that a patient's vision will be fine after LEFT PCA ISCHEMIC STROKE... Iam so worried about my Dady

FEEDBACK # 18

Gdmas Malik

Today, one of the memorable session was inculcated by our honorable mentor in j how to make it up by manly efforts . But all these were attained by insightful and contemplative compilation, the integrated girth of deliberation, the preordained ferocious intellectuality, astute descernment, and by his acuteness of reasonability .His fervour of undistracted contributions subdued our disposition and ignited a new spirits to honour your ego and divulged indispensable secrets of success.
Our great mentor segregated the jumbled chaos of GI and rectified for assimilation. By his predestined alluring traits purged all the enigma of the GI topic and asserted the legitimacy of this topic . He instinctively interlaced the

diverse phenomenon and interposed into a edible kernel for extrication of redundancy. Due to this constancy and fidelity to the cause and his disciples ,his name will be skied soon and will sequenced his status in a galaxy stars.
GI topic was started from oral cavity and was traced upto the anal canal .all the conditions from pharyngeal dysphagia upto rectal cancer were elucidated in a stepwise manner along with the principal points that were significant for exam point of view . He endorsed and depicted all the scenarios of exam to be memorised for osce. All the crucial and consequentials were discussed . The following diseases were mentioned.
1) pharyngeal dysphagia especially for liquid (mysthenia gravis, stroke and muscular paralysis)
2) Esophageal dysphagia (cardiac dysphagia ca esophagus)
3) Achalasia.
4) Barret esophagus
5) GERD
6) GASTRIC CA
7) SIGNET RING CA
😎 H,PYLORI AND ITS HAZARDS
9) DIARRHOEA
10) ISCHEMIC COLITIS
11) PEPTIC ULCER
12) PANCREATITIS
13)INTESTINAL Obstruction.
14) Crohn disease
15) ulcerative colitis
16) CA colon
17) Rectal ca
18) cholecystitis
19) Cholangitis
20) Diverticulitis
All important points were discussed eg, zenker diverticulum, the important point is crycopharyngus, contraction . Plummer vinson syndrome, oral ulcer in IBD, cardiac enlargement or bronchial growth may compress the esophagus lead to dysphagia , Achalasia , bird beak iron deficiency anemia which is indicative of ca colon untill proved otherwise, sign, H pylori , complications, CA and dyspepsia, investigation , ure breath test/ stool antigen test , faecal occult blood test, barium swallow, colonoscopy and blood cp,.
In short all the explanation and description cannot be reciprocated and allocated in this confined space .

Our great mentor professor Sir Ashfaque Ahmad sb impressive and calculated and exalted delivery if lecture could not be procured by any force and capacity to explore well .I learnt composite ,well polished , stainless and heart jolting things that imbibed a refreshing glamour over my mind. I am very very thankful and grateful and pray from the core of my heart for my mentor professor Sir Ashfaque Ahmad sb. May Allah grant him untiring /perpetual exaltation and reverence.

FEEDBACK # 19

Dr Aiman Nazir

It was a powerpack session of gastroenterology by Dr Sorathia, designed and oriented in such a way that the students/participants get the maximum benefit and learning . I would like to appreciate your efforts and your honesty towards your students to let them have maximum benefit in a short time. The style of teaching and making it simple to grasp more information , Discussions of detailed topics in concise manner that might take extended time and making sure every relevant piece of information stick to our minds is the art that only good teachers have and I am blessed that I have been one of the students/trainees of this program which is indeed very beneficial for me .
Today's session was yet again a wonderful session by Dr Sorathia in which he made sure to cover the maximum while making it easy for us for exam preparation and our clinical learning. Few topics to mention that were covered today were Esophageal disorders, Infectious esophagitis, DES, achalasia, esophageal diverticula, cancer, Barrett's esophagus, hiatal hernia. Disorders of stomach and duodenum include Gastritis, Hiatal hernia , gastric cancer, PUD, ZES. Small bowel disease topics include Diarrhea, acute and chronic , their etiologies, causative organisms and management, Malabsorption, Lactose intolerance, carcinoid syndrome ,IBS ,mesenteric ischaemia, diverticular disease, diverticulitis ,large bowel obstruction, colon and rectal cancer(Duke classification), GI bleeding , cholecystitis ,PBC etc.
Such a huge number of topics were discussed and yet Dr Sorathia made sure that nothing important was missed. Eagerly waiting for another amazing high yield gastroenterology session by Dr ASH .
Thank you so much for this wonderful session .Would be waiting for such wonderful knowledge filled sessions in future.
Dr Aiman Nazir
EMFP LGEM

FEEDBACK # 20

Dr Ruma Mustafa

Unremarkable session....kudos to your dedication!!!! you are a real goal achiever, Mashallah. u have fulfilled ur task. All the topics u covered all very nicely

I learnt many things today and cleared my concept, and updated myself

1-OESOPHAGEAL DISEASES

Dysphagia/odynophagia, oropharyngeal dysphagia /oesphageal dysphagia

Infectious esophagitis

In GERD, no odynophagia usually dysphagia

ACHALASIA LES impaired relaxation dysphagia to liquid first

Esophagus Diverticula

Cricipharyngeal muscl3 is zenkers diverticulitis

Oesphageal cancer SCC is the most common

Dysphagia to solids first

Diffuse oesophageal spasm

GERD/GORD

Sliding hiatal hernia

2-DISORDER OF STOMACH AND DUODENUM

Acute Gastritis NSAID, Alcohol, Stress, H.Pylori

Chronic Gastritis TYPE A

10% fundas & pernicious anaemia dur to intrinsic factor, thyroiditis,

Increased gastritis carcinoma greater curvature

TYPE B 90% Antrum of stomach NSAID, Alcohol, H.pylori

3-DISORDER OF SMALL INTESTINE

Diarrhoea

Chronic diarrhoea

Malabsorption

Lactose intolerance

Carcinoid syndrome

IBS

Mesenteric ischemia

Diverticular disorder

4-DISORDER OF LARGE INTESTINE

Large bowl obstruction

Colon and rectal carcinoma

5-GASTROINTESTINAL BLEEDING

6-BILIARY DISEASES

7-LIVER DISEASES

8-PANCREATIC DISEASES and many more...

Phenomenal session done by dr.Ash all the pathologies of GIT I just 1.5 hrs is just unbelievable... Sir u can do anything, Mashallah unmatchable 💕
JazakAllah khair
for ur continues support

FEEDBACK # 21

Dr Emmanuel Charles

A great learning experience no stone left unturned conceptually and clinically.
A high yield lecture indeed
From the basic definition Of vitals topics included in Gastroenterology causes inclusive of the pathophysiology.
The whole lecture covered the following points :
1)Esophageal Diseases
2) Diseases of Stomach and Duodenum.
3)Disorder of Small intestine.
4)Disorder of Large Intestine.
5)Gastrointestinal bleeding.
6)Biliary Disease.
7)Liver Disease.
8)Pancreatic disease.
In the end Dr Ashfaque invaluable guidance and medical tips were excellent as always
Thankyou Dr. Ashfaque Ahmed for facilitating the whole session.
Thankyou LGEM MRCP PROGRAMME TEAM.

FEEDBACK # 22

Dr Mariam Nawaz

Dr Ash how do you do this? How do you know everything so well? Apart from knowing things so well, Dr Ash also has a gift of teaching, you cannot get bored in his class and whatever he teaches will stay with you. Dr Ash taught us high yield gastroenterology today and covered almost everything in just an hour! Wow!
Some of the topics we discussed are:
Esophagitis,
Achalasia,
Diffuse Esophageal Spasm,
Esophageal Diverticulua,
Hiatal Hernia,
Esophageal Carcinoma,
Gastric Carcinoma,
Colonic Carcinoma,

Zollinger Ellison Syndrome,
Acute and Chronic Diarrhea,
Ulcerative Colitis,
Crohn's Disease,
IBD,
Small Bowel Obstruction,
Large Bowel Obstruction,
Gut Ischemia,
Mesenteric Ischemia,
Malabsorption,
Diverticular Disease,
Diverticulitis,
Hepatitis, Chronic Liver Disease,
Gastritis,
Acid Peptic Disease,
Upper GI Bleed,
Lower GI Bleed,
Primary Sclerosing Cholangitis, and lot lot more
Thankyou so much Dr Ash for yet another amazing session.
A proud GEM trainee

FEEDBACK # 23

Dr Ahmad Tanveer

An amazing session of own kind by my Super Heroic learned dedicated TEACHER whose focused teaching can prepare any doctor not only for exam but also become a safe doctor .
I attended the lecture in my mid day break of opd and it gave me immense pleasure to run along with my mentor's effort on us to have an updated knowledge understanding of GI pathologies in such a short time. As Dr Ash said all the slides were personally written by Sir himself , its an honour he shared his knowledge time with us for our better clinical updated RCP oriented learning.
Topic Included: exam focused prep of each and every topic from mouth to colon ...
whole GIT covered
Dysphagia/ odynophagia
Oropharyngeal liquids more then solid
& Oesophageal dysphagia solids more then liquids causes explained.
Infectious esophagitis
Candidia as AIDS defining illness with oral thrush and fluconazole as Treatment.

Diffuse Oesophageal spasm
Nutcracker oesopjagus
Presentation with chest pain dysphagia, odynophagia. Often precipated by ingestion of hot & cold liquids. Releived by Nitroglycerin
Dx Barium Swallow cork screw shaped oesophagus
Treatment
Nitrates & CCBs for sumptomatic relief . Surgery for severe incapacitating symptoms.
Achalasia
Motor disorder of liwer Oesophageal sphincter imapred relaxation abs loss of peristalsis jn distal 2/3rd of oesophagus.
Presentation progressive dysphagia regurgitation of undigested food chest pain weight loss and nocturnal cough.
Dx Barium swallow bird beak tapering if distal oesophagus.
Monometry increased LES prssure.
Treatment. Nitrates CCB or endoscopic inj of botulinm toxin. Pneumatic baloon dilatation or surgical myotomy are definite Treatment options.
Oesophageal diverticulum
2nd most xommon motility disorder.
Oesophageal cancers
Sq cell CA most common worldwide. While Adenocarcinoma is most prevalent in western countries associated with barrett's .alcohol and smoking major risk factors.
Hiatal Hernia
Herination of stomach portion jnto chest through diaphragnatic opening . 2 types Sliding 95% and paraesophageal
Disorders of stomach and duodenum
Gastritis acute vs chronic
Type A associated with pernicious anemia.
Gastric tumours generally Adenocarcinoma 2 types intestinal and diffuse.
Treatment surgical ressection .
Peptic ulcer disease
Zollinger ellison syndrome
Disorders of small bowel
Diarrhoea. Chronic diarrhoea.
Malabsorption
Lactose intolerance
Carcinoid syndrome
IBS
Small bowel obstruction

Mesenteric ischemia
Diverticular disease.
Large bowel obstruction.
Colon and rectal cancers.
Dukes classification defined.
Ischemic colitis
GI Bleeding
Biliary disease.
Acute cholecystitis
Ascending cholangitis
Primary sclerosing cholangitis.
Hepatitis
A huge list of topics blasted through in such a short time comprehensively Thank you Dr. Ash for such efforts and dedication for us we are honoured for having such great Teacher. Love You Sir your dedication is our motivation.

FEEDBACK # 24

Dr Noman Ahsan

Dr. Ash lectures are blessings for us. He is so academically strong and his grip on every topic is mind blowing.. He keep his lecture to the point and share his clinical experience with it and that makes his lectures more powerfully, interesting and absorbing...Today's session was one of them and he explained different gastroenterology related disorders and explained them very well as per learning and examination point of view too...
Topics discussed in today's lecture...
1) Oesophageal Diseases (odynophagia / Obstructive schatzi rings /strictures. Achalasia, Oesophageal Diverticula..
2) Disorders of the Stomach and Duodenum (Gastritis and its types)
3) Disorders of Small Intestine
4) Disorders of Large Intestine
5) GI bleed
6) Billiary Disease
Thanks a lot Dr. Ash for yet another informative learning session...

FEEDBACK # 25

Dr Leela Ram

Literally no words to describe Dr. Ash but I must say that Dr. Ash is exceptional, invariably committed & the most sincere man in the world who has the values of what one has achieved through sheer hardwork & sacrifices. He who is very much curious to teach & learn everywhere.
Today's session on High yield Gastroenterology remained fantastic which covered whole chapter within 1.5 hour which includes as following:

Oesophageal disorders:
Difficult swallowing (dysphagia) or pain with swallowing (odynophagia) due to abnormalities of the oropharynx or oesophagus.
Oesophageal dysphagia: difficulty passing material from the oropharynx to oesophagus usually involves liquids more than solids.
Causes: Neurologic or muscular (stroke, myasthenia gravis, Parkinson's disease. It's diagnosed by Cine-esophagram while esophageal dysphagia by Barium swallow followed by endoscopy, manometery & PH monitoring.
Odynophagia is diagnosed by upper endoscopy. Oesophageal webs is associated with iron deficiency anemia & glossitis (Plumber vinson syndrome).
Infectious esophagitis is caused by Candida albicans diagnosed by upper endoscopy & treated by Fluconazole,
HSV>> IV Acyclovir
CMV>> IV Ganciclovir
Diffuse oesophageal spasm is motility disorder causes abnormal peristalsis which is characterized by chest pain, dysphagia, odynophagia often precipitated by ingestion of hot and cold liquid and relieved by Nitroglycerine.
It is diagnosed by barium swallow which shows cork-screw shaped esophagus & treated with nitrates & calcium channel blockers & surgery oesophageal myotomy for severe condition.
Achalasia is a motor disorder of oesophagus characterized by impaired relaxation of LES & loss of peristalsis in the distal two-third of oesophagus.
Oesophageal diverticula: 2nd most oesophageal motility disorder.
Oesophageal cancer: SCC is the most common type of oesophageal cancer worldwide whilst Adenocarcinoma is most prevalent in the Western world, alcohol and smoking being the major risk factors.
Hiatal hernia: 95% Solid hiatal hernia.
Zollinger Ellison syndrome is gastrin producing tumour.
Disorders of the small intestine:
Diarrhea
Chronic diarrhea
Malabsorption
Lactose intolerance
Carcinoid syndrome
IBS
Mesenteric ischemia
Diverticular disorder
Large bowel obstruction
Colon and rectal carcinoma.

Session lasted smoothly and rapidly with important examination points. I'll try to digest it as a whole.
Thank you so much Dr. Ash for LGEM platform and also whole team of LGEM.

FEEDBACK # 26

Dr Nasir Hayat

This session was Amazing and well presented. I learned a lot and enjoyed. extensive class regarding mrcp 1 crash topics of Gastrointestinal system
This was really superb and important one. All the topics not only related to prep for MRCP1 but also much fruitful for the clinical study in our daily hospital life as an emergency or general medical physician.
How to differentiate between dysphagia odonophagia what is esophagus related dysphagia as well esophageal spasm stricture obstruction achalasia esphoge infection and its clinical presentation and its clinical correlation. he also explained barret esphoges how its change from gerd to barret and adenocarcinoma. Types of hiates hernia. Disorder of thevstomach and dudenum. Acute vs chronic gastritis. Type A gastritis and its cirrelation with prenecious anemia and carcinoma. Gastric ca and its risk factors. Zollinger ellison how to diagnose whats are its management. Mal absorption its causes like from gi to pancreas to billiary involvement. Acute vs chronic dirrhea. Gi infection like echoli sheggela salmonella and its clinical presentation and treatment. Clostriudium diffficile its presentation treatment from normal to life threatening. Primary billarry cirrhodis its diagnostic plan and treatment.. Sclerosing cholangitis. Lactose intolerance small bowel large bowl obstruction. Charcot triade. Mesenteric ischemia. Diverticulitis its patho physiology. Colorectal cancer inflamattory bowel disease. Irritible bowel syndrome. Each and every topic has its own weightage not for exam but for general understanding of all GI related topics. All slude were prepared for all the naive candidates who are going to garb the Mrcp 1 diet in a first go inshallah. Highly recommended for physicians to join it. Proud to be Lgem candidate

11th FEBRUARY 2023

EVENT NAME:

High Yield Major Trauma Session 1 By Dr Syed Ali Ahmed FRCEM

DOCTORS FEEDBACK

FEEDBACK # 1

Syed Suhail Ahmad

Today's session was all about major trauma topics
- Epidural & Subdural hematoma
- GCS tips for memorization
- C-Spine fracture dislocation
- Life-threatening chests injuries like massive hemothorax, tension pneumothorax, aortic rupture, and cardiac tamponade
- Blune and Penetrating trauma injuriesies
- Spinal cord injuries and their importance
- When to refer patients

Excellent session with lots of new learning points and take-home messages. Thank you Dr. Ali, LGEM, PEMA and LCC 👍👍👍

FEEDBACK # 2

Amir Ashraf

It was such an energetic thru and thru lecture , we covered so many Important trauma topics that are frequently asked in exam , it was an amazing power pack 2 hours session . Dr Ali is so passionate and energetic for teaching that he can honestly go on and on for hours if not stopped , he is so humble and always open to discussion , what an incredible person he is . Doesn't matter how tired he is , he delivers it so brilliantly that everything he teaches he makes a point out of it .

Topics we learned :

1)Sub dural haematoma
2) Extradural
3) Glasgow coma scale and it interpitation.
4)C.Spine injury.
5) Emergency thoracotomy and indications.
6)Penetrative thoracic injuries.
7) Blunt thoracic injuries.
8)Chest injuries including
9) Massive haemothorax.
10) Tension Pneumothorax.
11) Needle thoracocentecis and Finger thoracotomy
12) Life threatening chest injuries : (ATOM FC)

Air way obstruction
Tension Pneumothorax.
Open pneumothorax.
Massive haemothorax
Filial chest.

Cardiac temponade
13) Traumatic Aortic rupture.
14) Jefferson fracture.
15) Blood loss in Trauma and its classification.
16) —Spinal cord injuries.
—Central cord injury.
**Brown square syndrome.
and alot more
Thankyou Dr Ali for such an Amazing lecture , really learned and enjoyed .

FEEDBACK # 3

Saad Aslam

Covered a number of difficult to assess scenarios in EM. A very comprehensive session by Dr Ali in covering major trauma scenarios jotting down back to the basics and linking it up to clinical management. The following topics were covered during the session:
Hematomas and their types
GCS
Blood loss classfication
Chest trauma blunt vs penetrating
Thoracotomies
Airway obstructions
Life threatening chest injuries (Aortic dissection - Decelration injuries)
Jefferson's Fracture
Cervical Spine injuries/Spinal cord injuries

FEEDBACK # 4

Yasir Dilawar

In today's session we learnt about subdural and Extradural Hematoma it's CT findings and how to manage. another important topic Glasgow coma scale was discussed and very easy way was taught to us by Dr ali. then he discussed C spine injuries, chest injuries management, emergency thoracotomy it's indications and how it is done, air way obstruction, tension pneumothorax, needle thoracocentesis, cardiac tamponade, traumatic aortic rupture, Jefferson fracture, blood loss in trauma, spinal cord injuries, central cord injury and so much more Dr Ali you have taught us so much in these sessions thank you for all your efforts.

FEEDBACK # 5

Muzna Ahmed

In today's powerpack session Dr Ali explained the most critical challenging trauma scenarios in the best possible way that it seems like piece of cake to understand now.

He comprehensively covered topics :-
Extradural, subdural hemorrhage on CT scan and what would be the GCS
Life threatening situations:-
Tension penumothorax
Flail chest
Cardiac tamponade
Open pneumo
Massive hemothorax
Airway obstruction
Emergency thoracotomy indications contraindications
Needle thoracotomy indication and a new phenomenon finger thoracotomy (very surprising)
Some spinal cord injuries like central cord syndrome, brown sequard
Fractures of C1-C2 spines how to look on xray how to identify which structure is broken.
C6-C7 spine #
Classification of hemorrhages
All topics are well taught. For sure it will boost off preparation
Thank you Dr Ali Dr Ash and LGEM for this amazing lecture.

FEEDBACK # 6

Abrar N. Syed

Yet another amazing Session by Dr Ali.....He made sure that every concept of major trauma be grasped by each n every single candidate by explaining in d simple of words.
A lot of insight of how to handle n what to look for in major traumas n practical life threatening emergencies one face in ED were the focus of Lecture.
GCS, C Spine Injuries, Chest Trauma, Pneumothorax of diff types, Spinal Injuries and all other major aspects were Covered.
Extraordinary Session by an Extraordinary Teacher💯

FEEDBACK # 7

Rajab Abbas

Today's session on Trauma by Dr Ali was really a package of new learnings about neuro and cadiothoracic trauma, radiological findings regarding and thier criteria as well as management.
It was an interactive session and MashAllah every LGEM CANDIDATE is so enthusiastic in learning and is getting equipped with standard medicine practices and knowledge day by day.
Gist of topics which we learned today is:
• CT in head trauma
° Subdural / Extradural hematoma

° Easy way to assess GCS and it's importance in management
• C.spine # and assessment of sensory levels
• Chest trauma
• Indications for emergency Thorocotomy in blunt/ penetrating trauma
• Pneumothorax / Tension Pneumothorax / Haemothorax
• Finger thorocostomy
• Classification of hemmorhgic shock on the basis of blood loss
Thankyou Dr Ali and Dr Ash for this exam orientated session. Looking forward to have more sessions with Dr Ali
A proud LGEM candidate
Dr Rajab Abbas

FEEDBACK # 8

Imtiaz Ali Shah

Yet another marathon session by dr Ali regarding Major Trauma was carried out today.The session covered almost all the important Major Trauma injuries occurring in different regions.The session includes the following imp injuries .
Sub dural haematoma vs Extradural
Glasgow coma scale and it interpitation.
C.Spine injury.
Emergency thoracotomy and indications.
Penetrative thoracic injuries.
Blunt thoracic injuries.
Chest injuries including
Massive haemothorax.
Tension Pneumothorax.
Needle thoracocentecis.
Life threatening chest injuries including
Air way obstruction
Tension Pneumothorax.
Massive haemothorax.
Filial chest.
Cardiac temponade
Traumatic Aortic rupture.
Jefferson fracture.
Blood loss in Trauma and its classification.
Spinal cord injuries.
Central cord injury.
..Brown square syndrome.
It was an excellent session covering almost important injuries which we face daily in our routine practice. Dr Ali carried it out in a professional way as he

always does.The way he explains the things is amazing.He made the things easy to understand. The best thing about him is his friendly attitude which makes these sessions more interesting.
At the end I would like to thanks dr Ali for this wonderful presentation and also dr Ash for providing us this wonderful platform of learning in the form of London GEM

FEEDBACK # 9

Dr Mariam Nawaz

Wow! is the expression I always have after any teaching session by Dr Ali, he really has a way of captivating his audience while teaching. We covered a very important topic of Major trauma today, and the session was breathtakingly good.
Topics we covered are as follows
. Subdural hematoma
. Extradural hematoma
. Cervical spine injury
. Emergency thoracotomy
. Massive haemothorax
. Tension pneumothorax
. Life threatening chest injuries
. Aortic rupture
. Blood loss in trauma
. Central cord syndrome
. Brown sequard syndrome
Look forward to another amazing session by Dr Ali. Thankyou so much Dr Ali and Dr Ash

FEEDBACK # 10

Qaisar Shah

Dr Ali discussed high yield MCQs on the following and clear our concept very well:
• Subdural Haematoma: a type of brain injury caused by bleeding between the dura mater and the brain, often due to head trauma.
• Extradural Haematoma: a type of brain injury caused by bleeding outside the dura mater, typically due to a skull fracture.
• Glasgow Coma Scale: a scoring system used to assess the level of consciousness in patients with a suspected brain injury. Interpretation: A score of 3-8 indicates severe brain injury, 9-12 indicates moderate brain injury, and 13-15 indicates mild brain injury.
• C-Spine Injury: injury to the cervical spine, typically caused by trauma to the neck.

• Emergency Thoracotomy: a surgical procedure performed in emergency situations to access the chest cavity and treat life-threatening conditions such as cardiac tamponade or massive haemothorax. Indications: Cardiac arrest in the presence of traumatic injury, massive haemothorax, tension pneumothorax, or suspected aortic rupture.
• Penetrative Thoracic Injuries: injuries caused by a foreign object penetrating the chest, such as a stab or gunshot wound.
• Blunt Thoracic Injuries: injuries caused by a blunt force trauma to the chest, such as in a motor vehicle collision.
• Chest Injuries:
• Massive Haemothorax: a condition in which a large amount of blood accumulates in the pleural cavity, causing compression of the lungs.
• Tension Pneumothorax: a condition in which air accumulates in the pleural cavity, causing the lung to collapse and increasing pressure on the heart and great vessels.
• Needle Thoracocentesis: a procedure to relieve pressure in the pleural cavity caused by a pneumothorax or haemothorax.
• Life-Threatening Chest Injuries:
• Airway Obstruction: a blockage of the airway that prevents air from entering the lungs.
• Tension Pneumothorax: see above.
• Massive Haemothorax: see above.
• Filial Chest: a condition in which the chest wall is partially or completely collapsing.
• Cardiac Tamponade: a condition in which fluid accumulates in the pericardial cavity, compressing the heart and reducing its ability to pump blood.
• Traumatic Aortic Rupture: a tear in the aorta, the largest blood vessel in the body, typically caused by a traumatic event such as a motor vehicle collision.
• Blood Loss in Trauma: classification based on the amount of blood loss, with categories ranging from minor to massive.
• Spinal Cord Injuries:
• Central Cord Injury: a type of spinal cord injury that affects the central portion of the cord, causing paralysis and sensory loss in the upper extremities.
Thanks Dr Ali and Dr Ash for such an amazing session.

FEEDBACK # 11

Mominah Ahmed

As always superb session today the topics we covered today: cervical spine , SENSORY LEVEL above in cervical level, below in thoracic and lumbar, thoracotomy: 10 mins for blunt trauma-15mins for penetrating ,chest injury, deceleration injury high speed, blood loss trauma, spinal cord injury:

hemisection , brown seqeaurd much much more great great points we learnt today....superb @Dr.Ali Er UK Dr.Ash thankyou @Dr.Ash UK London

FEEDBACK # 12

Mukhtiar Pathan

Thank you very much Dr. Ali for such an excellent session.
You comprehensively covered all important points.
All scenarios were taught in a fantastic way,, specially the scenarios of Aortic Rupture and Pneumo/Hemothorax were superb and had many learning pearls.
Amazing facts about indications & contraindications of Thoracostomy were revealed.
Learned many new things about C-Spine injuries, it's presentations diagnosis and management accordingly.
Dr Syed Ali Ahmed the way you taught in a caring and loving way is exceptional
Many Thanks, Sir for such a wonderful teaching session.
May ALLAH PAK bless you

FEEDBACK # 13

Bushra Imran

Today It was another excellent session covering daily routine ER cases, teaching by scenarios with radiological findings ..sub rural haematoma, extradural haematoma, Glassgow coma scale with interpretation, C spine injury, emergency thoracotomy and indication, penetrating and blunt thoracic injuries, massi e haemothorax, needle thoracocentesis ,one finger thoracotomy, life threatening chest injuries, filial chest ,traumatic aortic rupture, Jefferson fracture central cord injury, brown square syndrome...
Thank you Dr Ali you taught in interesting way with memorization tone

FEEDBACK # 14

Azka Farhan Shamim

Aoa respected sir
Today we had a very energetic session with Dr Ali (ST 6 NHS UK) regarding Major trauma and the way Dr Ali elaborated and comprehensively covered each and every region was just amazing.. Dr Ali has put his full effort and energy in clearing our concepts and really it was a wonderful more than 2 hour session and we covered following important learning points:
*CT in head trauma , extradural/ subdural hematoma
* How to assess GCS and it's importance in management
* C spine fractures and assessment of sensory levels
*Penetrative thoracic injuries
* Emergency thoracostomy and it's indications

*Blunt thoracic injuries
* Chest injuries with massive hemothorax
*Tension pnemothorax
*Needle thoracocentesis
*Flail chest and cardiac tamponade
*Life threatening chest injuries with airway obstruction
*Traumatic aortic rupture
* Jafferson fracture
*Blood loss in trauma class 1-4
*Spinal cord injuries , central cord syndrom, brown sequard syndrom
Infact it was a full power pack session,and it is hard to believe that we have covered so much of high yield questions in just 2 hours with clear concepts and ideas..
Thank you so much Dr Ash for arranging these amazing sessions for GEM trainees..
Proud LGEM trainee
Dr Azka ✨

FEEDBACK # 15

Kashif Gulzar

Dr Ali as usual had an excellent lecture covering many aspects of major trauma and made our concepts crystal clear.
The topics discussed were.
1.Subdural vs epidural hematoma recognition on Ct brain images and the vessels involved in both type of bleed.
2.cervical spine injury - concept of difference in sensory levels in cervical spine injury and thoracic /lumber spine injury.
3.indications of emergency thoracotomy in blunt trauma and penetrating trauma.
4.contraindications for emergency thoracotomy
5.Resusitative thoracotomy.anterateral approach .clamshell thoracotomy.
6.massive hemothorax definition.clinical differentiation from tension pneumothorax clinically as well as by EFast scan.
7.Tension pneumothorax-neddle thoracentesis -finger thoracostomy and chest drain.
8.life threatening injuries in primary survey.ATOM-FC
9.Potential life threatening conditions in secondary survey
10.diaphragmatic rupture
11.Traumatic aortic rupture clinical and x-ray findings.
12.C1 burst fracture -Jefferson fracture

13.Blood loss in trauma -Differnt classes of hemorrhage and their clinical features.
14.sinal cord injury.central cord syndrome and it's clinical features
15.Brown sequard syndrome and clinical features.
16.communication skills regarding shifting some patient to other speciality.
Dr Ali is an excellent teacher with excellent teaching skills.I wish that you keep on teaching and we keep learning from you.
Anxiously waiting for the tomorrow's session.
May Allah bless you more and more .
Ameen.

FEEDBACK # 16

Syeda Maheen Ejaz

An excellent intense session with alot of new learnings
Thank you so much boss you are an amazing teacher thank you Dr Ash for providing us amazing tutors. The most interesting part of these sessions they are scenario based followed by questions and thorough explanation by Dr Ali sometimes you amazed us with your way of explanation loving every bit of the session not only this session but the previous 2 sessions of the series are also very amazing❤️
Some of the important topics we have been taught today are👇
Subdural and extradural hematoma
C spine
Sensory levels
GCS (first time got such an amazing explanation of GCS
Emergency thoracotomy
Its indication timings witnessed cardic arrest
Finger thoracotomy
Pneumothorax
Hemothorax
And a lot more

FEEDBACK # 17

Aymen Bashir

Today's session was power pack conducted by Dr Ali. His enthusiasm in dealing ED patients truly reflected in the session and we grasped a lot of new knowledge.
We were taught regarding.
* Extra dural hematoma and it's management
* C- spine fractures (detailed pictorial discussion was made by Dr Ali)
* Thoracotomy

*Indications of performing a emergency thoracotomy in patient with blunt trauma
(1. Unresponsive hypotension. Systolic BP is less than 70 mmHg.
2. Rapid exsanguination from chest drain more than 1500 ml)
*Contraindications to thoracotomy
(1. Multiple blunt trauma
2. Severe head injury
3.blunt thoracic injuries with no witnessed cardiac arrest)
*Massive hemothorax
(1. Decrease breath sounds
2.Decrease chest expansion
3.Dullness to percussion)
*Tension pneumothorax
* Life threatening chest injuries treated in primary and secondary survey
* Traumatic aortic rupture
Overall the session was fruitful and high yield for all doctors passionate to work in ED. We are grateful to Dr **Syed Ali Ahmed** for this amazing session.

FEEDBACK # 18

Javeria Wali

An amazing session conducted today by Dr. Ali Ahmed. A wide range of high yield Major trauma cases were discussed in an Extremely well thought out, comprehensive way including Sub dural and Extradural hematoma, GCS Score, Traumatic Aortic Rupture, pneumothorax, tension pneumothorax, hemothorax, C. Spine injuries, Jefferson / burst fracture, hemorrhage levels etc. The diagnosis and management was taught in such an easy to understand manner that each and every point was memorized instantly. Finger thoracostomy procedure, emergency thoracotomy indications and spinal cord injury were some of the amazing learning points covered today which really made the 2 hours lecture extremely worthwhile. Thank you Dr. Ali and Dr. Ash for these wonderful sessions

FEEDBACK # 19

Hira Nehal

• Subdural Haematoma
• Extradural Haematoma
• Glasgow Coma Scale Interpretation: A score of 3-8 indicates severe brain injury, 9-12 indicates moderate brain injury, and 13-15 indicates mild brain injury.
< 8 NEED INTUBATION
• C-Spine Injury.

• Emergency Thoracotomy. Indications: Cardiac arrest in the presence of traumatic injury, massive haemothorax, tension pneumothorax, or suspected aortic rupture.
• Penetrative Thoracic Injuries
• Blunt Thoracic Injuries
• Chest Injuries
• Massive Haemothorax: a condition in which a large amount of blood accumulates in the pleural cavity, causing compression of the lung
TENSION PNEUMOTHORAX
• Needle Thoracocentesis
• Life-Threatening Chest Injuries:
• Airway Obstruction.
• Tension PneumothoraX
• Massive Haemothorax
• Filial Chest
• Cardiac Tamponade
• Traumatic Aortic Rupture: a tear in the AORTA due to high speed collision tllof vehicle collision.
• Blood Loss in TRAUMA
• Spinal Cord Injuries:
• Central Cord Injury effect upper extremity
Thank you dr Ali and dr ashfaque for amazing lecture.
Dr hira nehal
LGEM TRAINEE

FEEDBACK # 20

Mina Khan

Dr Ali always come up with his best explanations and teach every topic quite comprehensively. Today's session was well updated as per National guidelines, we were taught about:
Subdural hematoma CT concave/cresent sign/ tears to bridging veins/GCS chart
Epidural hematoma CT biconvex sign/tear to MMA
Fracture dislocation C6-C7/ atlas has no spine spot on C-spine CT/sensory level(where she last felt sensations) over thumb C5-C6 [unaffected]/ mx immobilisation/neuro referral.
EM thoracotomy indications/blunt injury= CA <10 1000 ml drain SBP<70 /signs of life /penetrating injury=CA<15/ SBP<70/signs of life /decision immediate/contraindications blunt injury with no CA/multiple blunts/severe head injury/anterolateral thoracotomy left-side approach in all , can be extended towards right clam-shell/bilateral thoracotomy/.
Hemothorax/dull percussion/reduced breath sounds/hypotensive/dropped sats

Tension pneumothorax/ tracheal deviation/hyperreasonance/2nd intercostal midclavicular needle thoracocentesis replaced by 3-4th mid axillary due to quick access
Alte Chest injuries primary ATLS=Airway obs/Tension pneumo/Open pneumo/Massive hemo/Flail chest/cardiac tamponade
Ligamentum arteriosum incomplete tear/widend mediastinum/ right side brochus/ obliteration of aortic knob
Tracheal deviation/CT in stable pts/diagnosis go unnoticed/
Blood loss calculation class 1/2/3/
4 based on few parameters
Spinal cord syndromes
Thank You **London Global Emergency Medicine**/Dr Ashfaque (Director **Pema-Uk**) for providing us an outstanding platform to learn 🌹

FEEDBACK # 21

Anila Zafar

It was an amazing lecture. Dr Ali was marvellous as always. His way of teaching is very different and unique. Enjoyed every second of the whole two hour long lecture.
I learnt :
1)Sub dural haematoma
2) Extradural
3) Glasgow coma scale and it interpitation.
4)C.Spine injury.
5) Emergency thoracotomy and indications.
6)Penetrative thoracic injuries.
7) Blunt thoracic injuries.
8)Chest injuries including
9) Massive haemothorax.
10) Tension Pneumothorax.
11) Needle thoracocentecis and Finger thoracotomy
12) Life threatening chest injuries : (ATOM FC)
Air way obstruction
Tension Pneumothorax.
Open pneumothorax.
Massive haemothorax
Filial chest.
Cardiac temponade
13) Traumatic Aortic rupture.
14) Jefferson fracture.
15) Blood loss in Trauma and its classification.

16) —Spinal cord injuries.
—Central cord injury.
**Brown square syndrome.
and alot more
Thankyou Dr Ali for such an Amazing lecture , really learned and enjoyed .

FEEDBACK # 22

Beenish Manzoor

Today's we had a phenomenal session on major Trauma by Dr Ali .There was really a bundle of new learnings about neuro and cadiothoracic trauma, radiological findings their diagnostic criteria as well as management....
It was an interactive session.Dr Ali always teach in such enthusiastic way that it straight goes to heart. We always keep learning alot from you and is getting better in practiceand improving knowledge .
List of topics which we learned today is:
*Subdural / Extradural hematoma recognition on ct brain images and vessel involved
* Easy way to assess GCS and it's importance in management
* C.spine injury and assessment of sensory level in cervical thoracic and lumber spine
* Chest trauma
• Indications for emergency Thorocotomy in blunt/ penetrating trauma .
*Contraindications for emergency thoracotomy
Resuscitate thoracotomy
*Pneumothorax / Tension Pneumothorax / massive Haemothorax clinical Defination differentiation
*Finger thorocostomy and needle thoracocentesis plus chest drain (clear concept of new guidelines as well)
*Life threatening injuryin primary survey ATOM-Fc
*Potential life threatening condition in secondary survey
*Diaphragmatic rupture
*Aortic rupture xray fininding
*C1 brust fracture
*Blood loss and Classification of hemmorhgic shock on the basis of blood loss
*Spinal cord i jury
*BSS and its presenting feature
And much more
Cantt wait to hear from you tomorrow **Syed Ali Ahmed** ,,😍Allah bless you sir .. thankyou Dr **Ashfaque Ahmed** for arranging such an amazing faculty for us.
Proud GEM candidate

FEEDBACK # 23

Dr Afifa Younis Raja

We had an amazing session on major trauma by our awesome trauma expert dr Ali. We had two great sessions on minor trauma with Dr Ali now we starred in major trauma, and what a session it was full of high-yield topics in a comprehensive way, we were taught how to approach, identify and manage such critical topics. We covered:

- Extradural hematoma
- Subdural hematoma
- How to calculate the GCS score
- Massive hemothorax
- Life-threatening chest injury
- Aorta rupture
- Tension pneumothorax
- Jefferson burst fracture and classification
- Central cord syndrome

Thank you Dr Ash for bringing Dr Ali on board.

Kind Regards,

Dr Afifa

FEEDBACK # 24

Dr Amash Khan

Today's session was Q/A based on traumatic injuries on brain, C-spine, thorax. We learned about some management of those type of injuries, Glasglow coma score, extradural and epidural hematoma, thoracocentesis and thoracotomy, types of c-spine fractures.

Thank you Dr Ali Ahmed for your keen knowledge.

FEEDBACK # 25

Dr Ruma Mustafa

Unremarkable session ...full bundle of knowledge v.informative and intellectual lecture given by

Dr. syed Ali he is so humble , wise and dedicated person Mashallah

I learnt so many things, are as follows:

Left sided Subdural hematoma

Right sided Extradural hematoma

Glasgow coma scale and iilts interpretation

Spine injury fracture dislocation at level of C6,C7

Emergency thora otomy and its indications

Penetrative thoracic injuries

Chest injuries such as blunt..10 min

Penetrative....15 min

Massive heamothorax

Tension pneumothorax
Needle thoracocentasis
Life-threatening chest injuries such as in primary survay
ATOM FC
Airway obstruction
Tension pneumothorax
Open pneumothorax
Massive heamothorax
Flial chest
Cardiac temponade
In secondary survey
Simple pneumothorax
Heamothorax
Pulmonary contusion
Trachiobrachial tree injury
Blunt cardiac injury
Traumatic cardiac injury
Traumatic diaphragmatic injury
Traumatic aortic rupture
Jafferson fracture C1 fracture, axial load,
Overhand lateral displacement of both lateral masses odontoid view
C1 injury
C2 injury
Head injury
Vertebral artery injury
Cranial nerve injury
BLOOD LOSS IN TRAUMA Class 1234
Class 1:Blood loss up to 750 ml HR <100 RR 14-20 slightly anxious
Class 4 : >2000ml HR >140 RR>40
Confuse and lethargy
Spinal cord syndrome...central cord syndrome compromised vessel Anterior Spinal artery
Brown squared syndrome...hemisection of spinal cord..ipsilateral motor loss
All the injuries explained comprehensively precisly approached every topic thanks sOo much Dr.syed Ali for this wonderful session that was much needed for ED physician can't survive without having this knowledge in ED its helps in Exam too weither its primary or intermediate jazakAllah khair for ur great contribution to execute this exam requirements Bless u Sir always
Thanks to Dr. Ash
And the whole LGEM team

FEEDBACK # 26

Dr Nasir Hayat

Todays session of was amazing for 2 hours with dr ali was like a treasure of knowledge and he summed up all Atls course in 2 hours .. for major trauma, specially chest trauma , the most important thing is to differentiate btw cardiac tamponade , massive hemothorax and tension pneumothorax , a small clue can change the management of Pt and can make a big difference to save Pt precious life , dr ali made it a piece of cake on how to differentiate these major trauma differentials in practical way ! What I appreciate most is dr ali being an active member of nhs emergency medical system, is well aware of what are the practical difficulties we can face in terms of management and diagnosis of major trauma , he taught his years of experience in a very short time , that's what differentiate an academic doctor only from a practicing academic physician ! We are looking forward to learn more from you as straining our nerves for hours n hours memorising the protocols and algorithms , you made it fascinating for us the learning process and made boring algorithms a fun for us .. any physician can be a good practicing one but not everybody can transfer his knowledge so conveniently as he did it in todays session ..no words are well enough to show my gratitude to dr ali for his generous share of knowledge ..this wonderful team of teachers is what makes this brainchild of dr ash , London gem , so unique and standout from other programs. I would highly recommend it for ER physicians to join it. Proud to LGEM candidate.

FEEDBACK # 27

Dr Noman Ahsan

Today's Session by Dr.Ali was very important regarding Major Trauma in A&E ..We learnt how to approach and diagnose the case along with basic information to which investigations we hav to do and as per Updated NICE guidelines...He urged us to be updated with NICE guidelines and make the approach basic and logical...In today's detail session we learnt about how to make a diagnosis on CT and plan of management along with anatomy review...

Topics we learned :

1)Sub dural Haematoma
2) Extradural Haematoma
3) Glasgow coma scale and it interpitation.
4)C.Spine injury. (Most common to fracture are C6-7 and C1-2
5) Emergency thoracotomy and indications.
6)Penetrative thoracic injuries.
7) Blunt thoracic injuries.
8)Chest injuries including
9) Massive haemothorax.

10) Tension Pneumothorax.
11) Needle thoracocentecis and Finger thoracotomy
12) Life threatening chest injuries : (ATOM FC)
Air way obstruction
Tension Pneumothorax.
Open pneumothorax.
Massive haemothorax
Filial chest.
Cardiac temponade
13) Traumatic Aortic rupture.
14) Jefferson fracture.
15) Blood loss in Trauma and its classification.
16) —Spinal cord injuries.
—Central cord injury (Always Ant Spinal artery)
**Brown square syndrome.
and a lot more
Thankyou Dr Ali for such an Amazing lecture...Looking forward to learn more in next session as well

11th FEBRUARY 2023

EVENT NAME:

Gastro Rapid Review With Dr Ash Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Beenish Manzoor

Today we had power back Session on High Yield Gastroenterology in which all topics including gastrointestinal pathologies and prompt treatment was discussed in an elaborated way ...Most importantly sir had family trip still he prefers to conduct session for his traineer even when his family is waiting for the flight None other than our mentor Ashfaque Ahmed can do this..Hatts of to You Sir jee. salute you:)
Important points that we discussed today was
*Difference between dysphagia and odynophagia as later one involve liquid more than solids
*Esophageal spasm (corkscrew spasm)
*Esophagitis, (barret esophagus)

*Achalasia,
*Esophageal Diverticulua,
*Hiatal Hernia, and its types
*Esophageal Carcinoma, diagnose by barrium swallow studies
*Gastric Carcinoma,
*Colonic Carcinoma,
*Zollinger Ellison Syndrome, and management
*Acute and Chronic Diarrhea,
*Ulcerative Colitis,
"Crohn's Disease,
*IBD,
*Small Bowel Obstruction,
*Large Bowel Obstruction,
*Gut Ischemia,
*Mesenteric Ischemia,
*Malabsorption,
*Diverticular Disease,
*Diverticulitis,
*Hepatitis, Chronic Liver Disease,
Gastritis,
*Acid Peptic Disease,
*Upper GI Bleed,
*Lower GI Bleed,
*Primary Sclerosing Cholangitis, and
*Lactulose intolerance
It was such a phenomenal session no one can teach in such a magical way the whole gastrointestinal pathologies in just 1.5 hour yes!!!its one and only our supervisor .noone can be this much humble who allowed mrcem students to attend bonus lecture of mrcp group free of cost sir you are amazing and true leader. Ap murshid ha sir Sometimes i feel we should keep on listening to you all day long as it keeps morale high ..
Truly proud to be part of London Global Emergency Medicine (LGEM)
Thankyou Dr Ash
Thankyou LGEM team.👍

12th FEBRUARY 2023

EVENT NAME:

High Yield Major Trauma Session 2 By Dr Syed Ali Ahmed FRCEM

DOCTORS FEEDBACK

FEEDBACK # 1

Afshan Salman

Another wonderful session by Dr. Ali Ahmed on ' Major Trauma Injuries'. We learned:
Cardiac temponade and trauma, Spinal cord transection with spastic and flaccid bladder
Head injury and raised ICP management,
Indication of CT scan head in adults and easy way to memorize all the of it,
Signs of basal skull fracture, Abdominal trauma,
Fast scan,
pneumoperitoneum and various signs on Xray if patient is supine, like Doge's cap sign, inverted V sign, cupola sign etc,
Indication of cervical MRI Scan, Extra dural and subdural hematoma, tension pneumothorax,
unilateral dilated pupil, Holmes-Adie pupil,
Hangman's fracture,
Salter Harris classification in fracture and much more.
Thank you so much Dr. Ali for the comprehensive and brilliant session ✨✨
Thanks Dr. Ash and team LGEM.

FEEDBACK # 2

Hareem Zakir

One best session on major trauma injuries by Dr Ali. He discussed multiple cases with us . Each and every case was the one we deal on everyday basis in er. He always comes up with the most updated guidelines and amaze us with the New information . He makes us go through alot in just few hours and make us memorize alot of stuff. Thankyou for taking out time from your busy schedule. May Allah bless you with the best 😊

FEEDBACK # 3

Saad Aslam

An amazing, highly interactive session was taken by Dr syed ali ahmed which focused mainly on major trauma conditions that arrive in ED. A number of exam related high yield questions were discussed which include the following:
Cardiac tamponade and usg paracentesis
Lower spinal cord injury leading to urinary incontinence, levels and presentation of injury + management

Head injury, raised icp management, role of hypertonic saline and mannitol in management and review of latest RCEM guidelines
CT head and NICE guidelines
Head trauma, types of hematomas, identification and management
Blunt/stab/gunshot/penetrating abdominal trauma
FAST scan
Pneumoperitoneum and management
Rigler's, football, doge cap, capula signs
Cervical injuries (hangman's fracture)
Vertebral artery dissection
Focal Neurological deficit
Overall the session was very useful in covering a number of difficult to asses conditons in trauma, improving knowledge and assessment and answering a number of qbank questions

FEEDBACK # 4

Syed Suhail Ahmad

Extremely high yield and emphasis was given on the important points both from clinical and exam POV that included
- Cardiac Tamponade and Beck's triad
- Head Injury and when to chose Mannitol/Hypertonic Saline
- CT Scan in head injury NICE Guidelines
- Tension Pneumothorax
- MC viscera injured in Blunt and Penetrating traumas
- Important Xray signs like Rigler and Inverted V
- Spastic vs Flaccid Bladder
- Base of Skull fracture and its clinical signs
- eFAST scan
- Haemotypanum

Thank you Dr.Ali, Dr.Ash, LGEM and PEMA 👍👍👍

FEEDBACK # 5

Imtiaz Ali Shah

Another excellent session by dr Alii Ahmed regarding high yield trauma .It was an interactive session covering many aspects of major trauma including.
CARDIAC TEMPONADE with causes and BECK,S Triad
SPINALCORD TRANSECTION above and below T12 Level with spastic and flaccid bladder.
HEAD INJURY and use of mannitol.
BASAL SKULL FEACTURE with signs like
Haemotympanem. panda eyes, csf leakage from ear and nose, Battles sign.
Abdominal trauma caused by Blunt, penetrating and gunshot.

Fast scan.
Pneumoperitoneum.
Right sign and DOGE CAP SIGN.
Tension Pneumothorax.
Cervical injury and Hangman's fracture.
Again it was one of the best lectures I have ever attended.A session full with clinical knowledge and guidelines .The best thing about dr Ali is that he keeps you awake and alert through out the lecture by making the session more interactive.
At the end I would like to thanks dr Ali for this excellent presentation and also dr Ash for providing us this wonderful platform of learning.

FEEDBACK # 6

Yasir Dilawar

In this session we learnt about cardiac tamponade, it's diagnosis and management plan and beck's triad. what to use in a head injury patient with raised intracranial pressure i.e Mannitol or hypertonic saline. we learnt about spastic bladder and flaccid bladder. spinal cord transection above T12 cause spastic bladder and below T12 cause flaccid bladder. indications of CT in head injury patients. most commonly injured abdominal organs in blunt, penetrating and gun shot trauma. four areas to assess on FAST Scan. pneumoperitoneum and other signs to look for on x-ray.it was such a nice lecture by Dr Ali. thank you sir

FEEDBACK # 7

Dr Mariam Nawaz

A perfect lecture with combination of teaching how to apprach the exam and how to approach th epatient. He makes remembering things so easy. Its a pleasure to study from Dr Ali. I hope that you teach us rest of the topics for the exam too. He taught us amazing practice essentials and exam essentials today and taught us using exam based scenarios. Some of the imp things we learnt are:
. Cardiac temponade
. Spastic bladder vs flaccid bladeer
. Hypertonic saline vs mannitol in head injury patients
. Manniol contraindications
. NICE guidelines fot doing CT in head injury patients in 1st hour in 8 hours
. Base of skull fracture
. Abdominal trauma
. FAST scan
. Pneumoperitoneum
. Paeds truma
. Indications for MRI in c spine injury

. Cushings triad
. Subdural hematoma
. Extradural hematoma
. Hangmans fracture
loved the session. Thankyou Dr Ali and Dr Ash for this powerful session. Really looking forward to have more preparatory sessions with Dr **Syed Ali Ahmed**

FEEDBACK # 8

Mina Khan

We were taught about
Cardiac tamponade/distended veins/muffled jeart sounds hypotension/4causes cancer/uremia/post cardiac surgery/pericarditis/myocardial rupture/approach subxiphoid45' using Pocus
Above T12 spastic bladder
Empties as it fills Below 12 transection Flaccid bladder overstretches/overfills/detrusor relaxed/paralyzed.tx catheterize/complication infection/rupture
ICP raised preferable HTS (prevent hypotension) mannitol debatable (osmotic diuresis/hypotension) inc GFR contra in CCF/intracranial bleed/dehydration/PE/ anuria/ 0.25-1mg/kg dosage/ elevate head 45'/ high flow o2 hyperventilate btw 4.5-6 Pco2 /intubate gcs<8/
Nice CT head Criteria : GCS <13/GCS <15 in 2hrs/ post trauma seixure/focal neuro deficit/ skull/basal fractures/>1 vomits
Basal fractures= Racoon Eyes/hemotympanum/rhinorrhea/battles sign/ get CT in 1 hr
Abdominal traumas= spleen[blunt]/Liver[stabbed] Small gut[Gun shot]
4 areas E-FAST= Subxiphoid/LUQ/RUQ/trans/longi suprapubic
Tension Pneumothorax : initial X ray Contraindicated ... Examine manually / needle thoracocentesis.
Pneumoperitoneum: air under diaphram/XRay/ Rigglers/football/cupola/doge cap/ inverted V signs.dome sign
How to immobilize prox femoral shaft fract? By putting 10% body wt traction force !![iv morphine/fentanyl/intranasal diamorphine/Aceta/ibuprofen]
MRI or CT Head !! Neurological signs/vertebral artery injury/severely restricted neck / MRI exclusively for C-spine injuries
Angle of Safety: 5th space midaxillary[tilt45'obeseones]
Unilateral dilated pupil >holmes Adie/acute glaucoma/3rd N compression/tropicaimide drops
C2-C3 misalignment/Hangman's Fracture/Hyperextension injury.

Thank you so much **London Global Emergency Medicine** and Dr **Ashfaque** (Director **Pema-Uk**)...🌹 Special thanx to Dr Ali for putting his heart out for us !

FEEDBACK # 9

Bushra Imran

Today's in session 2 by Dr Ali ,it was knowledgeable understanding concepts based scenarios Emergency related topics ,discussion comprehensively on cardiac tamponade, distended veins,4 causes of cancer, uremia, post cardiac surgery, pericarditis, myocardial rupture, spastic bladder with spinal injury, Bladder stretch reflex, complications, raised ICP scenerio, new guidelines of usage of hypersonic saline over mannitol, indication of CT scan brain in 1hr,fracture of base of skull ,gunshot injury, FAST scan ,free gas under right dom of diaphragm, Ringler's sign, Football sign, inverted V sign, Doge cap sign ....your session mostly eye opening wonderful for me thank you dr Ali and Dr Ash

FEEDBACK # 10

Gdmas Malik

Sir Dr Syed Ali Sb conducted a fantastic session regarding major trauma Which was a complete edible arrangements glued over our minds and stripped out the obsolete redundancy . He presented all the topic in captivating way . He discussed the epidural, subdural hematoma and its picture presentation on ct scan and cleared well how to identify the conditions like biconvex shape is of epidural hematoma and crescent shape is of subdural hematoma. Arteries involved are middle meningeal artery in epidural and bridging veins in subdural Hematoma. Cardiac tamponade and its treatment was explained and its paracentesis was also taught . Mannitol was and its side effets that it cause extra cellular space expansion and aggravate so many conditions where there is already interstitial oedema or conditions which cause susceptibility of oedema . The goal to fitter the cerebral oedema can be achieved by administration of hypertonic saline .In case of unavailability of hypertonic saline mannitol could be administered provided that there is no contraindications . Spinal cord transection above T12 that is spastic bladder and below T 12 that cause flaccid bladder was elaborated . Different x rays signs were discussed which are doge's sign ,cap sign, inverted. V sign,cupola sign . Ct scan indication in head injuries was inculcated , abdominal injuries ,pneumoperitonium , most commonly injured abdominal organs , intestine, spleen , liver, and diaphragm was also discussed, pneumothorax, haemothorax, Adie pupil, salter harris classification , all aspects were enclosed herewith. This solid encompassed delivery of lecture captivated our heed and I leant completely new approaches and consolidated all these topics well that could embark a new thrill and pathway for future

advancements. I am very thankful to Sir Dr Syed Ali sb who imparted me this updated version and guidelines.l will also mention that my great mentor Sir Professor Ashfaque Ahmad sb has paved these tarred way to tread up and get honour and accreditation. His untiring efforts and attempts for our growth is unforgettable, unprecedented and matchless. I will remember and the gratitude would never deferred and can never be compensated by sayings few words if thanks .
May Allah grant him perpetual happiness.

FEEDBACK # 11

Zegham Abbas

Amazing session with wonderful teaching skill hard concept make easy to digest topic we cover are
Cardiac tamponade distended veins muffled jeart sounds hypotension mar different causes leading to to cardiac temponade.
Spinal cord injuries leading to bladder pathologies regarding different vertebral level Above T12 spastic bladder Empties as it fills Below 12 transection Flaccid bladder overstretches over fills detrusor muscle relaxed paralyzed treatments is catheterize different complication leading to infection and rupture.
Raised Intracranial Pressure has different outcome preferably Hypertonic Solution are use but mannitol is also used which inc GFR contra in CCF intracranial bleed dehydration PE anuria 0.25-1mg/kg dosage
Nice CT head Criteria GCS <13/GCS <15 in 2hrs post trauma seizure skull fractures Vomiting after trauma neurological deficit.
Basal fractures Racoon Eyes hemotympanum rhinorrhea battles sign/ get CT in 1 hr
Abdominal traumas
Spleen Rupture usually after blunt injury
Liver laceration after penetrating injury (Sharpe object)
Small gut injury usually after firearm
E-FAST scan
Subxiphoid
LUQ RUQ
transesophageal
suprapubic
Tension Pneumothorax
Examination manually needle thoracocentesis initial X ray Contraindicated.
Pnemopertonium: Dome Sign X-ray Abdomen Inverted V sign air under diaphram football/cupola/doge cap/
Proximal femoral shaft fracture proper handling by putting 10% body weight traction force iv morphine fentanyl intranasal diamorphine Ibuprofen

Angle of Safety: 5th intercostal space midaxillary line for chest tube
Unilateral dilated pupil and much more different topic were covered
Thanks Dr Ashfaque and Dr Ali for arranging such high yield sessions for us.

FEEDBACK # 12

Qaisar Shah

Dr Ali discussed high yeild MCQs on :
CARDIAC TAMPONADE:
Diagnostic tools:
Muffled heart sounds
Distended neck veins
Hypertension
Treatment:
U/S guided pericardiocentesis
SPASTIC VS FLACCID BLADDER:
Above T12: Spastic
Below T12: Flaccid
Treatment for both
Complications:
Rupture of bladder
Inflection
RAISED ICP:
When to use hypertonic saline
When to use mannitol
Advantages and disadvantages of both
CT SCAN:
Within 1 hour
Within 8 hours
ABDOMINAL TRAUMA:
Blunt trauma: commonly spleen ruptures
Stab trauma: liver
Gunshot trauma: intestine
Quadrants for POCUS
TENSION PNEUMOTHORAX.
it was an amazing session and learnt alot,thanks Dr Ali and Dr Ash for this wonderful session.

FEEDBACK # 13

Haider Ali

As like every lecture, this session by Dr. Ali ahmed was beyong amazing and i have no words to express that how he has summarized all the major & minor trauma in just 4 lectures of 1.5 hour each.

In Today's lecture different stems regarding exam purpose were discussed which includes cardiac temponade, spinal cord injuries at different levels, use of hypertonic salindle instead of mannitol in raised ICP and much more was discussed.
Active discussion was done on each stem and surely, it would help in solving exam questions.

FEEDBACK # 14

Anila Zafar

It was an amazing lecture. Dr Ali was marvellous as always. His way of teaching is very different and unique. Enjoyed every second of the whole two hour long lecture.
I learnt :
CARDIAC TAMPONADE:
Diagnostic tools:
Muffled heart sounds
Distended neck veins
Hypertension
Treatment:
U/S guided pericardiocentesis
SPASTIC VS FLACCID BLADDER:
Above T12: Spastic
Below T12: Flaccid
Treatment for both
Complications:
Rupture of bladder
Inflection
RAISED ICP:
When to use hypertonic saline
When to use mannitol
Advantages and disadvantages of both
CT SCAN:
Within 1 hour
Within 8 hours
ABDOMINAL TRAUMA:
Blunt trauma: commonly spleen ruptures
Stab trauma: liver
Gunshot trauma: intestine
Quadrants for POCUS
TENSION PNEUMOTHORAX.
it was an amazing session .

Thankyou Dr Ali for such an Amazing lecture , really learned and enjoyed .

FEEDBACK # 15

Muzna Ahmed

Today's session covers the most important topics regarding practice and exam and Dr Ali is an excellent marvellous tutor whatever he taught goes straight into mind and remember long.

Today we have an healthy discussion on following:-

Cardiac temponade

(Presentation, beck's triad, etiology, treatment, u/s as an important tool, Causes, More than 20 ml is abnormal, Pericardiocentisis is the rx

Ultrasound guided is recommended)

Spastic badder

(Anatomy-Above T12 ,Pt lost voluntary control)

Bladder stretch reflex

(Anatomy -Via splanchnic plexus of nerves

S2-S4, controls detrusor contraction)

Flaccid bladder

Anatomy-Below T12 ,Overstretching of bladder is pathology. Catherization is crucial and it leads to serious consequences:

1.Infection due to stasis of urine

2.Rupture

RAISED ICP scenario:-

hypertonic saline is preferred choice over mannitol until prescribed otherwise because it prevents from hypotension and brain ischemia.

Contraindications of mannitol:

Pulmonary edema

Intracranial bleeding

Dehydration.anuria

Cardiac failure

NICE guidelines of CT head is very important and useful

CT SCAN within 1 hrs

GCS less than 13 initial assessment

GCS less than 15 at 2 hrs

Open or depressed skull fracture

Any sign bass skull fracture

Post traumatic seizure

More than 1 episode of vomiting

Focal Neurological deficit (bleed somewhere so it causing focal deficit at that area)

CT SCAN within 8 hrs

Signs of base of skull fractures
Panda eyes
Battle's sign(due posterior auricular vessels trauma)
CSF leakage
Hemoperitoneum:-
Due to blunt trauma, gunshot and penetrating injuries Fast scan is done to exclude free fluid and CT abdomen with contrast is used to diagnose visceral injuries
Pneumoperitoneum:-
CT scan performed to confirm diagnosis
Some important signs are:-
Rigler sign
Football sign
Inverted V sign
Falciform ligament sign
Doge cap sign
Capolar sign
Immobilization of fracture in child:-
10% of body weight traction is applied
Tension pneumothorax:-
Its a clinical diagnosis xray is a waste of time.
Rx-needle thoracotomy and chest drain as per recent guidelines.
Last but not least is hangman # of C6-C7
It was wonderful lecture and we are highly grateful to Dr Ali's dedication and hardwork Thankyou LGEM for arranging lecture.

FEEDBACK # 16

Hira Nehal

Dr Ali a wonderful person and conducted a wonderful lecture covering major trauma in emergency .
It was exam oriented Long with clinical approch .high yield points were discussed
Cardiac temponade I missed
Spastic bladder and flaccid bladder and importance of injury at T12 VERTEBRAE .
RAISED ICP
RX HYPERTONIC SALINE 3% (to prevent hypotension nad cerebral edema)
MANNITHL
Dose 1to 2mg /kg
Contraindication of mannitol
INDICATION OF CT HEAD ADULT

2 ANATOMY
OPEN OR DEPRESSED FRACTURE OF SKULL
BASE OF SKULL FRACTURE
2 MEDICAL
POST TRAUMATIC EIZURE
FOCAL NEUROLOGICAL DEFICIT
3 NUMBERS
GCS <13/15 ON INITIAL ASSESMENT
GCS <15 AFTER 2 HRS
1 EPISODE OF VOMITING
BASE OF SKULL FRACTURE SING AND SYMPTOMS
PANDA EYES
BATTLE SIGN
CSF LEAKAGE FROM NOSE OR EAR
BLUNT TRAUMA TO ABDOMEN MC INJURED SPLEEN
PENETRATING TRAUMA TO ABDOMEN MC INJURED IS LIVER
GUNSHOT TRAUMA MC INJURED IS SMALL BOWL
FAST SCAN different views
Pneumoperitonium
Different signs
Rigler sign
Football sign
Inverted V sign
Falciparum ligament sign
Doge cap sign
Immobilisation fracture in child .
10 percent of body weight traction to be applied .
Cushing triad
Widening pulse pressure >40
Bradycardia
Hypertension
Irregular pulse
Managment of sub dural hematoma
Head tilt at 30 degree
Tracheal intubation and save airway early
High flow oxygen to control pco2
Reversal coagulopathy by vut K or FFP
Refer to neurosurgery.
Tension pneumothorax
No xray .immediate needle thoracotomy in 2 ICS

SAFE TRIANGLE FOR CHEST DRAIN
MRI to be done when ct cervical spine is normal and signs and symptoms of pain and restricted movement.
Hangman's fracture
Salt and Haris type 3 fracture the
Thankyou dr ashfaque and dr Ali for wonderful piece of work ❤️.
Dr Hira Nehal
LGEM CANIDATE

FEEDBACK # 17

Zia Hayat

It was an amazing lecture altogether, Dr. Ali teaching approach is quite remarkable, he makes sure everyone is listening and understanding the concepts, it was totally interactive session. He discussed many daily trauma presentations in the ED and the approach required to tackle such situations with evidence based medicine .He discussed about the Cardiac Temponade ,approach and Management in the Ed, Spastic Bladder presentation with spinal injuries ,to distinguish between spinal damage above T12 level and below it. Bladder stretch reflex, Faccid Bladder ,Complications, Raised ICP and to use the new guidelines which prefer hypertonic saline over mannitol use, Indications of CT scan Head within 1 hour ,CT Scan approach towards Signs if base of skull fracture ,Abdominal Trauma due to Blunt and penetrative injuries ,Gunshot trauma ,FAST SCAN views, Pneumoperitoneum ,Free gas under Right dome of Diaphragm ,Look for Rigler's sign ,Football sign ,Inverted V sign ,Doge cap sign ,Capula sign ,Crushing triad ,Initial Management of Subdural Hematoma ,Tension Pnemothorax presentation on chest Xray film, Use of Pocus while determining Angle of Safety, Preference of MRI scan over CT scan head ,Vertebral Artery Dissection, Hangman's Fracture involving C2 to C3,Salter Harris Type 3 fracture presentation on Xray .Thankyou Dr. Ash for arranging such an amazing lecture for us to learn and to be oriented for the approach of clinical scenarios in the exam .

FEEDBACK # 18

Dr Mishal Shan

The lecture was a continuation of the previous session on major trauma. It continued to give us a great deal of knowledge in a compact form which is extremely high yield for exams and practically relevant. We learned some very new things as well such as the use of 3% hypertonic saline in trauma over previously used mannitol. We were also taught an easy way to remember CT head guidelines by NICE.
Regards,
Mishal.

FEEDBACK # 19

Dr Afifa Younis Raja

Greetings of the day!!

Dr Ali is the master of trauma, the way he has covered such a gigantic and daunting topic in such a comprehensive way is superb, we were so immersed and engaged in the learning process that we never look at the clock and wonder what time it is or when it's going to end. We just want him to go on and transfer all his pearls to us:

Today we covered:

- Cardiac tamponade
- Spinal cord injury
- Spastic bladder vs flaccid bladder
- Raised ICP
- Mannitol vs hypertonic saline
- CT brain indication of head trauma
- Base of skull fracture
- Abdominal trauma
- FAST scan views
- Pneumoperitoneum
- Subdural hematoma
- Extradural hematoma
- Tension pneumothorax
- Hemotympanum
- Bilateral dilated pupils
- Hangman's fracture
- Salter Harris classification

Thank You so very much for making trauma this easy for us in just 4 lectures, just amazing.

Thank You Dr Ash for picking such a great teacher for us.

Kind Regards,

Dr Afifa

FEEDBACK # 20

Dr Ruma Mustafa

Fantaboulus session Mashallah, Dr. syed ali have a excellent grip on ED Trauma it was wonderful learning today

I learnt many things as follows

Cardiac temponade Beck's Triad

Spastic bladder vs flaccid bladder and importance of injury at T12 VERTEBRAE .

RAISED ICP

RX HYPERTONIC SALINE 3% (to prevent hypotension nad cerebral oedema)
MANNITOL
Dose 1 to 2mg /kg
Contraindication of mannitol
INDICATION OF CT HEAD ADULT
2 ANATOMY
OPEN OR DEPRESSED FRACTURE OF SKULL
BASE OF SKULL FRACTURE
2 MEDICAL
POST TRAUMATIC SEIZURE
FOCAL NEUROLOGICAL DEFICIT
3 NUMBERS
GCS <13/15 ON INITIAL ASSESMENT
GCS <15 AFTER 2 HRS
1 EPISODE OF VOMITING
BASE OF SKULL FRACTURE SING AND SYMPTOMS
PANDA EYES raccon eyes
BATTLE SIGN
CSF LEAKAGE FROM NOSE OR EAR
BLUNT TRAUMA TO ABDOMEN MC INJURED SPLEEN
PENETRATING TRAUMA TO ABDOMEN MC INJURED IS LIVER
GUNSHOT TRAUMA MC INJURED IS SMALL BOWL
FAST SCAN different views
Pneumoperitonium
Different signs
Rigler sign
Football sign
Inverted V sign
Falciparum ligament sign
Doge cap sign
Immobilisation fracture in child .
10 per cent of body weight traction to be applied .
Cushing triad
Widening pulse pressure >40
Bradycardia
Hypertension
Irregular pulse
Management of sub dural hematoma
Head tilt at 30 degrees
Tracheal intubation and save airway early

High flow oxygen to control pco2
Reversal coagulopathy by vit K or FFP
Refer to neurosurgery.
Tension pneumothorax
No x-ray needed
immediate needle thoracotomy in 2 ICS
SAFE TRIANGLE FOR CHEST DRAIN
MRI to be done when CT cervical spine is normal and sign/sym of pain and restricted movement.
Hangman's fracture
Salter and Harris type 111 fracture
Highly exam oriented....Long discussion with the clinical approach ,very important lecture not only for exams but also for daily practice in ED and in acute settings lot of informative things.
Thankyou dr ashfaque and Dr. Ali, for such amazing intellectual information every week, it's a big boost to be a good physician
JazakAllah khair

FEEDBACK # 21

Dr Nasir Hayat

This session was amazing and well presented .learned alot and was well organized. He answered all the Questions.
resurcitaion high yield...as always @FSIALIPDI did a commendable job and helped us understand all necessary topics for major trauma as an er physician.. we started with CARDIAC TAMPONADE: diagnostic tool: muffled heart sounds, distended neck viens, hypertension. treatmemt included u/s guided pericardiocentesis...SPASTIC VS FLACCID BLADDER...above t12 spastic. Below t12 flaccid treatment of both, complications rupture of bladder, inflection.. RAISED ICP: when to use hypertonic saline when to use mannitol adv and disadvantages of both... CT SCAN within 1 hour within 8 hours.... ABDOMINAL TRAUMA 1. blumt-m. commonly spleen ruptures...2stab traums-liver,3 gunshot trauma -intestine....4 QUADRANTS FOR POCUS....TENSION PNEUMOTHORAX.... overall the lecture was very fruitful and very beautifully covered. Highly recommended for ER physicians to join it and get the depth of knowledge and have bright future. Proud to be LGem candidate.

FEEDBACK # 22

Dr Noman Ahsan

Today was 2nd session on Major Trauma in A&E and Dr. Ali as always make it very interesting and very well explained different topics ..He tried to explain as per examination criteria along with learning new signs on x ray , CT scan ....

Topics discussed today...
1) Cardiac Temponade (causes and Treatment)
2) Spastic vs Flaccid Bladder and complications
3) Raised ICP (Management)
4) NICE guidelines Criteria for performing HEAD CT scan in adults with head injury..
5) Blunt vs Penetrating vs Gunshot Trauma
6) FAST scan
7) Pneumoperitonuem + Different Signs On X ray
8) Immobilisation of fracture in child (Traction... 10% of total body weight)
9) Cushing Triad (Widened Pulse pressure, Bradycardia and Irregular respiration)
10) Sub dural and Extra dural Hematoma
11) Pneumothorax
12) Hangman Fracture
13)Salter Haris Fracture
Thanks Dr. Ali for this wonderful power-packed lecture...

12th FEBRUARY 2023

EVENT NAME:

Pancreatitis for EM & Acute Physicians By Dr Nadeem Tehami Consultant Gastroenterologist NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Rabiyyah Bashir
A lecture par excellence ❤️❤️❤️
Unlike conventional way of teaching, it was highly interactive and energetic one ❤️
It largely covered :
✓life threatening differentials of acute pancreatitis and their distinction from it
✓the basic and first initial vital sign that marks deterioration
✓commonest causes of acute pancreatitis
✓initial investigations
✓decision of keeping the patient nill by mouth
✓apparently alarming scenarios that should not warrant starting on antibiotics

✓only condition in pancreatitis that suggests going for ERCP
✓role of cholecystectomy in gallstone pancreatitis
A big thanks for Dr Nadeem Sir ❤️, an exceptional way of teaching you have.
Thank you to our mentor Dr **Ashfaque Ahmed** Sir ❤️ for choosing the best teachers for us.
Utmost Regards for team **London Global Emergency Medicine** ❤️

FEEDBACK # 2

Muhammad Azeem Imran

Incredible gift by Dr Ash for arranging such a nice talk on acute Pancreatitis by Dr Nadeem . Feeling blessed to take it from learned person .
Important Learning points
1: First to make sure Diagnosis of acute pancreatitis is correct ?
2: Then rule out 3 important vascular cause never to miss in this same presentation that may kill the patient - Ruptured AAA aneurysm, Acute mesenteric ischemia, Acute Myocardial infarction.
3:Then first important clinical sign we should look for in acute pancreatitis is Tachypnea
4: confirm diagnosis of acute pancreatitis by measuring serum amylase more than 3 times the normal
5: Role of CT Scan abdomen only if there is clinical deterioration , sepsis or multi organ Failure 6: Role of ERCP within 72 hours only in case of cholangitis
7: Treatment involves Analgesia & I. V. Fluids
8: No role of prophylactic antibiotics.
9: 3 D,' s of treatment guidelines of acute pancreatitis - Delay ,Drain & deride
10: Crucial time period is 4 weeks to intervene of local complications develope , pancreatic abscess , .
Excellent passionate teacher, Clearing myths in treatment and humble human being .
I am thankful to My Mentor Dr Ash for his efforts to bring best for us . May Allah swt keep you safe sir .

FEEDBACK # 3

Imtiaz Ali Shah

An excellent session by dr Nadeem Tehami regarding Acute pancreatitis.He discussed different types, causes and managment of acute pancreatitis.The best thing about this lecture was that it has broken all the myths and practices which are carried out for years and years like
Antibiotics use that they have no role in managment of acute pancreatitis
Do not rush for CT abdomen in every patient.

The only indication for ERCP in acute pancreatitis with gall stones is cholengitis.
Not every patient needs catheterization or NG tube.
Do CT abdomen only if patient is deteorating ,sepsis or organ failure.
3 D,s of managment including
DELAY,DRAIN,DEBRIDE.
Over all it was an amazing session and this session has totally changed my approach towards pancreatitis patients. It was a fruitful session and we learnt a lot.
Thanks dr Nadeem for this wonderful session and also thanks to dr Ash for providing us this wonderful platform of learning in the form of London GEM

FEEDBACK # 4

Muhammad Ibrahim

Wonderful session by Dr Nadeem Tehami on Acute Pancreatitis. Sir completely revamp our knowledge of Acute Pancreatitis. Today I came to know that hou much we are making mistakes in managing patients of Acute Pancreatitis.
Some of the management mistakes that we do to Acute Pancreatitis patients and were addressed by Sir are:
1. Advising CT scan
2. Giving antibiotics
3. Putting every patient on NPO
4. Passing Folley's to every patient
5. Arranging ERCP for patient with Gallstone Pancreatitis

Beside all these myths that Sir addressed today, some very high yield points Sir also discussed regarding its important life threatening diagnosis.
Thankyou so much Dr Nadeem Tehami for this incredible session today

FEEDBACK # 5

Bushra Khan

What an amazing lecture it was. As rightly said by Dr Ashfaque Ahmed, myth buster session. Just heard the recording and it was mind blowing. So many important aspects I learned today regarding acute pancreatitis management.

FEEDBACK # 6

Bushra Imran

In Today's session by Dr Nadeem discusses interactively on Acute Pancreatitis clinical features, with increase pancreatic enzymes ,Differential Dx : vascular problems, cholecystitis, MI, duodenal ulcer,, rupture AAA, what information to collect like history taking, examination,, radiological findings, investigations, when and what blood tests needed, when to do CT scan and ERCP with clinical suspicions, not to NPO all patients with complaint of Pancreatitis, and not to start antibiotics in all suspected patients ,also discussed signs of deterioration,

what is conservative management,,3Ds ..Delay ,Drain ,Debride, the crucial time period,...when to refer the patient. Yes It was an excellent session thank you dr Nadeem and Dr Ash

FEEDBACK # 7

Yasir Dilawar

It was one of the best lectures of our course.Dr Nadeem Tehami presented a scenario of acute pancreatitis and talked about what symptoms we have to look for to diagnose Acute Pancreatitis in a patient.and also we should rule out important life threatening conditions like MI, ruptured AAA, mesenteric ischemia which can present with same symptoms and signs.then he told us that patients do not require CT scan initially in pancreatitis and also there is no role of antibiotics unless there is an infection.for infection we have to look for patient stability that whether he is having spikes of fever or he is constantly deteriorating despite of our management.he also talked about the indication of ERCP that those patients who have cholangitis should undergo ERCP and not all patients of Acute Pancreatitis.so the patients should be measured conservatively in Acute Pancreatitis and will settle in 4 weeks time.and also the first sign of deterioration in a patient is tachypnea that was a very important point for me.Thank you Dr Nadeem Tehami and Dr Ashfaque.

FEEDBACK # 8

Hareem Zakir

What an amazing talk by Dr Tehami on acute pancreatitis. Breaking all the myths of the management and making things so so easy for us . He made us realize that minimal and appropriate intervention is the best for the patient. He told us the emergencies one cannot afford to miss at any cost . The myths about keeping patients nil per oral, antibiotics , indications for ercp all were broken to make us the safe and efficient doctors . Thankyou sir for the Amazing pearls . Looking forward to more sessions from you .

FEEDBACK # 9

Beenish Manzoor

A very amazing and phenomenal lecture today by Dr Nadeem with different case secanrios and presentation

Feeling blessed to learn from expert and specialist person like Dr Nadeem.

The Learning points from todays session were

1: Diagnosis of acute pancreatitis

2: Then rule out 3 important vascular cause never to miss in this same presentation that may kill the patient - Ruptured AAA aneurysm, Acute mesenteric ischemia, Acute Myocardial infarction.

3:Then first important clinical sign we should look for in acute pancreatitis is Tachypnea

4: confirm diagnosis of acute pancreatitis by measuring serum amylase more than 3 times the normal
5: Role of CT Scan abdomen only if there is clinical deterioration , sepsis or multi organ Failure 6: Role of ERCP within 72 hours only in case of cholangitis
7: Treatment involves Analgesia & I. V. Fluids
8: No role of prophylactic antibiotics.
9: 3 D,' s of treatment guidelines of acute pancreatitis - Delay ,Drain & deride
10: Crucial time period is 4 weeks to intervene of local complications develope , pancreatic abscess ,
11. Common myths
*Overuse of antibiotics
*Ct scan is not always must
*Not all patients need ERCP .
Excellent passionate teacher, Clearing myths in treatment ..
Thanks Dr Ash for providing such a fruitful platform to all of us which own us .Proud to be LGEM candidate.
Regards

FEEDBACK # 10

Anila Zafar

Amazing lecture by Dr Nadeem. He is a marvellous tutor. He explain acute pancreatitis very comprehensively. I learnt my weak points and the mistakes we were making. Like
Advising CT SCAN, do CT if pt is in worsening sepsis or organ failure
Giving antibiotics
Keeping the patient NPO
Doing Foley's catheter on all patients
ERCP for pts with gallstone pancreatitis
. The only indication is that pt has cholengitis.
3 Ds of management are
Delay
Drain
Debride
Thankyou Dr Nadeem and Dr ASH for an amazing lecture.

FEEDBACK # 11

Mina Khan

Dr Tehami gave excellent explanations and delivered the best-est lecture I came across uptill now. I am never going to forget Him and yess gonna call him my ideal professor !! 💞
We were taught

Acute pancreatitis causes drug induced/azathioprine/steroids/tetracyclines/estrogens/alcohol/idiopathic/severe Hypertriglyceridemia/ultrasound initials/
Donts
No need of CT
No need of antibiotics
No need òf ERCP until disease course provens
None need NPO/NJ/NG/TPN
Tx: fluids/hydration / oxygen/ NPO /Referral
First sign of deterioration RR/tachypnea (may cause insensible loss /dehydration).
Case based scenario by Dr Tehami
Thank you **London Global Emergency Medicine**
Two favourites just listed
1.Dr Ash
2. Dr Tehami.🌹

FEEDBACK # 12

Qaisar Shah

Dr Nadeem discussed:
Acute Pancreatitis:
Clinical presentation: abdominal pain, nausea and vomiting, fever, elevated serum amylase and lipase levels
Differential diagnoses: vascular problems, cholecystitis, myocardial infarction, duodenal ulcer
Information collection: history taking, physical examination, imaging studies, blood tests
Ruling out possible causes: thorough history taking, blood tests (e.g. liver function tests, electrolyte levels, glucose), imaging studies (e.g. abdominal ultrasound, CT scan)
CT abdomen: consider when there is a high clinical suspicion of complications, or if initial imaging studies are inconclusive
NBM, NG/CVP/Foley's catheter: consider if there is evidence of dehydration or if abdominal pain is severe
Signs of deterioration: tachypnea, decreased urine output, increased heart rate, decreased blood pressure
Less interventions approach: conservative management, avoiding unnecessary interventions
Common mistakes: overuse of antibiotics, early CT scans, not considering alternative causes of symptoms

LFT derangements: elevated levels of liver enzymes (AST, ALT) may occur in acute pancreatitis, consider ERCP if there is evidence of biliary obstruction
3Ds rule: delay (surgery), drain (pancreatic or peripancreatic collections), debride (dead pancreatic tissue)
Proper management: individualized approach based on the severity of the condition, regular monitoring of clinical signs and symptoms, and prompt recognition and management of complications.
It was really a wonderful session by Dr Nadeem Tehami and lot of thanks to Dr Ashfaque for arranging this nice session.

FEEDBACK # 13

Zia Hayat

It was a wonderful session ,quite interactive one on Acute Pancreatitis discussing clinical features, with increase pancreatic enzymes ,Differential Dx: vascular problems, cholecystitis, MI, duodenal ulcer,, rupture AAA, what information to collect like history taking, examination,, radiological findings, investigations, when and what blood tests needed, when to do CT scan and ERCP with clinical suspicions, not to NPO all patients with complaint of Pancreatitis, and not to start antibiotics in all suspected patients ,also discussed signs of deterioration, what is conservative management,,3Ds ..Delay ,Drain , Debride, the crucial time period, Referral of the patient and also how to manage it in acute settings ,It was a powerpack session giving all the details in a very orderly manner and made us clear a lot of myths about management of Acute Pancreatitis ,Thankyou Dr. Ash for arranging such an amazing opportunity to learn and reflect on our mistakes in ED.
In the End what really inspired us all was Dr. Nadeem s way of teaching and explaining things in a very clear and logical approach which touched our hearts.

FEEDBACK # 14

Rizwan Ullah Siddiqui

What an amazing session with Dr Tehami, I has literally changed our way of practice, although I work in AnE UK, seen many Acute pancreatitis patients, But I learned hundreds of new concepts in management of acute pancreatitis today.
Especially learnt concepts:
When to perform ERCP
What is clinically Chollangitis when we offer ERCP
Main stay treatment in Acute Pancreatitis
Role of Antibiotics
When and how to refer a patient and to which Speciality
Clinical signs and symptoms of deterioration
First Cardinal sign of deterioration

I am really Grateful to Dr Tehami and Dr Ashfaq to bring this Magneficient session for us.
Many Thanks
Dr Rizwan Siddiqui

FEEDBACK # 15

Ghulam Saddique Saddique

A wonderful session conducted by Dr.Nadeem Tehami he today broke the old myth of managing the acute pancreatitis as far as I know we mostly managed the acute pancreatitis according to the myth .
Starting from recognizing the differentials like AAA ruptured, perforated duodenal ulceration, acute mesenteric ischemia which could not be delayed otherwise will harm pt. Identifying vascular causes, identifying signs of shock, deteriorating pt. 2 out of 3 for diagnosis of pancreatitis (imaging evidence, amylase/lipase 3 times upper limit of normal, typical abdominal pain)
Take home message:
DONOT SEND EVERYONE FOR CT SCAN- only do if after resuscitation pt is still deteriorating rapidly or considering other differentials like ruptured AAA, duodenal perforation)
DON'T GIVE ABX TO EVERY PT WITH PANCREATITIS (only consider if there is objective evidence of infection - associated cholangitis or post ERCP localize perforation/ leak, abscess)
-Two types of pancreatitis - 1) interstitial pancreatitis (80-85%) 2) necrotizing pancreatitis (15-20%)
-Initial management: fluids and analgesics
- Different Causes of pancreatitis GET SMASHED
-Drugs- azathioprine, mesalazine, steroids etc
- LFT and bilirubin can be deranged in pt with pancreatitis bcz of edema, swelling, inflammation in head of pancreas)
- ERCP is only indicated if there evidence of cholangitis (not in case if deranged lft, or stone in CBD etc)+ ERCP requiring pt should be refered early with in first 48-72hrs or delay referral for 10 days
-4 week time period (interstitial pancreatitis could result in pseudo cyst and necrotizing pancreatitis can result into walled off necrosis, so don't intervene before 4 weeks, send for drainage after 4 wks)
-3 Ds (Delay, Drain , Debride)
- How to evaluate that this is cholangitis or not? as there is leukocytosis, raised crp due to SIRS, deranged lfts, pt is tachypneac and tachycardic already in most scenarios - key is to identify the fluctuating course of progression due to bacteremia, rigors, blood test like procalcitonin etc.

Once again thankful to Dr.Nadeem Tehami for such a great and full of knowledge session.

FEEDBACK # 16

Gdmas Malik

Today ,Dr Nadeem Tehami sb conducted a fantastic aand alluring session regarding acute pancreatitis. By dint of his vast experience and clinical sense he presented the session in a highly appreciable and lustred manner . He emphasized all the cardinal points and compounded a broad sketch of management and tackling of the acute pancreatitis . , History, clinical picture, presentation, etiology investigation, differential diagnoses and stepwise management was discussed in a pleasantly surprised and calculated order that diverted our minds to instill all this lecture in cerebrum. He stressed to preclude first the life-threatening differential eg, myocardial infarction, abdominal aortic aneurysms rupture, peptic ulcer perforation, gallbladder perforation, because they need urgent intervention to be addressed timely to surmount the dilemma . He delineated a common mistake being commited all over the world ,is the undertaking of CT scan unnecessarily for acute pancreatitis which has no substantiated role to detect the ensuing pathology . He further elucidated that so many conditions are prioritized unnecessarily without being crucial for management and intervention . He exemplified that bile duct stone , cholilithiasis are dealt promptly without posing any threat to the life. These conditions are postponed untill the acute pancreatitis is settled down . Other mistakes being practised in management are ,every pt is kept NBM, NG tube is passed, and catheterised without being necessitated by the clinical conditions . Every patient should be treated accordingly and to the scale of updated guidelines . Another wrong approach was elucidated that frequently unindicated antibiotic prophylaxis is being practised which is unethical and loss of health and money , while the easy routine tests are neglected to pinpoint the diagnosis . Pancreatic amylase 3 time if the upper limits of normal and pancreatic lipase 3 times of the upper limits of normal are first should interpreted to follow the desired treatment . Indication of Antibiotic is the condition, where one come across over cholangitis which should be delineated well because the inflammatory response syndrome and cholangitis has closely enigmatic picture that need extensive attention and should be clearly elucidated to embark the definitive addressable. Otherwise,case of acute pancreatitis is treated by fluids and analgesic ,if complications are developed eg, pseudocyst , shock, should be addressed properly .

Dr Nadeem Tehami delivered a comprehensive enclosure of acute pancreatitis and cleared very important points that forged a new pathway for us to deal the patient in the right way at the right time through a right approach. I am very

thankful to Dr Nadeem Tehami sb for his comprehensive lecture and his handsome compilation .
I also very thankful to Sir, professor Dr Ashfaque Ahmad sb for providing us the platform and opportunities for such great knowledge and skills .May Allah reveal over him the eternal success and happiness.

FEEDBACK # 17

Dr Amash Khan

Today's lecture was amazing one and so many key points were taught by Dr Nadeem and each point were of so much importance. We were guided on diagnosis and management of acute pancreatitis in detail and were taught about how to diagnose pancreatitis and DXDs of epigastric pain, indication of antibiotics admistration in pancreatitis, when to go for ERCP, Delay-Drain-Debride in pancreatitis.
Thank you Dr Nadeem for your guidance wish we could have prolonged more of your lecture.

FEEDBACK # 18

Dr Zaid Ahmed Ansari

Dr Tehami discussed acute pancreatitis with a specific focus on various case scenarios throughput the presentation, which for me definitely enhanced the lecture's effectiveness.
The points of Dr Tehami's lecture were:

- Diagnosis of acute pancreatitis with a particular focus on three vascular causes, namely Ruptured AAA aneurysm, acute mesenteric ischemia and acute myocardial infarction. He emphasized the the need to not rule these causes out and consider them a very real possibility during diagnosis.
- Tachypnea is a definitive clinical sign that should be ascertained first.
- Serum amylase testing to confirm the diagnosis.
- He further discussed the importance of an abdominal CT scan if there is clinical detertioation, sepsis or multi-organ failure. He also laid out the use of EFCP in cholangitis.

Dr Tehami also talked about prophylactic antibiotics and how they should be used in a very limited capacity, preferably not at all. He also outlined the 3 Ds of treatment protocols of acute pancreatitis: delay, drain & deride. 4 weeks is a crucial time period for intervention to prevent the formation of local complications, including pancreatic abscesses.
I feel that the most crucial takeaway of the lecture was Dr Tehami dispelling common treatment myths, including the overuse of antibiotcis, employing th eCT scan as a must have diagnostic tool, and the prevalence of ERCP as a diagnostic criterion.

FEEDBACK # 19

Dr Emmanuel Charles

A great learning experience no stone left unturned conceptually and clinically. From the basic definition Of Pancreatitis and its causes , pathophysiology.
The whole lecture covered the following points :
1)Only indication of ERCP: Acute gallstone pancreatitis with stone in the Bile duct associated with Cholangitis
2) No Abx needed in acute pancreatitis the same applies for in necrotizing pancreatitis
3) Clinic presentation and symptoms :patient exhibits sharp epigastric pain radiating to the back.
Rule out life threatening vascular pathology like MI, AAA rupture and mesenteric ischemia is top priority
4) Causes: alcohol , recent travel, binge drinking, previous history of gallstones, hypertriglyceridemia , drug induced by steroids, diuretics and azathioprine.
5)Ct scan is not required in the first 48-72 hours.
6) Careful monitoring whether patient is in multi organ failure if yes then drainage of fluid will be done early
7) Complication: collection of pancreatic fluid pseudocyst in interstitial type and walled off necrosis in necrotizing.
8) 3Ds : 1)Delay for 4 weeks, 2)Drain, 3)Debrief necrosis.
In the end Dr Ashfaque invaluable guidance and medical tips were excellent as always.
Thankyou Dr. Ashfaque Ahmed for facilitating the whole session.
Thankyou Dr Nadeem Tehami Consultant Gastroenterologist NHS UK
Thankyou LGEM MRCP PROGRAMME TEAM.

FEEDBACK # 20

Dr Aiman Nazir

The session conducted by Dr Tehami on pancreatitis was beyond excellent. It was really a great session that cleared a lot of concepts and pointed out common mistakes that we do in the management . Dr Tehami is a great teacher and knows well how to teach and grips the attention of each one of us by explaining things in the most simple and interesting way and allows us to think by giving scenarios and then explains the correct answer in a very easy manner.
Today's session has cleared a lot of myths and common mistakes while managing pancreatitis . Excellent explanation on why imaging early is not required and does not add any extra benefit in management, there is no need to keep every patient nil by mouth or inserting foley's catheter is not ideal for every patient, no need of antibiotics in acute pancreatitis , 3 D's principle explained in detail, indications for ERCP , differentiating between actual

cholangitis or SIRS in pancreatitis to prescribe antibiotics , reason for deranged LFT in pancreatitis patient.
I cannot thank Dr Tehami enough for taking out time and teaching us great great learning points according to the latest developments/guidelines .His explanations were so on point that they have already been instilled in our minds and definitely today's session will have a great and positive impact on our practice in daily life.
Thank you Dr ASH and Dr Tehami for such a brilliant session . I hope to study more from Dr. Tehami in the future .I will be looking forward to it..
Dr Aiman Nazir
EMFP LGEM

FEEDBACK # 21

Dr Hira Nisar

It was a comprehensive lecture on Acute Pancreatitis that busted a lot of myths and flaws in approach to this condition. The key takeaways were:
The triad for diagnosing acute pancreatitis is:
1)Epigastric or central upper abdominal pain radiating to back
2)Serum amylase or lipase three times the normal limit
3)imaging evidence proving pancreatitis.
There are two types of Acute Pancreatitis:
Interstitial pancreatitis (80 to 85% of cases) and Necrotizing pancreatitis (15 to 20%)
Apart from the causes that I already knew, I learnt some new causes for acute pancreatitis such as
Hypertriglyceridemia and drugs including
Thiazide diuretics, steroids, azathioprine.
CT scan is not for initial management of pancreatitis as Pancreatitis is not visible in CT scan in the first 48 to 72 hours. You can do CT to rule out abdominal aortic rupture or any other viscus rupture.
If patient had epigastric pain, radiating to back, settles with IV fluids and analgesia. This confirms clinical diagnosis of pancreatitis.
Interstitial pancreatitis settles down with conservative management; however, Necrotizing pancreatitis requires intensive care and procedural intervention.
Tachypnea would be the first sign of patient's deterioration because there is insensible loss of fluid through tachypnea.
Not even patient needs to be NPO. Keep NPO only in mild to moderate pancreatitis where the patient cannot tolerate oral intake.
Takeaways for Acute pancreatitis
Don't do CT scan in everyone and don't give antibiotics.

CRP and TLC could be elevated due to inflammation. If there is inflammatory process, patient will show improvement with IV fluids and analgesia.
Temperature spikes (fever up and down) suggests an underlying infection because the disease course fluctuates in an associated infection.
CRP and TLC could be elevated due to inflammation.
Indication for antibiotics in acute pancreatitis:
If worsening LFTs with CRP (associated cholangitis)
OR Any localized abscess collection, not fluid collection.
Refer for ERCP only if there is an obstructive gallstone.
Deranged LFTs in pancreatitis could be due to pancreas edema causing biliary obstruction and not always due to presence of obstructive gallstones .
ERCP in acute pancreatitis only if there is associated cholangitis. ERCP not indicated in gallstones pancreatitis if gallstones in CBD unless associated with associated cholangitis.
If ERCP required, refer for it within first 48 to 72 hours, otherwise wait for at least ten days for local edema to resolve.
No surgical intervention before 4 weeks, whether interstitial or necrotizing type.
Only in multi-organ dysfunction with fluid collection, do drainage before 4 weeks.
3 Ds in the management of acute pancreatitis: Delay, Drain and Debride.
Start feeding patient as soon as orally tolerable, whether orally, NG or NJ.
Apart from these, he also taught us some important concepts about general management. These were:
Extract maximum information through history and observation.
Touch for examination but as little as possible.
Do as minimal intervention as possible.
If patient can tolerate oral antibiotics then don't give IV antibiotics.
Yours sincerely,
Dr. Hira Nisar,
London GEM Foundation trainee.

FEEDBACK # 22

Dr Mubashir Hussain

Wonderful session by Dr Nadeem Tehami on Acute Pancreatitis. Sir completely revamp our knowledge of Acute Pancreatitis. Today I came to know that hou much we are making mistakes in managing patients of Acute Pancreatitis.
Some of the management mistakes that we do to Acute Pancreatitis patients and were addressed by Sir are:
1. Advising CT scan
2. Giving antibiotics
3. Putting every patient on NPO

4. Passing Folley's to every patient
5. Arranging ERCP for patient with Gallstone Pancreatitis
Beside all these myths that Sir addressed today, some very high yield points Sir also discussed regarding its important life threatening diagnosis.
Thankyou so much Dr Nadeem Tehami for this incredible session today

FEEDBACK # 23

Dr Ahmad Tanveer

SUPERB Interactive lecture given by Sir Dr Nadeen Tehami. Extreme of pleasure and satisfaction . Many myths blasted. The 1st thing to ask , see & do while diagnosing acute pancreatitis from other causes
I cant explain in words what a world class teaching it was. Stunned to hear all the facts taught by Dr Nadeem it was simply marvellous 👌
Case based discussion was extreme of teaching
40yr old male 24 30 hrs acute onset sharp pain epigastric region
Past history
No drug allergy
no significant hx .
no routine treatment.
Drink occasionaly .
Bp is ok
Temp is fine
bsl normal .abd exam no concern on GPE .gaurding is there .
Pain is radiating pancreatitis
Myocardial infraction .
AAA
Perforation .
Vascular complications
Mesenteric ischemia
AAA
Myocardial infarction
MAY Miss other differntials but the above 3 are not to
Not affoard to miss .
Which can kill a patient .
How to differentiate it from other causes of epigastric pain
Pain to be under control
ABCD same management
U may not find gaurding and rigidity however pt is having lot of pain .
Discrepancy in clinical finding and patients symptom

Lab investigations .
Lipase 3 times above normal .
Imaging evidence USG CT MRCP .etc
Amylase 900 /100 normal
Nectrotizing pancreatitis

Causes
If BMI is high gallstones pancreatitis. Alcohol common things common .
Hypertriglyceridemias
Drug induced
Thiazide diuretics Azathioprine
Hypercalcemia
CT cant add anythung in first 72 hours .
Possible clear etiology if amylase 900 more then 3 times upper limit.
If pt is rapidly deteriorating
AAA to exclude rupture. Then CT can be considered.
CT only requested if concern abdominal aorta visceral rupture.
Management
Fluids
Analgesia
Monitoring .
NG TUBE . only nausea then tube.
Scoring
Severe mod mild
Not every pt needs folleys ng tube and cvp only to unstable
1st signs to deterotate

1st sign Tachypnea raised respiratory rate
INSENSIBLE LOSS OF FLUID . Dehydration occurs
Hypotension tachycardia
Urine output decreases.
1-Examine your pt without touching to extract max info.
2-What max i can do without intervene .
Eleviate problems rather then intervention .
Urine out put in manual uriner rather then intervention
ABGS is ok in unstable setting.

Not every pt is for NPO .
Nutrition is important .

Dont administer antibiotics

In acute pancreatitis
Even in neutrophils systemic inflam response so dont need antibiotics.

Dont want early imaging .
Interstitial edema and inflamation and waste money and increase inflammation.

Objective evidence of associated inflammation. Bilirubin is high CRP is going up . Associated cholengitis . Pancreatitis from other centers ERCP referral

3rd common mistake
Many referred for ERCP . Gallstones obstruction evidence.

Swelling in head of pancrease may lead to raised inflammatory markets in pancreatitis .

Acute gallstone obstruction with associated acute cholengitis in such patients only then ERCP
Liver blood tests abnormality can be seen in acute pancrtitis but its not the indication of ERCP.

If you have to refer for ERCP then to be done in first 48 to 72 hrs.
Or have to be done 10 days later to let it settle.
Decision making is important for the management.
In interstitial or necrotising pancreatitis .
4 wks cutoff time to intervene .
>If multiorgan failure with pancreatic collection then earlier intervention can be done

Delay drain debride 3 DS

Acute pancreatitis only to be managed by physicians
>In acute pancreatitis Majority of patients dont need surgery .

Do as little as possible to your patient but do as much as possible for your patient.
Golden

Pt who have gall bladder pancreatitis then cholecystectomy can be done

As soon as patient can tolerate then orally or NG tube can be started.
How to differentiate inflammatory from infective process

After starting of treatment of acute pancreatitis with fluids and analgesia he will start improving either slowly or fastly or platue or deterioration but gradual but not Fluctuating
In infection temperature spikes. Bacteremia showers of bugs deterioration and settling . Fluctuating along the course of treatment is infective.
Crucial timelines
72 hrs and 4 wks .
Thanks Dr Nadeem Again for
Beautiful lecture well explained. And above all Thanks Dr Ash for being with us even in family vacations sacrificing for us . Highly obliged.

FEEDBACK # 24

Dr Leela Ram

The session was superb which encompassed all essential pinpoints on management of pancreatitis in Emergency department and Acute medicine setting. Dr. Nadeem Tehami is an outstanding in addressing his presentation, he demonstrated multiple mismanagement on pancreatitis which might be practised worldwide.
Pancreatitis is classified as:
1. Acute Interstitial pancreatitis(80-85%)
2. Acute necrotizing pancreatitis (15-20%)
Acute interstitial pancreatitis leads to transient organ failure, acute fluid collection & mortality <2% whilst Necrotizing pancreatitis leads transient organ failure, moderately severe acute pancreatitis with mortality < 5%.
Acute interstitial pancreatitis results in complete resolution or pseudocyst whereas acute necrotizing pancreatitis results in walled off pancreatitic necrosis or infected necrosis.
Pancreatitis can occur with gallstones, cholangitis & hepatitis.
DD: Ruptured AAA, MI, Mesenteric ischemia
First sign in context of deterioration is increased breathing rate (tachypnea).
Serum amylase is more than 3 times the normal.
No role of CT abdomen if there's no deteriorating condition or multi organ failure. ERCP is indicated if there's suspicion of cholangitis concurrently.
Treatment: Mainly IV & Analgesia (good one).
No antibiotic is required in acute setting.
Good nutrition is required.
No need to keep patient NPO or delay parenteral nutrition unless condition is more severe or unable to take.
Crucial time to intervene is 4 weeks.

Good sign to monitor after IV fluid+ analgesia is alleviating symptoms which signifies the patient is getting well. In context of infection, fever fluctuates which should be confirmed through procalcitonin level and managed by physician.
Thank you so much Dr. Nadeem Tehami for brilliant session & Dr. Ash for bringing us best consultants of NHS.

FEEDBACK # 25

Dr Faiza Baig

Today's lecture was absolutely amazing and fascinating, an eye opener for me.

✨He explained that this unpredictable disease is managed surgically but surgery is not often involved and it is easy to think and manageable.
The progression may be gradual or rapid with severe epigastric pain radiating to back with nausea and vomiting.

✨Causes includes
- gall stones
- alcohol
- steriods
- drugs
- hyperlipidemia
- trauma

✨Signs include
- fever
- shock
- tenderness
- cullen's sign

✨Investigations
- serum amylase
- serum lipase
- ABG monitor
- acid base status
- CRP
- CXR
- US
- CT
- MRI for complications
-ERCP if lfts worsen

✨Acute pancreatitis is divided into two parts:-

1- Interstitial Pancreatitis
- 80-85% of cases
- transient organ failure
-acute fluid collection
-resolution of fluid infiltration
2- Necrotizing pancreatitis
- 15-20% of cases
- during first 2 weeks transient organ failure
- if it is severe acute then may be a sterile necrosis or infected necrosis.

✨Management:-
- nil by mouth
- analgesia
- bp, pulse, urine output
- identify vascular causes

✨From all the above assessments, the essential observation we need to see in these patients is a respiratory rate TACHYPNEA

📌TAKE HOME MESSAGE:-
Do not send everybody for CT scan
Do it only if patient is deteriorating rapidly
Acute deteriorating pancreatisis having deranged Lfts and due to swelling on head of pancreas causes edema and biliary obstruction
Then do not go for ERCP, it is only indicated in cholangitis.
It should be referred early within 48-72 hrs

✨3Ds
Delay
Drain
Debride

📌Do not give antibiotics unless there is an infection
It may be inflammtory or infectious and a physician has to evaluate it carefully and to identify the fluctuating course.

✨ In conclusion, Dr Tehami explained very well the role of CT scan, role of antibiotics and ERCP. It was a great and remarkable session, it broke down many misconceptions👏🤩

✨Thank you Dr Tehami and Dr Ash for conducting such an amazing session.

FEEDBACK # 26

Dr Nasir Hayat

This session was Amazing and very well presented .I learned alot.
Incredible gift by Dr Ash for arranging such a nice talk on acute Pancreatitis by Dr Nadeem . Feeling blessed to take it from learned person .
Important Learning points
1: First to make sure Diagnosis of acute pancreatitis is correct ?
2: Then rule out 3 important vascular cause never to miss in this same presentation that may kill the patient - Ruptured AAA aneurysm, Acute mesenteric ischemia, Acute Myocardial infarction.
3:Then first important clinical sign we should look for in acute pancreatitis is Tachypnea
4: confirm diagnosis of acute pancreatitis by measuring serum amylase more than 3 times the normal
5: Role of CT Scan abdomen only if there is clinical deterioration , sepsis or multi organ Failure 6: Role of ERCP within 72 hours only in case of cholangitis
7: Treatment involves Analgesia & I. V. Fluids
8: No role of prophylactic antibiotics.
9: 3 D,' s of treatment guidelines of acute pancreatitis - Delay ,Drain & deride
10: Crucial time period is 4 weeks to intervene of local complications develope , pancreatic abscess , .
Excellent passionate teacher, Clearing myths in treatment and humble human being.
I am thankful to My Mentor Dr Ash for his efforts to bring best for us . May Allah swt keep you safe sir. Highly recommended for physicians to join it.
Proud to be LGEM candidate.

FEEDBACK # 27

Dr Noman Ahsan

It was Dr. Nadeem Tehami's first ever lecture in LGEM and he blown away our minds and shattered lots of myths regarding the Topic...Such a wonderful soul and his dedication to discuss and explain every single point was spot on...He said
DO as Little as you can to your patient. But Do as much as you can for your patient...Such a wonderful words and every single doctor need to implement in his practice and life.. As far as today's topic is concerned. A brief discussion done regarding Acute Pamcreatitis on how we hav to do Diffrential diagnosis along with other causes and sign n symptoms....
Investigations....S.Amylase n Lipase (3 × higher the upper limit)
Imagine studies...No need ..can go for U/S To rule out gall stones ..
CT scan is of no use in first 72hrs unless thinking of AAA / Perforation)

No need for ERCP till u find Gall stones + Acute pancreatitis associated with Cholangitis..
IF there's Multiple organ failure then go for ERCP or else delay for 4 weeks ...
Remember 3Ds
Delay....4 weeks
Drain
Debride
Management....
Only Fluids and good analgesia..
In Nut Shell...
1) No ABX in Acute Pancreatitis
2) No CT scan (in first 72hrs)
3) No ERCP..
4) Less intervention, less problems
Thanks a lot Dr. Ash for bringing in Dr. Nadeem Tehami on board for such a wonderful learning experience....looking forward to learn more from him...

FEEDBACK # 28

Dr Mishal Shan

The lecture on acute pancreatitis was brilliant and busted so many myths that I am still surprised at the difference in management of acute pancreatitis that we see. We learned the masterly inactive approach to pancreatitis. We were taught the indications of doing CT, ERCP, ultrasound and giving antibiotics. We also learned how to exclude v important life threatening differentials in a patient with upper abdominal pain. The lecture will hopefully significantly impact my practice of managing acute pancreatitis.
Regards,
Mishal Shan Siddiqui.

15th FEBRUARY 2023

EVENT NAME:

EM Seminar In Maldives 2 Hours key Note Speaker Dr Ash (Join Us Live On FB)

DOCTORS FEEDBACK

FEEDBACK # 1

Dr Nalira Yaugoob

Good evening Sir/Madam

Im Nalira Yaugoob a 4th year medical student who attended Special CME conducted by Dr Ashfaque Sirathia about how to be a trauma team leader on 16th February 2023
I wanted to give my feedback
Over all the session was very informative and I learned a lot about how important it is to give proper order during an emegency. I also learned that the scope of an emegency medicine physician is really vast.
I think the session will have been more beneficial for us if there was a event for medical studnets so we couldve been involved actively.

FEEDBACK # 2

Dr Aishath Unadha

Good evening Sir/Madam
I am Aishath Unadha, a 4th year medical student who attended Special CME conducted by Dr Ashfaque Sirathia about how to be a trauma team leader on 16th February 2023
The session was very informative and learned a lot about emergency medicine. In a short amount of time i was able to grasp some basic concepts regarding on how to be trauma leader.
I think the session would have been more interesting for us if medical students were actively involved in the session such as in the scenarios.
Regards

FEEDBACK # 3

Dr Aminath Shafeenaz Moosa

Good Evening,
My name is Aminath Shafeenaz Moosa, a 4th year medical student from The Maldives National University, School of Medicine Batch 01, currently in my Orthopedics and Traumatology posting in IGMH.
I got to know about the CME from our Head of Department, Dr. Hussain Faisal and attended the "ER Special CME" by Dr. Ashfaque Sorathia which was held in IGMH, Maldives on the 16th of February 2023.
It was a very interesting and informative session taken by Dr. Ashfaque. I was able to learn alot about the role of an emergency medicine leader. The session was very interactive, which included playing scenarios . Most importantly, "The Rule of Four" was a very simple and easy way to remember the most important aspects when seeing an emergency patient.
Thank you Dr. Ashfaque for conducting such an amazing session.
Aminath Shafeenaz Moosa
MNUSM, Batch 01

FEEDBACK # 4

Dr Aminath Wafira

Dear Sir/Madam
I really appreciate for accepting me as a participant for the CME held today at The Maldive Indhira Ghandhi Memorial Hospital (IGMH).
Myself as a medical student, got to learn the very basics of emergency medicine in the moat simplest way possible. Such CME and educational seminars and forums will be great opportunities gor us medical students as well. We got to know more about your program and thus got some guidelines on how to proceed after our undergraduate course of MBBS.
The session was very educational and encouraging as well for further studies.
Thank you,
Sincerely,
Aminath Waafira
Student
The Maldives National University School of Medicine

FEEDBACK # 5

Dr Shifa Ishaq

Dear Sir/ Madam,
I am a 4th year medical student from Maldives National University School of Medicine. I attended the ER Special care CME by Dr.Ashfaque Sorathia, in IGMH, Maldives on 16/2/2023. I found the session very informative and the doctor´s approach of giving scenarios and involving the participants was great. I found the rules of 4 in approaching a patient in an emergency very helpful.
Thank you so much for the interesting session.
Sincerely,
Shifa Ishaq

24th FEBRUARY 2023

EVENT NAME:

Complex Ethical & Legal Aspects For ED Physicians By Dr Shum Dev Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Afifa Younas

We had an amazing session on Complex Ethical & Legal Issues in ED by Dr. Shum FRCEM NHS Consultant, Dr. Shum was an excellent choice for such a complex and daunting topic, I have always felt to be lacking in such an

important and critical area so I was very keen on attending this lecture by Dr. Shum and as always it was a marvelous experience. He designed the lecture in such a tactful way rather than giving us plain theory which just evaporates once the session ends, he had Q and A session with clinical scenarios revolving around ethics, communication, and the legal aspect in ED. This made the session very interactive and cleared so many of our concepts and I am very much sure we will be able to apply this in our practice amicably now.
Thank you so much, Dr. Ash, for selecting such a great topic and tutor amid our exam prep this will a much-needed session in exam point as well.

FEEDBACK # 2

Amir Ashraf

Thankyou for this amazing teaching session , it was the need of time and we are appearing for intermediate april diet and Dr Ash always knows what his trainees need in this particular stage , he always structure our lectures knowing where we lack and what needs to be taught 👍👍
Dr Shum is a brilliant tutor , his way of teaching and delivering the knowledge is really impactful . Although , i haven't studied this topic yet as i always find this particular part of preparation very challenging and complicated and i have it for the lest resort but here i want to mention the way Dr shum brought up these 30 SBAs with quite an intellectual explanation made it really interesting and now i will go back and revise all the topics related to it specially the Metal act 2005 which was emphasised more . Also, the important aspect we learned is to always read the question clearly that what is demanding from us as an ED physician , not as forensics not as anyother speciality so the major focus should be in the understanding of question , even if we have the idea still we can go wrong if we don't understand it . Overall its was a brilliant teaching session , i just woke up and logged in with even a cup of coffee and very honestly i didn't even need one because if was very clear and brilliantly presented .
The topics we learned today :
- Conflict resolution
- Mental health act
- escalation pathway
- breaking bad news
- questions on capacity

Thankyou Dr Ash for always bringing up unique topics in tge time of need .
Alhamdulillah proud being a trainee of LGEM .

FEEDBACK # 3

Tajwer Khan

An amazing session on Ethics and medicolegal aspects in ED conducted by Dr. Shum. He is indeed a gifted teacher.

We went over various scenarios covering a variety of topics that we encounter on a daily basis in ED.
Thank you Dr. shum for helping us revise these topics and retain the information. A very big thank you to Dr. Ash for arranging such an important lecture. 👍
Looking forward to more of these sessions Inshallah

FEEDBACK # 4

Mina Khan

Todays session was interactive , Dr Shum always comes up with his best explanations, we were taught about ethics in ED , which definitely is tricky and confusing as to what might be the situations and the dealings, we studying proper ethical principles , we need to be fully aware and have keen observation onto how comprehend the scenario and perform the best action required. Dr Shum very well managed to make us understand and talked on mental capacity act/mental health act/ jehovah witness/medical negligence/caldicott guardian act/disclosing information having all 30 sbas on these topics. THANK YOU **London Global Emergency Medicine** for providing us with a platform✨🌸

FEEDBACK # 5

Uzma Shaikh

Dr Shum once again is my fav teacher from UK faculty. He is born tutor. He simplifies every complex topic for us. Today yet another comprehensive session on SLO7 i.e ethical and legal issues in ED. He with his twisting and tricky SBAs taught us regarding mental capacity act, mental health act, fraser guidelines, complain and confidentiality and much more. I will memorize all those sbas and look for those "except, not and false" scenarios.
Best tip:- always understand what is being asked.

FEEDBACK # 6

Rida Rana

Alhamdulillah attended an eye opening session by Dr Shum on Complex Ethical and Legal Issues. The session was based on around 30 questions which were tricky to solve but clearly highlighted the significance of reading the question thoroughly . Especially important is the last line of question - of what is being actually asked . Knowing the theory and guidelines is important but how the question understood is what plays an imperative part for being successful in the examination . Dr Shum beautifully covered the entire range of topics under the banner of ethical & legal concepts for example - conflict resolution , mental health act , escalation pathway , mental capacity act , breaking bad news and a lot more . Thankyou Dr **Ashfaque Ahmed** for

bringing such an amazing faculty on board 👍 Alhamdulillah on being part of LGEM 😊👍

FEEDBACK # 7

Bushra Imran

In today's tricky ,complex senerios based session with clearly high lighted the significance of how to read and then properly answer for coming successful result in exam.The topic on ethics and legal issues always hard to revise for me .The whole topic i,e conflict resolution,mental health ,breaking bad news, capacity and more was taught and explained with clear discussion. THANK YOU DR SHUM AND LGEM TEAM

FEEDBACK # 8

Beenish Manzoor

It was an amazing session started. Dr shum is best tutor and make things easy to learn and understand.

Very interesting topic to learn today from him which we face daily in ED .

Some important points are

1).Breaking bad news

2). Question and capacity

3). Conflict resolution

4). Mental health pathway

5). Escalating Pathway

We came to know about several acts like Mental health act .Mental capacity act 2005 which i never heard before.. Although i have some internet problem but still it was an amazing SBA session fully exam oriented

Thanks Dr Ashfaque Ahmed for providing this platform and amazing teachers.

proud Gem candidate

FEEDBACK # 9

Muzna Ahmed

Such an awe-inspiring session by one of the senior faculty members of Royal College, LGEM and Consultant NHS UK Dr. Shum Dev on very sensitive, critical and complex topic of legal issues of ED and role of ER consultant. He is no doubt made to teach this topic.

Honestly in our region, such topics are only confined to books and teaching facets, of which understanding is also not widely spread among students and post graduates.

Firstly of all I'm thankful and humbled to our respected tutors Dr Shum and Dr Ashfaque for this session because of them we are now familiar with these aspects such as conflict resolution , mental health act , escalation pathway , mental capacity act , breaking bad news

Doctors on daily basis face these nerve-wracking situations so they must know how to keep someone's medical information private, what to do if there's a problem with a patient's mental health, and when to get the police involved as personal safety is a prime rule in healthcare section.
Dr Shum presented these topics through SBA format QAs how exam body tests in SBA diet and how to not get grabbed into examiner's tricks.
With 100% reassurance every candidate appearing in exam will be benefited and this weak zone of most of people will not create hurdles anymore in paper solving.
Thank you so much Dr Ashfaque and Dr Shum for clearing the concepts

FEEDBACK # 10

Naveed Memon

Today's lecture conducted by Dr Shum, taught us in amazing way directly retained in our brain.
Very interesting to learn this today from him which we face daily in ED .
Learned todays are
Breaking bad news
Question and capacity
Conflict resolution
Mental health pathway
Escalating Pathway
Thanks Dr Ash for providing this platform and amazing best teachers.

FEEDBACK # 11

Imtiaz Ali Shah

An other excellent session by dr Shum regarding complex Ethical And Legal issues in ED . The session was interactive and based on SBA questions .The session was comprehensive very informative covering most of ethical and legal issues while dealing with the patients
The session covered Different components of ethical and legal issues faced by ED doctors in routine practice like confidentiality, conflict resolution, mental health act,capacity, breaking bad news and Esclating pathway etc.
The session was an eye opner for us that after the session we realized that how deficient we are in practicing these components which are very important.
Dr shum has his own style of teaching in which he explains the things in a very polite and comprehensive manner and his sessions always have lots of new learning points for us.
At the end I would like to thanks dr Shum for this excellent session and also to dr Ash for providing us this wonderful platform of learning in the form of London GEM.

FEEDBACK # 12

Syed Suhail Ahmad

An excellent and informative session on Complex Ethical & Legal Aspects For EM Physicians by Dr. Shum.

30 interesting and tricky SBA questions were discussed interactively that involved the commonest ethical and legal aspects like MENTAL HEALTH ACT, Capacity, Confidentiality, Conflict resolution, When to inform security/police and other common real life scenarios.

Important learning point was to always focus on the question, read it carefully, and then answer.

Thank you Dr.Shum, Dr.Ash, PEMA, LGEM 👍👍👍

FEEDBACK # 13

Bushra Imran

In today's tricky ,complex senerios based session with clearly high lighted the significance of how to read and then properly answer for coming successful result in exam.The topic on ethics and legal issues always hard to revise for me .The whole topic i,e conflict resolution,mental health ,breaking bad news, capacity and more was taught and explained with clear discussion. THANK YOU DR SHUM AND LGEM TEAM

FEEDBACK # 14

Qaisar Shah

In todays session Dr. Shum discussed about some of the difficult ethical and legal issues that doctors face. We talked about 30 tricky questions that doctors might come across, like how to keep someone's medical information private, what to do if there's a problem with a patient's mental health, and when to get the police involved.

The most important thing I learned was to make sure I understand the question before trying to answer it. Dr. Shum told us that it's not enough to just know the rules - you also have to understand what the question is really asking.

Dr. Shum covered lots of different topics during the talk, like how to deal with conflicts, how to assess someone's mental capacity, and how to tell someone bad news. It was really interesting and I'm glad I got to be a part of it.

Thanks to Dr Ashfaque ahmad and Dr Shum for this nice session.

FEEDBACK # 15

Sana Hameed

Really appreciate the efforts sir ash put in his trainees and the efforts sir and the team of tutors are putting to make us understand the importance of every small and important topic that needs to be covered like today we did ethical issues and confidentiality issues doctors have to face and come across and medical practice. And then for mrcem trainees to solves these issues in forms of scenarios for their SBA exam.

A great session and informative lecture by sir Shum.

FEEDBACK # 16

Dr Ruma Mustafa

Fantaboulus SBA session done by Dr.Shum.
You r all-time favourite teacher.....
I learnt so many things earlier and now also when I presented my mental health case it was a great experience.
After a long gap, u gave a great come back with full pack of knowledge, ur calmness, ur peacefulness, and the intellectual way of delivering lecture make lecture more interesting , absorbale, and unforgettable
As I learnt, so many things today are as follows
1. Overdose patient approaching scenario
2.Communication skills
3. Ethical principle (escalation pathway)
4.ETHICAL Decision-making for patient care
5.Good understanding
6.Conflict Resolution
7.Consenting patient
8.Assess capacity of the patient
9.Mental Capacity Act 2005
10. Advance Directives for Patient
11.Confidentiality
12. Patient illness Disclosure
13. Breaking the bad news
14. Decision-making scenario
15. Decision-making making scenario
16. Principle of Mental Capacity Act 2005
17. Section 5 of MHA
18. Assessing capacity scenario
19. Capacity Assessment scenario
20.Decision-making scenario
21. Seizure scenario Decision for driving
22.RTA collosion with multiple injuries scenario
23. Mentally ill patient scenario MHA sectioning
24.MHA sectioning for police power 136
25. Criteria for Fraser guidlines
26.Death declaration (cardiorespiratory exmn)
27. Pronounced dead in ED inquist,
coroner service
29. Complaint procedure in ED

30. Medical negligence in ED
Conclusion:
Communication dilemmas are common in ED
Ethical issues are common in ED
Medico-legal aspects are important concepts to grasp to ensure best patient care
Thanks alot Dr. shum for amazing SBA.
your collection was fabulous
thanks so much Dr. Ash & team
Dr. Ruma Mustafa

FEEDBACK # 17

Dr Nasir Hayat

This session was Amazing and wonderful presented. learned alot. Answered All the Questions.
attended an eye opening session by Dr Shum on Complex Ethical and Legal Issues. The session was based on around 30 questions which were tricky to solve but clearly highlighted the significance of reading the question thoroughly. Especially important is the last line of question - of what is being actually asked. Knowing the theory and guidelines is important but how the question understood is what plays an imperative part for being successful in the examination. Dr Shum beautifully covered the entire range of topics under the banner of ethical & legal concepts for example - conflict resolution, mental health act, escalation pathway , mental capacity act , breaking bad news and alot more .I would highly recommend it for ER physicians to join it. Proud to be LGEM candidate.

FEEDBACK # 18

Dr Aiman Nazir

It was brilliant session today to teach us legalities and ethics of the NHS. Dr SHum Dev made it interesting by bringing up wide range of topics and made the session interactive which is way better than reading it from books only. Ethical and legal issues topics is a bit complex and needs full attention and understanding while answering the questions. Breaking bad news, conflict resolution, mental health act was emphasized more which tells us its importance in exam, appropriate escalation pathways, medical negligence and many more! But today's session pointed our mistakes and made us aware on how to read and understand questions correctly. Dr Shum Dev explained about not only correct options but also explained why the incorrect ones were incorrect.
Thankyou so much Dr Dev for bringing up those challenging questions and explanations and made us learn what we are missing.
Dr Aiman Nazir
EMFP LGEM

FEEDBACK # 19

Dr Muhammad Ghayoor Khan

A wonderful session on Complex Ethical and Legal issues in Emergency Department was conducted today by Dr. Shum Dev.

He is a brilliant teacher, who covers such complex issues effortlessly and precise easy to understand explanations of all topics.

He discussed important aspects of Mental Capacity with emphasis on Mental Capacity Act 2005, Conflict Resolution, Confidentiality, Disclosure of information, Escalation Pathway, Breaking Bad news, patient consent and trauma cases with legal and ethical dilemmas.

He explained all in the form of 30 SBA questions which helped a lot in understanding the tricky ethical scenarios. I will be waiting for Dr. Shum Dev next session.

Thanks

Dr. Shum Dev and LGEM

Kind regards

Muhammad Ghayoor Khan

FEEDBACK # 20

Dr Mariam Nawaz

Sessions conducted by Dr Shum are always a pleasure to attend and this session was no different. We did 30 MCQs on ethical and legal issues with main focus towards intermediate prep. At the end of each MCQ we discussed the answers. It was a very interactive session by Dr Shum. Some confusing scenarios were also discussed making our concepts clear. Some of the Things we discussed are as follows

. Mental health act

. Capacity

. Confidentiality

. Consent

. Breaking bad news

. Escalation pathway

. Conflict resolution

And so much more

Thankyou so much Dr Shum and Dr Ash for this amazing session

Dr Mariam Nawaz

A proud GEM trainee

FEEDBACK # 21

Dr Noman Ahsan

Today's session was very important when it comes to Clinical practice on how to deal these difficult situations with patients or with attendants...Dr.Shum gave

us a broad understanding and taught us how to ace these tricky exam questions by concentrate on key words in the stem in order to save time and select best possible answer ...Topics discussed with 30 different scenarios and he explained every single question very well..Topics were Conflict Resolution, Escalation Pathway , Mental Capacity and Mental Health Act, Breaking Bad news ... Thanks Dr.Shum for this wonderful session..learned alot...

FEEDBACK # 22

Dr Azka Shamim

Aoa respected sir

Today after a long gap we were blessed with this opportunity to be taught by one of our favourite UK LGEM faculty Dr Shum Dev and it was really an eye opening session for us on complex ethical and legal aspects , as we learnt alot regarding how to study this important topic and what level of knowledge and information we must have to fully grasp this topic ,, not only for SBA but also while working on field.

Dr Shum Dev conducted the session in form of 30 SBA questions and explained the right answers in such an easy to remember way..

All the following important aspects were covered and highlighted.

*Conflict Resolution

*Mental health act

*Escalation pathway

*Mental capacity act

* Breaking bad news

*Confidentiality and disclosure of information

*Patient consent

*How to handle Trauma based scenerios

Infact it was really an impactful session and Dr Shum explained each and every question in a wonderful way.. not only the concept behind the question but also how to reach the correct answer.. how to read the statement and extract the exact information which is required.. how to understand the question with these terms like EXCEPT and WHAT NOT IS IMPORTANT...

Thank you so much Sir Dr Ashfaque Sorathia for arranging these amazing sessions for us and letting us being taught by best faculty

Proud LGEM trainee

Dr azka ✨

FEEDBACK # 23

Dr Amash Khan

Lecture by Dr Shum was of so much importance as it is taught less to the doctors but is essential for the correct management of the patients.His lecture

was MCQs based in which he teached some of the necessary legal issues in the Emergency department.

25th FEBRUARY 2023

EVENT NAME:

MRCP MARATHON SESSION ONE, 9 Hours With Dr Ash For GEM MRCP Trainees (Free) Course fee worth £499

DOCTORS FEEDBACK

FEEDBACK # 1

Dr Nasir Hayat

This session was Amazing and very well presented. I learned alot .
Golden session of teaching by matchless teacher and great mentor DR ASHFAQUE SORATHIA whose dedication towards students is appladable and 8 hrs of non stop learning and guidance gave a boost to exam preparation wd systematic revision of all important topics and highlighted d trouble areas as well. Additionally a guided approach to crash mcqs wd exclusion technique. unique way of teaching and guidance make it easy for us to exam focused study and sail through d toughest exam in one go inshallah. This session is an eye opener for me and help me to rectify my mistakes and emphasised to get complete grip on core knowledge as well as gt me the right way to focus on a book and extract the desired content and make the revision notes wd bullet point form for exam revision in d end in one go wd minimum time and effort. The guidance I gt through ti's session really shape and change my preparation strategy on guided lines of sir ashfaque and skills to crack exam qs. I m blessed to hv such great teacher who realy wanted us all to get our dreams and who really owe our dreams AS HIS OWN DREAM.. thank u so much sir for being our teacher and mentor and show us d right path .....Highly recommended for physicians to join it. Proud to be LGEM candidate.

FEEDBACK # 2

Dr Faiza Baig

It was golden time session. Worth attending for all of us. He emphasized on reading the book step by step with mcqs.
How to deal with our mistakes and how actually to read, SKIM and SCAN the book and how to make BULLET POINTS✨
Honestly I am speechless Dr Ash is a fantabulous person who has power to pull

out our Brain errors in a particular direction 🤩✨
I truly appreciate you and I enjoyed every minute of this lecture.
Thank you Dr Ash
May you have countless blessings and may all your prayers will be answered
Regards
Faiza baig

FEEDBACK # 3

Dr Ahmad Tanveer

Today's session was breath catching indeed. Brilliant session leads me to realize the importance of core knowledge is must to aquire and go through before doing MCQs blindly . Philip Karla's revision notes reviewed in just rapid run off but the improtant exam oriented points were highlighted well by Sir Dr Ash.

Cardiology skimmed up in just 1 hour 💪

The way Sir crushed the Pharmacology gave me a true sence of ⚡ we should learn alot by heart to get this knowledge software update before to attempt any MCQ. the largest and extensive Q bank even not give us the confidence to go through the exam day comfortably. To nail the uncertainty and confusion , core knowledge is must to skimmed up and then MCQ practice will do the rest to master it. The GIT was taught at the end like confusing points of Primary billary cirrhosis vs sclerosing cholangitis, hepatitis was skimmed up in just 10min 😁
Sir shredded more then 30% of Karla in this power pack session of about 8 hours. Salute to Dr Ash 's heroic teaching skills and the motivation to adopt and build our knowledge.

⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐ Getting Convinced to get back to book to adopt reading correctly to skim the knowledge is the best Part of foundation of this success story.
Last but not the least even after about 7 & 1/2 hours continuous teaching session Dr Ash throwed about 37 mcqs from GIT and every MCQ was a new bowl new technique by Dr Ash and make it a tough survival series indeed 😍
Sir in short i can only say
U r a brilliant teacher who is more concerned about our success then ourselves
Sir Will adopt this reading and that will surely add up in knowledge strenght in future. THANKYOU DR ASH
Regards

26th FEBRUARY 2023

EVENT NAME:

High Yield Neonatology For EM Physicians By Dr Mir Ahmed Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Amir Ashraf

Dr Mir has always been one of my favourite tutor , the reason why because he makes the understanding so easy with sinole concepts , easy for us to grasp and absorb . It always pleasure learning from Dr Mir and i also request Dr Ash , if possible please arrange more SBA sessions with Dr Mir . He not only gave the theoretical knowledge but his main focus was to understand the question , look for key points , how to exactly go for the right option . Everytime we just bumped to the answer but he always stopped and asked us to look for key words , this i suppose it an intellectual way to attempt exam , because even if you know your thing but you didn't pick up the key word , there are alot chances you might go wrong in a pressure situation .

Today the topics we learned :

- Neonatal resus Algorithm
- Apgar score
- neonatal jaundice
- neonatal sepsis
- congenital heart disease

And alot more ..

My special thanks to @Dr Ash for always bringing up unique ways of learning for us , He always know what his trainees need at what time and this was much needed session , very exam oriented . 👍👍

Once again thankyou @Dr Mir Saaduddin Ahmad , hoping to learn more from you . 😊

FEEDBACK # 2

Hareem Zakir

Excellent session by Dr Mir on neonatology. He makes stuff so easy to grasp through illustrations and go through the high yield stuff related to the exam as well as for the daily cases we encounter in ER . He made us understand how to differentiate between different kinds of neonatal jaundice, explained all the basics and step wise approach about neonatal Resuscitation

FEEDBACK # 3

Muhammad Azeem Imran

Feeling blessed to have an excellent session on High Yield Neonatology for ED Physicians . Learning points were

Approach to solve SBA,'s find key point , avoid destrectors and then find correct answer. Neonatal Resuscitation Algorithm , APGAR Scoring , Neonatal Jaundice , Neonatal Sepsis , Congenital cyanotic Heart Disease . I always admire of Dr Mir - the great teacher who knows what strategy is the best to impart knowledge to adult learners. His way of teaching style is superb ,taking help of illustration to clear concepts attract me more . I appreciate and Humbly respect for the energy he put to make these presentations for us . May Allah swt give him more power to empower the students Last but not least I pay my humble tribute to our worthy Mentor Dr Ash for bringing such a unique faculty on board for keeping us updated with knowledge. Jaza kum Allah khair Dr Ash.

FEEDBACK # 4

Rida Rana

Alhamdulillah attended a super amazing session by one of my favourite tutors Dr Mir on High Yield Neonatology for ER Physicians . It was such a well elaborative lecture primarily focused on adopting the correct approach when attempting the questions in MRCEM examination. Dr Mir highlighted the significance of identifying the key words in the question and then opting for the answer. His approach literally helped us in solving each question in less than a minute . The topics explained were related to Neonatal Resuscitation Algorithm, Apgar Score , Neonatal Jaundice , Neonatal Sepsis , Congenital Heart Disease and alot more .

I must mention that Dr Mir has an exceptionally amazing style of teaching in the most easy to learn pattern ..Thankyou Dr **Ashfaque Ahmed** for bringing such a unique faculty on board. AlhumdulliAAllah on being part of LGEM 👍😊

FEEDBACK # 5

Qaisar Shah

During today's session on neonatology SBAs, Dr. Mir Ahmad provided us with a brilliant display of high-yield information. He covered almost every aspect of neonatal emergencies:

Neonatal resuscitation algorithms

Physiological and pathological jaundice,

Early and late onset sepsis in neonates,

The causative organisms, and management.

Additionally, we covered

APGAR scores

Congenital heart diseases

Biliary atresia

The SBAs covered a range of topics, and Overall, I learned a lot during this session, and I want to thank Dr.Mir Ahmad, London Global Emergency Medicine and Dr. Ashfaque Ahmad for providing us with such an informative platform.

FEEDBACK # 6

Syed Suhail Ahmad

An absorbing session on **High Yield Neonatology For EM Physicians By Dr Mir Ahmed Consultant NHS UK**.

Included SBAs that covered topics

- APGAR scores
- Neonal Resuscitation Algorithms
- Important steps of neonatal resuscitation
- Physiological and Pathological Jaundice
- Neonatal Sepsis and its causative organisms
- Cyanotic heart diseases
- Biliary atresia

Important learning point was to always look for the key points in SBAs and then choose an answer accordingly

Looking forward to more such sessions on SBAs from Dr.Mir.

Thank you LGEM, PEMA 👍👍👍

FEEDBACK # 7

Bushra Imran

Today Was Amazing Interesting And Eye Opening Senerios Session On Neonatology Covering Topics Apgar Score Cyanotic And Acyanotichearr Disease, Neonatal Jaundice, And Taught Us How To Read Question Before Answering...

Thank You Dr Mir And Gem Team

FEEDBACK # 8

Ubaid Ur Rehman Khizir

Excellent session by Dr mir on neonatalogy

He taught us

APGAR SCORE

NEONATES RESUSCITATION

ALOGRITHM

CYANOTIC HEART DISEASES

ACYANOTIC HEART DISEASES

PHYSIOLOGICAL JAUNDICE

PATHOLOGICAL JAUNDICE

Dr mir explained everything with scenrio based questions

He told us to pick key words from lengthy scnerios

And focus on those key words to
Solve questions
Thanks dr ash for arranging sessions regarding exmamination point of view and also clinically important
Dr khizir LGEM TRAINEE

FEEDBACK # 9

Anila Zafar

Very amazing session by Dr Mir on Neonatology.
Excellent learning points on
Neonatal resuscitation Algorithm
APGAR score
Neonatal jaundice
Neonatal sepsis
Congenital cyanotic heart disease
Thank you Dr ASh and Dr Mir.

FEEDBACK # 10

Aqsa Yaqoob

An excellent session given by Dr. Mir on Neonatology and Resuscitation through different scenarios , especially When to give five inflation breaths and when to call for help for an unresponsive neonate. Other topics covered were neonatal sepsis,(early onset and late onset), physiological and pathological Jaundice , Apgar score , Cyanotic and Acyanotic heart diseases. He also taught how to identify key words in a question which helps us in reaching towards right answer .Thank you Dr. Mir and Dr.Ash for arranging such amazing session for us.

FEEDBACK # 11

Muzna Ahmed

When we see name of Dr Mir in header of lecture our energy bar goes straight up and excitement goes next level because each an every word taught by him was well perceived, absorbed and left us amazed.
Magnanimous gratefulness is dedicated to Dr Mir for his time and teaching and changing our outlook as an Er physician and imparting best methods
Secondly to Dr Ash who knows everything about trainees lackings and how to recuperate.
This high yield session put emphasis on neonatal section of SBA, how to crack it, what to look for when reading question, especially with long stems and more fancy details, try to highlight keywords where the entirety lies, which conserves time.
Through QAs format Dr Mir explained newborn resus guideline every step of it and how to implicate them while solving question.

The most highlighted topics are:-
APGAR score, congenital heart diseases, jaundice, early onset sepsis, difficult scenarios encountering outside ED, resus scenario, what would be best management step or best possible next step, in newborn breathing component is the cornerstone and most important regarding resuscitation so rescue breathing comes at top because hpoxia is the major cause of cardiac arrest.
Thank you so much Dr Mir for these valuable session we always look forward to learn more from you and listen to your talk and thank you Dr Ash.

FEEDBACK # 12

Mina Khan

Todays session was very exiciting , in a way that dr Mir engaged us in his teachings and made us brain storming with the questions/SBAs, he briefed all important topics like apgar scoring on birth/types of jaundice/resusitation algorithm/ congenital heart diseases/antibiotics/first line tx/ and gram+/- organisms.
Learned alot which needs to be implemented practically as well
Thank you **London Global Emergency Medicine** and Dr Ashfaque for providing us with such platform 🌸

FEEDBACK # 13

Uzma Shaikh

When I think of SBA preparation I always remember DR Mir Ahmed.
He is mascot of sba prep. Today yet another brilliant display of high yield neonatology sbas was done, he taught us newborn resustication algorithm, neonatal sepsis, neonatal jaundice, cyanotic heart diseases and much more.
Thank you for those magnificently compiled sbas.

FEEDBACK # 14

ناصر فاطمہ

It was an amazing and excellent session conducted by our respected mentor. He taught us
APGAR score.. (multiple scenarios)
Neonatal resuscitation (multiple scenarios for next management step according to guideline)
Sepsis un neonates (and why benzylpenicillin and gentamicin are 1st line)
Physiological and pathological jaunduce
Billiary Atresia
Congenital Heart disease
And before teaching us correct answer.. he taught us the correct approach.. that what tips and tricks can be use to solve MCQs in order to save time and hustle..
jazakALLAH khairan kaseera Dr Mir.. and jazakALLAH khairan kaseera Dr Ash for arranging all this so nicely..✨💎

FEEDBACK # 15

Imtiaz Ali Shah

An excellent session by dr Mir regarding neonatology SBAs covering different aspects of neonatal resuscitation and emergencies. It was an interactive session based on different clinical scenarios. We covered variety of important topics including

APGAR SCORE

NEONATAL RESUSCITATION.

SEPSIS IN NEONATES.

PHYSIOLOGICAL AND PATHOLOGICAL JUINDICE.

CONGENITAL HEART DISEASES

BILIARY ATRESIA etc

The important thing we learnt today from exam point of view was to pick up a key word from SBA and then select the answer

Over all it was a wonderful session by dr Mir. He made the things easy to understand and we learnt a lot from today's session

At the end I would like to thanks dr Mir for this amazing session and also to dr Ash for providing us this wonderful platform of learning in the form of London GEM.

FEEDBACK # 16

Zegham Abbas

Amazing lecture by dr Mir on high yield topic of Neonatology through resus guideline every step of it and how to implicate them while solving question.

The most high yield topic are:

APGAR score

Congenital heart diseases

Jaundice

Sepsis

G6PD (HEINZ bodies Bite Cell)

Exam oriented and Scenario based questions of different topic were discussed with explanation thanks Dr Mir and Dr Ash for amazing SBA teaching session.

FEEDBACK # 17

Rajab Abbas

Today's session by Dr MIR was much awaited because Dr Mir is everyone's favourite, the way he teaches, explains and provides tricks how to approach in the exam is unique and really easy to grasp.

Main learning of today's session are: first identity the key words and relevant data in the question then it would be really easy to pick up the right answer.

And other is just focus on what is being asked.

Dr Mir made it so simple that we learned how to attempt and crack the exam.

He discussed high yield SBA related to neonatal resuscitation much briefly.
It was an interactive session and MashAllah every LGEM CANDIDATE is so enthusiastic in learning and is getting equipped with standard medicine practices and knowledge day by day.
Thankyou Dr Mir Ahmed and Dr Ash for this exam orientated session. Looking forward to have more sessions with Dr Mir
A proud LGEM candidate
Dr Rajab Abbas

FEEDBACK # 18

Sana Hameed

It was an hour session on the different scenarios of neonatology especially for SBA preparation.
Sir mir actually taught us how to attend a mcq in the exam what key points to look for and depending on those words what answers the question requires. So much covered in the amazing session with such easy pathways to remember and memorize the topics. Topics covered include from neonatal resuscitation to sepsis in neonates. Really grateful for such amazing lectures arranged by sir ash. Hopefully to accomplish our mentor's dreams for us.

FEEDBACK # 19

Dr Ruma Mustafa

A brilliant session by Dr. Mir Ahmed High yield SBA covering all important Neonatalogy in ED very comprehensive learning in a short span Mashallah
I learnt many points, and some are as follows
How to identify key points /key phrases/skiping the part of the question
SBA
1.Apgar Score
2. Congenital diseases PDA
3.V.next step after delivery Dry baby
4.CynoticCHD+murmur+blue on feeding
5.CynoticCHD+blue on feeding + murmur=TOF
6.Newborn +heinze bodies + bite cells=6GPD
7.Newborn 8d+chalky stool + wt.loss + yellow color =Biliary Atresia
8.Newborn 5min +cynotic hand &feet + rest normal Apgar score=9
9. Resuscitation +most neonatal deliveries=warming drying and stimulation
10.Baby resus in ED + no cry + dry raped =assess tone, breathing, heart rate
11.3 wk newborn + blue on feeding + inc. SVR/inc. preload TOF=squatting
12. Newborn not breathing after Assessment next step=5inflation breath
13.Baby delivery in ED toilet + still & silent + no breathing=call for help
14. Neonatal sepsis + most likely causative agent=Group B. streptococcus

15.Baby not breathing + gave 5 inflation breath + no heart sound next step =continue for 30 sec ventilation & re assess
16.Newborn Baby + hyponotic + cynotic +apnoeic + Bradycardia first management=warming drying &stimulation
17. Features not a part of APGAR SCORe =O2 sat
18. 1 week infant + pyrexic + floppy + unresponsive with bulging fontanelle + L.P G-rods= E. Coli
19.Newborn+most concern complication of neonatal jaundice=kernicterus
20.7d neonate + fever + drowsiness + difficulty breathing investigation= Blood C/S & L.P
21. Feature most concerning with neonatal jaundice =jaundice first appearing within 24hrs
22.Neonatal sepsis + most appropriate treatment=benzylpenicillin +gentamicin
23.2 weeks, baby + lips blue + difficulty feeding distressed +breathless =Tricuspid atresia CHD
24. The most common cause of jaundice
in neonats=Physiological jaundice
25. Recommended compression to ventilation ratio in neonates in life support =3:1
26. In term, infant jaundiced most likely Physiological =Serum Bilirubin<5mg/dl/24hrs in the first 2-4 days
27. Risk factor for neonatal jaundice =Prematurity
Superb knowledge shared by Dr.Mir Ahmed
Great effort.
Every SBA was a full pack of mastery Mashallah after having ur session, i feel to have a strong grip to tackle any difficult question in a smooth way with no difficulty inshallah!!!
JazakAllah khair for such amazing lectures
Highly appreciated!!
these types of lectures should be arranged frequently thanks a lot
Thanks a lot, Dr. Asfaque n team
Dr. Ruma mustafa

FEEDBACK # 20

Dr Nasir Hayat

This session was Amazing and very well presented.
When we see name of Dr Mir in header of lecture our energy bar goes straight up and excitement goes next level because each an every word taught by him was well perceived, absorbed and left us amazed.
Magnanimous gratefulness is dedicated to Dr Mir for his time and teaching and changing our outlook as an Er physician and imparting best methods

Secondly to Dr Ash who knows everything about trainees lackings and how to recuperate.
This high yield session put emphasis on neonatal section of SBA, how to crack it, what to look for when reading question, especially with long stems and more fancy details, try to highlight keywords where the entirety lies, which conserves time.
Through QAs format Dr Mir explained newborn resus guideline every step of it and how to implicate them while solving question.
The most highlighted topics are:-
APGAR score, congenital heart diseases, jaundice, early onset sepsis, difficult scenarios encountering outside ED, resus scenario, what would be best management step or best possible next step, in newborn breathing component is the cornerstone and most important regarding resuscitation so rescue breathing comes at top because hpoxia is the major cause of cardiac arrest.
Thank you so much Dr Mir for these valuable session we always look forward to learn more from you .Highly recommended for ER physicians to join it.

FEEDBACK # 21

Dr Ghayoor Khan

It was again an amazing session by Dr.Mir on neonatology.
He is always best with the his slides and explanation and we just love his teaching approach.
He made concepts to imprint so well that no one can forget in any way.
It was great session,we covered almost every aspect of neonatal resuscitation and emergencies and discussed all topics including;
-Algorithms
-Physiological/pathological jaundice/
-Early and late onset sepsis in neonates
-Causative organisms
-Management
-APGAR score
-Congenital heart diseases.
Feels blessed to be taught by mentors like Dr.Mir.
Waiting for next session.
Thanks
Dr.Mir And LGEM
Regards
Muhammad Ghayoor Khan

FEEDBACK # 22

Dr Aiman Nazir

It was a great learning session today by Dr Mir . He told us tips and tricks to read questions efficiently and quickly, focusing on the actual key words while reading questions so that we may not go wrong in understanding what's been asked in it.
He made us learn how to quickly scan the question while focusing on key words.
Neonatology topics were covered extensively and after each answer Dr Mir explained its pathology/physiology to help retain information in our minds . A Lot of emphasis was on neonatal resuscitation, APGAR score, Jaundice , CVS pathologies and sepsis . A lot of questions were covered in a short time and all of them were explained comprehensively .
It was great learning from Dr Mir and he made sure that all of us were actively involved in answering questions. Wish to have more sessions from Dr Mir in future.
Thank you so much for taking out time and teaching us neonatology that too very beautifully because I find it difficult to retain.
Aiman Nazir
EMFP LGEM

FEEDBACK # 23

Dr Mariam Nawaz

It was a fantabulous session by Dr Mir. Dr Mir's sessions are always amazing and just reading his name in the mail as the tutor makes me excited. The way he delivers the topic is rarely seen and not to forget his amazing presentations which make the topics even more intresting and easy to retain. We did 28 SBAs on neonatology in this session, discussing each answer along the way. Some of the Things we learned are as follows
. Apgar score
. Newborn lifesupport algorithm
. Heinz bodies and G6PD deficiency
. Cyanotic heart diseases
. Newborn sepsis
And so much more
Thankyou Dr Mir and Dr Ash for this session
Looking forward to having more sessions with Dr Mir
Dr Mariam Nawaz
A proud GEM trainee

FEEDBACK # 24

Dr Azka Shamim

Aoa respected sir

Today we had another amazing session for this week by our favourite LGEM faculty member Dr Mir Saaduddin (consultant NHS UK).. and we really wait for the sessions conducted by Dr Mir because he teaches us in such an interesting interactive and amazing way that we really don't want the session to come to end..

Today we were taught regarding high yield SBA questions covering neonatology and Dr Mir not only made the whole subject very easy to learn and understandable but also explained how to approach the questions..

As the options available for each question are not single correct answer but single best answer, Dr Mir guided regarding picking up the key points in the stem, what is being asked , and how to avoid distracters and irrelevant information...

Following important topics were covered in this one hour power pack session:

* neonatal jaundice physiological and pathological
*Biliary atresia
*Early and late onset neonatal sepsis
*Neonatal resuscitation algorithm
*Congenital cyanotic heart diseases
*sepsis organisms
*APGAR score

Infact it was a comprehensive session and a lot more important points were highlighted and we are eagerly waiting for more such sessions.. thank you so much Dr Ash for arranging these amazing teaching sessions for MRCEM trainees .. we are really blessed to be under your supervision

Proud LGEM trainee

Dr azka ✨

FEEDBACK # 25

Dr Afifa Younis Raja

Greeting of the day!!

My favourite mentor delivered a great session on High Yield Neonatology for ER physicians By Dr Mir Ahmed Consultant NHS UK, the session was so tactfully organized in a question and answer session, the great part was how he guided us to skim through the question and pick the KEY WORD and answer the questions. This approach will definitely help us to save time by skimming through the non-essential part of the question stem by picking the keyword we can have a targeted approach and reach the right answer quickly. The topics we covered:

- APGAR score
- Heinz body

- Neonatal resuscitation algorithm
- Neonatal sepsis (early and late onset)
- Pathological Neonatal jaundice
- Physiological neonatal jaundice
- Cyanotic and acyanotic heart disease

Thank you Dr Ash for always picking a great topic and an even great mentor to tutor us.
Kind Regards,
Dr Afifa

FEEDBACK # 26

Dr Noman Ahsan

Today's session was all about Neonatology. Lecture was all exam based and very well prepared and presented by Dr. Mir...He emphasised to look for key points in the stem and taught us a technical yet crucial approach to use while answering questions in exam to save time ...Topics discussed during sessions are Congenital Heart disease, Jaundice (Physiological and pathological), Sepsis (Early and late onset along with first line treatment), APGAR Score, Neonatal Resuscitation (very important and tricky topic as per examination , asking about different scenarios of delivery where neonate don't cry or breath or move and asked for Best possible Next step or best management step).
Overall Dr. Mir Brilliantly explained these tricky questions and answered our queries also...
Thanks Dr. Mir and Dr. Ash for this wonderful Lecture...
Dr. Noman Ahsan

FEEDBACK # 27

Dr Amash Khan

Today's lecture by Dr Mir Ahmed was a wonderful session on some of the important ER related issues which was BCQs based in which he taught about APGAR score, neonatal life support, neonatal infections; related early onset and late onset, along with the antibiotics to be administered and on neonatal jaundice.
Thank you Dr Mir for your lecture and wish to have many more.

26th FEBRUARY 2023

EVENT NAME:

MRCP Marathon Session 2 With Dr Ash for GEM MRCP Trainees Course Fee worth £499 (Free GEM Trainees)

DOCTORS FEEDBACK

FEEDBACK # 1

Zeeshan Ayaz

This was the 2nd day of MRCP marathon with dr Ash it was one of a rare occasion that I was able to concentrate continuously for so many hours. he made us believe that nothing is impossible if you are focused to achieve your goal.
Today Dr Ash covered
Whole Endocrinology in about 2 & 1/2 hr discussed from types of Hormones, mechanism and duration of action. Types of 2nd messengers involved.
Vit D is among steroid hormones and act like steroid hormone.
CALCIUM PTH VIT D axis
Hormones in pregnancy
Investigations to access excess and deficiency of hormones like Insulin stres test for GH excess and
Synacthen tests for ACTH
Prolactin and factors effecting.
Complete discussion of Thyroid hormones Thyrotoxicosis hypothyroidism diagnostic tests .
Pseudohypoparathyroidism
Hypo and hyperthyroidism
Congenital adrenal hyperplasia.
Diabetes inspidus
Cushings disease cushing syndrome.
Addisons conns
Diabetes
Haematology it's basic And it's clinical concepts
Anaemias defination clinical features causes
Macrocytosis (1) with Normal bone marrow (liver diseases .alcohol, myxedema pregnancy) (2)with hematological diseases(myelodysplasia, myeloproliferative disorders, aplastic anemia ,myeloma)
Thalassaemia
Aplastic anaemia
Iron metabolism :Fe2+ (ferrous iron) much better absorbed than Fe3+ (ferric iron)
Sickle cell disease (valine is substituted for glutamic acid in position six of the β chain. Precipitating factors for sickling are: hypoxia, dehydration, infection)
indications for exchange transfusion:
· Frequent severe sickle pain crisis
· Central nervous system sickling
· Priapism

· Chest syndrome not responding to conservative management
· Preoperatively or in pregnancy if there is a bad sickling history
Hydroxycarbamide (Hydroxyurea) is first line in the prevention of acute crises in sickle cell, and acts by increasing foetal haemoglobin (HbF)production
Hemolytic anemias Intravascular=>MRCGP(mnemonic)=> mismatched blood transfusion, red cell fragmentation: heart valves, TTP, DIC, HUS/cold autoimmune haemolytic anaemia, G6PD deficiency and paroxysmal nocturnal haemoglobinuria. In intravascular haemolysis, free haemoglobin is released which then binds to haptoglobin decreasing its levels . Free haemoglobin is excreted in the urine as haemoglobinuria, haemosiderinuria. Extravascular haemolysis(spleen)=> haemoglobinopathies: sickle cell, thalassaemia /hereditary spherocytosis, haemolytic disease of newborn, warm autoimmune haemolytic anaemia
Heriditary spherocytosis
PNH (Features are pancytopaenia, haemoglobinuria: classically dark-coloured urine in the night and thrombosis e.g. Budd-Chiari syndrome
MAHA (TTP, HUS,DIC,)
Haematological malignancies
ALL (good prognosis) AML (Auer rods ,M3 (vitamin a analogue used in its treatment)
CLL(is caused by a monoclonal proliferation of well-differentiated B-lymphocytes . It is the most common form of leukaemia seen in adults. Ix=> immunophenotyping is IOC) Rx is FCR
CML (BCR-ABL Philadelphia chromosome translocation , tyrosine kinase inhibitor i.e imatinib is used for treatment)
Remember in leukemias cns involvement is low while in lymphomas it is high
Hodgkins (young patient
Most common type is nodular sclerosing
Best prognosis is lymphocyte predominant while lymphocyte depleted is poor prognosis
AND NON HL (elder patient and extranodal involvement is common then HL
That Marathon session was worth attending and it surely gave us direction on how to prepare for MRCP exams .
I am surprised to see Dr ash commitment towards this program.
We are looking forward for such sessions in near future. Thank you Dr Ash for that wonderful session.

FEEDBACK # 2

Mukhtiar Pathan

Excellent ❤️

FEEDBACK # 3

Ahmad Tanveer

Thankyou Sir it will be a great Session INSHA ALLAH .

FEEDBACK # 4

Rizwan Siddeq

I attended the Dr Ashfaque Ahmed's marathon lecture regarding the MRCP exam preparation and I would like to share my feedback.

This 2 days crash course was extremely informative and the he had an excellent knowledge of the exam. The material covered was well-structured, starting with an overview of the exam and then providing detailed information about the different components. A number of illustrative examples were provided to demonstrate the practical aspects of the exam. This was especially helpful for visual learners.

He also provided a clear explanation of the test format and tricky mcq, he also touched upon potential strategies for success and the importance of staying motivated throughout the preparation process.

Overall, the lecture was beneficial for anyone considering taking or who is already enrolled in the MRCP exam.He did an excellent job of breaking down the study material and providing a comprehensive overview of the exam. I would highly recommend attending a similar sessions if you are planning to take the exam, He covered endocrinology and Haematology on 2nd day and On 25/2/23 we did cardiology, whole of pharmacology and gastroenterology. Thats a great experience with the 16 hours of teaching about MRCP exam. Dr ash answer all my questions in a timely and clear manner. I was able to understand the material easily and felt confident in my ability to use the study material learned and the approach when I have to study for the MCP exam . In nutshell , it was a very informative and enjoyable course that am glad was able to take. Dr ash is doing superb job 👏👏👏👏 he is trying his best to ensure the success of his trainee , this is the best part of the program.

FEEDBACK # 5

Dr Nasir Hayat

This session was Amazing and very well taught and organized.I learned alot.

I am writing to express my sincere appreciation for the wonderful lecture that you delivered on over all topic of endocrinology hematology and its basic concept

Your delivery was not only informative but also engaging and inspiring. Your ability to convey complex ideas and concepts in a simple and clear manner was truly impressive. I particularly enjoyed the way you incorporated real-life examples and stories to illustrate your points, which made the content more relatable and memorable.

Your expertise on the subject matter was evident, and it was evident that you

had spent a considerable amount of time preparing for the lecture. It was clear that you are passionate about your field, and your enthusiasm was contagious. Your presentation style was impeccable, and the use of visual aids and reading each and every element from the book added much color to ur presentation and the overall impact of the lecture was outstanding . You maintained a good pace throughout the session, ensuring that everyone could follow along and absorb the information.
Overall, your lecture was one of the best that I have attended, and I am truly grateful for the opportunity to have been there. It was an inspiring and thought-provoking experience, and I left feeling motivated to learn more about the way u teach and guidance
Once again, thank you for sharing your expertise and insights with us. Your lecture was truly exceptional, and I look forward to attending more of your talks in the future. May u b bless with countless shower of Almighty.Highly recommend for physicians to join it.Proud to be Lgem candidate.

FEEDBACK # 6

Dr Faiza Baig

I truly believe that all of us have a great time and days ahead by attending this power pack session.

It was quite remarkable✨✨
Dr Ash gave a lovely example

“Dive deep in the deep sea to find a pearl💎”

He explained how to skim through a deep ocean and find a treasure💫
He covered each and every part of these chapters
cardiology, pharmacology, gastroenterology and mcqs
Vast topic endocrinology
Vast topic heamatology
And basic concepts
Again i would say appreciative, helpful and motivated. And waiting for next session

Thank you Dr Ash✨🤩
Regards,
Faiza Baig

7th JANUARY 2023

EVENT NAME:

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

DOCTORS FEEDBACK

FEEDBACK # 1

Babar Hussain

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

FEEDBACK # 2

Syed Suhail Ahmad

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

Excellent case presentations by Dr.Nouman and Dr.Shafiq to sum it all up.
Thank you London Global Emergency Medicine and Pema-Uk 👍👍👍

FEEDBACK # 3

Qaisar Shah

Dr. JACOB gave a detailed session on COPD (chronic obstructive pulmonary disease) management in the emergency department. COPD is defined as having

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

FEEDBACK # 4

Yasir Dilawar

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

FEEDBACK # 5

Javeria Wali

Brilliant session on COPD conducted by Dr. Jacob baby on 7th January, 2023. He covered a lot of important points including and not limited to definition of COPD, Diagnostic criteria, MRC scale with helpful mnemonics, causes of COPD, COPD components namely
Chronic bronchitis & emphysema explained in extreme detail, important Clinical examination points of Emphysema and chronic bronchitis
Differential diagnosis, Investigations and management tO reduce symptoms and reduce exacerbation risk, criteria for NIV in COPD explained in detail.

FEEDBACK # 6

Bushra Imran

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

FEEDBACK # 7

Imtiaz Ali Shah

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

We also learnt about differential diagnosis of COPD AND ASTHMA.

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

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

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

It was a wonderful session and dr Jacob made the things easy and understandable. It was a session full of new knowledge and learning points. The session ended with two short cases presented by dr nauman and dr shahid.

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

FEEDBACK # 8

Ghulam Saddique Saddique

Thorough and detailed session conducted by Dr.Jacob

COPD explained as having Cough,breathlessness,

sputum production,chronic progressive and persistent symptoms.

Diagnostic points

Suspected diagnosis in >35yr of age known smoker or exertional breathlessness.

Risk factors are Smoker and Environmental smoke

MRC scale explained in detail. From grade 1 to grade5.

Most common causes of COPD explained.

Tobacco smoking

Occupational exposure in coal grains and silica exposure

Air pollution

Genetics -alpha 1 anti trypsin deficiency in younger people.

Past Ho of Chest infection in child hood.

Asthma may be a risk factor for COPD.

COPD has 2 components

Ch bronchitis & emphysema

Emphysema types
Centrilobular in smokers
Paraseptal
Panacinar in A1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examination points
Barrel chest in Emphysema
Cricosternal distance reduced less than 3 fingers
Cyanosis in Blue Bloaters
PINK Puffers pink skin
Key S/s pursing of lips
Use of accessory muscles
Inc AP diameter of chest
Heart sounds loudest a epigastric
D/D
asthma
HeartFailure
BRONCHIECTASIS
Tuberculosis
bronchiolitis obliterens
Differentiation between COPD & Asthma
Explained in detail
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
FEV1 >80 % mild
FEV1 50--79% moderate
FEV1 30--49% severe
FEV1 < 30% very severe
Investigations discussed in detail
Sputum culture.
Routine blood
ABGs
Serial home Peek flow measurement
ECG / Pro BNP / ECHO for cardiac failure or cor pulmonale.
CT Thorax to find any other lung pathology
Serum a1AT levels if younger age of symptoms and with minimal or no smoking history .

TLCO
Emphysema on CT is an independent risk factor for Lung CA.
MANAGEMENT discussed
Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
OXYGEN THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV IN Exacerbations
Abx Azithromycin role in COPD in non smokers only
ABCD COPD ASSESSMENT TOOL EXPLAINED.
Pharamcological treatment alogrithm by Gold Grades discussed.
Inclusion exclusion criteria for NIV in COPD explained well in detail.
It was a detailed comprehensive session by Dr Jacob .
At the end 2 case presentations by Dr Nouman and Dr Shafiq was interesting and detailed investigated cases of COPD exacerbation .
Thanks to Dr Nouman and Dr Shafiq for presentations.
Thanks to be a part of London GEM Programme

FEEDBACK # 9

Suhail Ahmed

Todays session was amazing contains alot of information
COPD defination.
Diagnostic points
Suspected diagnosis in >35yr with MRC scale explained in detail.
Most common causes of COPD explained.
COPD components
Ch bronchitis & emphysema
Emphysema types
Centrilobular in smokers
Paraseptal
Panacinar in a1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examination :
Barrel chest in Emphysema
Cricosternal distance reduced
Heart sounds loudest a epigastric

Differentials: asthma ,HeartFailure BRONCHIECTASIS
Tuberculosis
bronchiolitis
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
Investigations discussed in detail
Sputum culture.
Routine blood
ABGs
Serial home Peek flow measurement
ECG ,Pro BNP, ECHO for Heart failure.
CT Thorax to find any other lung pathology.
MANAGEMENT :
discussed Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
O2 THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV.
Abx Azithromycin role in COPD in non smokers.
alogrithm by Gold Grades discussed.
criteria for NIV in COPD explained well in detail.
Thank you Dr. Ash and Dr. Jacob Baby.

FEEDBACK # 10

Dr Leela Ram

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

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

FEEDBACK # 11

Dr Warda Yawar

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

FEEDBACK # 12

Dr Nasir Hayat

Todays session was amazing and wonderful presentation,learned alot extraordinary contains alot of material
COPD defination explained as having Cough, breathlessness,

sputum production, chronic progressive and persistent symptoms.
Diagnostic points
Suspected diagnosis in >35yr of age known smoker or exertional breathlessness
MRC scale explained in detail.
Most common causes of COPD explained.
Tobacco smoking
Occupational exposure in coal grains and silica exposure
Air pollution
Genetics -alpha 1 anti trypsin defciency in younger people.
Past Ho of Chest infection in child hood.
Asthma may be a risk factor for COPD.
COPD has 2 components
Ch bronchitis & emphysema
Emphysema types
Centrilobular in smokers
Paraseptal
Panacinar in a1ATD
a1ATD AR disease discussed
Serum electrophoresis to diagnose.
Clinical examation points
Barrel chest in Emphysema
Cricosternal distance reduced
Cyanosis in Blue Bloaters
PINK Puffers pink skin
Key S/s pursing of lips
Use of accessory muscles
Inc AP diameter of chest
Heart sounds loudest a epigastric
D/D asthma, Heart Failure BRONCHIECTASIS
Tuberculosis
bronchiolitis obliterens
Differentiation between COPD & Asthma
Explained in detail
Diagnostic
post bronchiodilator
Spirometery FEV1/FVC <70%
Grading severity of obstruction on the basis of FEV1
Investigations discussed in detail
Sputum culture.
Routine blood

ABGs
Serial home Peek flow measurement
ECG / Pro BNP / ECHO for cardiac failure or cor pulmonale.
CT Thorax to find any other lung pathology
Serum a1AT levels if younger age of symptoms and with minimal or no smoking history .
TLCO
Emphysema on CT is an independent risk factor for Lung CA.
MANAGEMENT discussed
Stable COPD TO reduce symptoms and reduce exacerbation risk.
STOP SMOKING
OXYGEN THERAPY
BRONCHODILATORS
LABA
LAMA
LABA + LAMA
LABA + LAMA +ICS
ROLE OF NIV IN Exacerbations
Abx Azithromycin role in COPD in non smokers only
ABCD COPD ASSESSMENT TOOL EXPLAINED.
Pharamcological treatment alogrithm by Gold Grades discussed.
Inclusion exclusion criteria for NIV in COPD explained well in detail.
It was a detailed comprihensive and power pack lecture by Dr Jacob excellent Sir
At the end 2 case presentations by Dr Nouman and Dr Shafiq was interesting and detailed investigated cases of COPD exacerbation .
Thanks to Dr Nouman and Dr Shafiq also for nice presentations. I learned a lot and highly recommended for ER physicians and physicians to gain the knowledge and get the practical skills to have bright future and be best doctor.
Proud to be LGEM candidate Mrcem and Mrcp. All the credit goes to SIR Dr. Ash for arranging such session for Doctors.

FEEDBACK # 13

Dr Amash Khan

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

FEEDBACK # 14

Dr Ghayoor Khan

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

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

. Smoking cessation is the key to good treatment outcome

. Asthma should be ruled out in any COPD presentation

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

. Alpha 1 antitrypsin deficiency was taught in detail

. NIV was taught in detail

We learned about the ABCD approach to COPD and managed details.

Emphysema and chronic bronchitis are types of COPD. Imp differentials and how to rule them out was taught

It was a very informative session.

Thank you

Dr Jaxob and Dr Ash

Regards

Muhammad Ghayoor Khan

FEEDBACK # 15

Dr Shahid Ahmad

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

lecture started with the classification, risk factors and moving on to further diagnostic criteria and accurate management.

new things for me in this lecture were

•ABCD COPD assessment tool,

•measuring crico-sternal distance in patient with COPD.

case based discussion was done at the end, which was very informative as well.

Thanks

Regards

Dr Shahid Ahmad

FEEDBACK # 16

Dr Mishal Shan

The lecture by Dr Jacob was quite comprehensive and a lot of important clinical pointers with exam clinchers were delivered in the talk. He talked about taking a comprehensive history and doing a clinical examination in COPD patients. We were taught to approach the patient systematically and not to miss signs of

raised pulmonary pressure. We also learned the management of stable COPD as well as exacerbation. It was a good refreshment of our knowledge.
Regards,
Mishal Shan Siddiqui

FEEDBACK # 17

Dr Nouman

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

FEEDBACK # 18

Dr Ghazala Sheikh

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

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

. Emphysema description (pink puffers)
~Centiacinar
~Panacinar
~Alpha1 antitrypsin deficiency
. Chronic bronchitis (blue bloaters)

- Examination features of COPD
- Differential Diagnosis

. TB
. Central Airways obstruction
. Bronchiectasis
. Asthma

- Difference between Asthma and COPD
- Treatment strategies

. Smoking cessation
. Inhaled therapy

. SABA
. LABA
. LAMA

FEEDBACK # 19

Dr Ahmad Tanveer

Todays session was extraordinary contains a lot of material
COPD definition explained as having Cough, breathlessness,
sputum production, chronic progressive and persistent symptoms.
Diagnostic points
Suspected diagnosis in >35yr of age known smoker or exertional breathlessness
MRC scale explained in detail.
Most common causes of COPD explained.
Tobacco smoking
Occupational exposure in coal grains and silica exposure
Air pollution
Genetics -alpha 1 anti trypsin defciency in younger people.
Past Ho of Chest infection in child hood.
Asthma may be a risk factor for COPD.
COPD has 2 components
Ch bronchitis & emphysema
Emphysema types
Centrilobular in smokers
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Serum electrophoresis to diagnose.
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post bronchiodilator
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Grading severity of obstruction on the basis of FEV1
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At the end 2 case presentations by Dr Nouman and Dr Shafiq was interesting and detailed investigated cases of COPD exacerbation .
Thanks to Dr Nouman and Dr Shafiq also for nice presentations.

FEEDBACK # 20

Dr Zaid Ahmed Ansari

Dr Jacob conducted an expansive lecture on COPD and its management protocols. Dr Jacob elucidated in detail the various risk factors for COPD, including smoking, occupational exposure, pollution, asthma and genetics. we had a comprehensive session regarding COPD and its managment by dr Jacob.

Dr Jacob also highlighted the difference between bronchitis and emphysema, with focus on its various types and clinical presentation. The genetic factors that create a predisposition to COPD was very fascinating, especially, A1ATD and the inSERPINA1 gene mutation in chromosome 14..
Dr Jacob also went in great detail about the differential diagnosis of COPD and asthma, and illustrated the diagnostic protocols for COPD by post bronchodilator spirometry.
He also comprehensively explained:
Managment of COPD withABCD COPD assessment
SABA, SAMA and LAMA with LABA regime +ICS
Dr Jacob as always delivered on the premise succintly and effectively.

FEEDBACK # 21

Dr Azka Shamim

Aoa respected sir
Today on 7th January we had an amazing session with Dr Jacob baby regarding COPD management.. it was a comprehensive 2 hour lecture with so much Up to date knowledge and guidelines... Dr Jacob covered the whole topic starting from its clinical picture, assessment, management and cleared so many concepts.
We covered following important learning points:
*True definition of COPD
*When to suspect a diagnosis
*MRC and mMRC dyspnea scale
*Risk factors
* Chronic bronchitis and types of emphysema
*A1ATD genetics
*Clinical examination findings
*Role of post bronchodilator spirometry and other investigations
*Management plan regarding stable COPD and acute exacerbations
*ABCD assessment tool
*Pharmacological treatment plan and NIV
*Long-term oxygen therapy
In fact it was a wonderful session conducted by Dr Jacob and many thanks to Dr Ash for arranging such important sessions for LGEM trainees by the NHS consultants..
Proud LGEM trainee
Dr Azka ✨

8th JANUARY 2023

EVENT NAME:

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

DOCTORS FEEDBACK

FEEDBACK # 1

Warda Yawar

This was an excellent lecture and i have learnt alot from it after this presentation i feel more confident, from cases to treatment everything was on point i never had this much understanding on this group of diseases and in GP setup they give treatment of asthma and tb for dpld which i could also do if I didn't attend this lecture.

Seriously change my diagnosis of many patients which I have seen already but didn't know how to diagnose and investigate before

and from now, my opinion of treating these patients will be different thank you dr Ash for this lecture and dr wasib is one of the best respiratory consultants out there

he also told us about different exposure to plus from different cities of Pakistan which was so kind of him so we couldn't mix the diagnosis

Thank you for this amazing lecture, proud to be part of London Gem.

FEEDBACK # 2

Sidra Asad

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

Thank you for this amazing lecture, proud to be part of London Gem.

FEEDBACK # 3

Saba Aslam Khan

It was comprehensive yet detailed lecture on ILD , Dr wasib started his presentation with the 5 cases on ILD and gave us adrenaline rush and got to know about our level of knowledge on ILD and then he descended down to our

level and took us to the depth of the topic ….!! It was well explained lecture from sign and symptoms to the management of the patients and different presentations thank you London GEM and dr Ash for arranging this lecture … Learned alot..
A proud GEM trainee,
Dr Saba Aslam ✨🌻

FEEDBACK # 4

Sana Hameed

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

FEEDBACK # 5

Suhail Ahmed

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

FEEDBACK # 6

Dr Leela Ram

Overall it was informative with numerous cases with CTs. It is broadening our understanding of Interstitial lung disease in view of many aspects.

Dr. Wasib described UIP pattern on radiology which is minimal ground glass opacity, subpleural reticulation & honey combing with tractional bronchodilation occurs 8-66% & NSIP pattern with no HC occurs 19-57%.
Organising pneumonia with reversed halo sign- 0-11% & LIP or DIP pattern<1%.
Lung manifestation of Rheumatoid arthritis: Most common extraarticular organ involved:
Parenchymal> ILD, Rheumatoid nodule,
Pleural involvement: Pleuritis, pleural effusion
Airways> Cricoarytenoids, bronchiolitis, bronchiectasis.
ILD is classified as histopathologic & clinical characteristics:
Etiology known:
Inorganic exposure: Asbestos, silica, hard metals, coal dust.
Oragnic exposure:
Birds, hay, mold, mycobacteria
Smoking: DIP, RB-ILD, LCH
Connective tissue disease: RA, Polymyositis/dermatomyosotis, scleroderma, Sjogren syndrome
Drugs: Nitrofurantoin, Amiodarone, Methotrexate, chemotherapy
Etiology unknown: Idiopathic interstitial pneumonia, rare LAM, Vasculitis, Granulomatosis: Sarcoidosis:
Clinical history: typical dyspnea on exertion & abnormal radiograph, symptoms are progressive.
Acute: Cryptogenic organising pneumonia, AEP, acute hypersensitivity pneumonia & so on
Subacute to chronic:
Connective tissue disease associated ILD, IPF, Sarcoidosis, CHP, NSIP, DIP, RB-ILD, LIP, CEP.
Dermatologic symptoms: Heliotrope rash, Gottron's papules, SLE (Malar flush, Photosensivity reaction, hair loss,
•Musculoskeletal symptoms,
• Ophthalmic symptoms
PMH: Prior diagnosis of connective tissue disease
Occupational hx: Inorganic+organic exposure
Medication hx: Nitrofurantoin, Amiodarone
Physical examination: typical Velcro crepts, Inspiratory squeaks
Chest imaging: abnormal CXR
Distribution of lung disease: Upper lung zone+ lower lung zone
Investigation: HRCT Most sensitive
Lab: Inc. LFT, Hypercalcemia

PFT
Bronchoscopy: BAL is very useful
Ebus
Surgical lung biopsy

Treatment: Objective of ILD:
•Slow progression
• improve symptoms
• Improve quality of life
• Early referral to tertiary care center
• Antifibrotics or immunosuppression
• Oxygen inhalation
• Rule out Pulmonary HTN
• Pulmonary rehabilitation
• Treatment of co-morbities particularly GOERD
• Referral for lung transplant
• Start palliative care if not possible lung transplant
• MDT approach: Rhematologist, Radiologist, Respiratory
It was extraordinary session
Learnt so many new things including clinical presentation including inspiratory squeaks, velcro crepts, dyspnea on exertion, abnormal CXR.
It will greatly enhance practice of respiratory medicine.
Thanks Dr. Syed Wasib for incredible session & thank you Dr. Ash for elaborating many things on ILD & thanks to LGEM platform.

FEEDBACK # 7

Dr Faiza Arshad Baig

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

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

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

Do not forget Co morbidities: GERD, COPD, Pulmonary Hypertension, Prevent osteoporosis, pulmonary rehabilitation, Lung transplant
Prognosis:
Median survival 7 years post diagnosis.
No doubt it is really a vast and time consuming topic Thank you Dr. Syed and Dr. Ash for providing us this platform.
Regards

FEEDBACK # 8

Dr Nasir Hayat

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

FEEDBACK # 9

Dr Mishal Shan

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

FEEDBACK # 10

Dr Ghazala Sheikh

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

- Interstitial lung disease
- Time course of disease Onset

♤Acute,,
. Cryptogenic organising pneumonia
. Acute eosinophilic pneumonia
. Diffuse alveolar hemorrhage
. Acute exacerbation of idiopathic Pulmonary fibrosis

♤ Subacute to chronic,,
. Connective tissue disease
. Idiopathic Pulmonary fibrosis
. Sarcoidosis
. Chronic hypersensitivity pneumonitis
. Occupational lung disease
. Chronic eosinophilic pneumonia
. Lymphocytic interstitial pneumonia

● Systemic Symptoms of ILD
. Night sweats, fever, fatigue and weight loss
. Wheezing especially with hypersensitivity pneumonitis, eosinophilic pneumonia and sarcoidosis
. Pleuritic chest pain
. Hemoptysis with diffuse alveolar hemorrhage

● Dermatologic Symptoms
. Heliotrope rash
. Detmatomyositis

● GI Symptoms
. Esophageal motility problems_ systemic sclerosis and polymyositis
. Chronic, intermittent aspirations can lead to progressive fibrotic lung disease
. Bloating and diarrhea_ IBD

● Muscuskeletal Symptoms
. CTD_ arthralgias, morning stiffness joint swelling and erythema
. Swollen fingers (sausage digits) _ systemic sclerosis and polymyositis
. Raynauds phenomenon_scelroderma, mixed CTD and SLE

● Ophthalmologic Symptoms
. Dry eyes_ Shogren syndrome
. Uveitis_ SLE and sarcoidosis

● increasing edema, syncopal events, exertional chest discomfort suggest P_HTN
● Palpitations and syncope in a sarcoidosis pateint suggests cardiac sarcoidosis
● pleuritic chest pain, swollen legs and worse SOB suggests PE
● past medical Hx is a must
. HIV disease is associated with lymphocytic interstitial pneumonia

. AKI or CKD suggests underlying vasculitis, Pulmonary renal syndromes and CTD
. Liver disease association with sarcoidosis and PBC
● MUST ask occupational Hx
Either organic or inorganic exposure
○ Inorganic exposure leads to
. Asbestosis, silicosis, berylliosis, coal workers pneumoconiosis,
○ organic exposure leads to bird breeders lung, farmers lung, ventilation pneumonitis, hot tub hypersensitivity pneumonitis
● Medication Hx Such as
. Amiodarone
. Nitrofurantoin
. NSAIDS
. Recent chemotherapy
. Immune modulating drugs
● physical examination which is a important part of PACES
. Velcro crypts_usually absent in sarcoidosis
. Inspiratory squeks_ COP
. Clubbing_IPF, DIP, IBD
. Skin involvement_ sarcoidosis, CTD, vasculitis and tuberous sclerosis
. Arthritis_CTD, sarcoidosis
. Eye changes (uveitis and conjunctivitis)_ sarcoidosis and CTD
. Muscle weakness_poly and detmatomyositis
. Neuropathy_sarcoidosis and CTD
. Lymphadenopathy_ sarcoidosis and CTD
● chest imaging
. 1st sign of ILD on chest Xrays
. Normal in sarcoidosis and CTD
● distribution of ILD
♤ upper zone
. Sarcoidosis
. Silicosis
. Coal workers pneumoconiosis
. Hypersensitivity pneumonitis
. Langerhans cell histiocytosis
. Berylliosis
. Chronic eosinophilic pneumonia
♤ lower zone
. Usual interstitial pneumonia

. Non specific interstitial pneumonia
. CTD associated ILD
. Asbestosis
. Desquamation interstitial pneumonia
● pattern of ILD
. Peripheral reticular
. Ground glass
. Nodular
. Cystic
● HRCT is more specific as compared to Chest X ray
● Laboratory Testing
. Elevated liver enzymes or hypercalcemia_ sarcoidosis
.Renal insufficiency_ Pulmonary renal syndromes
. Peripheral easinophilia_ chronic eosinophilic pneumonia, churg Straus syndrome and drug reaction
● Serological testing is must to check antibodies
● PFTS
● Broncoscopy
● Ebus
● surgical lung biopsy
● Treatment strategies in ILD
● Management of CTD e ILD
● don't forget Comorbids
● Prognosis
. Median survival is 7 years post Dx

FEEDBACK # 11

Dr Ghulam Saddique

It was an amazing session conducted by Dr Wasib.Session started with 5 cases of ILD

The term diffuse parenchymal lung disease (DPLD) refers to a group of disorders affecting the lung parenchyma that can be categorized into those of known and those of unknown etiology. Early diagnosis is important since some forms of DPLD are characterized by a rapid progression to respiratory failure.

Etiology wise classes.

Etiology known: organic causes

Inorganic

Smoking

Drugs

Connective tissue disease

Etiology not known:idiopathic interstitial pneumonitis

Symptoms: non specific cough , Dyspnea on exertion, progressive symptoms, patients are usually above 60 years old.
Phenotypes
UIP (usual interstitial pattern) (bad prognosis)
minimal GO, basal , subpleural reticulation and honeycombing(HC) with tractional bronchodilation
NSIP pattern
Extensive GO ,basal, subpleural sparing , some tractional bronchodilation, no HC
Organizing Pneumonia (Good prognosis)
focal GO, consolidation ,subpleural and peribronchial, reversed halo sign
Others (LIP or DIP)
GGO, cysts, centrilobular nodules, upper lobe predominant, peribronchovascular septal thickening
CPFE (combined pulmonary Fibrosing Empyysema)
Coexistant Emphysema, 50% of patients with smoking history who have got RA-ILD
Past Medical and occupational History is very important.
History of connective tissue disease, HIV disease, history of chronic kidney disease and liver problem
Occupational history: organic and inorganic exposure.
Medication history: Nitrofurantoin Amiodarone , NSAID and history of recent chemotherapy
Physical Examination :
• Typical 'velcro' crepts - IPF, crepts frequently absent in sarcoidosis.
• Inspiratory squeaks - COP.
• Clubbing- IPF, DIP, IBD.
• Skin involvement- Sarcoidosis, CTD, Vasculitis, Tuberous sclerosis.
• Arthritis- CTD, sarcoidosis.
• Eye changes (uveitis, conjunctivitis) - , Sarcoidosis, CTD.
• Muscle weakness- Polymyositis, dermatomyositis.
• Neuropathy- Sarcoidosis, CTD.
• Lymphadenopathy- Sarcoidosis, CTD.
Chest Imaging: • Abnormal chest radiograph is often the first indication of underlying ILD.
• Normal in Sarcoidosis, CTD, RB-ILD
Distribution of ILD:
Upper zones are involved in Sarcoidosis, silicosis, coal worker pneumoconiosis
Lower zones are involved in connective tissue disease, Asbestosis, usual interstitial lung pneumonia.

HRCT: more sensitive than other radiograph. Definitive UIP includes honey combing , peripheral sub pleural distribution etc
Lab test: elevated liver enzymes and hypercalcemia in Sarcoidosis, Renal insufficiency is pulmonary renal syndrome, Peripheral eosinophilia present in eoisinophilic pneumonia.
Serologic testing and
Pulmonary function test: most forms of ILD demonstrate restrictive ventilator defect due to dec compliance and inc recoil of lung parenchyma . Presence of obstruction suggest presence of obstructive lung disease or airway centered ILD.
Bronchoscopy : Bal is very useful
• Differential cell count , HP vs sarcoid
• Milky appearanc typical of LAM
(Lymphangioleio Myomatous)

• Sequential BAL for vasculitis like good pasteur,s syndrome, wegner,s etc
• TBLB for sarcoid
• Cryotherapy for ILD
• Rule out other infection
• BAL eosinophil count may be high in drug related ILD
Surgical lung biopsy where diagnosis is not reached and condition is not improving specially in parenchymal lung fibrosis.
Treatment Objectives : • slow progression
• Improve symptoms
• improve quality of life
• Early referral to tertiarv care centres
• Antifibrotics or immunosuppression
• Oxygen inhalation
• Rule out associated pulmonary hypertension
• Pulmonary rehabilitation
• Treatment of comorbidities particularly Gord
• Referral for lung transplant
• Start of Palliative care if not for lung transplant
• MDT approach -> rheumatologist, radiologist, respiratory
Therapeutic: Pirfenidone first line but have some side effects
Nintedenib is most successful, both should be continued for 6-12 weeks. Use when FVC is 50% and DlCo >15%
If condition worsen then lung transplant: Management of Connective tissues related ILDs
• Steroids >

• Initial management or exacerbations
• Wonderful in OP & NSIP pattern
• In UIP pattern disease improved or stabilised disease in 50%, despite treatment group having worse lung volumes
• No significant different in survival
• Different to IPF
• 0.5 mg/kg, wait for 1-3 months, taper to 10mg per day.
When steroid do not work :MMF and Azathioprine
Cyclophosphamide (fulminant)
Methotrexate:
• Not a risk factor for RA-ILD
• Might be protective from RA-ILD
• Pulmonary toxicity is very rare -since 2001 in RCTs on MTX in RA no cases reported
• Possibly increased of infections
• Close monitoring if started
Do not forget Co morbidities:GERD , COPD , Pulmonary Hypertension,
Prevent osteoporosis, pulmonary rehabilitation, Lung transplant
Biologics:
• TNF inhibitors have both profibrotic(worsen ILD) and antifibrotic effects
• Conflicting evidence
• Some studies showed progression of disease others improvement
• IF RA-Ild progressing with them STOP THEM
• Other biologics-
• Improvement or stability of lung functions
1. Rituximab better survival compared to TF inhibitors
2. Todilizumab
3. Abatacept
4. JAK inhibitors -tofacitinib, baricitinib. Don't forget comorbidities
• GERD -> 50%, PPI
• COPD
• Pulmonary Hypertension
• Prevent osteoporosis
• Pulmonary rehab, ambulatory Oxygen, Smoking cessation
• Lung transplant
Prognosis:
Median survival 7 years post diagnosis
I am proud to be a part of LGEM Programme

FEEDBACK # 12

Dr Zaid Ahmed Ansari

Dr Wasib delivered a well-rounderd lecture on ILD, its etiology, management and treatment plans. He discussed the various diseases that fall under this umbrella term, and also discussed diagnostic methodologies for these diseases, HRCT being of prime importance since it more sensitive than chest xrays in finding out issues.
What i found most enlightening was his discussion toward treatment plans. A few key points that found particularly useful were:

- The use of steriods; when and where should they be used, and where they are most effective. He also clarified that in face of steriod non responsiveness, MMF and Azathioprine can work effectively for lung fibrosis
- Cyclophosphamide is the ideal route to go for fulminant disease.
- Methotrexate is not to be avoided for RA-ILD, since pulmonary toxicity is very rare.
- TNF inhibitors have both profibrotic and anti-fibrotic effects
- Rituximab is the better treatment route than TNF inhibitors

8th JANUARY 2023

EVENT NAME:

Hypertensive Emergencies By Dr Nahal Raza Cardiology Registrar NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Sidra Asad

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

FEEDBACK # 2

Javeria Wali

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

FEEDBACK # 3

Mohid Kanan

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

Topic included :

Blood pressure stages:

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

What to do next?

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

If ABPM is unsuitable then offer HBPM

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

Complications of HTN:

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

Examine in a patient with HTN:

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

ECG features with BP

Nice guidelines : HTN in adults (Dx and Tx)

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

<55 yrs - A

> 55 yrs or black African or Caribbean family - C

Then A+C

Then add A+C+D

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

HTN stages recommendations as per BP readings

Ways to lower BP

HTN drug S/E table

CAUSES OF SECONDARY HTN

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

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

FEEDBACK # 4

Ayesha Mushtaq

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

FEEDBACK # 5

Shehzad Hussain

It was amazing session by Dr Nahal, She have delivered huge practical knowledge of hypertension.

Hypertension classification Bp figures explained very well management of Hypertension class wise explained, Hypertensive urgency and hypertensive emergency was explained well. Treatment as per NICE guidelines all explained stepwise. Complication n end organ damage investigation were explained in detail.

We encounter in ER multiple patients with hypertension since this lecture my vision to treat hypertension is cleared. Thanks Dr Nahal for this wonderful session. Thanks to Dr Ibrahim for good case presentation.

Thanks to Dr Ash n LGEM team for arranging this wonderful lecture.

FEEDBACK # 6

Bushra Imran

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

Thank you Dr Nahal.and Dr Ash

In the end the cases presented by Dr Ibrahim was excellent

FEEDBACK # 7

Farheen Naseem

This session was an other treasure box of knowledge which nicely briefly concisely deliverd by Dr nehal raza she is one of the best teacher of lgem program in this session she taught more foxed and give us brief knowledge about hypertensive emergencies

Treatment plan according to age as per NICE guideline

Complication of HTN and organ damage risks

LABS roles in Htn

Importants of fundscopy for Htn retinopathy

Treatment plan

Life style modificatio

Salt restriction smoking cessation

Role of daily exercise in Htn pt

BP monitoring

Lot of more everything was nicely delivered by Dr nehal raza thanx to u and our mentor @Dr Ashfaq Sorathia he always support us jazakAllah khair

Dr farheen neseem

FEEDBACK # 8

Hk Danish

An amazing lecture by Dr Nahal Raza . A very serious disease with very serious complications HTN is very common

This session revised all the investigations management and treatment options of HTN in different age groups and stages of the patients . I am now able to deal with HTN according to NICE guidelines .

I learned a lot in this session like :

λComplications of Hypertension : End organ damage in various systems

λA few things to do when presented with hypertension , Blood testes ACR , RFTS , HbA1C , fundoscopy to see retinopathy , 12 leads ECG to see changes related to HTN

λDifference between BP management according to the age of patient

λBlood pressure targets , according to NICE guide lines

λIn older patients and diabetics always consider postural hypo-tension by checking BP on lying and standing

λStages of hypertension .

λTreatment options according to stage of hypertension

λMajor adverse effects of anti hypertensive

λCauses of secondary hypertension

λHypertension Crisis : Umbrella term for hypertensive urgency and emergency or malignant hypertension

λHow to check end organ damage in case of hypertension

λCauses of hypertension crisis

λPrognosis of malignant hypertension

λHow to clinically assess a patient with hypertension .

λHypertensive urgency treatment : Goal = reduce BP <160/100 over several hours to days , Rapid reduction of BP can cause ischemia

λHypertensive emergency treatment : Admit straight away , more aggressive decrease in Bp .

λHypertensive emergency + ACS . In this case stick to general rule

λhypertensive emergency + aortic dissection I/V Labetolol / esmolol is first line treatment

λSevere HTN in pregnancy : treatment option Magnesium

λPhaeochromocytoma crisis treatment

λCocaine induced hypertension : Diazepam

Thanks DR Ash , Dr Nahal Raza and Lgem team for this amazing learning opportunity

FEEDBACK # 9

Dr Leela Ram

Very much informative session by Dr. Nahal, she explained everything very well from definition ie; BP> 120-139/80-89 is Hypertension;
Stage-1: BP: 140-159/90-99mmHg
Stage-2: 160 or higher/100 or higher
HTN crisis: Higher than 180/higher than 110
Complications: Stroke, hemorrhage, LVH, Coronary heart disease, Congestive heart failure, Retinopathy, proteinuria, Renal failure, peripheral vascular disease
End organ damage in HTN include Cardiovascular damage, heart disease, Nephropathy, Vasculopathy.
Investigation: Blood tests: ACR, Renal function tests, HbA1C
Fundoscopy: look for hypertensive retinopathy
12 lead ECG: look for changes associated with HTN
Choice of anti hypertensive drugs include ACEI/ARB, Thiazide diuretic/Calcium channel blockers
Causes of 2• HTN: Conn's syndrome, Cushing syndrome, Aortic Coarctation, hyperthyroidism, Phaeochromocytoma
Hypertensive crisis:
HTN Urgency: BP spikes with no organ damage and can lower safely within few hours with BP drugs
HTN Emergency: BP is so high that organ damage can occur & must be reduced immediately to prevent imminent organ damage.
Organ damage is checked as changes in mental status such as confusion, Stroke, chest pain (UA), Pulmonary edema, MI, Eclampsia (during pregnancy)
Management: 1.First key decision to admit to HDU or CCU for IV anti hypertensive treatment to lower BP over the next few minutes to hours
2. Admit the patient for oral anti hypertensive treatment ensure the patient will be regularly monitored and aiming to lower BP over 24 hours
3. Advise oral anti hypertensive drugs & allow patient home with appropriate follow-up.

Ways to lower BP: Check BP, eat healthy food, limit salt, take blood pressure medicine, be physically active, maintain a healthy weight, manage stress. Don't smoke, Do not drink alcohol, do not use drugs.
It will significantly improve our practice on daily basis while measuring blood pressure & detailed history for causes & management plan as per each case.

Thank so much Dr. Nahal Raza for great session & thank you so much Dr. Ash for such great LGEM learning platform.

FEEDBACK # 10

Dr Mubashir Hussain

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

FEEDBACK # 11

Dr Ghayoor Khan

A very important and interactive session on hypertensive emergencies by Dr. Nehal.
It started from definition, complications of HTN and their management.
We learned NICE guidelines to follow while treating HTN,Secondary HTN, Pheochromocytoma, hypertensive emergency & urgency.
We got to know the treatment recommendations of HTN in ACS, Pregnancy, Eclampsia, and cocaine induced HTN.
Case presentation by Dr.Ibrahim on hypertension was brilliant.
Thanks
Dr. Nahal And LGEM
Regards
Muhammad Ghayoor Khan

FEEDBACK # 12

Dr Aiman Nazir

It was a wonderful session on such a common and important topic conducted by Dr Raza.
Explaining in detail about hypertension , how to label someone as hypertensive and steps to follow after that.
Starting with the classifying Hypertension into stages , when to advise ABPM or HBPM, further examinations (like urine dip, fundoscopy,blood tests, 12 lead ECG) for diagnosis , explaining in detail about the test results , ECG changes in HTN, complications . Simply explained about the Hypertensive Urgency and Hypertinsive Emergency, difference between the two and how to act in both of the situations.
Next comes the management which was so beautifully explained according to the updated NICE guidelines arranged in charts and flow diagrams which made it quite simple and easy to learn. starting it with Lifestyle modifications and the

cutoff value where medications should be considered like any target organ damage , any cardiovascular disease, renal disease, DM , QRISK >10% , patients with age >80years with SBP>150mmhg.
Secondary hypertension was also discussed along with the causes and management. Not to miss out HTN in pregnancy(pre eclampsia) and its management was really important .All the medications were discussed in detail along with its side effects .Dr Raza did a wonderful job by keeping it concise and interactive which has proven to be very beneficial for us . Thank you so much for conducting an amazing session .
I Would like to learn more from Dr Raza in future.
Dr Aiman Nazir
EMFP LGEM

FEEDBACK # 13

Dr Faiq uz Zaman Khan

Almost everyone who works in the ER has come across a patient with HTN. And Dr Nahal's lecture gave us a simple way to manage such patients.
This lecture was a great source of revision of the topics we have studied and Dr Nahal emphasized on high yield exam pointers while guiding us on ways to improve our general practice .

Although network issues did disturb the momentum of the lecture but she explained the topic brilliantly as always .
Thank u LGEM for the opportunity.
Regards,
Dr Faiq uz Zaman Khan
Trainee
LGEM FP

FEEDBACK # 14

Dr Mishal Shan

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

FEEDBACK # 15

Dr Rehan Khalil

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

FEEDBACK # 16

Qaisar Shah

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

also provided treatment recommendations for hypertension in combination with other conditions, such as ACS and aortic dissection. In pregnancy, she discussed the use of magnesium in Eclempcia with Labetolol,Hydralazine,Methyl dopa , and cocaine-induced hypertension 1st line drug is diazapam.
Overall, the session provided a comprehensive overview of HTN and its management.
Thanks Dr Nahal for this amazing session.

FEEDBACK # 17

Dr Saad

Today's session was based hypertensive emergency. Dr Nahal comprehensively discussed the topic of hypertension. In the session following points were discussed:
>What is hypertension?
>Cut off value of hypertension
>Diagnosis of hypertension
>ECG manifestations of hypertension
>Difference between hypertensive urgency and emergency
>Complications of hypertension
>How to look for hypertension?
>Stepwise management of hypertension
The topic was discussed quite interestingly.
At the end Dr Ibrahim presented the case.
Thanks Dr Ash and London GEM for such valuable Session.

FEEDBACK # 18

Dr HK Danish

An amazing lecture by Dr Nahal Raza. A very serious disease with very serious complications HTN is very common
This session revised all the investigations management and treatment options of HTN in different age groups and stages of the patients. I am now able to deal with HTN according to NICE guidelines.
I learned a lot in this session like:
l Complications of Hypertension: End organ damage in various systems
l A few things to do when presented with hypertension, Blood testes ACR , RFTS , HbA1C , fundoscopy to see retinopathy , 12 leads ECG to see changes related to HTN
l Difference between BP management according to the age of patient
l Blood pressure targets, according to NICE guidelines
l In older patients and diabetics always consider postural hypo-tension by checking BP on lying and standing
l Stages of hypertension .

l Treatment options according to stage of hypertension
l Major adverse effects of anti hypertensive
l Causes of secondary hypertension
l Hypertension Crisis: Umbrella term for hypertensive urgency and emergency or malignant hypertension
l How to check end organ damage in case of hypertension
l Causes of hypertension crisis
l Prognosis of malignant hypertension
l How to clinically assess a patient with hypertension .
l Hypertensive urgency treatment: Goal = reduce BP <160/100 over several hours to days , Rapid reduction of BP can cause ischemia
l Hypertensive emergency treatment: Admit straight away, more aggressive decrease in Bp .
l Hypertensive emergency + ACS. In this case stick to general rule
l hypertensive emergency + aortic dissection I/V Labetolol / esmolol is first line treatment
l Severe HTN in pregnancy: treatment option Magnesium
l Phaeochromocytoma crisis treatment
l Cocaine induced hypertension: Diazepam
Thanks DR Ash , Dr Nahal Raza and Lgem team for this amazing learning opportunity

FEEDBACK # 19

Dr Zaid Ahmed Ansari

Date : 8th January 8, 2023

Dr Nahal as always brought an interactive session on HTN, its management according to NICE guidelines and the various kinds and manangement protocols for HTN.

Dr Nahal discussed:

- Complications of Hypertension, including organ damage and failure
- How to deal with HTN presentation such as blood tests, ACR , RFTS , HbA1C , fundoscopy, 12 leads ECG to see any progressive changes due to HTN.
- Managing BP with respect to the age of the patient with taking into account blood pressure targets as outlined by NICE guidelines.
- Postural hypotension in older patients
- Stages of hypertension and treatment plans for each stage
- Causes of secondary hypertension
- Hypertension Crisis and checking for end organ damage
- Causes of hypertension crisis
- Clinical assessment of hypertensive presenting patient.

- Goals of hypertensive urgency treatment; reduce BP <160/100 over several hours to days gradually, since rapid reduction of BP causes ischemia
- Trement options were also discussed in great detail:
- Hypertensive emergency treatment : immediate admission with aggressive focus on lowering BP
- Hypertensive emergency with aortic dissection: Intravenous Labetolol / esmolol as first choice
- Severe HTN in pregnancy: immediate trement with magnesium
- Cocaine induced hypertension: immediate treatment with diazepam
- Managing Phaeochromocytoma crisis

Dr Nahal's lectures always teach me something you and I look forward to her lectures .

14TH JANUARY 2023

EVENT NAME:

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

DOCTORS FEEDBACK

FEEDBACK # 1

Bushra Imran

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

FEEDBACK # 2

Abdul Ghaffar

This is wonderful lecture and got huge knowledge
Thx sir

FEEDBACK # 3

Rizwan Siddeq

Thanks to Dr Jacob for such a wonderful session on lung malignancies.

Dr Jacob explained lung cancer sign symptoms , investigations how to proceed for diagnosis , TNM classification treatment as per TNM classification n guidelines
Why hoarseness of voice occurs , left recurrent laryngeal nerve palsy, left phrenic nerve palsy, Pancoast tumors Types of lung ca Small Cell Carcinoma Squamous Cell Carcinoma
Adenocarcinoma
Large Cell Carcinoma
Paraneoplastic Syndromes
In small cell Ca 1. SIADH -> Hyponatremia
2. Increased ACTH - Cushings Syndrome
3. Carcinoid -> Flushing & Diarrhea
4. Eaton Lambert Syndrome , In Squamous cell ca
PTHrp - Hypercalcemia
Horner's Syndrome - Ptosis, Miosis, & Anhidrosis Pancoast's Tumor -> 1st & 2nd thoracic nerve - shoulder pain - ulnar nerve pain
adeno carcinoma 1. Pulmonary Osteoarthropathy - pain in hands or legs (XRAY -> Periosteal Elevation)
2. Marantic Endocarditis
large cell ca 1. SVC Syndrome
2. Gynecomastia
TUMOR MARKERS IMMUNOHISTOCHEMISTRY
•Adenocarcinoma-TTF| POSITIVE,CK7,CK20, NAPSIN A POSITIVE, BerEP4 positive
• Squamous cell carcinoma- TTF I Negative, p63,CK5, CK6 POSITIVE
• Small cell carcinoma-TTF I positive, CD56,SYNAPTOPHYSIN, CHROMAGRANIN POSITIVE
• MALIGNANT MESOTHELIOMA- CALRETININ,CYTOKERATIN 5/6,WILMS TOMOUR
D240negative. MANAGEMENT
• Surgery -stage I-111
• Chemotherapy
•Radiotherapy
• Immunotherapy. Surgery in stage 1-3a , LUNG FUNCTION FOR SURGERY
• Lobectomy -post-bronchodilator FEV I is > 1.5 litres
• Pneumonectomy - post-bronchodilator FEVI is >2.0 litre
. Vo2 max min 15ml/kg/minand chemotherapy radiotherapy n rest all explained well.
Thanks Dr Ash for this wonder-full plate-form to learn from the experienced pulmonologist

FEEDBACK # 4

Nasir Hayat

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

FEEDBACK # 5

Muzna Ahmed

Today's lecture was on the difficult topic but Dr. Jacob explained all the important aspects of Lung tumors. He described types which includes Adenocarcinoma most common, Squamous cell carcinoma, large cell carcinoma & small cell carcinoma. Risk factors include smoking, family history, second hand smoke, beta carotene, radon gas, exposure to asbestos or other pollutants & radiation.
All type of lung cancer cause paraneoplastic syndromes & hypercalcemia.
Superior vena cava syndrome is caused by local spread which blocks it & affecting recurrent laryngeal nerve results in Hoarseness of voice.
Sequence of investigation for diagnosis of lung cancer is the most important ie, chest x-ray within two weeks of unexplained symptoms then CT scan for liver, adrenals & lower neck. Tumor markers immunohistochemistry plays great role in treating lung cancer.
He explained management of lung cancer, TNM characteristics, Non-small cell cancer stages, small cell lung cancer stages, lung function for surgery, surgery or radiotherapy for people for not having lobectomy, surgery for small cell lung cancer, 19% survival rate in Non-small cell lung cancer and so on.
Thank you Dr. Jacob for such a great lecture which is very difficult to diagnose straightway and management required thorough understanding.
Thankyou LGEM and Dr Ash.

FEEDBACK # 6

Anila Zafar

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

FEEDBACK # 7

Warda Yawar

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

FEEDBACK # 8

Dr Mishal Shan

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

FEEDBACK # 9

Dr Ghazala Sheikh

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

- Types of lung Cancer

. Adenocarcinoma which is the most common
. Squamous cell ca
. Large cell ca
. Small cell ca 15%

- Risk factors for lung CA

. Smoking
. Second hand Smoking
. Family hx
. Dietary supplements
. Radiations
. Radon gas
. Asbestos
● Symptoms
. Fatigue
. Cough with or without blood
. SOB
. Repeated chest infections
. Back, shoulder n chest pain
. Blood clots
● Paraneoplastic Syndromes
● Lambert Eaton Syndrome
● Difference bw lambert Eaton and myasthenia gravis
● Hypercalcemia
● Superior Vena Cava Syndrome
● Hoarnessnes of Voice
● Left phrenic nerve palsy
● Pancoast Syndrome
● Sequence of investigations is a must in diagnosis of lung CA
● Chest X ray indications
. Urgent x ray done to be in a 2 week period
● CT chest
● NICE guidelines in Diagnosis and staging of lung CA
● Immunohistochemistry
. Tumor markers
● Managment of lung Ca
. Depends on small and non small cell CA,
● TNM 8_ primary tumor classification
● non small cell lung ca Stages
● Lung function for surgery
● programmed cell death ligand 1
● 19% is overall survival for 5 years

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

Very thanks to Dr Ashfaque Ahmed

FEEDBACK # 10

Dr Bushra Khan

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

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

Well done London Gem 💎

Thanks

Bushra

FEEDBACK # 11

Dr Amash Khan

Today's topic was beautifully delivered by Dr Jacob about the lung tumors. He described about the types of lung tumors, their risk factors, the paraneoplastic syndromes they cause along with superior vena cava syndrome, investigations needed for diagnosis of lung tumors and their metastasis, their TNM staging and need for radio and chemotherapy treatment for the tumors and some of it's survival rate.

The lecture was brief and he tried to encompass every important detail needed for the diagnosis of lung cancer.

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

FEEDBACK # 12

Dr Leela Ram

It was brilliant session by Dr. Jacob who explained all the important aspects of diagnosing Lung tumors. He described types which includes Adenocarcinoma most common, Squamous cell carcinoma, large cell carcinoma & small cell carcinoma. Risk factors include smoking, family history, second hand smoke, beta carotene, radon gas, exposure to asbestos or other pollutants & radiation.

All type of lung cancer cause paraneoplastic syndromes & hypercalcemia.

Superior vena cava syndrome is caused by local spread which blocks it & affecting recurrent laryngeal nerve results in Hoarseness of voice.

Sequence of investigation for diagnosis of lung cancer is the most important ie, chest x-ray within two weeks of unexplained symptoms then CT scan for liver, adrenals & lower neck. Tumor markers immunohistochemistry plays great role in treating lung cancer.

He explained management of lung cancer, TNM characteristics, Non-small cell cancer stages, small cell lung cancer stages, lung function for surgery, surgery

or radiotherapy for people for not having lobectomy, surgery for small cell lung cancer, 19% survival rate in Non-small cell lung cancer and so on.
Though it seemed difficult but tried to give more concentration on it & learnt so many new things. It will definitely improve our practice.
Thank you Dr. Jacob Baby for such a great lecture on lung tumors which is very difficult to diagnose straightway & thank you Dr. Shiraz for nice case & thank you Dr. Ash.

FEEDBACK # 13

Dr Ghulam Saddique

Excellent session and most difficult one discussed by Dr.Jacob in a very precise and easy way so we can assimilate it easily .
Types of lung cancers
Adenocarcinoma (most common)
Squamous cell carcinoma
large cell carcinoma
Small cell carcinoma
Risk factors are Smoking , Secondhand Smoking , Asbestosis , Dietary supplements (Beta carotene)
Symptoms are Back ach Shoulder pain, persistant cough, fatigue, Coughing up of blood, Repeated respiratory infections, unexplained weight loss and blood clot.
Paraneoplastic features are associated with these lung cancers as following
Small cell Carcinoma:

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

Squamous cell carcinoma:

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

Adenocarcinomas:

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

large cell carcinoma:

1. SVC syndrome

2.Gynaecomestatia
Proximal muscle weakness
That improves with movement
Difference between MG & LE syndrome discussed
Hypercalcemia Dehydration,RF could be due to malignancy ,Multiple myeloma
PTHrp 80% in Sq cell CA
PTH levels reduced ,Vit D is also reduced
Sodium can be low by SIADH
Superior venacaval syndrome from Local spread
Extensive network of veins on the chest
JVP dilated non pulsatile
Due to obstruction tumor on right side
Bronchogenic
Small cell
Sq cell
Lymphoma
If its emergency
Stenting of SVC
Chemotherapy can be directly effective
Hoarseness of voice due to left sided tumors
Left vocal cord due to recurrent laryngeal nerve palsy due to tumor
Left phrenic nerve palsy
Left raised hemi diaphragmatic
Pancoast syndrome
Shoulder pain
Tumor infiltrating the brachial plexusis
Hornor syndrome s/s
Paresthesia
Paresis of arm and hand
1 st and 2nd rib involvement
Sequence of Investigations discussed
That gives most information with least risk to the patient
X-ray
2 or more unexplained symptoms
Cough
Fatigue
Sob
Chest pain
Weight loss not responding

Persistent RTI
Finger clubbing
Supraclavicular lymhadenopathy
CT chest contrast enhanced
Include liver adrenals
Lower neck
Algorithm for Dx and staging assessment including updates from NICE GL NG 122 DISCUSSED IN DETAIL
CXR normal low suspicion
CXR abnormal CT CHEST
REFER FOR CHEST PHYSICIAN who takes Hx examines fitness assessment, spiromtery, basic blood tests
Choose investigations that gives max diagnostic and staging info with least risk
PT Who is having fitness status satisfactory then do chest CT if inconclusive then do PET SCAN
Pleural lesion then pleural biopsy
If PET +ve LYMPh node then EBUS IS next investigation
If there IS NO FDG +ve the CT guided biopsy
If pt is having poor performance status leave them for comfort care rather then go for extensive treatment
Tumors markers immunohistochemistry
Discussed . Differentiate different CA
MANAGEMENT
SMALL AND NON SMALL
TNM
TUMOR T1-4
NODE 1-3
METASTATIS 8TH PRIMARY TUMOR CLASSIFICATION
Tumor involving chest wall then T3
Same side of lung nodules T4
Metastatic then M1
Explained well
Non small cell CA
STAGE O ,I,II can go for surgery ,III, A surgery III B AND C & IV No surgery
IV IS MOST advanced metastases
If tumor is >7 cm then uts T4
SMALL CELL CA
LIMITED STAGE
EXTENSIVE STAGE

MANAGEMENT
SURGERY I-III
RESECTABLE AND OPERABLE
LUNG FUNCTION FOR SURGERY discussed
POST BRONCHODILATOR FEV 1>1 .5 L
Pneumonectomy - >2.0 L
Vo2 max min 15ml/kg/min cardiopulmonary excercise testing .
Surgery and radio with curative for non small cell CA
Surgery and radio for people not having lobectomy
SABR
Surgery for small cells can only be for very early stage
Chemo and radio is 1st line
Etoposide plus cisplatin
Chemoradiotherapy is
For extensive platinum based comb chemo
Metastatic non small Ca
Management
Check for mutations
EGFR In asian non smoker and adeno
ALK mutation
Younger
Metastatic
PDLI programmed cell deatg Ligand I
Check point protein
On immune cells T cells acts as a type of off switch
TREATMENT BASED on there positivity discussed.
SURVIVAL 19% overall
And for stage 1 treated 90%
About 80% directly related to smoking
Marvellous Case presentation by Dr.Sheraz.
Thankyou Dr Jacob for such a detailed topic presentation and picked many points which normally are confusing especially regarding diagnosis and Paraneoplastic syndromes .
Proud to be a part of London GEM Programme.

FEEDBACK # 14

Dr Ahmad Tanveer

A Big topic to cover
Types of LUNG CA
•Adeno ca most common
•Squamous CA

•Large cell CA
•Small cell 15%
Small & non small cell CA
RISK FACTORS
Smoking & 2nd hand smoking
Family Hx
Dietry supllіments B carotein
Radon Gas
Asbestosis
Radiation
S/s
Fatigue
Persistent cough
sob
Coughing up blood
Repeated RTI
Blood clots
Back and shoulder pain
Unexpected weight loss
Paraneoplastic
Small cell CA
SIADH,Inc ACTH
Carcinoid
Eaton lambort
SVC Synd
Sq cell Ca
PTHrp hypercalcemia
Horners
Pancoats tumor
Shoulder pain ulnar nerve
Adenocarcinoma
Pulmonary osteoartgropathy
Marantic endocarditis
Large cell CA
SVC synd
Gynecomastia
Lambert eaton
Antibodies against presynaptic NMJ
Dec acetylcholine release
Proximal muscle weakness

That improves with movement
Difference between MG & LE syndrome discussed
Hypercalcemia Dehydration,RF could be due to malignancy ,multple myeloma
PTHrp 80% in Sq cell CA
PTH levels reduced ,Vit D is also reduced
Sodium can be low by SIADH
Superior venacaval syndrome from Local spread
So many veins on the chest
JVP dilated non pulsatile
Due to obstruction tumor on right side
Bronchogenix
Small cell
Sq cell
Lymphoma
If its emergency
Stenting of SVC
Chemo can be directly effective
Hoarseness of voice due to left sided tumors
Left vocal cord due to recurrent laryngeal nerve palsy due to tumor
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Chest pain
Weight loss not responding
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CT chest contrast enhanced
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Explained well
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STAGE O ,I,II can go for surgery ,III, A surgery III B AND C & IV No surgery
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If tumor is >7 cm then uts T4
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LUNG FUNCTION FOR SURGERY discussed
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Vo2 max min 15ml/kg/min cardiopulmonary excerxise testing .
Surgery and radio with curative for non small cell CA
Surgery and radio for people not having lobectomy
SABR
Surgery for small cell ca only for very early stage
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Etoposide plus cisplatin
Chemoradiotherapy is
For extensive platinum based comb chemo
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Check for mutations
EGFR In asian non smoker and adeno
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Younger
Metastatic
PDLI programmed cell deatg Ligand I
Check point protein
On immune cells T cells acts as a type of off switch
TREATMENT BASED on there positivity discussed.
SURVIVAL 19% overall
And for stage 1 treated 90%
About 80% directly related to smoking
Dr Sheraz presented the case of 64yr old male life long smoker
With family hx of cancer
With + ve neuro ss
MRI head and CT non suggestive
Stroke consultant reviewed.
FREOM nystagmus
Ataxia
LP attempted 3 times but delayed to 2 wks
Pschy review done
All labs negative
CSF Wcc raised
WIth Flickering eyelids.
CT chest 2 LN
after 10 days of covid vaccine

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

FEEDBACK # 15

Dr Muhammad Saad

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

FEEDBACK # 16

Dr Zaid Ahmed Ansari

The lecture covered all important facets of lung tumors, with Dr Jacob highlighting cancerous conditions of the lung such as squamous cell carcinoma, adenocracinoma, large and small cell carcinoma etc. Adenocarcinoma by far is the most common. Risk factors include:

- Familial history
- Smoking
- Carcinogen exposure, such as asbestos, beta carotene and other pollutants.

All types of lung cancer tend to cause paraneoplastic syndromes & hypercalcemia in the lung tissue. Dr Jacob taked about one particular condition**,** **superior vena cava syndrome**, caused by metasis of the cancer from the lungs

to the vena cava. The blockage affects the laryngeal nerve and causes changes in voice, including hoarseness.
A particulat sequence of investigation for diagnosis of lung cancer should be followed and is the most important aspect:

- chest x-ray within two weeks of unexplained symptom presentation
- CT scan for liver, adrenals & lower neck.
- Tumor markers immunohistochemistry for further diagnostic investigation

Dr Jacob also explained in great detail:

- Management of lung cancer
- TNM characteristics
- Non-small cell cancer stages
- small cell lung cancer stages
- Lobetomy, when and where it is not applicable
- surgery for small cell lung cancer

Dr Jacob's lecture served as a referesher and provided much needed insight into the effective diagnosis and management protocols for lung cancer.

FEEDBACK # 17

Dr Aiman Nazir

It was a wonderful session equipped with up to date information and latest guidelines in terms of diagnosis , investigations and management. Beginning with broad classification, types , risk factors , symptoms and signs , criteria for cxray , 2 week wait clinics etc a lot of new information and concepts were introduced and explained very well.
Slides were organised, with easy and understable text and Dr Jacob was continuously highlighting and repeating important things to learn and retain for knowledge and exam purposes was really good. All lung cancers with paraneoplastic syndromes were explained in detail. How to look for signs of paraneoplastic syndromes , what to look for in investigations and what investigation to order next was very well explained
Tumor diagnosis and staging with TNM 8th staging was also explained in detail .
Management of small cell lung Ca(limited and extensive stage) and non small cell lung Ca(stage 0. I,II,III,IV) was beautifully taught and repeated to make us learn .
Emphasis on newer things like tumor markers immunohistochemistry and mutations(eGFR, ALK, PDL-I) in diagnosis and further management of metastatic non-small cell carcinomas was something new I learned today..
It was a very extensive yet important topic taught today with excellent teaching skills by Dr Jacob.

Thank you so much Dr Jacob and Dr ASH for arranging this session and making us aware of the latest guidelines and management plans and helping us learn complex things in an easy manner.
Dr Aiman Nazir
EMFP LGEM

15TH JANUARY 2023

EVENT NAME:

High Yield Cardiology By Dr Naila Sorathia NHS UK Consultant

DOCTORS FEEDBACK

FEEDBACK # 1

Rabiyyah Bashir

An important topic, explained beautifully...
Explicit explanation of difficult and tricky SBA questions... How ACS management can change under diff scenarios was informative.
Thankyou Dr Naila Ma'am for your effort and time ❤️❤️❤️

FEEDBACK # 2

Bushra Imran

Today was amazing informative session in which questions on daily practice use discussed. I learnt how to approach chest pain ,which patient will admit,who need urgent cardiologist consultation and who will discharge after treatment. ACS management, STEMI with LVF, and rescue PCI.Also discussion done on risk stratification TIMI score, GRACE ,EDAC score .We revised ECG with scenario .Thank you dr Naila for such a excellent session

FEEDBACK # 3

Yasir Dilawar

Topic was high yield cardiology. Dr Naila taught us scenarios of CVS their management. ECGs were discussed. Guidelines like TIMI score, GRACE and EDAC which are very important. such a good session. Thank you Mam

FEEDBACK # 4

Uzma Shaikh

CVS High yields were definitely high yields. Dr Naila amazingly taught us ecgs, management of various presentations of MI and multiple complications. We learnt regarding management and recognition of tachyarrythmias and bradyarrythmias, anticoagulants and their mechanism of actions.

Thankyou for these fantabulous sessions, looking forward to more SBA sessions from you.

FEEDBACK # 5

Muzna Ahmed

It was a most awaited session as it was conducted by dr Naila.
She taught us more than 15 real case based scenarios on HTN, arrythmias, Syncope,Bradycardia in pregnancy,bleeding,headache, chest pain. And How to manage them as an EM registrar. The steps to reverse and stabilize the pt's critical condition, ACS management / protocols on an updated curriculum was taught by her ,she also mentioned Newly introduced Antiplatelets medications and rectified many old usages of Unfractionated heparin/antiplatelets (that are being used blindly in our home country) she had prepared for fine management of acs ,HTn urgencies/Emergencies, chest pains rushing in to ER. Some high yield topics were: HAS-BLED /CHADVAS/ORBIT/TIMIS/HEART /Grace scores/Multifocal atrial tachycardia case/heart block type 1/3 ECgs/Nstemi/Stemi with hypotension/ Hemopericardium don'ts/ aortic dissection / best tx after managing an unstsble cvs pt =PCI, when to discharge/ whether to admit all pts/ VT/ SVT/ pt with pre syncopal symptoms bradycardic on atenolol frst line ? / cardiac first Aid 4 points Oxygen/Gtn infusion/pain killers/Beta blockers (cardio selective)/ urgent 20 mins INR before strting thrombolytics >3 contra, 2-3 assessment, ticagrelor reversible effects low risk/prasugrel irreversible high bleed risk usage.
In short span of time she excellently explained these high yield topics which will be remembered easily.
Thank you Dr Ash Dr Naila for such amazing session this will help in acing exam.

FEEDBACK # 6

Shehzad Hussain

Thanks to Dr Naila for such a wonderful session which started with patient presentations symptoms signs investigations differential diagnosis scoring and treatment all explained very well.
TIMI SCORE
GRACE SCORE
EDAC SCORE
HEART SCORE all explained well,
Ischemic chest pain n cardiac measures
Fondaparinux / Heparin indications
On Warfarin when to thrombolise in STEMI
Failure to re perfusion
Rescue PCI

Persistent n permanent Afib treatment all explained very well.
Thanks Dr Ash n LGEM team for this amazing session it's very helpful with clinically applicable knowledge, many things have been explained which only Trainees will know it's difficult to learn/ understand these things for non trainee Drs. Thanks Dr Naila for this excellent session.

FEEDBACK # 7

Ghulam Saddique Saddique

Session was conducted in a very precise and detailed way and made the session informative and interactive for the GEM participants.
It was case based discussions, topics included use of TIMI score for admission and treatment and predicts 30 days mortality
NICE recommends Grace Score predicts 6 month mortality
EDAC for low risk chest pain assessment in haemodynamically stable patients . Includes Age, sex, known case of CAD.
HEART (Hx, ECG, Age, Risk factors, Troponin)
Undifferentiated patients with possible ACS .
Pt. with low risk and repeat troponin after 3 hrs if negative , can be discharged with opd follow up.
Initial treatment for ACS , unstable angina, STEMI,NSTEMI same for all
Include: Oxygen if required not for all patient ,GTN,Morphine,B blockers
Antiplatelet and antithrombotic treatment: remember the MOA
Fondaparinux is given in ED
High bleeding risk assessment by using ORBIT/ HASBLED score
Use of Unfractionated Heparin to be given(in case of Renal failure with Cr clearness <30 then no fondaparinux) and monitor APTT 6-hourly.
Don't give Fondaparinux if PCI planned in 24hrs.
Absolute contraindications of BBs in ACS case scenario
Hypotension, Bradycardia, Cardio selective B blockers are preferred (atenolol etc)
urgent angio, High TIMI SCORE
CP not improving within 90min of treatment, STEMI
Remember Thrombolytics contraindications
Tenecteplase and Retiplase are given if PCI facility is more then 2 hrs away.
If already on Warfarin then check INR within 20min of sample if <2 then thrombolyse if >2 but ❤️ then consider risk benefit and if >3 no thrombolytic
If Re infarction repeat ECG in 90 min then rescue PCI
ADP receptor blockers -Prasugril irreversible blockers can use in young with low risk of bleeding patients and Ticagrelor in older patients with ACS - a reversible blocker.
Scenario with STEMI AND LVF - tx is PCI

If Post MI Cardiogenic shock and LVF- give Inotropes
RV infarction with Inf. Wall STEMI
then IV fluids to be given to expand preload
HTN case scenario:
Pregnant lady with Hypertensive Urgency Labetalol and if Pre eclampsia then MgSo4
Memorize Bradycardia algorithm
Aortic Dissection scenario- coronary sinuses with STEMI changes-referral to Cardiac surgery
CP with neurological symptoms
WPW pre-excitation A.fib ECG. Tx is cardioversion
Persistent Vs permanent A.fib
CHADVASC score for stroke prediction .
Use of DOACS
It was a brilliant session. Thanks to Dr.Niala for conducting a wonderful session.

FEEDBACK # 8

Mina Khan

Todays session was very comprehensive, Dr Naila always come up with best explanations. She taught us more than 15 real case based scenarios on HTN, arrythmias, Syncope, Bradycardia in pregnsncy, bleeding, headache, chest pain. How to manage them as an EM registrar. The steps to reverse and stabilize the pt's critical condition all exam related were revealed by her. ACS management / protocols on an updated curriculum was taught by her . Moreover she also mentioned Newly introduced Antiplatelets medications and rectified many old usages of Unfractionated heparin/antiplatelets (that are being used blindly in our home country) she had prepared us for a fine management of acs ,HTn urgencies/Emergencies, chest pains rushing in to ER. Topics included were HAS-BLED /CHADVAS/ORBIT/TIMIS/HEART /Grace scores/Multifocal atrial tachycardia case/heart block type 1/3 ECgs/Nstemi/Stemi with hypotension/ Hemopericardium don'ts/ aortic dissection / best tx after managing an unstable cvs pt =PCI, when to discharge/ whether to admit all pts/ VT/ SVT/ pt with pre syncopal symptoms bradycardic on atenolol frst line ? / cardiac first Aid 4 points Oxygen/Gtn infusion/pain killers/Beta blockers (cardio selective)/ urgent 20 mins INR before strting thrombolytics >3 contra, 2-3 assessment, ticagrelor reversible effects low risk/prasugrel irreversible high bleed risk usage. Thank you London Global Emergency Medicine for providing us such a high yield platform. Proud trainee🌹

FEEDBACK # 9

Afshan Salman

An excellent comprehensive session by Dr. Naila. We learned ECGs, STEMI, NSTEMI, arrythmias and algorithms and much more. Clinical scenarios, complications and management of various CVS ds. we were taught scores like TIMI, GRACE, HEART and EDAC useful in cardiac emergencies. Thankyou very much

FEEDBACK # 10

Faiq Uz Zaman Khan

Power Packed CVS Session by Dr Naila.
Her presentation consisted of SBAs, ECGs, Clinical Scenarios and Management of various CVS Disorders.
STEMI,NSTEMI, Afib, Bradycardia Algorithm, Tachyarrhythmias, Aortic Dissection, Tamponade ,etc, you name it , she went through the clinical management of all of these diseases in a question and answer format. Thank You Dr Naila for your time. I will definitely go through all of the scores and algorithms you mentioned. GEM of a lecture.

FEEDBACK # 11

Dr Shahid Ahmad

Learning points of this wonderful session are
1) Timi score
2) GRACE score
3) EDAC score
4) Ischemic chest pain n cardiac measures
5)Fondaparinux / Heparin indications
6)On Warfarin when to thrombolise in STEMI
7)Failure to re perfusion
8)Rescue PCI
9)Persistent and permanent Afib treatment
Thanks Dr Naila for this excellent session
Regards
Dr Shahid Ahmad

FEEDBACK # 12

Dr Mishal Shan

Like all of Dr Naila's lectures, this one was yet another delight! Loaded with information and high yield clinical pearls that have made me alot more confident in approaching cardiovascular emergencies in the clinic. These include STEMI, NSTEMI, MI with arrythmias, pulmonary edema, high BP etc. She also touched up on a number of scoring systems which help safely escalate treatment plans and also taught us when can a patient be safely discharged. The lecture was very interactive from start to finish and I'm looking forward to many more lectures by her.

Regards,
Mishal Shan Siddiqui.

FEEDBACK # 13

Dr Leela Ram

It was brainstorming session on CVS, it was interactive and very explanatory. It covered all the important cases of emergency; including TIMI Score, Risk stratification of ACS, EDAC, HEART & what's important for exam.
Many ECGs were discussed, all were important which included Atrial tachycardia, Ventricular tachycardia, WPW syndrome, STEMI, NSTEMI, Heart block & so on. Overall it was full packed knowledge session.
I have learnt that it's not easy to work independently without proper experience and expertise and address problems with other doctors for admission.
We can't admit every patient and we can't discharge every patient, there are certain guidelines to follow upon.
Thank you so much Dr. Naila Sorathia for this brainstorming & fantastic lecture & thank you Dr. Ash for great LGEM forum.

FEEDBACK # 14

Dr Ghazala Sheikh

Overall the session included important scenarios regarding MRCP exam, totally exam oriented, Eye opener session.
I learnt,
● Risk Straitification Pathways
To rule out admissions/discharge of pateint with cardiac sounding chest pain
● TIMI score
. Used for Prognosis and mortality assessment for 30 days
● Grace Score
. Used for Prognosis and mortality assessment upto 6 months
● 1st Aid to all pateints with ischaemic chest pain
. OXYGEN
. GTN
. MORPHINE
. B BLOCKERS
● Anti thrombin we use now is Fondaparinux,
. Before prescribing must access the bleeding risk through
. Orbits score
HAS BLED
● after giving Unfractioned heparin, access bleeding risk after every 6 hours
● in renal failure Fondaparinux is contraindicated
● Don't use Fondaparinux if you plan angioplasty within 24 hours
● Before giving B blockers use in cardiac pateint consider,

. Blood pressure
. Heart rate
● use cardioselective B blockers
. Bisoprolol
. Metoprolol
. Atenolol
● Conseder Urgent angiography when Timi score is high 6_7
● after thrombolysis if symptoms persist Or you repeat ECG after 90minutes but still ST elevation not resolved
. Then Go for PCI don't repeat thrombolysis
● door to balloon time for STEMI is 90 minutes
● Contraindications of thrombolysis
. Ischemic stroke in previous 6 months
. Recent surgery in 3 weeks
. Pt on warfarin
. CNS tumors
In pregnancy and PUD you can do
● if Pt successful thrombolysis,
Still they Need PCI stent in 24 hours
● STEMi with HF
. Do PCI don't waste time in managing HF
● Cardiogenic shock
. Give isotopes then consider intra Aortic balloon pump
● Inferior wall MI
. Give fluids, as they become very hypotensive
● POST MI
. you diagnose MR or VSD
. Its Ventricular wall rupture leading to Cardiac Temponade
. Don surgical correction its an acute emergency
● POST MI
. You diagnose type 1 Heart block
. Do pacing
● HTN urgency
. Don't drastically reduce the BP
. Only increase the dose of his current medication
● HTN emergency
. IV labetalol
● ACS with HTN
. Give GTN infusion
● HTN with AD

. Give labetaolo
● HTN e pregnancy
. Give labetalol
● hemopericardiun with AD
. Don't do pericardiocentesis
● new Onset A_Fib
. Stroke assessment by
. CHAD VASC
. DOCS given
. Warfarin given _ if significant valvular disease or mechanical valves
● MAT * multifocal Atrial tachycardia
. Common in COPD
Other than these points
There were alot of informational stuff

Thankyou dr naila and Dr Ashfaque for making out journey easy 💖

FEEDBACK # 15

Dr Nasir Hayat

This session was Amazing and wonderful taught. All the Questions was answered .I learned a lot.
By today lecture we learnt how to approach chest pain and which patient will admit and which we discharge
We also learnt risk stratification like TIMI score, GRACE, EDAC, HEART score and all pathways. We also refresh our mind in different ecg and we also revise different hypertension management. Besides these we also learnt where is our weak point in cardiology and how to study for MRCP. It was very nicely presented and was organised well.I would high recommend it for physicians and ER physicians to join it.Proud to LGEM candidate.

FEEDBACK # 16

Dr Amash Khan

Today's topic was seems somewhat like a mock test to recall most of the important aspect of some of Cardiovascular diseases presented in the ER by Dr. Naila. She provided with different scenarios and asked the questions related for the diagnosis, treatment and further management of the presented diseases while explained them as we move on to the next questions. These helped in re-remembering the knowledge and a guide to what the examiners ask for and expect us to know.
Thank you Dr. Naila for your guidance and lectures.

FEEDBACK # 17

Dr Muhammad Saad

Today's session was on high yield cardiology. Dr Naila extraordinarily described the gist of cardiology in such a short duration of time. It was an interactive interesting session. It was exam as well as emergency orientated. A lot of scenarios were discussed focusing on lab investigations and main treatments. It was such a wonderful session.
Thanks Dr Ash London GEM for arranging such session.

FEEDBACK # 18

Dr Ahmad Tanveer

It was a real brain storming session. Fast paced targeted for high yeild CVS topics of interest.
Exam oriented guidance at registrar level the performance RCP wants
•How tp access all chest pains who need admissiom significance of TIMI Score if its more then 4 then admission and cardiology consult.
TIMI score discussed that predicts 30day mortality
Scoring OF TIMI includes
Age>65, Already having 3 or more CAD risk factors,ASA in past 7 days,>2 episodes of angina in past 24hrs ,ST changes >0.5mm on ECG,+ ve cardiac markers.
Needed for prognosis and treatment stretegy.
Grace Score predicts 6 month mortality recommended by NICE.
EDAC for low risk chest pain assessment in haemodynamically stable patients .
Includes Age, sex, known case of CAD.
HEART (Hx, ECG, Age, R /Factors, Troponin)
Undifferentiated patients with possible ACS .
Patient having low risk and repeat troponin after 3 hrs is -ve can be discharged with opd followup.
If high risk then admission and serial assessment.
1st scenario is all about the theme how to proceed with a Chest pain in ED ,who needs admission and treatment ,referral to cardio team.
2nd scenario Base line treatment for ACS
INCLUDES
Oxygen
GTN
Morphine
B blockers
AND THIS remains same for ACS ,USA,STEMI,NSTEMI cases.
Then Antiplatelets treatment discussed in scenario
Fondaparinux is given in ED as 1st add.
High bleeding risk assessment to be done by using ORBIT/ HASBLED score

In case Unfractionated Heparin to be given(incase of Renal failure with Cr clearness <30 then no fondaprinix)then have to monitor APTT 6hourly.
No Fondaparinux if PCI planned in 24hrs.
Mechanism of all Antiplatelets and antithrombotics to be familiar with
CONTRAINDICATION of B blockers in ACS
1- HYPOTENSION
2-Bradycardia
Cardioselective B blockers are preferred
Consideration of urgent angio
High TIMI SCORE
CP not settling with in 90min of treatment
STEMI
Door to balloon time is 90min
Thrombolytics
Tenecteplase and Retiplase are given if PCI facility is more then 2 hrs away.
Contraindications discussed.
If already on Warfarin then check INR within 20min of sample if <2 then thrombolyse if >2 but <3 then consider risk benefit and if >3 no thrombolytic
If Re infarction repeat ECG in 90 min then rescue PCI
ADP receptor blockers
Prasugril in young with low risk of bleeding patients as its irreversible blocker
While Ticagrelor in older patients with ACS and its reversible blocker.
Scenario with STEMI AND LVF
then BEST TREATMENT is PCI
If Post MI Cardiogenic shock and LVF
then INOTROPES & IABP
RV infarction with IW STEMI
then IV fluids to be given to expand preload
Several ECGS discussed
HTN scenarios were wonderful as they are common encounters and confusing
Pregnant lady with Hypwrtensive Urgency Labetalol and if Pre eclampsia then MgSo4 can also be tried
Bradycardia alogrithm to be memorized.
Aortic Dissection scenario with lower extension leading to involvement of coronary sinusis with STEMI changes then surgical emergency referrral to Cardiac surgery
CP+ neurological symptoms dissection to be focussed.
Afib with pre excitation ECG in pt having WPW TREATMENT is cardioversion
Afib Persistent permanant discussed .

CHADVASC score for stroke prediction .
Use of DOACS
In clear view Dr Naila has stormed our brains very well in such a short period of time and She is excellent teacher . Make sense of every scenario what RCP needs us to know . Thanks alot Dr Naila for such a lively and power packed session .
Regards

FEEDBACK # 19

Dr Aiman Nazir

It was an excellent and brainstorming session on CVS related questions by Dr Naila . She started with revisiting important learning points and concepts and simultaneously highlighting the importance of those points for the purpose of the exam as well as in daily routine encounters .
Risk stratification was explained in detail like TIMI, GRACE , EDAC , HEART scoring to make right decisions at the right time and identify the likelihood of adverse outcomes in patients with IHD .
Best part was the whole session was very much interactive and not just teaching only. All the slides were in the form of case based discussions , further questions related to common topics and scenarios and how to act as an ED SHO/Reg and make correct decisions .
Common and most frequently encountered topics were discussed like Cardiac first aid in IHD patients, STEMI , Pulmonary edema, HF, Inferior wall MI with RV infarction Hypertension and Hypertensive encephalopathy, Atrial fibrillation, Aortic dissection , MAT , CHAD VaSC , HASBLED scoring systems , need and choice of anticoagulants. All of these topics were discussed and relevant ECG images , xray images were included to help us remember these topics . and choosing the next treatment/management option ,next investigation , next best step really helped us to identify and rectify our mistakes which are commonly made by us while solving questions .
The Entire session was so interactive and everybody was so involved in the session that it didn't get boring for even a second . Thank you so much for this brainstorming session , it was much needed at this hour.
Dr Aiman Nazir
EMFP LGEM

21ST JANUARY 2023

EVENT NAME:

Radiology Pearls for EM & Acute Physicians By Dr Muhammad Imran Consultant Radiologist NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Warda Yawar

As far as I think about this lecture that it should be a must in every setting institution training setup for a better understanding because every doctor has a right to understand between different modalities

We as a Pakistani dr is facing difficulties with every passing day's health system compromised dr Imran taught us to at least examine the diagnosis at the bed site of the emergency patient whether RTA head trauma spinal injury blood fluid in the stomach

he taught us every radiology modality in a 2.5-hour session in detail and answer every question we asked him

thank you so much dr Ash for organizing this lecture and thank you dr Imran for conducting such as extra ordinary lecture for us I will share my knowledge with my friends

FEEDBACK # 2

Qaisar Shah

Dr. Imran explained

Basic concepts of radiology ,Various imaging modalities ,Right imaging modality at the right time for the right patient ,How to interpret each imaging modality, Covering common and some uncommon presentation with What imaging next and how to request appropriately & How to avoid unnecessary imaging/radiation .

Dr. Imran explained epidural, subdural, and subarachnoid hemorrhage presentations on CT scans and how to look for signs of air, blood, CSF, collections, infarcts, and hemorrhage on CT scans. They were encouraged to think outside the box when making a diagnosis and considering the next steps in management. The speakers also touched on the use of MRI signal intensity for T1 and T2 . Overall, it was a comprehensive and valuable session that provided a solid foundation of knowledge and clinical correlation for the diagnosis of scenarios in the emergency department. Thank you to Dr. Ash for organizing such a beneficial session.

FEEDBACK # 3

Yasir Dilawar

It was an amazing session by Dr Imran. he taught us about the basics of X-ray, Ultrasound, CT and MRI. How to interpret CT and MRI. how the different structures like bone, blood, soft tissue look on CT and MRI. he also explained

CT brain and some cases like Extradural Hematoma, Subdural Hematoma, Subarachnoid hemorrhage, intraparenchymal hemorrhage. swirl sign which indicates active bleeding.mid line shift in a CT. Aneurysm and infarct. Some learning about the anatomical structures of brain.it was amazing. I enjoyed it so much. I am waiting for another session with Dr Imran.

FEEDBACK # 4

Mina Khan

Human body isc75% water, we see densities in imaging. X rays are unidirectional beams /opacity/lucency terminologies used.CT is same as X rays but are multidirectional 360/180' beams. Contrast X rays (IV pyelogram) are replaced by CT-KUB. Pregnancy/Renal impairement relative contraindications. CT has attenuation/densities/shades of gray/Hounsfield unit /CT aortogram/mesentericangiogram / pulmonogram/CT contrast pelvic/abdomen. Appreciate axial/transverse scans/sagittal scan/Air1000hu/Lung 500Hu/Fat 50hu/water 0hu / soft tissue/blood 50hu /bone 1000 hu. Fluid confined by inflammatory wall /renal abcess/appendicitis/SMA Thrombosis/ if RFTs are normal/hydration is good then do contrast. MRI has signals/ intensity/ no rasiation/no X rays used.Gadolinium dye/T2 show urine/CSF white/if pt moves in scanner then alignment gets disturbed image becomes blur/Ultrasound has echogenicity/sound waves / Contrast US dye air bubbles/microbubbles/prerequisites preganancy bladder should b full/ Posterior ischemic stroke -best is MRI (not picked on CT) EDH accumulation of mid meningeal arterial blood biconvex collection/ swirl sign clotted/unclotted acute blood a life threatening sign on ct / give and urgent call to neurosurgery in that case. SDH crosses the suture/ causes elderly falls/shaken baby syndrome /boxing. Intracparenchymal bleed/ basal ganglia/pons/cerebellum HTN bleed /arteriovenous malformation/venous sinus thrombosis/posterior fossa neoplasm/CT non contrast-acute hypodense round area/hematoma (mixed/iso hyperdense/deep ICH rupture into ventricles/lobar hematoma caused by cerebral amyloid angiopathy . SAH /order CT- Angiogram/ blood in SAH /ACA bleed most common/sylvian fissure(mid cerebral artery) bifurcation. Perimesencephalic Subarachnoid Hemorrhage /non aneurysmal . Active bleed (contrast pooling) CTA spot sign . if there is dural sinus clot venous infarct noted at a distance with reperfusion injury ,then CT venogram is indicated.

FEEDBACK # 5

Warda Yawar

As far as I think about this lecture that it should be a must in every setting institution training setup for a better understanding because every doctor has a right to understand between different modalities

We as a Pakistani dr is facing difficulties with every passing day's health system compromised dr Imran taught us to at least examine the diagnosis at the bed site of the emergency patient whether RTA head trauma spinal injury blood fluid in the stomach
he taught us every radiology modality in a 2.5-hour session in detail and answer every question we asked him
thank you so much dr Ash for organizing this lecture and thank you dr Imran for conducting such as extra ordinary lecture for us I will share my knowledge with my friends

FEEDBACK # 6

Muhammad Abubakar

A wonderful session by Dr. Imran about different Radiological modalities, their differences, how to interpret, what to do when to do & how to do in a specific patient.
Xray
Ultrasound
CT
MRI
He started from basics then to the specifics of each and every modality like how the CSF and brain tissue looks in CT, how to see subdural, extradural and intra parenchymal bleed, hemorrhagic infarct, venous infarct nd much more.
The great lecture overall. Thank you Dr. Ash and LGEM for arranging such an amazing faculty and topics for us.

FEEDBACK # 7

Dr Afifa Younis Raja

Greetings of the day!!
Today we had an amazing session on Radiology for EM & Acute Physicians By Dr Imran Consultant Radiologist NHS UK
Dr Imran had a great command over the topic and it was surreal learning from such a great mentor, especially on a very difficult subject for me. The most captivating thing about Dr Imran's lecture was the humbleness and the way he slowly and gradually went through his slides making sure we all were engaged and understanding each and everything.
First we covered the basics of all radiology modalities. Then we discussed thoroughly the neuroimaging of commonly presenting ER cases.
Extradural hemorrhage
Subdural hemorrhage
Subarachnoid hemorrhage
Intraparenchymal hemorrhage
It was an amazing session and I learned a lot which will definitely reflect in the

day to day practice
Thank You so much DR Ash for bringing on board such great mentors.
Kind Regards,
Dr Afifa

FEEDBACK # 8

Dr Mishal Shan

The lecture picked up from the very basics and ended up giving us a comprehensive practice of the CT scans which we might encounter in the ER. It was also great to learn how and when to request the relevant scans even before the neurologist/ neurosurgeon receives the patient. Even though we have learned about brain hemorrhages previously, I still learned so many new things which we were never taught before. e.g identifying ongoing bleed in CT, locating venous sinus thrombosis etc. Enjoyed every bit of it!
Regards,
Mishal Shan Siddiqui

FEEDBACK # 9

Dr Ruma Mustafa

Fantaboulus session taught by Dr.imran
he explained in a comprehensive way each n every slide was too intresting to understand
I learnt many important points
Imaging modalities
Right image... right time ... right patient
Avoid unnecessary imaging
Image interpretation
Xray...opacity vs. Lucency
CT...Attenuation/density
MRI...signal intensity
USG...Echogenicity
Nuclear...uptake
Fluoroscopy...filling defect
Contraindications... pregnancy, B. feeding,
Renal impairment
Xray.. specific to place/
CT..360 view of image(axiel/coronal/sagittal) contrast/without contrast
Acute Bleed,fractures
Different densities in CT
Air <Fat<Water<Soft tissue <Bone<metal
Lung window
Bone window

Soft tissue window
MRI ..T1.. Anatomy
T2..pathology
lesion,demylinating diseases, unidentified Ischaemic stroke
DWI
FLAIR
STIR
MRA
USG waves.. reflected.. solid gas..bright Transmitted.. fluid..dark
Doppler USG..direction of bloodflow Neuroimaging...Cerebral hemorrhage
Extradural.. swirl sign(active bleed),biconvex, unilat, fracture
Subdural.. cresentric, supra tentorial convexity
Subarchnoid.. Parenchymal...
stages of hemorrhage MRI
Hyper Acute<24hrs
Acute 1-3days
Early Subacute >3days
Late Subacute >7 days
Chronic > 14 days
Venous infarct
Cerebral ischemic infarct
How to look for blood and CSF
CTA<DSA<aneurysm >coiling
Although, everything precisely explained in 2 & half hr that r not enough for the radio seems more to learn inshallah Inshallah
Highly intellectual session in a very short span. greatful learning
Thanks alot to my mentor,
Dr. Ash
Dr. imran
Whole LGEM team

FEEDBACK # 10

Dr Wajeeh Nazar

Dr. Imran's talk on the Radiology for EM and Acute Medicine was VERY Well articulated. As a matter of fact, Dr. Imran presented the material in the most effective way possible. X-rays, CTs, MRIs, fluoroscopies, and ultrasound were among the imaging modalities he covered, along with their indications and contraindications. We Learned Very Important Ideas And New Concepts 1. Subdural Haemor. Hyperdense Cresenteric Spread Diffusely No Sutures To Cross Less Pressure On Brain Than Extradural 2. Subdural Generally Supratentorial May Cross The Stures Cause Is Mainly Is Rapid Movement Of

Head, Venous Disturbances Bleeds Slow Shaking Baby Syndrome Elderly Peoples With Repetitive Injuries 2. Learned Important Points Of Diagnosing Extradural Hem 3.Seen Ct Of Venous Infarcts, Mets, Tumors And Sol 4. Ct In Acute And Chronic Hem. 5.Dds By Location We are all eagerly awaiting the next presentation. Many Thanks to Drs. Ash and Imran for sharing their invaluable knowledge of radiology in emergency settings with us.

FEEDBACK # 11

Dr Amash Khan

Today's lecture by Dr. Imran was beautifully explained as simply as possible. He started with the basics of imanging and guided on what, when and how many types of radiological imaging to use in ER along with the findings shown. He covered the neuroimaging in detail. He lectured about houndsfield unit, CT brain, bone and soft tissue, MRI T1 and T2 and different findings which can be found in these imagings.

Thank you Dr. Imran and Dr. Ash for this lecture.

FEEDBACK # 12

Dr Mariam Nawaz

So much discussed in 2 hours but with the main aim of ensuring that everyone exits the lecture with clear concepts. Dr Imran has an impressive way of teaching. We had a session on radiology for nonradiologists, and Sir cleared so many of our concepts.

We learned about different radiological modalities available and how they work and how their views are interpreted. Then, we learned in detail about diagnosing extradural, subdural, SAH, and interparynchymal haemorrhage, aided my multiple images to clarify the subject. I learned a lot, I. These 2 hours. I am looking forward to more amazing sessions by Dr Imran. Thankyou Dr Imran, Dr. Ash, and Lodon GEM.

FEEDBACK # 13

Dr Azka Shamim

Aoa respected sir

Today on 21st January 2023 we had an amazing session with Dr Imran (consultant radiologist) NHS UK regarding the radiology for non radiologists .. so it was a power pack of 2.5 hrs with so much interactive discussion that made this topic palatable and easy to understand.

Dr Imran started the session teaching all the radiology basics , physics of x-ray , CT scan and MRI and basic concepts .. following important points were highlighted during the session

* various imaging modalities

*How to avoid unnecessary radiation,

*What imaging to be done next

*Different windows of CT
*Interpretation of CT in ischemic and hemorrhagic infarct
* How to look for density in CT and intensity in MRI
*Active bleeding in hemorrhagic infarct _ do NECT
*Epidural/subdural and subarachnoid haemorrhage
*Thrombus/perimesencephalic infarcts
*How to look for blood or CSF and intraparenchymal bleed
*T1 and T2 sequence of MRI
Infact radiology seemed to be a little difficult to understand but thanks to our great mentor Dr Ash for arranging the best sessions for us regarding any topic and bringing the right teacher for us .. Dr Imran explained every concept amazingly and made it very easy
Thank you so much Dr Ash for this great opportunity
Proud LGEM trainee

Dr Azka ✨

FEEDBACK # 14

Dr Leela Ram

Overall session was outstanding, it covered Radiology from very basic to advanced. Dr. Imran demonstrated everything in simple and digestible way, he explained Basics ie;
1. X-ray is read as opaque vs lucent
2. CT is read as attenuated/ dense
3. MRI: signal intensity
4. Ultrasound: echogenicity
5. Nuclear: uptake
6. Fluoroscopy: filling defect

Tissue density is measured in Housefield HU; it increases in this order ie;
Air>Fat >Fluid>Soft tissues>Bone>Metal.
We have to see specific window for specific structures in CT scan.
While MRI has two sequence: T1 & T2
T1: Water is dark: better for anatomy (Soft tissue structures)
T2: Water is bright: better for pathology (inflammation and oedema)
While Ultrasound waves are reflected by solid and gas are bright whereas transmitted(not reflected) by fluid is dark.
CT vs MRI:
CT: Acute setting, good for acute hemorrhage, may be good for acute ischemic stroke, good for fracture

MRI: good for those cases where Ischemic stroke not clear on CT, for space occupying lesions (SOL) further, for demyelinating diseases for example Multiple sclerosis.
Types of Cerebral hemorrhage:
1. Extradural
2. Subdural
3. Subarachnoid
4. Parencymal
Extradural hemorrhage is hyperdense, biconcave, more than 95% unilateral, supratentorial, doesn't cross sutures, compress underlying brain & skull fracture is present in 90-95%.
He discussed Subdural hemorrhage, different diagnosis by location, subarachnoid hemorrhage, Intraparenchymal hemorrhage, Cerebral ischemic infarct & taught many different CT scans & other scans.
Session was interactive & understandable. I learnt many new things, it cleared my concepts and more improved my reading of radiographs.
Thank you so much Dr. Imran for wonderful session and thank you so much Dr. Ash for considering the addition of Radiology for Acute Physicians for MRCP candidates.

FEEDBACK # 15

Dr HK Danish

Radiology is the key to diagnose in emergency medicine
DR Muhammad Imran Consultant Radiologist NHS explained every thing so nice and clear
Before this session I couldn't interpret CT , now I can differentiate between hemorrhage mass and infarct .
Some of the points that I learned in this session are ..
Basic Radiology investigations, their mechanism and how to perform them
Limitations, Indications and contraindications of various Radiology procedures
Ct scan views, axial coronal and sagittal. Tissue density difference . Soft tissue bone and lung window
MRI in t1 water is dark in t2 water is bright , t1 is used for better anatomy, in STIR like t2 but fat is dark for edema in tissue and perianal abscess
Ultrasound, acoustic shadow and enhancement, doppler study .
Neuro imaging. CT vs MRI
Cerebral hemorrhage types,
extradural looks better in NECT , extra dural is confined in sutures , it creates extra pressure. Extra dural hemorrhage 90 to 95 % have skull fracture. Swirl sign in hematoma suggest active bleeding . Occurs in accident due to manengeal artery injury

Sbdural hemorrhage, it shows crescent appearance. Between arachnoid and inner layer . Supratentorial convexity most common, occurs in elderly due to veins problem .
Acute on chronic subdurab hemorrhage.
DDS on the on the site of bleed .
Subarachnoid hemorrhage is 80% due to anurysm . Go for CT angiogram. Most common bleed is in anterior communicating artery.
Perimesencephelic subarachnoid hemorrhage.
Thanks Dr Ash and Lgem team for providing us this amazing learning experience

FEEDBACK # 16

Dr Nasir Hayat

This session was Amazingly presented.I learned alot .All the Question was Answered.
It was an interactive lecture ,which was almost for 2.5hrs duration.It was a comprehensive lecture explaining in detail the use and diagnosis based on Xray ,CT Scan ,CT Angio ,MRI ,Ultrasound .Then He explained about how to apply the knowledge in clinical settings ,medical conditions which we encounter in daily life in ER.The difference between the diagnosis of Epidural ,Subdural and subarachnoid hemorrhage presentations on CT scan in the ER setting .How to look to for Air ,Blood ,CSF ,collection ,Infarct ,Hemorrhage on CT scan and to think out of the box during diagnosis about the next management approach.MRI signal Intensity for T1 to detect water which will be dark used better for anatomy (soft tissue) ,and T2 signal where water is bright better to detection of Pathology ie collections ,Inflammation etc.Terms like DWI,FLAIR,STIR ,MRA which helps in different clinical diagnosis of MRI.Altogether it was a power pack session to give us basic knowledge and clinical correlation for diagnosis of scenarios in ED.I would highly recommend it for ER physicians and physicians to join it .Proud to be LGEM candidate.

FEEDBACK # 17

Dr Zaid Ahmed Ansari

The lecture delivered by Dr. Imran covered:

- The basic concepts of radiology
- Imaging modalities
- Selecting the correct imaging modality to suit a particular patient.
- Interpreting imaging modalities effectively
- Common and uncommon modalities to look out for.

Dr Imran very cleary showed how to identify:

- Epidural, subdural and subarachnoid hemorrhage presentations on CT scans

- How to look for air, blood, CSF collections, infarctions an hemorrhages on CT scans.

Dr Imran also emphasized the need to think outside ethe box to come up with treatment plans and diagnostic protocols, and also touched on some important aspects of MRI signal intensity. The lecture proved a valuable source of professional clinical knowledge for me.

28TH JANUARY 2023

EVENT NAME:

High Yield EM By by Dr Saba Shiraz Registrar EM NHS Uk

DOCTORS FEEDBACK

FEEDBACK # 1

Hani Suhail

High yeild emergency medicine by dr saba was an amazing session where we learnt about different topics in a very short time with up to the point knowledge and it was a very much needed session. thank you very much

FEEDBACK # 2

Syed Suhail Ahmad

An excellent exam oriented session on High Yield EM By Dr Saba Shiraz Registrar EM NHS UK.

Important SBAs were discussed interactively involving topics like Pre-eclampsia, Eclampsia, Anti-D immunoglobulin, Testicular appendage torsion and Blue dot sign, and some important radiological signs on x-rays like eyebrow sign, lisfranc injury, role of wet flags etc.

Thank you LGEM, PEMA for arranging such sessions 👍👍👍

FEEDBACK # 3

Khatija J. Farooqui

Such an amazing session by dr saba on on high yield EM SBA question of Mrcem exam based topics

Mainly covering Peads , Gynae (hypertensive emergency pre eclampsia&eclampsia)CVST,ortho and X-rays.

Thrombolysis in unstable, priapism testicular torsion (blue dot)eyebrow sign in orbit fracture ,mid foot ankle fracture sedate and manipulate nt wait for X-ray, Anti B immunoglobin indication,anti D indication, TIA thrombolysis and PE

management guideline, BRUE, Wet Flag ETT ,opioids naloxone indication and many more thanks to dr Ash and team LGem for this wonderful session.

FEEDBACK # 4

Rida Rana

AlhumdulliAAllah attending a super amazing session by Dr Saba Shiraz on High Yield topics commonly questioned in MRCEM Examination . It was in deed a very precise session , well focused on exam preparation and covered a wide range of topics starting from gynae and obs topic and ending with orthopedics. The best part was in that it was entirely interactive and comprised of questions and their answers. The topics were covered in the explanation of the answers and thus it grabbed the attention of every candidate . Hopeful to attend more of such session from Dr Saba . thank you so much Dr **Ashfaque Ahmed** for bringing such amazing faculty on board who teach us with the pure intention of making get through and through the exam . AlhumdulliAAllah on being part of LGEM. 🌹

FEEDBACK # 5

Rajab Abbas

Such a power pack knowledgeable session by Dr Saba in which she comprehensively covered very high yield exam oriented SBA questions starting from gynae to paeds,orthopaedic and x-rays.

Important learning points of today's session are :

• Indications for Anti D
• cases of pre eclampsia
• TIA and guidelines from DVLA
• Lisfranc #
• Importance of Shelton's line
• Drugs causing Priapism
• BRUE
• Indication for Naloxon infusion
• WET FLAG
• CVST

Thank you Dr Saba for this quite interesting and engaging session.

Thank you Dr ASH for arranging this session

A proud GEM Candidate

Dr Rajab Abbas

FEEDBACK # 6

Muhammad Azeem Imran

Power pack excellent session . important learning points were

1. Pre eclampsia start in 20 weeks UpTo 6 weeks Postpartum period. .

2: Pregnant female@10 week may present with loss of consciousness , headache & vomiting Differential include venous sinus thrombosis .
3: Patient with pulmonary embolism after CTPA , with worsening hypoxia & hypotension,the most appropriate step in treatment is Thrombolysis.
4: Massive pulmonary thrombus , unstable patient, cardiac arrest - treat with thrombolysis
5: WET FLAG question for ETT size diameter in 4 years old boy
6: Any fracture with neurovascular compromise - the initial management is sedation and manipulation.
7: Anti D immunoglobulin indications - closed abdominals injury/ fall in third trimester, APH , invasive procedure, Ectopic pregnancy, therapeutic termination of pregnancy, spontaneous abortion<12 weeks , threatened miscarriage>12 weeks.
8: BRUE in Prematurity
9: Blue Dot sign - torsion of testicular appendix management with pain killer , no surgery
10: Notify DVLA in TIA , PCA
11: antipsychotics - priapism
12: Eye brow sign of orbital emphysema
13: any breach in shenton line indicate NOF
14: Lisfranc fracture - wide gap in first metatarsal space , due to injury of Lisfranc ligament between medial cuneiform and second metatarsal bone. - C/ F Plantar ecchymosis. can't walk on tip toe.
so weight bearing XRay, oblique view should be taken .
Amazing session, to impart knowledge. Thank you Dr Ash for arranging such a vibrant platform for learning SBA MRCEM , Jaza kum Allah khair.

FEEDBACK # 7

Bushra Imran

Thank you dr Saba for today's informative session...discussion on basic ER related questions i.e on causes of eclampsia and preaclampsia with look for CVST ,appropriate treatment for pt with pulmonary embolism with thrombosis,WET FLAG and its components,also told how to calculate the size of oral ETT in 4yrs old child and then the formulas for size and length,,the pt with ankle fracture +nuerovascular compromise and need to sedate in ER ,management of OVERDOSE of opioid,high &low risk for BRUE.I learnt about testicular appendage/torsion and blue dot sign which need to treat conservatively rather than to refer for surgery +Lisfranc fracture which I doesn't know before.The drugs causing Priaprism ,x ray of facial fracture ,femur neck fracture and importance of shenton's line...though the session was interestingly excellent

Thank you dr Saba and Dr Ash

FEEDBACK # 8

Hamna Yaqub

Amazing session of high yield emergency medicine by Dr Saba
We learned that pre eclampsia can present up to 6 weeks post partum.
The first line in UNSTABE PE PATIENT is thrombolysis.
WET FLAG components.
BRUE in children.high and low risks of BRUE.
If you find neuro vascular compromise in fracture, immediately sedate and manipulate.
Anti B immunoglobulin indications.
management of opiod overdose.
Diagnosis and treatment of testicular appendage torsion(blue dot sign).
DVLA guidelines for TIA.
Shenton line importance in NOF.
Drugs causing priapism.
Eyebrow sign in orbital fracture.
Lisfranc fracture and its importance as it can cause unstable mid foot.
The whole session was interactive, Dr. Saba way of teaching was simple and explanations are very clear.
Thankyou Dr Saba.
Thank you Dr Ash for arranging thus session.

FEEDBACK # 9

Muhammad Yameen

Very productive and focused session conducted today by Dr. Saba Awan.
She covered different specialities in one hour session.
In this session we learnt about:
CVST
Pre-eclampsia
Thrombolysis in PE
ETT(oral) in pediatrics
Sedation and manipulation in deformed ankle
Anti D immunoglobulin in RH negative pregnant patient
Naloxone infusion in heroine addict
High risk BRUE
Testicular appendage torsion
Blue dot sign
Single and multiple TIA and DVLA instructions
Drugs causing Priapism
Eye brow sign in orbital emphysema

Shenton's line in NOF fracture
Lisfranc injury and it's importance.
The session was very nice that no one wanted it to end.
Thank you Dr. **Ashfaque Ahmed** for bringing such amazing tutors onboard.

FEEDBACK # 10

Amir Ashraf

It was a truly amazing session , such a power pack and informative session with wide range of Questions .
We were taught :
1) eclampsia and preeclamsia is seen after 20weeks of gestation till 6 weeks post partum , so if any pregnant pt presents before 20 weeks , look for CVST .
2) we thrombolyse the pt with PE as most appropriate management even if hemodynamically unstable .
3) WET FLAG and its components , specially how to size oral tube length .
4) it pt has ankle fracture with neuro vascular compromise , just sedate and manipulate don't wait for xray or ortho .
5) Indication for Anti B immunoglobin
6) managing opoid overdose pt , even if gcs drops after initial dose , start Naloxone infusion as its hald life is very short , intubation won't help much .
7) high and low risk for BRUE
😎 testicular appendage torsion and a blue dot sign . Manage conservatively with pain management , no need for surgery.
9) DVLA guidelines with TIAs
10) MC drugs causing priapism
11) xray of eyebrow sign in facial fracture.
12) neck of femur fracture and imp for shenton's line.
13) lisfranc fracture and how imp it is to diagnose as it can cause instable mid foot .
I will say todays session really woke me up after immediate long 8 hours duty .
Thankyouu Dr Saba 👍
Thankyou Dr Ash for arranging such an amazing lecture .
Proud LGEM trainee .
Dr Amir Ashraf

FEEDBACK # 11

Imtiaz Ali Shah

Today we had a comprehensive exam preparatory session by Dr Saba covering important emergency medicine topics.It was an interactive session with mcq,s of high yield topics and their explanation. Dr Saba did a wonderful job in this short period of time and tried her best to deliver most of important learning points.The different scenarios cover the following topics like

Pre-eclampsia.. up to 6 weeks post partum .
PE and need of thrombolysis.
Paediatric life support and use of WETFLAG .
INDICATIONS of Anti-D immunoglobulin.
Role of NALOXONE in opiates overdosage.
Assessment of patient with BRUE and HIGH RISK AND LOW RISK BRUE .
TESTICULAR APPENDAGE TORSION with blue dot sign.
TIA and ĎVLA.
Drugs causing PRIAPISM
It was an excellent session by dr Saba covering most of emergency scenarios He made the things interesting and understandable for us.Overall it was a fruitful session
At the end I would like to thanks dr Saba for this wonderful presentation and also dr Ash for providing us this amazing platform of learning in the form of London GEM.

FEEDBACK # 12

Yasir Dilawar

In this session Dr Saba discussed about difference between eclampsia and seizure in antenatal period. A scenario about venous sinus thrombosis, Patient with pulmonary embolism after CTPA with hypoxia & HTN most appropriate treatment Thrombolysis, WET Flag for ETT size, BRUE in prematurity and radiology scenarios which were very useful.

FEEDBACK # 13

Qaisar Shah

Today, Dr. Saba led a session that lasted for one hour. The topic of discussion during this session was high-yield MCQs, specifically those related to emergency medicine.
> Eclampsia and preeclampsia typically occur after 20 weeks of gestation and can continue up to six weeks post-partum. Therefore, if a pregnant patient presents before 20 weeks, it is important to consider the possibility of cerebrovascular sinus thrombosis (CVST).
>The most appropriate management for a patient with a pulmonary embolism (PE) is thrombolysis, even if the patient is hemodynamically unstable.
>Indications for administering anti-B immunoglobulin.
>In managing a patient with opioid overdose, if the patient's Glasgow Coma Scale (GCS) drops after the initial dose, it is important to start a Naloxone infusion as its half-life is very short and intubation may not be as effective.
>High and low risk factors for BRUE (bronchiolitis, RSV, URI, and exacerbation of asthma/COPD).

>DVLA (Driver and Vehicle Licensing Agency) guidelines for patients with TIAs (transient ischemic attacks).
>Medications that can cause priapism.
>If a patient presents with an ankle fracture and neurovascular compromise, it is best to sedate and manipulate the fracture immediately rather than waiting for an x-ray or orthopedic consultation.
>Testicular appendage torsion and the "blue dot sign." This condition can be managed conservatively with pain management and surgery is not typically necessary.
>Neck of femur fractures and the importance of Shenton's line in diagnosis.
>Lisfranc fractures and the importance of early diagnosis as they can cause instability in the midfoot.
>WET FLAG and its components, specifically the proper technique for determining the appropriate length of an oral tube.
>The "eyebrow sign" on an x-ray in the case of a facial fracture.
The session was extremely informative and beneficial, as it was filled with discussions that covered high-yield and important information. The material covered during the session is likely to be helpful for those preparing for medical exams or for practicing emergency medicine. Overall, the session was well-structured and contributed to a deeper understanding of the topic at hand.
Thanks Dr. saba and Dr. Ash for this amazing session.

FEEDBACK # 14

Afshan Salman

Today had very informative and useful session with Dr. Saba. MRCEM SBA Questions were discussed. We learned:
. CVST needs to be considered if patient with nausea, vomiting, headache comes before 20 wks of pregnancy and its not pre-eclampsia.
. Pre-eclampsia extends from 20th wk of gestation upto 6 weeks postpartum.
. Importance of WET FLAGs and how to calculate ETT length in children,
. Management of ankle dislocation with neurovascular compromise.
. Naloxone in opioid toxicity.
. Concept of BRUE.
. BLUE-DOT sign.
. TIA & DVLA,
Priapism, Shenton's Line, Lisfranc Injury and much more.
An interactive and interesting session. Thankyou very much Dr. Saba and Dr. Ash for the wonderful session

FEEDBACK # 15

Physician Aspirant

Learning points were👇👇

==> Eclampsia is common after 20 th week of gestation.
==> preclampsia starts after 20 th week & can remain up to 6 th weeks postpartum.
==> what is the difference between Appropriaite & next best treatment.
==> formula for Length of ETT oral tube to be used in children is (age /2) +12
==> Manipulation of ankle fracture.
==> learnt about the indication of Anti- D immuniglobulins.
==> How to use nalaxone infusion...?
==> Learnt about what is brue.? Risk factors for that.
most important risk factor is Pre-maturity
Brue is very benign disease.
==> What is DVLA guidance for TIA patients..
==> what is Blue dot sign.? what does it shows.
==> Drugs causing priapism.?
==> Also learnt about different x-rays,.
It was a really wonderful & fruitful session.
Proud to be the part of the London gem .❤️

FEEDBACK # 16

Rana Gulraiz

The lecture was a totally interactive session which was in mcq format to demonstrate all the important topics and life case scenarios which we encounter in day to day life in the ED. It comprised of diagnosis of Eclampsia and Preeclampsia ,CVST .Management of PE ,indications for administration of Anti-B immunoglobulin, Opioid overdose and risk of withdrawal symptoms to reappear if opioid removal is done all at once. High and Low risk factors for BRUE identification and management accordingly. DVLA guidelines of dealing with patients with TIAs and to change the management according to single or multiple TIAs, Medications that cause priapism .Tension appendage torsion and the blue dot sign used for diagnostic purposes, Neck Of Femur Fractures and importance of Shenton's Sign ,WET SIGN and appropriate length of an oral tube. The Eyebrow sign on xray of a facial fracture .Lumbric sign and Management accordingly.
Thank you very much Sir Dr Ashfaque Ahmed ❤️

FEEDBACK # 17

Mina Khan

Today's session was related to exam questions, she had put her hard earned efforts in making questions for all candidates. We were taught.
10weeks primigravida presenting with nausea /dizziness and seixures the next day , its CVDT , whereas eclampsia occurs after 20 weeks/ 40 yrs pt coming with hypoxia/sbp 80/ SOB/suspected PE , tx thrombolysis/ Pels WET FLAG/ in

case of joint vascular injury tx immediate sedation/manipulation/cant hold for an Xray/ 30 wks anemic gravida hx of fall/ no injury /us normal / B negative next step simple give anti D imm as a protocol in last smester of a negative pt/ opoid posioning nalaxone given/ gcs 7 improved /but deteriorating again/ start naloxone infusion / BRUE assessment (havent seen such diqgnosis in my home country) in premature babies/ guidance regarding TIA/ 1st episode no symptoms/ no notifying dvla/ban driving fr 1 month/multiple episodes notify dvla ban fr 3 months. Drugs causing priapism tcas/antidepressants/ lisfranc xray/ shentons line /eyebrow sign Xray/plantar ecchymosis . Learned and noted ... Thank you **London Global Emergency Medicine**

FEEDBACK # 18

Beenish Manzoor

Today we had a power pack and fully exam oriented case base discussion session on Many regular based emergency medicine cases..

Imp learning points were:

1.eclampsia and preeclampsia seen after 20 weeks. cvst should be in differentials if pregnant female present before 20 week

2.eclampsia can ve present after postpartum upto 6 weeks

3.thrombolyse pt with PE if pregnant and even if hemodynamically stable

4. DVLA guidelines about when to report them and what to do in case of TIA

5. fracture,tendency to missed diagnose it,how to manage it(surgica6 intervention)

6.xray findings (eyebrow sign) in case of facial fracture and looking for shenton's line in case of neck of femur fracture.

7. Testicular torsion- a clinical diagnosis which has similar symptoms to that of torsion but no surgical intervention required, just conservative management enough. Intervention is required only if symptoms not relieving or diagnosis is unclear.

8. case of ankle fracture with neuro vascular compression, don't wait for ortho ,simply sedate and manipulate the fracture.

9.when to give anti D Immunoglobulin to pregnant patients.

10.heroine abuse and when to give naloxone infusion, being mindful of full reversal of opioid as can lead to withdrawal symptoms.

11.high and low risk BRUE

12. Drugscausing priapism

13.how to diagnose CVST

14.west flag and how to calculate Ett size

Truly interactive session by Dr Saba .

Thanks Dr Ash

Thankyou LGEM candidate

Proud gem trainee 🙏

FEEDBACK # 19

ناصر فاطمہ

It was really amazing and comprehensive lecture. Dr Saba disscussed really important topics and that too in very palatable way

Some of the chunks for readers that what we learned, so that reading a comment can benefit them..

1) the duration for eclampsia and preeclampsia is from 20weeks of gestation till 6 weeks post partum.. so don't miss it in postpartum patient thinking she can't have it

2)if patient with PE is unstable.. top line management is thrombolysis

3)WET flag.. its really an important thing.. its a whole chart about how to calculate different measurements

4) many of the disclocations are supposed to be dealt by ER physician.. we shouldn't bother ortho peeps for the stuff, we can do.. but obviously in case of any complication or for the stuff that is beyond your capacity.. do ask them for help 🙂

5) indications for Anti-B immunoglobin in pregnancy.. these shouldn't be miss.. read and absorb them all 🙂

6) managment of opioid overdose patient.. Dr Ash taught this in workshop.. that reversal and infusion should be maintain if patient is deteriorating again and again.. and that patient shouldn't be discharged (Nalaxone has shorter half life)

7)high and low risk BRUE.. when to labell it

😎 managment of torsion of testicular appendage causing blue dot sign. Surgery is not required.. conservative management and reassurance is needed

9) DVLA guidelines for TIA patients and importance of documentation

10)facial injury Xray showing eyebrow sign

11) priapism..

12) shentons's line importance to see fracture of neck of femur in xray

13) lisfranc fracture.. ab yeh toh google kryn na ap 😁

jazakALLAH khairan kaseera Dr Ash.. for bringing all this to us.. can't thank ALLAH pak g enough.. Alhamdulilah for being part of LGEM

FEEDBACK # 20

Saba Aslam Khan

Comprehensive, exam oriented session with Dr Saba, it was highly interactive the thing I liked the most was we were in continuously in the state of brain storming because there were continuous MCQs before every topic so we were taught academically as well as reasoning and tricks to attempt the MCQs, how to understand the stem, what examiner is actually asking …..

topics we learned were,

-HTN in pregnancy
-CVST
-Pulmonary embolism
-use of Anti-D immunoglobulin
-DVLA guidelines
-Fractures (femur,ankle)
- Xrays
-blue dot sign
-testicular torsion
- opiods overdose and management
-BRUE
-Priapism causing drugs
Thank you so much Dr Ash for arranging high yield lecture …. Really helpful..
A proud GEM trainee
Dr Saba Aslam ✨🌻

FEEDBACK # 21

Zia Hayat

It was an amazing lecture for almost one hour covering all the major topics related to Emergency Medicine. The lecture was a totally interactive session which was in mcq format to demonstrate all the important topics and life case scenarios which we encounter in day to day life in the ED.It comprised of diagnosis of Eclampsia and Preeclampsia ,CVST .Management of PE ,indications for administration of Anti-B immunoglobulin, Opioid overdose and risk of withdrawal symptoms to reappear if opioid removal is done all at once. High and Low risk factors for BRUE identification and management accordingly. DVLA guidelines of dealing with patients with TIAs and to change the management according to single or multiple TIAs, Medications that cause priapism .Tension appendage torsion and the blue dot sign used for diagnostic purposes, Neck Of Femur Fractures and importance of Shenton's Sign ,WET SIGN and appropriate length of an oral tube. The Eyebrow sign on xray of a facial fracture. Lumbric sign and Management accordingly. Altogether it was a power pack session which was an eye-opener to study for the Exams with full confidence. Thankyou Dr. Ash for arranging the amazing session by Dr.Saba .

FEEDBACK # 22

Shehzad Hussain

Thanks to Dr Saba Today session on high yield SBA by Dr Saba was amazing she covered many topics Eclampsia Preclampsia Pulmonary Embolism BRUE DVLA Lisfrance fracture and many more topics she had done detailed discussion on Q and answers topic related. It was very good comprehensive

lectures with clinical exam based knowledge. Thanks to Dr Ash n LGEM team for arranging wonderful SBA high yield session.

FEEDBACK # 23

Anila Zafar

A very comprehensive session by Dr Saba , it was amazing from the exam point of view. It had me brainstorming the whole time. She also mentioned how should we approach the MCQ questions and how to really understand what is being asked.

I learned about:

Eclampsia

Preeclampsia

CVST

Fractures of femur and ankle

Pulmonary embolism

X-rays

Blue dot sign

Torsion

Drug overdose and its management

BRUE

I would like to thank Dr Ash for keeping this lecture , it really helped.

FEEDBACK # 24

Dr Ruma Mustafa

Wonderful session Amazing experience

I have leanrt so many informative things regarding the exam

1- Pre-Eclampsia.. seizures not before than 20 weeks till 6 weeks P.P

2- CVST.....Pureperium lady with alt.sinsorium cerebral venous sinus thrombosis could be missed tx HEPARIN

3- Thrombolysis... P.E, massive thrombus, unstable patient, cardiac arrest

4- ETT length for 4 Yrs....14cm... PLS WET FLAG

5- Sedate and Manipulate....Ankle fracture neuromuscular compromised

6- Anti-D immunoglobulin...RH Incompatibility With B- blood group...avoid hemolysis of foetal blood cells...falls

7- Nalaxone infusion uptill 4mg 24 hrs... herion addict,pinpoint pupil GCS 7, no need of intubation required

8- Prematurity....high risk feature of BRUE

Infant <2months <32 weeks at birth =/>1

event

9- Testicular appendages torsion... Blue dot sign ,no surgery required (new thing, in pk its Emergency) conservative management

10- Single TIA...1 month drive cessation, no notify DVLA/ Multiple TIA...3month drive cessation, must notify DVLA
11- Sertaline Most common anti depressent causing priapisam
12- intraorbital emphysema...frontal skull xray.... Curvilinear lucency superior aspect of the right orbit showing a black eyebrow sign..orbital fracture
13- Shenton's line..Hip xray....identifying NOF /lower limb trauma..loss of contour of Shenton's line is a sign of fractured NOF
14- Lisfranc injury ... Planter ecchymosis while footballing
Very informative and intellectual session given by Dr. Saba she is mastermind Mashallah ,super brainiac . She knows very well how to tackle the exam question
Thanks soOo much Dr.saba such amazing SBA practice
Thanks a lot, Dr.Asfaque, for everything and every effort ...can't thank u enough I am truly grateful

BLESS U AND WHOLE GEM TEAM 💚💙💜💖

FEEDBACK # 25

Dr Maimona Javaid

Good lecture on high yield SBA covered all imp topics , great learning it was though many of my Answers were incorrect . Still I learnt . Dr ash had a great start discussion . Followed by dr Saba lecture . Topics included eclampsia: preeclampsia, Thrombolysis , BRUE , high and low risk , DVLA, femur fracture. Lisfrance fracture was a new term for me . Eye brow sign in facial fracture and much more . Grateful dr Saba and dr ashfaque. Inshallah will revise it again.
Dr mamoona
London gem first batch

FEEDBACK # 26

Dr Ghayoor Khan

It was a wonderful session regarding exam.
Dr.Saba had covered all aspects very well,she prepared this session excellently.
Scenarios regarding Gynacological disorder, Poisoning(anti-dote), Drugs(side effects), X-rays(fractures and specific signs) and Paeds(wet flag formula)were discussed.
I have learnt a lot about exam that how to exactly answer the question which was asked.
I will be waiting for another session.
Thanks
Dr.Saba Shiraz and LGEM
Kind regards

Muhammad Ghayoor Khan

FEEDBACK # 27

Dr Amash Khan

Today's lecture was of discussion on MCQs of different topics which are seen in the ER like anti D and tetanus admistration, orbital edema, BRUE, lisfranc fracture, testicular appendage torsion, stroke, shenton's line, etc. They were very informative and of importance in Emergency medicine.

FEEDBACK # 28

Dr Faizan Ur Rehman

Assalam o alaikum Dr Ash. I hope you are doing well. I had a lot of fun with today's session. I feel that bcqs are best form of learning. The session was really fun and interactive. Multiple topics were discussed including gynae, orthopedics, pediatrics and some diagnosis that are easily missed in the ED.
Dr Saba did an amazing job with the presentation honestly not a moment was I out of it. All focus was on the questions. I really enjoyed the x ray part. I think such lectures are really helpful to me at this stage as I am prepping for PLAB 1.
In my opinion the best learning points that I thought i would miss were pre-eclampsia presents post partum 6 weeks as well so important not to miss that. Furthermore, it was nice to learn that we reduce fracture in the ED instead of calling orthopedics for all fractures. My love for emergency medicine really at it's peak rn.
Last but not the least like always I am grateful to this platform. I hope to continue learning in the future.
Thank you.

FEEDBACK # 29

Dr Afifa Younis Raja

Greetings of the day!!
Another awesome lecture arranged by Dr Ash, I am amazed how he foresees what topic to be arranged and when, arranging such a great session at the start of our exam is a mindful stroke to orient us with the format and keep us vigilant about the toughness of the exam as well.
We had a healthy discussion on High Yield Emergency Medicine By Dr Saba Shiraz Registrar EM NHS UK.
Dr Saba's way of teaching is phenomenal, selecting high yeild topics and then discussing the exam points this will definitely benefit in our exams. We covered:

- Preeclampsia
- Venous sinus thrombosis
- Opioids and Naloxone
- BRUE

- TIA and DVLA
- Testicular appendage torsion
- Priapism
- Lisfranc injury
- Orbital emphysema
- Shenton's line or NOF fracture
- PE and thrombolysis
- WET FLAG
- Anti D immunoglobulins

Thank you Dr Saba for such an informative session, I really wanted the lecture to continue for another hour as the learning process was so interactive.
Thank Dr Ash for bringing amazing faKIfacultyforward.
King regards,
Dr Afifa

FEEDBACK # 30

Dr Mishal Shan

EM doctors need to quickly evaluate a situation, reach a differential diagnosis and formulate a management plan. This lecture full of SBA type questions gave us a very thorough practice of how to approach such scenarios in the exam and in real life. I got to learn about CVST in pregnancy, infant BRUE, approach to naloxone poisoning, some orthopedic injuries, and alot more in this one hour. It was a great practice session and I am really looking forward to more of such brainstorming activities.
Regards,
Mishal Shan Siddiqui.

FEEDBACK # 31

Dr Nasir Hayat

This session was Amazing and well organised and very well taught.I learned alot.
Thanks to Dr Saba Today session on high yield SBA by Dr Saba was amazing she covered many topics Eclampsia Preclampsia Pulmonary Embolism BRUE DVLA Lisfrance fracture and many more topics she had done detailed discussion on Q and answers topic related. It was very good comprehensive lectures with clinical exam based knowledge. I would have highly recommend it for ER physicians to join it .she answerd all the Questions. Proud to be LGEM candidate

FEEDBACK # 32

Dr Aakash

Learning points were 👇👇

==> Eclampsia is common after 20 th week of gestation.
==> preclampsia starts after 20 th week & can remain up to 6 th weeks postpartum.
==> what is the difference between Appropriaite & next best treatment.
==> formula for Length of ETT oral tube to be used in children is (age /2) +12
==> Manipulation of ankle fracture.
==> learnt about the indication of Anti- D immuniglobulins.
==> How to use nalaxone infusion...?
==> Learnt about what is brue.? Risk factors for that.
most important risk factor is Pre-maturity
Brue is very benign disease.
==> What is DVLA guidance for TIA patients..
==> what is Blue dot sign.? what does it shows.
==> Drugs causing priapism.?
==> Also learnt about different x-rays,.
It was a really wonderful & fruitful session.

FEEDBACK # 33

Dr Nouman

It was an amazing session with very interesting mcqs that were discussed with a view on exam & clinical skills focus.
Dr Saba really put great effort in helping to understand the question & answers and everyone was eager to participate.
Thanks Team LGEM and Dr Saba for such informative session. Hoping to see more of this
Regards,
Dr Nouman

FEEDBACK # 34

Dr Zaid Ahmed Ansari

Dr Saba's lecture was a n interactive one hour session foucsed primarily on high-yield MCQs for emergency medicine.
Eclampsia and preeclampsia: clinical signs at 20 weeks if a pregnant patient. If presenting before 20 weeks, consider possibility of CVST.
Pulmonary embolism best management is thrombolysis, even with hemodynamic instability.
Naloxone infusion in patients with opioid overdose if GSC drops after intial administration.
Risk factors, bith high and low, for BRUE
DVLA Ag guidelines for patients with TIAs.
Medications that can potentially trigger priapism.

Sedate patient and manipulate ankle fracture immediately rather than wait for ortho consult or xrays.
Testicular torsion, blue dot sign. Pain management, surgery not necessary.
Neck, femur fractures and Shenton's line in xrays taht aids in diagnosis.
Early diagnosis of midfoot fractures through pinpointing Lisfranc fractures
WET FLAG and its components
Eyebrow sign and facial fracture x-rays
Apart from the usefulness from an exam POV, these little sniuppets of information can really help in a medical emergency and prompt quick action in the ER.

FEEDBACK # 35

Dr Aiman Nazir

It was a very comprehensive session consisting of SBA questions . Dr Saba did a wonderful job in selecting a wide range of topics and including them in today's discussion. Not only she made sure to go through important and commonly tested topics of different specialities but also explained the answers so nicely that no confusion should be left behind.
Interaction and training our minds to think efficiently and quickly in such scenarios has made these SBA sessions more interesting . A variety of x rays were shown and were explained very well. Learned something new called BRUE and it is quite a relevant and common thing to encounter in ED .
Thank you so much Dr Saba for today's session and all the explanations . Hope to have some more sessions from you in future .
Dr Aiman Nazir
EMFP LGEM

28TH JANUARY 2023

EVENT NAME:

Renal Dysfunction In Systemic Diseases MRCP High Yield By Dr Naila Sorathia Consultant NHS UK

DOCTORS FEEDBACK

FEEDBACK # 1

Rajab Abbas

Today's session was knowledgeable and exam oriented. In Two hours session she explain and elaborated every aspect affecting renal disfunction.

• Cause of AKI (pre/intra/post renal)
• Renovascular disease
• SLE Nephropathy
• Stages of diabetic nephropathy & Role of ACE inhibitors
• New knowledge what I learned today was about Renal Screen . It was new term for us in which causes of renal dysfunction is sought out. By sending labs for related connective tissue disorders.
• She talked about Amyloidosis in detail with exam point of view.
• She also explained renal vascular disease. Its pathophysiology and systemic involvement.
•Cinical difference with multiple myeloma and MGUS
• Difference between HUS and TTP .
Thank you Dr Naila and Dr Ash for this session.
A proud LGEM candidate
Dr Rajab Abbas.

FEEDBACK # 2

Mina Khan

Todays session by dr naila was very comprehensive , she taught about SLE nephropathy which has signs of proteinurea/nephrotic syndrome/progressive AKI/CKD/ drug induced sle does not involve kidneys/ drugs causing sle phenytoin/ hydralazine/biopsy is needed to stage disease/type 1/2 mild form no tx required/3/4 stage need high dose of steroid/cylophosphamide. Scleroderma crises (HTN/microangiopathic anemia/aki) tx ace inhibitors/Diabetic Nephropathy/microalbuminea/macro albuminea/capillary damage protein leakage/>200mg/L proteinuria/24hr urine test not possible, do albumin-creatinine ratio test/stage 1 GFR>20% /stge 2 hypertrophied kidneys/ hyper filtration/stgr3 microalbuminuria/stge4 macroalbuminuria/stgr 5 EKSD / tx ace inhibitors/ARBs /strict glycemic control/bp 130/80mmhg/ other causes of renal failure HUS/TTP/Hypertensive nephrosclerosis. Learned and noted a lot.
Thanks London Global Emergency Medicine

FEEDBACK # 3

Yasir Dilawar

In today's lecture Dr Naila gave us a lot of valuable concepts like RAAS system, SLE nephropathy, Diabetic Nephropathy, Micro and Macro Albuminuria, Stages of Diabetic Nephropathy, Thrombotic microangiopathies, HUS, difference between HUS and TTP, Myeloma vs MGUS, Vasculitis and it's classification, Wagener Granulomatosis and much more. she also discussed the various screening tests for kidney diseases and management of these conditions.it was very good lecture. Thanks to Dr Naila mam.

FEEDBACK # 4

Suhail Ahmed

A very commonly tested topic for MRCP exam yet very volatile to remember.
A hot subject in MRCP exam.
This teaching session gave me the great insight into this topic.
Dr. Naila included all the common. Systemic diseases that affects the kidneys such as Amyloidosis, Myeloma, Connective tissue diseases.
Thank you so much Dr. Nails and Dr. Ashfaque for this great learning activity.

FEEDBACK # 5

Ghulam Saddique Saddique

Exceptional session conducted by Dr.Naila Ashfaque Full of Knowledge pearls she shaired. Exam focused targed mcq points to be asked in scenarios .
AKI mostly presents with vague symptoms
Classification
Pre Renal Causes (vascular)
Renal causes Intrinsic
Post renal Obstructive cause
Renal causes then classified as
•Glomerular -nephritis nephrotic synd Glomerulonephritis
•Intrestitial mainly by medications
•Tubular by RTA,Medications contrast, amyloidosis, Rhambdomylosis.
Then such a details discussion done by Dr Naila about the Extrinsic causes leading to RENAL Failure in AKI setting. Systemic disorders like amyloidosis, RV diseases, connective tissue diseases, Diabetes, HTN, thrombotic micro angiopatheis.
Amyloidosis discussed in detail.
Presentation with Proteinurea, nephrotic syndrome renal failure.
AL Light chain with poor prognosis.
AA amyloidosis better prognosis then AL subtype.
Kidneys are the main target in AA.
Heriditary Amyloidosis
Biopsy of target organ to be done to confirm which stains congo red.
Explanation of amyloidosis pathophysiology was great as it comprisis of light chains of immunoglobulins being clumped up and deposit in kidneys leading KI, In heart leading to RCMP, Arrhythmias and LVH. Peripheral neuropathy macroglosia.
50% cases of amyloidosis have multiple myeloma
AA amyloidosis discussed secondary to
Ch suppurative disorders like TB
Ch inflammatory disorders like CTD

Rheumatological conditions .GI IBS,Whipples
Renovascular disease discussed in detail
Atherosclerosis as main pathophysiology.
Renal atery stenosis .
Fibromuscular dysplasia in young patients constitues 10% cases of renovascular with poor controlled HTN.
RAAS system explained.
For screenjng Doppler RV
Gold standard MRA / CTA
Then briefly Connective tissue diseases discussed.
Mixed CTD SLE RA
Renal screen a bunch of tests to get the confirnation about the cause of AKI explained. Heard it for 1st time.
Includes Myeloma screen
RA factor, cANCA pANCA , ANA ,anti dsDNA , Complient factors, HbA1c
Diabetes and its renal complications discussed as its #1 causes of renal failure.
Its screening
Proteinurea as micro and macro albumin urea discussed.
How to cath up with spot urinary ACR .
HTN leading to AKI
MGUS stable plasma protein disorder vs Multiple Myeloma with end organ damage discussed.
Vasculitis types affecting the kidneys discussed in details
HUP in children vs TTP in adults discussed
Whole session by Dr Naila non stopped covered all the high yield topics with such an extreme dedication of a TECHER . Highly obliged leared alot .

FEEDBACK # 6

Dr Ahmad Tanveer

Dr Naila's todays session was as usual more then expectations. Full of Knowledge pearls she shaired. Exam focused targed mcq points to be asked in scenarios .
AKI mostly presents with vague symptoms
Classification
Pre Renal Causes (vascular)
Renal causes Intrinsic
Post renal Obstructive cause
Renal causes then classified as
•Glomerular -nephritis nephrotic synd Glomerulonephritis
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Diabetes and its renal complications discussed as its #1 causes of renal failure.
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Proteinurea as micro and macro albumin urea discussed.
How to cath up with spot urinary ACR .
HTN leading to AKI

MGUS stable plasma protein disorder vs Multiple Myeloma with end organ damage discussed.
Vasculitis types affecting the kidneys discussed in details
HUP in children vs TTP in adults discussed
In nutshell this lecture Dr Naila non stopped covered all the high yield topics with such an extreme dedication of a TECHER and GURU. Highly obliged

learned alot .DR ASH thanks for todays lectures pearls by you too .

FEEDBACK # 7

Dr Ghazala Sheikh

Today's session was very useful in exam point of view, totally exam oriented, I learnt the importance of each topic related with systemic diseases impacting kidneys

● AKI
. Causes
. Classification
. Renal causes defined in detail
. Drugs causes interstitial nephritis
. Tubular nephritis by contrast, RTA etc
● Systemic disease such as SLE
. Mostly nephritic picture
. Amyloid depositions
. Sceleroderma
● Diebeties and kidney
. Stages of diebetic nephropathy
. Stages of Proteinuria
. Ace/Arbs renoprotective
● importance of renal Screening
● Thrombotic disorders and kidney
. HUS mostly in children
. Child+AKI+diarrhea. Must exclude hus
. Thrombopenic Thrombocytopenic purpura mostly in adults
● Myloma and kidney
. Difference bw multiple myeloma and MGUS
● Atherosclerosis in renal arteries
. Pathophysiology
● Fibromuscular Dysplasia

Overall lecture contained very important points, reviewing again and again will make us a better grip on Renal system

Thankyou mam naila for giving us your precious time 💖

FEEDBACK # 8

Dr Afifa Younis Raja

Greetings of the day!!

So today we got lucky and got BONUS LECTURE from DR ASH J

The topic was renal dysfunction in systemic diseases by Dr Naila Ashfaque, I love the way she teaches us and how she highlights the exam's favourite points.

Topics we covered today:

- Evaluation of AKI
- CAUSES of AKI (pre renal, renal, post renal)
- Renal causes of AKI (intrinsic and extrinsic)
- Common systemic disorders affecting kidney
- Amyloidosis classification
- AL Amyloid (light chain amyloid) can deposit everywhere in body apart from brain
  - For definitive diagnosis biopsy of involved organ with Congo red stain
- AA Amyloid
- Reno vascular disease (Renal artery stenosis, firbromuscular dysplasia)
- Connective tissue disorders affecting kidney
- SLE nephropathy
- Diabetic nephropathy
- Albuminuria
- Thrombotic microangiopathy
- HUS
- TTP
- HTN in kidney
- Myeloma and kidney

It was an amazing interactive session, and this has definitely polished our clinical skills.

Thankyou Dr Naila for an incredible session and Dr Ash for the bonus session.

Warm regards,

Dr Afifa

FEEDBACK # 9

Dr Mishal Shan

Like every lecture by Dr Naila, this one was also great and gave us alot of practical information which is relevant not only for the exam but also in routine practice. She covered a lot of causes and presentations of renal disease, told us which condition to suspect in which situation and how to proceed with further

investigations and management. 2 hours of the lecture were worth each and every minute!
Thank you very much for such useful classes!
Regards,
Mishal Shan Siddiqui.

FEEDBACK # 10

Dr Leela Ram

It was an awesome session on renal manifestations of systemic diseases by Dr. Naila Ashfaque, she explained the causes of Kidney failure:
1. Pre-renal(decreased kidney perfusion)
2. Intrarenal causes
3. Post renal causes (Obstructive uropathy)

Variety of causes affect kidney function from acute to drugs and insidious.
Amyloidosis remains one of the causes which affects kidney & causes proteinuria, nephrotic syndrome and CKD.
Biopsy reveals Congo-red staining. Classification of Amyloidosis:
1. Light chain (AL Amyloidosis) has poor prognosis
2. AA Amyloidosis: it targets heart
3. Hereditary Renal Amyloidosis

Atherosclerosis causes narrowing of renal arteries which result in activation of RAAS (Renin>Angiotensinogen>Angiotensin-I>Angiotensin-II>Aldosterone>Na+H2O retention+ ADH which causes retention of water) which increases blood pressure.
Common systemic disorders affecting kidneys are:
1. Amyloidosis
2. Renovascuar disease
3. Connective tissue disorders
4. Diabetic nephropathy
5. Thrombotic microangiopathy
6.Hypertension
7. Myeloma
8. Vasculitis
9. CCF

Some other causes include Fibromuscular dysplasia in younger patients with history of hypertension.
Entire session covered all investigations and treatment options and also side effects.
I have learned so many new things & will strive to give more and more input in studies for MRCP exam.

Thank you so much Mam for terrific session & thank so much Sir for motivating us for the best.

FEEDBACK # 11

Dr Nasir Hayat

This session was very well presented and Taught.I learned Alot.
Dr Naila's todays session was as usual more then expectations. Full of Knowledge pearls she shaired. Exam focused targed mcq points to be asked in scenarios .
AKI mostly presents with vague symptoms
Classification
Pre Renal Causes (vascular)
Renal causes Intrinsic
Post renal Obstructive cause
Renal causes then classified as
•Glomerular -nephritis nephrotic synd Glomerulonephritis
•Intrestitial mainly by medications
•Tubular by RTA,Medications contrast, amyloidosis, Rhambdomylosis.
Then such a details discussion done by Dr Naila about the Extrinsic causes leading to RENAL Failure in AKI setting. Systemic disorders like amyloidosis, RV diseases, connective tissue diseases, Diabetes, HTN, thrombotic micro angiopatheis.
Amyloidosis discussed in detail.
Presentation with Proteinurea, nephrotic syndrome renal failure.
AL Light chain with poor prognosis.
AA amyloidosis better prognosis then AL subtype.
Kidneys are the main target in AA.
Heriditary Amyloidosis
Biopsy of target organ to be done to confirm which stains congo red.
Explanation of amyloidosis pathophysiology was great as it comprisis of light chains of immunoglobulins being clumped up and deposit in kidneys leading KI, In heart leading to RCMP, Arrhythmias and LVH. Peripheral neuropathy macroglosia.
50% cases of amyloidosis have multiple myeloma
AA amyloidosis discussed secondary to
Ch suppurative disorders like TB
Ch inflammatory disorders like CTD
Rheumatological conditions .GI IBS, Whipples
Renovascular disease discussed in detail
Atherosclerosis as main pathophysiology.

Renal atery stenosis .
Fibromuscular dysplasia in young patients constitues 10% cases of renovascular with poor controlled HTN.
RAAS system explained.
For screenjng Doppler RV
Gold standard MRA / CTA
Then briefly Connective tissue diseases discussed.
Mixed CTD SLE RA
Renal screen a bunch of tests to get the confirnation about the cause of AKI explained. Heard it for 1st time.
Includes Myeloma screen
RA factor, cANCA pANCA , ANA ,anti dsDNA , Complient factors, HbA1c
Diabetes and its renal complications discussed as its #1 causes of renal failure.
Its screening
Proteinurea as micro and macro albumin urea discussed.
How to cath up with spot urinary ACR .
HTN leading to AKI
MGUS stable plasma protein disorder vs Multiple Myeloma with end organ damage discussed.
Vasculitis types affecting the kidneys discussed in details
HUP in children vs TTP in adults discussed
In nutshell this lecture Dr Naila non stopped covered all the high yield topics .I would high recommend it for physicians to join it. Proud to be LGem candidate.

FEEDBACK # 12

Dr Faiza Arshad Baig

Today's session was an eye opener and wonderfully informative. It was based on Mrcp exam high yields.
She described all the renal manifestations of systemic disorders step by step:
Renal causes and its classification
Pre renal causes
Renal causes
Post renal causes
She told us how to classify renal causes
First micro and macro albuminuria then for diagnosis aspects
1- glomerular
2-tubular
3- interstitial
4- vascular
Then she described Amyloidosis in detail with exam point of view
It's deposition, staining and classification: light chain with poor prognosis,

A-A amyloidosis main kidney organ and cardiac involvement
Heridatory

- peripheral neuropathy plus proteinuria and renal function deranged in amyloidosis
- AL infiltrate any organ other than brain.

She also explained renal vascular disease. Its pathophysiology and systemic involvement.
Renal screening:
BUN , eGFR, serum creratinine, urinalysis, Microalbuminuria,, UACR(urine albumin to creatinine ratio) ,
ANCA for Vasculitis, Glomerular basement membrane antibodies for Goodpastures ds,
ANA for SLE or other connective tissue disorders, Serum urine Electrophpresis for Myeloma,
C3 C4 for immune comlex Nephritis
C3,C4, ANA, ANCA, cryoglobulins,, MPO (myeloperoxidase antibodies), IgG IgA IgM
In the end of topic she explained diabetes and its renal complications and how HTN leads to cause AKI

- What is the clinical difference with multiple myeloma and MGUS
- what is the clinical difference between HUS in kids and TTP in adults

To summarize, Dr Naila covered all the high yield mrcp points of renal manifestations with dedication. Thank you Dr Naila and Dr Ash

FEEDBACK # 13

Dr Zaid Ahmed Ansari

Dr Naila' session was gearded twoeards an extensive study of renal dysfunction in systemic diseases. The lecture covered:

- Etiology of of AKI from pre to post renal
- Renovascular disease and SLE Nephropathy
- Stages of diabetic nephropathy
- Role of ACE inhibitors in diabetic neuropathy

Renal screens and amyloidosis were explained and dicussed in detail, along with the pathophysiology of renal vasucualr disease with focus on systemic spread, the clinical difference between multiple myelomas and MGUS, the difference b/w HUS and TTP.
This lecture provided a professional's perspective to renal dysfunction, which i feel would come in handy during exposure to such cases in a clinical setting.

FEEDBACK # 14

Dr Emmanuel Charles

Mrcp targeted interactive sessions with rapid review of vitals topics. All the important points were well summarized and explained.
From initial presentation of renal anomalies, management, treatment and life-style modifications
The lecture was case-based discussion covering the following points :Amyloidosis, Renovascular disease, Connective tissue disorders, Diabetic nephropathy, Thrombotic microangiopathy, Hypertension, Myeloma, Vasculitis, CKD and CCF
In end Dr Ashfaque invaluable guidance and medical tips were excellent as always
Thankyou Dr. Ashfaque Ahmed for facilitating the whole session.
Thankyou Dr Naila Sorathia
Thankyou LGEM MRCP PROGRAMME TEAM

29th JANUARY 2023

EVENT NAME:

Glomerulonephritis High Yield MRCP By Dr Yasir Baig Consultant Nephrologist NHS uk

DOCTORS FEEDBACK

FEEDBACK # 1

Ahmad Tanveer

A beautifully crafted lecture very well explained by Dr Yasir. More intrestingly the slides explanation with staining, Immunofluorescence and electron microscopy images added an actual picture. Pearls of knowledge shared by Dr Yasir was excellent.
Glomerulonephritis: a group of immune- mediatead disorders characterized by inflammation of the glomeruli.I
ntrinsic cause of AKI which can lead to CKD. 3rd MCC of ESRD following HTN and diabetes.
Types of GN
(Complexity vs Simplicity) -Histopathological Lesions on Biopsies
(Crescenteric GN, FSGS, MPGN)
-Immunopathogenesis based types (newer approach for targeted treatment)
Autoimmune GN(IgA, MN, ANCA, Anti-GBM, Lupus)

Infection related GN
(PSGN, HIV, Hep B&C)
Auto inflammatory GN(Compliment over activation and C3GN)
Monoclonal gammopathy related to GN.
(AL amyloidosis, light & heavy chain DD)
Clinical Presentation:
Nephrotic Syndrome:
Edema,
Albuminuria >3.5g in 24 hrs,
Serum Albumin <30g/L
Nephritic Syndrome:
Edema,Haematuria, HTN
•Both(Nephrotic + Nephritic /RPGN)
Sign and symptoms GN:
Lethargy, tiredness ,wt. Loss, rash, swelling, hemoptysis,
nasal/oral ulcers,
hearing loss, oligoanuria, HTN, hematoproteinuria, derranged renal functions.

Lab workup:
Urine dip, uACR / uPCR, FBC, U&C, Coagulation Profile.
If heamatoproteinuria with AKI then do
•Renal screening that include ANA, dsDNA, C3,C4, Anti GBM, Myeloma Screening.
ECG
Chest X-ray and Renal US.
Renal biopsy: Gold Standard for diagnosing GN.
General measures of Management:
History & examination, investigations & respond fast for managing Fluid balance, BP control measures,
Lifestyle adjustments
smoking cessation
salt restriction, exercise & involving the Specialist
GN with Nephritic and Nephrotic /RPGN:
1.Anti GBM antibodies mediated(90% develop ESRD antibodies against alpha 3 chain of typeIV collagen ,can cross react with alveolar BM- good pasture syndrome
Tx: steroids, cyclophosphamide
2.ANCA Vasculitis(MPA, GPA, EGPA)

CRESENT GN, Proteinase 3ab +ve in GPA, MPOab +ve in MPA, Eosinophilia with GPA (churug Strass Syndrome). IF -ve, on EM no deposited are seen but break in capillary BM.
Tx : steroids, cyclophosphamide,ritux
It can overlap with anti GBM .
3.Lupus Nephritis (20% progress to ESRD in 10 years)
5 stages of as per immune complex deposit
1 & 2 is mesangial deposited
3 (focal)4 (diffuse) proliferative = subendothelial deposited, hypercellularity, with necrotising and crescent lesions
Stage 5 membranous
IF: polyclonal IgG,IgA,IgM,C3,C1q.
Tx: hydroxycholine with life style stage 1 and 2
Steroid and low dose cyclophosphamide or MMF in 3&4
GN with nephritic syndrome:
Post streptococcal GN-1-2 % to ESRD, developed after throat (1-2 wks) or skin (4-6 wks) strep. Infx.
Hypercellularity of neutrophils,granular deposited in IF and subepithelial hump like deposits
Tx : culture and treat infx.
IgA Nephropathy (10% progress to ESRD highest in Asian)IgA antibodies form immune complex with glycosylated IgA1 leading to glumerular deposite.
Tx: RAAS inhibitor use and SGLT2 inhibitor if u ACR > 22.6mg/dlwith GFR 25---75.
Ritux or cyclo if crescent and rapid progression
GN with Nephrotic Syndrome:
1.Minimal Change Disease:
MCC of Nephrotic synd. In children, normal RFTs, Podocyte foot effacement in glomeruli on EM.
Very responsive to steroids ,Hyperlipidemia management, anticoagulation if albumin <20 to 25, fluid and salt management.
2.Membranous Nephropathy.
20 to 30% progress to ESRD
Primary MN anti PLS2Rab bind to receptors on podocytes on subepithelial area.
Secondary MS due to drug , malignancy ,Hep B
Thickened capillary walls ,spikes
Tx according to risk(eGFR , proteinuria ,serum albumin value)
3.FSGS (80% develop ESRD
Types :idiopathic, Genetic (APOl genes in Africans) secondary (drugs and HIV,CMV, lithium)

Podocytes effeacment
Tx: as per presence or absence of Nephrotic syndrome
4.C3 Glumerulopathies
5.Lupus Nephritis type 5
Mcqs were exam oriented and at right time and at right place that session was extremely interesting .
At the end the two cases by Dr Ash presented
1st interesting case of Pt having SLE with B/L blindness with suspected CKD.
2nd was of a pregnant lady with loin pain who was diagnosed with emergency usg evaluation to be having hydronephrosis were discussed.

Gem  of a lecture very well explained and Dr Yasir and Dr Ash thanks for such a great educational activity.

FEEDBACK

Faiza Baig

This session was comprehensive and well focused.
Dr.Baig explained the particular type of GN , complexity or simplicity. He first mentioned the physiology and pathology of kidney and then,
The definition and classification of GN. Clinical Presentation Based on
• Nephrotic Syndrome
- Edema
- Albuminuria >3.5g in 24 hrs
- Serum Albumin <30g/L
• Nephritic Syndrome
- Edema
- Haematuria
- Hypertension
• Nephrotic + Nephritic / RPGN
He also described microscopic picture of disease
Work Up
• Urine dip
• uACR/uPCR
• FBC, U&Es, Coagulation profile
• If haematoproteinuria with AKI then renal screening includes
ANA, dsDNA, ANCA, C3, C4, anti-GBM, Myeloma screen
• ECG
• Chest Xray
• Renal Ultra sound
Gold standard for diagnosis of GN is renal biopsy.

Always take general measures, take history and examination, think and do management quickly
Take vitals and maintain fluids.
GN with Nephrotic Syndrome
1. Minimal Change Disease
2. Membraous Nephropathy
3. FSGS
4. C3 Glomerulopathies(DDD)
5. Lupus Nephritis type5,
GN with Nephritic Syndrome
1. Post Strept Infection GN
2. IgA NephropathyLupus
Nephritis stages and treatment
• Hydroxycholine with life style in stage 1&2
• Steroids+ Low dose cyclophosphamide or MMF in 3&4
• Class V as MN mainly CNIs (cyclosporine and tacrolimus)
Mixed identifications and management GN with nephrotic plus nephritic.
In the end of lecture Dr Baig gave us 3 scenario based mcqs related to this topic, which were highly informative.
And lastly, Dr Ash told us a known case, was on renal thrombosis. How he diagnosed and managed that case.
Thank you Dr Ash and Dr Baig

FEEDBACK # 3

Anila Zafar

Dr Yasir's lecture on glomerulonephritis was amazing. He explained the different types with their distinctive points in a very comprehensive manner.
He classified them and also taught how to identify the type based on the patient's presentations, it's treatment.
He also differentiated it from nephritic.
He also explained their differences based on biopsy findings and according to their light and electron microscopy.
Thank you Dr ASH and Dr yasir.

FEEDBACK # 4

Ghulam Saddique Saddique

A wonderful session conducted by Dr Yasir he tried to clear our concepts about glomerulopathies and it's clinical presentations and what is required for workup.
Glomerulonephritis

is a term used to describe a group of immune- mediatea disorders characterized by inflammation of the filtration units of the kidney (the glomeruli).Intrinsic cause of AKI which can lead to CKD.

Types of GN (Complexity vs Simplicity) Histopathological Lesions on Biopsies
Crescenteric GN, FSGS, MPGN

Immunopathogenesis based types (newer approach for targeted treatment)
Autoimmune GN(IgA, MN, ANCA, Anti-GBM, Lupus)
Infection related GN
(PSGN, HIV, Hep B&C)
Auto inflammatory GN(Compliment over activation and C3GN)
Monoclonal gammopathy related to GN.

Clinical Presentation Based
Nephrotic Syndrome
Edema
Albuminuria >3.5g in 24 hrs
Serum Albumin <30g/L

Nephritic Syndrome
Edema
Haematuria
Hypertension 1

Nephrotic + Nephritic /RPGN

Sign and symptoms GN
1.HTN, 2. Abnormal RFTS, 3. Hematoproteinuria, 4. weightloss, 5. hemoptysis, 6. lethargy, 7. tiredness.

Workup:
Urine dip
u ACR/u PCR
FBC, U&C, Coagulation Profile.
If heamatoproteinuria with AKI then do Renal screening that include ANA, dsDNA, C3,C4, Anti GBM, Myeloma Screening.
ECG
Chest X-ray and Renal USG.
Gold Standard for diagnosing GN is Renal Biopsy.

General measures of Mangement
History & examination, think and respond quickly, Fluid balance, BP control measures, Lifestyle adjustments and involving the Specialist

GN with Nephritic and Nephrotic /RPGN
1.Anti GBM antibodies mediated(90% develop ESRD antibodies against alpha 3 chain of type4 collagen also cross rear to alveolar BM.
2.ANCA Vasculitis(MPA, GPA, EGPA)

CRESENT GN, Proteinase 3ab +ve in GPA, MPOab +ve in MPA, Eosinophilia with GPA (churug Strass Syndrome). IF -ve, on EM no deposited are seen but break in capillary BM.
It can overlap with anti GBM .
3.lupus Nephritis (20% progress to ESRD)
5 stages of lupus nephritis
1 & 2 is mesangial deposited
3 focal 4 diffuse proliferative = subendothelial deposited.
Stage 5 membranous.
GN with nephritis
Post streptococcal GN (granular deposited in IF and subepithelial hump like deposite
IgA Nephropathy (10% progress to ESRD highest in Asian)IgA antibodies form immune complex with glycosylated IgA leading to glumerular deposite.
RAAS inhibitor use and SGLT2 inhibitor if u ACR > 22.6mg/dlwith GFR 25---75.
GN with Nephrotic Syndrome.
1.Minimal Change Disease.(Podocyte effacement in glomeruli in children)
Very responsive to steroids ,Hyperlipidemia management, anticoagulation if albumin <20 to 25, fluid and salt management.
2.Membranous Nephropathy.
20 to 30% progress to ESRD
Primary MN anti PLS2Rab bind to receptors on podocytes on subepithelial area.
Secondary MS due to drug , malignancy ,Hep B
3.FSGS (80% develop ESRD types Genetic APOl genes in Africans secodry type due to drugs and HIV.
4.C3 Glumerulopathies
5.Lupus Nephritis type 5
Two case based discussion by Dr.Ashfaque .Thanks Dr.Ashfaque for providing us informative knowledge on LGEM platform
I am proud to be apart of LGEM programme.

FEEDBACK # 5

Beenish Naveed

Dr Yasir taught us one of the most difficult topic comprehensively. He explained what is required to know exactly about a particular type of GN. He started with explaining the definition and classification of GN.
How to identify different types according to the patient's presentation and it's specific treatment. When we classify them as nephrotic and when as nephritic. He also explained the different biopsy results related to the type of GN and it's electron microscopy presentation.

Dr Yasir explained the Mcqs as well which helped in understanding of the topic in depth.
Thank you Dr Yasir for wonderful explanation and thanks Dr Ash for providing us such knowledgeable teachers.

FEEDBACK # 6

Dr Raja Mobeen Ahmed

Another great lecture expertly delivered by Dr Yasir on a complex topic of Glomerulonephritis. He superbly taught about the types of GN, the clinical presentation, the necessary investigations, findings on histology and Immunofluorescence and the various treatment options.
He started with definition of GN as immune mediated disorders that cause inflammation of the glomerulus, leading to AKI and in some cases CKD, being the 3rd leading cause of CKD after Diabetes and HTN. He also showed how the glomerulus looks on histology slides.
He then told the classification of GN can be based upon
1) Histopathology (Cresentic, FSGS, MPGN),
2) Immunopathogenesis (Autoimmune such as IgA, ANCA, MN, anti GBM, Lupus nephritis)
3) Autoinflammatory (Complement over activation, C3GN)
4) Monoclonal Gammopathy related GN (AL amyloidosis)
The classification can also be done based on Clinical presentation such as Nephrotic (edema, hypoalbuminemia, proteinuria >3.5g/24h), Nephrotic (edema, hematuria, hypertension) and mixed Nephrotic and Nephritic (LN class III and IV, anti GBM, Cryoglobulinemic GN, ANCA vasculitis).
Dr Yasir taught about the signs and symptoms of GN which can include hypertension, hemoproteinuria, abnormal kidney functions and also S and S of the underlying disorder leading to GN e.g. vasculitis.
Then we discussed the workup required which includes Urine dipstick, uACR/uPCR, FBC U and E Coagulation profile, if hemoproteinuria with AKI to send renal screen which has ANA dsDNA ANCA C3 C4 antiGBM Myeloma screen, ECG, Chest X ray, Renal ultrasound. The gold standard test being the kidney biopsy.
Dr Yasir summarized the general management of these disorders with taking a good history and examination, to think and respond quickly, fluid balance, blood pressure control, life style modification (reduce salt, stop smoking , exercise) and to initiate specific therapy sooner than later. Then he moved onto the specifics of different GNs.
1) Anti-GBM vasculitis. 90% patients develop ESKD in weeks. Has auto antibodies to alpha-3 chain of Type IV Collagen. It can cross react with alveolar

BM leading to Goodpasture's syndrome. Linear pattern on IF. Treatment options include Steroids, Cyclophosphamide and Plasma exchange.
2) ANCA vasculitis. It causes Crescentic GN/RPGN. Associated with anti-PR3 Ab in GPA, MPO Ab in EGPA. It is pauci-immune (IF is negative). On Election microscopy no deposits but breaks in BM seen. Treatment is Steroids with Cyclophosphamide or Rituximab but no PEX (PEXIVAS trial). If overlap with anti-GBM then PEX is to be done but has poor prognosis.
3) Lupus Nephritis. 20% patients progress to ESKD in 10 yrs. Can be divided into 5 stages (Class I and II has mesangial deposits, Class III Focal, IV DPGN, Class V membranous). It has "Full House" staining with polyclonal IgG IgA IgM C3 C1q. Treatment is according to the stages. For Class 1 and 2 HCQ and lifestyle measures. For Class 3 and 4 with Steroids and Cyclophosphamide or MMF. For Class V use Calcineurin inhibitors (CNIs)
4) PSGN. 1-2% develop ESKD. Develops 1-2 weeks after URTI or 4-6 weeks after strep skin infection/impetigo. Microscopy shows hypercellularitt with neutrophils, Granular deposits on IF subepithelial humps. We have to culture and treat infection and take supportive measures.
5) IgA nephropathy. It's the most common GN in the world. 10% progress to ESKD in 10 years. Can be found in all age groups, highest in Asians. Crescents can be present/RPGN. Has mesangial expansion and proliferation. IF positive for IgA mesangial deposits. The IgA Ab forms immune complexes with Glycosylated IgA1 leading to deposition. Treatment includes supportive care (RAAS inhibitors, lifestyle), SGLT2i if uACR>22.6mg/mmol and eGFR 25-75. Trials with newer drugs like Atrasentan, Sparsentan, HCQ. If there is RPGN to give IS therapy with Rituximab or Cyclophosphamide.
Dr Yasir then discussed the GN with Nephrotic Syndrome picture which includes Minimal Change Disease, Membranous nephropathy, FSGS, C3 Glomerulopathies (Dense deposits disease), Lupus nephritis V.
1) MCD, a common cause of Nephrotic Syndrome in children. The kidney function remains preserved. Pathophysiology involves abnormal cytokines of T cells causing effacement of podocytes leading to selective proteinuria. The light microscopy is normal, on IF no deposits, on EM effacement of podocytes. The disease is very responsive to steroids. Other measures include salt restriction and fluid management, hyperlipidemia management and to Anticoagulated if serum albumin below 20-25.
2) Membranous nephropathy. 20-30 percent progress to ESKD. Can be divided into Primary MN (anti PLA2R Ab), Secondary MN (malignancy, drugs, hep B, LN Class V). Has thickened capillary walls with spikes, Granular deposits on IF, EM shows subepithelial deposits. The treatment is based on Risk classification. Low risk have normal eGFR with proteinuria<3.5 and

albumin>30 and treatment is wait and see. For moderate risk treatment is Wait and see OR Rituximab OR CNRI +- steroids. For high risk treatment with Rituximab OR Cyclophosphamide OR CNRIs OR steroids. For very high risk modified Ponticelli regime with altered every month pulse steroids and Cyclophosphamide. Immunosuppression is not usually indicated in secondary MN. Remember to give prophylactic anticoagulation with warfarin if Albumin<20-25.

3) FSGS. 80% progress to ESKD. EM shows podocytes effacement. Is associated with Genetics (APOL1 in Africans), Idiopathic, Secondary (drugs, HIV, CMV, lithium). Treatment for primary FSGS is with immunosuppression. For secondary, evaluate for causes of the secondary FSGS, consider genetic testing, do not start immunosuppression.

In the end of the lecture, Dr Ashfaque discussed 02 interesting cases. The first case dealt with a patient of Lupus who had loss of vision and importance of monitoring retinal toxicity of HCQ was made. The second case had a patient with loin pain who was eventually diagnosed with Renal Vein Thrombosis.

The whole lecture, from start to finish, kept me engrossed as Dr Yasir actively involved the participants and interspersed MCQs in between. I have learned a lot in this lecture which was very efficient and to the point.

Thank you Dr Yasir, Dr Ashfaque and the London GEM team for providing this learning opportunity.

Regards,

Raja Mobeen Ahmed

FEEDBACK # 7

Dr Ghazala Sheikh

A very exam oriented session

It included,

. Glomerulonephritis

. Types on the basis of

Histopathology

Immune complex depositions

Infectious

Autoimmunity

. Clinical presentation

. Nephritic syndrome

. Signs n symptoms of GN

. Lab investigations

. Managment options

. GN with nephritic and nephrotic syndrome

. GN with SLE

. IgA nephropathy
. Membranous Nephropathy
. Focal segmental Glomerulonephritis
. Minimal change disease
. C3 glomerulopathies
. Lupus nephritis type 5
At the end, Topic related MCQs helped alot
Dr Ash presented a very interesting case regarding renal thrombosis
Thankyou so much to both of you for giving us comprehensive understanding

FEEDBACK # 8

Dr Nasir Hayat

This session was Amazing and well presented and very well taughted.
Dr Yasir explained what is required to know exactly about a particular type of GN. He started with explaining the definition and classification of GN. Clinical Presentation Based
• Nephrotic Syndrome
- Edema
- Albuminuria >3.5g in 24 hrs
- Serum Albumin <30g/L
• Nephritic Syndrome
- Edema
- Haematuria
- Hypertension
• Nephrotic + Nephritic / RPGN
How to identify different types according to the patient's presentation and it's specific treatment. When we classify them as nephrotic and when as nephritic. He also explained microscopic picture of disease
Work Up
• Urine dip
• uACR/uPCR
• FBC, U&Es, Coagulation profile
• If haematoproteinuria with AKI then renal screen including
ANA, dsDNA, ANCA, C3, C4, anti-GBM, Myeloma screen
• ECG
• Chest Xray
• Renal Ultra sound
He also put the Mcqs as well which helped in understanding of the topic in depth. And realised how tough it could to grasp the real understanding of all GNs . GN with Nephrotic Syndrome

1. Minimal Change Disease
2. Membraous Nephropathy
3. FSGS
4. C3 Glomerulopathies(DDD)

5. Lupus Nephritis type5, GN with Nephritic Syndrome
1. Post Strept Infection GN
2. IgA NephropathyLupus Nephritis stages and treatment
• Hydroxycholine with life style in stage 1&2
• Steroids+ Low dose cyclophosphamide or MMF in
3&4
• Class V as MN mainly CNIs (cyclosporine and tacrolimus)

Mixed pictures Gn, identification and management , GN with Nephrotic+Nephritic /RPGN
1. Anti-GBM antibodies mediated
2. Lupus Nephritis(class 3&4)
3. Cryoglobulinemic GN
" Hide
4. ANCA Vasculitis (MPA,GPA, EGPA)
I would highly recommend it for physicians to join it.Proud to be LGEM candidate

FEEDBACK # 9

Dr Leela Ram

The most interactive and informative lecture conducted by Dr. Yasir Baig, he demonstrated from basic to complex including definition, types, clinical presentation, General approach, specific approach.
Types of Glomerulonephritis (Complex vs Simplicity)
• Histologic lesions on Biopsies
• Crescenteic GN
• FSGN
• MPGN
Immunopathogenesis based types (newer approach for targeted treatment)
•Autoimmune GN (IgA, MN, ANCA, Anti-GBM, Lupus GN)
• Infection related GN (PSGN, HIV, Hepatitis B & C)
• Auto inflammatory GN (compliment over activation)
• Monoclonal gammopathy related GN (Al Amyloidosis, Light and Heavy chain DD)
Clinical presentation:
Nephrotic syndrome: Edema, Albuminuria >3.5g/24h, serum albumin<30g/l

Nephritic syndrome: edema, haematuria, HTN
Signs and symptoms: lethargy, tiredness, wt loss, swelling, rash, hemoptysis, nasal/oral ulcer, hearing loss, oligoanuria, HTN, haematuria, abnormal renal function.
Work up:
Urine dipstick, uACR, uPCR, FBC, U&E, Coagulation profile if haematuria with AKI then Renal screen including ANA, dsDNA, ANCA, C3, C4, Anti-GBM, Myeloma screen), ECG CXR, Renal ultrasound. It also included several MCQs with discussion.
Overall it turned out to good learning from reading & discussing MCQs. I learnt several new things & hopefully will apply in practice.
Thank you Sir Dr. Yasir Baig for beautiful session & thank you so much Sir Ash for summarizing with cases presentation.

FEEDBACK # 10

Dr Zaid Ahmed Ansari

The session was comprehensive overview by Dr Baig detailing GN and its types, along with its clinical presentation. GNs discussed were:
• Nephrotic Syndrome, characterized by edema, albuminuria >3.5g in 24 hrs and serum albumin levels at <30g/L
• Nephritic Syndrome characterized by edema, haematuria and hypertension
• Nephrotic + Nephritic / RPGN
Dr Baig also detailed the work up needed for GN which include a urine dip, uACR/uPCR, FBC, U&Es, coagulation profile, ECG, chest Xray
Dr Baig stressed that gold standard for diagnosis of GN is renal biopsy and that a physician must always take general measure and act quickly to devise a management plan.
After discussing the various types of GN with their presentations, Dr Baig gave three scenario based MCQs, with Dr Ash(?) finishin off with a case study on renal thrombosis.
These lectures serve a dual purpose, the educational one and the other more important aspect of hearing from qualified and trained professionals.

FEEDBACK # 11

Dr Emmanuel Charles

Dr. Yasir delivered a very detailed and comprehensive session on Glomerulonephritis.
It started with the definition of important terms like Glomerulonephritis , and signs and symptoms of Glomerulonephritis, types of Glomerulonephritis (GN),Clinical Presentation, Sign and symptoms, Investigations, lifestyles modifications, and difference between them and their management.
The slides explanation with staining, Immunofluorescence and electron

microscopy images helped in understanding the lecture better.
In the end, Dr. Ash completed the session with two clinical teaching cases which made implementation of the lecture points in daily practice.
Thankyou Dr. Ashfaque Ahmed for facilitating the whole session.
Thankyou Dr YASIR Consultant Nephrologist NHS UK
Thankyou LGEM MRCP PROGRAMME TEAM

29TH JANUARY 2023

EVENT NAME:

High Yield Trauma By Dr Syed Ali Ahmed FRCEM

DOCTORS FEEDBACK

FEEDBACK # 1

Hani Suhail

A wonderful session by Dr Ali, very informative with a lot of precise and conceptual discussion to our daily approached cases in our routine management. Thank you for this great session regarding trauma.

FEEDBACK # 2

Farheen Naseem

It was fruitful and full of interactive session.in This sessions he more focused on exam material which is more help full for all mrcem exam like primary intermediate and osce.he taught us more about major trauma topics
First time briefly learn about canadian c spine rules
Upper and lower limb fractures
Ottawa rules for ankle fractures
Learn about blocks
Management of tetanus
More learn about montagia fracture
Shoulder dislocations
Meniscus tear presentation
All session was excellent and it's clear my concepts for primary exam most of upper limb fractures.thank u dr @Dr Ali and @Dr Ash for such nice learning platforms where we grow and polished day by day thank u again

FEEDBACK # 3

Syed Suhail Ahmad

A comprehensive and absorbing session on **High Yield Trauma By Dr Syed Ali Ahmed FRCEM**, a born teacher and presenter 👏

Excellently covered some of the most common yet important ED presentations that we encounter daily in our clinical settings, covered T&O that included
- Canadian C-Spine rules for X-Rays
- Ottawa ankle rules
- Common upper limb fractures often missed and confused like Monteggia and Galezzi
- Shoulder dislocations
- Hillsach's and Bankart's lesions
- Hematoma and Bier's blocks
- ACL and Meniscal tears, Lachman and Pivot shift tests
- TFCC and Piano key sign importance
- Tetanus-prone and high-risk would
- Tetanus vaccination and Immunoglobulin administration

Looking forward to more such interactive and interesting sessions from Dr. Ali.
Thank you LGEM, PEMA and Dr.Ash for such an outstanding LGEM faculty 👍👍👍👏👏👏

FEEDBACK # 4

Haider Ali

A very exam oriented session on trauma and orthopaedics was delivered Dr. Ali ahmed.
Different types of fractures of upper and lower limb were discussed in detail with their management. The best part was the discussion regarding how to read and what to look for in exam scenarios.
Candian C Spine rule and tetanus prone wound were also discussed at the end of the lecture.
Thanks Dr. **Ashfaque Ahmed** and **London Global Emergency Medicine** for arranging such amazing sessions.

FEEDBACK # 5

Nazish Nazi

One of the bestest lecture I ever attended on High yield trauma with such amazing Radiographs, i always lack motivation to read black n white radiographs but Dr Ali made those black n white radiographs so much interesting and easy to understand , he taught it very actively with interactive Question answers indeed it was a brainstorming session today ....
He taught very important stuff like Canadian C Spine rule, Upper limb fractures , unique lesions related to it like Bankart lesion , Lower limb injuries with radiographs, especially Salter Haris Classification, and most interestingly tetanus wound classification with its vaccination , it was all very useful and very interesting learning session today .
Many Thanks to Dr Ali and Sir Ash for todays session. 🙂

FEEDBACK # 6

Anila Zafar

Today's session by Dr Ali was very informative and comprehensive. He mentioned in detail the scenario, it's diagnosis, differentiating points, management. He highlighted the high yield points in relevance to exams. Amazing. Thank you very much Dr ASH and Dr Ali.

FEEDBACK # 7

Muzna Ahmed

It was an amazing knowledge pack session of orthopedics in which many ED physcians are not skilled and its investigations are mainstay to reach diagnosis as some fractures may present with symptoms with the lapse of time.
Dr Ali is an excellent arduous tutor he puts his 100% into every task whether lecture or hands on workshop and clears all the confusions of every candidate.
Today we have covered high yield topics of:-

✓Canadian C spine rule

✓Supracondylar fracture of humerus

✓Galezzi fracture

✓Ant discoloration of shoulder

✓Hill sach's lesion & bankart lesion

✓Post dislocation of shoulder (rim sign and trough line sign)

✓Reverse Hill sah's & reverse Bankart lesion

✓Ottawa ankle rules

✓Exclusions of ottawa ankle rules

✓Monteggia fracture

✓SALTR classification with examples

✓Colley's fracture, complications and indication for manipulation & reduction

✓Bier's block

✓ACL tear (Lachman's test, pivot shift test)

✓Pulled elbow

✓TFCC injury and piano key sign (role of MRI)

✓Meniscal tear and cooper's sign

✓Toodler's fracture /CAST fracture

✓Barton's fracture and need of fixation

✓Tibial plateau fracture and Schatzker classification

✓ABC of tetanus prone and high risk tetanus wounds.

This is such kind of orthopedics knowledge which Majority doesn't know. I'm highly grateful to Dr Ash and Dr Ali for bringing up this.

FEEDBACK # 8

Saba Aslam Khan

Woah! What an amazing session we had today with Dr Ali, the feel of lecture was like having discussion with our kind senior, Dr Ali is exceptional speaker he has power to grasp the attention of audience and engage them.. his way of delivering lecture is like a breeze of cool air in boring lectures … the session was not only exam oriented but also applicable to ED and had touch of legal advices …. The highlights of lecture were ,

-Canadian C-spine rules

-upper and lower limb fractures with their radiological presentation

-ottawa rules

-Regional Blocks

-tetanus management

-tetanus prone wounds classification and it's management

-*What is your name doctor* 😁

Thank you so much Dr Ash for arranging such a high yield session we never wanted this lecture to finished …

A proud GEM trainee,

Dr Saba Aslam ✨🌻

FEEDBACK # 9

Muneeb Ahmed

Attended this session by one of my favorite tutor Dr. Syed Ali held a successful session on high yield trauma SBA. We learnt scenarios based learning on Canadian C-Spine Rule, Supracondylar Fracture of Humerus and its classification, Galeazzi Fracture ,Anterior and posterior dislocation of shoulder and its complications(Hill-Sachs Lesion Bankart/Reverse Hill-Sachs & Reverse Bankart Lesion, Ottawa Ankle Rules: guidelines for ankle injury assessment to determine need for radiograph, Exclusions of Ottawa Ankle Rules, Monteggia Fracture: a fracture involving forearm and elbow, SALTR Classification, Colley's Fracture, Complications & Indications for Manipulation & Reduction: a fracture near the wrist, Brief review about Bier's Block, ACL Tear (Lachman's Test & Pivot Shift Test).

Unfortunately couldn't attend last few minutes due to bad signals but it was overall very informative and we loved his teaching skills.

Thanks Dr. Ali and Dr. Ash for this amazing session.

FEEDBACK # 10

Imtiaz Ali Shah

Today Dr Ali carried out an amazing session about high yield trauma. What a session it was,a treat to listen and watch.A session full with learning and absorbable knowledge .lucky to have such an amazing and energetic teacher like dr Ali who always try to give his hundred percent.
It was an interactive session covering important points of high yield trauma including
CANADIAN C SPINE RULUES.
GALLEZI,S FRACTURE ,HILLSAC LESION.
ELBOW INJURIES
MONTEGGIA FRACTURES.
ANTERIOR/POSTERIOR DISLOCATION OF SHOULDER JOINT.,BANKART LESION.
OTTAWA ANKLE RULES.
SALTER AND HARRIS CLASSIFICATION.
KNEE INJURIES AND MENISCAL INJURIES.
TETANUS AND WOUND MANAGEMENT.
AS mentioned earlier that it was a wonderful ful session, A session jam packed with knowledge and excellent teaching skills.
I would like to thanks dr Ali for such a wonderful session and also dr Ash for providing us this wonderful platform of learning in the form of London GEM.

FEEDBACK # 11

Faiq Uz Zaman Khan

In this session Dr Ali discussed common cases that we daily see in A&E. Each scenario was presented to the participants and it's diagnosis, management and clinically significant points were discussed. Dr Ali's holistic approach towards each scenario was brilliant. On every case he discussed the high yield pointers with regard to FRCEM primary , intermediate and OSCE exam. Yes that's right, one scenario and he discussed it on 3 different levels. Along with that he was guiding us on how to improve our clinical skills. Undoubtedly a great teacher.

FEEDBACK # 12

Qaisar Shah

Dr. Syed Ali held a successful session on high yield trauma MCQs. The session was beneficial for both clinical practice and exams and covered a range of high yield points related to trauma.
•The Canadian C-Spine Rule: a set of guidelines for neck injury assessment to determine need for cervical spine x-ray
•Supracondylar Fracture of Humerus: a fracture near the elbow at the upper end of the arm bone
•Galeazzi Fracture: a fracture involving the forearm and elbow, with break in radius and wrist joint dislocation

•Ant Discoloration of Shoulder: a sign of possible shoulder dislocation, with bruised/discolored skin in joint area
•Hill-Sachs Lesion & Bankart Lesion: shoulder dislocation-related damage to humeral head and labrum, respectively
•Post-Dislocation of Shoulder (Rim Sign & Trough Line Sign): signs of shoulder dislocation, with changes in humeral head shape and position
•Reverse Hill-Sachs & Reverse Bankart Lesion: lesions due to repeated shoulder dislocations, with damage to glenoid and humeral head, respectively
•Ottawa Ankle Rules: guidelines for ankle injury assessment to determine need for radiograph
•Exclusions of Ottawa Ankle Rules: conditions requiring radiography of ankle even if rules not met (fractures, nerve/vessel injuries)
•Monteggia Fracture: a fracture involving forearm and elbow, with break in ulna and radial head dislocation
•SALTR Classification with Examples: a system to categorize and classify distal radius fractures based on location and break pattern
•Colley's Fracture, Complications & Indications for Manipulation & Reduction: a fracture near the wrist, complications can include nerve/vessel damage, reduction may be indicated for displaced fragments
•Bier's Block: a regional anesthesia for limb surgical procedures to provide pain relief
•ACL Tear (Lachman's Test & Pivot Shift Test): a knee injury with tear in anterior cruciate ligament, diagnosed with Lachman's and Pivot Shift tests
•Pulled Elbow: an injury in children involving elbow dislocation of radial head from humerus
•TFCC Injury & Piano Key Sign (Role of MRI): injury to wrist stability-providing triangular fibrocartilage complex, diagnosed with Piano Key Sign and confirmed by MRI
•Meniscal Tear & Cooper's Sign: a tear in the knee joint cushion, the meniscus, diagnosed with Cooper's Sign
•Toddler's Fracture & CAST Fracture.
Overall the session was excellent and informative, gaining valuable knowledge and skills.
Thanks Dr. Ali and Dr. Ash for this amazing session.

FEEDBACK # 13

DrKiran Feroz

Wonderful session ....as always Dr. Ali...Today's topic Canadian C spine rule.... supracondylar fracture ...fracture of radius and ulna..ant. dislocation of shoulder...post dislocation of shoulder ....interestingly Hill _Sachs lesion which is Hill of humerus....Bankart lesion .... trough line ....ankle injuries...uttawa rules

of foot...John's fracture.. Salta haris fracture...colles fracture... knee injuries...Barton's fracture...and last but not the least most imp tetanus wound classification all beautifully explained....a session extremely useful for all of us....Thanku Ashfaque bhai ...Dr.Ali ....the LGEM team for bringing us closer to highly knowledgeable faculty ...God bless u all

FEEDBACK # 14

Rana Gulraiz

Today started an amazing session about high yield trauma.
What a session it was,a treat to listen and watch.A session full with learning and absorbable knowledge .
lucky to have such an amazing and energetic teacher like dr Ali who always try to give his hundred percent.
It was an interactive session covering important points of high yield trauma including
CANADIAN C SPINE RULUES.
GALLEZI,S FRACTURE ,HILLSAC LESION.
ELBOW INJURIES
MONTEGGIA FRACTURES.
ANTERIOR/POSTERIOR DISLOCATION OF SHOULDER JOINT.,BANKART LESION.
OTTAWA ANKLE RULES.
SALTER AND HARRIS CLASSIFICATION.
KNEE INJURIES AND MENISCAL INJURIES.
TETANUS AND WOUND MANAGEMENT.
AS mentioned earlier that it was a wonderful ful session, A session jam packed with knowledge and excellent teaching skills.
Special Thanks to my mentor my director My teacher **Ashfaque Ahmed**❤️

FEEDBACK # 15

Hareem Zakir

Thankyou so much Dr Ali for such an amazing session . You're definitely one of the most dedicated teachers of the team. You instil the passion in us and make us eager to learn more . The best part of the session was your quote "we learn for the patients,not for the exams only . We have to make difference in their lives "

FEEDBACK # 16

Phota Ram

Today an Excellent session by Dr Ali as we have learned a lot from from Dr Ali in Ultrasound workshop related to emergency today we have learned importants topics of upper and lower limb fractures and dislocations, that high yield and exam oriented ,all fracture and dislocations we studied many times but we

forgot but the way Dr Ali has taught it will easily remembered and cleared many concepts. *Learning points* :
Canadian C spine rules
Gallezi fracture
Colles fracture
Montegia fracture
Anterior and
Posterior dislocation of shoulder
Bankart lesion
Ankle Ottawa Rules
Ottawa rules for hand
Salter Haris fracture
Wound and tetanus prone wound and high-risk tetanus wound.

FEEDBACK # 17

Uzma Shaikh

Marvellous session by Dr **Syed Ali Ahmed** on orthopedic trauma and wound management.
He taught us regarding Canadian C spine rule, ottawa ankle and foot imaging rules, their indications and contraindications.
We learnt regarding glazzi, monttegia, colles, barton, supra condylar fracture, toddlers fracture, lateral tibeal plateu fracture anterior and posterior shoulder disslocations. He taught us Hill sachs leison, Bankart leison, ACL, meniscal tears.
Tetanus prone, high tetanus prone and clean wound classification.
Indications of tetanus and immunoglobulins.
I request Dr **Ashfaque Ahmed** to assign him more lecs on trauma so that we can learn and pass our exams under his guidance.

FEEDBACK # 18

Kamlesh Kumar Lilani

First of all Congratulations to you Sir for clearing FRCEM. It was a very amazing to listen you again but this time not an ultrasound but on how to recognize different cases on trauma with proper management. You explained Trauma of Limbs very well with details and added OSCE scenarios and how to read questions and to get better answer for that.

FEEDBACK # 19

Bushra Imran

From where I will start about today's session, it was interesting like to not ending long lasting, by Dr Ali with understandable concise way and beneficial descriptions of x Ray's and scenarios. The Canadian C -Spine(the most important),how to manage elbow injury, Galerzi fracture ,Hill sach's lesion,

posterior and anterior shoulder dislocation with x ray description, Bankart lesion(which I don't know before),ankle fractures, Uttawa rules of foot , Monteggia fracture, knee elbow ,wrist injuries and management ,High risk tetanus wound ,ACL tears,.. in the end its was best session by Dr Ali
Thank you GEM team and Dr Ash

FEEDBACK # 20

Anila Zafar

Today's session by Dr Ali was very informative and comprehensive. He mentioned in detail the scenario, it's diagnosis, differentiating points, management. He highlighted the high yield points in relevance to exams. Amazing. Thank you very much Dr ASH and Dr Ali.

FEEDBACK # 21

Zia Hayat

It was an amazing lecture by Dr.Ali ,was very interactive and kept us all pumped up till the end .His way of teaching is totally extra ordinary with great impact on the mind and keeping exam focused material which enhanced our skills for preparation all together .He gave an overview of all the major topics and case based scenarios which we face on a daily day to day basis.
He spoke about the Canadian c spine rules ,upper and lower limb fractures ,Ottawa rules for ankle injury, Regional blocks ,tetanus Management, Gallezi Fracture ,Montegia Fracture ,Anterior and Posterior Dislocation of Shoulder ,Bankart lesion,Salter Haris Fracture ,knee injuries like ACL tear ,PCL tear ,Meniscus tear presentations and management, Altogether it was power pack session covering all important points and topics related to trauma and resuscitation in ED .Thankyou Dr.Ash for arranging such and amazing learning opportunity for us all .

FEEDBACK # 22

Rabiyyah Bashir

THE PERFECT LECTURE !
covered

✓Canadian C spine rule

✓Supracondylar fracture of humerus

✓Galezzi fracture

✓Ant dislocation of shoulder

✓Hill sach's lesion & bankart lesion

✓Post dislocation of shoulder (rim sign and trough line sign)

✓Reverse Hill sach's & reverse Bankart lesion

✓Ottawa ankle rules

✓Exclusions of ottawa ankle rules
✓Monteggia fracture
✓SALTR classification with examples
✓Colley's fracture, complications and indication for manipulation & reduction
✓Bier's block
✓ACL tear (Lachman's test, pivot shift test)
✓Pulled elbow
✓TFCC injury and piano key sign (role of MRI)
✓Meniscal tear and cooper's sign
✓Toodler's fracture /CAST fracture
✓Barton's fracture and need of fixation
✓Tibial plateau fracture and ✓Schatzker classification... Bumper fracture
✓ABC of tetanus prone and high risk tetanus wounds.
All this in just 1.45 hrs.... Dr Ali Sir gave 45 mins over time... We are blessed to have such dedicated Mentors..
THIS IS THE FIRST TIME I KEENLY LISTENED A LECTURE RELATED TO ORTHO!
A BIG THANKYOU Dr **Syed Ali Ahmed** Sir for a wonderful lecture and Dr **Ashfaque Ahmed** Sir for making it possible for ppl like me.
Huge Regard for **London Global Emergency Medicine**
❤️❤️❤️❤️

FEEDBACK # 23

Dr Mariam Nawaz

> Seldom do you get to have a powerful session like the one we had
> today. Dr Ali is an exceptionally good teacher. He taught us amazing
> practice essentials and exam essentials today and taught us tausing
> exam based scenarios. It was an honor to study from him. Some of the
> imp things we learnt are
> Canadian C spine rules
> Managing elbow injury
> Gallezi fracture
> Hill Sach's lesion
> Posterior dislocation of shoulder
> Bankart lesion
> Ankle Ottawa Rules
> Ottawa rules for hand
> Montegia fracture
> Salter Haris fracture

> Colles fracture
> Biers block
> Knee injuries
> Elbow injuries
> Wrist injuries
> Accidental vs non accidental injuries in kids
> Wound management
> Thankyou Dr Ali and Dr Ash for this powerful session. Really looking
> forward to have more preparatory sessions with Dr Ali

FEEDBACK # 24

Dr Amash Khan

Today's session was on High yield Q/A
based lecture regarding some trauma and orthopedic related cases which comes in ER by Dr Ali Ahmed which was so great and helped recalling the previous topics thoroughly.
Thank you for your time and I wish to have these lectures more often.

FEEDBACK # 25

Dr Nasir Hayat

This session was Amazing and well organised and very well taught.I learned alot and all the Questions were answered.
Dr Ali is an exceptionally good teacher. He taught us amazing practice essentials and exam essentials today and taught us tausing exam based scenarios. It was an honor to study from him. Some of the imp things we learnt are
Canadian C spine rules
Managing elbow injury
Gallezi fracture
Hill Sach's lesion
Posterior dislocation of shoulder
Bankart lesion
Ankle Ottawa Rules
Ottawa rules for hand
Montegia fracture
Salter Haris fracture
Colles fracture
Biers block
Knee injuries
Elbow injuries
Wrist injuries
Accidental vs non accidental injuries in kids

Wound management.
I would highly recommend it for ER physicians and physicians to join it.Proud to be LGEM candidate.

FEEDBACK # 26

Dr Faizan Ur Rehman

Excellent presentation by Dr Saad. It was quite precise and to the point. I think the beauty of the presentation was that the concepts of ED management of trauma were cleared up. Like a lot of scenarios discussed are common that we see frequently and manage. So learning the concept behind management and presentations was really helpful.
Last but not least props to Dr Saad for his dedication to teaching. It could be seen that a lot of hard work was put into this presentation. It was really fun good from a learning perspective.
Once again thank you to Dr Ash for providing us with such an amazing platform.

FEEDBACK # 27

Dr Afifa Younis Raja

WOW what a lecture we had today, it was a marathon of knowledge. Today we discussed High Yield Trauma & Resuscitation by DR Syed Ali Ahmed FRCEM, his teaching style is great, and the way he kept us all engaged, kept it interactive, and targeted the high yiled topics that's not only clinically important but also exam favourite , is commanbible. Today we covered so many topics:

- Canadian C spine rule
- Supracondylar fracture
- Galeazzi fracture
- Anterior dislocation of shoulder
- Posterior dislocation of shoulder
- Ankle injury and Ottawa rule
- Colles fracture
- Hematoma and beis blick
- Knee (ACL) injury
- Pulled elbow
- Triangular fibrocartilage complex injury
- Meniscal tear
- Toddlers fracture
- Barton's fracture
- Right lateral tibial plateau fracture
- Wound management (tetnus-prone prone injury)

It shows Dr Ali's dedication and passion for teaching that he stayed 45 min extra, and to be honest we were happy to even continue it for another hour as

the teaching style was engaging and we learned a lot of things today that will help both our clinical practice and exam as well.
Thank dr Ash for arranging such an amazing lecture at a crucial time.
kind regards,
Dr Afifa

FEEDBACK # 28

Dr Zaid Ahmed Ansari

Dr Syed Ali went on to discuss high yield Mcqs in the sessions, some of which were:
•Canadian C-Spine Rule
•Supracondylar fracture of humerus
•Galeazzi fracture
•Hill-Sachs and Bankart lesions
•Post-dislocation of shoulder covering the Rim Sign & Trough Line Sign
•Reverse Hill-Sachs & reverse Bankart lesions
•Ottawa Ankle Rules
•Exclusion of Ottawa Ankle Rules:
•Monteggia Fracture
•ACL Tear
•Pulled elbow, also commonly called nursemaid's elbow
•TFCC injury and the Piano Key Sign
•Meniscal Tear and the Cooper's Sign as a diagnostic pointer
•Toddler's fracture & CAST fracture.
The session was informative and very put to the listeners. Again, extremely important in the ER.

FEEDBACK # 29

Dr Shahid Ahmad

Dr. Syed Ali held a successful session on high yield trauma MCQs.
Learning points of this session were
1)The Canadian C-Spine Rule: a set of guidelines for neck injury assessment to determine need for cervical spine x-ray
2)Supracondylar Fracture of Humerus: a fracture near the elbow at the upper end of the arm bone
3)Galeazzi Fracture: a fracture involving the forearm and elbow, with break in radius and wrist joint dislocation
4)Ant Discoloration of Shoulder: a sign of possible shoulder dislocation, with bruised/discolored skin in joint area
5)Hill-Sachs Lesion & Bankart Lesion: shoulder dislocation-related damage to humeral head and labrum, respectively

6)Post-Dislocation of Shoulder (Rim Sign & Trough Line Sign): signs of shoulder dislocation, with changes in humeral head shape and position
7)Reverse Hill-Sachs & Reverse Bankart Lesion: lesions due to repeated shoulder dislocations, with damage to glenoid and humeral head, respectively
8) ottawa Ankle Rules: guidelines for ankle injury assessment to determine need for radiograph
9)SALTR Classification with Examples: a system to categorize and classify distal radius fractures based on location and break pattern
10)Colle's Fracture, Complications & Indications for Manipulation & Reduction:
11)Bier's Block:
12)ACL Tear
13)Pulled Elbow: an injury in children involving elbow dislocation of radial head from humerus
Overall it was a great session
Thanks Dr. Ali and Dr. Ash for this amazing session.
Regards
Dr Shahid Ahmad

17th DECEMBER 2022

EVENT NAME:

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

DOCTORS FEEDBACK

FEEDBACK # 1

Syeda Maheen Ejaz

A very informative session…we have been to pneumonia many times but this session has been the best one extremely precise, practical oriented additionally exam-oriented as well. Thank you so much, Dr Jacob. Some of the pearls of the session
1. Atypical pneumonia features Diarhhea, bullous myringitis, and rash and should not be missed its less common but not rare
2. CRP utility in the case of LRTI is very useful
3. CRB 65 and CURB 65 score and clinical judgement in the management
4. When to follow up
5. Role of nebs, steroids and a lot more

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

FEEDBACK # 2

Kamlesh Kumar Lilani

It covered all from defenation, presentation, Pathology investigation management, exam oriented Mcqs, CURB65 and CXR very well.
Thanks Dr. Jacob and Dr. Ash for amazing session.

FEEDBACK # 3

Imtiaz Ali Shah

Today we had a great session regarding pneumonia by Dr Jacob.It was a session with full of clinical l knowledge. Important learning points were ad followed.
TYPES OF PNEUMONIA.
Hospital acquired pneumonia. (HAP)
COMMUNITY ACQUIRED PNEUMONIA..
Lower respiratory tract infection.
ETIOLOGY. Bacterial, viral, fungal, protozoa.
Typical Agents...S pneumonia, H influenza, S aureus. Klebsialla pnumonae and pseudomonas.
ATYPICAL AGENTS.. legionella mycoplasma Chlamydia, adeno viruses .
ETIOLOGY OF PNEUMONIA..
Alcoholism, COPD, smoking, dementia, stroke, lung abcess, exposure to birds and rabbits.
We also learnt the Utiloty of CRP in LRTI.
INVESTIGATIONS...Oxygen saturation, ABGS, chest radiography, urea electrolyte CRP.FBC LFTS.,Sputum culture.
ÙRINE ANTIGEN TEST..,legionella urine antigen
Throat swabfir mycoplasma PCR.
We also realised the importance of CRB65 SCORE AND CURB65 SCORE for severity assessment 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,
Dr Saba Aslam ✨🌻

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

Thank 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 assessment ,Safe discharge from hospital over all its a power pack session 👍 this credit goes to Dr Ash for London GEM MRCP programme 👏
I learn to many new things from 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

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

Feedback by 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

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

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

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

FEEDBACK # 39

Dr Ghazala Sheikh

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

- Pneumonia Definition, causes, etiology, types, signs and symptoms
- Curb_65 criteria for mortality risk assessment
- Community acquired Pneumonia
- Epidemiologic factors suggesting possible causes of CAP
- Differential Diagnosis of CAP on the basis of normal and abnormal chest radiograph
- Atypical pneumonia (mycoplasma pneumonia, chlamydophila pneumonia, legionella pneumophila)
- Atypical pneumonia features (fever, diarrhea, bullous myringitis, lung rales/crepitations and Rash)
- Nonzoonotic Atypical Bacterial pneumonia

● General investigations done to a pateint admitted in hospital (O2 saturation, ABGs where necessary, chest x rays, urea electrolytes, C reactive protein, CBC, LFTs)
● tests for legionnaire`s disease
● tests for mycoplasma pneumonia
● tests for chlamydia species
● Severity Assessment
● Microbiological tests
● timely diagnosis and Managment
● safe discharge from hospital
● BTS and NICE recommendations
Thankyou so much Dr Ash.

FEEDBACK # 40

Dr Leela Ram

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

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

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

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

➡️ CRP utility in LRTI:
• CRP< 20mg/litre, don't give antibiotics

• CRP ranges between 20-100mg/litre depends upon symptoms and consider antibiotics
• CRP>100mg/litre requires antibiotics

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

FEEDBACK # 41

Dr Muhammad Ghayoor Khan

It was amazing teaching session by Dr.Jacob on pneumonia, lots of knowledge delivered regarding pneumonia presentations, etiology, pathology, investigation and management, when to admit and when to discharge the patient, CRB65 and CURB65, use of antibiotics and when to repeat CXR,he literally cleared "Every wheeze is not asthma and every white patch is not pneumonia".
Thanks to Dr Ash, presented very good informative cases plenty of exam MCQs discussed, discussion about clinical presentation and reports was pretty informative and helpful.
Thanks
Dr.Jacob And Dr.Ash
Kind regards
Muhammad Ghayoor Khan

FEEDBACK # 42

Dr Mubashir Hussain

He thoroughly classify pneumonia .
Will explained it's all features .
All its investigations and management .
Thanks to Dr ash thanks to doctor jacob

FEEDBACK # 43

Dr Mariam Nawaz

An amazing module on pneumonia by Dr Jacob today, got to learn so much in 1 hour, the pearls i gathered are as follows: 1. Pneumonia is an infection of the lung tissue, confirm by CXR
Types

A) CAP: less than 24 hrs after admission
B) Hospital acquired pneumonia: occurs after 24hrs of hosp admission
Mortality rate increases if the hospital stay increases more than 8 days
2. LRTI:
Acute illness present for 21 days or less
Cough is the main presenting symptom,
3. CAP diagnosis
Cough + one other symptom
New focal sign on chest exam
At least one other systemic feature
No other explanation for illness
4. CAP etiology:
Bacteria:
• Typical agents: Streptococus, Staph aureus, Klebsiella,H flu
• Atypical agents:
Fungi
Virus
protozoa
5. Alcoholics can aspirate leading to pneumonia
Pseudomonas auregenosa is common organism in bronchiectasis pt
Lung abscess: look for poor oral hygiene, Staph are common organisms
Hotel and cruises, think of legionella
Exposed to birds: chlamydia
Exposed to rabbits, Francis taularenesis
6. Clinical features with common specific pathogens
Streptococus pneumoniae
Legionella pneumoniae
Mycoplasma pneumoniae
Coxiella
Chlamydia
Elderly present with non specific symptoms
7. DD of CAP:
• Abnormal chest radiograph
CHD
Pulmonary emboli
ILD
Aspiration pneumonia
Pulmonary fibrosis acute exacerbation
Bronchiectasis acute exacerbation
• Normal Chest Radiograph

COPD
Pertusis
8. Atypical pneumonia features:
Fever
Diarrhoea
Bullous myringitis
Lung rales
Rash: think of viral pneumonia
9. Chlamydia often has isolated single lobe involvement
Legionella has bilateral involvement
Covid has bilateral lung opacities, specially in the peripheries
If patient worsens then repeat the CXR, otherwise repeat CXR during treatment is not required
10. CRP utility in LRTI:
If < 20 don't give antibiotics or
Between 20 an 100: delay antibiotics use
¬ 100: Start antibiotics
11. General Investigations
Sputum cultures: needed to diagnose legionella,
If already started antibiotics culture has no use
Mycoplasma pneumoinia: not needed, if required do PCR
Chlamydia: chlamydia antigen
12. Severity Assessment:
¬ CRB65 score for mortality risk assessment in primary care:
Confusion
Raised RR: 30 or more
Low BP: diastolic 60 or less, or systolic less than 90
Age 65 or more
¬ Use clinical judgement along with CRB65 or CURB65 for admission decision
¬ CURB65 Score:
Blood urea is added
It calculates 30 days mortality
¬ Microbiological tests are done based on CURB65 score
13. Antibiotics
Amoxicillin if CURB65 0 to 1,
Amoxilcillin + Clarithro CURB 2
CURB 3 to 4 IV co amoxiclav with clarithromycin
NICE guidelines says give antibiotics for 5 days, BTS says give for 7 days

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

FEEDBACK # 44

Dr Aiman Nazir

It was a wonderful session today on a very common yet challenging topic: Pneumonia .
Dr Jacob is really an amazing teacher to teach and share great knowledge in a very effective and simple way.
Never heard any better explanation of pneumonia than what Dr Jacob told today. Pneumonia is an infection of lung tissue where air sacs are filled with microorganisms, fluid and inflammatory cells and as a result of which lungs are not able to function properly. Diagnosis is based on history , signs and symptoms and imaging(xray) 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 .

Aiman Nazir

LGEM EMFP

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.

Regards,

Raja Mobeen Ahmed

LGEM MRCP Candidate

FEEDBACK # 46

Dr Rehan Khalil

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

Some of the things learnt are as follows:

1- Definition of pneumonia
2- Types of Pneumonia that is CAP and HAP
3- Definition of a type of Pneumonia
4- Causes of each type
5- Streptococcal Pneumonia being the most common pathogen in CAP.
6- Clinical and Presenting features of pneumonia
7- Aspiration is a risk factor for CAP in elderly.
8- Diffrentials of CAP with an abnormal CXR and with Normal CXR.
9- Atypical Pneumonia causative agents and their associated features.
10-Investigations tod o in suspected CAP.
11- Use of CRB65 and CURB65 score in severity assessment in Community and Hospital Setting.
12-In any patient >50 that presents with pneumonia, do a CXR 6 weeks after discharge from hospital to rule out MALIGNANCY!

Along with the above lecture there were two uniques cases presented by Dr Ash.

1st was the case of Cold resolving Abscess throwing emboli and 2nd was the case of COPD with retention of CO2 + LRTI+ Right heart failure.
Warm regards,
Dr Rehan Khalil, EMFP

FEEDBACK # 47

Dr Zaid Ahmed Ansari

Pneumonia is a commonly mismanaged respiratory illness. Dr Jacob's insights and presentation on the etiology, the causative organisms and treatment protocols was very helpful. It served both as a refresher and furnished much needed information as well. Dr Jacob went into great detail to explain the typical and atypical pneumonia agents CRB65 and CURB65 and elucidated treatment protocols very effectively.
I found his explanation of the CXR as a diagnostic and management tool in geriatic pneumonia to be very helpful; it is repeated after 6 weeks in elderly with complications, and for admitted patients CXR should be conducted when the patient progressively does not respond to treatment.
Dr Jacob explained CURB-65 scoring; The CURB-65 is a severity score for CAP that consists of 5 variables, each of which is worth 1 point. age 65 years, new-onset disorientation, urea >7 mmol/L, respiration rate 30 minutes, systolic blood pressure >90 mmHg, and/or diastolic blood pressure 60 mmHg.
However, he was clear in explaining the the CURB-65 scoring should be the only diagnostic and management criterion; clinical judgement in formulating a treatment plan is of great value. This was the most profound take away for me. Often young doctors like us are hesitant to rely on our clinical judgement and instead rely on testing methodologies to guide us along. Dr Jacob's assertion was a much needed confidence boost.
Dr Ash's discussion of two respiratory illness case studies were very interesting. The diagnosis of a septic embolism infarction was very informatively explained in the first case. The second case discussed a cloaked LRTI pneumonia, and it was educational learning about the diseases it was cloaked by and ways the diagnosis was tackled.

EVENT: 17th SEPTEMBER 2022

EVENT NAME:

DO NOT ATTEMPT CPR ETHICAL & LEGAL ASPECTS BY DR ABINAS GURUNG ST6 Geriatrics UK

DOCTORS FEEDBACK

FEEDBACK # 1

Wajahat Khan

This session totally changed my approach regarding DNACPR, never attended such beautiful and comprehensive session on such important topic. DR Abinas explained brilliantly in the easiest and simplest way:

* Basics of DNACPR
* Significance of DNACPR
* When to revoke
* Protecting pts from non-beneficial treatments
* Cleared our misunderstandings about DNACPR form

*Osce session was very amazing by Dr Ash putting our Gem candidate in realife situations

I must thanks DR Ashfaque Ahmed as well for putting that much effort for GEM candidates that they can compete with every EM Physician in world, Thanks a lot sir, very much appreciated 👏🏻👏🏻

FEEDBACK # 2

Syed Suhail Ahmad

A very important session on **"DO NOT ATTEMPT CPR ETHICAL & LEGAL ASPECTS BY DR ABINAS GURUNG ST6 Geriatrics UK"** including some OSCEs from Dr. Ash. A little bit confusing because at times it can get tricky, but the important learning points like **COMMUNICATION, SECOND OPINIONS, CONSENT, RESPECTING PATIENT's RIGHTS** can make a big difference. Thank you London GEM for arranging these informative and interesting sessions. 👍👍👍

FEEDBACK # 3

Abrar N. Syed

An Excellent Topic encompassing the most encountered real time scenario..... Explained in Depth by DR Abinas and Finally Clarified by management of a very Complex Situation by DR Ash himself.....This session definitely goanna save many possible Medical Complexities especially related to effective counseling.

FEEDBACK # 4

Rida Rana

Alhamdulillah attended the class on the topic which is not taught or even discussed by the senior consultants. Yet the situation of DNA CPR is frequently encountered by the clinicians at all levels on their duties. DR Abinas explained in the simplest form, easy to learn pattern. The best thing is the topic was taught from the scratch, from the basics, the significance of DNA CPR , when to revoke it , and when to protect your decision as a clinician . The flavor of TEP

and ACP was also given Thankyou DR Ashfaque for the bringing such amazing faculty on board. I literally had no idea about the details and particulars of this topic. And yes DR Ash OSCE simulation was excellent and boosted the confidence in ourselves regarding how to deal with such scenarios .Thankyou Sir for literally dictating us what is to said and how questions are to be answered
Alhamdulillah on being part of LGEM

FEEDBACK # 5

Nasir Hayat

Very nice and lovely presentation by DR Abinas and sir DR ash much needed talks for ER physicians to understand the deep of DNAR

FEEDBACK # 6

Saba Asghar

Today's session was amazing. Hear for the first time from London GEM platform about DNACPR. The legal and ethical issues were wonderfully discussed by Dr. Abinas. The OSCE station by Dr. Ash added crunch to the whole session. Help a lot in understanding how to handle such situations. Learn a lot. Thank you LGEM

FEEDBACK # 7

Sadia Khan

Wonderful points learnt today about DNAR at initial stage of career. All credit goes to DR Ash, DR Abinas and London GEM team. What is DNAR how to explain it to patient and family? What conditions we do DNAR and OSCE by DR Ash thank you!

FEEDBACK # 8

Mukhtiar Pathan

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions are made commonly in healthcare but can be a source of ethical concern and legal challenge. They differ from other healthcare decisions because they are made in anticipation of a future event and concern withholding, rather than giving, a treatment.
DNACPR decisions are made to protect patients from invasive treatments that had little or no chance of success. However, inconsistencies in decision making, communication, and documentation have led to misunderstandings about what DNACPR means and to delivery of poorer care to some patients.
In today's Session on DNACPR DR Abinas discussed the problems with current practices and outlined newer approaches that place the patient, and their family, at the center of the discussions.
DR Abinas focused on overall treatment plans and emphasized on supporting clinicians and patients to make shared decisions about emergency treatments.

I congratulate all GEM Candidates for being part of this wonderful session and I'll request everyone specially DR **Muhammad Azeem Imran**, DR **Aurangzaib Ahmed**, DR **Ubaid Ur Rehman Khizir**, and all others to implement these protocols in your hospital, which must be supported by a clearly defined Departmental / Hospital Written Policy duly signed by Hospital Administration and accredited by Healthcare Commission, like it should be accredited by Sindh Healthcare Commission (SHCC).
Excellent and valuable input by DR **Nousherwan Soomro**.
Thank you very much **DR Abinas** for conducting such an excellent session.
Many Thank to **DR Ashfaque** for providing this wonderful opportunity to learn DNACPR
Stay Blessed 💔

FEEDBACK # 9

Maimona Javaid

It was a wonderful lecture by DR Abinas and very well explained. It's totally a new knowledge to me. Never had this kind of lecture in past. Looking forward to learn more
DR Ash is always a superhero of GEM. Best mentor, best supervisor,
case discussion was superb by all consultants, totally new info for me. Keen to learn more communication skills as a doctor.
Superb learning as always
Thanks DR ash for treating us
Super GEMS
Stay blessed
Grateful to all consultants for sharing amazing things with us

FEEDBACK # 10

Muhammad Ibrahim

Ironically how common CPR is and how we never heard of DNACPR before. This was a first time DR Ash introduced us with this term and arranged a very comprehensive lecture on this very important topic by a senior UK trainee DR Abinas who made us completely well-versed with this unfamiliar topic.
Thank you so much DR Ash and DR Abinash

FEEDBACK # 11

Javeria Siraj

Amazing session by DR. Abinas on DNACPR. It cleared lots of misconceptions about such a sensitive topic. Thanks a lot
Lastly, thanks Dr. Ash for adding important points related to communicating and counseling the patient's family about the decision

FEEDBACK # 12

Rana Gulraiz

DNA CPR is frequently encountered by the clinicians at all levels on their duties. DR Abinas explained in the simplest form, easy to learn pattern. The best thing is the topic was taught from the scratch, from the basics , the significance of DNA CPR , when to revoke it , and when to protect your decision as a clinician . The flavor of TEP and ACP was also given Thankyou DR Ashfaque for the bringing such amazing faculty on board. I literally had no idea about the details and particulars of this topic. And yes DR Ash OSCE simulation was excellent and boosted the confidence in ourselves regarding how to deal with such scenarios .Thankyou DR ash DR abinas for this wonderful ❤️ ❤️

FEEDBACK # 13

Hani Suhail

Always something new to learn and a step forward to know what are the capabilities of doctors and how knowledge is power.
A wonderful session discussing DNAR and different conditions with different approach towards conducting DNAR, TEP, and ACP.
An OSCE which cleared all the doubts and made us realize the importance of communicating with patient, attendants and senior doctors.
Thank you Dr. Ash and Dr. Abinas

FEEDBACK # 14

Ahmad Bin Khalid

An important session on DNACPR by DR Abinas and OSCE conducted by DR ASH is just phenomenal.
The ethical and legal aspects of this session were amazing it helped a lot to learn how to tackle these situations. Thank you LGEM 💓

FEEDBACK # 15

Aurangzaib Ahmed

A nice class presented by DR Abinas regarding a very sensitive topic that has a very huge impact on the ethical side of our practice the DONOT ATTEMPT CPR. When we should not opt for it and when should we respect it. What are the legal bindings of the DNACPR document and how should we focus our pra tuce around it. It was a nice lecture in which he tried to address someone our concerns. Thank you London gem for arranging such session.

FEEDBACK # 16

Gdmas Malik

Respected sir g, today once again a glittering session was genially interpreted that divulged the concentric aspects of DNA CPR. The session was gloriously administered and impressively implicated by DR Abinas sb. He handsomely elaborated DNA CPR and took in communication, ethical, moral, and legal aspects .His stance was to prevent invasive treatment with minimum output.

Although it doesn't allow stopping medical treatment, He instituted legality pertaining to DNA CPR in case of frailty and unsustainability of the patient. He exonerated all the factors which hinder the way of smooth applicability of rules framed for proper manipulation of DNA CPR. HE Elucidated in way that smashed out the dingdong regarding DNA CPR . I am very thankful to DR Abinas sb for his dazzling session.

Once again I will deliberate the discernment of our reverend and well glorified mentor excellency, Sir prof Ashfaque Ahmad sb who splendidly mentored the position and unveiled the perplexity. He disentangled the plaited complexities and emphasized on following. The principles enacted in this regard that could absolve us from legal eclipse and extricate us from GMC or court entanglement. He delineated DNA CPR by a case scenario where was gracefully depicted and exemplified. This presentation endowed us keen foresight and inscribed us a penetrating percievement. He denounced that most of the peoples don't follow the creed of acceptance and understanding .His gracious sculpture captivated us, His amicability forfeited our attention. His gracefulness confiscated our concentration. He is mentoring us friendly. This highness enforce us to be wholeheartedly honest and dedicated disciples of the saint mentor. His grandiose plan should be reverberated in the world and his good thoughts be sublimed by the spirits of allegiance. . What his greatness, behoove me to thank him is beyond of my compass. I am inept to retaliate and garlande him with the wreath of honor and dignity. I am praying our great sir may be blended with sheer success and eternal happiness.

Dr Gulnawaz khan wazir

FEEDBACK # 17

Obaid Ur Rehman

Knew nothing about it before the lecture and in our Hospital, we just take a written signed agreement/consent of full code or pharma code or whatever they tell us to do from the patient's attendant, as in Pakistan patient's attendant has all the power. Didn't know we as a doctor can also make the decision. Which patient is suitable for DNAR, when to revoke it, how to communicate efficiently and make the patient and their family understand it considering the religious and culture factors. TEP and ACP all were new to me. It was such an important session, as it can cost you your whole carrier if done improperly. DR Ash 's OSCE in the end was important and interesting as ever.

FEEDBACK # 18

Imran Farooka

This session was on Do Not Attempt CPR i.e. DNACPR, Treatment Escalation Plans i.e TEP and ACPs i.e Advance Care Plans by DR Abinas ST 6 Geriatric medicine NHS followed by OSCE simulation on DNACPR by DR Ash. DR

Abinas started his talk by narrating certain facts and figures about CPR like 1. CPR protocols were first introduced in 1960 and DNACPR was introduced after 10 years in 1970.2. According to 2014 data CPR success rate is less than 20 percent in hospital and less than 5% on roads arrests.3. CPR outcomes include rib fractures in about 97%, sternal fractures in around 43% and internal injuries like pneumothorax in 1-5 % of patients.

DNACPR is mainly for irreversible conditions like Dementia, Cancers advanced and metastatic, massive intra cerebral bleeds and in advance age patients with multiple co morbidities and poor life expectancy. DNACPR is opinion of the clinician and discussed with patient and relatives but the decision lies with the clinician.

DNACPR is anticipatory i.e. prevents futile, inappropriate and or unwanted attempts at CPR. it is good to have a witness and legal duty to consult with and inform the patient unless it is going to cause harm to the patient but the patient does not need to agree to it.

DR Abinas discussed DNACPR with reference to different case scenarios and explained we can even revoke it when need be like in easily treatable or reversible conditions.

DNACPR does not mean that patient will be deprived of other medical treatments like iv anti biotics, any investigations, chemotherapy etc. DNACPR is not denying care to the patient but giving an opportunity for a dignified death.

TEPs means how far you want to push the patient receiving treatment. ACPs are more community based. It is about what is important to patient, what patient wants to happen, what he doesn't want to happen and who would speak for the patient.

Last part of session was conducted by Dr Ash and there was a OSCE simulation on DNACPR.

I learnt a lot about DNACPR and vow improve the knowledge about this important topic at my workplace by conducting teaching sessions to my fellow and junior colleagues.

FEEDBACK # 19

Saba Aslam Khan

Waiting anxiously

FEEDBACK # 20

Muzna Ahmed

Wonderful talk on DNACPR by DR Abinas he explained everything very nicely with the help of scenarios and documents used for it and solved audience's queries side by side which makes the presentation very interactive and interesting.

DR Ash did an OSCE mock with a complicated scenario and it gives many many learning points to us and clear confusions and queries. It was helpful both for exam purpose and for real life situation.
Thanks a lot DR ASH and DR Abinas

FEEDBACK # 21

ناصر اطہف

It was just too amazing.. i love to attend live lectures.. Faculty is amazing. This programme is a blessing.. DNACPR is a clinical decision. We just have to communicate well so that decision is conveyed properly.. Furthermore, TEP and ACP forms should be filled.. pur duty work should be done in our duty time.. these ethical points should be opt by all of us. And that's wonderful. We are learning counselling skills too.

FEEDBACK # 22

Anila Zafar

A marvelous presentation by DR Abinas on DNACPR. He covered the ethical and legal aspects of a very sensitive topic.
The OSCE session by DR Ashfaque was the cherry on top and always a treat.
Thank you.

FEEDBACK # 23

Javeria Wali

Today, our session was about DNACPR, a topic about which doctors in our country are largely unaware of. DR Abinas explained everything nicely i.e history of CPR and the Basics / significance of DNACPR, When to revoke DNACPR and the ethical and legal aspects of Protecting patients from non-beneficial treatments.
In the end, OSCE session by DR Ash showed a really complex real life case in which understanding the basics of DNACPR was vitally important.

FEEDBACK # 24

Muhammad Abubakar

Great session by DR. Abinas on DNACPR, TEP and ACP. The Doctor have to face a patient with multiple co-morbidities and when the patient goes into cardiac arrest it's really challenging for the doctor to decide whether to resuscitate or not by focusing on the outcome and also by the pressure of patient attendees that is the thing explained very well in the lecture.
And as always the input from **Dr. Ashfaque Ahmed** is highly appreciable the mock station discussed was very well simulated and presented.
It is the beauty of this Course and our mentor Dr. Ash.
Thank You LCC.

FEEDBACK # 25

Rajab Abbas

Today we had a great session on *DNACPR* by DR *Abinas St6 registrar emergency in NHS and By Dr Ashfaq Consultant Emergency NHS*.
This is a really complicated and misunderstood topic by most of the doctors working in any healthcare system particularly in Pakistan. But DR Abinas explained it very beautifully, making our concepts clear about *DNACPR*.
The discussion was scenario based and interactive to give us insight what real meaning of DNACPR is and what should be a doctor's approach in different cases.
We learned that *DNACPR* is to prevent futile efforts and insavive treatment with minimum output.
It's a Clinician decision along with discussion with pt or next to the kin based on the given scenario.
Patients wish should always be respected but keeping in mind his/her mental capacity. And it does not allow to stop ongoing medical treatment.
DR Abinas further told about Communication skills, ethical, moral, legal aspects and documentation of DNACPR. And importance of communication and discussion with the patients or next to kin before and after DNACPR signed.
He also discussed about treatment escalation plan and advanced care plan.
In the end DR ASH conducted an OSCE station and it was wonderful learning today.
Thank you DR Abinas
Thank you DR ASH
A proud GEM CANDIDATE.

FEEDBACK # 26

Zegham Abbas

It was something new to learn about DNACPR very good teaching method by DR Abinas very well explained totally a new knowledge to me. Never had this kind of lecture in past and look forward to learn more
Dr ash is always a superhero of gem. Best mentor, best supervisor , case discussion was very helpful In understanding the concept.

FEEDBACK # 27

Yasir Dilawar

Very good session on DNACPR by DR Abinas. Honestly, I had very little knowledge about this topic. But today, I have learnt some useful stuff from this lecture which will be helpful in future. Thank you DR Ash for arranging such lectures for us

FEEDBACK # 28

Zia Hayat

It was very precise and up-to-date presentation with clear understanding about the concepts of DNAR and prospective in terms of real life scenarios, Thank you DR Abinas and DR Ash for adding in some extra points along a brief OSCE station.

FEEDBACK # 29

Humanity need you ·

It was very precise and up-to-date presentation with clear understanding about the concepts of DNAR and prospective in terms of real life scenarios, Thank you DR Abinash and DR Ash for adding in some extra points along a brief OSCE station.

FEEDBACK # 30

Farah Anwar

Great session and such an important topic to be discussed by Dr. Abinas made it so comprehensive especially with the cases scenarios that he discussed. Thank you Dr. Abinas and Dr. Ash!

FEEDBACK # 31

Ali Kazim

Today's Session on DNACPR was wonderful. I learned a-lot from it. DR Abinas comprehensively explained about DO's and DONT's of DNACPR. He also gave us a great insight knowledge about Treatment Escalation Plan (TEP) and Advance care plans (ACP) .

At the end the OSCE Session was also mind blowing.

Thank you DR Ash and DR Abinas!

FEEDBACK # 32

Maria Aslam

Attended a very important learning session today about DNACPR by DR Abinas and a well explained topic with case examples and how to approach the whole situation, patient' consent, family' wishes doctor' assessment and especially communication skills. DR Ashfaque' OSCE simulation with great communication skills helped a lot to understand this complex topic. Thank you DR Ashfaque and DR Abinas for this session.

FEEDBACK # 33

Amir Ashraf

Excellent presentation on DNA CPR (donot attempt cardiopulmonary resuscitation) TEP (treatment escalation plan) ACD (Advanced cared plan) by DR Abinas

These entire topics were briefly covered:

-Leading cause of deaths in UK (dementia and alzheimer)

- Out comes of CPR (rib fracture, sternal fracture)

-DNA CPR detail form

- DNA CPR just means do not attempt cardiopulmonary resus, it doesn't involve any medication, imaging or surgical treatment.
- How to prevent inappropriate or futile CPR attempts .
-TEP (ITU, HDU, WARD, END OF LIFE)
-Advanced care plan.
The technical case scenarios were presented to make our knowledge and understanding more clearly.
The challenging yet interesting case scenario of a an elderly pt with an intracranial bleed and his son is a neurosurgery resident and you have to discuss a DNACPR with him, given by DR Ash was very informative, although very advanced but this was a real every day scenario , in discussing and while studying it might looks simple but its sometimes a horrible situation to be in that case , but it was beautifully explained by DR Ash .
Thank you DR @DR Ash and DR Abinas. It was pleasure attending this topic.

FEEDBACK # 34

Ghayoor Khattak

It was such a wonderful and comprehensive session. I have learned a lot of learning point regarding when to do and when not to do CPR
Specially in a case of Anaphylactic shock (Reversible Case)
DR Abinas has a great skills of teaching.
Also thanks to:
DR Mukhtiar
DR Ashraf Alsaadny
DR Noosherwan soomro
For adding important points
At last but not least DR Ash has great skills to summarize such lecture
Thanks a lot London Gem
Regards
DR Muhammad Ghayoor Khan

FEEDBACK # 35

Hamna Kirn

A very important topic in medical ethics was discussed today. Learn great points for effective decision making. A comprehensive lecture was given by DR Abinash and thought provoking scenarios were discussed. Follow by DR Ash discussion of a very complex case. How to tackle with such situations? Learn about the importance of second opinion, how to work as a team and back each other up and effective counselling.
Thank you LGEM.

FEEDBACK # 36

Imtiaz Ali Shah

An excellent session by Dr Abinas regarding DNACPR. It is an important as well as very sensitive topic .we learnt about the conditions and stage of illnesses where CPR is not possible or it has no outcome. The discussion was scenario based and interactive .It was a new learning for me. TEP and ACP (advance care plan) were also discussed. DR Abinas covered this topic in a simple manner but he delivered his massage successfully
Thanks DR Abinas for such knowledge able presentation.

FEEDBACK # 37

Shehzad Hussain

Thank you DR Abinas and DR Ash it was wonderful session on DNACPR Lot of applicable knowledge delivered, thank you DR Ashraf and DR Sumroo for amazing OSCE,
Thank you very much DR Ash.

FEEDBACK # 38

Noman Ahsan

Wonderful session by DR Abinas on DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) , TEP (Treatment Escalation Plan) and ACD (Advance Care Plan) ...
OSCE session by DR Ash was very helpful in order to how to introduce yourself and communicate with patient, attendants and with specialty doctors.

FEEDBACK # 39

Umair Khalil

Today's session was something which we didn't know before. We used to sign on a paper and get the relatives sign under a statement about resuscitation and DNR.
DR Abinash made it easy to understand need of DNACPR form, its usage with different case examples. We also learnt about TEP and ACP and there usage. At the end, DR Ash gave real life touch with an OSCE session with 2 Consultants working in UK. The difficulty level was high and it gave a real glimpse of how candidates need to prepare themselves for the exam. It was a full time learning session of 2 Hrs.
Thankyou DR Abinash and DR Ash

FEEDBACK # 40

Dr Mishal Shan

The talk by Dr Abhinas was very enlightening as this concept is something many of the junior doctors working in our setups are not familiar with. Dr Abhinas explained everything very nicely and comprehensively. He also gave us clinical cases as examples to teach us real life scenarios. It was new information for us that DNACPR is entirely the decision of the doctor and while

patients need to be informed, they are not the prime decision makers. He also encouraged us to make an informed clinical decision and be confident about it.
Regards,
Mishal.

18th SEPTEMBER 2022

EVENT NAME:

Delirium & Dementia in ED, By Dr Ash & Pam Trangmar

DOCTORS FEEDBACK

FEEDBACK # 1

Wajahat Khan

Very brilliantly and nicely explained such confusing topic in such an interesting and simple way, I always find this topic Dementia and Delirium in Elderly pts very boring and sometimes scary as well because many things very intermingling with one another, but now Alhamdulillah by the efforts of Dr. Pam and our mentor, supervisor 😍 Dr. Ashfaque Ahmed it looks very easy, cleared all my confusions. Alhamdulillah, now I am very confident in diagnosing such pts. Dr. Pam elaborated:
*What is dementia?
*Types of dementia
* Alzeihmer vs Dementia
* Dementia with parkinsons
* Delusions and Hallucinations in such pts and how to deal with such pts
* How to de-escalate aggressive pts?
* Delirium
* Types of delirium?
We learnt so much by the experiences of Pam, Dr. Ash shared, how you can make someone's and his/her family's life better. Thank you so much sir!! 🙌

FEEDBACK # 2

Shehzad Hussain

Thank you Dr. Pam n Dr. Ash it was amazing lecture with loads of practical knowledge and the way to deal with Dementia Delirium is extraordinary. It's one of most dry topic but Dr. Pam make it amazing easy thorough comprehensive we learnt many things specially to get involved in

Hallucinations is awesome. Thank you Dr. Ash to bring us this lecture with Dr. Pam. Thank you all!

FEEDBACK # 3

Zia Hayat

Today lecture was really amazing with all the details about dementia and delirium in clinical settings, enjoyed every minute of this talk and was full of energy. Thank Dr. Pam and Dr. Ash for inviting her for this learning opportunity.

FEEDBACK # 4

Ubaid Ur Rehman Khizir

THE SESSION DELIVERED BY Mrs. PAM ON "DELIRIUM AND DEMENTIA" WAS SUPERB. How to differentiate between delirium and dementia We have many patients around us with delirium and dementia Mrs. Pam told about stages and diagnostic criteria of both How to manage these conditions The session was full of energy by Mrs. Pam Most of the time we get bored by psychiatric topics but Dr. Pam did allow us to move from screen she made it interesting The last 10 minutes by Dr. Ash were about community issues we have in around us Most of the time we ignore them but We should diagnose them and treat them accordingly I always thought how to deal such patient but I have got a lot of knowledge about it now Thanks Dr. ash for arranging such excellent session by such energetic Mrs. Pam.

FEEDBACK # 5

Kamlesh Kumar Lilani

Dementia and Delirium by Miss Pam, These diseases are common and misunderstood in our society. Patients' needs moral and motivational support rather than ignorance and adjust and Miss Pam summarized it very well and in the end Dr. Ash as always added many more points and hopes to us. Thanks Miss Pam and Dr. Ash for wonderful day.

FEEDBACK # 6

Babar Hussain

Today's session was on dementia and delirium. It was really an important session beautifully conducted by Dr. Pam. I love the energy she had, it was a nice and comprehensive teaching especially the trade mark identification point that the "patient with dementia will communicate with eye contact and patient with delirium will communicate without eye contact". Overall it was really a brilliant session. I really learned a lot. So thank you very much Dr. Pam for such an amazing presentation. I would like to thank Dr. Ashfaque Ahmed for arranging such an amazing session and for letting us learn from the best 😍.
A proud GEM candidate

FEEDBACK # 7

Obaid Ur Rehman

What an insightful session on dementia and Delirium by Dr. Pam. Her passion and empathy towards geriatric field and patients were clearly felt during her session. She not only taught us the medical knowledge she also shares her years of experience and was clearly successful in making us curious about geriatric field which most of us had the perception of boring. She gave us the lesson of being empathic towards patients which is the basis and key for treating them.
"It is easier to build strong children than to repair broken men"
Frederick Douglass
It takes a whole patients family each, member to take care a patient with dementia or delirium ,to get involve in their hallucinations and play along, to understand them even if they are wrongly accusing you with stealing etc. because of their conditions ,to take notes of things even the patient can't tell or don't remember which is very difficult from normal patient who is able to tell you everything or recall etc. to be able to deal with them when they are aggressive and have patience ,Man these patients require so much more energy and much more ,than just treating them medically. She completely changed my perception of geriatric field. Hope to learn more from her. Hats off to London GEM and Dr. Ash for bring such a qualified faculty and choosing such topics which are blind spot in our society /Pakistan.

FEEDBACK # 8

Maimona Javaid

Today lecture was outstanding indeed and first ever best lecture on dementia and delirium. Pam had done a great job. She has a beautiful smile and beautiful personality. And she taught and delivers a very different lecture of its kind. We never had this kind of lecture before in life in our medical experience.
Extremely grateful to Dr. Pam for her precious time and look forward to learn more and more
This lecture will help us teach train and provide mass communication as its vimp imp in Pakistan as every single home must be having one patient especially after COVID.
Dr. Ash talk gave me new ideas of education. New strategies regarding how to deal with these patients and always a very helpful talk
Thankyou Dr. Ash for giving us opportunity of this lecture
Stay blessed.

FEEDBACK # 9

Muhammad Taha Zaman

A fantastic lecture delivered by Pam on delirium and dementia. Precise and comprehensive information was provided including the predisposing factors, methods for assessments, diagnostic criteria and management of the patients for

the same. MOCA assessment, MCA, DOLS and GPCOG for the dementia patients and PINCH ME, behavioral and environmental modification techniques were also discussed in the lecture. In the end, thank you very much Dr. Ash for arranging such an amazing session today..
Regards

FEEDBACK # 10

Muhammad Abubakar

Today's lecture was fantastic just due to the Dr. Pam who kept all the listeners indulge by the way of her teaching, explaining the dementia, delirium and other diseases in such delicate way and her energy to the topics and especially to the geriatric medicine & diseases was exceptional. The small differentials she taught and common aggravating factors that can be dealt easily were also appreciable.
Thank You Dr. Ashfaque Ahmed and Pam

FEEDBACK # 11

Syed Suhail Ahmad

One of the most comprehensive and informative session on DEMENTIA and DELIRIUM by PAM, it cannot get any better than this. Two of the most common complaints in the Geriatrics, that are often overlooked and misdiagnosed. The energy and effort put by PAM in it made it even more interesting. 👍👍👍

FEEDBACK # 12

Rida Rana

What an amazing lecture by one of the best tutors i have ever come across. Pam literally you taught a topic which is boring and which no one wants to talk about; in the best way possible. It was taught with the statistics data , risk factors , presenting complain , most common presentation , diagnosis , management especially the cases encountered on routine basis by a practitioner in geriatrice were so interesting . The way to deal hallucination, the difference of dementia and delirium, how to counsel the family and you have elaborately explained the significant role that counselling and family members play in such patients. Thank you Dr. Ashfaque for bringing such an amazing faculty on board, The 2 hour lecture just passed like within a blink of eye, the tutor was herself so much keen and interested in pouring out the knowledge about which we had no idea. This was yet a very interesting flavor in the LGEM curriculum. Alhamdulillah on being part of LGEM 😊

FEEDBACK # 13

Afshan Salman

Thank you Dr. Ash for bringing such outstanding faculty for GEM sessions, it was a long wonderful session by Pam and not a single moment our attention got diverted anywhere. Never learned Dementia and Delirium that way before and she not only delivered the lecture but, spoke out of her heart, shared how she deals with such patients which was really worthwhile.
In the end Dr. Ash discussion about patients with delirium and dementia made us think in a completely new way about such patients. We need to identify such patients around or in hospital and not only treat but also support them and educate their families.
We do take care of our elders physically but when it comes to their mental issues, we label them as part of their aging which is quite wrong.
Hope Dr. Ash will bring Geriatric healthcare to Pakistan as well as he knows what this country/society actually needs.

Thanks Pam, Dr. Ash and LGEM team ❣

FEEDBACK # 14

Hani Suhail

Patience is the Key to unfold mysteries. Today's lecture was about something that all of us go through on a daily basis, let it be hospital or at home and always have a thought in our minds that how should we deal with this matter and what could be the way to break free from this. Pam made it clear in her lecture today about "DELIRIUM AND DEMENTIA" it's not the fault of the people but its a fault of our minds that we forgot how to handle. Dealing with patients and putting yourself n their shoes is the way to understand them and be able to communicate with them in their language. From killing insects to treating them as the professionals they used to be, and the love to care for them is what they require, which requires a lot of patience. Thank you Dr. Ash and Pam for making us realize what we had known but forgot through this wonderful lecture, presented in the most beautiful way to grab our attention and fill us with realization.

FEEDBACK # 15

Noman Ahsan

Indeed Delirium and Dementia is one of the Dry and difficult topic to discuss/ understand but the way Pam delivered this session with all of her heart and great presentation and explanation skills, it made it very interesting and easy to understand those situations. These patients are mostly ignored and failed to get diagnosed which leads to lots of family issues with bad outcomes. Pam thanks for sharing your clinical experiences ...Thanks Dr. Ash for bringing in GEM like Pam on board to discuss these important topics.

FEEDBACK # 16

Nasir Hayat

Nicely presented by Dr. Pam and sir Dr. Ash with lovely teaching and much needed for ER physicians to get hold on it learned a lot
Thanks LGEM and Sir Dr. Ash for nice lecture

FEEDBACK # 17

Qaisar Shah

Today's session about Delirium and Dementia by madam pam was so amazing, she taught so well the difference between delirium & dementia, facts, risk factors, consequences, indicators, driving and Dementia, non-medical and medical treatment, and at last Dr. Ash added that the main purpose of this session is to diagnose & identify these patients and educate their families about their mental condition & may help support and deal accordingly.
Thanks madam pam, Dr. Ash & LGEM for this one.

FEEDBACK # 18

Aqsa Yaqoob

A very excellent and comprehensive lecture on dementia and delirium given by ma'am pam. Types of dementia, life expectancy, driving and dementia, diagnosis and treatment were explained very efficiently. Delirium, how do we identify it and management of such patients, it was the best lecture conducted on this difficult topic. Thank you Dr. Ash and ma'am Pamela for arranging this lecture for us

FEEDBACK # 19

Imtiaz Ali Shah

Excellent session by Mrs. Pam regarding dementia and delirium, a very common presentation in ED and clinical setups but most of the time ignored or misdiagnosed leading to more serious consequences. Pam presented this tricky and difficult topic in such a manner that understanding and learning became much easier .she elaborated different types of dementia, common symptoms, difference between dementia and Alzhimers, diagnosis and treatment in a very comprehensive way. She also discussed DELIRIUM, its risk factors and risk assessment along with its management in detail.
The way Pam explained these topics was remarkable. We had a very good understanding of these issues today and the consequences if remained ignore or untreated
Once again thanks to Mrs. Pam for providing us in depth knowledge of both these topics which will help us in management of such patients in future.

FEEDBACK # 20

Rana Gulraiz

The way to deal hallucination, the difference of dementia and delirium, how to counsel the family, you have elaborately explained the significant role that counselling and family members play in such patients and Thanks Dr. Ashfaque

for brining such amazing faculty on board. The 2 hour lecture just passed like within a blink of eye, the tutor was herself so much keen and interested in pouring out the knowledge about which we had no idea. Thanks Dr. Ash & Miss Pam ♡

FEEDBACK # 21

Salman Ilahi

Thanks you so much Dr. Pam for teaching us new things about dementia and delirium it was really a great session the way she delivered was tremendous

FEEDBACK # 22

Faiq Uz Zaman Khan

Such an in-depth and detailed lecture, Mrs. Pam really showed us the compassionate way to deal with patients with dementia and delirium and Dr. Ash blending these topics with our Desi culture, definitely made this lecture one of a kind

FEEDBACK # 23

DrKiran Feroz

Such an informative session....never thought that people suffering from dementia ...delirium are the badly sufferers in the society ....and they need help....well explained session which gave a clear insight of the diseases in most elderly pts....thank u Dr. Pam for sharing the valuable knowledge....hope to have more sessions from you soon...Thanks London Gem♥

FEEDBACK # 24

Jawad Jutt

Thank you for giving lecture on dementia, its types, difference between delirium and dementia in most understandable way .really appreciate your efforts PAM and Dr. Ash

FEEDBACK # 25

Rabia Nagri

Thank you for giving this informative and in depth lecture about dementia and delirium. I have learned many new aspects and information about this topic today which I missed even during my psychiatry rotation

FEEDBACK # 26

Soura Jawed

Today's lecture regarding dementia and delirium by ma'am pam was really interesting she explained everything briefly and efficiently. The way she shared her experiences made us learned a lot. Thanks Dr. Ash and Mam Pamela for today's session.

FEEDBACK # 27

Hk Danish

Thanks Dr. Pam for making this boring topic so interesting. I learned lewy body dementia, frontotemporal dementia, picks disease, difference between dementia and delirium. Just so much knowledge in such a small time
These patients are often ignored and suffer a lot. Now I feel ready to serve them with the best of my knowledge

FEEDBACK # 28

Zia Hayat

Today lecture was really amazing with all the details about dementia and delirium in clinical settings, enjoyed every minute of this talk and was full of energy. Thankyou Pam and Dr. Ash for inviting her for this learning opportunity.

FEEDBACK # 29

Muzna Ahmed

Excellent talk today on dementia and delirium by Mrs. Pam and Dr. Ash
She covered the whole topic very beautifully and comprehensively. There were lots of learning points regarding different types of dementias Alzheimer's disease how these conditions start developing and progress through the course of time and how it produces consequences to patient and his/her family if left undiagnosed. It could become debilitating and life-threatening due to delusions and hallucinations. Patient should be provided with separate cubicle and attention when they first arrived at ED.
So that disease can be picked up at early stages and then it will not be a havoc to manage such sensitive, care and empathy needed condition. Modifiable risk factors should be addressed promptly like vascular diseases DM constipation etc.
Lastly Dr. Ash summed up the whole talk by telling different real life stories and how he deals with them so that if we encounter any such condition we should be mentally prepared.
Thanks a lot Mrs. Pam and Dr. Ash.

FEEDBACK # 30

Khatija J. Farooqui

Dementia …always found difficult to understand but Dr. Pam was so awesome beautifully describe and make it so interesting to catch up little differentiation between delirium n dementia.

FEEDBACK # 31

Anila Zafar

What an amazing session by Pam. Her way of delivering the lecture on a very dry topic is commendable. She had my attention the whole time. I really appreciate how she explained everything with examples and scenarios she had already witnessed and very marvelous and comprehensive explanation of

dementia and delirium. I learned that it can be hypoactive and hyperactive and even mixed. It opened my eyes how we can approach it with a different perspective. Thank you for an awesome lecture.

FEEDBACK # 32

Uzma Shaikh

Outstanding and detailed lecture on delirium and various types of dementia by Dr. Pam and she was so keen to teach, engrossing in her deliveries. Point of the day for me was "to treat hallucinations be part of their hallucinations."

FEEDBACK # 33

Javeria Wali

It was an awesome and very comprehensive session on dementia and delirium by Pam trangmar and her energy and dedication were truly admirable. She delivered an amazing talk on one of the most difficult and misdiagnosed cases to present to emergency department in which she discussed everything with examples and real life scenarios to make it extremely interesting and worth studying further in detail. Difference between normal ageing and dementia, Types of dementia i.e Alzheimer's disease, Vascular dementia, Dementia with Lewy Bodies and Frontotemporal dementia were explained in an easy to understand way alongwith various Facts & statistics about dementia, Symptoms (memory, cognitive, communication, concentration problems), Modifiable / non modifiable factors, importance of Familiar, calm and comfortable environment in their management, Life Expectancy And The Treatment (support, education, medication, memory clinic sessions). Also delirium was comprehensively discussed and perfectly explained. In the end, Dr. Ash's golden words and short discussion on diagnosing and education of the family, and management gave us food for thought as well.

FEEDBACK # 34

Rajab Abbas

A two hour comprehensive session on a geriatric topic was delivered by Miss PAM Physician assistant & DR ASH Consultant Emergency and Acute medicine. In which she discussed about the

• Difference between normal ageing and dementia
• *Types of dementia*
°Alzheimer's disease
°Vascular dementia
°Dementia with
Lewy Bodies
°Frontotemporal dementia
• Facts & statistics about dementia
• *Symptoms* (memory, cognitive, communication, concentration problems)

• *Modifiable factors* (control of DM, HTN, Alcohol and smoking cessation, exercise, weight control, education)
• *Non-Modifiable Factors* (Age, ethnicity, gender, genetics)
• Good Vs bad food
• *Managing Behaviour*
°Familar and calm environment
°Encouragement
°Orientation
°Live with hallucinations was one of the most important learning point today to lessen the confusion of patient.
• Importance of Avoiding driving and notification to license agency
• Dementia Vs Alzheimer's
• Detailed discussion about disease process (Early Stages & Late Stages)
• Life Expectancy
• Mixed Dementia
• *Atypical Alzheimer's*
°PCA
°Logopenic aphasia
°Frontal Alzheimer's
• *Diagnosis*(Rule out other organic causes)
• *Treatment* (support, education, medication, memory clinic sessions)
• NHS GUIDLINES
It was a comprehensive session on dementia by Miss PAM and Dr. Ash input in the lecture regarding diagnosing and education of the family, support and management was concise. Dr. ASH services in evolving the Emergency medicine in Pakistan are admirable. Indebted to you sir
THANK You Dr. ASH.
THANK YOU Mrs. PAM

FEEDBACK # 35

Nazish Nazi

What a great session by Dr. Pam on such a wonderful topic, she gave a deep insight on what's the difference between Dementia and Delirium, Management of such patients, counselling of family and how to empathize with them, I really feel Dr. Pam passion for Geriatrics it was all transparent in her lecture how dedicated and sincere she is , really grateful to Dr. Ash for bringing such a wonderful teacher to teach us ! ☺

FEEDBACK # 36

Dr Zaid Ahmed Ansari

Dr Pam's presentation on dementia and delirium in the elderly was particularly informative, since i believe that geriatic medicine practice sorely lacks in the

implementation of best practices. The lecture included refreshers on dementia, alziehmer's vs dementia and management protocols for delusions and hallucinations in the elderly. Delirium and management protocols were also discussed in great depth.
What i felt after taking the lecture is that this knowledge should become more mainstream. Many families in South Asia take care of their elderly without much help; i feel as if this knowledge if simplified for the lay person could potentially make families better understand their elderly and help them to manage the patients more effectively.

FEEDBACK # 37

Dr Mishal Shan

The lecture by Dr Pam was one of the best I've taken in this program. The way geriatric care is approached in the UK, even in the ED always amazes me and gives me some new pointers to improve my clinical practice.
We were taught the different types of dementia, how to tackle such patients and how to maximize their comfort and help them lead normal lives. We also learned about the triggering factors and approaches to delirium, how we can help them come out of this acute state and what are the commonly performed malpractices which often make delirium worse. Simplest examples are the use of restraints in such patients, adoption of a threatening/ defensive body language by healthcare professionals, neglect towards constipation and urination and even polypharmacy.
I Learned a lot today and will hopefully keep these pearls in mind when working with patients.
Regards,
Mishal.

24th SEPTEMBER 2022

EVENT NAME:

DKA Step Wise Management First 24 hours

DOCTORS FEEDBACK

FEEDBACK # 1

Muhammad Ramzan

The session started with excellent presentation by Dr. Azeem. Later on detail 2 hours teaching was done by Dr. Ash. Every minute and small details were explained and candidates were engaged by questioning them.
One interesting story I would like to share. In less than 4 months I have attended huge amount of lectures and achieved more than 60 plus hours of CME/CPD. When I submitted the certificates to the management where I work. They cross questioned and ask me explanation.
Moral of story = No one believes you for getting this much of teaching.
Thank you @ DR Ash GEM and thank you London Gem. ✌🏾✌🏾😊😊

FEEDBACK # 2

Noman Ahsan

Excellent Presentation by Dr. Azeem on DKA..
Dr. Ash as always nailed this lecture with his great teaching skills..Lecture covered all the aspects of Diabetic Ketoacidosis including Presentation, Diagnosis and most importantly how to Manage DKA.

FEEDBACK # 3

Babar Hussain

Today's session was on DKA started with presentation from DR Azeem. It was an excellent presentation, Great effort.
Followed by DR Ashfaque Ahmed conducted the whole session of 2 hrs. I would say it was one of the best lectures. Especially learnt a lot of new things with practical approach. DR ashfaque covered everything from presentation, investigation, Diagnosis, calculations, management and also managing complications, overall it was a very comprehensive and wonderful lecture and I am very grateful to DR Ash for making it very simple with his special skills❤️.
Thank you very much DR Ash for this amazing session.
GOD blesses you😍.

FEEDBACK # 4

Sana Hameed

Much precise and understanding lecture given by the great dr. Ash on management of DKA. Learned new things and many misconceptions cleared too.
It's not just the labs in DKA it's the fluids/ electrolytes/ insulin even when the patient is out of the emergency phase.
Really appreciate DR. Ash's greatness to teach us with so much interest and so much dedication.
Proud to be known as his trainees and a part of his GEM students.

FEEDBACK # 5

Hira Nehal

Wonderful session sir .diagnosis management monitoring discharge .structured fluid replacement in DKA pt along with fix insulin infusion .followed by k infusion and when to continue when to stop .and then shifting them to variable insulin infusion and basal bolus insulin should be given along with fix infusion .then shifting them to daily insulin dose .calculate total body insulin via variable insulin infusion in last y hr and divide them and then calculate the daily dose of insulin and divide them for e.g. 60 percent before bf and 40 percent after dinner. Thank you DR ash DKA management was not always that easy To understand .An ED approach towards DKA pt was explained and made us quiet simple for us to understand. Wonderful session.

FEEDBACK # 6

Hani Suhail

DKA a puzzle that puzzled everyone with its presentation and management. Simplified step by step guide on how to diagnose and manage DKA in emergency with facilities and without much facilities was a brainstorming lecture that brought us to the point of why did we actually became doctors and how life saving can a simple yet effective intervention be.
Thank you DR Ash.

FEEDBACK # 7

Maimona Javaid

It was a superb lecture as always by DR ash. Lots and lots of new things I learnt. Though DKA topic is always bit difficult for me due to calculations. I will listen to it again and again to have a good grip on topic. It was a first ever time a very detailed lecture on DKA. Grateful DR ash .stay blessed

FEEDBACK # 8

Syed Suhail Ahmad

A very comprehensive and step wise management of DKA by Dr. Ash according to RCEM guidelines. Myths and Confusions were cleared. Keeping a SIMPLE and PRACTICAL approach is the way forward. 👍👍👍

FEEDBACK # 9

Rajab Abbas

A 2.5 hour long session started by the excellent presentation by DR Azeem, it was a wholesome case presentation along with complete management plan according to guide lines,
Followed by 2 hour comprehensive teaching on the topic of DKA in first 24 hours. He taught us today

- Pathophysiology of DKA
- Clinical signs and symptoms of DKA
- Diagnostic criteria of DKA & Investigations
- Fluid management (type of fluid, volume and rate)

• Insulin and potassium requirement (when to replace and when to hold)
• Monitoring (fluid balance chart, serum Electrolyte, blood glucose and ketones levels, urine output, consciousness)
• Bicarbonate replacement
• Insulin requirement fixed rates v/s variable rates
• Complications of Mismanagement and their management (cerebral edema)
• Calculation of total daily insulin requirement (TDD)
• Difference b/w DKA V/S SEVERE DKA
• Importance of serum ketones than urinary in monitoring the management

DR ASH taught in a really simple n concise way that's looked so plateable and very convenient to understand. Only DR ASH can teach complicated topics in such simple way .It feels like learned the knowledge and experience of years. Due to prevalence of Diabetes and influx of DKA patients in emergency we daily encounter the pts of DKA in ED. This session will improve our approach and management of DKA.

THANK YOU DR ASH

A PROUD GEM CANDIDATE.

FEEDBACK # 10

Muhammad Ibrahim

A very comprehensive teaching session on the management of DKA, we never knew that how much we were lacking in this topic and how disoriented we were from following the proper protocol.

A wonderful learning experience today and now equipped with proper protocol to manage DKA patients practically.

Thanks DR Ash.

FEEDBACK # 11

Naveed Memon

A worthful weekend again, today's lecture conducted by DR Ash himself on DKA and its stepwise lifesaving management in first 24 hours.

Lecture started by DR Azeem (gem candidate) case presentation followed by detail lecture by DR Ash.

We learn today.

Proper definition of DKA and severe DKA, Possible causes of DKA, Pathophysiology, Clinical presentation and management stepwise including rehydration of body fluids, and correction of potassium and insulin regimes.

The complications if untreated DKA.

Once again thanks DR Ash for teaching such an important topic.

FEEDBACK # 12

Shehzad Hussain

Thank you DR Ash for such an amazing lecture on DKA these two n half hours were priceless the things we learnt did not learn in decade, multiple times read DKA listened lectures but the way DR Ash explained today is just amazing I feel like right away from today I can treat DKA without any support/supervision. Thank you DR Ash n team may Allah SWT bless you with success.

FEEDBACK # 13

Mukhtiar Pathan

Excellent Presentation by **DR** **Muhammad Azeem Imran** ❤️ followed by Superb Lecture by **DR** **Ashfaque** on Diabetic Ketoacidosis ❤️👏👏👍

DR Ash precisely covered and taught all aspects of Diabetic Ketoacidosis including its Presentation, it's Diagnosis and it's Management.

Truly learned a lot

Excellent way of teaching DR Ash

May ALLAH PAK bless you ❤️

FEEDBACK # 14

Abdul Rehman

Wonderful lecture. Learnt DKA in a new way. Thanks DR. Ash

FEEDBACK # 15

Muhammad Abubakar

Wonderful session by **Dr.** **Ashfaque Ahmed** on DKA. It is one of the topics which should be mastered by every doctor working in any region of the world. Learned many things that I lack. Always Dr. Ash has a unique and perfect way to deliver and indulge everyone attending in the lecture and keep them interested in the topic.

Also the great presentation by Dr. Muhammad Azeem Imran. Dr. Azeem you always wants to give others all you have + all you can get to help others in every manner either it is knowledge or time, respect or could be anything, that is your beauty.

FEEDBACK # 16

Rabiyyah Bashir

Simply... The best lecture ever!!!!

Anyone can read from the books, but instilling this much practical insight is amazing...

Thank you **DR** **Ashfaque Ahmed** and team **London Global Emergency Medicine** ❤️❤️❤️

FEEDBACK # 17

Muhammad Azeem Imran

One of beauty of Mentor is to give motivation to his students and I feel blessed. He give me assignment, I make points but Boss always make things easy, simple, practical and beautifully explained easy to digest. Today's session was so productive as ever

*Topic*was

DKA STEPWISE MANAGEMENT 1st 24 HOURS BY DR ASH

He taught us today

• Pathophysiology of DKA
• Clinical signs and symptoms of DKA
• Diagnostic criteria of DKA & Investigations
• Fluid management (type of fluid, volume and rate)
• Insulin and potassium requirement (when to replace and when to hold)
• Monitoring (fluid balance chart, serum Electrolyte, blood glucose and ketones levels, urine output, consciousness)
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THANK YOU DR ASH

A PROUD GEM CANDIDATE.

FEEDBACK # 18

Ali Kazim

Today's Session on DKA was extremely superb. There were so many new information that I learnt today. Sir Ashfaque made the management really simple. It helped me a lot. Presentation by DR azeem was also great .

Thank you DR Ash!

FEEDBACK # 19

Muhammad Yameen

The 2 hours session on DKA was amazing.

I just attended the lecture, went on duty.

Found a case of DKA. The patient was dropping blood sugars. when I reached there. I found out that she is being given insulin infusion of 10units/hr.

According to her weight, it was 6units/hr. I adjusted the dose and started D/W 10%. Patients hypoglycemia got corrected. She became conscious after 4hrs. The amount of confidence I had today while managing DKA patient was 200%. And that was all made possible because of **Dr. Ashfaque Ahmed**. The way he taught us DKA management, No one can teach very simple and concise.
Hats off to you Sir ❤️❤️

FEEDBACK # 20

DrKiran Feroz

Wooo woohoo what a boom boom session....Masha Allah beautiful presentation by Dr. Ashfaque....no concentration losses from the start till the end...what is diabetic ketoacidosis .... How it will be identified. What is the proper management all clearly explained in one extended session.....hats off to u Ashfaque bhai ...May Allah give u more strength Ameen

FEEDBACK # 21

Muhammad Taha Zaman

Apologies about providing a late feedback though… A very well arranged and precise session conducted by DR Ash about the management of DKA within the first 24 hours of presentation in A and E. The diagnostic criteria, initial assessment and clinical practice in management of DKA were made ridiculously simple by Dr. Ash. The exact definition of DKA and all necessary steps prior management and within the same was effectively explained in the session. Especially the dosage and basal bolus of insulin was one of the key learning points included in the lecture. Again, I'm extremely satisfied and thankful to LGEM and Dr. Ash in providing highest quality information and arranging sessions to help the doctors of Emergency Medicine spark in the field and to progress better in the next process of their careers. Thank you.

FEEDBACK # 22

DrKiran Feroz

Yes I missed Dr. Azeem's session unfortunately (our Professor Sahab) must be a good one....will see the recorded session later Inshallah

FEEDBACK # 23

Ghayoor Khattak

Excellent Presentation by Dr. Muhammad Azeem Imran on DKA Management, followed by an excellent session by Dr. Ashfaque Thank you, Dr. Ash, for making everything so simple. It was a great experience. The information presented is extremely awesome. DKA management is one of the most difficult management in medicine but you people make it easy for us.
Amazing session
Thanks Sir
Regards

Dr.Muhammad Ghayoor Khan

FEEDBACK # 24

Muneeb Ahmed

Attended this detailed session 2.5hrs long starting from case presentations followed by detailed stepwise approach in managing DKA.
Dr. Ash discussed pathophysiology/clinical diagnosis/initial 60mnt management/investigation/classification of DKA on the basis of severity and respective management plan/identifying complications/Fluid replacement strategy/potassium replacement /insulin regime (fixed rate/variable rate) /Treatment goals.
Thanks London GEM for such detailed teaching.

FEEDBACK # 25

Hassan Tariq

Superb and excellent presentation by DR ash his way of presentation is very impressive and he knows the way to deliver.
Well done Azeem.
Thanks for London GEM.

FEEDBACK # 26

Syeda Maheen Ejaz

A very comprehensive lecture a purely practical approach to DKA management loving every bit of it. Our mentor doesn't let minor details of the topic be missed. Thank you so much, Dr. Ash and London Gem team ❤️

FEEDBACK # 27

Maria Aslam

Awesome presentation and a great way of delivering the lecture! A very detailed and stepwise approach to DKA presentation in the ED was comprehensively explained and covered by DR Ashfaque. Learn many new things about DKA management from the session. Thank you DR Ashfaque

FEEDBACK # 28

Khatija J. Farooqui

DR Azeem presentation was amazing on explaining DKA and then DR Ashfaque detail analysis on ketoacidosis and managements were excellent absolutely a new way of learning and knowing DKA.

FEEDBACK # 29

Imran Farooka

Today was a 2 hour session by dr Ash on DKA stepwise management in first 24 hours. Lecture started with case presentation on DKA by DR Azeem. Then DR Ash discussed DKA in detail. Important points included definition of severe DKA, first hour aims and targets that includes replace fluids, suppress

ketogenesis and correct acidosis. Fluid replacement, insulin infusions, potassium replacement and monitoring were discussed.
It was a great learning experience because of practical way of handling DKA beyond books. DR Ash is an amazing teacher, his grip on the subject and the way he simplifies concepts is admirable.

FEEDBACK # 30

Zegham Abbas

Excellent approach step by step management about DKA in 1st 24 hours was so amazing
Dr. Azeem presentation on the case of DKA covering all aspects.
Dr. Ash teach us the stepwise hourly management of DKA in 1st 24 hours.
Recognization of sever DKA its sign symptoms was absolutely perfect.
The most important thing in today's lecture was the Potassium replacement and how much should give hourly was phenomenal.
He explained DKA sign & symptoms, diagnostic criteria, fluid management, insulin requirement, insulin infusion, fixed rate vs variable rate, potassium requirement, managing complications like cerebral edema etc.
Another important point regarding Insulin was potassium level not to give insulin if potassium is too low was fabulous thanks again to a teacher who own its leftover doctors hats off to DR Ashfaque Ahmed.

FEEDBACK # 31

Dr Mariam Nawaz

With DR Ash you learn what bo one else teaches! He gives all his heart to his lectures and gives us a priceless blueprint of managing a patient. Books will teach you the management, but DR Ash will teach you exact step wise approach which will benefit in both, the exam and clinical practice. This session was no different. We learned about the very important presentation of DKA in ED and its stepwise management. It was 2.5hr session loaded with learning pearls.
Thank you DR Ash, forever grateful. A proud GEM trainee

FEEDBACK # 32

Rida Rana

Alhamdulillah attended another amazing session yet it from my best tutor **DR Ashfaque Ahmed**. An excellent presentation, with thought provoking questions, simplified explanation, easy to learn points with respect to the Management of DKA patients in ED. To be honest, no one could have taught this topic in a better way than him. There were so many important points which were grey in our minds regarding the accurate fluid administration, insulin and potassium dose calculation, when to stop insulin, fixed rate insulin, variable infusion , total daily requirement calculation .Each and every point was most

imperative to be learnt by A&E practitioners. Thank you DR Ash for such an amazing lecture. Alhamdulillah on being part of LGEM.

FEEDBACK # 33

Imtiaz Ali Shah

Another wonderful lecture by DR Ash regarding DK management in first twenty four hours. A very common presentation in ED but at the same time a very tricky one and a bit difficult to manage. DR Ash thought us a stepwise approach towards its management. The way DR Ash delivered the lecture, made it easy for us to understand the management of DK. He covered all aspects of the topic right from definition, diagnosis, management, complications and outcome. We learnt fluid replacement, insulin dosing, electrolyte balance and DR Ash made these difficult steps looks so easy that if we fallow these steps we can save the life of a patient with DK.

Once again thanks to DR Ash for this session and providing us a wonderful platform of learning in the form of London GEM.

FEEDBACK # 34

Muzna Ahmed

Marvelous session today by one and only DR ASH on the topic of DKA I have learned a lot of new things today and know the actual management of DKA that must be followed everywhere. Posters and flow charts can help remember the management regime which basically revolves around correction of electrolytes high sugars management and fluid replacement.

Dr azeem has presented case in a very excellent way.

Thank you DR ASH for giving this opportunity to all. From now onwards GEM students won't let DKA patient die by doing wrong management. 🙂

FEEDBACK # 35

Anila Zafar

DKA session by **DR Ashfaque Ahmed** was marvelous and very well explained. It covered all the point in such a comprehensive manner. It cleared A lot of my confusions and helped me to come up with a more practical approach to manage DKA in my setting.

I am currently posted in ICU and managing DKA myself with ease after the lecture. I am able to question my seniors on so many fronts about the steps in management which is clearing out the concept even further.

I learnt a lot from the session, Thank you Sir.

FEEDBACK # 36

Ahmad Bin Khalid

Excellent present by DR Azeem and brilliant lecture by our mentor DR ash on DKA and learned many things from this lecture on how to approach and manage DKA in ER.

Honestly I read this topic and took so many lectures on this but the way our mentor explained in a simple way is just phenomenal 🙂

FEEDBACK # 37

Saba Asghar

Wonderful and amazing session by our mentor Dr. Ash in his own style and learned so many things for the first time. Dr. Ash simplified the complicated stuff beautifully. This 2 1/2 hour session was really great. How to approach DKA in ED, and all steps were explained simply and in an easy to understand way. Thank you Dr. Ash

FEEDBACK # 38

Saba Aslam Khan

Lecture started with good news, which will be open for public soon ..

Congratulations

DR Ash I will so privileged to be the part of this prestigious institution.

Then DR Azeem presented case along with Management guidelines…

Follow by 2 hours comprehensive lecture by DR Ash.

Highlights of the lecture

1. Pathophysiology of DKA
2. Clinical signs and symptoms
3. Definition and diagnostic criteria (and I was amazed 90% of us were wrong about this)
4. Fluid management
5. Role of insulin and potassium and some critical thinking about when to start and when to stop.
5. Bicarb replacement
6. Complications of mismanagement
7. What to do when we don't have ketone measurement facilities at our setup

I have done DKA management throughout my house job, I have seen it every possible ward, but I am

Amazed that today I learn the basis of its management.

I love teaching methodology of DR Ash how he make the toughest topic easiest for us ….

Thank you so much DR ash for arranging this session.

A proud GEM trainee,

DR Saba Aslam ✨🌻

FEEDBACK # 39

Aqsa Yaqoob

Excellent lecture on DKA conducted by DR Ash today and my concepts are now clear on DKA pathophysiology, its types, fluid resuscitation, fixed rate

insulin infusion and variable insulin infusion rate and complications of DKA and very informative lecture.

FEEDBACK # 40

Qaisar Shah

Today's 2.5 hours session by DR Ash about DKA management in 1st 24 hours was so amazing.
Dr. Azeem well presented a case of DKA covering all aspects.
Dr. Ash gave us the stepwise hourly management of DKA in 1st 24 hours.
He explained DKA sign & symptoms, diagnostic criteria, fluid management, insulin requirement, insulin infusion, fixed rate vs variable rate, potassium requirement, managing complications like cerebral edema etc.
No one before taught us so well,
Really thanks my Mentor for this one.

FEEDBACK # 41

Phota Ram

Very excellent lecture by DR Ash, one of the most difficult topic everyone doctor, PG, surgeon, obstetrician, pediatrician and ED doctor has encounter such case. today have learned a lot from DR Ash about step wise management of DKA, pathophysiology, signs and symptoms, how to diagnosis, criteria for diagnosis, important investigation and treatment Goals: fluid resuscitation, correct electrolytes and insulin.
Fixed rate iv insulin, insulin dosage.
Monitor ABG, blood glucose, k+, bicarbonate and blood ketone levels Variable rate of insulin infusion.

FEEDBACK # 42

Amir Ashraf

Today was another wonderful day because the lecture was delivered by our own supervisor @DR Ash.
He has some amazing teaching skills the way he teach, goes directly to heart. I was very tired and drained due to double shifts since last night but when I sat to attend the lecture 2.5 hours passed in a blink of eye. The way DR Ash presents is magnificent, he makes all the complicated topics so easy that it becomes very easy us juniors to grasp the knowledge and understand what is actually he is trying to convey.
Today the Topic was About DKA (diabetic ketoacidosis)
The session started with very detailed and amazing presentation by @DR Muhammad Azeem Imran, it was written and delivered beautifully. DR Azeem is very talented, he has very nice grip on presenting and teaching any topic that comes in his way.
Then the session was continued by our very own DR Ash our mentor.

He explained all the important points as follows:
-Pathophysiology of DKA
-sign and symptoms
- Difference b/w DKA and severe DKA. (Amazing point when you are discussing on call with your consultant and you have to explain the pt on phone)
-causes of DKA
-basic investigations
-importance of ketones and when ketones investigation not available , the role of bicarb .
- Fluids and potassium replacement.
- Management with in 60 mins and the next 6 hours then 12 and 24 hours.
- Basal insulin regimen
-Discharge plan and calculation of daily total insulin requirement in you are unaware of how much insulin pt takes daily.
-Hypoglycaemic diasater
-Cerebral oedema.
And lastly the interesting case shared by us about the patient who stopped taking insulin believing that now his sugar levels are with in normal limit and he doesn't require insulin and how on that DR Ash highlighted the possibility of CKD in that patient and after renal profile it was evident .
Thank you so much DR Ash for teaching us this topic, it was definitely the need of the day.

FEEDBACK # 43

Uzma Shaikh

Wonderful lecture on DKA, never learnt such practical and to the point management of DKA. We learnt hour to hour management, adjustment of insulin dosages, fixed rate insulin, variable rate insulin, and conversion of mmol to mg/dl, dynamics of potassium management, to continue regular dosage of insulin and glucose 10%. Criteria's of classifying DKA were well explained.
Thank you DR Ash for fabulous lecture and now I will confidently manage patient of DKA with hourly instructions.
DR Azeem fantabulous presentation on DKA, took screenshots of few slides for my own learning.

FEEDBACK # 44

Dr Mishal Shan

The lecture was absolutely brilliant as it comprehensively covered each and every aspect of DKA right from presentation to safe patient discharge. The lecture started off with an interesting case by Dr Azeem. Then Dr Ash explained to us the management goals of DKA and a step by step simplified approach to fluid balance, ketogenesis suppression, electrolyte replacement, management of

cerebral edema and so on. We were also taught how to fix the basal bolus dose of insulin once the patient is out of DKA. There were some very important new learning points for us including the simplest things such as the importance of weighing the DKA patient. He also encouraged us to make our own departmental protocols for DKA to be able to manage such cases more efficiently.

Regards,

Mishal