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1. Cost-effectiveness of a national quality improvement programme to improve survival after emergency abdominal surgery: Learning from 15,856 patients

Authors Yang F.; Walker S.; Richardson G.; Stephens T.; Pearse R.M.; Phull M.; Thompson A.
Source International Journal of Surgery; Dec 2019; vol. 72 ; p. 25-31
Publication Date Dec 2019
Publication Type(s) Article
PubMedID 31604139
Database EMBASE
Abstract Background: Patients undergoing emergency abdominal surgery are exposed to a high risk of death. A quality improvement (QI) programme to improve the survival for these patients was evaluated in the Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial. This study aims to assess its cost-effectiveness versus usual care from a UK health service perspective.
Method(s): Data collected in a subsample of trial participants were employed to estimate costs and quality-adjusted life years (QALYs) for the QI programme and usual care within the 180-day trial period, with results also extrapolated to estimate lifetime costs and QALYs. Cost-effectiveness was estimated using incremental cost-effectiveness ratios (ICERs). The probability of being cost-effective was determined for different cost-effectiveness thresholds (13,000 to 30,000 per QALY). Analyses were performed for lower-risk and higher-risk subgroups based on the number of surgical indications (single vs multiple).
Result(s): Within the trial period, QI was more costly (467) but less effective (-0.002 QALYs). Over a lifetime, it was more costly (1395) and more effective (0.018 QALYs), but did not appear to be cost-effective (ICER: 77,792 per QALY, higher than all cost-effectiveness thresholds; probability of being cost-effective: 28.7%-43.8% across the thresholds). For lower-risk patients, QI was more costly and less effective both within trial period and over a lifetime and it did not appear to be cost-effective. For higher-risk patients, it was more costly and more effective, and did not appear cost-effective within the trial period (ICER: 158,253 per QALY) but may be cost-effective over a lifetime (ICER: 14,293 per QALY).
Conclusion(s): The QI programme does not appear cost-effective at standard cost-effectiveness thresholds. For patients with multiple surgical indications, this programme is potentially cost-effective over a lifetime, but this is highly uncertain.
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2. A national UK audit of suprapubic catheter insertion practice and rate of bowel injury with comparison to a systematic review and meta-analysis of available research

Authors Hall S.; Parkinson R.; Ahmed S.; Reid S.; Thiruchewam N.; Biers S.; Sahai A.; Hamid R.; Harding C.
Source Neurourology and Urodynamics; Nov 2019; vol. 38 (no. 8); p. 2194-2199
Publication Date Nov 2019
Publication Type(s) Article
PubMedID 31532853
Database EMBASE

Abstract Objectives: Limited data exist on the risks of complications associated with a suprapubic catheter (SPC) insertion. Bowel injury (BI) is a well-recognized albeit uncommon complication. Guidelines on the insertion of SPC have been developed by the British Association of Urological Surgeons, but there remains little evidence regarding the incidence of this complication. This study uses contemporary UK data to assess the incidence of SPC insertion and the rate of BI and compares to a meta-analysis of available papers.
Method(s): National Hospital Episodes Statistics data were searched on all SPC insertions over an 18-month period for operating procedure codes, Code M38.2 (cystostomy and insertion of a suprapubic tube into bladder). Patients age, 30-day readmission rates, 30-day mortality rate, and catheter specific complication rate were collected. To estimate the BI rate, we searched patients who had undergone any laparotomy or bowel operation within 30 days of SPC insertion. Trusts were contacted directly and directed to ascertain whether there was SPC-related BI. PubMed search to identify papers reporting on SPC related BI was performed for meta-analysis.
Result(s): 11 473 SPC insertions took place in the UK in this time period. One hundred forty-one cases had laparotomy within 30 days. Responses from 114 of these cases reported one BI related to SPC insertion. Meta-analysis showed an overall BI rate of 11/1490 (0.7%).
Conclusion(s): This is the largest dataset reported on SPC insertions showing a lower than previously reported rate of BI. We recommend clinicians use a risk of BI of less than 0.25% when counseling low-risk patients.
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3. Consenting practice for post-operative diarrhea in patients undergoing laparoscopic cholecystectomy needs attention

Authors Tahir A.A.; Mahmood F.; Hussain A.; Waheed M.R.; Khan M.N.
Source Journal of Medical Sciences (Peshawar); 2019; vol. 27 (no. 2); p. 107-110
Publication Date 2019
Publication Type(s) Article
Database EMBASE
Abstract Objective: To determine consenting practice for post-cholecystectomy diarrhea at a single UK tertiary care center and how it could be improved to ensure patients are fully informed.
Material(s) and Method(s): Data on discussed complications was obtained from consent forms between February 2015 to August 2015 in a single unit high-volume UK teaching hospital (Royal Stoke University Hospital, Stoke-on-Trent, UK). All adults (aged 18 or more) undergoing either emergency or elective laparoscopic cholecystectomy as a primary procedure for gallstones, acute cholecystitis and biliary colic, were included. The re-audit following educational intervention was completed between June 2016 and November 2016. Data was analysed according to grade of consenting surgeon.
Result(s): During the first audit involving 74 patients, only 22 (29.7%) were consented for risk of post-operative diarrhoea, all by consultants. Following re-education and subsequent re-audit, 45 out of 75 patients (60%) were consented for post-operative diarrhoea, representing an increase.
Conclusion(s): Effective education can raise awareness about post-operative diarrhoea following cholecystectomy. This will enable effective awareness and manage patient expectations following surgery.
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4. An Intracerebral Hemorrhage Care Bundle Is Associated with Lower Case Fatality

Authors Parry-Jones A.R.; Rowland J.; Paroutoglou K.; Birlson E.; Lee S.; Cecchini L.; Massyn M.; Patel H.; Sammut-Powell C.; Emsley R.; Bray B.
Source Annals of Neurology; Oct 2019; vol. 86 (no. 4); p. 495-503
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31291031
Database EMBASE

Abstract Objective: Anticoagulation reversal, intensive blood pressure lowering, neurosurgery, and access to critical care might all be beneficial in acute intracerebral hemorrhage (ICH). We combined and implemented these as the "ABC" hyperacute care bundle and sought to determine whether the implementation was associated with lower case fatality.

Method(s): The ABC bundle was implemented from June 1, 2015 to May 31, 2016. Key process targets were set, and a registry captured consecutive patients. We compared 30-day case fatality before, during, and after bundle implementation with multivariate logistic regression and used mediation analysis to determine which care process measures mediated any association. Difference-in-difference analysis compared 30-day case fatality with 32,295 patients with ICH from 214 other hospitals in England and Wales using Sentinel Stroke National Audit Programme data.

Result(s): A total of 973 ICH patients were admitted in the study period. Compared to before implementation, the adjusted odds of death by 30 days were lower in the implementation period (odds ratio [OR] = 0.62, 95% confidence interval [CI] = 0.38-0.97, $p = 0.03$), and this was sustained after implementation (OR = 0.40, 95% CI = 0.24-0.61, $p < 0.0001$). Implementation of the bundle was associated with a 10.8 percentage point (95% CI = -17.9 to -3.7, $p = 0.003$) reduction in 30-day case fatality in difference-in-difference analysis. The total effect of the care bundle was mediated by a reduction in do-not-resuscitate orders within 24 hours (52.8%) and increased admission to critical care (11.1%).

Interpretation(s): Implementation of the ABC care bundle was significantly associated with lower 30-day case fatality after ICH. ANN NEUROL 2019;86:495-503.

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5. S01.14 Lung Cancer MDT

Authors Baldwin D.

Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)

Publication Date Oct 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract The Lung Cancer MDT David R Baldwin Consultant Respiratory Physician and Honorary Professor of Medicine Nottingham University Hospitals and University of Nottingham, UK Multidisciplinary Team (MDT) meetings or "Tumour Boards" are increasingly becoming a central component of lung cancer services. Management of lung cancer patients through diagnosis, staging, fitness assessment and treatment is a multidisciplinary endeavour. Good communication between disciplines means that the goal of personalised treatment can be realised because of the complexity of modern management, not least the rapid change in treatments. Many lung cancer services have a meeting of professionals at key points along the clinical pathway that is commonly at the point of decision to treat and where diagnosis and/or staging is complex. There are a number of documents that describe the membership of the MDT and how the meetings should function. Key is that all relevant professional groups are represented and that there is a clear record of the discussion. Despite the widespread adoption of MDT meetings, there remains limited evidence for their effectiveness. This is because the integration of MDTs into the lung cancer services has evolved as management has become increasingly complex. It would be difficult to devise an experiment to test the efficacy of the MDT as they are now so embedded in services. With respect to lung cancer screening, it is important that MDTs adhere to guideline-driven management so as to reduce the harms that may accrue. The place of the lung cancer MDT is in relation to a high probability of cancer. In screening it is probably better to have a separate MDT to advise on the management of nodules and incidental findings, again using guideline-driven management. All MDTs should record data for audit, quality improvement and research. Keywords: multidisciplinary team, Guideline-driven, Multiprofessional

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6. WS03.08 Panel - Emerging Therapies - Immunotherapy

Authors Thomas R.

Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)

Publication Date Oct 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract

IASLC Abstract for Presentation. By Rachel Thomas This panel session will focus on emerging immunotherapies, the aim is to bring the UK perspective to the panel particularly focusing on the role of the Lung Cancer Clinical Nurse Specialist (CNS) and how to support and counsel patients who are about to commence one of the new therapy combinations. The presentation from the UK will look at the current therapies in immunotherapy and then also look at two case studies which will bring the clinical trial data into real time perspective. In the UK there have been no new immunotherapies launched, however, what the landscape of immunotherapies is changing in the UK for non-small cell lung cancer patients in the form of multi-drug combinations. Most recently we have seen the introduction of Durvalumab as a treatment for locally advanced unresectable non-small cell lung cancer post platinum based chemoradiation (1). This combination is still awaiting formal NICE approval but NHS patients can access this via a Cancer Drugs Fund. The PACIFIC Trial demonstrated that patients who received Durvalumab after platinum based chemoradiation had a significant improvement in their progression free survival when compared to chemoradiation plus a placebo. The median duration of progression free survival was 17.2 months in the Durvalumab arm compared to 5.6 months in the placebo arm. The median time to death or distant metastases was 28.3 months in the Durvalumab arm compared to 16.2 months in the placebo arm (2). In the advanced metastatic setting there has recently been the introduction of the KEYNOTE-189 data which is looking at pembrolizumab + platinum/pemetrexed in patients who did not have any molecular mutations. This trial demonstrated an overall survival with a 51% reduction in the risk of death and superior progression free with a 48% reduction in the risk of progression or death. In March 2019 The IMpower150 trial showed significant improvements in progression-free and overall survival with atezolizumab plus bevacizumab plus carboplatin plus paclitaxel (ABCP) versus the standard-of-care bevacizumab plus carboplatin plus paclitaxel (BCP) in chemotherapy-naïve patients with non-squamous metastatic non-small-cell lung cancer who have an ALK rearrangement or who have an EGFR mutation. This combination has now been approved by NICE and will provide patients who progress on a tyrosine kinase inhibitor a multi-drug treatment combination which has been demonstrated in the Impower 150 trial to deliver overall survival of around 19.2 months when compared to bevacizumab/carboplatin and paclitaxel. The UK has demonstrated the importance of the input of the Lung Cancer CNS in supporting patients who are about to commence treatment and also in proactively monitoring patients for potential adverse events (3). However, with the emergence of multidrug treatments how do we as Lung Cancer CNS's assess which adverse events are related to the immunotherapy and which are related to the chemotherapy. Looking at the current clinical trial data from the studies above and then focusing on two real life patient case studies will provide some clear guidance on how to support patients whilst monitoring for any potential adverse events and dealing with these in a timely and accurate manner. The table below sets out just some of the main challenges faced in identifying immunotherapy related adverse events. [Figure presented] We as nurse specialists are now experienced at caring for patients on single agent immunotherapy treatments but one of the many challenges is that many lung cancer patients will have co-morbidities which can cloud the identification of immunotherapy adverse events. For example 40-70% of lung cancer patients will also have a diagnosis of COPD. Pneumonitis can present in a very similar pattern to organising pneumonia and chest infections meaning that accurate and detailed assessments are needed to ensure adverse events are identified and treated accordingly. However, when you also add into the treatment plan platinum doublet chemotherapy with or without radiotherapy the potential for adverse events increases, the panel will look at the PACIFIC data to assess the reporting of adverse events in this patient group. The panel will also then assess the trial data for platinum doublet chemotherapy and immunotherapy in the treatment of metastatic non-small cell lung cancer and whether this patient group with a potentially higher symptom burden reported an increase in the number of adverse events when compared to either single agent immunotherapy or platinum doublet chemotherapy alone. One other important focus of the panel discussion will be to look at what the future treatment landscape for patients may be and how this will impact on progression free survival and living with lung cancer. This will mainly cover recent updates from ASCO and will aim to provide a flavour of what we may see coming into clinical practice in the coming months. References: Durvalumab for treating locally advanced unresectable non-small-cell lung cancer after platinum-based chemoradiation. Technology appraisal guidance [TA578] Published date: 01 May 2019. Overall survival with Durvalumab after chemoradiotherapy in Stage III NSCLC. Scott. A; Augusto, V; Davey, D et al. The National Lung Cancer Audit (2018) Yoest JM (2017) Clinical features, predictive correlates and pathophysiology of immune related adverse events in immune checkpoint inhibitor treatments in cancer: a short review. Immunotargets Therapeutics. 6. P 73-82. Copyright © 2019

7. IBS06.02 Real Time Data from US (SEERS)

Authors Van Gerwen M.; Alpert N.; Taioli E.; Wolf A.; Flores R.
Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Introduction: The association between asbestos exposure and malignant mesothelioma has been well established. Exposure to asbestos mainly occurs through work although environmental exposure has been documented. Several countries have put in place an active epidemiologic surveillance of mesothelioma cases. Through a PubMed and Google Scholar search using the key words "mesothelioma" and "registry", and by reviewing data sources of studies described in a review of environmental exposure and malignant mesothelioma, we identified existing mesothelioma registries. Countries with mesothelioma specific registries are Australia, Belgium, France, Germany, Italy, Japan, South Korea, South Africa, Turkey, and the UK. Nation-wide coverage is obtained in Italy, Australia and South Korea. Registries in Australia, France, Italy, and South Korea use interviews to obtain exposure data from the patient or a close relative, although none of these countries has a tissue bank. The UK has a mesothelioma tissue bank although it is not linked with the National Mesothelioma Audit registry. All registries have or will develop linkage with death index registries to monitor survival outcomes. (Table 1) The Scandinavian countries including Norway, Sweden, Finland and Denmark, have a population based cancer registry that includes mesothelioma and is linked to other databases, such as an occupational database, thus has more comprehensive information on each case. Mesothelioma surveillance in the US to date Currently, no nation-wide, mesothelioma specific registry exists in the US. Various existing databases are used to investigate mesothelioma, for instance the National Cancer Database has been used to look at prognostic factors; gender and race differences in mesothelioma survival have been studied using the Surveillance, Epidemiology, and End Results (SEER) database. All these datasets suffer of a time-lag between case occurrence, reporting, registration and eventually data availability for research purposes; these are serious limiting factors in the case of mesothelioma. Because of the rarity and lethality of the disease, a real-time capture registry is needed to thoroughly collect exposure data, complete data on treatments, quality of life before and after treatment, symptoms and pain management. All these elements are lacking in the existing databases. Because the US mesothelioma incidence is not decreasing as quickly as predicted and new cases still occur as well the fact that mortality rates are steady overtime, the overall health burden due to mesothelioma in the US still remains. Although the use of asbestos has been restricted or banned since 1980, several scientific questions remain open due to the long latency period between exposure and mesothelioma clinical occurrence, and to gaps in knowledge of the carcinogenesis process. Data on occupational and environmental asbestos exposure and co-exposure to other carcinogens are needed. Certain patterns, such as differences in outcomes by gender, differences in incidence rates by race, as well as geographic clusters of increased number of cases, are hard to explain with the existing data. Possible next steps towards a US mesothelioma registry "Real time" enrollment is important in order to systematically collect information on asbestos and other exposures through interviews with mesothelioma patients or a close relative. Furthermore, optimal coverage, preferably population based and nation-wide, and a simplified consent process are needed in order to capture a maximum number of cases. A centralized quality control system, standardized data collection methods, and the ability to link to relevant other existing registries are important in order to integrate the registry with clinical and prognostic information. Additionally, consistency in the design and questionnaire content with other countries would be ideal, in order to conduct comparisons and possibly pool the data. The flexibility to add or modify modules to tailor to future research questions are other preferable features for a US mesothelioma registry. (Figure 1) A discrete amount of work has been devoted to molecular markers such as mesothelin and certain germline mutations as prognostic factors. The role of these biomarkers could be validated on larger populations of patients if a comprehensive registry that includes tissue is implemented. Summary and conclusions In conclusion, with the remaining health burden due to mesothelioma, the changing landscape of asbestos exposure, and the many unanswered scientific questions, a nation-wide, real-time US mesothelioma registry is urgently needed. Methods for data sharing, linkage to existing tissue banks, and data access should be implemented and tested on a small scale before being implemented nationwide. One of the most practical outputs of these efforts would be the ability to conduct pragmatic trials that could be built out of a "real time" case capture system. [Figure presented] [Figure presented] Keywords: Mesothelioma, epidemiology Copyright © 2019

8. P2.16-11 ADVANCE-1: Development and Feasibility Testing of a Benchmarking Approach for Quality Improvement in Lung Cancer Care

Authors Mccann B.; O'Rourke N.; Muhr R.; Blum T.; Kollmeier J.; Misch D.; Bauer T.; Milroy R.; Van Der Horst J.; Morrison D.; Sens B.; Massalski O.
Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Background: Benchmarking is successfully utilized in industry to improve working process and productivity. In its original sense benchmarking is a systematic process for comparing performances, functions or processes of organisations against the best in the world. However, the majority of research within lung cancer is focused on prevention, diagnosis and treatment rather than examining infrastructure or processes of managing lung cancer patients. ADVANCE-1 is a European Respiratory Society (ERS) funded pilot study with the aim of creating a benchmarking tool that can easily document and reflect the structure and process within a lung cancer centre and its associated registry and how these processes impact on the pathway of a patient through the individual centres.

Method(s): The ADVANCE-1 study group was constituted by the two ERS fellowship-holders and senior lung cancer specialists from the two participating lung cancer services in the Beatson West of Scotland Cancer Centre, Glasgow, Scotland, and the Lungenklinik Heckeshorn in the Helios Klinikum Emil von Behring, Berlin, Germany. We created the study design with direct cooperation of the German Benchmarking Centre as well as the University of Glasgow. Final results were externally reviewed by the German Society for Quality Management in Health Care.

Result(s): Two benchmarking tools were created; the first for documentation of the service provided at each centre, the underlying cancer registry and a test of the robustness and comprehensiveness of information and data collecting resources available at each centre. Secondly; a patient pathway tool to reflect the journey of a patient through each of the relevant centres. Patient satisfaction surveys and staff satisfaction surveys were also created. Prospective testing of these benchmarking tools in Glasgow and Berlin will allow a comparison between the two centres in order to ascertain best practice and learning from each centre in a so called 'collaborative' benchmarking approach.

Conclusion(s): This unique study has created a benchmarking tool that can easily document the service of a lung cancer centre and the pathway of a patient through that service. With comparison and learning from each other using this tool we aim to improve the patient care and journey through a lung cancer service. Keywords: benchmarking, service, Quality Improvement

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9. High-Risk Emergency Laparotomy in Australia: Comparing NELA, P-POSSUM, and ACS-NSQIP Calculators

Authors Eliezer D.D.; Holmes M.; Sullivan G.; Gani J.; Pockney P.; Gould T.; Gramlick M.; Rugendyke A.; Ming J.; Jones S.; Coleman H.; Hawthorne J.; Green S.; Zardawi D.; Hampton J.; Francis G.

Source Journal of Surgical Research; Feb 2020; vol. 246 ; p. 300-304

Publication Date Feb 2020

Publication Type(s) Article

Database EMBASE

Abstract Background: The National Emergency Laparotomy Audit (NELA) highlights the importance of identifying high-risk patients due to the potential for significant morbidity and mortality. The NELA risk prediction calculator (NRPC) was developed from data in England and Wales and is one of several calculators available. We seek to determine the utility of NRPC in the Australian population and compare it with Portsmouth Physiological and Operative Severity Score for the enumeration of mortality and Morbidity (P-POSSUM) and American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) calculators.

Method(s): A retrospective review of all emergency laparotomies undertaken at four Australian centers was performed between January 2016 and December 2017. Data extracted from patient records were used to calculate NRPC, ACS-NSQIP, and P-POSSUM scores for 30-day mortality risk. The sensitivity of NRPC was assessed using the NELA high-risk cohort score of $\geq 10\%$ and this was compared with the other two calculators.

Result(s): There were 562 (M = 261, mean age = 66 [+/-17] y) patient charts reviewed in the study period. 59 patients died within 30 d (10.5%). NRPC was able to identify 52 (sensitivity = 88.1%) of these as being within the high-risk group. Using the NELA high-risk cutoff, NRPC identified 52 deaths of 205 (25.4%) high-risk patients, P-POSSUM identified 46 of 245 (18.8%), and ACS-NSQIP identified 46 of 201 (22.9%). Using the McNemar test, no significant difference was noted between NRPC and P-POSSUM ($P = 0.07$) or NRPC and ACS-NSQIP ($P = 0.18$).

Conclusion(s): In the Australian context, the NRPC is a highly sensitive and useful tool for predicting 30-day mortality in high-risk emergency laparotomy patients and is comparable with P-POSSUM and ACS-NSQIP calculators.

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10. Minimal and Mild Hearing Loss in Children: Association with Auditory Perception, Cognition, and Communication Problems

Authors Zobay O.; Ferguson M.A.; Moore D.R.

Source Ear and hearing; Oct 2019

Publication Date Oct 2019

Publication Type(s) Article

PubMedID 31633598

Database EMBASE

Abstract

OBJECTIVES: "Minimal" and "mild" hearing loss are the most common but least understood forms of hearing loss in children. Children with better ear hearing level as low as 30 dB HL have a global language impairment and, according to the World Health Organization, a "disabling level of hearing loss." We examined in a population of 6- to 11-year-olds how hearing level ≤ 40.0 dB HL (1 and 4 kHz pure-tone average, PTA, threshold) is related to auditory perception, cognition, and communication. **DESIGN:** School children ($n = 1638$) were recruited in 4 centers across the United Kingdom. They completed a battery of hearing (audiometry, filter width, temporal envelope, speech-in-noise) and cognitive (IQ, attention, verbal memory, receptive language, reading) tests. Caregivers assessed their children's communication and listening skills. Children included in this study (702 male; 752 female) had 4 reliable tone thresholds (1, 4 kHz each ear), and no caregiver reported medical or intellectual disorder. Normal-hearing children ($n = 1124$, 77.1%) had all 4 thresholds and PTA < 15 dB HL. Children with ≥ 15 dB HL for at least 1 threshold, and PTA < 20 dB ($n = 245$, 16.8%) had minimal hearing loss. Children with $20 \leq \text{PTA} < 40$ dB HL ($n = 88$, 6.0%) had mild hearing loss. Interaural asymmetric hearing loss (left PTA - right PTA ≥ 10 dB) was found in 28.9% of those with minimal and 39.8% of those with mild hearing loss. **RESULT(S):** Speech perception in noise, indexed by vowel-consonant-vowel pseudoword repetition in speech-modulated noise, was impaired in children with minimal and mild hearing loss, relative to normal-hearing children. Effect size was largest ($d = 0.63$) in asymmetric mild hearing loss and smallest ($d = 0.21$) in symmetric minimal hearing loss. Spectral (filter width) and temporal (backward masking) perceptions were impaired in children with both forms of hearing loss, but suprathreshold perception generally related only weakly to PTA. Speech-in-noise (nonsense syllables) and language (pseudoword repetition) were also impaired in both forms of hearing loss and correlated more strongly with PTA. Children with mild hearing loss were additionally impaired in working memory (digit span) and reading, and generally performed more poorly than those with minimal loss. Asymmetric hearing loss produced as much impairment overall on both auditory and cognitive tasks as symmetric hearing loss. Nonverbal IQ, attention, and caregiver-rated listening and communication were not significantly impaired in children with hearing loss. Modeling suggested that 15 dB HL is objectively an appropriate lower audibility limit for diagnosis of hearing loss. **CONCLUSION(S):** Hearing loss between 15 and 30 dB PTA is, at $\sim 20\%$, much more prevalent in 6- to 11-year-old children than most current estimates. Key aspects of auditory and cognitive skills are impaired in both symmetric and asymmetric minimal and mild hearing loss. Hearing loss < 30 dB HL is most closely related to speech perception in noise, and to cognitive abilities underpinning language and reading. The results suggest wider use of speech-in-noise measures to diagnose and assess management of hearing loss and reduction of the clinical hearing loss threshold for children to 15 dB HL.

11. Performance of emergency surgical front of neck airway access by head and neck surgeons, general surgeons, or anaesthetists: an in situ simulation study

Authors Groom P.; Schofield L.; Hettiarachchi N.; Pickard S.; Brown J.; Sandars J.; Morton B.
Source British Journal of Anaesthesia; Nov 2019; vol. 123 (no. 5); p. 696-703
Publication Date Nov 2019
Publication Type(s) Article
PubMedID 31451190
Database EMBASE
Abstract Background: The 'cannot intubate cannot oxygenate' (CICO) emergency requires urgent front of neck airway (FONA) access to prevent death. In cases reported to the 4th National Audit Project, the most successful FONA was a surgical technique, almost all of which were performed by surgeons. Subsequently, UK guidelines adopted surgical cricothyroidotomy as the preferred emergency surgical FONA technique. Despite regular skills-based training, anaesthetists may still be unwilling to perform an emergency surgical FONA. Consultant anaesthetists, head and neck surgeons, and general surgeons were compared in a high-fidelity simulated emergency. We hypothesised that head and neck surgeons would successfully execute emergency surgical FONA faster than anaesthetists and general surgeons.
Method(s): We recruited 15 consultants from each specialty (total of 45) at a single tertiary care hospital in the UK. All agreed to participate in an in situ high-fidelity simulation of an 'anaesthetic emergency'. Participants were not told in advance that this would be a CICO scenario.
Result(s): There were no significant differences in total time to successful ventilation between anaesthetists, head and neck surgeons and general surgeons (median 86 vs 98 vs 126 s, respectively, $P=0.078$). Anaesthetists completed the emergency surgical FONA procedure significantly faster than general surgeons (median 50 vs 86 s, $P=0.018$). Despite this strong performance, qualitative data suggested some anaesthetists still believed 'surgeons' best placed to perform emergency surgical FONA in a genuine CICO situation.
Conclusion(s): Anaesthetists regularly trained in emergency surgical FONA function at levels comparable with head and neck surgeons and should feel empowered to lead this procedure in the event of a CICO emergency.
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12. Variation in acute and community service provision of care of the elderly services across Scotland: Findings from the scottish care of older people (SCoOP) initial scoping survey clinical

Authors Donaldson A.I.C.; Neal S.R.; Myint P.K.; McAlpine C.H.; Quinn T.; Shenkin S.D.; Ellis G.
Source Journal of the Royal College of Physicians of Edinburgh; 2019; vol. 49 (no. 2); p. 105-111
Publication Date 2019
Publication Type(s) Article
PubMedID 31188337
Database EMBASE
Abstract Background This scoping survey is a preliminary part of the Scottish Care of Older People (SCoOP) audit programme, which aims to assess specialist service provision for older people with frailty in Scotland, and provide benchmarking data for improving services. Methods The survey was distributed to nominated consultant geriatricians based in 12 of the 14 Scottish health boards who completed data to the 'best of their knowledge'. Data collected were: consultant and specialty doctor level workforce; days of frailty unit operation; multidisciplinary team discussion frequency; and, physiotherapy and occupational therapy availability. Consultant cover was correlated with population data, and scores for service components used to derive separate acute and community service provision scores. Results Consultant geriatrician availability varies widely across Scottish health boards with a median of 1.45 [range: 0.54-2.40; interquartile range (IQR): 0.71-2.28] full-time equivalent consultant geriatricians per 10,000 people >=65 years. Variation was also present in the service provision scores [score range 0 (none) to 1.0 (very good)]: for acute services, the median national service provision score was 0.81 (range: 0.50-0.89; IQR: 0.75-0.85) and for community services 0.60 (range: 0.48-0.82; IQR: 0.52-0.65). Conclusions This report clearly demonstrates mismatch between workforce and services in both acute and community settings in the context of the population size. Future surveys will build on this preliminary information to audit service provision for older people at an individual hospital level. Copyright © 2019, Royal College of Physicians of Edinburgh. All rights reserved.

13. National quality improvement programmes need time and resources to have an impact

Authors Cook R.; Martin R.; Lamont T.
Source The BMJ; 2019; vol. 367
Publication Date 2019
Publication Type(s) Article
PubMedID 31597637
Database EMBASE
Abstract The study Peden CJ, Stephens T, Martin G et al. Effectiveness of a national quality improvement programme to improve survival after emergency abdominal surgery (EPOCH): a stepped-wedge cluster-randomised trial. Lancet 2019;393:2213-21. This project was funded by the NIHR Health Services and Delivery Research Programme (project number 12/5005/10). To read the full NIHR Signal, go to <https://discover.dc.nihr.ac.uk/content/signal-000789/national-quality-improvement-programmes-need-time-and-resources-to-have-impact> Copyright © Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to.

14. Assessment of steroid use as a key performance indicator in inflammatory bowel disease-analysis of data from 2385 UK patients

Authors Selinger C.P.; Parkes G.C.; Parisi I.; Pollok R.; Bassi A.; Limdi J.K.; Ludlow H.; Patel P.; Smith M.; Saluke S.; Ndlovu Z.; George B.; Saunders J.; Adamson M.; Fraser A.; Robinson J.; Donovan F.; Tidbury J.; Gray L.; Scott G.; Raine T.
Source Alimentary Pharmacology and Therapeutics; Nov 2019; vol. 50 (no. 9); p. 1009-1018
Publication Date Nov 2019
Publication Type(s) Article
PubMedID 31595533
Database EMBASE

Abstract Background: Patients with IBD are at risk of excess corticosteroids.
Aim(s): To assess steroid excess in a large IBD cohort and test associations with quality improvement and prescribing.
Method(s): Steroid exposure was recorded for outpatients attending 19 centres and associated factors analysed. Measures taken to avoid excess were assessed.
Result(s): Of 2385 patients, 28% received steroids in the preceding 12 months. 14.8% had steroid excess or dependency. Steroid use was significantly lower at 'intervention centres' which participated in a quality improvement programme (exposure: 23.8% vs 31.0%, $P < .001$; excess 11.5% vs 17.1%, $P < .001$). At intervention centres, steroid use fell from 2015 to 2017 (steroid exposure 30.0%-23.8%, $P = .003$; steroid excess 13.8%-11.5%, $P = .17$). Steroid excess was judged avoidable in 50.7%. Factors independently associated with reduced steroid excess in Crohn's disease included maintenance with anti-TNF agents (OR 0.61 [95% CI 0.24-0.95]), treatment in a centre with a multi-disciplinary team (OR 0.54 [95% CI 0.20-0.86]) and treatment at an intervention centre (OR 0.72 [95% CI 0.46-0.97]). Treatment with 5-ASA in CD was associated with higher rates of steroid excess (OR 1.72 [95% CI 1.24-2.09]). In ulcerative colitis (UC), thiopurine monotherapy was associated with steroid excess (OR 1.97 [95% CI 1.19-3.01]) and treatment at an intervention centre with less steroid excess (OR 0.72 [95% CI 0.45-0.95]).
Conclusion(s): This study validates steroid assessment as a meaningful quality measure and provides a benchmark for this performance indicator in a large cohort. A programme of quality improvement was associated with lower steroid use.
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15. Designing a nurse-delivered delirium bundle: What intensive care unit staff, survivors, and their families think?

Authors Bannon L.; Clarke M.; Blackwood B.; McGaughey J.; McAuley D.F.
Source Australian critical care : official journal of the Confederation of Australian Critical Care Nurses; May 2018; vol. 31 (no. 3); p. 174-179
Publication Date May 2018
Publication Type(s) Article
PubMedID 29580965
Database EMBASE
Abstract BACKGROUND: Implementation of quality improvement interventions can be enhanced by exploring the perspectives of those who will deliver and receive them. We designed a non-pharmacological bundle for delirium management for a feasibility trial, and we sought to obtain the views of intensive care unit (ICU) staff, survivors, and families on the barriers and facilitators to its implementation.
OBJECTIVE(S): The objective of this study is to determine the barriers and facilitators to a multicomponent bundle for delirium management in critically ill patients comprising (1) education and family participation, (2) sedation minimisation and pain, agitation, and delirium protocol, (3) early mobilisation, and (4) environmental interventions for sleep, orientation, communication, and cognitive stimulation.
METHOD(S): Nine focus group interviews were conducted with ICU staff ($n = 68$) in 12 UK ICUs. Three focus group interviews were conducted with ICU survivors ($n = 12$) and their family members ($n = 2$). Interviews were digitally recorded, transcribed, and thematically analysed using the Braun and Clarke framework.
RESULT(S): Overall, staff, survivors, and their families agreed the bundle was acceptable. Facilitating factors for delivering the bundle were staff and relatives' education about potential benefits and encouraging family presence. Facilitating factors for sedation minimisation were evening ward rounds, using non-verbal pain scores, and targeting sedation scores. Barriers identified by staff were inadequate resources, poor education, relatives' anxiety, safety concerns, and ICU culture. Concerns were raised about patient confidentiality when displaying orientation materials and managing resources for early mobility. Survivors cited that flexible visiting and re-establishing normality were important factors; and staff workload, lack of awareness, and poor communication were factors that needed to be considered before implementation.
CONCLUSION(S): Generally, the bundle was deemed acceptable and deliverable. However, like any complex intervention, component adaptations will be required depending on resources available to the ICU; in particular, involvement of pharmacists in the ward round and physiotherapists in mobilising intubated patients.
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16. The Impact of Accreditation for 10 Years on Inpatient Units for Adults of Working Age in the United Kingdom

Authors Chaplin R.; Raphael H.; Beavon M.
Source Psychiatric services (Washington, D.C.); Oct 2018; vol. 69 (no. 10); p. 1053-1055
Publication Date Oct 2018
Publication Type(s) Article
PubMedID 30041590
Database EMBASE

Abstract Psychiatric inpatient units in the United Kingdom have been criticized for having falling bed numbers, staff shortages, and brief compulsory admissions. This column describes the impact over 10 years of a voluntary U.K. quality improvement program to provide accreditation for inpatient wards. Performance on evidence-based standards was assessed during peer review visits, and 92 of the 140 wards participating are currently accredited. Improvement was found in patient contact, access to therapies, safety, crisis planning, ability among staff to take breaks, and doctor availability. Availability of activities outside working hours needs improvement. Further work is needed to incorporate clinical outcomes in the accreditation program.

17. Paediatric dento-facial infections - a potential tool for identifying children at risk of neglect?

Authors Schlabe J.; Chapireau D.; Fan K.; Kabban M.
Source British dental journal; Oct 2018; vol. 225 (no. 8); p. 757-761
Publication Date Oct 2018
Publication Type(s) Article
PubMedID 30361599
Database EMBASE
Abstract Introduction: Child neglect has a significant impact on children's physical and emotional health and development with lifelong consequences. Dental decay can lead to maxillofacial space infections which can have life-threatening complications and may indicate that a child has suffered dental neglect. Aims and method: In this retrospective audit, we reviewed children below sixteen years who were admitted under oral and maxillofacial surgery for incision and drainage of a dental/facial abscess, under general anaesthesia, between January 2015 and January 2017, to understand if they had experienced dental neglect. We also assessed if they were or had been known to Children's Social Services (SS) before hospital admission.
Result(s): Twenty-seven children were included in the study, eleven children (40%), were known to social services (SS). On average 3.2 teeth were extracted with an average hospital stay of 2.5 days.
Discussion(s): Our data indicate that a significant number of children admitted for maxillofacial space infection are already known to social services.
Conclusion(s): Our recommendation is that all children admitted with dental/maxillofacial space infections, where dental neglect may be present, should be discussed with the local safeguarding team.

18. P1.06-19 Regional Mesothelioma Multidisciplinary Team Meetings: Perspectives from a UK Cardiothoracic Tertiary Centre

Authors Slaven K.
Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: The 2018 British Thoracic Society Guideline for the Management of Pleural Mesothelioma recommend that discussion at Specialist Mesothelioma Multidisciplinary Team (MDT) Meeting 'may improve diagnostic accuracy and recruitment to clinical trials', and that all cases of mesothelioma should be 'referred to a regional mesothelioma MDT'. Royal Papworth Hospital is a tertiary centre situated in Cambridgeshire and is home of the Mesothelioma Centre for the East of England. February 2018 saw the emergence of the weekly Regional Mesothelioma MDT.
Method(s): Data from MDT minutes, recorded on an electronic database, from the first year (01.02.2018-31.01.2019) was compared with the targets set by the 2018 National Mesothelioma Audit. Information collected included clinical trials consideration, TNM stage, ECOG performance status, referring hospital, age, histological subtype, asbestos exposure and gender.
Result(s): 160 discussions took place concerning 93 patients. Median age 71yrs (range 45-92). 84(90%) had documented occupational asbestos exposure. 9(10%) female. Referrals from distant district general hospitals were more evident. Histological subtype was recorded for all patients who had a biopsy. Second opinion histology was reviewed; no diagnosis overturned. 9(10%) patients had a clinical radiological diagnosis of mesothelioma confirmed. Patients were referred for discussion for various reasons including confirmation of diagnosis, suggested disease management, consideration of trials, and for second/'specialist' opinion. [Figure presented]
Conclusion(s): Prior to the Regional Mesothelioma MDT, patients were discussed within the lung cancer MDT. The Regional Mesothelioma MDT provides opportunity for discussion among experts who see more than 30 mesothelioma patients each year. More patients are being referred from the local and distant district general hospitals. The hope is that this offers equitable care, treatment and access to clinical trials for all patients with mesothelioma. Future work will look at short and long term outcomes for these patients. Thank you to the Royal Papworth Hospital Mesothelioma MDT for their support with this abstract. Keywords: Mesothelioma, MDT, Audit
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19. OA05.05 Transforming the Patient Experience in Lung Cancer Through the Use of Clinical Nurse Specialist Virtual Clinics - The Liverpool Experience

Authors Mciver A.V.; Maddock N.; Dunbar J.; Sanders S.; Ledson M.; Walshaw M.; Smyth C.
Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: To improve the patient experience in lung cancer, in 2014 we introduced to the UK the concept of "virtual" clinic working, where following secondary care review of suspicious CT scans taken in the community a lung cancer nurse specialist (LCNS) conducts a clerking/holistic assessment via telephone and offers an investigation plan where appropriate. In 2017, this model of care was adopted into UK National Lung Cancer Optimal Pathway guidance. We were interested to review the effect of our innovative service on patient experience.
Method(s): We looked at patient feedback, staff perceptions and impact on the lung cancer pathway of our virtual clinic 2016-18.
Result(s): Of the 1498 patients with a suspicious CT scan, over 75% were diagnosed with cancer. Overall 802 (70%) were diagnosed via the outpatient service and 705 (88%) chose virtual clinic assessment and diagnostic test facilitation. Qualitative audit has shown an overwhelmingly positive feedback, where 98% of users felt that the virtual clinic was a better option, and patients felt well informed and supported. In addition, the LCNSs feel they are utilising their knowledge and skills in a more timely fashion with an appropriate population. The early assessment facilitates the start of that therapeutic relationship that leads to patient needs being addressed, symptom management advice, reducing distress and optimising patient performance status and quality of life. Furthermore 'virtual' working has seen a dramatic reduction in medical outpatient activity, allowing that resource to be used more efficiently for the benefit of cancer patients.
Conclusion(s): This service review has shown that the data and patient and staff experience all support this new model of care delivery. The benefits are multifocal: care is patient-centred, appropriate skill-set use improves staff morale, and the freeing up of infrastructure allows organisational resource reallocation and cost saving. We have advocated the role of the LCNS to take the lead in this model of working across the UK, as we feel the LCNS are best placed to do these sensitive and complex assessments. We welcome the opportunity to share our experience worldwide. Keywords: Virtual working CNS
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20. MA19.09 Assessing Clinical Frailty in Advanced Lung Cancer Patients - An Opportunity to Improve Patient Outcomes?

Authors Gomes F.; Baker K.; Woods J.; Bruce J.; Eaton M.; Higham P.; Cove-Smith L.; Garbett A.; Cree A.; Ng C.; Blackhall F.; Bayman N.
Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: The median age of non-small cell lung cancer (NSCLC) diagnosis in England is 73 years. At that age, 40% of the general population has some degree of clinical frailty which may impact survival, quality of life, anti-cancer treatment tolerability and access to clinical trials. However, clinical frailty is often not addressed or managed at the time of anti-cancer treatments. This project was designed to integrate frailty assessments and build frailty pathways within an advanced cancer care setting in order to better support patients and improve outcomes.
Method(s): This quality improvement project that used Plan-Do-Study-Act (PDSA) methodology. Phase one of the project focused on establishing a multidisciplinary team to integrate a frailty screening tool, the Rockwood Clinical Frailty Scale (CFS), into standard clinical practice. The primary aim was to implement and screen $\geq 80\%$ of all new lung cancer patients at a high-volume tertiary cancer centre. The secondary aim was to explore the correlation of CFS with age, performance status (PS), treatment selection and systemic anti-cancer treatment (SACT) tolerability. Specialised training was provided to the clinical team and the CFS was integrated from 26/11/2018 on an electronic form routinely completed by clinicians. A digital dashboard was set-up to monitor real-time data and the frail group was defined as CFS score >3 . Data cut-off for this analysis was 29-03-2019.
Result(s): 335 lung cancer patients were screened using CFS by a team of 20 clinicians with a compliance rate of 89%. There was a strong correlation between PS and CFS ($r = 0.77$, $p < 0.01$). The distribution of both CFS and PS correlated with ageing ($r = 0.2$ and $r = 0.17$, respectively; $p < 0.01$). Patients ≥ 70 years were more likely to be frail (56% vs 40%; OR 1.4, 95%CI 1.2-1.7; $p < 0.01$). Frailty reduced the likelihood of receiving any anti-cancer treatment by 20%. Amongst those who started SACT, patients classed as frail were less likely to go beyond the first cycle of treatment (64% vs 91%; OR 0.7, 95%CI 0.5-0.9; $p < 0.01$).
Conclusion(s): CFS screening is feasible within a busy clinical practice when incorporated as a digital tool. CFS helps to identify patients who may potentially benefit from specialised frailty assessment and management. This could ultimately be used to better inform on treatment selection, and support requirements during treatment, to improve outcomes for patients in the future. Keywords: frailty, elderly, Lung cancer
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21. P1.13-11 An Audit on IASLC Compliance of Lymph Nodes Dissection and Impact on Survival After Surgery for Non-Small Cell Lung Cancer

Authors De Sousa P.; Barbosa M.; Mansour F.; Booth S.; Klein H.; Mani A.; Nizami M.; Von Crease C.; Ladas G.; Finch J.; Asadi N.; Beddow E.; Mcgonigle N.; Anikin V.; Begum S.; Jordan S.; Lim E.; Montero-Fernandez A.; Robertus J.; Rice A.; Nicholson A.

Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)

Publication Date Oct 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract Background: The IASLC proposed minimal criteria for 6 nodes / stations to ascertain certainty status of complete (R0) resection after lung cancer surgery and in 2017, Edwards et al presented that failure of compliance leading to R0 (un) status was associated with poorer survival. The aims of this audit are to assess compliance of the IASLC recommendations on lymph node staging and determine the impact of R0 (un) status on prognosis in an independent cohort.
Method(s): We included patients who underwent lobectomy or pneumonectomy for primary lung cancer. Data was obtained from electronic records and survival status obtained from NHS Spine.
Result(s): From January 2010 to December 2017, 2,521 patients underwent lung resection for primary lung cancer staged using TNM7. The mean age (SD) was 67 (10) and 1,235 (49%) were men, the primary diagnoses were either adenocarcinoma or squamous carcinoma in 2,057 (82%). The IASLC compliance with 6 node / stations was 627 (25%) and when sub-carinal station was mandatory it was 608 (24%). After exclusions, we were left with 1,859 patients and on adjustment of T and N category, there was no difference between IASLC non-compliance R0 (un) on overall survival with a hazard ratio of 0.95 (95% CI 0.74 to 1.21; P=0.657) compared to R0 compliant. After adjusting for T and N category there was no significant difference in total lymph nodes stations harvested with a HR 1.01 (0.97 to 1.04, P=0.712) or number of positive stations HR 1.04 (0.92 to 1.16; P=0.543) in survival. [Figure presented]
Conclusion(s): Independent validation of R0 (un) status did not concur with poorer survival. The designation carries uncertainty and likely to be influenced by the extent of N2 dissection. When adjusted for stage, there was no difference on number of stations harvested nor the total number of positive stations on survival.
Keywords: lymph node, Lung cancer, surgery
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22. ES26.01 The Impact of Specialist Nursing Intervention in Lung Cancer

Authors Leary A.

Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)

Publication Date Oct 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract

Introduction In the UK the role of the Clinical Nurse Specialist is well established. Lung Cancer Clinical Nurse Specialists (LCNS) often start a therapeutic relationship with patients and families before formal diagnosis has been made. LCNS often manage the care of people with lung cancer but in an environment of austerity their worth to employers is still questioned. This series of studies examined the impact of the LCNS on outcomes for lung cancer patients. The focus of this abstract is one of the studies which looks at receipt of treatment for lung cancer. Treatment choices for people with lung cancer may be influenced by contact and engagement with lung cancer nurse specialists (LCNSs). We investigated how service factors, LCNS workload, and LCNS working practices may influence the receipt of anticancer treatment. Materials and methods English National Lung Cancer Audit data and inpatient Hospital Episode Statistics for 109,079 people with lung cancer surviving 30 days from diagnosis were linked along with LCNS workforce census data and a bespoke nationwide LCNS survey. Multinomial logistic regression was used to determine adjusted relative risk ratios (RRRs) for receipt of anticancer therapies associated with LCNS assessment, LCNS workforce composition, caseload, LCNS reported working practices, treatment facilities at the patients' attending hospitals, and the size of the lung cancer service. Results Assessment by an LCNS was the strongest independent predictor for receipt of anticancer therapy, with early LCNS assessments being particularly associated with greater receipt of surgery (RRR 1.85, 95%CI 1.63-2.11). For people we considered clinically suitable for surgery, receipt was 55%. Large LCNS caseloads were associated with decreased receipt of surgery among suitable patients (RRR 0.71, 95%CI 0.51-0.97) for caseloads >250 compared to ≤150. Reported LCNS working practices were associated with receipt of surgery, particularly provision of psychological support (RRR 1.60, 95%CI 1.02-2.51) and social support (RRR 1.56, 95%CI 1.07-2.28). [Figure presented] Conclusion LCNS assessment, workload, and working practices are associated with the likelihood of patients receiving anticancer therapy. Enabling and supporting LCNSs to undertake key case management interventions offers an opportunity to improve treatment uptake and reduce the apparent gap in receipt of surgery for those suitable Early nurse specialist contact is associated with greater receipt of therapy. *Receipt of surgery is less likely where nurse specialists have large caseloads. *Therapy receipt is more likely if key nursing interventions are routinely provided. *Managing nurse specialists' workload could address disparities in therapy uptake. Are working practices of lung cancer nurse specialists associated with variation in peoples' receipt of anticancer therapy? (2018) Stewart, Iain et al. Lung Cancer, Volume 123, 160 - 165 Keywords: Nursing, Advanced practice, treatment Copyright © 2019

23. IBS14.02 Best Management of Early Stage NSCLC in ILD Patients

Authors Louie A.
Source Journal of Thoracic Oncology; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Interstitial lung disease (ILD) is characterized by diffuse inflammation and fibrosis within the lung parenchyma.¹ Although a heterogeneous group of diseases, invariably, it is associated with a restrictive defect on pulmonary function testing, and a reduced ability for gas exchange.² On imaging, features of ILD can include reticulation, traction bronchiectasis and honeycombing. Interestingly, a diagnosis of ILD is an independent risk factor for the development of lung cancer.³ Stereotactic ablative radiotherapy (SABR) is a common radical treatment modality for patients with early stage NSCLC and is characterized by its convenience, tolerability, and high efficacy.⁴ Given these features, it has been popularized as an attractive option in early stage NSCLC patients with significant medical co-morbidities. Early stage NSCLC patients with co-existing ILD, however, are a high-risk group for any type of treatment, both for treatment-related toxicities and for acute exacerbations of ILD. These toxicities can be severe, and in extreme scenarios, fatal. The focus of this abstract will be on the use of SABR for early stage NSCLC patients with ILD, with an aim to discuss emerging data and future research directions. Despite the generally favorable toxicity profile of SABR, there are an increasing number of reports of serious toxicities in patients with pre-existing ILD. These reports have largely been retrospective in nature, heterogeneous in the radiation doses employed, with findings of extreme ranges in treatment related death rates. Arguments can be made on whether some of these reports, especially in those with exceptionally high rates of extreme toxicity, confer an element of publication bias. This refers to the phenomenon whereby there is an inclination to report results that are more remarkable (i.e. major toxicity or treatment-related death). Therefore, although it is likely that SABR incurs a greater risk in this setting compared to standard lung SABR cases, the true risk is unclear. To further delve into this issue, our group recently performed a systematic review and meta-analysis of outcomes following several different treatment modalities for early-stage lung cancer patients with ILD.⁵ From this initiative, 13 studies assessing outcomes after SABR were identified, and recognizing the caveats of the available data, we concluded that there was a 1 in 4 risk of severe radiation pneumonitis (defined as grade ≥ 3), and a 15% risk of treatment-related grade 5 toxicity. A specific diagnosis of idiopathic pulmonary fibrosis (IPF) appeared to be associated with the greatest risk, whereby treatment related mortality was 1 in 3, as compared to 14% for non-IPF fibrotic ILD. When considering this potential increased risk, it is important to recognize that the IPF patient population has a significant background risk of acute exacerbations of their disease, with an annual reported range of 5-19%.⁶ The Canadian Pulmonary Radiotherapy Investigators group (www.capriclinicaltrials.com) has designed a single arm phase II trial to evaluate the role of SABR in T1-2N0M0 NSCLC patients with co-existing ILD who are not surgical candidates. The trial (clinicaltrials.gov, NCT03485378) is entitled: Assessment of Precision Irradiation in Early Non-Small Cell Lung Cancer and Interstitial Lung Disease (ASPIRE-ILD). To our knowledge, this will be the first prospective trial evaluating this clinical scenario, and it is novel in that patients will be stratified using the ILD-GAP score, which is an index that incorporates ILD mortality risk according to Gender, Age and Physiology.⁷ The starting SABR dose will be 50 Gy in 5 fractions, and the dose fractionation will be escalated or de-escalated depending on toxicities observed in different cohorts of the trial. The appropriateness of SABR in any, or some of these patients can certainly be questioned in light of the potential serious toxicity. On the other hand, the median survival of untreated stage I NSCLC has consistently been reported to be less than 1 year in various studies.⁸ Therefore, the value of treatment would ideally be answered through a randomized controlled trial, however, this is probably unfeasible as patients and physicians alike may be uncomfortable with randomization. Given the inherent risks of both untreated cancer as well as any cancer-directed treatment, we encourage investigators to continue to report on their experiences in this challenging clinical dilemma, whether positive or negative, so that additional research can inform shared decision making. REFERENCES 1. Maher EJ, Timothy A, Squire CJ, et al. Audit: the use of radiotherapy for NSCLC in the UK. *Clin Oncol (R Coll Radiol)* 1993;5:72-79. 2. Bradley B, Branley HM, Egan JJ, et al. Interstitial lung disease guideline: the British Thoracic Society in collaboration with the Thoracic Society of Australia and New Zealand and the Irish Thoracic Society. *Thorax* 2008;63 Suppl 5:v1-58. 3. Naccache JM, Gibiot Q, Monnet I, et al. Lung cancer and interstitial lung disease: a literature review. *J Thorac Dis* 2018;10:3829-3844. 4. Louie AV, Palma DA, Dahele M, et al. 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Keywords: interstitial lung disease, Early Stage Lung Cancer, toxicity
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24. P1.01-48 EGFR Testing in England - Real World Evidence from the National Lung Cancer Audit (NLCA) Spotlight on Molecular Testing

Authors Tweedie J.; Khakwani A.; Hubbard R.; Wood N.; Harden S.; Beckett P.; Navani N.
Source *Journal of Thoracic Oncology*; Oct 2019; vol. 14 (no. 10)
Publication Date Oct 2019

Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: In 2010, the use of tyrosine kinase inhibitors (TKIs) was approved for the first-line treatment of patients with advanced non-small cell lung cancer (NSCLC) harbouring an epidermal growth factor receptor (EGFR) mutation, and EGFR mutation analysis in these patients has become a standard of care. However, limited real world data exist in the UK on EGFR testing, and treatment and outcome. We therefore carried out a nationwide retrospective study to evaluate sample acquisition, testing, turnaround times and therapies related to EGFR testing in routine clinical practice.
Method(s): In collaboration with Public Health England, a dedicated portal was designed allowing hospitals in England to log in and provide information on patients identified with stage 3B and 4 PSO-2 NSCLC diagnosed between June and December 2017. The portal for data collection was open for a period of 11 weeks, from 19 October 2018 to 4 January 2019.
Result(s): Of the 142 hospitals in England, 60 took part in this spotlight audit of which 19 had on-site EGFR testing; 1,157 individual patient records were uploaded on to the portal; 512 (44%) patients were female, 353 (31%) were under the age of 65 and 758 patients (66%) had adenocarcinoma. Common methods of tissue acquisition were percutaneous lung or lymph node biopsy (31%), endobronchial ultrasound (EBUS) (24%) and from pleural fluid or pleural biopsy (11%). In a multivariate analysis, patients undergoing pleural procedures as an initial investigation were twice as likely to require a second procedure for molecular analysis as patients undergoing EBUS. Of the 758 patients with an adenocarcinoma subtype, 701 (92%) underwent EGFR testing. Testing failed in only 3% of patients and 71 (9.4%) had a sensitising EGFR mutation. The median time from biopsy to EGFR result was 18 days (interquartile range 14-23) with a median of 9 days from arrival in the molecular lab to EGFR result. In patients with a sensitising EGFR mutation, 53 (75%) received a first-line TKI, 3 (4%) received first-line chemotherapy, 1 (1%) patient received immunotherapy and treatment was unknown in 14 (20%). The median survival of patients with an EGFR mutation was 19 months
Conclusion(s): In this study, samples acquired by pleural procedures were less suitable for EGFR testing. Comprehensive EGFR testing has been successfully implemented on a national scale using regional centres. Further quality improvement measures are required to reduce time to EGFR result. Keywords: adenocarcinoma, real world, EGFR
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25. Insulin use and hypoglycemia prevalence in an Australian public hospital setting

Authors Piya M.K.; Fletcher T.; Myint K.P.; Zarora R.; Simmons D.
Source Diabetes; Jun 2019; vol. 68
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Aims: Diabetes management in hospital often focuses on tight glycemic control. Insulin use is, therefore, more common in the hospital inpatient setting. We sought to determine the prevalence and patterns of insulin use and hypoglycemia among inpatients with diabetes on medical wards in a tertiary Sydney hospital.
Method(s): A daily census was conducted on three medical wards (79 beds) over 44 weeks from June 2017. Inpatients with diabetes were audited using a questionnaire based on the UK National Diabetes Inpatient Audit. Those admitted for >7 days were audited for the last 7 days of admission.
Result(s): Among 822 patients with diabetes, 96% had T2DM, mean age (SD) was 69.1(12.3) years, 54.8% male. Overall, 29.6% were on insulin on admission but 44.7% were prescribed insulin during their hospital stay. Hypoglycemia (<4.0mmol/L) occurred in 111 patients (13.5%) with 225 episodes, and severe hypoglycemia (<3.0mmol/L) occurred in 39 patients (4.8%) with 52 episodes. Insulin was prescribed during hospital stay in 78.4% of patients who had hypoglycemia, and 92.3% who had severe hypoglycemia. There was a greater prevalence of hypoglycemia out of hours (5pm-8am) compared to 8am-5pm (167 vs. 58 episodes).
Conclusion(s): Hypoglycemia and severe hypoglycemia were common among hospital inpatients, and insulin use in this group was high. Insulin use was a major risk factor for hypoglycemia, particularly with new insulin initiation and after hours. These data highlight the need to weigh the risk of hypoglycemia against the benefit of tight glycemic control when considering insulin initiation in hospital. Extra vigilance is also needed after hours when there is a higher risk of hypos with fewer staff.

26. Effect of ideglira on HbA1c and weight: Data from the association of british clinical diabetologists (ABCD) ideglira audit

Authors Noronha S.; Lumb A.N.; Bickerton A.; Sim S.Y.; Gallen I.W.; Adamson K.; Ryder R.E.
Source Diabetes; Jun 2019; vol. 68
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Unique in the UK armoury of injectable agents for diabetes, the combination IdegLira offers the clinical advantages of degludec and liraglutide, with the convenience of a once daily injection. The ABCD IdegLira audit, commenced in April 2017, is a nationwide audit evaluating whether the favourable effects of IdegLira on HbA1c and weight previously shown in clinical trials translate into similar advantages when the agent is used in real clinical practice. Data to date has been obtained nationwide via two routes: a physician populated online audit tool and a cloud-based IT system (Eclipse), capable of integrating with existing primary care systems to facilitate audit, risk stratification and patient empowerment. The inclusion criteria were people with type 2 diabetes started on IdegLira, who had HbA1c and weight measured at baseline and 6 months into treatment. Baseline values were defined as the most recent values in the 6-month period prior to initiation of IdegLira. Endpoint data was accepted within a collection window of +/- 45 days. We identified thirty-five patients for HbA1c (15M, 20F, mean +/- SD age 57.4 +/- 8.2) and twenty-eight patients for weight (13M, 15F, mean +/- SD age 75.0 +/- 8.6). Baseline HbA1c and weight were compared with the 6-month values with 2-sided p-values using a paired T Test. Mean +/- SD HbA1c fell by 1.43% +/- 2.04, from 10.17% +/- 1.93 to 8.73% +/- 1.74 (p<0.0005). Mean +/- SD weight fell by 0.53kg +/- 5.77, from 105.24kg +/- 24.44 to 104.71kg +/- 24.17 (p=0.63). These findings confirm that real world experience with IdegLira is consistent with trial evidence, showing statistically significant reductions in HbA1c and a lack of weight gain. IdegLira is therefore a valuable option when treatment intensification is required in patients with type 2 diabetes. Given that the total yearly cost of IdegLira is less than separate degludec and liraglutide at the equivalent dose, these data would support use of the combination product.

27. Is the use of e-cigarettes for smoking cessation associated with alcohol consumption? A population-level survey of successful quitters in England

Authors Jackson S.E.; Beard E.; West R.; Brown J.; Michie S.
Source Addictive Behaviors; Feb 2020; vol. 101
Publication Date Feb 2020
Publication Type(s) Article
Database EMBASE
Abstract Objective: To examine associations between the use of e-cigarettes for smoking cessation and levels of alcohol consumption, high-risk drinking, and attempts to cut down alcohol consumption compared with use of nicotine replacement therapy (NRT) or no aid.
Method(s): Cross-sectional survey of adults (>=16 years) in England. The sample included a total of 961 people who had quit smoking with the use of either e-cigarettes (n = 425), NRT (n = 116), or no aid (n = 421) within the past year and were still abstinent at the survey. Drinking behaviour was assessed with the AUDIT.
Result(s): Mean (SD) alcohol consumption among those who quit smoking with e-cigarettes, NRT, and no aid was 7.78 (13.41), 7.12 (13.85), and 5.55 (8.70) units/week, respectively. The prevalence of high-risk drinking was 43.3% (n = 184), 32.2% (n = 37), and 36.8% (n = 155), respectively. Among high-risk drinkers, the prevalence of attempts to cut down alcohol consumption was 22.3% (n = 41), 18.9% (n = 7), and 27.7% (n = 43), respectively. After adjustment for covariates, those who quit with e-cigarettes had significantly higher alcohol consumption than those who quit unaided (B = 1.69, 95%CI 0.21-3.17), but there was no significant difference relative to those who quit with NRT. Differences in high-risk drinking and attempts to cut down were not significant, but Bayes factors indicated the data were insensitive (range: 0.47-0.95).
Conclusion(s): Recent ex-smokers who used e-cigarettes to help them quit consumed around two more units of alcohol each week than those who quit unaided, but their alcohol consumption was similar to those who quit with NRT. Data on differences in high-risk drinking and attempts to cut down alcohol consumption among high-risk drinkers were inconclusive.
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28. Modelling the costs and consequences of reducing healthcare-associated infections by improving hand hygiene in an average hospital in England

Authors Guest J.F.; Keating T.; Gould D.; Wigglesworth N.
Source BMJ Open; Oct 2019; vol. 9 (no. 10)
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31575536
Database EMBASE

Abstract Objective To assess the potential clinical and economic impact of introducing an electronic audit and feedback system into current practice to improve hand hygiene compliance in a hypothetical general hospital in England, to reduce the incidence of healthcare-associated infections (HCAIs). Methods Decision analysis estimated the impact of introducing an electronic audit and feedback system into current practice to improve hand hygiene compliance among front-line healthcare practitioners (HCPs). Results The model assumed 4.7% of adult inpatients (ie, ≥ 18 years of age) and 1.72% of front-line HCPs acquire a HCAI in current practice. The model estimated that if use of the electronic audit and feedback system could lead to a reduction in the incidence of HCAIs of between 5% and 25%, then the annual number of HCAIs avoided could range between 184 and 921 infections per hospital and HCAI-related mortality could range between 6 and 31 deaths per annum per hospital. Additionally, up to 86 days of absence among front-line HCPs could be avoided and up to 7794 hospital bed days could be released for alternative use. Accordingly, the total annual hospital cost attributable to HCAIs could be reduced by between 3% and 23%, depending on the effectiveness of the electronic audit and feedback system. If introduction of the electronic audit and feedback system into current practice could lead to a reduction in the incidence of HCAIs by at least 15%, it would have a ≥ 0.75 probability of affording the National Health Service (NHS) a cost-effective intervention. Conclusion If the introduction of the electronic audit and feedback system into current practice in a hypothetical general hospital in England can improve hand hygiene compliance among front-line HCPs leading to a reduction in the incidence of HCAIs by $\geq 15\%$, it would potentially afford the NHS a cost-effective intervention.
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29. Predictive validity, diagnostic accuracy and test-retest reliability of the strength of urges to drink (SUTD) scale

Authors Beard E.; Brown J.; West R.; Michie S.; Drummond C.; Kaner E.
Source International Journal of Environmental Research and Public Health; Oct 2019; vol. 16 (no. 19)
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31581626
Database EMBASE
Abstract This study compared the 1-item Strength of Urges to Drink (SUTD) scale with the 10-item Alcohol Use Disorders Identification Test (AUDIT) on (i) test-retest reliability, (ii) predictive validity, and (iii) diagnostic accuracy. Data come from 2960 participants taking part in the Alcohol Toolkit Study (ATS), a monthly population survey of adults in England. The long-term test-retest reliability of the SUTD was 'fair', but lower than that for the AUDIT (Kappa_{weighted} 0.24 versus 0.49). Individuals with "slight/moderate" urges to drink had higher odds of reporting an attempt to cut down relative to those not experiencing urges (adjusted odds ratios (AdjORs) 1.78 95% confidence interval (CI) 1.43-2.22 and 1.54 95% CI 1.20-1.96). Drinkers reporting "moderate/slight/strong" urges to drink had mean change in consumption scores which were 0.16 (95% CI -0.31 to -0.02), 0.40 (95% CI -0.56 to -0.24) and 0.37 (95% CI -0.69 to -0.05) units lower than those reporting no urges. For all outcomes, strong associations were found with AUDIT scores. The accuracy of the SUTD for discriminating between drinkers who did and did not reduce their consumption was 'acceptable', and similar to that for the AUDIT (ROC_{AUC} 0.6). The AUDIT had better diagnostic accuracy in predicting change in alcohol consumption. The SUTD may be an efficient dynamic measure of urges to drink for population surveys and studies assessing the impact of alcohol-reduction interventions.
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30. Comparing clinical trial data against a real world dataset - progression-free survival on Len/Dex and Bor/Dex following 1-3 prior lines of treatment

Authors Waters J.; Benjamin R.; Cuthill K.; Deppe S.; Gunning D.; Kazmi M.; Mason A.; Rice C.; Bowcock S.; Maestre A.D.; Patrick H.; Milner G.; Streetly M.
Source Clinical Lymphoma, Myeloma and Leukemia; Oct 2019; vol. 19 (no. 10)
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Background: Much of the existing published data on myeloma outcomes is derived from randomised controlled trials where patient selection and management is dictated by trial protocol. A need remains to collect and analyse 'real world' data from patients treated outside of clinical trials to check that these results are being replicated. Here we present survival data collected as part of a retrospective multi-centre audit of relapsed myeloma patients in the UK. All patients were treated with lenalidomide (Len) or bortezomib (Bor) in the decade in which these drugs became available for relapsed myeloma in the UK, 2007 to 2017 (with 75% of patients receiving treatment in 2013-15). Rev became available for relapsed patients from 2007 on clinical trials, and for non-trial patients in 2009. Vel received NICE approval for relapsed patients in 2008.

Method(s): Several clinical trials of the last decade used Len/Dex (Aspire and Tourmaline) or Bor/Dex (Panorama and Endeavor) as their control groups. These were taken as comparators for progression-free survival (PFS) with a dataset extracted from existing clinical records as part of an ongoing myeloma outcomes audit. All patients were being treated following 1st, 2nd, or 3rd relapse. 53 patients received Len/Dex and 27 patients received Bor/Dex in the audit dataset. 389 patients received Len/Dex on Aspire (commencing 2010-14) and 360 on Tourmaline (commencing 2012-14). 381 patients received Bor/Dex on Panorama (commencing 2009-13) and 465 on Endeavor (commencing 2012-14).

Result(s): PFS compares favourably between the audit and clinical trial datasets for both Len/Dex and Bor/Dex patients. The median PFS for audit Len/Dex patients was 17 months, while it was 17.6 months on Aspire and 14.7 months on Tourmaline. The median PFS for audit Bor/Dex patients was 15 months, while on Endeavor it was 9.4 months. Stratified results illuminate this comparison further. We present additional comparisons by line of treatment, by prior exposure to immunomodulatory drugs (ImiDs) or proteasome inhibitors (PIs), and by prior autologous stem cell transplant status. Bor/Dex median survival times are longer in the audit dataset than in any of the clinical trial results regardless of stratification, while Len/Dex median survival times tend to be longer, though with a few notable outliers. These initial comparisons suggest a general parity or better between clinical trial control groups and real world patients. While the smaller sample size (and the presence of a small proportion of patients who received autografts, which may favour increased survival times) may introduce some bias, this is difficult to determine - especially as median age, another factor in survival rates, tends to favour the clinical trial groups. These findings are significant as a test for the clinical trial results, indicating that in this case contemporaneous 'real world' outcomes may be better than is often assumed. Keywords: clinical trials real-world evidence relapsed Tracks: Treatment of Previously Treated Myeloma

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31. An audit of the clinical outcomes of dafne singapore (2011-2018)

Authors Tan S.; Rama Chandran S.; Boon Lim H.; Adaikan K.; Goh S.-Y.; Gardner D.

Source Diabetes; Jun 2019; vol. 68

Publication Date Jun 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract Background: The Dose Adjustment for Normal Eating (DAFNE) is a type 1 diabetes (T1D) group education program to enable self-management. Shown to improve outcomes in the UK, its application in Asian countries remains uncertain. We assessed the outcomes of Singapore (Sg)DAFNE, which remains the only Asian centre, from 2011-2018.

Method(s): Prior to DAFNE entry, most had received one-on-one education from DAFNE educators. HbA1c, total daily dose (TDD) of insulin were retrieved at these timepoints: 1y before, at entry, 1y after, latest profile. Paired sample t-tests and Chi square tests were used; data is presented as means+/-SD.

Result(s): n=115 (33.9% male), age 28.3+/-8.5y, T1D duration 11.2+/-8.4y, follow-up post-DAFNE 3.5 +/-2.3y. n=104 completed 1y follow-up post-DAFNE. Mean HbA1c pre-DAFNE fell by entry into DAFNE: pre-vs.-entry: 8.5+/-1.68% (68 mmol/mol) vs. 7.9+/-1.4%, p<0.001. This fall was sustained 1y post-DAFNE and at latest follow-up (HbA1c 7.8+/-1.3%, 7.9+/-1.3%, all p<0.001). Proportion of those in HbA1c category <= 7.5% rose while the proportion in higher HbA1c categories fell post-DAFNE (Figure). TDD insulin fell alongside improvement in glycaemic control (pre-vs.-post-DAFNE: 45.5+14.9 vs. 42.5+12.0, p=0.02).

Conclusion(s): This demonstrates the effectiveness of SgDAFNE. Sustained improved glycaemic control was achieved with reduced insulin dosages, reinforcing that the quality of insulin use matters more than the quantity.

32. The association of british clinical diabetologists uk-wide audit of freestyle libre use in diabetes-effect on glycaemic control

Authors Deshmukh H.; Wilmot E.G.; Bishop D.; Lipscomb D.W.; Banatwalla R.; Zaidi R.; Smith Z.V.; Overend L.; Kamaruddin S.; Hall C.M.; Macfadyen J.; Kilvert A.; Ryder R.E.; Walton C.; Sathyapalan T.

Source Diabetes; Jun 2019; vol. 68

Publication Date Jun 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract

Aims: The FreeStyle Libre (FSL) flash glucose monitoring device was made available on the UK National Health Services (NHS) drug tariff in 2017. This national audit aims to explore the UK real world experience of FSL and the impact on glycaemic control.

Method(s): Clinicians were invited to submit FSL user data to a secure web-based tool held within the NHS N3 network. Data were analysed from available initial submissions from the 60 out of 120 NHS hospital trusts registered for the audit. R3.5.0 was used for statistical analysis and T-test was used to compare the baseline and follow-up HbA1c. Within-person variations of HbA1c calculated $\text{adj-HbA1c-SD} = \text{SD}/\text{sq. Root } [n/(n-1)]$.

Result(s): Data were available for 2,438 (2,348 people with type 1 diabetes) FSL users; age 34(IQR =19-51) years, 54% female, diabetes duration 14 (IQR=19-51) years, and BMI of 24(IQR=21-28) kg/m^2 and participants had 10 (IQR=7-12) scans/day. The baseline HbA1c was 67.8(+/-17) (8.4%), and after a median follow-up of 6 months (n=625) HbA1c reduced to 61.8 (+/-14) (7.8%) mmol/l ($P<0.0001$). HbA1c reduction was greater in those with initial HbA1c ≥ 69.4 ($>8.5\%$) mmol/mol ; HbA1c reduced from 85.8 mmol/mol (+/-15) (10%) to 73.1 mmol/mol (+/-15) (8.8%). FSL use was also associated with reduced within-person HbA1c variability (5.37 pre-FSL vs. 3.15 post-FSL, $P<0.0001$). In the immediate 12 month period prior to FSL initiation, 5% patients reported a hospital admission related to hyperglycaemia/diabetic ketoacidosis. During the ongoing median follow-up of 6 months following FSL initiation this was 1%.

Conclusion(s): These initial FSL audit data demonstrate significantly improved glycaemic control, reduction in HbA1c variability and less hyperglycaemia related hospital admissions in the first 6 months follow-up. Data collection is ongoing. Further analyses with longer follow-up may confirm these findings and inform future clinical practice and policy.

33. Are clients satisfied with integrated care? Enhancing client feedback on discharge from a domiciliary based multidisciplinary integrated care service

Authors Boyle N.; O'Shea D.; McDonnell S.; Balasubramanian S.; Reynolds N.; Geary N.; Hession E.

Source Age and Ageing; Sep 2019; vol. 48

Publication Date Sep 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract Background: Te Integrated Care Programme for Older People has supported the development of integrated care services at pioneer sites in Ireland, each developed to meet local needs. Patient Reported Experience Measures (PREMs) have been used to evaluate user experience in intermediate care in the United Kingdom. Tis project aimed to evaluate client experience of a domiciliary based, multidisciplinary, integrated care service. Method(s): A qualitative audit of the experience of clients of the Older Persons' Integrated Care Team (OPICT) was performed. Tis project was undertaken in conjunction with the Royal College of Physicians of Ireland's Quality Improvement in Action programme. A feedback questionnaire was designed and distributed to consecutively discharged clients from OPICT from February 2019, providing qualitative assessment for service improvement. Te results of feedback from the first questionnaire design are reported. Result(s): Twenty OPICT clients received a feedback questionnaire following their final interaction with the OPICT service. Eighteen clients responded: 11 males and 9 females with mean age 81 years. Two male clients did not return the questionnaire (mean age 86 years). In terms of the treatment and advice provided by the team, all 18 clients agreed with statements that they were involved in decision making, treatment was explained in a way that they could understand and was effective and met their needs. All clients responding indicated that they were listened to, treated with dignity and had confidence and trust in the team. All 18 respondents would recommend the service to another older person. Respondents also provided individual comments which all indicated satisfaction with the service. Conclusion(s): Older people accessing integrated care delivered in their home reported a positive experience and can provide important information on further service development.

34. Pyjama paralysis: Time to make a move!

Authors Fitzpatrick D.; Doyle K.; Finn G.; Gallagher P.

Source Age and Ageing; Sep 2019; vol. 48

Publication Date Sep 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract Background: The adverse effects of inpatient falls are well known. The harms of unwarranted bedrest and prolonged immobilisation present insidiously but, arguably, have a greater impact. Deconditioning, itself, is a major contributor to falls in older adults. There is still a troubling assumption that falls can be prevented through restraint and preventing at-risk patients from mobilising.

Method(s): We reviewed medical and nursing notes and conducted brief-structured interviews with nurses and brief bedside observations for medical inpatients aged ≥ 75 . We constructed a research template based on the UK National Falls audit 2015¹ and the Hospital Elder Life Program (HELP) - mobility toolkit². We included all patients on medical wards over the age of 75, admitted for 3 or more days. We excluded patients who were critically unwell or imminently dying.

Result(s): We reviewed 100 medical inpatients aged over 75. Patients' mobility deteriorated significantly from their baseline, with 73% of patients requiring assistance compared to 22% at baseline. PJ paralysis was endemic with only one third of patients wearing day clothes. 75% of patients spent more than half of the day in bed. There were 8 falls during the entire study period. Poorer levels of mobility correlated with delirium and incontinence.

Conclusion(s): The deleterious effects on older patients of the traditional model of acute hospital care with gratuitous bedrest are universally acknowledged. Falls should be prevented through supervision rather than restraint. Campaigns such as "End PJ Paralysis" and the HELP mobility toolkit can enable a cultural change within hospitals. Such change is impossible without the staffing and leadership to endorse it.

35. Impact of dedicated geriatrician involvement on national emergency laparotomy audit standards and outcomes

Authors Coary R.; Mitchell E.; Shipway D.; Jenkins K.; Pullyblank A.
Source Age and Ageing; Sep 2019; vol. 48
Publication Date Sep 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: Older patients undergoing emergency laparotomy (EmLap) have high levels of mortality and morbidity. The National Emergency Laparotomy Audit (NELA) in the United Kingdom records processes and outcome measures for patients undergoing EmLap. Recent data shows that geriatrician review is associated with reduced post-surgical mortality (Oliver C.M. et al., British Journal of Anaesthesia 2018). Geriatrician review of all patients aged ≥ 70 years is a NELA standard. However, the most recent national report shows only 23% compliance, falling short of the target of 80% and consistently the poorest performing standard.

Method(s): In August 2018, we established a dedicated gastrointestinal surgery liaison service to replace ad hoc geriatrician reviews. We evaluated the impact on NELA standard compliance and patient outcomes. Data were extracted from the local NELA database on all patients aged ≥ 70 years, for the first six months of the service (September to February). These were compared to the same time period in the preceding year prior to service launch.

Result(s): Following service introduction, increased numbers of patients aged ≥ 70 years underwent EmLap: 50 (2018-9) vs 31 (2017-8). Geriatrician review occurred in 86% (n=43) in 2018-9, compared to 16% (n=5) in 2017-8. Inpatient mortality fell from 23% (n=7) in 2017-8 to 14% (n=7) in 2018-9. Discharge to own home rose to 76% (n=38) in 2018-9 from 68% (n=21) in 2017-8. One patient in each cohort was newly discharged to a nursing home. Mean length of stay was 17.9 days in 2018-9 (range 3-75), versus 17.6 in 2017-8 (range 3-94).

Conclusion(s): Introduction of a dedicated geriatric surgical liaison service is associated with increased compliance with NELA standards. Despite more emergency laparotomies being performed on older patients, this was associated with improved mortality and rates of home discharge, consistent with published data. Targeted investment in surgical liaison services may therefore be warranted.

36. Collateral damage: The cost of failing to take a comprehensive collateral history for older adults with cognitive impairment

Authors Doyle K.; Fitzpatrick D.; Finn G.; Gallagher P.
Source Age and Ageing; Sep 2019; vol. 48
Publication Date Sep 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Background: Age-related syndromes of cognitive impairment, including delirium and dementia, are becoming more prevalent in our hospitals. Patients with cognitive impairment are often unable to provide information relating to their pre-morbid cognition and function as well as their admission diagnosis. Such information is essential to correctly identifying delirium and dementia, as well as making an accurate diagnosis and planning appropriate treatment. It is the standard of care recommended by both the Irish National Audit of Dementia 2014 and the UK National Audit of Dementia Care 2017 that a collateral history is obtained. Method(s): We reviewed the medical notes and conducted brief structured interviews with nursing staff for 100 medical inpatients aged ≥ 75 . Result(s): Only 44% of patients with cognitive impairment had a collateral history. Half of patients described as having dementia did not have any further detail on the severity of dementia documented. 80% of collateral histories were sourced by the admitting NCHD; if the collateral history was not obtained on admission, it was unlikely to be obtained at all. Among those for whom a collateral history was obtained, the level of detail regarding pre-morbid cognition, function, mobility and continence was sparse. The most common informant was the patient's son or daughter (66%), followed by spouse (16%). Only 13% of patients had formal cognitive testing. Conclusion(s): Acute illness characteristically causes significant impairments in cognition and function in frail older patients. Identifying and reversing these impairments is impossible without a comprehensive collateral history. It is alarming that such an essential component of clinical assessment is so often disregarded and highlights the lack of awareness from clinicians of the importance of collateral history in the management of patients with dementia and delirium. This must be emphasised in both undergraduate and postgraduate teaching. An appropriate admission proforma would also promote competent collateral history taking.

37. An audit of the frequency of early swallow screens performed in patients diagnosed with a stroke

Authors Kelly L.; Murtagh N.; Leonard R.; O'Malley T.
Source Age and Ageing; Sep 2019; vol. 48
Publication Date Sep 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: The National Stroke Audit 2015 showed that Ireland had made great advances in stroke care but one notable area of deficiency was in access to early swallow screening (within 4 hours). An early swallow screen is recommended by the Royal College of Physicians Stroke Guidelines (2016) to minimise the risk of aspiration pneumonia. The National Guideline for Swallow Screening in Stroke was released in May 2017 and outlines the need to have staff who are trained in swallow screening available 24/7. This audit aimed to evaluate the percentage of stroke patients in our hospital who received a documented swallow screen within 4 hours of admission. Method(s): Data relating to swallow screens/assessments and the time in which they were performed was extracted from our hospital's HIPE database. The sample size included all confirmed strokes seen by the stroke service in our hospital in the first 6 months of 2018 (1/1/2018- 30/06/2018 inclusive). This amounted to 78 patients. Result(s): In our hospital >90% of patients diagnosed with stroke get admitted to our stroke unit. Of the 78 patients, 38 (48.1%) had a documented swallow screen/assessment during admission, 27 did not have a documented swallow screen/assessment (34.2%) and for 14 patients (17.7%) it was unclear whether they had one during admission. Of the 38 patients who had documented swallow screens/assessments during admission 5 (13.2%) of these occurred within 4 hours of admission. Conclusion(s): In summary while our hospital is succeeding in getting the vast majority of diagnosed strokes into our stroke unit we are not currently meeting the UK target for early swallow screening. We aim to roll out an education and training programme targeting nurses and doctors in our stroke unit regarding early swallow screening and re-audit this in 6-12 month's time.

38. The accreditation system of Italian medical residency programs: Fostering quality and sustainability of the national health service

Authors Mazzucco W.; Vettor R.; Silenzi A.; Gray M.
Source Acta Biomedica; 2019; vol. 90 ; p. 15-20
Publication Date 2019
Publication Type(s) Article
PubMedID 31517885
Database EMBASE

Abstract Summary. Background and aim: In June 2017, University and Health Ministries jointly enacted a decree implementing a new accreditation system for the Italian post-graduate medical schools (residency programs). We report the innovations introduced through the reform.
Method(s): Universities were called to submit post-graduate medical school projects to the National Observatory on medical residency programs, the inter-institutional committee responsible for the entire accreditation process, through an interactive web platform. The adherence to minimum standards, requirements and the performances were measured. After this first assessment, universities were asked to provide programs of improvement for critical schools. At the end of the evaluation, residency schools were proposed for a full or a partial accreditation.
Result(s): Of the 1,431 post-graduate medical school projects submitted to the National Observatory by 37 public and 4 private Universities, 672 (47.0%) obtained a full accreditation, 629 (43.9%) a partial accreditation, with a gap to be filled within a two-year period according to a specific improvement programme, while 130 (9.1%) were not accredited. Further, 1,254 out of the 1,301 schools with a full or partial accreditation were activated according to the available public financial resources, excluding those performing the lowest. Annual surveys were in place to investigate the residents' level of satisfaction concerning the quality of the training programs. The National Observatory further developed an experimental methodology to conduct on-site visits to support quality improvement.
Conclusion(s): This reform can be considered an important initiative to guarantee high standards in the quality of care and to face the challenge of sustainability for the National Health System. (www.actabiomedica.it).
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39. Admission patterns and survival from Status Epilepticus in Critical Care in the United Kingdom: An analysis of the Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme database

Authors Damian M.; Ben-Shlomo Y.; Howard R.; Harrison D.A.
Source European journal of neurology; Oct 2019
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31621142
Database EMBASE
Abstract BACKGROUND: Factors influencing outcome after Critical Care Unit (CCU) for patients with status epilepticus (SE) are poorly understood. We examined survival for these patients to establish (a) whether the risk of mortality has changed over time and (b) whether admission to different unit types affects mortality risk over and above other risk factors.
METHOD(S): We analysed the Intensive Care National Audit & Research Centre (ICNARC) database and the Case Mix Programme Database (CMPD) (January 2001 - December 2016). Units were defined as neuro-CCU (NCCU), general CCUs with 24-hr neurological support (GCCU-N) or general CCU with limited neurological support (GCCU-L).
RESULT(S): There were 35,595 CCU cases of SE with a threefold increase over time (4,739 in 2001-2004 to 14,166 in 2013-2016). More recent admissions were older and were more often unsedated on admission. Mortality declined for all units though this was more marked for NCCUs (8.1% in 2001-2004 to 4.4% in 2013-2016 compared to 5.1% and 4.1% for GCCU-L). Acute hospital mortality was 2-3 times higher than CCU mortality although this has also declined with time. GCCU-L appeared to have lower mortality than NCCUs (OR 0.84, 95% CI 0.72, 0.98) but after post-hoc adjustment for case mix there were no differences. Older age and markers of morbidity of seriousness were all associated with increased mortality risk.
CONCLUSION(S): The number of patients admitted to CCU for SE is rising but critical care and acute hospital mortality is decreasing. Patients treated in NCCU have higher mortality but this is explicable by more severe underlying disease.
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40. Type A aortic dissection in patients over the age of seventy in the UK

Authors Bashir M.; Harky A.; Shaw M.; Adams B.; Oo A.
Source Journal of cardiac surgery; Oct 2019
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31618487
Database EMBASE

Abstract OBJECTIVES: Recent guidelines have stated that age alone should not be a limiting factor for offering life-saving surgery to patients with acute type A dissection (ATAD). The objective of this study was to review the outcomes of patients above the age of 70 undergoing surgery for type A aortic dissection (TAAD) in the UK. METHOD(S): Prospectively collected data of procedures undertaken on patients with an age of 70 years or more were extracted from the National Institute for Cardiovascular Outcomes Research (NICOR) National Adult Cardiac Surgery Audit registry. All operations were performed in England and Wales between 1 April 2007 and 31 March 2013. The primary outcome for this study was in-hospital mortality. The secondary outcome was mid-term mortality followed up to 5 years. RESULT(S): A total of 507 patients were included in the study. The highest number of procedures performed by a single surgeon during the study period was 12. The overall in-hospital mortality rate for all ATAD patients aged 70 or over was 22.5% (114 patients); the stroke rate was 11% (57) and postop dialysis rate 15% (76). CONCLUSION(S): ATAD is a life-threatening condition with a high mortality rate if left untreated. Our results show that surgery for ATAD in patients over 70 is feasible with acceptable mortality rates. However, similar to previous studies, rates of stroke in older patients may be higher. The present study supports the notion that age should not be a discriminating factor in operating on patients with TAAD. Copyright © 2019 Wiley Periodicals, Inc.

41. Quality of British and American Nationwide Quality of Care and Patient Safety Benchmarking Programs: Case Neurosurgery

Authors Reponen E.; Tuominen H.; Korja M.
Source Clinical Neurosurgery; Oct 2019; vol. 85 (no. 4); p. 500-507
Publication Date Oct 2019
Publication Type(s) Article
Database EMBASE
Abstract BACKGROUND: Multiple nationwide outcome registries are utilized for quality benchmarking between institutions and individual surgeons. OBJECTIVE(S): To evaluate whether nationwide quality of care programs in the United Kingdom and United States can measure differences in neurosurgical quality. METHOD(S): This prospective observational study comprised 418 consecutive adult patients undergoing elective craniotomy at Helsinki University Hospital between December 7, 2011 and December 31, 2012. We recorded outcome event rates and categorized them according to British Neurosurgical National Audit Programme (NNAP), American National Surgical Quality Improvement Program (NSQIP), and American National Neurosurgery Quality and Outcomes Database (N²QOD) to assess the applicability of these programs for quality benchmarking and estimated sample sizes required for reliable quality comparisons. RESULT(S): The rate of in-hospital major and minor morbidity was 18.7% and 38.0%, respectively, and 30-d mortality rate was 2.4%. The NSQIP criteria identified 96.2% of major but only 38.4% of minor complications. N²QOD performed better, but almost one-fourth (23.2%) of all patients with adverse outcomes, mostly minor, went unnoticed. For NNAP, a sample size of over 4200 patients per surgeon is required to detect a 50.0% increase in mortality rates between surgeons. The sample size required for reliable comparisons between the rates of complications exceeds 600 patients per center per year. CONCLUSION(S): The implemented benchmarking programs in the United Kingdom and United States fail to identify a considerable number of complications in a high-volume center. Health care policy makers should be cautious as outcome comparisons between most centers and individual surgeons are questionable if based on the programs. Copyright © 2018 by the Congress of Neurological Surgeons.

42. Does the implementation of a quality improvement care bundle reduce the incidence of acute kidney injury in patients undergoing emergency laparotomy?

Authors Doyle J.F.; Sarnowski A.; Saadat F.; Huddart S.; Quiney N.; Dickinson M.C.; Forni L.G.; Samuels T.L.; McCormick B.; deBrunner R.; Preece J.; Swart M.; Peden C.J.; Richards S.
Source Journal of Clinical Medicine; Aug 2019; vol. 8 (no. 8)
Publication Date Aug 2019
Publication Type(s) Article
Database EMBASE

Abstract Purpose: Previous work has demonstrated a survival improvement following the introduction of an enhanced recovery protocol in patients undergoing emergency laparotomy (the emergency laparotomy pathway quality improvement care (ELPQuiC) bundle). Implementation of this bundle increased the use of intra-operative goal directed fluid therapy and ICU admission, both evidence-based strategies recommended to improve kidney outcomes. The aim of this study was to determine if the observed mortality benefit could be explained by a difference in the incidence of AKI pre- and post-implementation of the protocol.
Method(s): The primary outcome was the incidence of AKI in the pre- and post-ELPQuiC bundle patient population in four acute trusts in the United Kingdom. Secondary outcomes included the KDIGO stage specific incidence of AKI. Serum creatinine values were obtained retrospectively at baseline, in the post-operative period and the maximum recorded creatinine between day 1 and day 30 were obtained.
Result(s): A total of 303 patients pre-ELPQuiC bundle and 426 patients post-ELPQuiC bundle implementation were identified across the four centres. The overall AKI incidence was 18.4% in the pre-bundle group versus 19.8% in the post bundle group $p = 0.653$. No significant differences were observed between the groups.
Conclusion(s): Despite this multi-centre cohort study demonstrating an overall survival benefit, implementation of the quality improvement care bundle did not affect the incidence of AKI.
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43. Exploring the feasibility of general health promotion in UK dental primary care: ENGAGE in Scotland

Authors Bonetti D.; Hempleman L.; Deas J.; Shepherd S.; Clarkson J.; Young L.
Source British dental journal; Oct 2018; vol. 225 (no. 7); p. 645-656
Publication Date Oct 2018
Publication Type(s) Article
PubMedID 30310225
Database EMBASE
Abstract Introduction Despite UK dental guidance recommending opportunistic health promotion, it's rare for GDPs to discuss more than oral hygiene with their patients. The ENGAGE intervention incorporates UK guidance and evidence-based behaviour change techniques to motivate patients to make lifestyle changes (reduce smoking, alcohol consumption and/or improve diet). It was designed to take less than five minutes and be delivered during a routine dental check-up, and includes a take-home patient handout signposting to free NHS lifestyle counselling helpline services. Aims To determine the feasibility (patient and GDP acceptance) of implementing ENGAGE in Scottish dental primary care. The overall aim is to examine feasibility UK-wide before testing its effectiveness for influencing patient outcomes in a multi-centre UK trial. Methods Study 1: patient survey: N = 1000 adults from all health boards in Scotland were randomly selected from an NHS data base of medical patients and emailed the study invitation and link to an online questionnaire. Study 2: GDP workshop, audit, survey: N = 50 GDPs across Scotland were invited to participate in the training workshop (limited to the first 20 applicants), implement the intervention with their next 20 adult patients in for a check-up, audit their experience, then complete an online questionnaire. Results Study 1: 200 people completed the survey (52% male; 37% were 55 years or younger; 90% had visited their dentist in the previous 12 months). Less than (<) 15% were asked about their smoking, alcohol intake and/or diet when they last visited their dentist for a check-up; < 10% would be embarrassed/offended if their dentist or dental hygienist asked them lifestyle questions during a dental check-up; more than (>) 70% would be reassured by the professionalism of their dentist or dental hygienist if they were asked; < 4% would be embarrassed/offended if given a leaflet with NHS helpline information by their dentist. Study 2: N = 18 GDPs from nine out of 14 NHS regional health boards in Scotland delivered the ENGAGE intervention to 335 patients (averaging 18 patients each). N = 17/18 participants agreed that this intervention could be delivered during a check-up, was an improvement on what they currently did and thought that it may make a difference to what their patients thought, felt, and/or did about reducing health risk. Conclusion The ENGAGE intervention is feasible to implement in Scottish dental primary care. Comments from patient and GDP participants will inform its development and further feasibility studies set in other UK regions.

44. A global prospective observational study in paediatric-onset IBD: The PIBD-SETQuality inception cohort

Authors Aardoom M.; Tindemans I.; Samsom J.; De Ridder L.; Kemos P.; Croft N.; Ruemmele F.
Source Journal of Pediatric Gastroenterology and Nutrition; Sep 2019; vol. 69 ; p. 61-62
Publication Date Sep 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Objectives and Study: The consequences of paediatric IBD (PIBD), such as growth failure, bowel resection at young age and a lifelong risk of treatment-related adverse events can have strong and lasting effects on the patient's further development and quality of life. Unfortunately we are still not able to predict which patients are at risk of developing a complicated disease course. In order to investigate this, large prospective international studies with long term follow up are needed. Currently there are no European or Asian international cohorts to compare findings during follow up within or between countries. In this first global cohort we aim to evaluate which patients are at risk based on patient and disease characteristics, immune pathology and environmental factors.

Method(s): In this international prospective observational study, which is part of the PIBD Network for Safety, Efficacy, Treatment and Quality improvement of care (PIBD-SETQuality), children and adolescents diagnosed with IBD < 18 years are included at disease diagnosis. Follow up is based on a visit schedule that is in line with standard PIBD care and is intended to continue for up to 20 years. Patient and disease characteristics, as well as results of investigations, are collected at baseline and during follow up. In addition environmental factors are being assessed. In specific centres with the ability to perform extensive immunological analyses biomaterial is being collected and analysed in therapy naive patients at baseline and during follow up. A preliminary analysis on baseline data was performed.

Result(s): Eighteen centres in the United Kingdom (UK), The Netherlands (NL), Italy, Israel, France, Malaysia and the United Arabic Emirates are together currently recruiting over 15 PIBD patients per month. Sixteen extra centres (in 5 new countries) are preparing for their first recruitment. Since January 2017 265 PIBD patients (69% Crohn's disease (CD), 22% ulcerative colitis (UC), 9% IBDU) have been recruited which equals 29% of the target number. Patients have varied ethnicity (67.9% white; 11.1% South Asian; 2.5% black, 0.8% South East Asian; 0.4% East Asian; 0.4% Hispanic/Latino; 16.9% other or mixed race). Baseline findings are presented in Table 1. Magnetic resonance enterography (MRE) findings around diagnosis were assessed in 87 patients (72% CD, n=63) and showed stricturing or fibrostenotic behaviour in 19% of those CD patients and penetrating behaviour in 3% of CD patients. The proportion of UC/IBDU patients receiving prednisone as induction therapy is higher in UK (74%, n=41) compared to NL (30% n=6), while the median disease activity score was 45 in both groups (IQR 27.5-72.5 vs. 30.0-62.5 respectively, p=0.88). Analysis of international and racial differences regarding presenting phenotype, performed diagnostics and induction therapies are ongoing.

Conclusion(s): As the first global inception cohort including data from European and Asian countries, this reveals valuable data on standard clinical practice and immune pathology, facilitates comparisons on diagnostic and therapeutic strategies between countries and with other national cohorts. This study enables the investigation of predictors of therapy effectiveness and provides more insight in factors associated with the risk of a complicated disease course. (Table Presented).

45. Radiologically vs endoscopically-placed gastrostomy feeding tubes: An audit of current practice and clinical outcomes in a large, multi-site UK NHS trust

Authors Pannick S.; Hicks L.; Kim J.; Velji Z.; Colucci K.; Wright A.; Howson W.

Source Endoscopy; Apr 2019; vol. 51 (no. 4)

Publication Date Apr 2019

Publication Type(s) Conference Abstract

Database EMBASE

Abstract

Aims: The optimum method for gastrostomy tube placement is unclear. A Cochrane review found insufficient evidence to promote either percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG). Here, we audit practice and clinical outcomes for gastrostomies across our three acute hospitals.

Method(s): We searched the electronic medical record for patients undergoing their first attempted PEG or RIG insertion between 01/01/17 and 31/12/17. Indications, procedure details and 30-day complications were identified retrospectively. Summary statistics, group comparisons (chi-squared test) and multivariate logistic regression were calculated in Stata 14.2.

Result(s): 155 patients were identified; most had RIGs (85.2%). The median age was 64, and 5.8% had dementia; median preprocedure CRP was 11.6 mg/l. The most common indications were unspecified dysphagia (45.2%), head or neck cancer (36.8%), and stroke (12.3%). 40.2% RIG patients had no documented contraindication to PEG. Patients seen by a nutrition specialist were significantly more likely to have a PEG (23.2% vs. 1.7%, p < 0.001). 30-day complication rates are shown in Table 1. Peri-procedural hypoxia was more common with PEG (13.0% vs. 1.5%, p = 0.004). In a multivariate model accounting for age and CRP, tube type was not significantly associated with any complication. Higher CRP was associated with an increased risk of post-procedure bleeding (OR 1.04, p = 0.02).

Conclusion(s): In this cohort, 30-day complications were very common. Peri-procedural hypoxia was more common with PEG, but aspiration pneumonia and tube displacement may have been more common with RIG. A randomised trial would better establish benchmark quality metrics, to be implemented by nutrition teams for optimal tube selection.

46. Large non-pedunculated colorectal polyps removal and results in a uk district hospital over a 12 months period

Authors Mohamad A.; Sabri S.; Solkar M.; Kroening H.; Saleem A.

Source Endoscopy; Apr 2019; vol. 51 (no. 4)
Publication Date Apr 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Aims: To identify results, pit falls to formulate recommendations based on audit of LNPCP removal over a 12 months period and to compare it with BSG (British Society of Gastroenterology Society) guide lines and to see that it meets recommended BSG standards. Data collection was between Aug 2016 till Aug 2017.
 Method(s): A retrospective data collection was conducted of LNPCP removed over a 12 months period 14 different parameters were used for each polypectomy conducted and results were analyzed on MS Excel.
 Result(s): 50 patients had LNPCPs removed during this 12 months duration. The demographic results shows that majority of patients were in there eighties. 56% were female and 44% were male. Majority of polyps were in distal sigmoid and hepatic flexure which constitutes 36%. The majority of the polyps removed were between 2 - 3 cm which makes 36% of total sample size. 82% of polyps were removed by hot snare cauterisation. The majority of indication for colonoscopy was previous polyps and this was 28%. 54% of polyps were completely removed and remaining were piecemeal. 26% of patients received midazolam and 50 mg of Fentanyl. 62% of cases pit pattern was not recorded in the endoscopy report. 66% of cases paris classification was not noted. 100% polyps were retrieved. 54% polyps were removed completely. One adverse event was noted which was patient discomfort. 66% polyps had histology of tubovillous adenoma with low grade dysplasia. 72% polyps were regarded as complete by histopathologis. No patients were readmitted. 4 patients had adenocarcinoma.
 Conclusion(s): Pit pattern and paris classification of polyps to be entered religiously to rule out suspicious lesion. Referral pathway to facilitate the management of LNPCP to be developed. Mdt to discuss complex LNPCP. Endoscopist to be highly experienced in standard polypectomy. Primary therapeutic management of LNPCPs to be undertaken in 8 weeks.

47. Superior mediastinal lymphadenectomy in totally minimally invasive oesophagectomy for cancer: Clinical and oncological outcomes

Authors Soile O.; Shanmuganathan K.; Hussain A.; Akitikori T.; Farhangmehr N.; Sdralis E.; Lorenzi B.; Charalabopoulos A.
Source Diseases of the Esophagus; Sep 2018; vol. 31 ; p. 111
Publication Date Sep 2018
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: Minimally invasive oesophagectomy (MIO) is a challenging procedure associated with high rate of complications and mortality. The exact benefits of superior mediastinal lymphadenectomy (SML) have long been debated with no clear evidence pertaining to better outcomes for patients. With this study we aim to compare the short-term outcomes of MIOs that also underwent SML against the UK national average.
 Method(s): Thirty-nine consecutive patients underwent totally MIO under a surgical team from September 2016 to December 2017. SML included left and right paratracheal nodes (including the paratracheal retrocaval compartment) as well as the nodes along the left and right recurrent laryngeal nerves throughout their mediastinal course. Eligible patients had to have undergone SML during either a 3-stage or a 2-stage MIO. Comparisons of the following outcomes were made against the data released by the UK National Oesophago-Gastric Cancer Audit (NOGCA) 2017; anastomotic leak rate, chyle leak rate, 30-day mortality, 90-day mortality, length of stay (LOS), cardiac complications, respiratory complications, wound infection, unplanned surgery.
 Result(s): Seven patients were identified as eligible according to the criteria. 30- and 90- day mortality was reduced in the participant group compared to national average (0% vs 1.9% and 0% vs 3.3% respectively). Wound infection and cardiac complications were also reduced in the participant group (0% vs 5.3% and 0% vs 2.8% respectively). There were no anastomotic or chyle leaks noted (vs National 3.8% and 6.3% respectively), but conversely rate of respiratory complications was considerably higher in our group (42.8% vs 16.9%). There was 1 right recurrent laryngeal nerve palsy noted. Median LOS was longer in the sample group (16 vs 12 days), with no reoperations (0 vs 10.2%). Median total lymph node count was 45 (IQR, 37-68), with median SML count being 8 (IQR, 5-22).
 Conclusion(s): The small sample size is immediately recognised as a limiting and infuencing factor in the results of this study. However MIOs with SML may provide some, although not comprehensive, benefit in oncological outcomes without adding any further significant morbidity. Larger studies are needed to assess the role SML can play in improving patient outcomes.

48. The effect of lymph node harvest upon mortality from oesophagectomy for oesophageal adenocarcinoma: National population-based cohort study

Authors Markar S.; MacKenzie H.; Hanna G.; Varagunam M.; Brand C.; Cromwell D.; Maynard N.
Source Diseases of the Esophagus; Sep 2018; vol. 31 ; p. 12
Publication Date Sep 2018
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Background: In an era of increased utilisation of multimodality treatment for oesophageal adenocarcinoma the role of radical lymphadenectomy remains controversial. The objectives of this population-based cohort study were to evaluate the influence of lymph node harvest upon short- and long-term mortality following oesophagectomy for oesophageal adenocarcinoma, with subset analysis of patients receiving neoadjuvant therapy.

Method(s): The UK National Oesophago-Gastric Cancer Audit (NOGCA) was used to identify suitable patients operated on between 1st April 2012 and 31st March 2016. Logistic regression of confounders was used to generate predicted mortality probabilities for utilisation in Risk-Adjusted Cumulative Sum (RA-CUSUM) analysis to identify the lymph node harvest change-points associated with changes in one-, two- and three-year mortality.

Result(s): Within the three-year study period, 3883 patients were included of these 2192 patients (56%) received neoadjuvant chemotherapy. For all patients there were non-significant change-points in 1-, 2-, and 3-year mortality at 19, 27 and 19 lymph nodes respectively. For patients receiving neoadjuvant therapy change-point analysis did show statistically significant reductions in 2-year mortality (44.9% before to 39.2% after 19 lymph nodes; P = 0.017) and 3-year mortality (55.0% before to 47.4% after 20 lymph nodes; P = 0.035). 30-day and 90-day mortality and anastomotic leak were not significantly by lymph node harvest of greater than 19 lymph nodes.

Conclusion(s): The results of this national population-based cohort study suggest that at least 20 lymph nodes should be harvested during oesophagectomy given the prognostic importance in oesophageal adenocarcinoma, and the benefits to improve pathological staging of the patient and appropriately allocate adjuvant therapy.

49. Acute transient psychotic disorder precipitated by Brexit vote

Authors Katshu M.Z.U.H.
Source BMJ Case Reports; Oct 2019; vol. 12 (no. 10)
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31575521
Database EMBASE
Abstract A man in his 40s was brought to the accident and emergency department in an acute psychotic state, 3 weeks after the European Union referendum results in the UK were declared. His mental health had deteriorated rapidly following the announcement of the results, with significant concerns about Brexit. He presented as agitated, confused and thought disordered. He had auditory hallucinations, and paranoid, referential, misidentification and bizarre delusions. He recovered completely within 2 weeks after a brief admission and treatment with olanzapine. He had experienced a similar episode of much less severity 13 years previously after major work related stress which resolved completely within a few days. He was experiencing stress related to work and family prior to the current episode which could potentially have been a contributory factor. Political events can act as major psychological stressors and have a significant impact on the mental health of people, especially those with a predisposition to develop mental illness.
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50. Endocrine disorders in pregnancy

Authors Chong H.P.; Alazzani H.; Boelaert K.
Source Obstetrics, Gynaecology and Reproductive Medicine; Nov 2019; vol. 29 (no. 11); p. 301-305
Publication Date Nov 2019
Publication Type(s) Review
Database EMBASE
Abstract Endocrine disorders in pregnancy are common. Good outcomes can be achieved with multi-disciplinary care in pregnancy. The primary objective of this review is to provide the reader with an overview of national guidelines and where applicable, recent advances with regard to care of women with endocrine disorders in pregnancy. We have outlined care for a broad range of conditions ranging from diabetes and thyroid disorders, to the rarer conditions such as pheochromocytoma. In addition to the reading list below, we would encourage the reader to keep up to date with reports from the United Kingdom Obstetric Surveillance Service (UKOSS) which studies a range of uncommon conditions in pregnancy as well as the confidential enquiry into maternal and child death [Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)]. The latter is especially useful for lessons learnt from past maternal deaths, the most common cause of which were indirect maternal deaths from pre-existing medical conditions.
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51. Analyzing Hospital Transfers Using INTERACT Acute Care Transfer Tools: Lessons from MOQI

Authors Popejoy L.L.; Vogelsmeier A.A.; Alexander G.L.; Crecelius C.A.; Flesner M.; Rantz M.; Galambos C.M.; Ge B.; Canada K.
Source Journal of the American Geriatrics Society; Sep 2019; vol. 67 (no. 9); p. 1953-1959

Publication Date Sep 2019
Publication Type(s) Article
PubMedID 31188478
Database EMBASE
Abstract OBJECTIVES: We explored the differences in potentially avoidable/unavoidable hospital transfers in a retrospective analysis of Interventions to Reduce Acute Care Transfers (INTERACT) Acute Transfer Tools (ACTs) completed by advanced practice registered nurses (APRNs) working in the Missouri Quality Improvement (QI) Initiative (MOQI). DESIGN: Cross-sectional descriptive study of 3996 ACTs for 32.5 calendar months from 2014 to 2016. Univariate analyses examined differences between potentially avoidable vs unavoidable transfers. Multivariate logistic regression analysis of candidate factors identified those contributing to avoidable transfers.
Setting(s): Sixteen nursing homes (NHs), ranging from 120 to 321 beds, in urban, metro, and rural communities within 80 miles of a large midwestern city. PARTICIPANTS: A total of 5168 residents with a median age of 82 years. MEASUREMENTS: Data from 3946 MOQI-adapted ACTs.
RESULT(S): A total of 54% of hospital transfers were identified as avoidable. QI opportunities related to avoidable transfers were earlier detection of new signs/symptoms (odds ratio [OR] = 2.35; 95% confidence interval [CI] = 1.61-3.42; P <.001); discussions of resident/family preference (OR = 2.12; 95% CI = 1.38-3.25; P <.001); advance directive/hospice care (OR = 2.25; 95% CI = 1.33-3.82; P =.003); better communication about condition (OR = 4.93; 95% CI = 3.17-7.68; P <.001); and condition could have been managed in the NH (OR = 16.63; 95% CI = 10.9-25.37; P <.001). Three factors related to unavoidable transfers were bleeding (OR =.59; 95% CI =.46-.77; P <.001), nausea/vomiting (OR =.7; 95% CI =.54-.91; P =.007), and resident/family preference for hospitalization (OR =.79; 95% CI =.68-.93; P =.003).
CONCLUSION(S): Reducing avoidable hospital transfers in NHs requires challenging assumptions about what is avoidable so QI efforts can be directed to improving NH capacity to manage ill residents. The APRNs served as the onsite coaches in the use and adoption of INTERACT. Changes in health policy would provide a revenue stream to support APRN presence in NH, a role that is critical to improving resident outcomes by increasing staff capacity to identify illness and guide system change. J Am Geriatr Soc 67:1953-1959, 2019.
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52. Establishing a sustainable anaesthetic education programme at Jimma University Medical Centre, Ethiopia

Authors Burton Z.A.; Ayele Y.; McDonald P.
Source Anaesthesia and Intensive Care; Jul 2019; vol. 47 (no. 4); p. 334-342
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PubMedID 31390882
Database EMBASE
Abstract Lack of continuing education and physician anaesthetist support are commonly cited problems amongst Ethiopian anaesthetic providers. Whilst operating at Jimma University Medical Centre (JUMC), Operation Smile volunteers identified a clear need for improvement in anaesthetic care delivery at JUMC. JUMC is a 450-bed university teaching hospital 350 km southwest of Addis Ababa. At the start of this programme it had two physician anaesthetists, with the majority of anaesthesia historically having been provided by non-physician anaesthesia providers. A visiting lecturer programme was established at JUMC in 2012 following collaboration between two consultant anaesthetists, working for Operation Smile and JUMC respectively. UK trainee anaesthetists in their final years of anaesthetic training volunteered at JUMC for periods of two to six months, providing sustainable education and consistent physician anaesthetist presence to support service provision and training. Over its six-year history, nine visiting lecturers have volunteered at JUMC. They have helped establish a postgraduate training programme in anaesthesia, assisting in the provision of a future physician anaesthetist workforce. Four different training courses designed for low- and middle-income countries (LMICs) have been delivered and visiting lecturers have trained local anaesthetists in subsequent course delivery. Patient safety and quality improvement projects have included introducing the World Health Organization Surgical Safety Checklist, Lifebox pulse oximeters, obstetric spinal anaesthesia packs, improving critical care delivery and establishing two post-anaesthetic care units. Development of partnerships on local, national and global platforms were key to the effective delivery of relevant sustainable education and support. Instilling local ownership proved fundamental to implementing change in the local safety culture at JUMC. Sound mentorship from anaesthetic consultant supervisors both in the UK and in Jimma was crucial to support the UK trainee anaesthetists working in a challenging global setting. This model of sustainable capacity building in an LMIC with a significant deficit in its physician workforce could be replicated in a similar LMIC setting.
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53. Good news for the autopsy: Genomic analysis of metastatic cancer deaths

Authors Lucas S.B.
Source Journal of Clinical Pathology; Oct 2019; vol. 72 (no. 10); p. 649-650
Publication Date Oct 2019

Publication Type(s) Editorial
PubMedID 31527050
Database EMBASE

54. 1668 A National Survey: Evaluating Current Practice and Risk Assessment in Morcellation Amongst Gynecologists in the United Kingdom

Authors Ghai V.; Jan H.
Source Journal of Minimally Invasive Gynecology; 2019; vol. 26 (no. 7)
Publication Date 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Study Objective: To evaluate current practice and adherence to AAGL and BSGE power morcellation guidelines. Design(s): Multiple-choice questionnaire. Setting(s): United Kingdom. Patients or Participants: 157 NHS hospitals offering gynaecological services. Intervention(s): n/a. Measurements and Main Results: Power morcellation practice patterns, informed consent processes and outcomes over the last 12 months. We received 136 responses (87% response rate). Power morcellation was performed by a third (59, 37.6%) of all UK hospitals. The median number of gynecologists performing morcellation per organisation was 2 (Q1-Q3: 2-4). A median of 7 morcellators (Q1-Q3: 0-17) were purchased and 7 morcellators (Q1-Q3: 1.25-15.75) used per annum. A median of 10 (Q1-Q3: 2.0-15.0) laparoscopic hysterectomies and 5 (Q1-Q3: 0.5-9.0) myomectomies requiring morcellation were performed per annum. Almost, a third of trust did not perform an endometrial biopsy or MRI. 79.7% (47) of trusts consented for power morcellation and 76%, (46) explained risk of inadvertent leiomyosarcoma. 83.3%, (50) had no patient literature and almost half had no audit process 45%, (27). Conclusion(s): Current UK practice does not reflect recommendations from the AAGL or BSGE. Deficiencies were identified in pre-operative evaluation, local governance procedures, and consenting practices regarding use of a power morcellator and risk of occult leiomyosarcoma. Copyright © 2019

55. Routine use of feeding jejunostomy in oesophageal cancer resections: results of a survey in England

Authors Tham J.C.; Dovell G.; Berrisford R.G.; Humphreys M.L.; Wheatley T.J.; Sanders G.; Ariyaratnam A.V.
Source Diseases of the esophagus : official journal of the International Society for Diseases of the Esophagus; Oct 2019
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31608935
Database EMBASE
Abstract Nutrition and post-operative feeding in oesophageal cancer resections for enhanced recovery remain a controversial subject. Feeding jejunostomy tubes (FJT) have been used post-operatively to address the subject but evidence to support its routine use is contentious. There is currently no data on FJT use in England for oesophageal cancer resections. Knowledge regarding current FJT usage, and rationale for its use may provide a snapshot of the trend and current standing on FJT use by resectional units in England. A standardised survey was sent electronically to all oesophageal resectional units in the United Kingdom (UK) between October 2016 and January 2018. In summary, the questionnaire probes into current FJT use, rationale for its usage, consideration of cessation of its use, and rationale of cessation of its use for units not using FJT. The resectional units were identified using the National Oesophago-Gastric Cancer Audit (NOGCA) progress report 2016 and 1 selected resectional unit from Northern Ireland, Scotland, and Wales, respectively. Performance data of those units were collected from the 2017 NOGCA report. Out of 40 units that were eligible, 32 (80.0%) centres responded. The responses show a heterogeneity of FJT use across the resectional centres. Most centres (56.3%) still place FJT routinely with 2 of 18 (11.1%) were considering stopping its routine use. FJT was considered a mandatory adjunct to chemotherapy in 3 (9.4%) centres. FJT was not routinely used in 9 (28.1%) of centres with 5 of 9 (55.6%) reported previous complications and 4 of 9 (44.4%) cited using other forms of nutrition supplementation as factors for discontinuing FJT use. There were 5 (15.6%) centres with divided practice among its consultants. Of those 2 of 5 (40.0%) were considering stopping FJT use, and hence, a total of 4 of 23 (17.4%) of units are now considering stopping routine FJT use. In conclusion, the wider practice of FJT use in the UK remains heterogenous. More research regarding the optimal post-operative feeding regimen needs to be undertaken. Copyright © The Author(s) 2019. Published by Oxford University Press on behalf of International Society for Diseases of the Esophagus. All rights reserved. For permissions, please e-mail: journals.permissions@oup.com.

56. Cost-effectiveness of a national quality improvement programme to improve survival after emergency abdominal surgery

Authors Yang F.; Walker S.; Richardson G.; Stephens T.; Pearse R.M.; Phull M.; Thompson A.
Source International journal of surgery (London, England); Oct 2019
Publication Date Oct 2019

Publication Type(s) Article
PubMedID 31604139
Database EMBASE
Abstract BACKGROUND: Patients undergoing emergency abdominal surgery are exposed to high risk of death. A quality improvement (QI) programme to improve the survival for these patients was evaluated in the Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial. This study aims to assess its cost-effectiveness versus usual care from a UK health service perspective.
METHOD(S): Data collected in a subsample of trial participants were employed to estimate costs and quality-adjusted life years (QALYs) for the QI programme and usual care within the 180-day trial period, with results also extrapolated to estimate lifetime costs and QALYs. Cost-effectiveness was estimated using incremental cost-effectiveness ratios (ICERs). The probability of being cost-effective was determined for different cost-effectiveness thresholds (13,000 to 30,000 per QALY). Analyses were performed for lower-risk and higher-risk subgroups based on the number of surgical indications (single vs multiple).
RESULT(S): Within the trial period, QI was more costly (467) but less effective (-0.002 QALYs). Over a lifetime, it was more costly (1395) and more effective (0.018 QALYs), but did not appear to be cost-effective (ICER: 77,792 per QALY, higher than all cost-effectiveness thresholds; probability of being cost-effective: 28.7% to 43.8% across the thresholds). For lower-risk patients, QI was more costly and less effective both within trial period and over a lifetime and it did not appear to be cost-effective. For higher-risk patients, it was more costly and more effective, and did not appear cost-effective within the trial period (ICER: 158,253 per QALY) but may be cost-effective over a lifetime (ICER: 14,293 per QALY).
CONCLUSION(S): The QI programme does not appear cost-effective at standard cost-effectiveness thresholds. For patients with multiple surgical indications, this programme is potentially cost-effective over a lifetime, but this is highly uncertain.
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57. Variation in responsiveness to warranted behaviour change among NHS clinicians: Novel implementation of change detection methods in longitudinal prescribing data

Authors Walker A.J.; Powell-Smith A.; Goldacre B.; Pretis F.
Source The BMJ; 2019; vol. 367
Publication Date 2019
Publication Type(s) Article
PubMedID 31578187
Database EMBASE
Abstract Objectives To determine how clinicians vary in their response to new guidance on existing or new interventions, by measuring the timing and magnitude of change at healthcare institutions. Design Automated change detection in longitudinal prescribing data. Setting Prescribing data in English primary care. Participants English general practices. Main outcome measures In each practice the following were measured: the timing of the largest changes, steepness of the change slope (change in proportion per month), and magnitude of the change for two example time series (expiry of the Cerazette patent in 2012, leading to cheaper generic desogestrel alternatives becoming available; and a change in antibiotic prescribing guidelines after 2014, favouring nitrofurantoin over trimethoprim for uncomplicated urinary tract infection (UTI)). Results Substantial heterogeneity was found between institutions in both timing and steepness of change. The range of time delay before a change was implemented was large (interquartile range 2-14 months (median 8) for Cerazette, and 5-29 months (18) for UTI). Substantial heterogeneity was also seen in slope following a detected change (interquartile range 2-28% absolute reduction per month (median 9%) for Cerazette, and 1-8% (2%) for UTI). When changes were implemented, the magnitude of change showed substantially less heterogeneity (interquartile range 44-85% (median 66%) for Cerazette and 28-47% (38%) for UTI). Conclusions Substantial variation was observed in the speed with which individual NHS general practices responded to warranted changes in clinical practice. Changes in prescribing behaviour were detected automatically and robustly. Detection of structural breaks using indicator saturation methods opens up new opportunities to improve patient care through audit and feedback by moving away from cross sectional analyses, and automatically identifying institutions that respond rapidly, or slowly, to warranted changes in clinical practice.
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58. Care Quality Commission spotlights effective quality improvement initiatives

Authors Glasper A.
Source British journal of nursing (Mark Allen Publishing); Nov 2018; vol. 27 (no. 20); p. 1202-1203
Publication Date Nov 2018
Publication Type(s) Article
PubMedID 30418854
Database EMBASE
Abstract Emeritus Professor Alan Glasper, from the University of Southampton, discusses a recent report showing how trusts rated as outstanding by the regulator have embedded a culture of change that involves all staff.

59. 2921 Trends in Endometrial Hyperplasia Over the Past Decade - Is It on the Increase?

Authors Skelly C.; Breen J.; Johnston K.M.
Source Journal of Minimally Invasive Gynecology; 2019; vol. 26 (no. 7)
Publication Date 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Study Objective: Atypical Hyperplasia carries a 30% risk of developing endometrial cancer over 20 years. Endometrial cancer has increased by 54% since the 1998. Overall hysterectomy rates are falling, and obesity increases. We reviewed 3 snapshot years over 10 years, in terms of hyperplasia numbers, management and surveillance.
 Design(s): Retrospective case note audit with histological diagnosis of endometrial hyperplasia with or without atypia for 2008, 2013 and 2018.
 Setting(s): Northern Health and Social Care Trust, Northern Ireland Patients or Participants: 74 patients with a histological diagnosis of endometrial hyperplasia with or without atypia were identified.
 Intervention(s): Medical treatment or hysterectomy.
 Measurements and Main Results: * Endometrial Hyperplasia incidence 2008 - 19 cases (23% atypical / 77% without atypia); 2013 - 24 cases (42% atypical / 58% without atypia) and 2018 - 31 cases (29% atypical / 71% without atypia). * Mean BMI was 35, 39 and 36 in 2008, 2013 and 2018 respectively. * Age range 33 - 80 years. Mean age 2008 - 59; 2013 - 56; 2018 - 53. * 74% (n=17) with atypical hyperplasia underwent hysterectomy. 26% (n=6) had medical treatment with levonorgestrel IUS or oral progestogens, and surveillance due to surgical unsuitability or patient choice. * Hyperplasia without atypia was managed conservatively with progestogens and surveillance in 71% (n= 36) whilst 29% (n= 15) underwent hysterectomy; persistent bleeding in the absence of progressive histology being the main indication. * 84% (n= 26) of 2018 cohort were followed up according to 2016 Royal College of Obstetricians and Gynaecologists guidance.
 Conclusion(s): Overall hyperplasia incidence is increasing. While BMI is elevated, there was no upward trend observed. Does the insidious decline in age demographic suggest that hyperplasia is occurring in younger women? Our review did not demonstrate a continuous increase in atypia, however there was a higher incidence in the 2013 group, who were also the most obese. Adherence to best practice surveillance in our hospitals was falling short.
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60. 2898 200 Cases of Endometrial Cancer - 10 Year Outcomes

Authors Skelly C.; Wilson S.; McCracken G.
Source Journal of Minimally Invasive Gynecology; 2019; vol. 26 (no. 7)
Publication Date 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Study Objective: To investigate the outcomes of 200 women with early stage Endometrial Cancer managed at a District General Hospital over a 10 year period.
 Design(s): Retrospective audit of 200 patients with confirmed endometrial cancer, within one Trust in Northern Ireland, from 2009-2018. Information was collected from Northern Ireland Electronic Care Record, and subsequently analyzed using Microsoft Excel.
 Setting(s): Southern Health and Social Care Trust, Northern Ireland Patients or Participants: 200 patients were identified from one surgeon's database of recorded cases Interventions: N/A
 Measurements and Main Results: 88% were overweight or obese, 74% presented with postmenopausal bleeding, 54% women underwent total laparoscopic hysterectomy (TLH), 28.5% abdominal hysterectomy, 13.5% vaginal hysterectomy (VH), 3.5% Laparoscopic assisted vaginal hysterectomy (LAVH), 0.5% transcervical resection and mirena. Overall complication rate was 5% for both laparoscopic and abdominal hysterectomy groups, 1% for vaginal and LAVH. Breakdown of specific complications available. Conversion rate from laparoscopic to open hysterectomy was 3.6%. Pre-operative histology compared with hysterectomy specimen matched in 78% cases. 3% were significantly upgraded from low to high grade. Pre-operative radiological staging matched the hysterectomy specimen in 69% of cases. 6% were upstaged from Stage 1, to Stage 2 or 3. Overall confirmed recurrence rate was 2.5%. None were detected through standard follow-up pathways.
 Conclusion(s): This study supports the strong association between high BMI and endometrial cancer. Despite obesity presenting significant surgical challenges, complication rates are low considering the patient demographic. The shortest median length of stay was with vaginal and laparoscopic hysterectomy. Preoperative grading and staging are relatively accurate in our department. Confirmed recurrence rates are low, although a significant proportion of patients are still in follow-up. Clinical follow-up is not useful in detecting recurrence in the majority of patients, which supports a Self Directed Aftercare approach in the majority of early stage endometrial cancers.
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61. 2887 Hysterectomy after Failed Endometrial Resection and Endometrial Ablation Techniques. Can We Work Out When It is Going to Fail?

Authors Skelly C.; Sheehan E.; Niblock K.; Johnston K.M.
Source Journal of Minimally Invasive Gynecology; 2019; vol. 26 (no. 7)
Publication Date 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Study Objective: Heavy Menstrual Bleeding is the most common reason for gynaecological consultation in the United Kingdom. We aimed to identify factors that may contribute to failed ablation/resection of endometrium, to improve future patient selection and counselling.
Design(s): Retrospective audit was performed for women who underwent hysterectomy, January 2012 - December 2018, following a Thermablate, NovaSure, or transcervical resection of endometrium (TCRE).
Setting(s): Northern Health and Social Care Trust, Northern Ireland. Patients or Participants: 85 patients were identified by clinical coding department.
Intervention(s): N/A.
Measurements and Main Results: Mean age at hysterectomy was 43 years, Average body mass index (BMI) was 31.73 kg/m². 87% underwent a pre-operative pelvic ultrasound scan, of these 32% had fibroids detected. 72% underwent endometrial ablation using Thermablate, 17% NovaSure, 2% Thermablate followed by NovaSure, 2% had Thermablate twice, performed nine months apart, and 7% patients had transcervical resection of the endometrium. 47% had a trial of Mirena IUS prior to ablation. Mean ablation to hysterectomy interval was 23 months. The main indication for hysterectomy was heavy menstrual bleeding (75%), followed by pelvic pain (13%), then both heavy menstrual bleeding and pelvic pain (11%). Mean specimen weight at hysterectomy was 183g. Abnormal pathology was confirmed in 70% of hysterectomy specimens (Fibroids 54%, adenomyosis 14% and combined pathology including fibroids, adenomyosis, simple hyperplasia and endometriosis in 32%. Dysmenorrhoea, parity, previous normal vaginal deliveries/caesarean section, BMI and type of ablation did not reach clinical significance in terms of predictive parameters.
Conclusion(s): When ablation/ resection fails our results demonstrated that the pre-operative demographics above were a poor predictor. Associated identified pathologies particularly fibroids and adenomyosis suggests that pre-operative diagnosis of these would be valuable in optimizing patient selection and counselling.
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62. Osteoradionecrosis rates in patients receiving radical radiotherapy for head and neck cancer at the Royal United Hospital Bath

Authors Wade L.; Fitton J.; Colbert S.; De Winton E.
Source Clinical Oncology; Oct 2019; vol. 31
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Head & neck. Background to the audit: Osteoradionecrosis (ORN) is a recognised complication of radiotherapy for head and neck cancer. We have reviewed our local rates of this complication and the predisposing risk factors to identify ways to reduce the incidence. Standard: An international systematic review reported the rate of ORN in patients undergoing radiotherapy treatment to be 7% (1), but this data includes patients treated with outdated radiotherapy planning techniques. Results from a UK institution, treating a high proportion of patients with IMRT, are published at 5.5% (2). Indicator: Rate of ORN in patients treated with radical radiotherapy for head and neck cancer at our hospital. Target: To ensure ORN rates in line with reported rates in UK practice. Methodology: 176 patients who received radical radiotherapy for head and neck cancer at our centre from 2015 to 2017 had their notes reviewed. ORN cases were identified and data collected on site, severity, time to development, the pre treatment dental assessment, average dose to mandible and other risk factors for ORN like smoking. Results of first audit round: 7 cases of ORN were identified - a rate of 3.97%. These patients all had additional risk factors for ORN. 100% of patients had a pre treatment dental check with the majority receiving prophylactic extractions. Average dose to the mandible ranged from 36 to 51Gy. Poor recording of periodontal status, variability between dental assessments and limited feedback from oral surgery to clinical oncology teams was noted. First action plan: To introduce a dental assessment proforma to improve recording, standardise outcomes and facilitate feedback between teams. Results of second audit round: We will reaudit after introduction of the proforma, it may be possible to build information from dental assessments into our radiotherapy planning process to further reduce dose to areas at risk. References: 1. S. Nabil, N. Samman. Incidence and prevention of osteoradionecrosis after dental extraction in irradiated patients: a systematic review. International Journal of Oral and Maxillofacial Surgery, Volume 40, Issue 3, 2011, Pages 229-243. 2. De Felice F, et al. Osteoradionecrosis following treatment for head and neck cancer and the effect of radiotherapy dosimetry: the Guy's and St Thomas' Head and Neck Cancer Unit experience. Oral Surgery, Oral Medicine, Oral Pathology and Oral Radiology. Volume 122, Issue 1, 2016, Pages 28-34.
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63. An audit of 30 and 90 day mortality following radiotherapy

Authors Shaw R.; Parikh O.; Chatten N.
Source Clinical Oncology; Oct 2019; vol. 31
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Radiotherapy. Background to the audit: Audit of 30 day mortality following palliative radiotherapy has been recommended by the Cancer Strategy(1) as an indicator of avoidable harm, and recommended by the RCR. The recent radiotherapy service specifications(2) recommend audit of 30 day mortality following adult palliative radiotherapy and 90 day mortality following adult radical radiotherapy. Standard: No national standard exists. Other published data recommends levels of 13% 30 day mortality following palliative radiotherapy and 2.3% 90 day mortality following radical radiotherapy Lerner(3). Indicator: The proportions of patients dying within 30 days of receiving palliative radiotherapy, and within 90 days of receiving radical radiotherapy. Target: Early mortality rates should be comparable with other centres, and in line with RCR recommendations(4). Methodology: A single centre retrospective audit was conducted at the Rosemere Cancer Centre in Preston. Using the MOSAIQ scheduling system, all patients undergoing external beam radiotherapy during 2017 were identified. Data collected included palliative or radical intent, fractionation, primary diagnosis, site of treatment, and date of first treatment. Death data was acquired from the national registry. Results of first audit round: A total of 3712 patients were treated during 2017. Of these patients, 2600 patients were treated radically, and 1112 patients were treated with a palliative intent. 28 radical patients died within 90 days of treatment, constituting 1.08%. 108 palliative patients died within 30 days of treatment, constituting 9.71%. First action plan: These results are in line with other centres. Analysis of performance status in future audits. Separate analysis of MSEC data of 14 day mortality following radiotherapy, may be more appropriate for this group of patients. Re-audit annually. References: 1. Improving outcomes: A strategy for cancer. January 2011. Department of Health. 2. NHS England, 2019. Schedule 2 - The Services. Adult External Beam Radiotherapy Services Delivered as Part of a Radiotherapy Network [online]. London: National Health Service. Available from: [Accessed 28 March 2019]. 3. Lerner, A. Phillips, I. and Ezhil, V. Early mortality following radiotherapy - meeting standards and improving patient selection. Clinical Oncology. 2015;27:S5-S6. 4. Lees, K. 2012. Audit of 30 day mortality following radiotherapy [online]. Available from: [Accessed 4 April 2019]. Copyright © 2019

64. Early stage breast cancer and radiotherapy practice in a developing country

Authors van Griethuysen J.; Brooks C.
Source Clinical Oncology; Oct 2019; vol. 31
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Other.
 Purpose(s): To compare and contrast radiotherapy practice for early stage breast cancer in Nepal with current UK practice. Methods and materials: All women who underwent radiotherapy for breast cancer following breast-conserving surgery over a one-year period (December 2017-November 2018) at a single centre in Nepal were identified (n=51). Although our study was conducted at a single centre it is currently one of only three centres in the country with a linear accelerator. Data was retrospectively collected using electronic records and compared with the results of The Royal College of Radiologists' national breast cancer audit (published 2013). Result(s): The mean age of our population was 45 years [range 26-66 years] compared to 60 years in the UK [range 25-92 years]. The histological subtypes were; 37% ductal, 2% lobular and 57% carcinoma of undefined type compared to 87.2% ductal and 9.3% lobular in the UK population. 35% of tumours were T1, 57% were node negative and 49% were oestrogen receptor positive compared to 66.3%, 74.1% and 83.9% respectively in the UK population. 86% of cases were treated with hybrid intensity modulated radiotherapy (IMRT) and 0% with deep inspiratory breath hold. 100% of patients received a boost (35.6% in the UK) and this was delivered sequentially in 100% of cases. The most common fractionation used was 40.05 Gray (Gy) in 15 fractions with a boost of 10 Gy in 5 fractions.
 Conclusion(s): Our study population was younger and had more advanced disease compared to the UK population. The change in practice in radiotherapy fractionation as demonstrated by the START trial has been adopted in Nepal. The difficulties of accurate pathological classification, implementation of more complex radiotherapy techniques and need for improved education and access to healthcare have been highlighted. Copyright © 2019

65. Audit of Turnaround Time for external PET-CT referrals. Are we fit for the future?

Authors Gomes Moura A.; Soneji N.; Alves L.; Win Z.
Source Clinical Oncology; Oct 2019; vol. 31
Publication Date Oct 2019
Publication Type(s) Conference Abstract

Database EMBASE
Abstract Category: Service quality. Background to the audit: This audit aimed to determine the time between external referral receipt and report authorisation for PET-CT studies at our institution and assess for causes of delays. Standard: The standard is the impending NHS England targets: 7 days from referral to report. Indicator: Time between external referral receipt and report authorisation. Target: Authorise all external PET/CT referrals within 7 days from referral receipt. Methodology: Data was retrieved using the statistics unit of the radiology information system (RIS) for patient's referred to our Trust for a PET-CT scan that were scanned between 01/07/2018 and 30/09/2018. Out of 93 patient's records retrieved from Soliton statistics, only 28 entries could be fully analysed once inclusion and exclusion criteria was applied. Results of first audit round: The target of 7 days turnaround time from referral to report authorisation was only achieved for 4 patients (16% of the analysed sample). The average number of days from referral received to report authorised was 17.54 days, with a range from 3 to 86 days. First action plan: Only a few external referrals meet the target turnaround time of PET-CT studies. This is predominately due to external referral booking processes and limited scanning capacity. This has been addressed by booking team training and extended hours scanning and a re-audit will be performed to assess for improvement. Reference: (PET12 indicator).
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66. Lung stereotactic ablative body radiotherapy (SABR): Patient outcomes from Edinburgh and South-east Scotland

Authors Mactier K.; Phillips I.; Siddiqui S.; Little F.
Source Clinical Oncology; Oct 2019; vol. 31
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Lung. Background to the audit: Stereotactic ablative body radiotherapy (SABR) has become the non-surgical treatment of choice for stage I and II non-small cell lung cancer (NSCLC). It is important that local practice outcomes reflect nationally accepted standards. We present data from patients treated with this technique at the Edinburgh Cancer Centre 2013-18. Standard: The survival rates for NSCLC patients treated SABR should be at least equivalent to that presented in the UK SABR Consortium Guidelines [1] and in line with similar series from other centres. Indicator: 1. Overall survival (OS) at 12, 24 and 36 months. 2. Local control (LC) rate at 12, 24 and 36 months. Target: 1. 82.8%, 54.5% and 57.7% respectively. 2. 91.8%, 86.9%, 80.6% respectively. Methodology: A database was kept of all patients who underwent SABR treatment at the ECC. This included patient demographics, tumour size, histology and radiotherapy. Disease status was assessed by reviewing the radiologists' reports on the NHS Scotland Picture Archive System (PACS). Mortality data was obtained from electronic patient record systems (Trakcare and SCL eResults). Statistical analysis was undertaken using SPSS 25 and Microsoft Excel. Results of first audit round: One hundred and forty-eight patients were included. Eight-one (54.7%) were female, mean age 74.1 years (range 52-93). Five patients had more than one site treated with SABR, in these cases only the first treatment was included. Tumour stages n(%) were as follows: T1a 12 (8%); T1b 81 (55%); T1c 41 (28%) T2a 12 (8%), T2b 2 (1%) OS at 12, 24 and 36 months in our cohort were 87.2%, 79.7% and 71.6% respectively. LC rates at 12, 24 and 36 months were 98.6%, 97.4% and 95.4% respectively, corresponding to 5 local relapses in the first 3 years of follow-up. First action plan: Our OS and LC rates were similar to, or better than, other published series [1-4]. References: 1. UK SABR Consortium Guidelines 2016. 2. Timmerman R, JAMA 2010; 303 (11) p 1070-1076. 3. Chi A et al., Radiother & Oncol 2010; 94 p1-1119. 4. Murray P et al., BJR 2017; 90(1071): 20160732.
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67. Machine learning methods applied to audit of surgical outcomes after treatment for cancer of the head and neck

Authors Tighe D.; Lewis-Morris T.; Freitas A.
Source British Journal of Oral and Maxillofacial Surgery; Oct 2019; vol. 57 (no. 8); p. 771-777
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31358374
Database EMBASE

Abstract Most surgical specialties have attempted to address concerns about unfair comparison of outcomes by "risk-adjusting" data to benchmark specialty-specific outcomes that are indicative of the quality of care. We are building on previous work in head and neck surgery to address the current need for a robust validated means of risk adjustment. A dataset of care episodes, which were recorded as a clinical audit of complications after operations for squamous cell carcinoma (SCC) of the head and neck (n = 1254), was analysed with the Waikato Environment for Knowledge Analysis (WEKA) machine learning tool. This produced 4 classification models that could predict complications using data on the preoperative demographics of the patients, operation, functional status, and tumour stage. Three of them performed acceptably: one that predicted "any complication" within 30 days (area under the receiver operating characteristic curve (AUROC) 0.72), one that predicted severe complications (Clavien-Dindo grade 3 or above) within 30 days (AUROC 0.70), and one that predicted a prolonged duration of hospital stay of more than 15 days, (AUROC 0.81). The final model, which was developed on a subgroup of patients who had free tissue transfer (n = 443), performed poorly (AUROC 0.59). Subspecialty groups within oral and maxillofacial surgery are seeking metrics that will allow a meaningful comparison of the quality of care delivered by surgical units in the UK. For these metrics to be effective they must show variation between units and be amendable to change by service personnel. Published baseline data must also be available. They should be modelled effectively so that meaningful comparison, which takes account of variations in the complexity of the patients' needs or care, is possible.
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68. Adequacy of trauma c-spine X-rays: a case for;straight to CT?

Authors Munjal I.; Ng C.; Imtiaz Z.; Cooper R.; Cope L.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: MSK. Background to the audit: Plain film cervical spine (c-spine) imaging is commonly used to assess suspected injuries and is the firstline option where computed tomography (CT) is not available. Accurate assessment of c-spine injuries using plain film can be problematic.¹ To reduce missed injuries, plain films should be diagnostic in quality, and where appropriate, CT may be performed instead. Standard: C-spine radiographs should be of diagnostic quality and meet National Institute for Health and Care Excellence (NICE) and The Royal College of Radiologists' (RCR) iRefer guidelines.^{2,3} Indicator: % of plain radiographs with three projections and adequately visualised anatomy. % of scans with clinical details that meet referral guidelines. Target: 100% of c-spine radiographs should be diagnostic in quality and where not possible, reasonable attempts made. 100% of radiological examinations should be justifiable. Methodology: Retrospective analysis of plain film and CT examinations of the cervical spine performed in 2017 and 2018. Results of first audit round: Half of plain film studies were assessed as adequate. CT was performed after plain film in 10% of patients, of which 1% overall had a fracture. 16% of CTs performed firstline had a fracture. 56% of plain film requests met referral criteria compared to 100% in CT. First action plan: Developed a new 'straight to CT' protocol that advised CT as firstline imaging modality for suspected c-spine fractures in patients over 65 or with a 'brittle spine'. Raise awareness with main referring body (emergency department). Results of second audit round: 57% increase in CT performed, from 7.5 to 11.9 per month. 72 patients met criteria in 'straight to CT' protocol with 15% of patients having a fracture. Adequacy of c-spine plain films was unchanged. CT was performed after plain film in 11% of patients, of which 2% overall had a fracture. 73% of plain film requests met referral criteria compared to 97% in CT. Second action plan: Further re-enforcement of new departmental protocol needed to create lasting and meaningful impact. References: 1. Woodring JH, Lee C. Limitations of cervical radiography in the evaluation of acute cervical trauma. J Trauma 1993; 34(1): 32-39. 2. National Institute for Health Care Excellence. Spinal injury: assessment and initial management. London: National Institute for Health and Care Excellence, 2016. 3. Parizel PM, van der Zijden T, Gaudino S, Spaepen M, Voormolen MHJ, Venstermans C et al. Trauma of the spine and spinal cord: imaging strategies. Eur Spine J 2009; 19(S1): 8-17.
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69. Audit to assess compliance with the RCR/SCoR guideline: The radiological investigation of suspected physical abuse in children

Authors Gladwell C.; Simpson E.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Category: Paediatrics. Background to the audit: The Royal College of Radiologists (RCR) and Society and College of Radiographers (SCoR) issued new guidance on the investigation of suspected physical abuse in 2017 containing updates on required views, reporting timescales and recommendation for follow-up skeletal surveys. Standard: RCR/SCoR 2018. The radiological investigation of suspected physical abuse in children. Revised first edition. Indicator: Percentage compliance. Target: 100% Methodology: Retrospective data collection of 20 cases from July-October 2018 at Bristol Royal Hospital for Children using the radiology information system and picture archiving and communication system. Results of first audit round: Initial skeletal survey: * 13/20 (65%) were conducted within 24 hours. When excluding three cases delayed for clinical reasons, 13/17 (76%) were conducted within 24 hours. * 14/20 (70%) obtained the recommended views obtained. When excluding five cases that deviated for clinical reasons, 14/15 (93%) complied with the standard views. * 100% obtained by two named radiographers. * 498/533 (93%) of films were of adequate quality. * 15/20 (75%) reported within 24 hours. * 19/20 (95%) conducted and reported within 72 hours of request. Follow up skeletal survey: * 16/16 (100%) were conducted at our institute within the 28 days. * 16/16 (100%) obtained the standard views by two named radiographers. * 12/16 (75%) were reported within 72 hours. Neurological: * 17/17 (100%) of children under one year had neurological imaging. First action plan: 1. Feedback results to team to encourage good work on initial skeletal survey but flag the importance of timely reporting of the follow-up skeletal survey. 2. Future audits to more accurately quantify 'time of request' as the time that the study was discussed with radiology and vetted/accepted. Consider electronic prompt when requesting. References: 1. Colney, BD. Caffey's Pediatric Diagnostic Imaging. (13th edn). Philadelphia: Elsevier, 2019. 2. The Royal College of Radiologists and Society and College of Radiographers. The radiological investigation of suspected physical abuse in children. Revised first edition. London: The Royal College of Radiologists, 2018
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70. Imaging according to NICE head injury guidelines - an audit of requesting and reporting over three years

Authors

Ward D.; Dwivedi K.; Tse G.; Martin A.; Connolly D.J.A.; Burton E.

Source

Clinical Radiology; Oct 2019; vol. 74

Publication Date

Oct 2019

Publication Type(s)

Conference Abstract

Database

EMBASE

Abstract

Category: Service quality. Background to the audit: The National Institute for Health and Care Excellence (NICE) head injury guidelines state specific indications for computed tomography (CT) examinations and advise that they should be reported within one hour. As radiology and emergency department (ED) workloads increase, barriers exist to timely reporting. Following guidelines should allow prioritisation of high-risk patients and reduce unnecessary tests. Standard: 1. Clinical indication for CT head meets NICE criteria in 100% of cases. 2. 100% of ED CT heads reported within one hour. Indicator: 1. Indication for CT head. 2. Time from scan to written radiology report. Target: 100% compliance. Methodology: Picture archiving and communication system (PACS)/radiology information system (RIS) were accessed for requesting information and reports. Clinical details were checked against NICE criteria. The first report (provisional or direct final) was reviewed to check compliance with the one-hour target. Results of first audit round: 102 CT heads from October 2015 were reviewed, of 547 performed that month. Clinical details were insufficient in 14 cases (13.7%). 30 studies were reported formally without a provisional report. 83 studies (81.3%) were reported within one hour. First action plan: Present findings. Implement independent registrar final CT head reporting. Results of second audit round: Of 625 studies performed in October 2018 (14% increase in workload), 101 were reviewed. Clinical information was insufficient in 36 (35.6%) cases. 41 studies were reported formally without a provisional. 77 studies (76.2%) were reported within one hour. Compliance with NICE guidance has reduced over time. Fewer studies are being reported within one hour and growing overnight studies suggests worsening workload pressure. Reports are increasingly verified without a provisional report due to competent registrars being able to formally report studies. Second action plan: Present findings. Consider additional ways of improving the quality of requests and ensuring timely reporting. Regularly re-audit. Reference: 1. National Institute for Health and Care Excellence. NICE clinical guideline 176. Head injury: assessment and early management. London: National Institute for Health and Care Excellence, 2017.
Copyright © 2019

71. Adequacy of clinical information on requests with reference to the Ottawa knee rules

Authors

Rahman S.; Bailey H.; Duncan K.

Source

Clinical Radiology; Oct 2019; vol. 74

Publication Date

Oct 2019

Publication Type(s)

Conference Abstract

Database

EMBASE

Abstract Category: Appropriateness of referral. Background to the audit: The Ottawa knee rule has demonstrated potential for reducing the need for unnecessary radiography in knee trauma. Numerous studies have demonstrated that the Ottawa knee rule is highly sensitive in identifying patients who require a radiograph to exclude fracture.¹⁻³ Standard: Ottawa knee rules state that for patients presenting with a history of knee trauma, radiographs of the knee are only required if patient meet at least one of the five criteria: 1. Age 55 years or older 2. Tenderness at head of fibula 3. Isolated tenderness of patella 4. Inability to flex knee to 90 degrees 5. Inability to bear weight both immediately and in the emergency department (four steps). Indicator: Percentage of referrals providing adequate clinical information with reference to the Ottawa knee rules. Target: 95% Methodology: Retrospective review of emergency department referrals over a one-month period. Referral details collected using electronic system for imaging. 104 knee radiographs carried out in this time period for knee trauma. Exclusion criteria were patients involved in polytrauma (n=7), age <16 years and presentations of non traumatic knee pain (n=12). Results of first audit round: Sample size of 85 patients. Percentage of referrals providing adequate clinical information with reference to the Ottawa knee rule = 61%. Worst performance in recording ability to flex to 90 and weight-bearing status. First action plan: 1. Education of radiology and emergency department staff regarding Ottawa knee rule. 2. Laminated posters beside emergency department computers. Results of second audit round: Sample size of 81 patients. Improvement in percentage of referrals providing adequate clinical information, increased to 72%. Second action plan: 1. Induction for new staff to include reference to Ottawa knee rule 2. Introduce electronic version of rules onto referral. 3. Re-audit in one year References: 1. Bulloch B et al. Validation of the Ottawa knee rule in children: a multicenter study. Ann Emerg Med 2003; 42(1): 48-55. 2. The Royal College of Radiologists. RCR iRefer guidelines: Making the best use of clinical radiology. London: The Royal College of Radiologists, 2017. 3. Bachmann LM, Haberzeth S, Steurer J, Lang ES. Review: the Ottawa knee rule accurately rules out knee fractures and can substantially reduce the need for x rays in patients with acute knee injuries. Evid Based Med 2004; 9: 151. Copyright © 2019

72. Email helpline for non-urgent radiological advice - experience in North Wales

Authors Chen J.; Corr C.; Govind P.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Service quality. Background to the audit: An email helpline was setup in 2017 in the radiology department at Wrexham Maelor Hospital to provide general practitioners within the Betsi Cadwaladr catchment a direct platform to non-urgent radiological advice and to streamline the consultation process within the radiology department. We completed two audit cycles and a survey to assess the usage and performance of the platform. Standard: Radiology advice should be given in a timely manner to primary care colleagues. The advice given should be succinct and clinically relevant. Submission of queries should be done securely with adherence to trust information governance. Queries should be appropriate for the platform. Indicator: Advice was given in a timely manner and clinically relevant to the question asked. Queries were submitted securely and appropriately. Target: 90% of queries answered within two working days. 100% of request should be submitted using secure NHS Wales email, appropriate per platform usage guideline, and request should be submitted in accordance to information governance guidelines. Methodology: Review of all queries within the mailbox from February 2017 to December 2018 (first cycle) and from January 2018 to June 2018 (second cycle). Data collected and analysed on Excel spreadsheet. Survey conducted using SurveyMonkey - sent to all users of the platform and data collected anomalously. Results of first audit round: Response rate - 88% within 48 hours (99% within five working day, longest delay six days). Appropriateness of query - 97%. Security - 99% of query sent securely on NHS Wales email. Information governance - 71% conformance to guideline. First action plan: Present result to department at local audit meeting. Result also presented to general practice (GP) colleague at local primary care meeting - reiterated/discussed/re-distributed platform and information governance guidelines to platform users. Longest delay caused by some confusion as to which consultant is covering the mailbox that week at the inception of the platform. The platform now supervised by two named consultants. Planned survey to collect direct user feedback - to further develop the platform and address weaknesses/pitfalls, if any. Results of second audit round: Response rate - 85% within 48 hours (96% within five working day, longest delay 15 days). Appropriateness of query - 100%. Security - 100% of query sent securely on NHSWales email. Information governance - 76% conformance to guideline. SurveyMonkey Result - Overwhelmingly, our GP colleagues found the platform useful in their day-to-day clinical practice, with the clinical information given relevant and within a reasonable amount of time. Copyright © 2019

73. Adequacy of modified CT urogram technique and its impact on the opacification of urinary tract using simplified scoring system

Authors Atiq Siddiqui S.; MacKenzie N.
Source Clinical Radiology; Oct 2019; vol. 74

Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Service quality. Background to the audit: Computed tomography urogram (CTU) is the choice of imaging for workup of macroscopic haematuria.¹ Various techniques of CTU have been described in the literature with modification over the past decade.^{2,3} Distal ureter remains the most difficult segment to opacify.⁴ We found suboptimal opacification of urinary tract in CTU which lead to ambiguity and further unnecessary investigations. Standard: No UK national guideline or standard for CTU. Locally agreed standard and target. Indicator: Optimal urinary tract opacification. Target: 90% (score of 5.4/6). Methodology: We included 52 consecutive patient in intial audit with pre-existing protocol followed by modified triple split bolus protocol (introducing 'Table Roll-over' 360 degrees at 3.5 mins after the first bolus) in 100 patients for re-audit. Locally designed systematic scoring system used in evaluating the level of pelvicalyceal (PC) and ureteric (U) opacification, assigning a separate score of maximum up to three to give a total score of six. Results of first audit round: 52 patients (24 female, 28 male, mean age 64.9 years, age range 34-87 years). - Mean total score = 4.1 - Mean PC score = 2.3 - Mean U score = 1.8 Overall, did not meet target. Most problematic area was ureter opacification. Negative correlation between increasing age and scan quality was also identified. First action plan: Change protocol to allow patient to 'roll on table' prior scan. Results of second audit round: 100 patients (62 male, 38 female, mean age 61.9 years, age range 18-90 years). PRONE * N = 84 o Mean total score: 5.4 o Mean PC score: 2.9 o Mean U score: 2.5 (Excluded 16 supine patients from sample.) Linear regression model confirmed strong positive correlation between pelvicalyceal and ureteric opacification. Second action plan: *Target met (90% compliance with the overall score of 5.4 out of 6). *Adherence to the current modified protocol of CT urogram and re-audit on annual basis. References: 1. The Royal College of Radiologists. RCR iRefer guidelines: making the best use of clinical radiology. London: The Royal College of Radiologists, 2017. 2. Van Der Molen AJ et al. CT urography: definition, indications and techniques. A guideline for clinical practice. Eur Radiol 2008; 18: 4-17. 3. Washburn Z et al. Computed tomographic urography update: an evolving urinary tract imaging modality. Semin Ultrasound CT MR 2009; 30(4): 233-245. 4. Kawamoto S et al. Opacification of the collecting system and ureters on excretory phase CT using oral water as contrast medium. AJR 2006; 186: 136-140.
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74. Is stone score still effective for predicting diagnosis of ureteric stones on CTKUB in emergency settings? A clinical re-audit

Authors ElGendy K.; Twemlow M.; Wilkinson M.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: CT and PET-CT. Background to the audit: Acute flank pain due to renal colic is a common presentation to the emergency department. Stone score has been introduced to guide the need of computed tomography kidneys, ureters and bladder (CTKUB) to diagnose urinary stones. This audit aims to evaluate compliance to stone score and its efficiency in improving diagnostic accuracy of CTKUB. Standard: RCR (Al-Bakir et al, 2017) recommends: 1. CTKUB should detect calculi in 44-64% of patients 2. Alternate diagnoses in 6-10% 3. In regards to the stone score: Low: <10% stone positive CTKUB Moderate: 50% stone positive CTKUB High: 90% stone positive CTKUB Indicator: Positive diagnosis of renal stones on CTKUB and stratification according to stone score. Rate of alternative diagnosis. Target: 100% compliance to stone score. Meeting RCR recommendations. Methodology: Retrospective audit included all patients who presented to emergency care hospital and underwent CTKUB as part of their management. First audit: 9/04/2018 to 06/05/2018 (n=64) Second audit: 01/01/2019 to 31/01/2019 (n=79) Results of first audit round: Diagnostic accuracy of CTKUB was 41%. Alternative diagnosis rate was 23%. First action plan: Reinforce through presentations and email communication that the use of stone score emphasising CTKUB should be done in patients with suspected renal colic not for diagnosing generalising abdominal pain. Results of second audit round: 92.4% of the requests reported stone score. There was overestimation of stone score by requesting physicians (8.96 of reported score versus 8.02 of calculated score). Alternative diagnosis was reached in 7.5%. There is improvement of overall diagnostic accuracy of CTKUB (47%) and also positive diagnosis according to stone score: Low: 0% Moderate: 40.9% High: 83.3% Second action plan: Presenting and communicating the results with emergency departments to increase awareness. Including detailed stone score as part of requesting forms for CTKUB. References: 1. (last accessed 21/8/2019). 2. The Royal College of Radiologists. RCR iRefer guidelines: making the best use of clinical radiology. London: The Royal College of Radiologists, 2017. 3. (last accesses 21/8/19).
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75. Interdepartmental communication in emergency radiology: documentation of referrer opinion on A&E radiographs

Authors Foley R.W.; Pollentine A.
Source Clinical Radiology; Oct 2019; vol. 74
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Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Service quality. Background to the audit: Emergency department radiographs are commonly reported in retrospect. It is important that any discrepancy in radiograph interpretation between emergency department (A&E) staff and the reporting radiologist be highlighted. In our hospital, documentation of the referrer opinion can be performed via the use of a 'canned note' within the picture archiving and communication system (PACS) viewing software. Standard: All radiographs undertaken from emergency department should have an opinion documented by the referrer, which should be available to the radiologist at the time of reporting.¹⁻³ Indicator: Percentage of radiographs from A&E that have an accompanying opinion from the A&E referrer. Target: 100% documentation of referrer opinion. Methodology: A random sample of 120 A&E radiographs were taken over a three-week period in September-October 2018. Following the first action plan, a further random sample of 120 A&E radiographs were collected over a three-week period in February-March 2019. Results of first audit round: In total, 28% of A&E radiographs had an accompanying referrer opinion. Increased documentation of referrer opinion was seen in musculoskeletal radiographs (47%), minors patients (61%) and in radiographs requested by nursing staff (60%). First action plan: The results were presented to the radiology and emergency department at their respective clinical governance meetings. Documentation of referrer opinion was then included in the emergency department induction pack. Results of second audit round: At re-audit 34% of A&E radiographs had an accompanying referrer opinion. This represented a 6% improvement in comparison to the initial audit (p=0.33; Fisher's test). Second action plan: Attempts to improve documentation of referrer opinion from junior doctors and consultant will include education and posters within the emergency department. These posters will target the areas of A&E with lower documentation rates, namely resus and majors. References: 1. (last accessed 21/8/19). 2. The Royal College of Radiologists. Standards for the communication of radiological reports and fail-safe alert notification. London: The Royal College of Radiologists, 2016. 3. Royal College of Emergency Medicine. Best practice guideline: management of radiology Results in the emergency department. London: Royal College of Emergency Medicine, 2016.
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76. Auditing the quality of CT neck and chest imaging

Authors Kumar R.; Gandy N.; Ettienne-Chen P.; Samji S.; De Silva H.; Lingam R.
Source Clinical Radiology; Oct 2019; vol. 74
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Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: CT and PET-CT. Background to the audit: A computed tomography (CT) neck and chest with contrast is performed to assess mediastinal extension of deep neck collections and occasionally for head and neck (H&N) cancer staging. RCR protocol indicates that a CT neck should be performed with the arms down. Standard: Arms down for 100% scans. 85% scans should have good image quality. Indicator: Visually assessing streak artefact, adequate coverage, symmetry, image resolution and noise. Target: Arms down for 100% scans. 85% scans should have good image quality (score of $\geq 20/25$ for image quality). Methodology: Retrospective review of scans performed by two observers independently. Note was made of the indication, radiation and contrast dose, scanner make, arm position and neck position. A score out of five was given for the quality of the scan by visually assessing streak artefact, adequate coverage, symmetry, image resolution and noise. Results of first audit round: 25 scans were included. 9/25 (35%) had arms down, not meeting the RCR standard. 13/25 (52%) scans scored $\geq 20/25$ again not meeting our target. Several unavoidable patient factors for example, kyphosis and dental amalgam reduced image quality. First action plan: Reviewing the trust imaging protocol to perform a CT chest with arms up and then a CT neck with arms down as two separate scans with two contrast boluses. Re-audit within one year. Results of second audit round: 32 scans were included. 24/32 (75%) had arms down, demonstrating an improvement but not meeting the RCR standard. 23/32 (72%) scans scored $\geq 20/25$. Radiation doses were on average increased with the new protocol due to scan overlap at the upper thorax. Second action plan: Reduce scan overlap between CT chest and CT neck scans by scanning the CT neck to the sternal notch. Radiologists to be encouraged to select the new protocol appropriately. Radiographers to be educated of the new protocol scanning technique. Re-audit in one year. Reference: 1. The Royal College of Radiologists. Recommendations for cross-sectional imaging in cancer management, Second edition. London: The Royal College of Radiologists, 2014.
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77. Clinical audit of radiology department communication system for critical, urgent, and unexpected significant findings

Authors Shahwaiz Babar H.; Khalid Niazi I.; Khalil Chaudhry S.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Category: Service quality. Background to the audit: To analyse the existing system for communication of critical unexpected radiological findings in a tertiary care hospital according to the hospital policy and Joint Commission International Accreditation (JCIA) guidelines. To create awareness of guidance on radiology results communication and of compliance with this guidance throughout the hospital. Standard: The Royal College of Radiologists' standards. Indicator: Informing findings to the clinician within an hour of scan acquisition. Target: 100 percent. Methodology: In our department, regular quarterly audits are done on critical results communication and we are presenting data from January 2017 to June 2018. Data of all the patients for whom critical alerts were generated within one hour of scan acquisition, were gathered from the hospital information system (HIS), the parameters analysed included findings, name, and employee code of the clinician and read back confirmation. Later, a template for the generation of critical alerts was introduced and doctors were also educated about communicating urgent findings on time. Results of first audit round: In the first quarter the results of the critical findings were 88% which peaked to 92% by the end of 2017. First action plan: We added read back confirmation and employee code of the doctor to whom findings were informed. Results of second audit round: Later in 2018 with the introduction of the template and regular education of doctors, the results soared up to 100% and have recently plateaued at 96%. Reference: 1. The Royal College of Radiologists. Standards for the communication of radiological reports and fail-safe alert notification. London: The Royal College of Radiologists, 2016. Copyright © 2019

78. Auditing the consent process for patients undergoing testicular vein embolisation, a non-urgent interventional procedure

Authors Watkins L.; Anwar J.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Service quality. Background to the audit: General Medical Council (GMC) and The Royal College of Radiologists' (RCR) guidelines for consent indicate this is a process and patients need time to reflect on decisions. For elective procedures therefore, consent discussion should occur in advance of the procedure. Standard: Consent discussion for testicular vein embolisation should be separate in both time and place from procedure. Consent discussion should be documented. Indicator: Consent form as evidence of discussion should be scanned into the patients record and dated as per date of discussion. Target: 100% of patients should have consent discussion documented. 90% of patients should have consent discussion in advance of procedure. Methodology: For both cycles, retrospective data was collected over a six-month period from multiple sources including the computerised radiology information system (CRIS), portal and the angio lab book. This enabled capture of all patients undergoing testicular vein embolisation. Availability of consent form and when the patient was consented was collected. Results of first audit round: Only 53% of patients had their consent form uploaded to their radiology records. All of these consent forms were completed on the day of procedure. No discussions in advance of procedure date were documented. First action plan: Introduction of an interventional radiology (IR) clinic to allow prospective discussion between patient and IR consultant for this elective procedure. Reminder disseminated to staff regarding correct scanning and uploading of consent forms. Results of second audit round: 89% had their consent form uploaded appropriately. The remaining 11% had clear documentation of consent discussion within records of the IR clinic. Almost 80% were consented at least five days in advance of their procedure. Second action plan: Telephone clinic appointments for out of area patients. Re-audit at a later date - prompt evaluation of the changes likely captured settling in problems of the new pathway. References: 1. The Royal College of Radiologists. Standards for patient consent particular to radiology, second edition. London: The Royal College of Radiologists, 2012. 2. General Medical Council. Consent: patients and doctors making decisions together. London, General Medical Council, 2008. 3. (Last accessed 21/8/19). 4. Promoting management and leadership. informed consent for radiological procedures. Health Management.org 2010. 10:5. Copyright © 2019

79. Overutilisation of CTPA for suspected pulmonary embolism

Authors Connor S.J.; Gupta M.; Kearney S.; Chooi Oh T.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Category: Appropriateness of referral. Background to the audit: Aim was to assess usage of computed tomography pulmonary angiography (CTPA) in suspected pulmonary embolism (PE) in our trust in accordance with National Institute for Health and Care (NICE) guidelines. Standard: NICE Guidelines CG144 Venous thromboembolic diseases (2012 updated 2015). Indicator: Recent chest X-Ray (CXR) (within seven days). Wells score present on 100% of referrals with appropriate clinical information. Detection of PE ≥ 15 -37.4%. Alternate diagnoses found $\leq 56\%$. Target: 100% of all referrals should have recent CXR, Wells score \pm D-dimer and appropriate clinical information. Methodology: Retrospectively selected 50 CTPA requests selected randomly from between September and December 2017. In the second round 100 CTPA requests were randomly selected between August and December 2018. Results of first audit round: 84% of patients had CXR within seven days. 8% had wells score on clinical request. Detection of PE 18%. Alternative diagnosis in 46% of patients. 8% had D-dimers done when Wells score >4 . 42% of requests were unjustified. First action plan: Strict adherence to NICE protocol and display protocol on trust intranet to help reinforce management of PE. More vigorous vetting of CTPA requests. CTPA requests must mention Wells score \pm D-dimer. D-dimer should only be done in cases with wells score ≤ 4 . Results of second audit round: 89% had CXR within seven days. 20% had wells score on clinical request. Detection of PE 17%. Alternate diagnosis in 47%. 17% had D-dimers done when Wells score >4 . 32% of requests were unjustified. Second action plan: Re-educate clinicians/radiologists about Lancashire Teaching Hospital's investigating PE protocol and what is required for accepting a CTPA. Change electronic request forms so Wells score or D-dimer is a text field requirement before the CTPA can be requested, with a box confirming a CXR has been done in the last seven days, Explore methods of reducing number of D-dimers done before Wells scores. References: 1. Wells PS et al. Derivation of a simple clinical model to categorize patients' probability of pulmonary embolism: increasing the model's utility with the SimpliRED D-dimer. *Thromb Haemos* 2000; 83: 416-420. 2. National Institute for Health and Care Excellence (NICE) guidelines. CG144 Venous thromboembolic diseases. London: National Institute for Health and Care Excellence, 2015. 3. The Royal College of Radiologists. RCR iRefer guidelines: making the best use of clinical radiology. London: The Royal College of Radiologists, 2017. Copyright © 2019

80. NELA's new pathway - delivery feasibility for the RVI

Authors Wallace-King S.; Scott M.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: Service quality. Background to the audit: A region-wide emergency laparotomy pathway has recently been introduced; following on from work undertaken by the National Emergency Laparotomy Audit (NELA), and as a requirement to qualify for the best practice tariff. This audit aims to determine the feasibility for implementation of the pathway in our hospital. Standard: The pathway stipulates that patients presenting with abdominal pain and a NEWS2 (National Early Warning Score) of ≥ 3 in who bowel pathology is suspected should undergo emergency computed tomography (CT). The scan should be performed within one hour, and reported within one hour after that. Indicator: Time from referral to CT scan. Time from scan to final report. Target: 100% of patients scanned within one hour of referral. 100% of scans reported on radiology information system (RIS) within one hour. Methodology: Patients undergoing emergency laparotomy between 28/4/18 and 27/10/18, with a preceding emergency CT were retrospectively identified from the NELA database. Relevant data extracted from the NELA database and hospital RIS. Results of first audit round: 95 patients were included, with 93 of the CTs being reported by a consultant (two by SPRs). Time to scan: - Average time to CT was 03:18 - 33% were scanned within an hour Reporting target: - 39% reported within one hour (79% of these by registrars). - 92% reported by two hours. - 100% reported in <12 hours. - 69% of patients reported Copyright © 2019

81. Outsourced PET-CT: are they reaching NHSE benchmark for reporting times?

Authors Pettit W.; Meriman S.; Soneji N.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Category: Service quality. Background to the audit: Due to capacity issues and significant increase in demand, the trust outsources some positron emission tomography computed tomography (PET-CT) scans. This audit assesses whether these outsourced scans meet the target turnaround-times (TATs) set out by NHS England (NHSE). Standard: NHSE Standard for PET-CT scans. Indicator: Time elapsed between each stage of request to scan process. Target: Seven days from scan request to report and 48 hours from scan completion to report. Methodology: Retrospective analysis of data collected from IEP systems, conducted over two three-month periods (October to December 2017 and July to September 2018) with an interim period of seven months. Results of first audit round: 11 out of 63 total patients (17%) met the 48 hour benchmark, while three out of 63 (4.7%) met the seven-day TAT. The most significant delay occurring between request and scan date, as well as delays between when images were received via IEP to the completion of the scan on the trust system. First action plan: Scan uploading process refinement at outsourced location and increase in reporting capacity. Results of second audit round: 31 out of 110 total patients (30%) met the 48-hour benchmark. 16 out of 110 (15%) met the seven-day target, demonstrating a marked improvement from the first audit. Second action plan: PET dedicated admin staff to ensure timely progression of scan uploading from IEP to the completion of the scan ready to report as this was consistently the longest delay. Explore cloud-based image sharing system across the region to optimise scanner capacity and data transfer. Reference: 1. (last accessed 22/8/19). Copyright © 2019

82. The imaging modality of choice for patients with a suspect scaphoid fracture who have normal initial radiographs: a UK-wide audit

Authors Ayub Chunara M.H.; McLeavy C.; Paton D.; Kesavanarayanan V.; Ganguly A.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Category: MSK.
Purpose(s): The prevalence of scaphoid fractures in the young and active patient population is high. The clinical examination and scaphoid series are both imperfect tests, often resulting in premature wrist immobilisation, associated with significant lifestyle and socioeconomic implications. Magnetic resonance imaging (MRI) is an effective modality for the investigation of radiographically-occult scaphoid fractures, yet there remains a striking inconsistency in the modality of choice both in the UK and internationally. Methods and materials: A survey monkey questionnaire was sent to 140 eligible NHS trusts derived from the NHS England database following exclusion of all non-acute and specialist centres. Four questions were asked regarding: the provision of MRI for radiographically-occult scaphoid fractures, time-to-MRI, number of departmental MRI scanners and alternative imaging offered.
Result(s): Responses were received from 74 trusts (53%). Thirty-eight offered MRI as a firstline test in plain-film occult scaphoid injury, 25 preferred computed tomography (CT) and 11 opted for repeat plain radiographs. Of the 38 trusts who offered MRI, 26 provided this within one week; the rest within two weeks. No trends were identified based on the size of the hospital or its geographical location. Statistical analysis of the data revealed no significant relationship between the number of MR scanners and the provision of MRI, nor between the numbers of MR scanners and the time-to-MRI.
Conclusion(s): MRI has been recognised in the literature as a highly-specific, highly-sensitive and cost-effective tool, yet only 51% of trusts provide this service in the UK. For those who cannot offer MRI firstline, CT remains a very accurate and reliable alternative.
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83. Recognition and management of IV contrast reactions - a re-audit

Authors Millar-Mills M.; Filippini C.; Carter R.; Elhassan H.; Chen J.
Source Clinical Radiology; Oct 2019; vol. 74
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Category: Contrast. Background to the audit: Over 60,000 contrast enhanced computed tomography scans (CTs) are performed per annum at Oxford University Hospitals NHS Foundation Trust (OUH). Acute contrast reaction is a recognised risk. There were 14 reactions following iodinated IV contrast in the last five years at OUH. Standard: The RCR recommends there should always be an individual in the department who is trained to recognise and treat severe contrast reactions. Radiologists should be able to recognise and manage an acute contrast reaction. Indicator: To evaluate radiologists' recognition and management of acute contrast reactions. Target: The standard should be achieved in 100% of cases. Methodology: A questionnaire was distributed among the radiologists, across the trust. 39 consultants and registrars completed the questionnaire. Results of first audit round: 100% recognised previous anaphylaxis as a risk factor for a contrast reaction. Only 75% recognised asthma as a risk factor. 73% would consider the risk versus the benefit of administering contrast to a high risk patient. 12.5% would monitor patient post procedure. 72% recognised and gave intramuscular (IM) adrenaline for anaphylaxis. No one knew where the adrenaline preparations were located in the department. 82% knew where to inject IM adrenaline, but only 15% knew the dose. First action plan: An e-learning module was created. Posters were put up in the CT control room and inside the contrast reaction box. Results of second audit round: 77% recognised asthma as a risk factor. 90% would consider the risk versus benefit of giving contrast. 89% would monitor post procedure. 62% recognised and treated a mild reaction. 92% recognised and treated anaphylaxis. 49% knew the location of IM adrenaline. 72% knew the location of IV adrenaline. 59% knew the route, volume and dose of IM adrenaline. 85% knew where to inject. Second action plan: Creation of lanyard cards containing signs of an acute reaction and treatment details. Further encouragement to complete the e-learning module. References: 1. The Royal College of Radiologist. Standards for intravascular contrast agent administration to adult patients, third edition. London: The Royal College of Radiologist, 2015. 2. Resuscitation Council UK. Emergency treatment of anaphylactic reactions: guidelines for healthcare providers. London: Resuscitation Council UK, 2008. Copyright © 2019

84. National British Orthodontic Society (BOS) Orthognathic Audit 2017-2018

Authors Ireland A.J.; Atack N.E.; House K.; Sherriff M.; Sandy J.R.; Cunningham S.J.; Hunt N.P.; Cobourne M.
Source Journal of orthodontics; Oct 2019
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31595815
Database EMBASE
Abstract OBJECTIVE: To carry out a UK national clinical audit of orthognathic acceptance criteria and information provided to orthognathic patients before treatment. DESIGN: National clinical audit. SETTING: Data collected using Bristol Online Surveys. PARTICIPANTS: Sixty-nine UK hospital orthodontic departments submitted data. METHOD(S): Data were collected at two time points using Bristol Online Surveys over a period of 12 months. These were before treatment at the first multidisciplinary clinic (MDT) and immediately after surgery. The data collected included: Index of Orthognathic Functional Treatment Need (IOFTN); Index of Orthodontic Treatment Need (IOTN); age; previous orthodontic treatment; attendance at an MDT; treatment times; and information provision. RESULT(S): Eighty-five units agreed to take part in the audit with 69 submitting data, giving a response rate of 81%. The data from 3404 patients were uploaded, 2263 before treatment and 1141 immediately after surgery. Of patients, 91.07% had an IOFTN score of 4 or 5 and 88.73% had an IOTN score of 4 or 5. The mean age at the first MDT was 22 years in the first cohort and 21 years and 4 months in the second immediate post-surgery cohort. Of patients, 37.93% had undergone some form of previous orthodontic treatment, but only 0.28% had undergone previous orthognathic treatment; 96.93% had an MDT confirm that orthodontic treatment by itself was insufficient to adequately correct their functional symptoms. The average treatment time from bond up to surgery was 2 years and 6 months. With respect to information provision, patients received information from a number of sources, principally the British Orthodontic Society (BOS) patient information leaflets and the BOS website Your Jaw Surgery. CONCLUSION(S): In the UK, the majority of orthognathic cases fulfil the criteria for acceptance for NHS-funded orthognathic treatment, as outlined by the Chief Dental Officer's interim guidance on orthognathic treatment. This suggests any prior approval process would not be a good use of NHS resources in the commissioning of orthognathic treatment.

85. An evaluation of a multifaceted, local Quality Improvement Framework for long-term conditions in UK primary care

Authors Gabel F.; Listl S.; Chambers R.; Cox T.; Maskrey N.
Source Family practice; Oct 2019; vol. 36 (no. 5); p. 607-613
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 30576438
Database EMBASE

Abstract BACKGROUND: The evidence that large pay-for-performance schemes improve the health of populations is mixed-evidence regarding locally implemented schemes is limited.
OBJECTIVE(S): This study evaluates the effects in Stoke-on-Trent of a local, multifaceted Quality Improvement Framework including pay for performance in general practice introduced in 2009 in the context of the national Quality and Outcomes Framework that operated from 2004.
METHOD(S): We compared age-standardized mortality data from all 326 local authorities in England with the rates in Stoke-on-Trent using Difference-in-Differences, estimating a fixed-effects linear regression model with an interaction effect.
RESULT(S): In addition to the existing downward trend in cardiovascular deaths, we find an additional annual reduction of 36 deaths compared with the national mean for coronary heart disease and 13 deaths per 100000 from stroke in Stoke-on-Trent. Compared with the national mean, there was an additional reduction of 9 deaths per 100000 people per annum for coronary heart disease and 14 deaths per 100000 people per annum for stroke following the introduction of the 2009 Stoke-on-Trent Quality Improvement Framework.
CONCLUSION(S): There are concerns about the unintended consequences of large pay-for-performance schemes in health care, but in a population with a high prevalence of disease, they may at least initially be beneficial. This study also provides evidence that a local, additional scheme may further improve the health of populations. Such schemes, whether national or local, require periodic review to evaluate the balance of their benefits and risks.
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86. Retrospective study of early stage endometrial cancer in Portsmouth hospital NHS trust, uk an audit on adherence of United Kingdom guidelines and overall survival

Authors Lwin M.; Uherek M.; Khoury G.; Gardner F.; Yeoh C.C.
Source International Journal of Gynecological Cancer; Sep 2019; vol. 29
Publication Date Sep 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Objectives We audited the management of early stage (Stage 1) endometrial cancer in our institution's adherence with British Gynaecological Cancer Society (BGCS) guidelines. The guidelines state 1) Hysterectomy and bilateral salpingo-oophorectomy is recommended for Grade 1-2 disease. Lym-phadenectomy is not recommended in low risk cases. 2) Low risk disease does not require adjuvant treatment, 3) For intermediate risk, adjuvant vaginal vault brachytherapy is recommended. 4) For high intermediate risk to consider external beam radiotherapy if nodal status unknown and to consider vaginal brachytherapy if node negative. 5) For high risk to consider EBRT vs vaginal brachytherapy. Methods All stage I endometrial cancer patients registered to our institution from June 2015 to March 2018 were selected from database. Electronic record of case notes, histology, blood results, imaging results and multi-disciplinary team meeting outcomes were retrospectively reviewed. Results A total of 120 patients, age 32-88 years (median age 65 years). 113 patients underwent surgery (87 had TH + BSO and 26 had TH+BSO+lymphadenectomy). 7 patients were not fit for surgery and treated with hormone. Post op histology showed 76 patients G1, 20 patients G2 and 17 patients G3. 111 patients had FIGO IA and 2 patients had IB. 26 patients were given adjuvant radiotherapy (3 EBRT and 23 Brachytherapy). Conclusions Rate of adherence with BGSC guidelines for surgery and adjuvant radiotherapy were 90% and 88.5% respectively. Some grade changes between pre and post-op histology, findings in clinical examination and imaging were attributed to the main management reason to treat outside BGCS guidelines. Recurrent rate was 2.5%.

87. A review of electronic rheumatology referrals at the queen elizabeth university hospital (glasgow, uk) and how this has led to service improvements

Authors Laws A.; Noor S.; Hannington L.; Ingram G.; Bawa S.; Batool S.; Graham K.; Mitchell J.; Crosbie D.
Source Annals of the Rheumatic Diseases; Jun 2019; vol. 78 ; p. 2059
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Background: Our department provides a service for inpatient Rheumatology reviews Monday to Friday, 9am to 4pm, with a guaranteed review timeframe of 48-72 hours. We work predominantly on the QEUH site, which comprises 1677 acute inpatient beds. We launched an electronic referral system for inpatient Rheumatology reviews in February 2018. Interspeciality referrals are an essential part of most inpatient stays. In a time of increasing service demand within the NHS it is important that we have an effective system to manage our time and resources^{1,2}. Electronic referrals allow us to audit our workload, our efficiency at reviewing patients and allow for accountability of both the referrer and reviewer, therefore improving patient safety³. Using a set proforma allows us to improve communication, the quality of the referral and triage effectively⁴.

Objective(s): We performed a baseline review of the new system.

Method(s): We reviewed all electronic referrals between 8.2.18 and 13.8.18. We collected data on demographics, timing, reasons for referral and outcomes.

Result(s): There were 346 referrals (58.4% female, mean age 64 years). Most (78%) were made from medical wards; the mean number of referrals per month was 49.4. Referrals were most frequently made on Fridays (23%). Most were in-hours (81%). The most common reason for referral was: a request for review (212; 61.3%); phone advice (70; 20.2%); procedural requests (50; 14.5%). 207 referrals (59.8%) were made for new patients, 91 (26.3%) for patients known to Rheumatology prior to admission, and 48 (13.9%) for patients already seen during the current admission. 50% of procedures were performed on knees and 50% on other joints. 82% of patients were seen within 72 hours. Acute hot swollen joint was the commonest reason for referral of new patients (38%), followed by vasculitis (6%). Questions regarding pre-existing disease management (59%) or DMARD questions (24%) predominated amongst referrals for patients known to Rheumatology prior to this admission.

Conclusion(s): The use of the electronic referrals system has made it simple to review the workload of our Rheumatology on-call service. We have used the data on 'reason for referral' to guide the topics for our educational meetings to improve patient management. We actively contribute to the procedural teaching on knee joint aspiration both in junior doctor's formal training sessions, and opportunistically on wards following referral. This is a core procedure required for training completion for medical trainees in the UK and should help reduce referrals and manage patients in a more time efficient and cost-effective manner. We have also improved documentation by recording the time, date and name of the reviewer in our electronic entry. We intend to collect data in the same period this year, to assess changes in referral pattern in the 12 months since the system was initiated and the impact of our interventions.

88. An audit of management of gout according to the British society for rheumatology guidelines, 2017 in a teaching hospital rheumatology unit

Authors Banerjee S.; Anver H.; Chaudhuri K.
Source Annals of the Rheumatic Diseases; Jun 2019; vol. 78 ; p. 1899-1900
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Background: Gout is the most common form of inflammatory arthritis worldwide. Its prevalence is 2.49% in UK general practice. In spite of the availability of effective treatments in the UK, the incidence of gout has increased in the last decade, the reasons for which are many. There is also evidence that gout is being sub-optimally treated in primary and secondary care. (1) Fewer than 50% of patients receive urate lowering therapy (ULT), and many patients on ULT do not achieve the target serum urate level of 300 mmol/l or lower, which is essential to prevent further attacks of gout. This target has been proposed by the British Society for Rheumatology (BSR), in the latest guideline from 2017. (2) Objectives: To assess the compliance of gout management with the BSR 2017 guideline in our unit (a teaching hospital rheumatology department): a) Urate lowering therapy should be discussed with all patients diagnosed with Gout. b) ULT is strongly advised in patients with recurrent attacks (>2 over 12 months), chronic gouty arthritis, tophi, renal impairment (eGFR <60), patients on diuretics and primary gout at an early age. c) Aim of urate lowering to reduce serum urate to <300mmol/l. (2) Methods: Inclusion criteria: All patients being treated for gout in the department of rheumatology, between 1st October 2016 to 31st September 2017, were included in this retrospective study. Demographics, treatment details obtained from electronic patient records. Adherence to the BSR guidelines was expressed as percentage.

Result(s): Total number of patients with gout was 113. Among these, 83 patients remain under rheumatology follow up, 30 were discharged within the 1 year period. 113 were considered were audit standard 1 and 2, and 83 were considered for standard 3. (Table presented) Among the 113 patients being followed up in Rheumatology, 83% were on Allopurinol, 19 were on Febuxostat, 1 patient was on Benzbromarone. 10 patients were not on Urate lowering therapy. However, 2 among them had first attack of gout without any sign of chronicity, organ damage or tophi, so not started on ULT. * Median Allopurinol dose was 300mg. (IQR 200mg-700mg). * 25 patients among the 113 had tophaceous gout, and 5 of them achieved BSR treatment target * 22/83 (26.5%) patients on Allopurinol achieved BSR treatment target of <300nmol/l. 7/19 (37%) patients on Febuxostat achieved BSR treatment target of <300nmol/l

Conclusion(s): It is clear that a "treat to target" approach have not been adopted for x% of the patients. Gout has been shown to have better outcomes with treat to target approach. (3) Adequate escalation of ULT is essential to achieve target serum urate level, where as the median dose of Allopurinol here is 300mg. Gout remains inadequately treated, even in secondary care * A consistent "Treat to target" approach needed for treatment of gout. * Annual gout review clinic may be an effective strategy and is now being.

89. Are psoriatic arthritis outcomes better in early arthritis service? Study from a national award winning centre

Authors Nisar M.K.
Source Annals of the Rheumatic Diseases; Jun 2019; vol. 78 ; p. 617
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Background: There is good evidence that dedicated early arthritis clinics (EACs) improve referral lag time and reduce delay in establishing disease- modifying therapy. However it remains arguable whether such clinics improve outcomes especially for arthritides other than RA. In the UK, only 57% of units have dedicated EACs. Our early arthritis service won national best practice commendation award for achieving high standards. Objective(s): We analysed our psoriatic arthritis (PsA) population data to ascertain whether this cohort benefits from EACs. Method(s): The department set up an early arthritis service with introduction of six clinics (EACs) every week. An agreed treatment protocol incorporating ultrasound was developed to ensure standardised approach to early initiation of treatment, drug education and timely review. This is a retrospective study of all patients with PsA presenting to the service in the first year Results: Our catchment area covers a population of 350,000 with 40% ethnic minorities. Of 1884 patients referred, 482 (25.5%) were triaged into EACs based on set criteria. All were reviewed within 3 weeks. 247 (51%) were confirmed to have early inflammatory arthritis (EIA). Mean age was 52.4 years (17-86y). 157 (63.5%) were women. 177 (71.6%) were White, 58 (23.5%) of Asian and twelve of other background. 159 (64.3%) had RA, 55 (22%) with PsA and 33 had other inflammatory arthritides. There was median 26 weeks delay (0.4-1043 weeks) from symptom onset to GP presentation. Median time for GP referral to the department was 4.0 days (0-84 days). All PsA patients had regular PsARC assessment. Mean tender (TJ) and swollen joint (SJ) counts at first visit were 8.2 (1-35) and 3.5 (0-14) respectively [n=55]. The patient (PtGA) and physician (PhGA) global assessments mean were 3.0 and 2.9 (1-5). 95% commenced their DMARDs within 3 week of initial review. Other 5% who missed the target was owing to patient factors. Target [TJ & SJ <=2] was achieved for 38 patients (69%) and good PsARC response for a further four (7%). Median time to achieve the target or good response was 22 weeks (0-48 weeks). Of 55, only four (7%) patients required escalation to biologic therapy. Final TJ and SJ mean was significantly better at 1.2 (0-4) and 0.3 (0-2) [p <.0001] with similar improvement in PtGA [mean 1.8 (1-4)] and PhGA [mean 1.6 (1-3)]. Only six (11%) patients were true non-responders as the remaining seven declined therapy. Conclusion(s): Dedicated EACs help achieve good clinical outcomes in majority of PsA patients. Nearly 76% of our cohort attained the target or good PsARC response in less than six months. This was despite a significant delay in patients presenting to their GPs and moderately-high disease activity. 100% of our patients were treated to target facilitated by protocol driven escalation of therapy in these clinics. This is in contrast to the national audit findings whereby only 68% of patients were treated with disease modifying drugs within 6 weeks of referral and 89% had treatment to target. This study shows that the establishment of dedicated EACs improve the prognosis of psoriatic arthritis in terms of primary clinical outcomes compared to patients managed outside of EACs.

90. An audit of management of gout according to the British Society for Rheumatology guidelines,2017 in a teaching hospital rheumatology unit

Authors Banerjee S.; Anver H.; Chaudhuri K.
Source Annals of the Rheumatic Diseases; Jun 2019; vol. 78 ; p. 1899-1900
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Background: Gout is the most common form of inflammatory arthritis worldwide. Its prevalence is 2.49% in UK general practice. In spite of the availability of effective treatments in the UK, the incidence of gout has increased in the last decade, the reasons for which are many. There is also evidence that gout is being sub-optimally treated in primary and secondary care. (1) Fewer than 50% of patients receive urate lowering therapy (ULT), and many patients on ULT do not achieve the target serum urate level of 300 mmol/l or lower, which is essential to prevent further attacks of gout. This target has been proposed by the British Society for Rheumatology (BSR), in the latest guideline from 2017. (2) Objectives: To assess the compliance of gout management with the BSR 2017 guideline in our unit (a teaching hospital rheumatology department): a) Urate lowering therapy should be discussed with all patients diagnosed with Gout. b) ULT is strongly advised in patients with recurrent attacks (>2 over 12 months), chronic gouty arthritis, tophi, renal impairment (eGFR <60), patients on diuretics and primary gout at an early age. c) Aim of urate lowering to reduce serum urate to <300mmol/l. (2) Methods: Inclusion criteria: All patients being treated for gout in the department of rheumatology, between 1st October 2016 to 31st September 2017, were included in this retrospective study. Demographics, treatment details obtained from electronic patient records. Adherence to the BSR guidelines was expressed as percentage. Result(s): Total number of patients with gout was 113. Among these, 83 patients remain under rheumatology follow up, 30 were discharged within the 1 year period. 113 were considered were audit standard 1 and 2, and 83 were considered for standard 3. (Table Presented) Among the 113 patients being followed up in Rheumatology, 83% were on Allopurinol, 19 were on Febuxostat, 1 patient was on Benzbromarone. 10 patients were not on Urate lowering therapy. However, 2 among them had first attack of gout without any sign of chronicity, organ damage or tophi, so not started on ULT. Median Allopurinol dose was 300mg. (IQR 200mg-700mg). 25 patients among the 113 had tophaceous gout, and 5 of them achieved BSR treatment target 22/83 (26.5%) patients on Allopurinol achieved BSR treatment target of <300nmol/l. 7/19 (37%) patients on Febuxostat achieved BSR treatment target of <300nmol/l Conclusion(s): It is clear that a "treat to target" approach have not been adopted for x% of the patients. Gout has been shown to have better outcomes with treat to target approach. (3) Adequate escalation of ULT is essential to achieve target serum urate level, where as the median dose of Allopurinol here is 300mg. Gout remains inadequately treated, even in secondary care A consistent "Treat to target" approach needed for treatment of gout. Annual gout review clinic may be an effective strategy and is now being implemented as a result of this audit.

91. Treatment: How to implement it and how to monitor adherence?

Authors Muhammad K.J.
Source Annals of the Rheumatic Diseases; Jun 2019; vol. 78 ; p. 25
Publication Date Jun 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: The key to achieving the benefits of an FLS on the population and the patient level is to ensure enough high-risk patients are initiated and then adhere to therapy. There is a low rate of primary and secondary adherence by patients with osteoporosis. Treatment initiation requires co-developed decision making with patients and clinicians balancing locally agreed intervention thresholds with effective and efficient risk and treatment communication. Treatment adherence depends on patient, treatment and healthcare service characteristics. Objective(s): Describe the current status of treatment recommendation in the UK Describe the current methods for improving adherence globally Methods: Review of the data from the UK Fracture Liaison Service Database and IOF Capture the Fracture audits.

92. DISSECTING ALCOHOL USE AND MISUSE: A GENOME-WIDE AND POLYGENIC RISK SCORING APPROACH

Authors Sanchez-Roige S.; Palmer A.; Johnson E.; Agrawal A.; Clarke T.; Edwards A.
Source European Neuropsychopharmacology; Oct 2019; vol. 29
Publication Date Oct 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Abstract: Alcohol use disorders (AUD) can be broadly disarticulated into two core components - the extent to which an individual consumes alcohol and the potential problems that they experience related to their intake. We obtained quantitative measures using the Alcohol Use Disorder Identification Test (AUDIT), which is a 10-item screening questionnaire that measures both aspects of alcohol consumption (items 1-3, AUDIT-C) and problematic use (items 4-10, AUDIT-P), from a population-based cohort, UK Biobank (UKB, N=121,630), and performed two genome-wide association analyses. Next, we calculated polygenic risk scores (PRS) of AUDIT-C and AUDIT-P and we estimated their correlations with several alcohol-related outcomes in four independent samples with differing age and ascertainment characteristics. Data on alcohol-related phenotypes were drawn from a cohort ascertained for family history of alcoholism, the Collaborative Study on the Genetics of Alcoholism (COGA; N=6,850); and three population-based cohorts, the Avon Longitudinal Study of Parents and Children (ALSPAC; N=5,911), Generation Scotland (GS; N=17,461), and a subset of the UKB (N=245,947). We identified that genetic liability to AUDIT-C was positively correlated with educational achievement and unrelated to psychopathology, whereas liability to AUDIT-P was negatively correlated with educational achievement and positively correlated with psychopathology. In general, AUDIT-P PRS was associated with a range of alcohol-related phenotypes, including DSM-IV alcohol dependence (COGA, $R^2=0.70\%$, $p=1.9e-9$; ALSPAC, $R^2=0.50\%$, $p=5.75e-4$) and ICD AUD-related disorders (UKB, $R^2=0.20\%$, $p=2e-16$), DSM-5 symptom count (COGA, $R^2=0.70\%$, $p=9.76e-11$), maximum drinks (COGA, $R^2=0.50\%$, $p=2.53e-8$, ALSPAC, $R^2=3.3\%$, $p=1.59e-3$), CAGE (a screener for problem drinking) scores (GS, $R^2=0.40\%$, $p=9e-7$), and increased risk of onset of alcohol dependence (COGA, HR = 1.15, $p=1.64e-08$), in both population-based and high-risk clinically ascertained cohorts, while AUDIT-C PRS showed less utility in the ascertained cohort. These series of studies provide empirical evidence that alcohol consumption and AUD have an overlapping yet distinct genetic architecture. Our findings demonstrate the influence of ascertainment schemes on polygenic analyses, as well as the AUDIT-P's correlation with a range of alcohol phenotypes from regular use to misuse. Disclosure: Nothing to disclose. Copyright © 2019

93. Successful implementation of remote consultation for patients receiving home parenteral nutrition

Authors Bond A.; Abraham A.; Taylor M.; Ablett J.; Teubner A.; Slater C.; Anabelle C.; Leahy G.; Lal S.
Source Transplantation; Jul 2019; vol. 103 (no. 7)
Publication Date Jul 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Introduction: Our national Intestinal Failure Unit provides care for patients from across the UK and beyond. Type 3 IF patients are routinely reviewed at 3-6 month intervals. Between Mar 2007-2017 there was a 90% increase in type 3 patients attending our outpatient. Coping with the increasing demand whilst maintaining outpatient capacity and standards is a key component of IF care. Telemedicine provides a strategy for achieving this.
Method(s): QI methodology was used to implement and evaluate remote video consultations. Implementation began Dec 2015 via patient consultation and small tests of change. Clinical data were obtained from a prospectively maintained database forming part of ESPEN audit standards. A face to face discussion via the internet using the video call service Skype. An anonymous qualitative satisfaction questionnaire was subsequently completed.
Result(s): During the study period, patients receiving HPN rose by 13.7% to 285. Twenty-one patients used telemedicine service, totaling 55 contacts. Mean potential distance traveled by telemedicine cohort was 118.6 miles (10-441.8), mean cumulative miles saved was 8600 miles. Twelve patients used the service on multiple occasions. Seventy percent of patients rated their satisfaction with the system at $\geq 90\%$, with the mean satisfaction of 83%. The mean duration between outpatient appointment offered reduced from 103.7 days to 100.4 days in 2017. One patient had a CRBSI following commencement of telemedicine. 9.5% of the telemedicine cohort were admitted with an HPN complication, compared to an admission rate of 23.5% for the whole HPN cohort.
Conclusion(s): Telemedicine can release some HPN clinic capacity and help reduce the increasing pressure for patient access to HPN services. Whilst maintaining compliance with NICE and ESPEN guidance, patient satisfaction and patient safety.

94. GP incentives to design hypertension and atrial fibrillation local quality-improvement schemes: A controlled before-after study in UK primary care

Authors Otete H.; Chauhan U.; Fell C.; Smith T.
Source British Journal of General Practice; 2019; vol. 69 (no. 687)
Publication Date 2019
Publication Type(s) Article
PubMedID 31455643
Database EMBASE

Abstract Background Financial incentives in the UK such as the Quality and Outcomes Framework (QOF) reward GP surgeries for achievement of nationally defined targets. These have shown mixed results, with weak evidence for some measures, but also possible unintended negative effects. Aim To look at the effects of a local intervention for atrial fibrillation (AF) and hypertension, with surgeries rewarded financially for work, including appointing designated practice leads, attendance at peer review workshops, and producing their own protocols. Design and setting A controlled before-after study comparing surgery performance measures in UK primary care. Method This study used published QOF data to analyse changes from baseline in mean scores per surgery relating to AF and hypertension prevalence and management at T1 (12 months) and T2 (24 months) for the intervention group, which consisted of all 58 surgeries in East Lancashire Clinical Commissioning Group (CCG), compared to the control group, which consisted of all other surgeries in north-west England. Results There was a small acceleration between T0 (baseline) and T2 in recorded prevalence of hypertension in the intervention group compared to the controls, difference 0.29% (95% confidence interval [CI] = 0.05 to 0.53), $P = 0.017$, but AF prevalence did not increase more in the intervention group. Improvement in quality of management of AF was significantly better in the intervention group, difference 3.24% (95% CI = 1.37 to 5.12), $P = 0.001$. Conclusion This intervention improved diagnosis rates of hypertension but not AF, though it did improve quality of AF management. It indicates that funded time to develop quality-improvement measures targeted at a local population and involving peer support can engage staff and have the potential to improve quality. Copyright © British Journal of General Practice

95. Quality improvement of prescribing safety: A pilot study in primary care using UK electronic health records

Authors Kosari S.; Deeks L.S.; Goss J.; Naunton M.
Source British Journal of General Practice; 2019; vol. 69 (no. 687); p. 490
Publication Date 2019
Publication Type(s) Letter
PubMedID 31558521
Database EMBASE

96. Interpreting and reporting fracture classification and operation type in hip fracture: implications for research studies and routine national audits

Authors Masters J.; Metcalfe D.; Achten J.; Griffin X.L.; Costa M.L.; Parsons N.R.
Source The bone & joint journal; Oct 2019 (no. 10); p. 1292-1299
Publication Date Oct 2019
Publication Type(s) Article
PubMedID 31564146
Database EMBASE
Abstract AIMS: This study explores data quality in operation type and fracture classification recorded as part of a large research study and a national audit with an independent review.
PATIENTS AND METHODS: At 17 centres, an expert surgeon reviewed a randomly selected subset of cases from their centre with regard to fracture classification using the AO system and type of operation performed. Agreement for these variables was then compared with the data collected during conduct of the World Hip Trauma Evaluation (WHiTE) cohort study. Both types of surgery and fracture classification were collapsed to identify the level of detail of reporting that achieved meaningful agreement. In the National Hip Fracture Database (NHFD), the types of operation and fracture classification were explored to identify the proportion of "highly improbable" combinations.
RESULT(S): The records were reviewed for 903 cases. Agreement for the subtypes of extracapsular fracture was poor; most centres achieved no better than "fair" agreement. When the classification was collapsed to a single option for "extracapsular" fracture, only four centres failed to have at least "moderate" agreement. There was only "moderate" agreement for the subtypes of intracapsular fracture, which improved to "substantial" when collapsed to "intracapsular". Subtrochanteric fracture types were well reported with "substantial" agreement. There was near "perfect" agreement for internal fixation procedures. "Perfect" or "substantial" agreement was achieved when the type of arthroplasty surgery was reported at the level of "hemiarthroplasty" and "total hip replacement". When reviewing data submitted to the NHFD, a minimum of 5.2% of cases contained "highly improbable" procedures for the stated fracture classification.
CONCLUSION(S): The complexity of collecting fracture classification data at a national scale compromises the accuracy with which detailed classification systems can be reported. Data around type of surgery performed show similar tendencies. Data capture, reporting, and interpretation in future studies must take this into account. Cite this article: Bone Joint J 2019;101-B:1292-1299.

97. Introduction of a head and neck cancer dental screening pro forma

Authors Ban J.; Ali S.; Barber A.; McNally L.
Source British dental journal; Sep 2018; vol. 225 (no. 6); p. 539-544
Publication Date Sep 2018
Publication Type(s) Article

PubMedID 30237555
Database EMBASE

98. An audit of antimicrobial prescribing by dental practitioners in the north east of England and Cumbria

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Abstract BACKGROUND: Inappropriate prescribing of antimicrobials is a significant threat to global public health. In England, approximately 5% of all antimicrobial items are prescribed by dentists, despite the limited indications for their use in the treatment of oral infections in published clinical guidelines. The objective of this study was to survey antimicrobial prescribing by dental practitioners in North East England and Cumbria, identify educational and training needs and develop a self-assessment tool that can be used for Continued Professional Development by individual practitioners.
METHOD(S): During October 2016, 275 dental practitioners used a standardised form to record anonymous information about patients who had been prescribed antimicrobials. Clinical information and prescribing details were compared against clinical guidelines published by the Faculty of General Dental Practitioners UK.
RESULT(S): Dental practitioners provided data on 1893 antimicrobial prescriptions. There was documented evidence of systemic spread, such as pyrexia in 18% of patients. Dentists recorded patients' pain (91.1% of patients), local lymph gland involvement (41.5%) gross diffuse swelling (55.5%) dysphagia (7.2%) and trismus (13.6%). Reasons for prescribing antimicrobials included patient expectations (25.8%), patient preference (24.8%), time pressures (10.9%), and patients uncooperative with other treatments (10.4%). The most commonly prescribed antimicrobials were amoxicillin, accounting for 61.2% of prescriptions, followed by metronidazole (29.9%). Most prescriptions for amoxicillin were for either 5days (66.8%) or 7days (29.6%) and most prescriptions for metronidazole were for a 5-day course (65.2%) or 7-day (18.6%) course.
CONCLUSION(S): In most cases, when an antimicrobial was prescribed, practitioners used the correct choice of agents and usually prescribed these at the correct dose. However, some evidence of suboptimal prescribing practices when compared to the Faculty of General Dental Practitioner guidelines were identified. The audit has identified training needs across the region and aided the development of Continued Professional Development sessions. Further work to identify barriers and facilitators for improving antimicrobial prescribing and determining appropriate methods to improve clinical practice are required.

99. Patient preferences for involvement in health service development

Authors Finn V.; Stephenson J.; Astin F.
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Abstract BACKGROUND:: patient involvement in the design, planning and delivery of health services is acknowledged to be a local and national priority. AIMS:: to improve service quality through a quality improvement initiative to explore patient preferences for involvement in health services design, planning and delivery.
METHOD(S):: a questionnaire was developed to: assess patient preferences for involvement in hospital service development; and explore differences in responses between patient subgroups. FINDINGS:: 162 patients were recruited. Most were positive about being engaged in all service developments, not just those used personally. Involvement through questionnaires with infrequent email communication was favoured over attendance at public meetings. Time was a greater barrier to being involved than distance or remuneration. Conclusion' Patients valued involvement in health service development, but finding free time during working hours was difficult. There were no differences in preferences for involvement between subgroups defined by gender, ethnicity, home situation or health.

100. A SYSTEMS APPROACH TO INTEGRATING HEART FAILURE CARE: A 'HOW TO' ROAD MAP BASED ON LIVED EXPERIENCE

Authors McKelvie R.; Harkness K.; Sherrard H.; Iverson A.; Leung J.; Woodward G.
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Abstract

Background: National guidelines recommend a system level approach to organizing care for patients with heart failure (HF). The spoke-hub-and-node (SHN) model represents an organization of care that works collaboratively with the primary care sector and is highly integrated with community-based multidisciplinary teams of health care professionals and specialty care. In Ontario, two sets of standards were released - the SHN model for integrated HF care (care organization) and the Quality Standard for HF Care in the Community (delivery of care). The purpose of this quality improvement project was to develop a set of recommendations, or a 'Roadmap' that provides guidance and critical considerations on 'how to' implement integrated and evidence-based HF care in regional teams using 'on the ground' experience from early adopter teams in Ontario.

Methods and Results: This quality improvement project led by CorHealth Ontario involved three early adopter teams (London, Ottawa, and Guelph regions). Between June 2018 - March 2019 each site mobilized clinical and administrative leadership to implement the two sets of standards. CorHealth provided each site with a dedicated project manager (PM) to help organize local implementation activities and construct detailed notes of activities and lessons during this initiative. Biweekly meetings were held with CorHealth and early adopter teams. A provincial HF task group was constructed to help consolidate learnings from each early adopter team into a 'Roadmap' that identified critical requirements and provided guidance on the 'how to' implement integrated evidence-based HF care. This group had clinical, administrative and patient representation.

Result(s): The Roadmap describes the implementation process in 3 phases: 1. Getting started; 2. Taking Action; 3. Sustaining, Scaling up and Spreading. Several requirements that are critical for success are integral to the implementation of this HF quality improvement endeavor. These requirements are a common thread across the recommendations in each phase and include: 1. Patient/caregiver voices; 2. Collaborative leadership; 3. Education; and 4. Data and reporting. Early learnings revealed that the effort required up front is significant. A sustained commitment of time, energy and resources from clinical and administrative partners is vital.

Conclusion(s): Although a systems approach to organizing care for patients with HF is recommended, the actual 'how to' remains poorly understood. The 'Roadmap' outlines recommendations based on key critical requirements from 'the lived experience' of primary and specialty care clinicians and administrators as they worked together to generate locally meaningful and innovative system-level solutions to address current gaps in HF care.

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