BSOA NEWSLETTER

Welcome to the December edition of the BSOA newsletter

British Society of Orthopaedic Anaesthesia

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British Society of Orthopaedic Anaesthetists

Immediate Past President's Message

Per fer les coses bé cal:
primer, l'amor, segon, la técnica
(To do things right, first you need love, then technique)
Antoni Gaudí

Dear Members,

As Dr Vijayaraghavan and I hand over the leadership of this fine society to Prof Hormis and Dr Moll, I realise we have served the BSOA for a while. Personally, on my journey with the society I have held positions as a member, committee member, treasurer and finally president. I will be eternally grateful for the advice, camaraderie, guidance and support I have had along the way. The academic, emotional and managerial growth, I have experienced over this time has been invaluable.

The quality of presentations and research from the younger members in our meetings has been both refreshing and reassuring. It demonstrates that we needn't worry about both the future of our care as patients and the society its self.

We thank Dr Huglar for continuing to lead the variety of workshops during our annual meetings.

We wish our successors luck and energy.

Very best wishes

DR EDA SILVA

Dr EJ da Silva
Immediate Past President of the BSOA

President's Message

Dear BSOA Members

It is such a great honour that I have been elected to be the President of the BSOA for the next term. I really want to thank Dr EJ da Silva and Dr Ramesh Vijayaraghavan for their leadership in steering the BSOA in the post COVID era.

Our Annual Scientific Meeting in Birmingham was one of the best Anaesthetic meetings of the year. The combination of world class speakers and the workshops in the heart of Birmingham was a joy to attend and the delegate feedback was overwhelmingly positive. I would like to congratulate Dr Rachel Baumber who was the recipient of the President's Medal this year. This newsletter also contains the posters that were submitted to the conference by trainees.

Dr Tim Moll has taken over from Ramesh as the Treasurer for the next term. We have both found the BSOA to be in a strong financial situation which will be the basis of moving forwards in 2025 and beyond.

My aim in the next 12 months is to really raise the profile of the BSOA in the Anaesthetic and Surgical communities. Orthopaedic Anaesthesia is likely to be the one of the largest sub-specialities within Anaesthesia, so we must also raise our own profile with colleagues in our hospitals. I am hopeful that we can also collaborate with many of the Anaesthetic specialist societies.

I have reached out to many of the Orthopaedic specialist societies to increase their awareness of our society and how we can we can work with our surgical colleagues to enhance patient care. We would also really like to encourage trainees to join the BSOA and contribute to our newsletter and educational forums.

Please also save the date for the BSOA ASM 2025 - which will be held in Sheffield on November 3rd and 4th 2025. Please encourage colleagues from your departments to attend.

I wish you all a restful and peaceful holiday time and I will be updating the BSOA members on our new initiatives for 2025 in due course.

See you soon.

Very best wishes

Anil Hormis

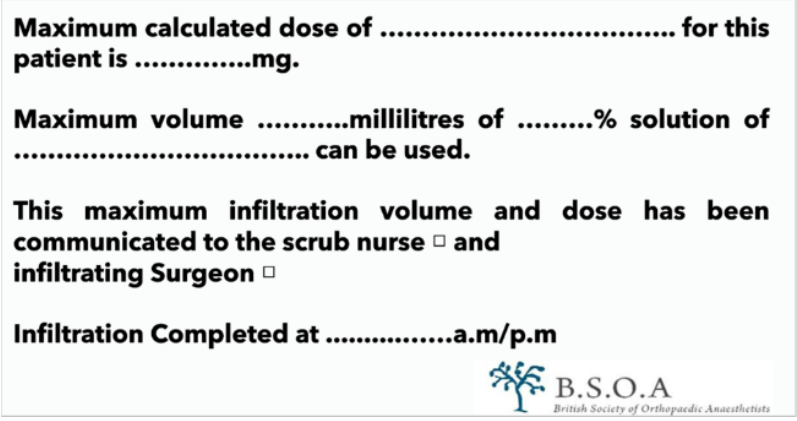
Professor Anil Hormis
President of the BSOA

Contents

Infiltration of Anaesthesia BSOA Guidelines

The BSOA Executive team met following a request for input from the Royal College of Anaesthetists (RCoA) based on a “Preventing Future Deaths” notification from the coroner;

The BSOA suggests/recommends that the following steps are clearly documented in the Anaesthetic charts, within the area detailing local, regional and neuraxial blockade.



This documentation may be on pre-printed stickers or embedded into an anaesthetic chart. It does not negate the need for CPD for nurses and surgeons that include the explanations for calculations that demonstrate conversion of Milligrams to percentages and vice-versa. The training curriculums may need input for inclusion of these calculations.

We recommend that the local anaesthetic approach to each patient should be discussed in the pre-surgical "WHO Huddle meeting" with limits on dose of infiltration for individual patients.

This recommendation has considered the fact that the injecting practitioner is not the calculating practitioner. However, the anaesthetist is best placed to make those calculations as they would have also done relevant calculations for nerve blocks and would be able to work on the "balance" remaining. Invariably they will also judge the duration between pre-operative blocks and end-of procedure infiltration injections of local anaesthetic.

The following Anaesthetists were involved in the discussion and conclusion:

- Dr Vassilis Athanassoglou (Oxford)
- Dr Eric Nguyen (Oxford)
- Dr Egidio da Silva (Birmingham)
- Dr Anil Rao (Birmingham)
- Dr Tim Moll (Sheffield)
- Prof Anil Hormis (Rotherham)
- Dr Ramesh Vijayragavan (London)
- Dr Bernadette Ratnayake (London)
- Dr Jan Cernovsky (London)
- Dr Robbie Erskine (Derby)

Additional specialties where this label may be useful is Plastic surgery in aesthetic clinics in which high volume local anaesthesia is used regularly.

Yours sincerely

DR EDA SILVA

Dr Egidio J da Silva
Immediate Past President of the BSOA

Anil Hormis

Professor Anil Hormis
President of the BSOA

Trainee Article

2024 Highlights in Orthopaedic Anaesthesia

Written by Neelesh Mohan[1] and Huy Nguyen[2]
1. ST7 Anaesthetics Trainee, Birmingham School of Anaesthesia
2. ST7 Anaesthetics Trainee, Oxford School of Anaesthesia

Following a literature review of articles from 2024 pertaining to developments in anaesthesia for orthopaedic surgery, we have compiled a collection of 4 articles that we felt were worthwhile and may influence your anaesthetic practice in the new year.

1

Liu et al. BMC Anesthesiology (2024) 24:144
https://doi.org/10.1186/s12871-024-02530-9

BMC Anesthesiology

RESEARCH Open Access

The efficacy and safety of perioperative glucocorticoid for total knee arthroplasty: a systematic review and meta-analysis

Fangyan Liu[1†], Mei Duan[1†], Huiqun Fu[1] and Tianlong Wang[1,2,3,4*]

Liu et al (2024) published a systematic review and meta-analysis of the current evidence base using 36 randomised control trials for Total Knee Arthroplasty (TKA), with sample size ranges between 23-323 participants. They reported baseline Visual Analog scores (VAS) in the glucocorticoid group to be significantly improved at postoperative day 1 (POD1), day 2 (POD2) and at 3 months (POM3). Morphine consumption was significantly reduced, range of movement (regardless of systemic or intraarticular administration) were also improved in this group vs control. Biochemically, CRP and IL-6 were shown to be significantly reduced in the glucocorticoid group. There were significantly increased blood glucose levels on POD1, but not on POD2. Wound healing and venous thrombosis were not shown to have increased risk in the glucocorticoid cohort. PONV was significantly reduced not just on POD1 but the whole post operative period. And finally, length of stay was reduced in the glucocorticoid cohort (by 0.27 days).

Nielsen et al (2021) group's double-blind trial on high dose dexamethasone in total knee arthroplasty (TKA), and subsequently the Dex-2-TKA (Gasbjerg et al 2022) has garnered momentum for ongoing research into higher doses of glucocorticoid for TKA.

Afshar et al (Sep 2024) published a triple blind RCT to look at specifically 4mg, 8mg and 16mg perioperative dose for TKA. They demonstrated in a sample set of 90 patients, 16mg doses showed the most pronounced effects at 12, 24 and 48 hours postoperatively in terms of VAS Pain Score and sleep quality

2

Original research

Single-bolus injection of local anesthetic, with or without continuous infusion, for interscalene brachial plexus block in the setting of multimodal analgesia: a randomized controlled unblinded trial

Patrick Rhyner [1], Matthieu Cachemaille,[1] Patrick Goetti,[2] Jean-Benoit Rossel,[3] Melanie Boand,[1] Alain Farron,[2] Eric Albrecht [1]

This publication of original research by P Rhyner et al (Regional Anaesthesia and Pain Medicine 2024), sought to compare post operative outcomes using single bolus injection of local anaesthetic (LA) for interscalene brachial plexus block with or without a continuous infusion, alongside a multimodal systemic analgesia regimen. The current body of evidence suggests continuous infusion of LA significantly reduces opioid consumption, pain scores and post operative nausea and vomiting at 48 hours following major shoulder surgery, compared with single bolus injection. However, there is a lack of use of a multimodal analgesia strategy in these trials. In this study, 60 patients undergoing shoulder arthroplasty or rotator cuff repair were randomized to 0.5% ropivacaine 20ml with or without 0.2% ropivacaine 4-8ml/hr infusion for the interscalene brachial plexus block, in addition to a multimodal analgesic regimen consisting of intravenous dexamethasone, magnesium, acetaminophen and ketorolac. The primary outcome was morphine patient-controlled analgesia (PCA) use in the first 24 hours, and secondary outcomes were of pain scores and function at 48 hours. The results suggested that in this context, a continuous infusion of LA for an interscalene block does not provide superior analgesia after major shoulder surgery, when such a multimodal analgesic regimen is utilized. This raises the question of whether perineural catheters are required for such operations.

Original research

3

Improved outcomes for spinal versus general anesthesia for hip fracture surgery: a retrospective cohort study of the National Surgical Quality Improvement Program

Eliana R Weinstein, Richard B Boyer, Robert S White, Roniel Y Weinberg, Jacob M Lurie, Nicolas Salvatierra, Tiffany R Tedore

This is a large retrospective cohort study by Weinstein et al (Regional Anaesthesia and Pain Medicine 2024) to assess the effect of spinal anaesthesia compared to general anaesthesia on post operative morbidity and mortality in hip fracture surgery, adding to the current conflicting body of evidence. The data set of 40527 patients aged 50 (2016-2019) taken from the American College of Surgeons National Surgical Quality Improvement Programme (ACS-NSQUIP), identified 9847 patients in the spinal group and 30680 patients in the general anaesthesia (GA) group. Primary outcomes included the incidence of stroke, myocardial infarction (MI) or death at 30 days; secondary outcomes included 30-day morbidity, hospital length of stay (LOS) and operative duration. The outcomes suggest that spinal anaesthesia is associated with lower post operative mortality at 30 days (5.6% vs 4.4%), however, no significant differences in stroke or MI, or LOS. The subgroup analysis revealed that patients in the American Society of Anaesthesiologists (ASA) Score IV category receiving GA had greater chance of post operative combined risk of stroke, MI and death; while no statistically significant differences were seen in ASA I-II and ASA III cohorts. The GA group also revealed statistically significant increases in rates of acute renal failure, DVT and thrombophlebitis. They were demonstrated to have longer operative times compared with spinal anaesthesia, although it was acknowledged that patient selection and case complexity is accountable in part for this. To conclude, spinal anaesthesia seems to favour improved outcomes in terms of 30-day mortality/stroke/MI risk, in high-risk patients of ASA score 4.

Review

4

Rebound pain prevention after peripheral nerve block: A network meta-analysis comparing intravenous, perineural dexamethasone, and control

Zih-Sian Yang [a], Hou-Chuan Lai [a], Hong-Jie Jhou [b], Wei-Hung Chan [a,**], Po-Huang Chen [c,*]

This network meta-analysis (NMA) by Yang et al (Journal of Clinical Anaesthesia December 2024) aimed to compare the effectiveness of different routes of dexamethasone administration in tackling the well-known phenomenon of rebound pain following block resolution. The meta-analysis compared IV and perineural administration with a control. The NMA included seven randomized controlled trials with 561 patients undergoing

perioperative peripheral nerve blocks. Primary outcome measured was the incidence of rebound pain. Secondary outcomes included median time to first analgesic request, rebound pain resolution time, difference in pain scores before and after PNB resolution and nausea and vomiting. The results showed that both modalities of dexamethasone administration significantly reduced the incidence of rebound pain following peripheral nerve block compared to the control group. IV dexamethasone ranked first (OR 0.13, 95% CI 0.07 – 0.23). All of the secondary outcomes also favoured dexamethasone administration over the control group. Regarding median time to first analgesic request, perineural dexamethasone ranked first (9.68 hours vs 6.21 hours). IV dexamethasone performed better when comparing the difference in pain scores before and after PNB resolution, as well as reducing the incidence of nausea and vomiting. Discussions suggest that the benefit of dexamethasone administration results from systemic absorption of the drug irrespective of its route of administration, and is effective as part of the multi-modal perioperative analgesic regimen. Given the results and this discussion, this network meta-analysis concludes that both IV and perineural dexamethasone are effective in reducing rebound pain following peripheral nerve blocks and that IV administration appears to be the most effective option.

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Weinstein, E. et al, "Improved Outcomes for Spinal vs General Anaesthesia for hip fracture surgery: a retrospective cohort study of the National Surgical Quality Improvement Program", Reg Anesth Pain Med 2024;49:4–9.

Yang, Z.-S. et al, 'Rebound pain prevention after peripheral nerve block: A network meta-analysis comparing intravenous, perineural dexamethasone, and Control', Journal of Clinical Anesthesia December 2024; 99

Special Article

Perioperative management of patients with long bone fractures secondary to metastatic bone disease

Dr Sean Roberts[1], Dr Amour Patel[2], Dr Rachel Baumber[1]
Affiliations: 1- Royal National Orthopaedic Hospital, Stanmore, 2- The Royal London Hospital

Introduction

Metastatic bone disease (MBD) poses a significant challenge in oncology as bone is one of the commonest sites for metastatic disease. The incidence is poorly defined with variability in the literature ranging between 12% to 70%.[1] The commonest primary tumour types causing bone metastases are lung (24.8%), prostatic (19.4%), breast (19.3%), gastrointestinal (9.4%) and urological (6.5%).[2] Cancer Research UK report that rates of cancer are projected to rise and more than half of new cancer cases in the UK are made up of the previously listed primary sites. This means there will be an increasing population being diagnosed and living with MBD. Consequently, skeletal related events (SRE's) and pathological fractures will also increase. The tumours with the highest rates of pathological fractures are renal (5.8%), myeloma (3.4%), female reproductive (3.2%), lung (3.2%) and breast (2.7%). SRE's are associated with significant impairment to the activities of daily living and quality of life (QoL).[3, 4] Cancer pain due to bone metastases is the most common cause of pain in advanced disease, with approximately 80% of patients reporting moderate to severe pain.[5, 6] Treatment options include radiotherapy and bisphosphonates, but many require treatment with long term opioids. This makes effective perioperative pain management more challenging if they suffer an SRE and require surgical intervention.

The British Orthopaedic Oncology Society (BOOS) guidelines recommend a defined pathway for patients with MBD emphasizing the importance of a structured approach from presentation to rehabilitation.[7] Patients with suspected MBD should have a staging CT within 24 hours of orthopaedic assessment and be referred to a recognised tertiary centre. Those without an obvious primary site should be discussed with the local acute oncology service and multidisciplinary team (MDT) decisions on the use of (neo)adjuvant therapy should be recorded. The presence of bony metastases causes a significant reduction in 1, 3 and 5-year survival compared to stage before metastases in all cancer types.[8] This means that the diagnosis of MBD can cause significant changes to prognosis in many patients. Surgical interventions should outlast the lifetime of the patient therefore a diagnosis and staging are key to planning fixation. As a result, many patients are left bedbound awaiting investigations and MDT decisions. The BOOM audit assessed adherence to BOOS guidelines and found that 39% of centres did not have a designated MBD lead, 19% of patients didn't have adequate radiographs and 29% didn't have an up-to-date staging CT.[7]

Problems

NICE guidelines recommend fixation of a fragility hip fracture on the day of, or day after, admission.[9] Most hospitals have instituted pathways that have been shown to be effective in reducing postoperative complications, length of stay and mortality.[10] Similar guidelines and pathways exist for other types of fragility fractures.[11] However, when a patient is diagnosed with MBD this guidance does not apply and there is no rush to fix them, which often leaves them bedbound and deconditioned. The discrepancy in urgency underscores the need for a shift in approach to MBD, recognising the significant impact of timely intervention on patient outcomes and quality of life.

As per BOOS guidelines, referral to a recognised tertiary centre is required in patients with solitary bone lesions. This inevitably leads to delay waiting for tertiary surgical opinions, biopsy results to identify the primary site and surgical management decisions. Decisions around surgical management should be based on the patient's prognosis and life expectancy. Many patients are no longer under regular oncological follow-up or may be presenting with a new primary cancer diagnosis, making prognostication difficult. This means that early referral to multidisciplinary care is paramount in expediting decision-making and reducing delays to surgery. In the BOOM audit oncological opinion was only sought in 69% of cases and prognosis estimations made in 38% so compliance

is poor at present.[7] This reduction in delays to transfer is especially important in patients with pathological femoral fractures. These patients remain bedbound, often in traction whilst awaiting a surgical management decision which cannot be made without knowing the primary diagnosis and the likely prognosis. Patients are also unable to start oncological treatments for their metastatic cancer until they have fully recovered from their surgical intervention. This means that any increased time spent in hospital with a fracture or recovering from surgery, increases the time before they can receive systemic treatment for their metastatic disease, risking further progression.

There are many reasons for delays in transfer (if required) but some of the common ones we have seen in our experience are non-completion of staging investigations as recommended by guidelines, inadequate imaging to plan surgical fixation, lack of prognosis to guide appropriateness of surgical intervention, medical conditions precluding surgery (e.g. current chest infection or urinary tract infection), lack of confirmed date for surgery or bed available for transfer. In addition, on arrival at the tertiary hospital, additional delays have been seen due to lack of perioperative medicines management or optimisation of readily reversible conditions, such as hyponatraemia. Delays in transfer processes also compound issues with pain management and end of life planning, increasing the likelihood of adverse outcomes in this deconditioning population. It is well established that prolonged immobilisation has many deleterious effects on physiology including loss of muscle mass and strength.[12] Prolonged time from fracture to fixation is associated with longer recovery and increased risk of complications.[13] Consequently, the fitness of these patients to return to further oncological therapies may be delayed or removed completely highlighting the long term impacts of delays to surgery.

Recommendations

Whilst there is a good body of evidence to inform recommendations around the perioperative care of fragility fractures, evidence for the management of those caused by metastatic bone disease is lacking. We therefore decided to undertake a Delphi process to form recommendations to address the issues outlined above. This was done in multiple stages. Initially a survey was performed which was distributed across the UK to clinicians from multiple disciplines with an interest in metastatic bone disease, and to members of the BSOA and BOOS. From the results of this survey several recommendations were written and then a second stage undertaken to seek approval from a multidisciplinary panel with significant expertise managing this group of patients. Lastly, the final recommendations were then presented at the BSOA annual scientific meeting in November to seek a consensus opinion from BSOA members. Eight recommendations received final approval and will be endorsed as standards of care by the BSOA. The final recommendations are currently being written up for publication which is hoped to be achieved by early 2025.

Thank you to all BSOA members who completed the initial survey and to those who attended the annual scientific meeting where final consensus was achieved. Your contribution is much appreciated and helped us complete this project.

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Accountant Column

Autumn Budget 2024

The UK's Autumn Budget 2024 introduced significant tax reforms across multiple areas, targeting individuals, businesses, and property transactions. Here's a summary of the main changes:

Income Tax and National Insurance

- The income tax and NIC thresholds in England and Wales will remain frozen until the end of 2027–28, when they will begin to rise in line with inflation.
- Rates of income tax and NICs paid by employees will remain unchanged.
- Employers' NICs will rise from 13.8% to 15% on a worker's earnings above £175 from April 2025, and the threshold at which employers start paying the tax on each employee's salary will be reduced from £9,100 a year to £5,000.
- The employment allowance will increase from £5,000 to £10,500.

Capital Gains Tax

- CGT rates will increase from 10% to 18% for basic rate taxpayers, and from 20% to 24% for higher rate taxpayers, matching existing rates for property which stay the same. Rates on chargeable gains from selling additional property remain unchanged at 18% and 24%, respectively.
- Business asset disposal relief will remain at 10%, before rising to 14% on 6 April 2025, and 18% from 6 April 2026.

Corporation Tax

- The main rate of corporation tax paid by businesses on taxable profits over £250,000 will stay at 25% until the next election.
- Small profits rate (profit under £50,000) – 19%
- Marginal rate £50,001 - £250,000) – 26.5%

Inheritance Tax

- The IHT threshold of £325,000 to remain until 2030.
- From April 2027, inherited pensions are subject to IHT.
- From April 2026, agricultural property relief and business property relief will be reformed, with the highest rate of relief remaining at 100% for the first £1m of combined business and agricultural assets on top of the existing nil-rate bands. The rate of relief will reduce to 50% after the first £1m.
- Offshore trusts will no longer be able to shelter assets from IHT, and there will be transitional arrangements for people who have made plans based on current rules.

Stamp Duty Land Tax

- The higher rate for additional dwellings surcharge of SDLT in England and Northern Ireland will rise from 3% to 5%, from 31 October 2024.

Value Added Tax

- The standard rate of VAT will remain at 20%.
- VAT at the standard rate will be added to private school fees and boarding services from 1 January 2025.

NHS Pensions – The Pension Remedy Mcloud

Pension Tax

Some members affected by the Public Service Pensions Remedy also known as McCloud will need to update their pension tax information with HM Revenue & Customs (HMRC).

This is because as part of the remedy these members have had their pensionable service between 1 April 2015 and 31 March 2022 moved from the 2015 Scheme to the 1995/2008 Scheme.

This move may have changed their pension tax position for the tax years 2015/16 through to 2021/22 and could mean they have an annual allowance tax refund to claim or a small number may have extra tax to pay.

Remediable Pension Savings Statement (RPSS)
Before you can check with HMRC, you will need your RPSS. This is a letter that gives you information about your revised pension growth and your pension input amounts in both the 1995/2008 and 2015 Schemes, for all the tax years affected by the remedy.

If you need an RPSS, NHS Pension will automatically send it to you.

Your RPSS shows you:

- any updated pension input amounts in both the 1995/2008 Scheme and 2015 Scheme
- your old pension input amounts in both schemes
- any annual allowance charges you asked the scheme to pay on your behalf to HMRC using 'Scheme Pays'.

Where NHS Pension have the information to calculate your pension input amount for the tax year 2022/23, they' include this information in your RPSS, and you will not receive a separate Pension Saving Statement (PSS).

Important Action Required
You'll need the information included in your RPSS to use the HMRC 'Calculate your public service pension adjustment' tool, specifically designed to support members affected by the Public Service Pensions Remedy.

AF Tax are providing a specific service to HELP with the above.

Christmas Parties and Staff Gifts

Christmas Parties
There is a tax exemption for employee entertaining if the event is:

1. An annual party/function
2. Open to all employees
3. Cost does not exceed £150 per head

The total cost of the party is the whole cost of the event, from the start to the end. It includes food, drink, entertainment, taxis home, overnight accommodation, etc.

The limit of £150 per head applies to all those attending the function, not just employees. So, if employees are allowed to bring guests, the total cost should be divided by the total number of employees and guests.

If there are multiple annual events, they will still be exempt as long as the combined cost is no more than £150 per head.

If you've already used up the £150 exemption on an event, you'll have to report and pay tax on the full costs of any additional events, even if they cost less than £150 per head on their own.

A taxable benefit in kind will arise if either the limit is exceeded, or the function is not open to all staff or it is not an annual function.

Please be aware that the £150 per head limit is an exemption, not an allowance – go just a penny over the £150 and the full cost becomes taxable.

The benefit must be reported on each employee's form P11D. The employee will pay income tax on the benefit, and the employer will be charged Class 1A national insurance.

Alternatively, the employer can apply to pay the grossed-up tax through a PAYE Settlement Agreement (PSA).

Client entertaining is generally not an allowable expense for corporation tax purposes. However, the cost of employee entertaining is an allowable expense, and therefore the cost of the staff Christmas party can be deducted.

Gifts to Employees

Seasonal Gifts

The employer may wish to give employees a seasonal present, such as a turkey, a bottle of wine, or a box of chocolates. Provided the cost of the Christmas staff gift is 'trivial' – typically less than £50 a head – the gift will usually not be taxable.

If the Christmas gift to staff exceeds this value, it will be taxable and it will need to be reported to HMRC on either a form P11D or through a PSA.

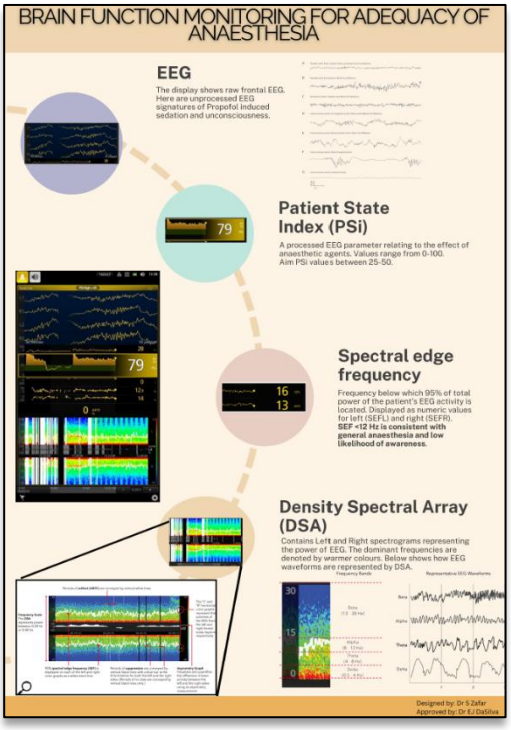
Directors of close companies (broadly 5 or fewer shareholders) can receive trivial benefits up to £300 in a tax year. So, for a limited company that has 2 directors (i.e. husband and wife) the total exempt amount would be £600 (subject to the cap of £50 for each single purchase).

For further information or for a free initial consultation to discuss your tax affairs please contact Andrew Fenton (Director at AF Tax Solutions Ltd) or Scott Thompson (Senior Tax Manager) on 01323 845083 or email andrew@aftax.co.uk or Scott@aftax.co.uk.

Andrew is a Chartered Tax Adviser (and a former Inspector of Taxes with HMRC) and has many years of experience in dealing with the tax affairs of medical professionals.

Scott is a Chartered Tax Adviser working in tax for over 20 years. Scott focuses on personal tax and owner managed businesses to mitigate income tax and capital gains tax liabilities, and to reduce exposure to inheritance tax on family and business succession.

BSOA ASM 2024 Poster Presentations



Brain Function Monitoring for Adequacy of Anaesthesia

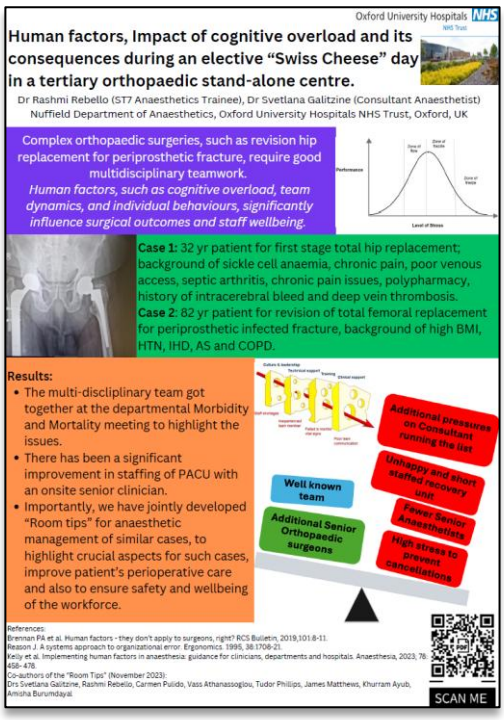
Dr Shahzeb Zafar
The Royal Orthopaedic Hospital NHS Foundation Trust, Birminham

Click here to view the poster

A Lump in the Throat or a Pain in the Neck?
Anterior Cervical Spine Osteophyte (ACO) Induced Dysphagia and Airway Compression

Dr Aamer J Mughal MBBS, BSc, FRCA[1]; Mr Mohsin Khan FRCS (Tr&Orth)[2]; Mr Simon Hughes FRCS (Tr&Orth)[3]; Dr Egidio J da Silva MBChB, DA, FRCA, FFICM, CUBS[4]
[1]Specialty Registrar in Anaesthesia; [2]Specialty Registrar in Trauma and Orthopaedics; [3]Consultant in Trauma and Orthopaedics; [4]Consultant in Anaesthesia and Perioperative Care, Royal Orthopaedic Hospital Birmingham

Click here to view the poster



Human factors, impact of cognitive overload and its consequences during an elective "Swiss Cheese" day in a tertiary orthopaedic stand-alone centre.

Dr Rashmi Rebello (ST7 Anaesthetics Trainee), Dr Svetlana Galitzine (Consultant Anaesthetist)
Nuffield Department of Anaesthetics, Oxford University Hospitals NHS Trust, Oxford, UK

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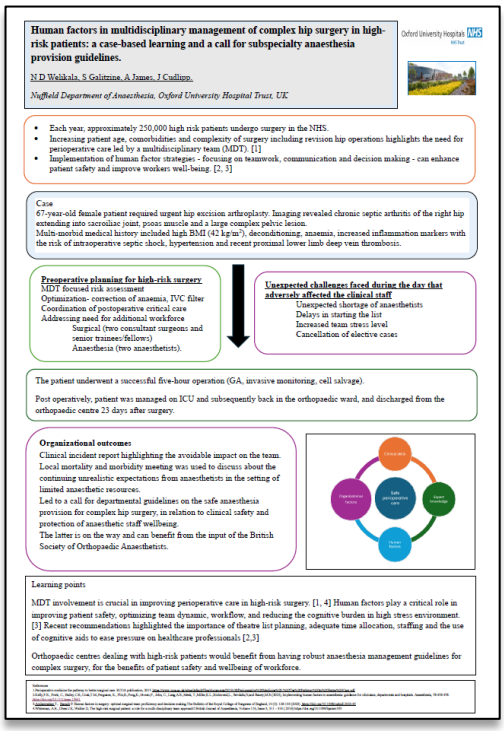

Human factors in multidisciplinary management of complex hip surgery in highrisk patients: a case-based learning and a call for subspecialty anaesthesia provision guidelines

N D Welikala, S Galitzine, A James, J Cudlipp.
Nuffield Department of Anaesthesia, Oxford University Hospital Trust, UK

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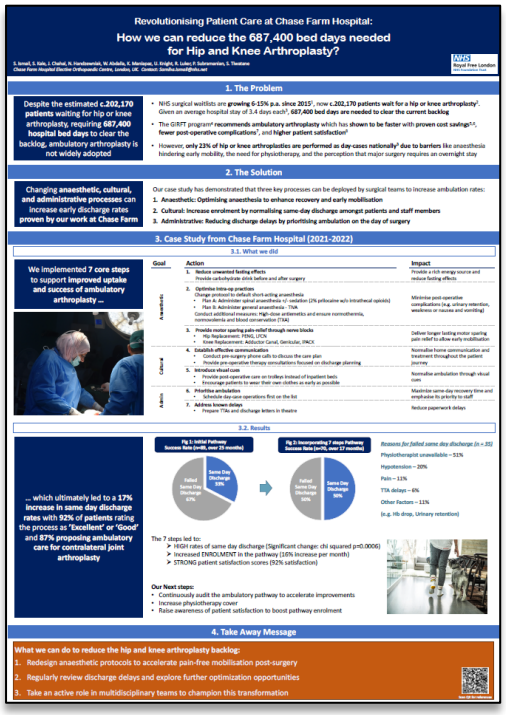

Revolutionising Patient Care at Chase Farm Hospital: How can we reduce the 687,400 bed days needed for Hip and Knee Arthroplasty

S. Ismail, S. Kale, J. Chahal, N. Handzewniak, W. Abdalla, K. Manlapaz, U. Knight, R. Luker, P. Subramanian, S. Tiwatane
Chase Farm Hospital Elective Orthopaedic Centre, London, UK.

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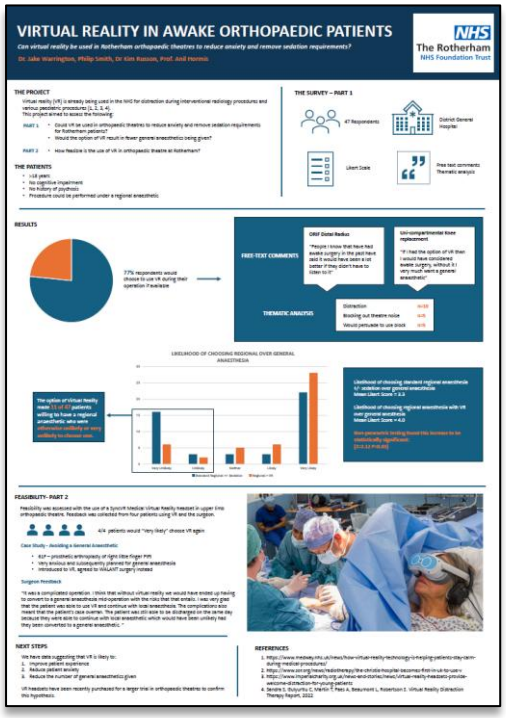

Virtual Reality in Awake Orthopaedic Patients

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