AUTUMN NEWSLETTER

November 2022

Dear BSOA Members,

Welcome to the November 2022 edition of the Society's Newsletter.

I am extremely grateful to the team that manages our website and charity society. Furthermore, I express heartfelt gratitude to the consultants and registrars who give their time freely to the growth of this society.

Sadly, guidance from governing and guiding bodies does little to enable the inclusion of these roles within valid specialist programmed activity times within job plans. This omission does not lend itself to easy recruitment of team members to facilitate the progress of smaller societies like the BSOA.

I implore those that value this organisation to get involved. I understand the phase of quite quitting that the nation is going through. But we have so much to give and so much to teach and learn. Let the quite quitting legacy not be our legacy.

In our annual meetings, we aim to combine the aspects of Peri-operative care, Anaesthesia, acute and chronic pain, and Critical care in our meeting in a way that puts the patient at the centre of care and not individual specialties. The challenge of the orthopaedic anaesthetist lies in the fact that orthopaedics affects all ages, genders, races, body topographies and co-morbidities very much in a cross-sectional fashion.

With this in mind, we look forward to an excellent meeting on the 1st & 2nd December 2022 in Loughborough which aims at managing the wide ranges of that cross-sectional population. There will be both workshops and talks that are timely and valid. Book via this link https://emdevents.eventsair.com/bsoa-annual-scientific-meeting/registration

In this edition, please have a look at the enjoyable article on erector spinae blocks by Dr Timothy Moll, and an article by Mr Andrew Fenton a chartered tax advisor.

Consultant in Anaesthesia, Sheffield Teaching Hospitals NHS foundation trust, Sheffield, UK

Tim and Andrew will be running workshops at our December 2022-23 meeting.

Look forward to seeing you in December.

Very best wishes

DR EDA SILVA

Dr EJ da Silva
President of the BSOA

Anaesthesia Associate Delivered Erector Spinae Plan (ESP) Block: The Sheffield Experience

Dr Tim Moll
Consultant Anaesthetist, Sheffield Teaching Hospitals

Introduction
Sheffield Teaching Hospitals is one of the three Yorkshire Major Trauma Centres. We receive over 300 patients with severe chest injuries per year. A severe chest injury may be defined as

- >3 fractured ribs
- flail chest
- displaced or comminuted rib fractures.

Severe chest injuries are painful and may result in significant morbidity and mortality. Pain may decrease the ability to breathe deeply, mobilize and cough effectively with resultant deteriorating respiratory function. In the elderly these risks are increased with a reflected increase in mortality risk.

Analgesia for Chest Injuries
Effective analgesia is key to managing the acute phase of following admission. Most units manage chest injured patients using a form of chest injury analgesia protocol. These involve commencing a variety of drug combinations through several routes of administration. However, if this does not control pain sufficiently to allow deep breathing, mobilizing and coughing - upgrading to a regional anaesthetic technique is usually indicated.

Why not thoracic epidurals/paravertebral blocks always for chest injured patients?

Traditionally the gold standard regional technique was thoracic epidural anaesthesia (or its cousin the paravertebral block). However, there are barriers to chest injured patients receiving epidural and paravertebral analgesia. These potentially include:

- lack of trained anaesthetist to perform the technique
- difficult patient positioning (due to pain)
- presence of sepsis (e.g., ITU patients - risk of epidural abscess)
- coagulopathy (either trauma induced or all too frequently these days the patient on the dreaded "blood thinners")
- hypotension risk (not ideal in trauma)
- potential for rare but devastating complications (epidural haematoma/epidural abscess)
- reluctance to keep in for over 72hrs (due to fears of infection)
- additional workload for nursing.

Being attached to pumps may further reduce the patient's mobility…. but mobility is key to the patient's recovery and discharge!

Alternative regional technique?

Erector Spinae Plane (ESP) blocks/catheters are a new technique which may provide excellent analgesia for chest wall injuries. ***A single shot ESP block may give significant analgesia for up to 12 hours with a catheter extending the analgesia to potentially a week.*** *The catheters are attached to an elastomeric local anaesthetic pump which require virtually zero nursing input except changing them when they run out.*
Superficially the technique looks like thoracic epidural insertion but importantly the catheter is inserted laterally to the spinal canal.

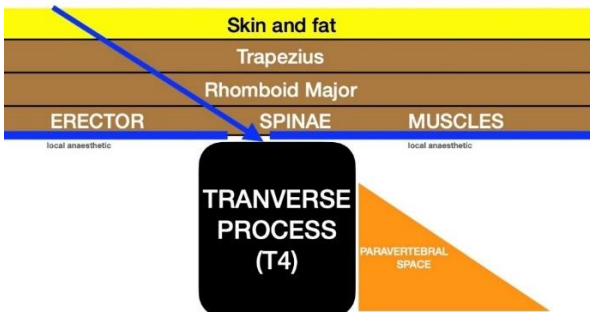
What is an ESP block and how do you do it?
The ESP block was first described by Forero et al in 2016 (their technique differed slightly in injection placement). There are excellent YouTube resources explaining and demonstrating ESP blocks and catheter placement. I would recommend the ones by Prof Ki Jinn Chin for their clarity, practical focus and evidence-based approach.

https://www.youtube.com/watch?v=dH0gjOHCsDc

https://www.youtube.com/watch?v=rxIPrSDDpOU

An ESP block/catheter relies on depositing local anaesthetic beneath the erector spinae complex of muscles in the patients back. This is done in our department (after consenting the patient, doing safety checks "prep-stop-block" etc.) by:

- *Positioning the patient lateral or sitting according to patient/operator preference and scrubbing up and using similar sterile technique as for an epidural*
- *preparing a catheter kit; we use 100mm "catheter through needle" kits.*
- *the back is scanned in the parasagittal plane starting laterally then sliding the probe medially toward the midline*
- *round ribs and easily visible pleura soon morph into square tombstone transverse processes with the pleura dropping away sharply.*
- *at around T4 level, the transverse process is identified with ultrasound - it has a unique "Tombstone" appearance. The erector spinae muscle complex overlies it.*
- *at this level three muscle layers may be identified. From superficial to deep: Trapezius, Rhomboid Major, Erector Spinae Muscle complex*
- *the needle is guided (in plane) using ultrasound onto the transverse process of T4 under the erector spinae muscle fascia. (PICTURE 1.) If performing a single shot block (which tends to last up to 12 hrs.) 20 milliliters*
- *of 0.25% Bupivacaine is injected. Look for a highly characteristic dark striped "whoosh" of caudal/cephalic local anaesthetic lifting the muscle complex up off the transverse process.*
- *if a catheter is to be placed, after injection of local anaesthetic, 5 cm of catheter is threaded into the space and the catheter secured as for an epidural using a commercial epidural fixation dressing. <u>We use skin glue to block up the entry hole</u> (may stop LA tracking back and lifting the fixing devices). The catheter is attached to an elastomeric pump containing local anaesthetic which has the advantages of simplicity, mobility and low nursing involvement/training. The catheters are left in for up to 7 days.*



PICTURE 1.

The patient will begin to benefit after 10-15 minutes. In our experience pain is significantly reduced (although not usually eliminated entirely). Of particular importance patients who cannot cough "*it hurts too much*" tend to be able to demonstrate a good effective cough minutes after the block.

Results from our pilot are described below. Although already demonstrating excellent improvements in pain and ability to cough I like to think that this may have improved further as we have gained experience with the technique.

Single Shot Block or Catheter?

A single shot block lasting 12 hours is little use to a patient with chest injuries that will be significantly painful for several days. It is almost cruel to give them a taste of great analgesia before it wears off all too soon and they're back where they started! Therefore, we favour catheters.

An important advantage of an ESP catheter is that they may be kept in for longer than an epidural (a week vs 3 days). However, a low skill single shot may function as a "bridging block" until someone is available to place a catheter. An example might be a single shot block placed in the Emergency Department to 'buy time' until a catheter can be placed later in critical care or the ward.

Who does the ESP blocks?

In our unit we trained our 4 senior anaesthesia associates (AAs) to place the ESP catheters. We reasoned that it would be preferable to train a small cohort of AAs who would gain experience rather than train 140 consultants who might only do one a year or less! Furthermore, the Anaesthesia Associates work 0800-1800 daily, making them more available than consultants attending to other aspects of their job plans.

"Anaesthesia Associates"?

Anaesthesia Associates (AAs) are typically senior nurses, senior ODPs or science graduates who have done a 2-year Postgraduate Diploma to become an Anaesthesia Associate. After 2 years of practical and theoretical training (and after

having passed an exit MCQ and OSCE) they work in theatres as part of the anaesthetic team. They anaesthetise and manage patients closely supervised by an anaesthetic consultant on either a 1:1 or 2:1 basis.

Immediately following qualification, AAs must work very closely supervised by a consultant anaesthetist. Induction and eduction of anaesthesia must be done under direct consultant supervision and a consultant must be available to attend their theatres within 2 minutes. Spinal anaesthesia and nerve blocks are not part of the curriculum during the 2 years. However, after qualification departments can train their AAs to perform additional skills according to local need.

The AAs in Sheffield have been upskilled to perform:

- solo induction and emergence from anaesthesia
- spinal anaesthesia
- a range of upper and lower limb nerve blocks

Over years, the AAs have become extremely skilled at performing ultrasound guided blocks for hand surgery and for trauma/lower limb surgery. When trained, AAs are comparable in skill to supervising consultants. It was easy to train them to perform ESP catheters. They had ultrasound skills, they were used to full aseptic precautions due doing spinals, they had received simulator training in LA toxicity management.

Training Method

We trained four experienced qualified AAs (each having been qualified for over 5 years).

Training Afternoon

Before the training afternoon - online resources and YouTube videos were signposted along with written information and case studies

On the day, the theory and practice of ESP catheters was covered. Indications, contraindications, anatomy (using 3D computerised anatomy software and a plastic spine) management of LAST. The catheter kits were opened, and the team familiarised themselves with them.

Then off to theatre to scan volunteers' backs until each team member could confidently identify the three important sonographic appearances - ribs and pleura (too lateral) flat "crocodile back" lamina (too medial) and dark tombstones with pleura dropped away (the optimal).

Once the AAs were deemed competent at the sonoanatomy they performed a few blocks under my supervision, and I signed them off. This took a couple of blocks each as it is a straightforward technique to master.

Then the AAs were free to "fly solo" completing an audit form for each patient. The plan was to gather data on fifty patients with the aim of determining (amongst other things):

- correct sterile technique
- correct monitoring
- correct consent taken
- pain scores pre and post block/catheter
- ability to cough pre and post block/catheter
- adverse events

After 50 patients there were no adverse events.

How do the patients get an AA delivered catheter?

Referral process

Monday to Friday there is an Anaesthesia Associate carrying the "ESP Bleep." Carrying the bleep is a voluntary service.

The referrals come from the Acute Pain Team, the Major Trauma Team (who visit all patients admitted with a high Injury Severity Score) the cardiothoracic wards and increasingly HDU/ITU where it is felt they are helpful for

a) reducing patients at risk of respiratory deterioration ending up being ventilated
b) providing analgesia for sedation holds/extubation in chest injured patients.

Logistics

The AA carrying the bleep will get details about the patient and book them onto the theatre data system. They then arrange a spare anaesthetic room or theatre where the block can be performed. They contact their supervising consultant and arrange to be freed up for around an hour to perform the block.

This is much more efficient than booking the patients onto the emergency theatre list (as used to happen) and interrupting the flow of the patients requiring emergency surgery. It is an excellent example of parallel processing.

The patient is brought to theatres for a catheter - the wards and ED not being felt suitable to place a catheter for reasons of logistics and sterility. The patient is monitored, iv access confirmed/gained, consent obtained, and the patient is prepared in a similar fashion to an epidural.

Initially the AAs found it very time consuming to locate and assemble the necessary bits of kit and local anaesthetic. They designed an ESP trolley which contains catheter kits, local anaesthetic, drapes, chlorhexidine, US probe sheaths and relevant adjuncts) - a mobile one stop shop for use in anaesthetic room/theatre/ITU and drastically save on time.

The catheter is placed and the AA fills in the audit form whilst the patient is monitored for 30 minutes. Monitoring is (as stated previously) for two reasons:

1) signs of local anaesthetic toxicity
2) any respiratory depression (they may have been on large opioid doses)

After 30 minutes they return to the ward and the acute pain team will follow them up daily. The only input required from ward nursing staff is to change the elastomeric pump when it runs out.
The patients are potentially mobile once pain is reduced; they can walk around carrying the elastomeric pumps in a little bag.

Effectiveness

After 50 catheters the audit was analyzed. Mean and median pain scores were significantly reduced after catheter placement. The ability to cough was especially marked with only 20% of patients able to cough pre catheter placement but 80% afterwards. There were no adverse events recorded.

One point worth noting, pain scores may not always be the best way to judge effectiveness for the following reason.

- if you ask a patient to take a breath pre block they will take a breath in and report their pain score

	PAIN SCORES BEFORE BLOCK	**PAIN SCORES AFTER BLOCK**
AT REST	6/10	1/10
DEEP BREATHE	9/10	3/10
COUGHING	10/10	5/10
ABILITY TO COUGH?	YES - 2/10	YES - 9/10

- if after the block you then ask them to take a deep
  breath, again they will do so until it hurts and report their pain. The difference in pain score might not look impressive - but the patient may have taken a **much bigger breath** after the block! - breathed in until it hurt! There may be a large and beneficial functional difference that wouldn't be reflected in measured parameters.

After 50 catheters I sought feedback from the Pain team, cardiothoracic ward, Major Trauma Team and ITU. There was universal agreement that the catheter service should be continued. Surprisingly, the most encouraging feedback came from critical care where it was concluded that a population of patients were avoiding proceeding to IPPV once catheters were placed. Also, catheter placement pre sedation hold and extubation were felt to be helping extubate these patients early.

I do not have any morbidity or mortality or length of stay data yet due to the difficulty of gathering this but hopefully this will be possible soon

Next Steps

The AAs admirably volunteered to form the catheter service despite being given no extra time or resources. This is not sustainable or fair! I would like them to be given specific paid time in the day to provide the catheters. This is a work in progress!

The Anaesthesia Associates work Monday to Friday. We are currently exploring methods to provide the blocks and catheters at the weekend. One solution involves training the ED consultants, another might be training the consultants who do the weekend trauma lists. However, the weekend "ESP gap" is an issue that needs resolving. Efforts to turn on the "money tap" are currently proving especially tricky. Complicating the funding is that ESP catheters benefit several departments. Should they be funded from the critical care budget? Cardiothoracic, the pain service? Major trauma? There is a definite "little red hen" effect in that everyone wants ESP catheters but prefer someone else to pay for the service…

How can I introduce ESP blocks to my department?

Optimally there is someone in your department with the skill or a local "block course" where you may be instructed by experts. However - if not - you could teach yourself…!

I DON'T WANT TO TEACH MYSELF!! THAT'S INSANE!

No problem! At the BSOA Meeting in December there will be a workshop where you will get a demonstration of how to scan a patient's back and practical tips in performing ESP blocks and catheters from one of our top Sheffield Anaesthesia Associates and myself!

Like in Star Wars where Darth Vader starts off as the pupil and then becomes the master, I will be there being supervised by the AA that I originally taught! He has done many more catheters than me now and will be delighted to share his experience with you.

If you are unable to join us there, please feel to contact me for any advice.

Dr Tim Moll
Consultant Anesthetist Sheffield Teaching Hospitals
Major Trauma Consultant
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Cars – Personal vs Company vs NHS Employee Reward Scheme

Mr Andrew Fenton
Chartered Tax Advisor

Cars – Personal vs Company vs NHS Employee Reward Scheme

Personal Ownership

If you decide to go with the personal purchase option, the car will have to be paid for out of taxed income so Doctors will need additional dividends to pay for it.

Doctors won't qualify for tax relief on the cost of the vehicle or certain running costs, such as insurance and road tax but if you use your personal car for work* then you can claim back 45p per mile for the first 10,000 miles you travel for work in a year.

Buying a Car through the company

If you're looking at the implications of a company car, your business could be eligible for relief on the initial cost of the car via capital allowances (the rate of capital allowances will depend on the CO2 emissions of the car) but you will have a taxable benefit in kind (BIK) which is based on the list price and CO2 emissions of the vehicle. This BIK tax is payable each year that you have use of the car.

e.g. if you purchased a Tesla electric car with a list price of £60,000, you would pay 2% BIK, so £1,200 for the tax year 2022-23 (60,000 x 2%).

The cost for a 40% taxpayer would be £1,200 x 40% = £480.

Your business should get tax relief for the cost of insurance and car tax, but the business mileage you are able to claim is at a significantly lower rate than private ownership as the mileage rate doesn't just cover fuel but the full running costs of the vehicle.

A company car is likely to be best if the car has very low CO2 emissions and low list price. Personal ownership is preferable if the car has a high list price and high CO2 emissions, however, anywhere in between it is worth doing the calculations.

Electric cars are now becoming an increasingly popular choice for company cars, which is hardly surprising considering the Government's bid to remove all petrol and diesel cars from sale by 2030. The benefits of electric cars shouldn't be overlooked, attracting a significant lower BIK rate than their petrol and diesel counterparts.

In addition to this, 100% capital allowances may also apply so the cost of the vehicle can be fully written off against profits in the year of purchase, making electric cars a cost-effective option when selecting and running a company car.

From a company point of view, the car would be eligible for first year allowances for corporation tax purposes at 100% of the cost price (provided the car is brand new and unused or a demonstrator).

However, there is a clawback as when you sell the car, you will pay tax on 100% of the proceeds. Remember also that corporation tax rates are increasing to 25% in April 2023.

The company would also pay class 1A National Insurance Contributions ("NIC") at 13.8% on the benefit calculated, but this is treated as an allowable expense for corporation tax so in essence, the company would pay 11.17% (13.8% x 81%), based on 19% Corporation Tax so the example given here, the cost to the company would be £134.14 (£1,200 x 11.17%).

From April 23, the rate is increasing to 25% so rate becomes 10.35% (13.8% x 75). The cost to the company would be £124.20.

Leasing a car through the company

If you lease the car and the company owns the car at the end of the lease (e.g. hire purchase), the rules are the same as for 'Buying the car through the company' above.

If you only lease the car for a certain number of years and then give it back, the car will not be an asset in the company. The monthly lease payments will be treated as any other company expense and will reduce your corporation tax by 19% (25% from April 2023).

The tax implications for you personally will be the same as above (benefit in kind).

NHS Employee Rewards Scheme

Example

Under salary sacrifice, the Doctor permanently reduces their salary (thus saving Income tax and Employee NICs) and the NHS provides benefits in exchange for this.

For example, assuming your NHS car quotation suggests that you will reduce your gross salary by £2,001.27 per month.

This will impact your net salary as follows:	**£**
Reduction in gross salary	(2,001.27)
Reduction in Income Tax at 40%	800.50
Reduction in employee National Insurance Contributions ("NIC") at 2%	40.02
Increase in Income tax on benefit in kind	(57.53)
Reduction in net salary	**1,218.28**

The benefit in kind charge above is calculated by applying a percentage to the car's quoted list price. The percentage is determined by the CO2 emissions of the car and in this case, it is an electric vehicle, therefore the CO2 emissions are nil.

In this case the percentage applied in 2022/23 is 2 per cent of the quoted price of £86,290. This produces a "benefit in kind" value of £1,725.80 which at a marginal income tax rate of 40 per cent produce an annual tax bill of £690.23 or £57.53 per month.

HMRC will be notified of your new vehicle in due course and an appropriate adjustment to collect this additional tax monthly will be made to the Doctor's PAYE code.

In terms of the salary sacrifice scheme in general, please bear in mind that:

- Your actual salary will be lower because of your salary sacrifice, which this could affect the amount of money you can borrow when you apply for a mortgage or other loan.
- It could also affect your amount of sick pay if applicable
- Pension contributions may be affected, as the percentage amount of your now-lower salary will be less.

Please also be aware that the percentages applied to quoted list prices of cars can be changed each year by HMRC so the tax position set out above may change in the future.

The tax rules concerning cars are complex and the information provided here is for illustration purposes only and specialist advice should be sought before taking any action.

For further information or to discuss your tax affairs please contact Andrew Fenton (AF Tax Solutions Ltd) on 07775 503475 or email andrew@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.

UPCOMING BSOA EVENTS

Annual Scientific Meeting 2022

B.S.O.A
British Society of Orthopaedic Anaesthetists

British Society of Orthopaedic Anaesthetists Annual Scientific Meeting at Holywell Park Conference Centre, Loughborough.
Thursday 1st – Friday 2nd December 2022.

Pending Approval for 12 CPD Points

Programme to include the following:

Workshops:

- Tax Advice for Doctors
- Erector Spinae Blocks and Catheters
- Regional Anaesthesia - Lower Limb Blocks
- Regional Anaesthesia - Upper Limb
- Prone Positioning in Critical Care and Spinal Surgery
- Radiology for Anaesthetists

Sessions:

- Litigation and Peri-operative Care
- Complexity of Orthopaedic and Spinal Patients
- Peri-operative Care Progress
- Not so Basic Orthopaedic Anaesthesia
- Regional Anaesthesia in Day Surgery
- Updates in Internal Medicine

Meeting to include:
Poster Presentations | Free Paper Session | Registrar Prizes
Meet with Trade and Key Suppliers from Industry

2 On-site Hotels

Rates are as follows:
Consultant/SAS Member - £195.00 (1 day) or £300.00 (2 days)
Consultant/SAS Non-Member - £210.00 (1 day) or £350.00 (2 days)
Trainee Member - £100.00 (1 day) or £200.00 (2 days), Trainee Non-Member - £140.00 (1 day) or £250.00 (2 days)
Retired/PA(A)/ODP/Pre-operative Nurses - £90.00 (1 day) or £120.00 (2 days)

For more information, please visit:
bsoa.org.uk/conference/2022-annual-scientific-meeting

For more information contact: Event Management Direct Telephone: 0114 299 5922
Email: chloewragg@eventmanagementdirect.co.uk

Scientific Programme

Thursday 1st December – Workshops

Tax Advice for Doctors	*Andrew Fenton* *AF TAX Solutions*
Regional Anaesthesia – Lower Limb Blocks	*B Braun* *Dr Tony Sutherland*
Erector Spinae Blocks and Catheters Caudal and Neuraxial Blocks	*Dr Tim Moll* *Mr Brian Corrin* *Dr Bill Rea*
Regional Anaesthesia – Upper Limb	*B Braun* *Dr Ben Smith* *Dr Hulgur*
Prone Positioning in Critical Care and Spinal Surgery – Avoiding Injury	*Care Surgical* *Dr Da Silva* *Dr Cernovsky*
Radiology for Anaesthetists (Reading a CTPA/Reading a CXR/C-SPINE Investigation)	*Dr Christine Azzopardi* *Dr Anish Patel*

Thursday 1st December – Workshops

08:00-08:45	**Registration for Workshops**
08:45-12:00	**Parallel Workshops – All Workshops Will Run Four Times**
08:45-9:25	First Session
09:30-10:10	Second Session
10:10-10:35	**Break**
10:35-11:15	Third Session
11:20-12:00	Fourth Session

Scientific Programme

Thursday 1st December 2022 – Day 1	
12:00-13:00	**Lunch Break and Exhibition**
13:00-14:30	**Session 1: Litigation and Peri-operative Care – Chair: Dr EJ da Silva**
13:00-13:25	Litigation and Medical Care *Jonathan Godfrey KC, Barrister*
13:25-13:50	NHS Litigation associated with Anaesthesia in England *Professor Tim Cook, Bath*
13:50-14:15	Top Tips for the Defendant Anaesthetist *Dr David Levy, Nottingham*
14:15-14:30	Question and Answers *Chair: Dr E J da Silva, Birmingham*
14:30-15:00	**Coffee Break**
14:40-15:00	**Annual General Meeting**
15:00-16:30	**Session 2: Complexity of Orthopaedic and Spinal Patients – Chair: Dr Svetlana Galitzine**
15:00-15:25	Complex Orthopaedics in Centres with Level 2 Critical Care *Dr Ben Smith, ROH, Birmingham*
15:25-15:50	UK's Epidemic of Revision Arthroplasty *Mr Jonathan Stevenson, ROH, Birmingham*
15:50-16:15	LL Joint Revisions: Anaesthetic and Surgical Challenges *Mr Ben Kendrick, Oxford*
16:15-16:40	Pelvic Pain in Musculoskeletal Patients *Dr William Rea, ROH, Birmingham*
16:40-17:00	Questions and Answers
17:00-18:00	**Cheese and Juice/ Wine Reception** *BSOA and Sponsors*
19:00-22:00	**Annual Dinner** *Annual Dinner Motivational Speaker – Spinal Stroke Rehabilitation – a Personal Experience* *Mr Keith Mason*

Friday 2nd December 2022 – Day 2

08:30-09:00	**WELCOME: Coffee and Exhibition**
09:00-10:30	**Session 3: Peri-operative Care Progress – Chair: Dr Liana Geary**
09:00-09:25	Current concepts in the perioperative management of diabetes *Dr Nicholas Levy, Suffolk*
09:25-09:50	Anaemia-iron Infusion Clinics CPOC *Dr Henry Murdoch, Gloucestershire*
09:50-10:15	Frailty and Orthopaedics-How Do We Get Surgeons To Look Beyond The Bones? *Dr Barry Evans, Derby*
10:15-10:30	Questions and Answers
10:30-10:45	**Coffee Break**
10:45-12:15	**Session 4: Not So Basic Orthopaedic Anaesthesia – Chair: Dr Bernadette Ratnayake**
10:45-11:10	Mitigating the harms from pre- and post-operative opioids *Dr Nicholas Levy, Suffolk*
11:10-11:35	Long Duration Prone Positioning *Dr Jan Cernovsky, London*
11:35-12:00	Peripheral Neurological Injuries as a Result of the COVID Pandemic *Mr Dominic Power, Birmingham*
12:00-12:15	Questions and Answers
12:15-13:15	**Lunch Break and Exhibition**
13:15-14:45	**Session 5: Regional Anaesthesia in Day Surgery – Chair: Dr Kim Russon**
13:15-13:40	Day Case Shoulder Surgery *Dr Amr Hassan, Nottingham*
13:40-14:05	Lower Limb Blocks in Day Case Surgery *Dr David B-St. Laurent, Wales*
14:05-14:30	Day Case Spinal Anaesthetics *Professor Anil Hormis, Rotherham*
14:30-14:45	Questions and Answers
14:45-15:00	**Coffee Break**
15:00-16:30	**Session 6: Understanding Cardiology/Endocrine/Respiratory Updates – Chair: Dr Zehrin Nassa**
15:00-15:30	Pearls and Pitfalls of the Athletes Heart *Professor Kiran Patel, Coventry*
15:30-16:00	An Avalanche Warning: Respiratory Compromised Patients in the POST-COVID Era *Dr James Bonnington, Nottingham*
16:00-16:30	Just Getting a Shiny New Hip Is Not Enough *Ms Jess Lacey, Oxford*
16:30-17:00	**Registrar Prize Awards and Conclusion**

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Adverse events should be reported
Reporting forms and information can be found at **www.yellowcard.mhra.gov.uk**.
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*Information about this product, including adverse reactions, precautions, contra-indications and method of use can be found at **EXPAREL.eu/hcp/uk/***
Prescribers are recommended to consult the summary of product characteristics before prescribing

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POM

MEMBER BENEFITS

- ✓ Reduced registration fees for BSOA meetings
- ✓ Access to free webinars
- ✓ BSOA e-newsletters and the opportunity to publish articles in future issues
- ✓ Participation and voting rights at upcoming Executive Committee elections as well as eligibility to nominate and be nominated to the Executive Committee
- ✓ Participation and voting rights at the Annual General Meeting
- ✓ Access to the members-only area on our website including documents Library to search documents and Member Forum to join discussions and/or search topics

Questions? Comments? Suggestions? Email us anytime: info@bsoa.org.uk

Dr EJ da Silva
Editor and President, BSOA Executive Committee