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Poster 1
SIMS checklist – a ward based daily brief/debrief tool
Foster, K. Shipley, M. South Tyneside District Hospital
**Background:**
It is commonly recognised that the use of checklists in medical scenarios, for example the surgical safety checklists introduced in 2008 by WHO, can significantly improve patient safety as well as team communication and dynamics. At present there is no similar recommendation in the medical ward setting.

**Aim:**
The SIMS checklist aimed to improve team communication between medical staff on ward leading to enhanced patient care.

**Method:**
The SIMs checklist was created covering keys areas including: basic introductions, to confirm all team members were known and individually aware of their role for the day; highlighted urgent tasks including investigations that needed requesting or any outstanding results and ensured all members of the team were aware of the senior support available on each particular day.

The checklist was trialled over an four month period before evaluation was sort from each team member regarding how the checklist helped to aid optimal team work and patient care.

**Results:**
Evaluation of the checklist concluded that there was a significant positive effect of the use of the checklist. Results showed 100% of staff felt it led to improved organisation, team morale and opportunity to raise any concerns. Most members of staff felt the checklist helped to ensure teaching sessions were attended; roles and responsibilities were known and led improvement in patient safety.
Conclusion:
Overall the SIMS checklist had a positive outcome and showed to have significant improvement in team communication and organisation which was ultimately was felt to lead to improvement in patient safety.
Abstract

We report a case of a 28-year-old lady, with previous history of tuberculosis as a child. She presented with an eight-day history of fever, nausea, and dry cough. She had travelled to India eight months previously, but no history of recent contact with tuberculosis. On examination, she was febrile but haemodynamically stable. There were multiple small, tender lymph nodes in the cervical region bilaterally. The rest of the examination was unremarkable. Initial investigations revealed mildly raised CRP, mild neutropenia and lymphopenia, and increased LDH. She was started on intravenous antibiotics and escalated to meropenem, but continued to deteriorate. All cultures, respiratory, viral, serological, and atypical screens were all negative, including AFB cultures. After 48 hours, she became pancytopenic, with deranged LFTs and clotting screen, and she developed a maculopapular rash. Cervical lymph node biopsy revealed features consistent with Kikuchi-Fujimoto disease.

A second echocardiogram was performed when she became hypotensive which revealed an EF of 28% with hypokinetic and akinetic septal wall motion abnormalities. She was then transferred to a different site for left ventricular assisted device therapy. Pyrexia of unknown origin is usually due to an atypical presentation of a common disease. Kikuchi-Fujimoto disease is a rare, mostly self-limiting disease, presenting usually in women with cervical lymphadenopathy and fever. We report an unusual life-threatening case of Kikuchi-Fujimoto disease, which to the best of our knowledge has only been reported once in the literature 28 years ago. This case highlights the importance of keeping a broad differential in mind, in medically stable patients, as this patient deteriorated rapidly in the final stages of her stay in our hospital. If potential treatment had been initiated earlier, there could have been a different outcome. Therefore, clinicians need to be aware of this disease and how to manage a severe manifestation of this disease.
Poster 3
TB Knowledge amongst the San population of rural Namibia
Taylor, R. McCabe, S. Vuuren, R. Lifeline Clinic, N/a’an ku sê Foundation, Namibia

Background
The Lifeline Clinic, part of the N/a’an ku sê Foundation, provides free healthcare to the San, an impoverished population in Namibia. Pilot clinic data suggests a 6-month TB prevalence of 5-10%, with a relative risk of 10.5 compared with other ethnic groups.

Informal discussion suggested poor TB knowledge, contributing to poor health-seeking behaviour and TB spread in the community.

We therefore formally assessed the TB knowledge of the San.

Methods
8 questions were asked. Participants were identified randomly. They were interviewed with the help of the clinic TB translator.

Results
25 people were included; all San. Their age range was 18-75 years. 44% currently or previously had had TB.

Participants struggled to define TB. Most described it as a disease, but could not elaborate further.

Only 52% could name one World Health Organisation screening symptom (cough, haemoptysis, weight loss, fever, night sweats). None named all five.

52% attempted to answer how to stop TB spread. Only a few were correct, with a minority knowing to cover their mouth if coughing.

People were asked why some patients spend longer in hospital (relapse patients are admitted for 8 weeks of streptomycin). Most thought it was due to poor patient behaviour.

MDR-TB patients are transferred to the capital, Windhoek. This was appreciated, but as a concept of ‘strong TB’. No answers related to antibiotic resistance.

Answers were divided into those people who had had TB and those who had not. There were slightly more correct answers in the previous TB group, but overall knowledge remained poor and many struggled to name a symptom.

Conclusion
TB knowledge was lower than expected, hindering our efforts to reduce TB incidence. We have now involved the San community and developed a patient education leaflet in pictorial format.
Poster 4
A quality improvement project to look at the use of clotting screens on patients admitted to the Acute Assessment Unit and a further cost-benefit analysis
Harvey-Jones, E. Liu, C. Chelsea and Westminster Hospital

Aims:
• A quality improvement project looked at the use of clotting screens in patients admitted to the Acute Admissions Unit (AAU) at Chelsea and Westminster Hospital
• To help reduce cost on non-essential tests and improved quality of hospital stay for patients

Methods:
• A retrospective collection of data, looking at all patients admitted to AAU from 1st January-1st February 2016 (n=166)
• A second cycle looked at data from December 1st 2016 -January 1st 2017 (n=143) following introduction of a new guideline.
• From this data case notes were looked at to determine the clinical status of the patient, and whether a previous clotting study had been carried out in A&E.
• The notes were looked at in detail to determine whether a clear indication for the test was documented.

Outcomes:
• Clotting screens cost £8.07p per test
• Cycle 1: 17% of clotting screens were clinically indicated. Of the 166 patients included, 98 (59%) patients already had clotting screen sent in the ED. Of these 21 (21.4%) were appropriately tested. The department spent a total of £1340 on clotting screens. Only £221 was spent appropriately.
• In comparison after the second cycle the department spent less in total on clotting screens (£1,154.01) with more appropriate tests requested (66%).
• This data was compared to a mirror study carried out in A&E which performed significantly less well.

Conclusions
• Local guidance was based on the Imperial college healthcare trust guidance, and clinical advice from leading consultants in the AAU department at Chelsea & Westminster
• Following the introduction of local guidelines the department was able to save a significant sum of money per month
• The study improved patient care and reduced need for unnecessary tests.

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Poster 5
A case of episodic hypotension leading to diagnosis of capillary leak syndrome.

Al-Talib, I. Sheffield Teaching Hospitals

Abstract

Systemic Capillary Leak Syndrome—also known as Clarkson’s disease—is a very rare disorder with about 200 reported cases. The disease is characterised by recurrent, random attacks of leakage of plasma fluids and protein through capillary endothelium.

The authors describe an interesting case of a fifty-nine year old female admitted to a tertiary hospital with recurrent episodes of lethargy, dizziness and syncope. These symptoms were preceded by a history of increasing shortness of breath, wheeze and facial swelling for a few days. These attacks were associated with a severe hypotension (systolic blood pressure of 70 mmHg) and acute kidney injury (ranging form mild to severe with profound metabolic acidosis). The differential diagnosis of this case included common and rare diseases (sepsis, adrenal insufficiency, mast cell disease, hereditary angioedema, carcinoid syndrome, anaphylaxis syndromes and capillary leak syndrome).

Extensive investigations were conducted to identify the cause with most of investigations need to done within the first four hours of hospital admission.

Even though the attacks are usually self-limiting, the patient required multiple hospital admissions for vigorous intravenous fluid resuscitation and close monitoring with one of the attacks requiring inotropic support and a renal replacement therapy in intensive care unit. Due to the rarity of the disease, a majority of treatment options are empirical with controversial evidence.

References

AIM
1. To identify the proportion of patients who were either assessed/reviewed by a consultant/middle grade doctor, presenting with atraumatic chest pain (aged 30 years and over) and abdominal pain (aged 60 years and over) prior to discharge during a three-month period.
2. Recognising and implementing methods of improving the risk management for these patients by actively increasing consultant or middle grade doctor sign-offs in the absence of a consultant.

METHOD
This was a retrospective audit from April-June 2017, sample size of 333 patients. (n=333).

These patients were identified using a database of patients’ clinical notes called ‘Therefore’. Patients were short-listed and arranged in a chronological order of presentation in a tabulated format in Microsoft excel.

- Patients were then grouped into the following categories:
  A  Seen by an A&E consultant.
  B  Reviewed by an A&E consultant.
  C  Seen by a middle grade doctor.
  D  Reviewed by a middle grade doctor.
  E  None of the above

RESULTS
The images below display the relative proportion of patients and the trends in the monthly variation of patients in relation to categories A to E.
CONCLUSIONS
The need to expand consultant/middle grade/locum doctor posts and alter their working schedules to enable them to spend more time on the ‘shop floor’- assisting in greater number of sign off. Thus, ensuring patient safety and enhancing the quality of care delivered to patients.
The need to educate and encourage junior doctors to approach consultant/middle grade doctors working in the department to review patients in the absence of a consultant e.g. through meetings, educational seminars, wall posters, sign-off stamps in the patients’ notes.

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Year of publication-2016-2017, Pages- 1 to 8.

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Poster 7
Landing in the Western Isles: Introducing a Best Possible Destination Approach for Acute Coastguard Admissions

Rochester, A. Western Isles Hospital

AIM
The Western Isles Hospital (WIH) is a rural island hospital in Stornaway with general medical provision but without specific subspecialties such as an intensive care unit or primary invasive cardiac interventions. The hospital receives a number of patients from the Coastguard service. The coastguard’s main focus is the rapid delivery of patients to a medical place of safety for ongoing care and rapid redeployment of the coastguard team. At times, bringing patients to WIH may be the quickest option but may not be appropriate patient-centered care in terms of time to definitive care.

METHODS
A review of patients brought to WIH over the past 6 months was carried out jointly between the coastguard team and the hospital. The nature of presenting complaint, location of retrieval and requirement to transfer to another hospital was recorded.

OUTCOME

The area covered by coastguard transfers was widespread, including some from the mainland to WIH. We received 10 patients in the 6 months. 4 patients presented with chest pain or collapse. Based on their presenting complaint, these patients may have been suitable candidates for Primary Percutaneous Coronary Intervention (PPCI) and transfer to WIH precluded this. In total 3 patients required transfer to a mainland hospital for definitive care. In addition to potential medical implications, patients being brought to an island hospital may face significant logistical difficulties in getting home.
CONCLUSION

There can be conflicting agendas with regards to acute hospital admissions. Rather than considering ‘time to care’, in a patient-centered NHS, we should consider time to appropriate care. Based on these findings a correct destination approach for Major Trauma, PPCI, Stroke, Paediatrics and burns is being introduced. The aim is to balance tying up an air asset and delivering the patient to the best possible destination for their condition with due aeronautical considerations.
Aim:
Given that approximately 1% of patients with community acquired pneumonia (CAP) will have an undiagnosed lung malignancy corresponding to the initial radiological changes, we wished to identify the proportion of patients admitted to Maidstone District General Hospital with radiologically-confirmed CAP over a three-month period who underwent review and/or repeat imaging at 6-8 weeks, as per British Thoracic Society (BTS) guidelines.1,2

Method:
A sample of patients over 50 years of age with a primary/radiologically confirmed diagnosis of CAP who were admitted to Maidstone Hospital more than 8 weeks prior to time of data collection was selected. The hospital radiology system (PACS) was checked for repeat imaging (X-ray/CT) and the discharge system interrogated for follow-up requests on their electronic discharge notes (EDN). If follow-up was unsuccessful, GPs were contacted to ascertain subjective barriers to this. A poster was then issued around the hospital highlighting follow-up procedure prior to re-audit several months later.

Results:
Round one; n=21, mean age 74 years. 9.5% had imaging requested on EDN and 4.5% had imaging available on PACS. Barriers identified by GPs were ignorance of the guideline, absence of requests on EDN and if patients are housebound. All stated follow-up would be arranged if requested in the discharge summary. Round 2; n=25, mean age 74 years. Following distribution of the poster 28% had imaging both requested on EDN and performed at 8 weeks.
Summary:

Follow-up of patients with CAP is poorly facilitated by hospital and community physicians alike. Visual prompt by means of an informative poster increased follow-up requests at discharge by 18.5% and successful completion of repeat imaging by 23.5%. However, three-quarters of patients identified as being at high-risk of malignancy did not receive follow-up, suggesting an ignorance of BTS guidelines by discharging staff is a major barrier and that inclusion of written requests for follow-up at discharge is paramount.

References


Poster 9
Frequent Attendances in A&E of patients known to neurology services: Get the back story on the front door

Theochari, E. Royal Surrey County Hospital

Abstract

‘Frequent attenders’ have been defined as patients who attend a health care facility repeatedly. It is estimated that 1-2% of attendances to U.K. Emergency Departments are made by ‘frequent attenders’ (1-3) representing a disproportionate burden upon clinical & financial resource. Given the fact that acute neurological problems are common and account for between 10 and 20% of acute medical admissions (3,4), we designed this quality improvement project to gather data on frequent A&E attenders known to neurology services.

We retrospectively analysed clinical notes of patients with more than 6 A&E attendances in 2 time periods, January 2016 - January 2017 and February 2017-July 2017 (when acute services were re-organised directing “Stroke” patients to a nearby hyper-acute stroke Unit). We analysed data on the number and reasons for attendances, mode of transport, admissions, discharge, mode of follow up and background neurological diagnosis.

In a total of 3772 yearly A&E presentations of frequent attenders, 736 (20%) were for patients known to neurology services. Attendances fell to 10% when hyperacute stroke services were unavailable in our hospital. Neurology patients had a higher average number of attendances (9.1 verse 6.6 in the year 2016-2017). More than half of the patients known to neurology were admitted. One third were discharged to their GP for follow up. Sixty-six percent of “neurology” patients came by ambulance; this explains the reduction of attendances of “neurology” patients since ambulance crews redirect cases for assessment to a hyperacutre stroke unit when presenting with a neurological complaint.

A background diagnosis of epilepsy and/or non-epileptic attack disorder was present in 40% (27% with epilepsy, 13% with non-epileptic attack disorder) and functional disorder in 1/3. Redesign of Neurology services would improve the care for these patients in the community. Specialist nurses, especially in epilepsy, and (neuro-)psychiatry, are paramount to achieving this goal.

References


A change in culture - learning to talk about Medical Advanced Plans

Jones, S. Kitchen, J. McKeogh, M. Stoke Mandeville Hospital

Aim

Medical Advance Plans (MAPs) allow patients, in consultation with clinicians, family and significant others, to make decisions about their future healthcare (1). They ensure treatment wishes are documented and respected for future reference (2). Admission to hospital presents an opportunity to discuss & document resuscitation and treatment goals.

MAPs help ensure appropriate levels of treatment are delivered and have been shown to benefit junior doctors with decision making, especially during on call shifts (3). In a survey of 33 Junior doctors in the Royal Berkshire Hospital (RBH), 81% strongly agreed and 12% agreed that MAPs aid decision making out of hours. This prompted a quality improvement project to increase completion of MAPs on admission of patients to the Acute Medical Unit (AMU) and High Dependency Unit (HDU).

Methods

From November 2016 to June 2017, several initiatives were implemented to increase completion of MAPS. Stickers were placed in medical clerking proformas to prompt completion. AMU staff had interactive briefings about the importance of completing MAPs. Initial data was presented at grand rounds, highlighting the importance of MAPs to a wider audience. Audits were completed to document the completion of MAPS.

Results

In November 2016 only 7% of patients (2 out of 28) in the AMU/HDU had a MAP in place. This improved to 42% following local teaching & use of stickers in March 2017. This increased further to 55% in June 2017 following the grand round presentation.

Conclusion Educating doctors and highlighting the benefits of MAPS improved completion rates significantly. This should lead to improved patient experience.

References

Case

A 73 year old male presented with a 6 month history of a severe left sided headache and a 4 month history of sudden onset visual loss in the left eye. He was initially treated for giant cell arteritis with high dose prednisolone.

Over the next four months he experienced a general decline in condition and a rapidly progressive left sided proptosis.

Examination confirmed the visual loss and proptosis, together with left sided ptosis, a sluggish dilated pupil, lateral rectus palsy and reduced sensation over the ophthalmic division of the trigeminal nerve.

A contrast MRI demonstrated two pathologies; an acute left parietal occipital infarct and a left orbital apex mass extending into the left cavernous sinus. Of note, an MRI head performed at initial presentation some months earlier had not identified any mass.

Following neurosurgical advice, the patient commenced dexamethasone for a likely diagnosis of malignancy. He subsequently underwent a staging CT however no significant abnormalities were detected.

The diagnosis was eventually revealed following histological examination of tissue samples obtained via transsphenoidal endoscopic surgery. Despite no history of significant immunosuppression, the patient was diagnosed with invasive cerebral aspergillosis.
The patient was transferred to a local infectious disease unit where he was treated with intravenous voriconazole. Surgical reduction of the lesion was felt to be unfeasible.

Discussion
Cerebral aspergillosis is a rare, opportunistic fungal infection of the central nervous system. It is usually associated with significant immunosuppression and has high morbidity and mortality1. With increased use of immunosuppressive agents the incidence is rising2, however, it is still very unusual in immunocompetent individuals.

Despite the prolonged use of high dose steroids, this patient was otherwise immunocompetent and the most likely port of entry was felt to be the sinuses, secondary to chronic sinusitis.

References
Poster 12
Intravenous paracetamol prescribing within short stay unit

Royal Victoria Hospital

Intravenous Paracetamol Prescribing within Short Stay Unit: Quality Improvement Project
B Thompson, P Armstrong, J S Costello, G Millar, SW Gingles, L Browne, S O’Donnell  LJM Cross

Medication errors and harm caused to patients by adverse drug effects are common within the NHS. Paracetamol prescribing and in particular that in relationship to intravenous route has been associated with many medication errors and direct harm to patients in the past. Paracetamol administrated by the intravenous route is a common prescribed medicine within the Belfast Trust as an analgesic and antipyretic. A policy guidance was written by the Belfast Trust in 2013 and despite this the usage of iv paracetamol has increased as shown in Figure 1

Figure 1

Usage of IV Paracetamol in the BHSCT 2011-2013

Audit Standards

Subsequent to this the medicine governance group identified iv paracetamol prescribing as potential high risk and set audit targets as outlined in Fig 2.

Background and Aim

In people with atrial fibrillation (AF), anticoagulation reduces the risk of cardioembolic stroke but increases the risk of cerebral bleeding (1). Little data exists on the types of stroke in people with AF admitted to hospital.

This study seeks to characterise types of AF-related stroke admitted to hospital.

Methods

All individuals admitted to the Stroke Unit at Pilgrim Hospital, Boston, UK between (01 August 2013-01 August 2015) with a primary diagnosis of cerebrovascular accident and AF were extracted from the Stroke Sentinel National Audit Programme database. Case records were reviewed for type of stroke, use of anticoagulant and value of the international normalised ratio (INR) on admission (if on warfarin).
Figure 2

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Target</th>
<th>March 2014 Results</th>
<th>Dec 2014 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients prescribed IV paracetamol should not include an option for another route</td>
<td>100%</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>When a weight-dependent drug is prescribed, the weight should be recorded on the kardex</td>
<td>100%</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>The dose and frequency prescribed should be appropriate based on the patient's weight</td>
<td>100%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Every patient prescribed IV paracetamol is for an indication specified in the local policy</td>
<td>100%</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>No other concurrent paracetamol product prescribed on kardex</td>
<td>100%</td>
<td>N/A</td>
<td>96%</td>
</tr>
</tbody>
</table>

Results

Since 2014 the repeat of the audit has shown improvement in the weight being recorded to 95%. The criteria for an indication and concurrent prescribing remained similar to 2014. Again, the dose adjustment was not occurring at good standard.

Conclusion

This highlights the importance of understanding the need for adjustment of IV paracetamol dose for low weight patients and for other indications such as elderly and frail, hepatic and renal impairment and chronic malnourishment. Following this repeat audit this has now become a quality improvement project with differing interventions such as education sessions. This ongoing intervention we feel may slowly improve the results attained in dose adjustment.
Poster 13
Renal sarcoidosis: An unusual presentation in a young male adult, Case report

Ooi, A. Colchester Hospital University Foundation Trust

Case Report:

26 year old Caucasian male, normally fit and well, presented with 1 month history of increasing joint swelling in his hands and feet, feeling generally unwell and pyrexia. He took NSAIDs for 2 weeks prior to presentation. On admission to the emergency assessment unit, he was found to be in acute renal failure and hypercalcaemic. He was treated with IV fluids and given 2 doses of IV pamidronate.

Further investigations included CXR which showed normal cardiac size and mediastinal contours. Lungs and pleural spaces are clear. USS KUB showed right kidney appears enlarged measuring 148mm but is of normal shape and echotexture. The left kidney measures 130mm and appears normal in shape and echotexture. No hydronephrosis or calculi seen. No bladder wall defect seen.

Bloods showing high calcium, low vitamin D, low parathyroid hormone. HIV screen was negative. Serum ACE level was elevated. Myeloma and autoimmune screen came back negative.

CT Chest high resolution: No obvious hilar adenopathy even on this unenhanced study. No pathological axillary lymph nodes. No lung parenchyma changes. No nodules. Review of the imaged skeleton shows no bony destructive lesion. Echo: normal, LV size and wall thickness - normal, ejection fraction >=55% (normal)

Seen by renal team and biopsy was performed, which showed patchy interstitial inflammatory changes in keeping with acute tubulo-interstitial nephritis, accompanied by one, sizeable, non-necrotising granuloma. Supporting a diagnosis of renal involvement by sarcoid.

Patient was treated with oral steroids and his renal function improved subsequently.

Discussion

Renal manifestations in renal sarcoidosis include abnormal calcium metabolism, nephrolithiasis and nephrocalcinosis, and acute interstitial nephritis with or without granuloma formation. The classic renal lesion is noncaseating granulomatous interstitial nephritis. Hypercalciuria and hypercalcemia are most often responsible for clinically significant renal disease. Glomerular disease, obstructive uropathy, and end-stage renal disease (ESRD) may also occur but are uncommon. The incidence and prevalence of renal involvement in sarcoidosis remain uncertain as most patients are asymptomatic.
Learning points

The case highlights the importance of having a degree of suspicion of renal sarcoidosis in young patients presenting with hypercalcaemia and renal failure. Prompt referral for renal biopsy by the renal team for diagnosis and treatment with steroids.

REFERENCES


Background

A 73 year male patient had a radical right nephrectomy for renal cell carcinoma (RCC) with vascular invasion in 2001. He refused adjuvant chemotherapy. In 2007, progressive disease was diagnosed with a metastatic left renal primary cancer. There was a partial response to chemotherapy. In January 2015, he presented with anaemia and melaena. Gastroscopy showed a sausage like lesion in the second part of duodenum extending distally for about 22cm with an ulcerated, oozing proximal end (Fig 1). CT scan (Fig 2) showed the duodenum to be displaced towards right nephrectomy bed with an elongated infiltrative soft tissue mass related to the lateral duodenal wall centred upon the D2 level extending both above and below the level of the ampulla with marked luminal distortion. Bulky liver metastases were present. The biopsies of the duodenal mass showed a clear cell carcinoma consistent with metastatic RCC with appearance similar to the primary RCC resected in 2001.

Spread in RCC is lymphatic, haematogenous, transcoelomic or by direct invasion. Common sites of metastasis from RCC are lung (75%), lymph nodes (36%), bones (20%), liver (18%) adrenals, kidneys, brain, heart, spleen, intestine and skin [1]. About 7.1% metastases to small bowel are from RCC, others being from melanomas, lung, cancer, cervical cancers, thyroid cancer, hepatomas and Merkel cell carcinomas [2]. Metastasis to duodenum from RCC is rare with only a few cases described in English literature [3]. It can occur years after diagnosis-cases have been reported at 19 years post nephrectomy [4]. Most cases present with bleeding or bowel obstruction.

The patient was given supportive management with blood transfusion and proton pump inhibitors. He was not considered fit for any interventional therapy and discharged with palliative care input.

References

Primary HIV infection: an opportunity to test in the emergency medical setting

Jankee, P. St Thomas A&E

Aim:
More than 50% of individuals with primary HIV infection are thought to develop a symptomatic seroconversion illness (1). These symptoms are non-specific in nature and may mimic many common febrile illnesses such as tonsillitis or gastroenteritis (2). Early diagnosis at this critical stage of acute HIV infection represents a unique opportunity for treatment and prevention interventions prior to development of advanced disease. To investigate the extent to which primary HIV infection presents to emergency healthcare providers at St. Thomas’s Hospital and the degree to which it is recognized.

Method:
Retrospective review of all patients that have presented to A&E/UCC over a year (August 2016-August 2017) with symptoms of primary HIV infection. This study identified individuals with indicator illness’s, specifically tonsillitis, gastroenteritis and pyrexia of unknown origin in those aged 15 and over.

Outcome:
Of the 308 subjects, 305 (99%) were diagnosed with tonsillitis, of which just over half were female (52%). The most common presenting complaint was that of a sore throat and had been symptomatic for >48 hours prior to presentation. Of these only 81 were tested for HIV in the A&E department, making testing rates for this cohort of individuals at just over a quarter (26.5%)

Conclusion:
HIV should be preferably diagnosed in its early stages, and to optimize the chances of doing this, HIV testing in patients with one of several indicator diseases in the A&E setting in vital (3,4). This retrospective review highlights that more testing needs to be done in the A&E setting with a view to catching those that are often missed in the early stages of HIV. Indicator illness targeted testing will diagnose more patient’s acute HIV illness, allowing for early treatment and management.
References:


Poster 16
Treatment Escalation Decisions in Critically Unwell Medical Patients
Choubey, A. Findlay, A. Ealing Hospital / London Northwest Healthcare NHS Trust

Aim
The aim of this audit was to evaluate the proportion of medical patients (particularly critically unwell patients) whose ceiling of care had been considered or acknowledged up to the time of or during the post-take ward round within 12 hours of admission.

Methodology
The audit was carried out at Ealing hospital (London Northwest Healthcare NHS Trust). Medical admission proformas were retrospectively reviewed from case notes over the duration of 1 week.

Results
The total number of included medical admissions was 149. In total, a ceiling of care decision was made before or during the post-take ward round in 20% of admissions. 41 patients were transferred to hospital as a priority call. Of these patients, 41% had a documented ceiling of care decision by the end of the post-take round.

77 patients admitted were over the age of 65. Of these, 29% were critical transfers. 70% of patients over 65 did not have a ceiling of care decision by the end of the post-take ward round. 46% of critically unwell elderly patients did not have an acknowledged or documented ceiling of care by the end of the post-take ward round.

Conclusions
The results reflect that a very small percentage of total medical admissions (20%) had a documented ceiling of care either by the time of or during the first Consultant assessment. In the majority of cases (59%), there was no consideration of ceiling of care in critically unwell patients.

These decisions affect the quality of care that clinicians are able to provide. The Resuscitation Council (UK) advises that there should be early involvement of a senior, experienced clinician in decision-making in such scenarios where CPR or higher-level care may be appropriate.
The following actions are proposed:

- Educational presentation
- Trial modification of the medical clerking proforma
- Re-audit in September 2017

References

1. Decisions relating to cardiopulmonary resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing Resuscitation Council (UK), British Medical Association and Royal College of Nursing, 2016.
Introduction
Community acquired pneumonia (CAP) is one of the most common presentations seen in acute hospital settings. The annual UK prevalence of CAP is 0.5 to 1%. Of adults who present to GPs with symptoms of LRTI, 5-12% are diagnosed with CAP, with around 1/3 needing hospital admission. The mortality rate is between 5 and 14%. Therefore there is a pressing need to reduce the length of stay and mortality for patients with CAP.

Methods
Over a 28 days period patients were identified through medical take lists as those with CAP, which was defined as evidence of infection with consolidation on CXR/CT (clinician or radiologist reported).

Results
There were 22 complete data sets out of 27 identified patients.
18% of patients had a pathogen identified.
18% of productive patients didn’t have a sputum culture.
90% had urine pneumococcal/legionella antigens taken, with 9% positive. The time from admission to result was 38 hours.
Mean time from IV to PO step down was 6d 11h. We estimated 45% could have been stepped down earlier.
36% of patients sat in the chair in the first 24 hours.
27% had HFNC, with a further 18% potentially could have had.

Conclusion
The proportion of patients with an identified pathogen, was lower in real life practice than in the literature. Sputum cultures are underused. Despite being a rapid antigen detection test, the mean time to result for urine antigens was nearly 2 days. Patients have prolonged courses of IV antibiotics, which lengthens inpatient stay and has been demonstrated to increase morbidity. Furthermore, simple interventions such as sitting in the chair and choice of oxygen delivery are underused. The BTS CAP bundle includes four basic interventions (CXR in <4h, CURB-65 scoring, oxygen assessment, antibiotics in <4h).
detailed care bundle could lead to reduced length of stay, improved antimicrobial stewardship, and reduced mortality.

References

1. Pneumonia: Diagnosis and management of community and hospital acquired pneumonia in adults: NICE Clinical Guideline (December 2014)


Poster 19
Pulmonary Embolism Management: A Quality Improvement Project
Kandasmamy, R. Mohamedally, S. Royal Devon r& Exeter Hospital.

Aim:
In accordance with CG144 (NICE, 2015) guidance on management of pulmonary emboli we tried to optimise the investigation, treatment and follow-up of pulmonary emboli. We performed an audit, put in place IT and teaching-based interventions to improve the adherence to the guidelines, and increase general awareness of the management protocols, before remeasuring the adherence. We extended the scope of the quality improvement project to include criteria for thrombolysis, as this was identified as an area of uncertainty.

Methods:
We collected a patient set by looking at all positive CTPAs from the periods November 2016 to January 2017 and August to November 2016, and reviewing their notes and imaging to identify PEs. We identified 19 patients in the first audit and 42 in the second audit.

Results:
The initial audit identified major shortfalls in the management of PEs, particularly:

• Poor use or documentation of Wells score during initial workup
• Screening for potential malignancy not performed when indicated
• Poor information quality given to GPs regarding follow-up and ongoing management

In order to improve the areas lacking, we:

• Designed a PE Proforma to be distributed to assist in complete workup for these patients
• Discharge-related IT changes to remind clinicians regarding follow-up
• Streamlined D-Dimer booking and Wells assessment to expedite correct workup

In both audits we noted shortfalls in the understanding of junior clinicians regarding indications for thrombolysis and so we discussed index cases at grand round, and guidelines for best practice.

Discussion:
We have achieved improvement in diagnosis, management and follow-up of PEs. The areas still lacking, within those, are the examination of breasts, measuring serum calcium, mammogram in follow-up and documenting the physical examination more thoroughly.
Data collected about consideration of thrombolysis reflects some uncertainty discussed at previous meetings. The next step is to find interventions to target these shortfalls.

References

Pabrinex: Improving Prescribing Habits in Secondary Care

Peachy, R. Salford Royal Hospital.

Background:
Pabrinex is an intravenous medication indicated for use in treatment and prevention of vitamin B deficiency, particularly thiamine (vitamin B1) deficiency. In secondary care, it is commonly prescribed for three indications: treatment of Wernicke’s Encephalopathy, prophylaxis of the same condition in at-risk alcohol dependent patients and Refeeding Syndrome. Different prescribing regimes exist for each indication at Salford Royal NHS Foundation Trust (SRFT)1,2. Pabrinex is not an inexpensive medication (£2.08 per dose at SRFT, excluding costs associated with administration).

Aim:
To improve the prescribing of Pabrinex in accordance with SRFT hospital guidelines.

Methods:
An initial audit analysed Pabrinex prescribing events across the whole Trust for one month. Cost of the actual prescribed course was compared to cost of the ideal prescribed course (based on hospital guideline for the particular indication). Main outcomes were a) daily and b) estimated annual overspend on Pabrinex medication. Interventions involved distribution and presentation of a poster summarising the multiple hospital Pabrinex prescribing guidelines. A re-audit took place in the two weeks immediately following the intervention.

Results:
Large overspends are occurring due to open-ended and incorrect regime prescribing. Following interventions, a reduction in daily overspend from £85.75 to £42.14 (50.8% reduction) was seen. Reductions in estimated annual overspend led to a predicted annual saving of £15,917.65. The number of prescriptions with correct course durations also increased.

Conclusion: Our interventions raised awareness regarding different prescribing regimes and appropriate course durations. Compliance of Pabrinex prescribing according to hospital guidelines improved. This led to a reduction in overspend on Pabrinex of 50.8%.

References
Poster 21
Posterior circulation stroke due to large vessel vasculitis ie. Giant cell arteritis

Cheung, A. Wigan Infirmary

Summary

A 76-year old lady with background of hypertension and polymyalgia rheumatica presented with a new left-sided temporal headache, pain when chewing and combing her hair, blurred vision, dizziness, numbness in her right face, arm and leg. She had been on prednisolone for 3 years due to recurrent flare up of her polymyalgia symptoms. She managed to wean it off completely 2 months prior to this admission. On examination, she had diplopia but otherwise neurology examination was grossly normal. Her blood test shows raised inflammatory markers including ESR 61 and CRP 25. CT head was nil acute. She was treated as giant cell arteritis with high dose prednisolone with rapid improvement of her symptoms. She was later reviewed in rheumatology and stroke clinic in which further investigations were requested. MR angiogram revealed bilateral occipital infarction and occlusion of posterior cerebral artery. She was advised to continue her prednisolone (reducing regime) for further 18 months with bone protection therapy. She was also given anti-platelet for secondary prevention of cardiovascular diseases.

Literature review

Posterior circulation stroke accounts for 20-25% of ischaemic strokes in the UK. The main causes are vertebrobasilar artery atherosclerosis / dissection and embolism from the heart. A study by Gonzalez-Gay shows that out of 287 patients with biopsy-proven giant cell arteritis, 8 of them (2.8%) had stroke between the onset of symptoms and 4 weeks after starting steroid therapy. Among the 8 people with stroke and giant cell arteritis, 7 of them (87.5%) had posterior circulation infarction. In view of the finding, posterior circulation stroke is a known but uncommon complication of large vessel vasculitis.

This case report illustrated posterior circulation stroke secondary to large vessel arteritis. On clinical practice, for any patients presented with stroke like symptoms, headache and raised ESR, giant cell arteritis should be considered as one of the differential diagnosis.

References

MYOCARDIAL INFARCTION CAUSED BY TRIPLE-HIT LYMPHOMA
Amanuel, H. Darent Valley Hospital.

Abstract
Triple Hit Lymphoma (THL) is an extremely rare and aggressive form of Non Hodgkin’s lymphoma with morphologic, phenotypic and genetic features of both diffuse large B cell lymphoma (DLBCL) and Burkitt lymphoma (BL). Its characteristic cytogenetic abnormalities involve chromosomal rearrangements of c-MYC, BCL-2, and BCL-6 genes. It has been recognised, in the 2016-revised WHO classification of lymphoid neoplasms, as “High-grade B-cell lymphoma, with MYC and BCL2 and/or BCL6 rearrangements”. We describe a case of a 68 years old male with two years history of stable low-grade follicular lymphoma suddenly transforming into acute leukaemia caused by THL. During the aggressively progressive phase, he developed Non-ST Elevation MI (NSTEMI), diagnosed by raised troponin and new anterolateral ST depressions on his ECG. His MI was attributed to leukostasis, anaemia and coagulopathy. THL carries the poorer prognosis than either DLBCL or BL alone; thus it should be recognised as haematological emergency.

Conclusion
We present this case to share lessons we have learned, which are:
• Triple hit lymphoma is a rare but very aggressive entity and patients with this disease should be managed on haematology high dependency units as a haematology emergency.
• All transformed follicular lymphomas should be checked for MYC, BCL6 and BCL2 mutations
• Once Triple-Hit lymphoma is confirmed, early frank discussion with patient and family about the extremely poor prognosis and early palliative care involvement are necessary
• The acute leucocytosis, anaemia and electrolyte disturbance secondary to disease progression can lead to acute myocardial infarction and close monitoring and treatment of such patient should be provided at high dependency unit.

Key words: Triple Hit Lymphoma, Acute leukaemia, NON-ST Elevation Myocardial Infarction, Haematology Emergency
References


Case Report:

A 38 year old female was referred to the East Surrey Hospital Acute Medical Unit Ambulatory Clinic. The patient reported a two-week history of intermittent left arm blueness, swelling, and paraesthesia. The patient was 39 weeks pregnant with her second child but no other significant personal or family medical history and was taking no medications.

No recent trauma was reported and symptoms only occur when walking exclusively outside with resolution at rest. On systems review the patient reported only mild dyspnoea gradually increasing in the previous month.

On examination the patient was comfortable at rest, observations were within normal range with bilateral peripheral saturations of 97%. Upper limb examination revealed no gross abnormality, oedema, tenderness, measurable size difference, vascular insufficiency or neurological signs. Cardiovascular exam and respiratory exam were normal. Blood tests including FBC, U&E and clotting were normal. Left arm ultrasound doppler revealed patient, anatomically normal vasculature. Walking the patient for 5 minutes elicited no symptoms.

Further history revealed that the onset of symptoms correlated with the purchase of a new bag which the patient wore over the left shoulder. Further 5 minutes walking with bag in situ over the shoulder elicited ipsilateral paraesthesia.

The diagnosis of venous thoracic outlet syndrome (TOS) was made, exacerbated by pregnancy. Use of an over-shoulder bag was stopped and symptoms have not recurred. Follow-up has been arranged for chest radiograph postpartum to rule out bony abnormalities which are present in 29% of patients. Diagnosis of TOS is problematic with a constellation of signs and symptoms being key in group of clinically distinct disorders with compression of one or more neurovascular elements as they traverse the thoracic outlet - neurogenic ~95%, venous ~3%, arterial ~1% . Provocation manoeuvres have been described although there is significant interexaminer reliability and disputable sensitivity and specificity.

References


Audit of prescription and supply of anticipatory medications for palliative patients being discharged to the community

Woods, A. Worthing General Hospital

Aim

1. To evaluate our current practice of prescribing and supplying anticipatory medications for end of life patients who are being discharged to the community.
2. To identify the obstacles to giving these medications in the community.

Methods

A retrospective audit was performed, using data from the Palliative care team’s records from Worthing General hospital and St Richard’s hospital of patients who had been ‘fast-track’ discharged to the community. The standards were taken from the Palliative care adult network guidelines.

The standards were that patients had been discharged with the appropriate medication for nausea, pain, anxiety and secretions, and that the doses were appropriate. The community records were then cross-referenced for any problems post discharge.

Results

52 patients were included cross-site. 41 patients had medication from all four categories prescribed, 8 had none prescribed, and 7 had inappropriate doses prescribed. Where inappropriate doses were prescribed it was due to long acting painkillers and patches not being accounted for.

The community data revealed that the majority of problems related to lack of supply of vials, syringes or water for injection or missing community prescription forms.

Conclusion

A need was identified to improve current prescribing and supply of anticipatory medications, and to ensure that patients are being discharged with adequate quantities of medications and the supplies required to administer them.

To ensure an improvement we are developing a guideline for the prescription and supply of anticipatory medication as well as developing a pack for patients to be discharged with that includes syringes, needles and water for injection.
References


2. Guidance for care of patients in the last days of life – Coastal West Sussex Clinical Commissioning Group http://nww.westernsussexhospitals.nhs.uk/assets/Guidance___caring_for_patients_in_last_days_of_life__June_2014_Final_.pdf
Mind over food' - service improvement in tier 3/4 obesity service

Hanson, P. UHCW

Overeating contributes to obesity epidemic and has many causes. Evidence shows that problematic eating behaviours can be modified with mindfulness. In the UK the use of mindfulness in management of obesity has been studied only once before. We aimed to pilot a new weight management course that would improve patients’ skills and confidence in ability to lose weight, and improve their eating style.

The course covered mindful eating, compassion and self-esteem, managing relapses and weight loss orientated marketing. Four interactive sessions were delivered by dietitians and psychologists over 8 weeks, resulting in frequent contact with participants. Patients were invited to participate in this course following their first appointment, and received normal follow-up regardless of their participation.

Twenty-six patients were included in the final analysis. Anonymized feedback and eating style questionnaires were collected before and after the course. Average weight loss was 0.78kg. Patients were seen more frequently in the initial phase of their treatment pathway, leading to improved experience.

Patients became more confident, compassionate and felt more in control. Eating styles were assessed by a validated questionnaire focusing on 7 distinct eating styles associated with obesity. Paired t-test was applied to analyse results. Statistically significant improvement was found in overall eating style (p=0.002), unappetizing atmosphere (p=0.05), fast foodism (p=0.05) and solo dining (p=0.02).

This holistic course equipped patients with new skills to change eating behaviours, coping strategies and changed their mindset and is already incorporated into the standard service for all bariatric patients. However, the results of this project have global implications as management of obesity should incorporate holistic approach and utilize mindfulness in future.

References

Aims and Objectives:

Hypokalemia (K≤ 3.4mmol/l) is a common metabolic abnormality encountered in Acute Medical inpatients. Measuring magnesium levels and treating it if low is considered to avoid refractory potassium replacement and complications arising from low potassium level. Our aim was to look into Hypokalemia Treatment adherence within our trust guidelines, identification and treatment of Hypomagnesaemia in patients with moderate (K: 3.1 to 3.4mmol/l) to severe Hypokalemia (K <2.5mmol/l) patients, GP follow up to recheck electrolytes in improving patient care.

Methods:

Retrospective audit of 314 patients with Hypokalemia on Adult Acute Medical unit over a period of 3 months from February 2016 to April 2016 was done. The data source was collected from the metabolic medicine department (lab results of patients with hypokalemia). We examined the electronic prescribing system of these patients looking at the treatment compliance of hypokalemia, hypomagnesaemia; discharge summaries to look at GP follow up and measured it against set standards.

Results:

In 314 patients, there were 62% (females) and 38% (males) of variable age from 18 to 90 yrs. We measured the following parameters against set audit standards (100%): hypokalemia treatment adherence was 48%, recognition of hypomagnesaemia was 52%, treatment of hypomagnesaemia was 40% and GP follow up to recheck electrolytes was 23%.

Conclusions:

Hypokalemia Treatment adherence to trust guidelines is average to poor. Checking magnesium levels and treating it if low was inadequate and GP follow up to check electrolytes after discharge was poor. We have recommended to update our current Hypokalemia guidelines, educate our doctors and re-audit after 5 months to improve treatment adherence and work towards better patient care.
<table>
<thead>
<tr>
<th>Audit parameters</th>
<th>Target</th>
<th>Evidence</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypokalemia Treatment Adherence</td>
<td>100%</td>
<td>UHL Trust Hypokalemia Guidelines</td>
<td>48%</td>
</tr>
<tr>
<td>Magnesium Check (When K: ≤ 3.0 mmol/l)</td>
<td>100%</td>
<td>Arch Intern Med. 1992 Nov; 152(11):2346</td>
<td>52%</td>
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<tr>
<td>Magnesium Treatment if low (&lt;0.7 mmol/l)</td>
<td>100%</td>
<td>Arch Intern Med. 1992 Nov; 152(11):2346</td>
<td>40%</td>
</tr>
<tr>
<td>GP Follow-up to check Electrolytes post discharge</td>
<td>100%</td>
<td>Good Clinical Practise</td>
<td>23%</td>
</tr>
</tbody>
</table>

References

2. Refractory potassium repletion due to magnesium deficiency

Arch Intern Med. 1992 Nov; 152(11):2346
Case
A 77-year-old Asian lady, not known to have Diabetes Mellitus, presented with typical symptoms of hypoglycaemia such as sweating, palpitations and multiple syncopal episodes with loss of consciousness. Whipple’s triad of hypoglycaemia was confirmed by a very low blood sugar (1.2mmol/l), relevant clinical manifestation and resolution of symptoms upon treatment. She had a background medical history of urinary bladder carcinoma.

Her drug history did not include any anti-diabetic medications. Initial investigations revealed normal short synacthen test with a reasonable level of ACTH which excluded adrenocortical failure. Her insulin levels were low with a normal CT abdominal scan, hence Insulinoma was excluded from differentials.

With a very high level of IGF 2 and C-Peptide, low Insulin level in a patient with urinary bladder cancer, a diagnostic possibility of Non-islet-cell tumour hypoglycaemia (NICTH) was made. Treatment was initiated with glucocorticoid therapy followed by future plans with referral to Urologists for consideration of a debulking surgery to reduce the IGF-2 burden secreted by the tumour itself. [1]

Discussion:
NICTH, a rather uncommon clinical entity, should be considered as a part of evaluation of hypoglycaemia. NICTH may be associated with any neoplasm other than an Insulinoma. Pathophysiology of hypoglycaemia in NICTH appears to be due to tumour cells producing either IGF-2 or sometimes, IGF-2 like peptides which act like insulin on hepatocytes and skeletal muscle cells. IGF-2/IGF-2 like peptides also suppress the counter regulatory hormones such as glucagon and growth hormone causing a cumulative effect of severe hypoglycaemia [2].

Hypoglycaemia, being a common presentation in acute medicine, mandates a thorough investigation in a non-diabetic patient. This case highlights the importance of diagnosing NICTH as one of the causes of hypoglycaemia with a view to diagnosing solid tumour in an earlier stage.

References
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Poster 28
FAST screening - is it effective in recognising acute stroke patients in East and North Herts?

Sheth, S. Zosmer, M. Hughes, D. Allawai, Z. Dangri, P. East and North Herts NHS Trust

Introduction
It is well documented that stroke causes a significant social and financial burden in the UK. Treatment is only effective if administered rapidly. In July 2008, FAST (face arm speech test) was included in the national institute of clinical excellence (NICE) guidelines as a recommended pre-hospital screening tool for diagnosis.

We performed an audit to investigate the success of our stroke service in identifying patients with stroke.

Method
In our Trust, referrals are received by stroke nurses (based on site, 24-hours) who liaise with the stroke medical team. We looked at referrals in April and July 2016. We subdivided the patients into those admitted and those not admitted to the stroke ward, and identified FAST positive and FAST negative presentations. We then looked at the patients’ final diagnoses to ascertain the effectiveness of the FAST tool and the success of our stroke service in identifying strokes and admitting to the stroke unit.

Results
Out of 542 referrals, 46% were admitted to the stroke unit. 54% of admitted patients had a final stroke diagnosis.

All patients with a final stroke diagnosis had been admitted to the stroke unit. 18% of total strokes were FAST negative. 8% of stroke patients were thrombolysed. The majority of patients were outside thrombolysis window at arrival, had haemorrhagic strokes or contra-indication to thrombolysis.

Discussion
Our stroke service is successful in identifying strokes and enabling admission to the stroke ward. FAST is a sensitive pre-hospital screening tool for stroke (82% sensitivity). Further study is required for FAST negative stroke identification.
References:

3. The IST-3 collaborative group. (2012). The benefits and harms of intravenous thrombolysis with recombinant tissue plasminogen activator within 6 h of acute ischaemic stroke (the third international stroke trial [IST-3]): a randomised controlled trial. The Lancet. 2012;379(9834):2352-2363
4. Harbison J, Hossain O, Jenkinson D, Davis J, Louw SJ, Ford GA. Diagnostic accuracy of stroke referrals from primary care, emergency room physicians, and ambulance staff using the face arm speech test. Stroke. 2003;34:71-76. DOI: 10.1161/01.STR.0000044170.46643.5E.
Poster 29
Crowned Dens Syndrome – an acute presentation of calcium pyrophosphate dehydrate crystal deposition disease
Bhalla, A. Kings Collegew Hospital

Abstract:
Crowned Dens syndrome (CDS) is a rare manifestation of calcium pyrophosphate dehydrate crystal deposition (CPPD) in the soft tissue surrounding the odontoid process. It typically presents with severe cervical pain, neck stiffness and systemic evidence of inflammation (fever, raised inflammatory markers). As a result, it is can be misdiagnosed as meningitis, cervical spondylitis or polymyalgia rheumatica. CT is the most useful diagnostic modality – typically demonstrating calcification of the periodontal ligaments. Treatment is focused on anti-inflammatory medications. We suggest that Crowned Dens syndrome is an important differential to consider in patients presenting to the acute medical take with febrile neck pain. We present an interesting case of simultaneous acute gout & Crowned Dens syndrome, discuss the key clinical & radiological features of CDS, management steps and review previous literature.

Introduction:
A 54 year old lady presented with a 2 month history of recurrent severe neck & shoulder pain, left knee swelling & pyrexia. Her background included gout (with chronic hyperuricaemia – on allopurinol, oral prednisolone & weekly IV methyprednisolone) ulcerative colitis, previous pancolectomy, significant small bowel excision and resulting jejunostomy. She had resultant short bowel syndrome with extensive stoma output and malabsorption to such an extent that she developed osteoporosis, multiple vitamin deficiencies and had a brachiobasilic fistula in situ for self administration of intravenous fluids and magnesium at home.

Synovial aspirate of the knee joint revealed urate crystals consistent with acute gout. CT c-spine demonstrated features suggestive of Crowned Dens syndrome. She was treated with pulsed methylprednisolone and rapidly improved.

References
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