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Title: Laparoscopic procedure in patient with Ventriculoperitoneal shunt

Muhammad Kashif Munir, University Hospitals of Derby and Burton, UK

Title: Treatment strategies for thromboembolism-in-transit with pulmonary embolism

Hiroki Sakai, Iizuka Hospital, Japan

Title: Pericardiectomy for constrictive pericarditis via Median Sternotomy in a resource constraint setting

Isaac Okyere, Kwame Nkrumah University of Science and Technology, Ghana

Title: Improving pharmacological venous thromboembolism prophylaxis assessment and prescription on an acute surgical ward (2022)

Basit RH, Bradford Teaching Hospital Foundation Trust, UK

Title: Metaphyseal sleeve revision knee arthroplasty as treatment for highly comminuted Schaztker VI tibial plateau fractures

Matthew McSorley, Royal Infirmary of Edinburgh, UK

Title: Why mechanism matters: A literature review of simultaneous Ipsilateral Tibial Tuberosity Avulsion and patella fracture with case report

Alexander Jaques, Lister Hospital, Stevenage, UK

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Patient outcomes after caesarean delivery under neuraxial anaesthesia following a change to earlier removal of an indwelling urinary catheter

Hilary Leeson, Elloise Bush, Christine Rowcliffe, Nolan McDonnell
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Introduction: International consensus on enhanced recovery after caesarean section advocates removal of the indwelling urinary catheter (IDC) by 6-12 hours postpartum.1 Neuraxial morphine may increase the incidence of bladder issues post-operatively, this risk may be mitigated with appropriate bladder care post-catheter removal. Following a review of the evidence, the long-standing policy in our institution for the IDC to remain in for a minimum of 24 hours post caesarean delivery and neuraxial morphine was reduced to a minimum of 12 hours.

Methods: Demographic and clinical data and potential risk factors for postpartum bladder issues were identified a-priori on 100 randomly selected women who delivered by caesarean with neuraxial morphine in April 2022.

Results: The IDC was removed at the 12 hour mark in 64 women, 6 of whom failed their first trial of void, with 4 of these having a residual volume 500mL. No cases of bladder over stretch injury occurred. The average number of risk factors in women who successfully completed their first trial of void was 1.9, compared to 3.5 in those who had a residual volume of >500mL.

Conclusions: In women receiving neuraxial morphine for caesarean delivery, where the IDC was removed at the 12 hour mark the incidence of a PVR>500mL was 3.1%, compared to no cases for women in whom the IDC was left in for a prolonged period. The women who had a PVR>500mL tended to have multiple risk factors present for an increased PVR. This suggests that with appropriate bladder care, the IDC can be safely removed at the 12 hour mark as per ERAS guidelines while in women with multiple risk factors for urinary retention, it may be prudent to leave the IDC in for more than 12 hours.

Table One

	Group A n=64	Group B n=36
Risk factors for Urinary Retention		
Elective caesarean	36 (56%)	17 (47%)
Non elective caesarean	28 (44%)	19 (53%)
Obesity	21 (33%)	18 (50%)
LGA baby	6 (9%)	6 (17%)
Nulliparous	19 (30%)	10 (28%)
Non-english speaking	1 (2%)	0 (0%)
Prolonged 1st stage	1 (2%)	1 (3%)
Bladder Outcomes		
Passed 1st Trial of Void	58 (91%)	36 (100%)
Failed 1st TOV, PVR<500ml	4 (6%)	0 (0%)
Failed 1st TOV, PVR>500ml	2 (3%)	0 (0%)
Failed 1st TOV, PVR>1L	0 (0%)	0 (0%)

Data are presented as n(%). LGA=large for gestational age, TOV=trial of void, PVR=post void residual volume

Recent Publications

1. Bollag L, Lim G, Sultan P, Habib AS, Landau R, Zakowski M, Tiouririne M, Bhambhani S, Carvalho B. Society for obstetric anesthesia and perinatology: consensus statement and recommendations for enhanced recovery after cesarean. Anesthesia & Analgesia. 2021 May 1;132(5):1362-77.

2. Myo J, Pooley S, Brennan F. Oral, in place of intravenous, paracetamol as the new normal for elective cases. Anaesthesia. 2021 Aug;76(8):1143-1144.

3. Schug S, Palmer G, Scott D. Acute Pain Management: Scientific Evidence. 5th Edition 2020.

Biography

Hilary Leeson completed her medical degree in Trinity College Dublin in 2019. She is currently working in perioperative medicine as a Resident Medical Officer in Australia. She has an interest in perioperative medicine and anaesthetics.

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Laparoscopic procedure in patient with Ventriculoperitoneal shunt

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Patients with long term ventriculoperitoneal shunt have many on-going issues. Headaches are common problems. However certain surgical procedure requires meticulous approach to avoid complications. Procedures requiring pneumoperitoneum can have serious complications if safe approach is not used. I am presenting a instance of 41 years older lady who was listed for elective cholecystectomy. She had multiple GA and one caesarean section under subarachnoid block. She was under care of neurology team in our hospital since 2008 for treatment of headaches, poor memory. Has CT scan in 2008 which confirmed good position of shunt with no evidence of hydrocephalus; remained under the care of ENT for choking episodes and vomiting as well. She had pre-op assessment and as she had no problems with previous surgery, so nothing was flagged up in pre-op clinic. As this particular surgery required pneumoperitoneum, so risk was different compared to previous GA. I explained about all different complications including pneumocephalus, hydrocephalus, meningitis and shunt getting blocked due to intra-abdominal clots. After extension discussion we decided to refer her neurosurgical centre. She recently had CT brain which did not show any sign of hydrocephalus. She will be operated there with neurosurgical back up. BJA published an article on effect of laparoscopic surgery on intracranial pressure. Even in that particular case report they have isolated the distal end of shunt and tried to keep intra-abdominal pressure less than 12. There are some case reports of uncomplicated laparoscopic surgeries performed without isolating distal end of shunt. Research data and guidelines do not support performing laparoscopic surgery without isolating distal end of shunt.

Biography

Munir is currently working as Consultant in Anaesthesia and Pain Management in University Hospitals of Derby and Burton, UK. He has given two previous international presentation and multiple poster presentations.

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Treatment strategies for thromboembolism-in-transit with pulmonary embolism

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A 46-year-old obese woman undergoing treatment for bipolar disorder presented with acute shortness of breath, chest pain, and palpitations. She was tachypnea and tachycardia, but blood pressure was stable. Computed tomography angiogram revealed bilateral pulmonary embolism. Echocardiogram revealed thrombus in transit.

She underwent surgical embolectomy only for thrombus-in-transit and closure of the Patent Foramen Ovale (PFO). However, pulmonary hypertension worsened, hemodynamical instability prolonged and hepatic congestion progressed. After Veno-Arterial Extracorporeal Membrane Oxygenation (VA-ECMO) insertion, we performed thrombectomy by catheter and anticoagulation therapy. One month later, the patient was transferred to another hospital for rehabilitation.

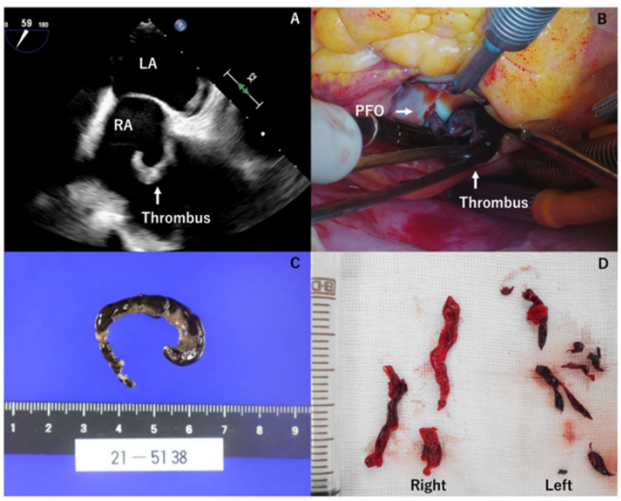

Figure 2: (**A**) Transoesophageal echocardiography, worm-like thrombus (arrows) straddling the PFO in both atria. (**B**) Clot retrieved at embolectomy. A worm-like thrombus was lodged into the PFO. (**C**) Pathologically, the thrombus has no malignant findings. LA: left atrium; PFO: patent foramen ovale; RA: right atrium. (**D**) Clot retrieved at thrombectomy by aspiration using a catheter. White and red thrombi were removed from the right PA. Many red thrombi were removed from the left PA. (A color version of this figure appears in the online version of this article.)

Recent Publications

1. D. S. Hui, F. Fleischman and P. M. McFadden. Thromboembolism-in-transit and patent foramen ovale: Should screening echocardiogram be routine for thromboembolic disease? Ochsner J 2016;16:321-3.
2. V. S. Ellensen, S. Saeed, T. Geisner and R. Haaverstad. Management of thromboembolism-in-transit with pulmonary embolism. Echo Res Pract 2017;4:K47-k51.
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Surg 2019;34:202-04.

4. W. T. Kuo, M. K. Gould, J. D. Louie, J. K. Rosenberg, D. Y. Sze and L. V. Hofmann. Catheter-directed therapy for the treatment of massive pulmonary embolism: Systematic review and meta-analysis of modern techniques. J Vasc Interv Radiol 2009;20:1431-40.
5. H. Tajima, S. Murata, T. Kumazaki, K. Nakazawa, H. Kawamata, T. Fukunaga et al. Manual aspiration thrombectomy with a standard ptca guiding catheter for treatment of acute massive pulmonary thromboembolism. Radiat Med 2004;22:168-72.
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Biography

Hiroki Sakai is a surgeon, specialist on cardiothoracic surgery at Iizuka Hospital, Japan.

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Pericardiectomy for constrictive pericarditis via Median Sternotomy in a resource constraint setting

Isaac Okyere, Perditer Okyere
Kwame Nkrumah University of Science and Technology, Ghana

Background: Constrictive pericarditis is the endpoint of the natural history of acute pericarditis of different aetiologies where a chronic inflammatory process results in a thickened, fibrotic and inelastic pericardium with consequent impairment of diastolic function and systemic congestion.

Aim: The purpose of this study was to evaluate the clinical features, diagnosis, surgical management and outcome of patients with constrictive pericarditis as managed in a local setting of a tertiary hospital in Ghana.

Patients and Methods: It is a retrospective cohort analysis of patients who had undergone pericardiectomy for constrictive pericarditis at a teaching hospital.

Results: Ten patients underwent pericardiectomy for the period of study. There were 8 (80%) males. The mean age was 20.4 ± 17.2 years. Six of the patients 6 (60%) were in NYHA Class III. Preoperative diagnostics included Chest x-ray, echocardiography, and computer tomography (CT) scan. The surgical approach for the pericardiectomy was median sternotomy. The mean operative time was 159.9 ± 43.0 mins. The mean postoperative days spent before being discharged was 6.9 ± 2.3 days. Nine (90%) of the patients were in NHYA Class I after a mean follow up of 19.3 ± 16.7 months. One patient died 6 weeks after surgery with heart failure and one patient was lost to follow up.

Conclusion: Surgical pericardiectomy via median sternotomy is still the standard treatment for constrictive pericarditis and this can be done without cardiopulmonary bypass especially in less resource centres with excellent results.

Keywords: Median Sternotomy, Pericardiectomy, Constrictive Pericarditis, Tuberculosis

Recent Publications

1. Constrictive pericarditis – UpToDate [Internet] 2017. [cited 2020 Jun 3]. Available from: https://www.uptodate.com/contents/constrictive-pericarditis?search=const....
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Biography

Isaac Okyere is a Cardiovascular and Thoracic Surgeon. He is a Senior Lecturer at the Department of Surgery, Kwame Nkrumah University of Science and Technology, Kumasi Ghana and Consultant Cardiovascular and Thoracic Surgeon, Komfo Anokye Teaching Hospital, Kumasi, Ghana.

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Improving pharmacological venous thromboembolism prophylaxis assessment and prescription on an acute surgical ward (2022)

Basit RH, Anwar A
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Introduction: Venous thromboembolism represents a major cause of morbidity and mortality of acute surgical admissions. Previous audits, and NHS campaigns, have greatly increased VTE prophylaxis (pharmacological/mechanical methods). In trusts, with electronic prescribing, the VTE risk assessment tool often prompts doctors to complete the assessment through multiple, window notification reminders. NICE/SIGN/Trust guidelines recommend VTE risk assessments and prophylaxis is completed within 14 hours post-admission, with reassessment 24 hours post-admission if high bleeding/thrombosis risk.

Methods: 269 patients were assessed in total, across 6 months, through 3 PDSA cycles. Data collection was undertaken retrospectively post-discharge; the specified timepoints were within 14 hours post-admission and 24 hrs post-admission. Initial data collection (first cycle) was used to determine baseline practices with additional 2 further data collection points 2 months/4 months post-intervention (departmental poster education and awareness). Average VTE prophylaxis rates were averaged at each point of data collection and an unpaired T-test was used to determine a p-value for significance.

Results: Current baseline practice assessment revealed 92% and 16% of patients, had VTE risk assessment tool and appropriate prophylaxis prescribed within 14 hours and 24 hours of admission respectively. Post-intervention 2 months later, VTE risk assessment and prophylaxis improved to 98% ($p<0.05$) and 86% ($p<0.001$) respectively for 14 hours and 24 hours post-admission. At 6 months VTE risk assessment and prophylaxis rates decreased to 96% and 62% of patients respectively for 14 hours and 24 hours post-admission. ($p<0.05$, $p<0.001$ compared to baseline practice respectively.

Discussion: VTE reassessment significantly improved post departmental poster-education and awareness at both 14 hours and 24 hours post-admission. This is an important consideration, given the high turnover of the acute surgical admission; often with blood results, investigations, and surgical/anaesthetic operation risk assessment guiding further patient management requiring VTE reassessment to minimise bleeding/thrombosis. The drop in VTE risk assessment and prophylaxis at the 6-month time point could be explained by the new cohort of junior doctors, in their first foundation year job, with a lack of exposure to previous departmental VTE education.

Biography

He is currently a medical doctor working in the United Kingdom.

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Metaphyseal sleeve revision knee arthroplasty as treatment for highly comminuted Schaztker VI tibial plateau fractures

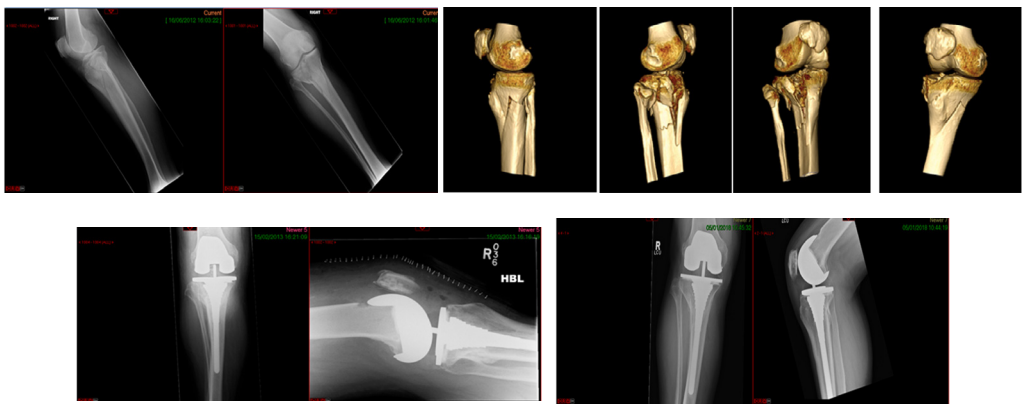
Matthew McSorley
Royal Infirmary of Edinburgh, UK

Traditional treatment of tibial plateau fractures is with open reduction and internal fixation, or external fixation in severely displaced and comminated fractures. Total joint arthroplasty for unreconstructedly hip fractures is a successful and widely accepted treatment, however such surgery for tibial plateau fractures is not common practice.

We present 2 cases of highly comminated Schaztker VI tibial plateau fractures in patients over the age of 65. Both patients had a metaphyseal sleeve revision knee arthroplasty as delayed primary treatment. Both patients have had excellent clinical and radiographical results at 6 months and 5 years follow-up respectively.

We present the first description in the literature of this implants use for bone loss as a result of trauma. There is growing evidence that total joint arthroplasty is an effective treatment in tibial plateau fractures, in particular for elderly patients who may be at high risk of failure from internal fixation.

Keywords: tibial-plateau fracture, Schatzker VI, revision knee arthroplasty, metaphyseal sleeve, trauma arthroplasty



Biography

Matthew McSorley graduated from Queen's University Belfast in 2020. From there he moved to Edinburgh to undertake his foundation training including a rotation in Trauma and Orthopaedics in the Royal Infirmary of Edinburgh. Having interests in Trauma and Sports Medicine he will shortly be taking up a volunteer post in South Africa at George Hospital to further his clinical experience in Orthopaedic Surgery prior to applying for Core Surgical Training in the UK.

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Why Mechanism Matters: A Literature Review of Simultaneous Ipsilateral Tibial Tuberosity Avulsion and Patella Fracture With Case Report

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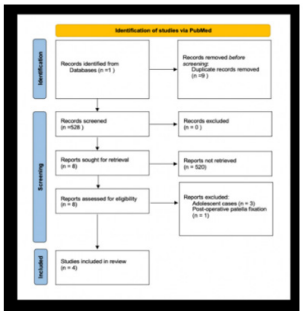
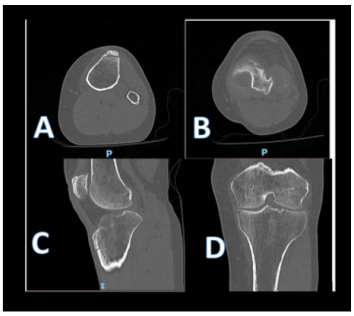
[2]Orthopaedics and Trauma, Royal Surrey County Hospital, Guildford, GBR

Simultaneous ipsilateral tibial tuberosity avulsion and patella fractures are rare in adults. They are often associated with patients who have underlying bone disease and other medical co-morbidities. Here we describe a case where this injury was attributed to direct trauma and demonstrate our department's management for such an injury. In addition to our case report, we have performed a systematic literature review to identify other cases of the same injury. Only four other cases have been reported. Here we summarise and compare the management and outcome measures reported in each case. All patients are managed differently, yet all authors report satisfactory outcomes. With this being a relatively rare injury, further research is required to establish a gold standard for the management of such patients.





Recent Publications

1. Acute tibial tubercle avulsion fractures. McKoy BE, Stanitski CL. Orthop Clin North Am. 2003;34:397–403
2. Fracture of tibial tuberosity in an adult with Paget's disease of the bone - An interesting case and review of literature. Raad M, Ndlovu S, Høgsand T, Ahmed S, Norris M. https://doi.org-10.1016/j.tcr.2021.100440. Trauma Case Rep. 2021;32:100440.
3. Comminuted patella fracture in elderly patients: a systematic review and case report. Matthews B, Hazratwala K, Barroso-Rosa S. Geriatr Orthop Surg Rehabil. 2017;8:135–144.

Biography

Alexander Jaques is a junior doctor working within the Orthopaedic Department in Lister Hospital, Stevenage. He has a passion for medical education and over his foundation years a keen interest in Orthopaedic Surgery and is hoping to pursue this as he progresses through his career. His other current research extends into Non-traumatic limb amputations in a changing demographics and its effects on operative management.

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