bida
Journal

The mental well-being of Doctors:

Often ignored, but important as suicide prevention strategy

Arachnoid Cyst Case Reports & Discussion

Organ Donation: What is new?

Osteoarthritis of the knee: Is running a cause?

Degeneration of the spinal cord in chronic HIV infection A Case Report

The Journal of The British International Doctors' Association

Issue No.3, Volume 25
October 2019

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Cipla

How a little change can make a big difference[1–8]

Sereflo is therapeutically equivalent with the same dosing as Seretide. It's also the least expensive salmeterol/fluticasone propionate pMDI combination available, offering significant savings when compared to the market leader Seretide Evohaler.[1–8]

Sereflo is part of Cipla's UK respiratory portfolio.

Sereflo is indicated in the regular treatment of adult patients (18 years and older) with moderate to severe asthma where use of a combination product (long-acting β_2 agonist and inhaled corticosteroid) is appropriate.[1,2]

pMDI = pressurised metered dose inhaler.

Sereflo®

(salmeterol/fluticasone propionate)

Sereflo® Metered Dose Inhaler (salmeterol xinafoate/fluticasone propionate)

Prescribing Information

Please consult the full Summary of Product Characteristics (SmPC) before prescribing

Sereflo 25 microgram (µg) salmeterol xinafoate /125 µg or 250 µg fluticasone propionate per actuation pressurised inhalation, suspension. For both dose strengths the equivalent delivered dose per actuation is 21 µg of salmeterol and the delivered fluticasone propionate is 110 µg, for 125 µg dose strength and 220 µg, for 250 µg dose strength.

INDICATIONS: For use in adults with asthma 18 years of age and older only. Sereflo is indicated in the regular treatment of patients with moderate to severe asthma where use of a combination product (long-acting β_2 agonist and inhaled corticosteroid) is appropriate:
- patients not adequately controlled on a lower strength corticosteroid combination product or
- patients already adequately controlled on an inhaled corticosteroid in a mid or high strength and a long-acting β_2 agonist.

POSOLOGY AND ADMINISTRATION: Patients should be instructed in the proper use of their inhaler (see SmPC and patient information leaflet). Recommended doses in adults 18 years and older - Two inhalations of 25µg salmeterol and 125 µg or 250 µg fluticasone propionate twice daily. A short-term trial of salmeterol and fluticasone propionate may be considered as initial maintenance therapy in adults with moderate persistent asthma for whom rapid control of asthma is essential. In these cases, the recommended initial dose is two inhalations of 25 µg salmeterol and 50 µg fluticasone propionate twice daily. **Note:** Sereflo is not available in a lower strength product containing salmeterol 25 µg and fluticasone propionate 50 µg. Therefore, when initiating therapy, or when it is appropriate to titrate down to a dose below 125 µg, an alternative fixed-dose combination of salmeterol and fluticasone propionate containing a lower dose of the inhaled corticosteroid is required. *Use of a spacer device;* where required in those with difficulties in coordinating actuation of the inhaler with inspiration of breath, it is recommended ONLY for higher strength Sereflo containing salmeterol 25 µg and fluticasone propionate 250 µg. Patients should continue to use the same make of spacer device (Volumatic or the AeroChamber Plus) as switching between spacer devices can result in changes in the dose delivered to the lungs. **See the SmPC for further information on initiation, titration down and spacer use.**

CONTRAINDICATIONS: Hypersensitivity to either of the active substances or to any of the excipients.

SPECIAL WARNINGS AND PRECAUTIONS: Sereflo should not be used to treat acute asthma symptoms for which a fast- and short-acting bronchodilator is required. Patients should be advised to have their inhaler for relief in an acute asthma attack available at all times. Patients should not be initiated on Sereflo during an exacerbation, or significantly worsening or acutely deteriorating asthma. Serious asthma-related adverse events and exacerbations may occur with Sereflo. Patients should continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation. Treatment should not be stopped abruptly due to risk of exacerbation. Therapy should be down-titrated under physician supervision. All inhaled medication containing corticosteroids should be administered with caution in patients with active or quiescent pulmonary tuberculosis and fungal, viral or other infections of the airway. Salmeterol and fluticasone propionate should be used with caution in patients with severe cardiovascular disorders or heart rhythm abnormalities and in patients with diabetes mellitus, thyrotoxicosis, uncorrected hypokalaemia or predisposition to low levels of serum potassium. Prescribers should also be aware of risk of adrenal suppression and acute adrenal crisis which may occur in patients on prolonged treatment with high doses of inhaled corticosteroids. Systemic effects may occur with any inhaled corticosteroid and it is important therefore, that the patient is reviewed regularly and the dose of inhaled corticosteroid is reduced to the lowest dose at which effective control of asthma is maintained. **Drug Interactions:** Concomitant use should be avoided with; non-selective and selective β blockers, ritonavir and other potent/moderate CYP3A inhibitors, unless potential benefit outweighs the risk. Particular caution is advised in acute severe asthma as this effect may be potentiated by concomitant treatment with xanthine derivatives, steroids and diuretics. **See the SmPC for further information on contraindications and precautions.**

PREGNANCY AND LACTATION: Balance risks against benefits.

UNDESIRABLE EFFECTS: Adverse events which have been associated with salmeterol/fluticasone propionate include: *very common*; nasopharyngitis and headache; *common;* candidiasis of the mouth and throat, pneumonia, bronchitis, hypokalaemia, throat irritation, hoarseness/dysphonia, sinusitis, contusions, muscle cramps, traumatic fractures, arthralgia and myalgia. **For other adverse events please consult the full SmPC.**

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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellowcard in the Google Play or Apple App Store. Adverse events should also be reported to Cipla (EU) Ltd on 0203 684 7710, drugsafety@cipla.com

References.
1. Sereflo 25 microgram/125 microgram. Summary of Product Characteristics.
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April 2019 CIPSER20190010

bida Journal

Editorial

Mr. Amit Sinha
FRCS (Trauma & Ortho)
Editor, BIDA Journal.
Consultant Orthopaedic Surgeon.

Another year has passed and the medical fraternity has withstood the intense pressure of Dr Bawa Garba's case, which has rocked the foundation of how we practice medicine in the NHS. BIDA will continue to fight for a "just culture".

BIDA has had its ARM/AGM meeting last month at Preston. This edition presents the report. These would form the base for preparation of its strategies in the New Year ahead.

At present, we remain worried and wait with trepidation wondering how "Brexit" may affect the environment in which we all would be expected to work in the future.

Brexit on the door?

By the time, this edition of BIDA Journal reaches our members, it is possible that Brexit might have happened, although I still have my doubts.

In the 40 years that the UK has been a member of the EEC, European laws and policies have guided almost every aspect of life. A strong economy is essential to provide the security that is the basis for good health and public services, such as the NHS and social care. Is the UK economy strong at present?? It's not.

It's ironic that the government talks of turbo-charging preparations to leave without a deal. The leaked Yellowhammer document reveals that a no deal Brexit will have especially severe implications for the supply of medicines, medical devices and medical isotopes. The supply of plasma and plasma-derived products has also been questioned.

The NHS and social care bodies will have to undertake contingency planning. I have a strong suspicion that all these planning are still in the dark. The recent BMJ article states "Much of this is secret, and the Dept. of Health and Social Security has imposed at least 26 non-disclosure agreements on those advising it" I urge BIDA to ask the Dept. of Health to release their plans.

Trainees

I was unaware that trainees are being charged for accommodation, when on call at night – some as much as £65 a night. A trainee working a non-resident on call shift 1:4 and paying at least £25 each time would spend £1140 in a year. Is this fair? Don't forget, most Trusts have taken away facilities for rest rooms or even the doctors' mess. There is no provision for proper meals when on call in the night. Are we not looking after our juniors? I sincerely hope BIDA gives full support to the Junior Doctors' Committee and fights for their cause.

Doctor's well being

Edward Livingston Trudeau's philosophy was ***"to cure sometimes, to relieve often, to comfort always"***. He was a great doctor, who suffered with tuberculosis and had to endure great distress. He never ceased to rebel and conquered fate and at the same time serve his people. The working environment in the 19th century cannot compare to the current one. Dr Mudholkar and Mr Buddhdev present an excellent article, which highlights the fact that *"poor working conditions are affecting the staff morale"*. I don't think we have any inkling or understanding of its impact on our colleagues, who may be suffering from a mental illness.

This edition includes some interesting case reports on Arachnoid Cysts, written by 3 experienced physicians. There is need to do some lateral thinking in cases of HIV, when they present with neurological symptoms. HIV patients quite often have malabsorption leading to Vit B12 deficiency.

Prof David Brigden has a wealth of experience in providing various strategic solutions for education and training. The BIDA Journal will be publishing a series of articles on these strategies. "Writing for publication" is a must read for all trainees.

Running is one of those important things you could do, if your knees are in a good state. If not, then take up walking. That would keep you happy.

"Happiness is more than doing fun things. It means doing meaningful things" (Maxime Legace).

Best wishes

Amit Sinha
Editor, BIDA Journal.

BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

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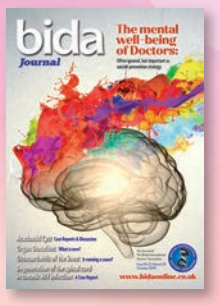

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BIDA National President's Report

Dr Birendra Sinha
National President, BIDA

Dear Colleagues,

We recently had our successful ARM/AGM 2019 at the Samlesbury Hotel in Preston organised by Blackburn Division. This annual event always guides us with policies to take us through the year and long-term. It was very successful indeed. I would like to thank the Blackburn Division especially Dr Ramesh Rautray, Dr Murthy Motupalli, and Dr Rakesh Sharma.

I would also like to thank the Central Office staff, Alison & Mandy, especially Mandy, who has worked very hard to coordinate this mega event. I would also like to thank Ms Margaret Barron for taking the minutes at the ARM/AGM.

You are probably aware that due to Alison's recent illness and her absence, Mandy has been left with the extra workload at Central Office. I must thank and congratulate her, as she has taken it boldly and sincerely. I would request our members to have patience at this time when contacting Central Office or when e-mailing, taking into consideration that Mandy is alone in the office. She ensures that she will do her best to address your query in a timely manner.

The strength of any organisation is membership and hence I would urge all Divisional Chairmen and Secretaries to help us increase the membership. I have suggested that in the future, all Executive Committee meetings will concentrate on improving membership and the more members we have, the stronger our fight will be to achieve Fairness & Equality for all our members. Our General Secretary, Dr Ashish Dhawan is working on the membership drive.

I would like to thank our National Chairman, Dr Chandra Kanneganti for raising these vital and relevant issues involving the BME on various platforms in medical politics.

We have had a very successful cricket season and on behalf of all our BIDA Members, I congratulate North East Division, who won the championship, although our other finalist Blackburn played equally well. As you are all aware, we recently introduced Table Tennis and Badminton championships and they are running well too. I would sincerely like to thank the National Sports coordinator, Dr Raghu Hegde for all his hard work.

I am extremely grateful to our National Treasurer, Mr Pranab Sarkar, who despite our financial restraint is trying hard to keep our financial health in good shape and has been a great support to Mandy at Central Office

Finally, the quality of our BIDA Journal is improving every year and I proudly read the medical articles, which is not only interesting and informative but helps me in my personal professional development. On behalf of all BIDA Members, I would like to thank the whole editorial board led by Mr Amit Sinha and Dr Ashish Dhawan.

I wish you all good luck in the coming year of 2020

Long live BIDA!

Dr Birendra Sinha
National President, BIDA

BIDA National Chairman's Report

Dr Chandra Kanneganti
National Chairman, BIDA

Dear Colleagues,

I am delighted to report that we had a very productive ARM meeting on the 20th-22nd September 2019, at The Samlesbury Park Hotel, Preston.

This year's ARM was hosted by Blackburn Division and I would like to thank them for a memorable weekend. Thanks to our ARM Chair, who skillfully managed all the ARM motions presented by the Divisions. We had good discussions on all of these motions, of which a number were passed, and these will form the work plan for BIDA's Executive team for next year. As per the last 3 years, Saturday afternoon workshops and panel discussions had been organised, and this year's series of presentations featured speakers including Claire Light, Head of Equality, Diversity and Inclusion, GMC; Professor Iqbal Singh, Member Honours Committee Health, CESOP Chair; Dr. Cicely Cunningham, Doctors Association UK, and Manda Coppage from NHS resolutions.

All ARM representatives and BIDA members who attended the ARM participated in the panel discussions. We have had good outcomes. We had an excellent guest speaker for ARM dinner, Dr. Julian Simpson, who has written extensively about international doctors and their contributions to the NHS.

My thanks to all BIDA officers, the Executive Committee, and Mandy from Central Office whose invaluable support contributed greatly to the success of the ARM. We are looking forward to our next ARM in Stoke in 2020.

Next year I can confirm that we will be holding BIDA's International Conference in Vietnam and Cambodia, as had been previously planned. Please look for the advert and information soon.

I would like to congratulate BIDA North East Division, who won the BIDA President's Cup Cricket Tournament this year.

I pledge that BIDA's Executive Committee and Officers will continue to work for all members' interests and for equality and fairness for all doctors in the NHS.

Dr Chandra Kanneganti
National Chairman, BIDA

BIDA National Treasurer's Report

Mr Pranab K Sarkar
National Treasurer, BIDA

Dear Members,

Our recently finished ARM/AGM on 20th to 22nd September 2019 at the Mercure Samlesbury Hotel, Preston was a huge success. The organising team of Blackburn under the leadership of Dr Ramesh Rautray, Divisional President, Dr M Motupalli, Divisional Chairman, and Dr Rakesh Sharma, Divisional General Secretary deserve our special thanks for hosting the event.

This does not give me any pleasure at all to inform you that financially we are facing a challenging time ahead as our last year's annual income from members' subscriptions has declined very significantly following the trend of the past 5 years. This is going to put significant pressure on our budget.

At the last year's ARM/AGM, in our attempts to improve our financial circumstances, delegates agreed to support my proposal that our annual subscription rate is increased by 10% in all categories effective from 1 October 2019. We expect to generate some extra income with this increase. However, as this measure may not be enough to meet the demand on our finances, we should seriously consider to prioritise our spending, paying particular attention to our financial affordability. Otherwise, it would be difficult to balance our books. In view of our present financial circumstances, we should agree to adapt sensible financial strategies to include further cost-saving initiatives.

At this year's ARM/AGM, following considerable discussions delegates agreed that for the present time BIDA would financially support the publication costs of BIDA Journal, while we will continue to look out for external funding.

I would like to thank everyone at BIDA, in particular the members of the finance committee and NEC for their support throughout the last financial year. I would like to especially thank our accountant, Mr Zahur of Altman Smith & Company, Chartered Accountants, for preparing our annual financial report and providing financial advice at the time of our needs. I would like to extend my sincere thanks to Alison and Mandy at our Central Office for their hard work in managing our business. Mandy deserves our special thanks, as she has worked extremely hard to arrange this year's ARM/AGM and also helping me with all the financial matters over the past few months during the absence of Alison due to illness.

Mr Pranab Kumar Sarkar
National Treasurer, BIDA

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10th September 2019

British International Doctors Association
316A Buxton Road
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Sk2 7DD

Dear BIDA Member
At the last ARM/AGM in October 2018 the representative body unanimously voted and agreed that the Annual Membership Fees should be increases with effect from 1st October 2019.
The new Annual Membership Subscription Rates are as follows:

Standard (Staff Grade & Above	£110.00
Training Grades (all training grades & Trainee Gps	£50.00
Retired (Fully retired from clinical practice)	£55.00
Couple Membership	£160.00
Life Membership	£1100.00
Life Membership for Couples	£1600.00

As you pay your annual subscription by Direct Debit, you do not need to do anything.
If you normally pay by cheque, please make cheque payments to British International Doctors Association Ltd. The bank will no longer accept cheques with the name BIDA.

We Will collect your next payment for your Annual Subscription by Direct Debit on or after the 1st October 2019.
If you need any more information, please do not hesitate to contact me through the Central office.

Mr Pranab Kumar Sarkar
Honorary National Treasurer
British International Doctors Association.

BIDA Fellowships 2019

Dr Ikram U Shah FRCP

Dr Dr Ikram U Shah is a well-respected Consultant Physician at Wrexham Maelor Hospital in North Wales. Apart from his clinical services he has been involved in education, research and training.

He is credited with establishing the North Wales Division of BIDA. He has led this division and maintained the enthusiasm with his leadership qualities and excellent communication. As a consultant, he has supported numerous overseas doctors and given them jobs, clinical attachments and career advice. He continues to attend majority of the educational meetings organised by the North Wales BIDA Division even after retirement from his NHS services.

Prof. Iqbal Singh OBE

Professor Singh has been a major contributor to healthcare and medical regulation in the UK. He holds the Chair of the global Centre of Excellence in Safety for Older People (CESOP) and has been a leading contributor to healthcare and medical regulation. He is the founder commissioner of HealthCare Commission and was a council member of the GMC. He is a member of the National Platinum Awards Committee and medical vice-chair of the Advisory Committee for Clinical Excellence Awards (ACCEA) North West, and is also in the Health Honours Committee. He is also chair of the GMC BME Doctors' Forum. He has contributed to BIDA over several years by promoting equality, diversity and human rights within the NHS.

As chair of Blackburn Division of BIDA, and working with Dr Rautray as Secretary, he led the revival of the Blackburn Division, creating the foundations for a strong and effective division. He continues to support the Division in all its activities.

Dr Shamim Rose

Dr Rose has made valuable contributions in her career as an Anatomy demonstrator in the University of Liverpool, the Prison service and now as a GP. She has been responsible (along with the healthcare team) for provision of Primary Care Services in 2 new PFI prisons in Liverpool and Manchester before becoming a GP. She has been on the Local Medical Committee elected since 2001. She is skilled in Clinical Commissioning and taken on the responsibilities of medical management as well as the more strategic Governing Body roles.

She speaks passionately for overseas doctors, arguing their case for their social wellbeing as well as fairness in the workplace, in her role as Liverpool CCG Governing body. As a Member of BIDA she has been meticulous in attending meetings and events and has been an active participant in BIDA Conferences.

Congratulations!

The Mental well-being of doctors:

Often ignored, but important as suicide prevention strategy

Dr Santosh Mudholkar
President, British Indian Psychiatry Association (BIPA), Associate Registrar (Membership Engagement), Royal College of Psychiatrists, London.

Buddhdev Pandya MBE
Director, Policy, British Association of Physicians of Indian Origin (BAPIO). Formerly Director of Policy and Governance, British Indian Psychiatry Association.

"For doctors with mental health problems, 'help me' can be the hardest words".

Introduction

World Mental Health day was celebrated on 10th October 2019 and it is appropriate to highlight the importance of mental well-being of doctors. It is now recognized that the NHS is facing a healthcare workforce with high staff turnover, stress, poor staff morale and burn out which is affecting recruitment and retention. Most front-line clinicians will admit that year on year funding cuts by successive governments is having an adverse impact on the quality and standard of care provided for patients. The financial crisis of 2008, which swept away billions from financial markets, led to a tightening of public spending and a decade of austerity measures. Each NHS trust is having to save 2% more than previous years recurrent and non-recurrent (one off) by cost improvement provision (CIPs). On one hand, the cost of delivering the health service is rising each year, along with increased public expectation from the NHS as a public funded organisation, leaving the healthcare workforce to pick up the pieces. Is this chronic stress, a situation of "learned helplessness" affecting the medical workforce? Are International Medical Graduates (IMGs) more vulnerable? What can be done about it? This article attempts to look at the issue of the mental well-being of doctors more closely.

What is the extent of problem?

In contrast to U.K. medical graduates, International Medical Graduates (IMGs) experience additional stresses of exams and career progression following immigration, in addition to being dislocated from their supportive family and community network. IMGs are more likely to take a longer time to be successful in post-graduate assessments, and have poorer outcomes in recruitment compared to U.K. graduates. Also, medical students from BAME groups have poorer academic and recruitment outcomes compared to white doctors regardless of their country of primary medical qualification. A recent survey by the BMA highlighted that up to 20 per cent of doctors will experience depression during their careers and a quarter of NHS staff sickness relates to mental health. There is a lack of information regarding the suicide rate among various medical specialities, with no current statistics available.

One of the key points made in the report of the Working Group 'Working for a Healthier Tomorrow' (2008) on the health of health professionals was that the organisation and structure of work have a much greater impact on health than the nature of the work itself [1]. It also said that work can be good for health and that the workplace can have a key role in promoting the health and well-being of its employees. But the work environment can also lead to ill health, initiating a ripple effect on family, social and professional life. Doctors are vulnerable to stress and depression in the same way as the general population. Historically, the medical profession is rooted in perfectionism, which is idealised. The medical profession is bound by Hippocrates' oath: "First do no harm".

Mental health services, a Cinderella specialty in the NHS, has historically been under-funded by each successive government for several years. A crude measure of its' service quality could be the rate of suicides in mental health service users. The National Confidential Inquiry of Suicide and Homicide (NCISH), published in 2016, reported that of 17,931 patients following up with mental health service users, forming 28% of the general population, there were 1,612 patient suicides in 2016 of which 106 were by in-patients [2]. The death of a patient by suicide can have a very strong emotional impact on psychiatrists. However, the impact of such patient suicides on psychiatrists and front-line staff is less well publicised.

Psychiatrists working in mental health services have unique work-related stress. Whilst Surgeons may face a GMC disciplinary hearing for a procedure or surgery gone wrong, psychiatrists face a Coroner's inquest following any death of a service user or a suicide. As highlighted by Gibbons et al (2019)[2], majority of psychiatrists experience the death of a patient by suicide at least once during their career. The weeks following such an adverse event can be an extremely stressful period for psychiatrists, and is exacerbated by organisational processes including serious incident enquiries and the Coroner's inquest. The process of the Coroner's inquest can be extremely anxiety provoking and can lead to changes in clinical practice. Chemtob et al (1988) 53% of psychiatrists reported stress levels in the weeks following a suicide comparable to those reported in studies of people seeking treatment after the death of a parent [3].

Complaints by service users locally, to regulators such as the Care Quality Commission (CQC) and the General Medical Council (GMC), can also be a source of additional stress and can take its own toll. The Royal College of Physicians' report (2015) highlighted the *"inextricable link between levels of engagement and wellbeing of NHS*

staff and the quality of care these staff are able to provide". Several reports allude to common threads that point to fundamental causes such as the poor working environment, and systemic inadequacies that test an individual's capacity to cope with a creaking service. Doctors work under increased pressure of changing demands in NHS, while attempting to balance their professional career and personal life.

Although there is generally a greater openness about mental health, for medical professionals the stigma about mental health suffering remains. *"For doctors with mental illness, 'help me' can be the hardest words,"* said the former Chair of the Royal College of General Practitioners, Dr Clare Gerada MBE (2014). If a doctor admits that they are suffering from stress and mental disorder such as depression they must inform their NHS employers who may have to report this to the GMC. The recent case of a North London GP with young family who killed himself, fearing he would lose his job if he talked about his mental health, proves the point of how the stigma continues to be a barrier in accessing help.

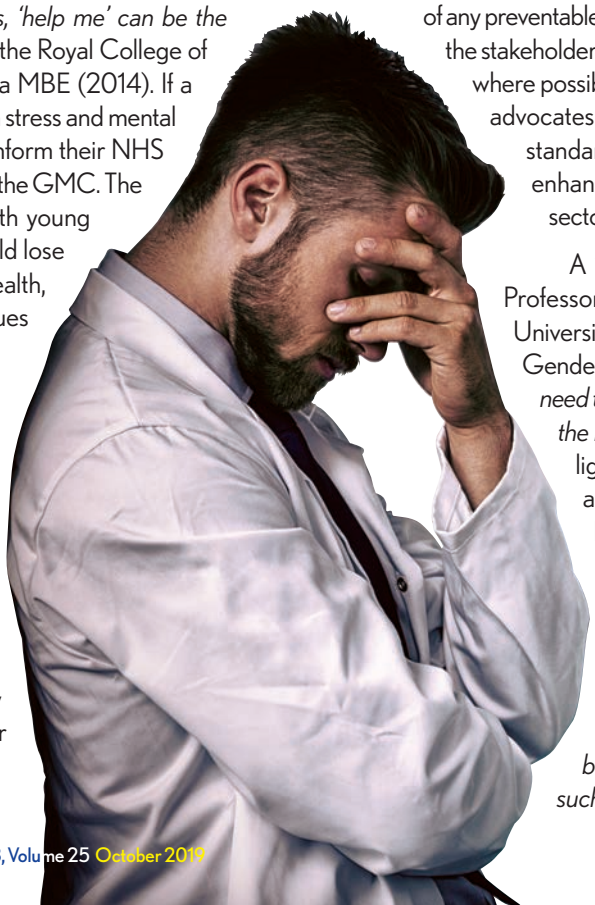
Although it may seem reasonable for patient safety, it may also be the reason why depression in doctors is diagnosed late and remains untreated for a longer time, until it becomes obvious to work colleagues and subsequently impairs their ability to work in what is usually a highly stressful environment. Increased sickness rates in doctors are probably more worrying as it affects their capability to serve patients as well as look after themselves.

What is its impact?

So, it is important to look at the data regarding doctors' suicide. A set of data collected by the Office for National Statistics showed that between 2011 and 2015, 430 doctors died by suicide. In the March edition of 'Pulse', a report under the heading 'Preventing suicide amongst GPs needs a system-wide change' both Dr Clare Gerada MBE and Dr Kailash Chand OBE, a former GP and Honorary Vice-President of the BMA, noted the underlying issues for doctors (GPs) which included: uncertainties about their future, including how to fund their premises; increasing costs of staff; failure to recruit new GPs; demands from the CQC; forced practice mergers; and the rising culture of complaints, which all add to the pressures GPs have to deal with. They added, *"It is hardly surprising, therefore, that increasing numbers of GPs are becoming depressed and sadly, some of these doctors are taking their own lives."*

Hawton et al (2001) studied suicides in doctors and found that suicide in the medical profession was associated with both depressive disorders and alcoholism. Two-thirds of doctors had significant problems related to work and multiple interrelated problems [4]. Hawton et al (2001) recommend better management of psychiatric disorder in doctors and alleviation of work-related stress. In March 2019 at their conference in Belfast, the LMCs' leaders repeated calls for urgent action to tackle the increased risk of suicide among GPs, after one senior GP called the NHS' failure to care for doctors 'as barbaric as sending young men over the top at the Somme'.

Undoubtedly, the concerns are most likely to be echoed by the medical fraternity, demanding action to tackle the increased risk of suicide by ensuring that all major stakeholders seek better understanding of any preventable triggers and adverse drivers that lie within the stakeholders' influence, in order to seek their removal where possible. The Farmer-Stevenson report (2017) advocates the development of core mental health standards for employers, identifying additional enhanced standards for those in the public sector.



A 2014 report written by Prof Mala Rao, Professor of International Health at East London University, and Ms Jacqui Stevenson, an expert in Gender Equity and Human Rights, quoted, *"The need to address racism and discrimination within the NHS is incontrovertible."* The report highlighted experiences of racism, exclusion, and discrimination as contributors to low levels of well-being among black and other minority ethnic (BME) groups, including staff in the NHS. It also raised concerns of racist verbal and physical attacks, bullying, and harassment. It says, *"The links between race, racism, and complaints, and the impact that has on staff both directly affected and those aware of such incidents and made insecure by them."*

The General Medical Council (GMC) estimates that 1 in 8 doctors in training have suffered bullying.

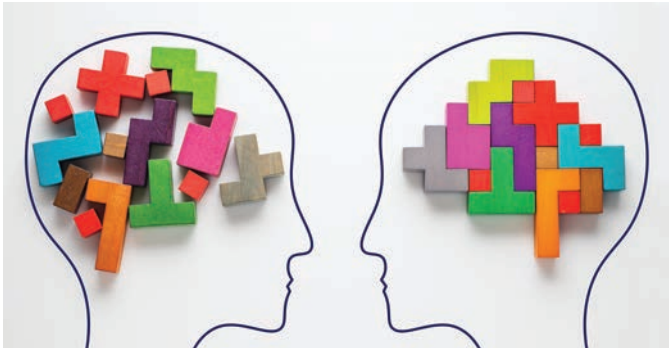
Recent developments

An NHS England spokesperson said: *"We launched the NHS GP Health Service in 2017, a world-first, nationally funded confidential service which specialises in supporting GPs and trainee GPs experiencing mental ill health and which has already helped more than 1,500 GPs. NHS Trusts and clinical commissioning groups may offer additional support for professionals in their area, for example CCGs in London have commissioned the NHS practitioner health programme (NPHP) for their staff."*

A report by Health Education England (HEE), **"Stepping forward to 2020/21: The mental health workforce plan for England"**, recommends supporting staff mental health by creating healthy workplaces [5,6]. Yes, one would agree that some initiatives have been developed to support doctors, but much more needs to be done in terms of empowering them through training to recognise their own emotional reserves. This is likely in the context of serious untoward incident (SUI) to improve their support while they are looking after some complex mentally disturbed mental health service users who can churn feelings of despair and helpless-ness, in a culture of naming and shaming and litigious environment.

Continued overleaf...

One of the compounding factors is the constant reorganisation in the NHS which escalates and destabilises relationships, coupled with early retirements and the moving of older and more established doctors, which remove the continuity and corporate memory that builds resilience in institutions. Often, reports claiming 'systemic failures' are advanced without actually pinning down specific elements with expectations of time-bound redress. These regulators have the potential to assess 'bad employers' and "unsafe environments" and can list what specific and systemic changes are required. More so, the mechanism needs to be more formalised so that it can act as a deterrent for the failing boards and senior management of the NHS Trusts. For example, the GMC, equipped with relevant data extracted from their casework handling, could easily identify employers that continue to maintain unsafe working environments. Working in collaboration with the CQC and other such agencies, they can play a valuable role in providing useful evidence for the DoH to hold the NHS Board members to account.



What can be done?

It is argued that many of the potential service gains envisaged in Five Year Forward View (FYFV) will not be secured with progress locally unless the mental health and wellbeing of psychiatrists and their concerns are addressed. Secondly, it would be prudent, in our view, for the DoH to contemplate replacing failing hospital management with a 'salvage' team to ensure some core "well-being standards" are re-established. NHS management needs to be held responsible for any failure to provide adequate safeguards for doctors. We feel that poor NHS management is equally responsible for adverse patient outcomes and needs to be held accountable. There are virtually no effective sanctions that deter these managing bodies from hiding behind 'lack of funding' as a defence to cover poor management. NHS England (NHSE) have now taken this on board and NHSE (2016b) paper suggests providing financial incentives for Trusts for introducing health & wellbeing schemes for staff, including mental health services.

In July 2018 the Royal College of Psychiatrists, London, published a Position Statement on Mental Well-being[7]. It highlighted the need for looking into the mental wellbeing of the mental health workforce closely in order to improve recruitment retention and preventing burn out. The Royal College of Psychiatrists also run a psychiatric support service (PSS), a confidential telephone helpline for College members who are experiencing stress. PSS provides 1:1 telephone support from psychiatrist advisor who sign-posts the caller to the appropriate avenues of treatment. The RCPsych also endorses that the NHS should increase incentives and sanctions as levers to encourage employers to promote staff mental health and wellbeing, with further engagement with local initiatives and organisational improvement.

At Mental Health Trust level there is an opportunity to strengthen Occupational Health Departments, improve support structures and provide confidential advice to doctors after any patient suicide. Improving working conditions, the support of managers, good job-planning and a robust support system is likely to be much more helpful than just paying lip service to yoga, mindfulness and meditation. We wonder whether the RCPsych would be willing to provide training for psychiatrists in this specialist Occupational Health Psychiatry (OH) in future. Addressing the mental wellbeing of doctors should be seen as part of a strategy for suicide prevention.

Disclaimer

The article was commissioned by the British International Doctors Association (BIDA). The views expressed in this article are those of the authors and do not in any way represent the views of the Organisations to which they are affiliated.

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Sub-acute combined degeneration of the Spinal Cord in chronic HIV infection

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Introduction

Neurological manifestation among patients with HIV infection is common. It is mainly due to HIV infection itself, opportunistic infection or drug related. Although malnutrition and deficiency of vitamins and essential minerals are fairly common, cases of Sub-Acute Combined Degeneration of the Spinal Cord (SACD) due to Vitamin B12 deficiency are rarely reported. We present a 50 yr old HIV-infected man who was not on Highly Active Antiretroviral Therapy (HAART) presented with symptoms and signs of SACD. He was treated with Vitamin B12 IM injection and completely recovered.

Background

Vit B12 deficiency is a metabolic disease with many causes and is very common among chronically HIV-infected patients, particularly untreated HIV infection. Neurological presentation is common in HIV patients, both in pre- and post-HAART era. Neurological manifestations of Vitamin B12 deficiency and HIV infection are over-lapping.

Therefore, the diagnosis of Vitamin B12 deficiency as a cause of neurological manifestation in HIV infection is frequently overlooked.

Case Presentation

A 50 year old man transferred his HIV care to our department. He was diagnosed with HIV infection in another genitourinary medicine clinic. He had gradual onset of burning sensation and pain in both feet since he was diagnosed with HIV infection. Although highly active antiretroviral therapy was commenced soon after his diagnosis, he took it only for 2 months and stopped after that as there was no improvement of his symptoms. He was off treatment for 5 years when he attended our service. On presentation, his past medical history was insignificant and he had no HIV-related co-morbidities.

On examination, he was mentally stable with normal vital signs. Central nervous system and cranial nerves were normal. However, examination of the peripheral nervous system revealed that he loss of proprio-ception, decreased vibration sensation in both feet with mild impairment of pin prick sensation. He had slight weak-ness of the distal muscles of his lower limbs, however normal reflexes were noted.

His CD4 count was 270 cells/micl and HIV viral load was 73,600 copies/ml. Haemoglobin was 10.5 g/dl; red blood count 4.61 x 1012 /l; haematocrit 0.497; mean corpuscular volume (MCV) 107.8; mean corpus-cular haemoglobin (MCH) 36.4 pg; mean corpuscular haemoglobin concentration 33.8 g/dl, red cell distribution width (RDW) 54.6; platelet count 130 x 109. Liver function and kidney function parameters were normal.

Continued overleaf...

Sub-acute combined degeneration of the Spinal Cord in chronic HIV infection

Investigations

Serum B12 was 168 ng/l, serum folate level was 11 ug/l and serum creatinine kinase 39 IU/L. Blood film showed macrocytic red cells with normal appearance of white cells. Bone marrow aspirate showed definite evidence of megaloblastic changes in white cells and developing red cells with megakaryocytes. The appearance of the bone marrow biopsy (BM) was compatible with B12 deficiency.

He was naturally immune to Hepatitis A and B. Hepatitis C antibody was negative. He was treated for syphilis in the past and had n serological evidence of reactivation or reinfection of syphilis.

Differential Diagnosis

Peripheral neuropathy (PN) is a common neurologic presentation at any stage of immune dysfunction associated with HIV infection, although HIV associated co-morbidities and opportunistic infections are reported to have declined since the introduction of HAART [1]. Distal symmetrical polyneuropathy (DSP) is the most common neurologic manifestation in HIV infection. Neurotoxicity of the HIV virus and its product is the primary pathogenic cause for DSP [2]. Adverse neurotoxic effects of antiretroviral medications and medications used to treat other co-morbidities associated with HIV infection is the other neurotoxic mechanism attributed to the pathogenesis of the DSP [3,4].

Other PNs described in chronic HIV infection are diffuse infiltrative lymphocytosis syndrome (DILS); inflammatory demyelinating polyneuropathy (IDP), progressive polyradiculopathy, mononeuritis multiplex, mononeuropathy and autonomic neuropathy [5,6,7]. Currently, neurosyphilis is rarely seen, although it should also be considered as a differential diagnosis.

In our case, a provisional diagnosis of subacute combined degeneration of the spinal cord was made from presenting symptoms and signs and the findings from full blood count and blood picture. Treatment was started with B12 IM injection 1mg once the diagnosis is confirmed with serum B12 level and BM biopsy.

Treatment

He was treated with weekly IM injections of Vit B12 for 10 weeks followed by 3 monthly injection.

Outcome and Follow-Up

His symptoms gradually improved and the numbness, weakness and pinprick sensations completely recovered in the 18 months since we commenced treatment.

Discussion

Vit B12 is an essential co-factor in DNA synthesis and is also linked to folate metabolism. Vit B12 is also an important co-factor in two bio-chemical processes involving methylmalonic acid (MMA) and homocysteine precursors. Deficiency of Vit B12 impairs the conversion of methylmalonic acid to Succinyl Co-A, and impairs the conversion of homocysteine to methionine which is important in neural function. Vit B12 with folate is important in haematopoiesis and bone marrow function.

Therefore, Vit B12 deficiency can present either with haematological manifestations (anaemia with macrocytic blood picture) or CNS manifestations. CNS manifestation can be mild to moderate with dysaesthesia/paraesthesia, polyneuropathy and depression or severe with sub-acute combined degeneration (SACD), dementia or cognitive impairment. SACD is a progressive neurological degeneration of the posterior and lateral columns of the spinal cord. Neurological disease associated with B12 deficiency can be irreversible, therefore early diagnosis and treatment of B12 deficiency is important to prevent permanent neurological damage [8].

Risk factors for B12 deficiency are advancing age, chronic use of some medications (such as metformin, H2 receptor blockers, proton pump inhibitors, anticonvulsants, antiretrovirals), gastrointestinal illnesses which can lead to malabsorption including Crohn's disease, coelic disease or upper gastrointestinal surgeries and poor dietary intake of Vit B12 (vegan diet) [9].

Vit B12 deficiency is commonly reported in HIV-infected patients. It is mainly due to malabsorption of Vit B12 due to infection of HIV itself and other opportunistic infections of the gut resulting in inadequate intake.

Diagnosis if B12 deficiency relies on the detection of low serum Vit B12:

Probably B12 deficiency: <200 ng/l

Possible B12 deficiency: 201-350 ng/l

Unlikely B12 deficiency: >350 ng/l

A full blood count (FBC) with peripheral smear is the first and most useful evidence of macrocytosis and anaemia, leukopenia or thrombocytopenia. It may also show the classic hypersegmented polymorphonucleated cells with megakaryocytes. These indicate more severe and prolonged Vit B12 deficiency. Therefore normal values of FBC and PS are not useful to rule out the diagnosis of B12 deficiency. Using markers of tissue deficiency such as homocysteine, MMA and holotranscobalamin has improved the early diagnosis of B12 deficiency, but these tests are not commonly available.

Learning Points / Take Home Messages

1. B12 deficiency should be included in the differential diagnosis in cases of peripheral neuropathy in patients with HIV infection.
2. Keeping a low threshold to offer B12 replacement in suspected cases to prevent permanent neurological damage.

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Junior Doctors writing for publication

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University of Bolton
University of Liverpool

As the number of medical students increase the competition for foundation and specialist-training posts becomes more intense. One way to strengthen your application is to show the selection committee that you have written articles that have been reviewed and published in respected journals. This article is intended to guide you through the process of writing for publication.

An article can take many forms. Your article may describe some original research carried out by you or by others; alternatively it may provide advice which will be of relevance to your audience.

Whatever you decide to write about, it must always be informative, but if you can make it engaging, then so much the better.

This article will show you how to present your ideas in an appropriate manner before submitting work for peer review.

This article is split in four parts.

1: Searching the Literature

A proper literature search involves a systematic exploration of relevant material already produced or a particular topic. There may be many reasons to do a literature search.

a) To find out what exists on a topic.

b) Increase your knowledge of that topic.

c) Use earlier work as a foundation.

d) Find gaps, errors, and inconsistencies on previous work.

e) Generate ideas for your own work.

f) Avoid duplication of previous work.

g) Justify and lend authority to your work

Keep a record of all the potentially useful articles you discover. Make sure you record all the details necessary for the reference section that will form the end of your article. It is a good idea to document these details thoroughly and consistently as you go along to avoid hours of painstaking work at the end; above all make sure your references are accurately reported on your finished article.

Be sure to know when to stop. It is easy to go on searching for new material, ending up with too many references that do not add anything to your arguments. It is better you only list necessary references that support your arguments, without overwhelming or confusing the reader. A large number of cited references do not necessarily mean that your article will be well received by the peer reviewers.

The type of article you refer to is also important. Many writers prefer to start a literature search with the Internet. However, it is always worth cross checking web based information against traditional sources; the internet is quicker, but the information often less reliable. It is better to concentrate on primary and published research articles when getting to grips with the current literature on your topic of study. Using non-primary published articles should be the exception rather than the rule.

In summary, you should ensure that references are:

a) Accurate.

b) Appropriate (not too many).

c) Primary and published where possible.

2: Planning

Once you have established your idea, use it as a focal point for a mind map. From this mind map begin to consider different areas you wish to cover and use them as your initial headings. Write any thoughts under your headings and begin to create a visual picture of how the various elements can be connected together. Bounce your ideas off others; ask for their comments about whether or not they think anyone would be interested in the topic you have in mind. They may point you in a different direction, or you may realise that there is still a great deal of research to be done. Your initial mind map and initial thoughts form the skeletal framework of your article; you now need to add the flesh.

An article is really no different from any other piece of written work in that if it is going to succeed, it must be well planned and structured.

Break your article down into three basic parts:

(i) Introduction.

(ii) Body (methods, results and discussion).

(iii) Conclusion.

Each part needs to be carefully considered, with your main points running as a continuous theme throughout. Detail can be refined when writing your first draft. Time spent on planning is never wasted.

Junior Doctors writing for publication

3: The First Draft

Remembering the three basic parts previously mentioned, you need to start with a concise introduction that defines the topic. It is essential to highlight the most important points you are going to cover in order to give the reader a good idea of what the article is about.

Writers often struggle with their introductions because they think it must be pithy and witty, otherwise they will immediately lose the reader's attention. The introduction can be the hardest part to write, so it is sometimes better to put off writing it until the end. Apart from anything else, the final version of the article may not resemble the first draft, so if you write your introduction last, you will have the advantage of knowing exactly what is in your article.

You need a middle section, which forms the main body of the article. This is where your main points will be discussed in detail and the majority of your work will be presented.

Keep your paragraphs short and restrict each one to a single point. Draft out the order in which you think they should be arranged. The paragraphs may fall into some sort of chronological order or you may decide that they should be arranged in a hierarchy of importance. Ensure that your paragraphs flow naturally and do not read as a series of disjointed points.

Finally, your ending should reiterate your main points to the reader, make sure these are clear before finishing with your conclusions and opinions. There is a saying that is applicable to both giving a presentation and to writing:

"Tell them what you are going to tell them, tell them, then tell them what you have just told them"

4: Good English is Clear, Concise and Correct

Doctors do not have to be good writers to be good clinicians, but if your initial idea is ever going to be published, then you must be able to write well. It is therefore vital to have a good understanding of the structure of the English language.

Essentially "good English" must always be clear, concise and correct. The final part of this article deals with writing good English, editing and re drafting. It highlights some of the basic rules of English grammar and punctuation and outlines a strategy for editing.

In a vain attempt to impress the reader, some authors construct long sentences made up of clauses, sub clauses and phrases, all of which are separated by commas. It is better to have a number of short sentences, than one long sentence. This makes sure that the meaning is not obscured by overuse of commas. You should avoid superfluous words and phrases, (e.g. at the present time, instead of "now") as they serve no other purpose than to waste time and distort meaning.

Ambiguity is the sign of poor writing and can be caused by three things:

1. *Poor syntax.*
2. *Incorrect or overuse of punctuation.*
3. *Overuse of pronouns.*

The arrangements of words and phrases to create grammatically correct sentences is known as the syntax. The normal word order is subject, verb, object, dependent clause. You are less likely to make syntactical errors if you restrict the length of your sentences, but too many short sentences will make your article seem disjointed. To avoid this, try to vary the length of your sentences to help retain the reader's attention.

Reading anything that is littered with punctuation is difficult. As a general rule leave out all punctuation , except full stops in the first draft and only insert commas, semi colons and colons later where they are absolutely necessary to the meaning and sense. A full stop is used to mark the end of a sentence. However, it is acceptable to separate a series of short sentences using semi colons or commas. Modern writing tends to omit full stops after initials or abbreviations, e.g. B.M.J. is better written as "BMJ".

Colons are used in front of a list, or to divide a sentence where both parts are grammatically complete in themselves. Since colons are generally used to separate items in a list where each item could form a sentence in itself, a comma is used in complex sentences to separate clauses. The apostrophe is a much-abused punctuation mark. It serves one of two purposes; it shows that a letter has been omitted e.g. "it's" meaning "it is", or that something belongs to someone or something e.g. "Dr Brown's office".

In short, you should ensure every sentence is syntactically correct and punctuation is as it should be; be consistent with your use of punctuation. It is much better to make the subject of a sentence clear by using their name rather than repeatedly using pronouns.

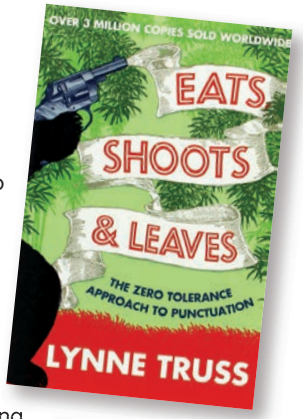
Every writer has their own method of editing their written work. The purpose of editing is to prepare the article for publication by correcting, shortening or improving it.

Conclusions

Writing for publication is a skill, which must be developed through practice. Writing can be a complex process because of its very personal nature, but it can be simplified by approaching it in a methodical way as has been suggested here.

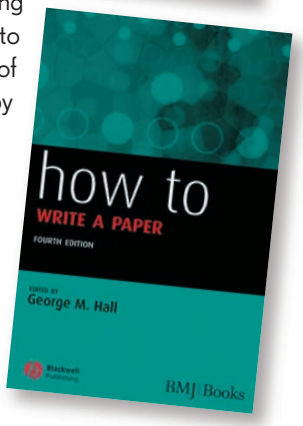
Further Reading:

1. ***Eats Shoots and Leaves.***
   Lynne Truss 2003



The zero tolerance approach to punctuation is a non fiction book written by Lynne Truss, the former host of BBC Radio 4's Cutting a Dash programme. In the book, published in 2003, Truss bemoans the state of punctuation in the United Kingdom and all the United States and describes how rules are being relaxed in today's society. Her goal is to remind readers of the importance of punctuation in the English language by means of humour and instruction.

2. ***How to Write a Paper***
   George M Hall 2003
   Fourth Edition,
   BMJ Publishing Group, London.



Arachnoid Cyst

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(pictured right)

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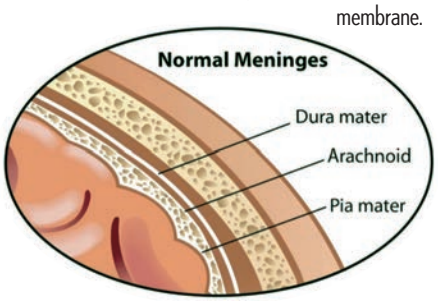
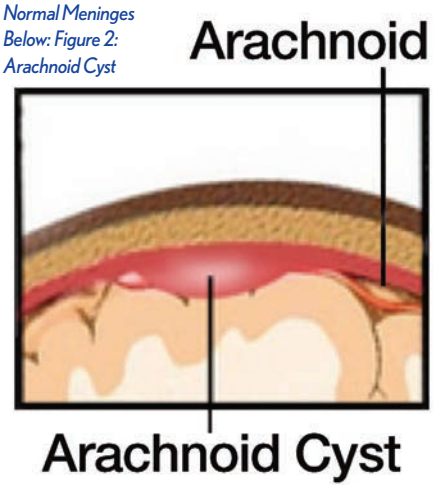
Introduction

Cerebrospinal Fluid (CSF) is a naturally occurring protective fluid in the subarachnoid space that surrounds the brain and spinal column (Figure 1). An arachnoid cyst occurs in the space between the brain, or spinal column, and arachnoid membrane (Figure 2). Arachnoid cysts are fluid filled sacs that occur due to splitting of the arachnoid membrane.



Above: Figure 1: Normal Meninges
Below: Figure 2: Arachnoid Cyst



In children, arachnoid cysts are usually congenital, or present at birth. These cysts are called primary arachnoid cysts. Arachnoid cysts that develop later in life are called secondary arachnoid cysts. Primary arachnoid cysts are more common than secondary arachnoid cysts.

We present 2 cases with Arachnoid cysts, who presented with varied neurological symptoms.

Case Reports

Case 1

A 76 year old female was admitted following an episode of left sided tonic-clonic seizure with secondary generalisation. On arrival her Glasgow Coma scale was 3 which fully improved to 15 within an hour. Neurological examination revealed a left facial droop and reduced power in the left upper and lower limbs (MRC 3/5). She had a similar episode 10 years ago when she was diagnosed with an arachnoid cyst in the right cerebral hemisphere and had undergone surgical intervention.

CT scan of the brain showed a large (5.5 x4.4 x4.6cm) right porencephelic cystic lesion typical of an arachnoid cyst creating a mass effect with gross midline shift (Image 1). There was also a small defect in the cranium consistent with previous surgical intervention (Image 2)

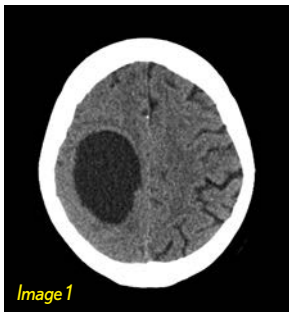


Image 1

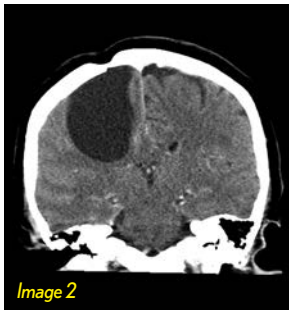


Image 2

She was treated with sodium valproate and was referred to the neurosurgeons to consider further surgical intervention.

Case 2

A 48 year old was admitted with weakness of right arm and slurring of speech while laying the floor of his house. His GCS was 15 but neurological examination revealed expressive dysphasia, and decreased power in right upper limb. His symptoms improved within 24 hours.

CT brain scan (without contrast) showed a CSF density collection adjacent to the anterior aspect of the left temporal lobe consistent with a simple arachnoid cyst. Associated remodelling of the left cranial fossa was also noted.

The patient was discharged from the hospital and did not attend the follow up appointments.

6 years later he presented with another episode of difficulty speaking after a bout of sneezing while driving his car. Neurological examination showed expressive dysphasia but no motor weakness. The speech deficit lasted for a few hours only.

MRI scan of the brain done within 24 hours of presentation showed the longstanding arachnoid cyst with no significant enlargement. There was no evidence of an acute infarct (Images 3 and 4).

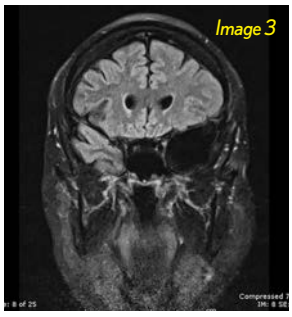


Image 3

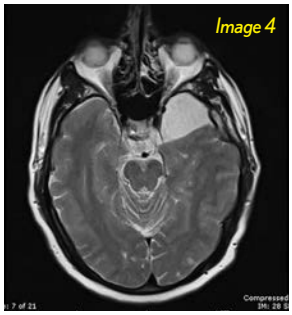


Image 4

We suspect his symptoms were due to transient increase in intracranial pressure causing local compression leading to the neurological symptoms. He has been referred to neurologists for further evaluation.

Discussion

These benign lesions are thought to be developmental anomalies from the defects in neural tube folding or are secondary to trauma. A thick layer of collagen lines the wall, likely due to increased collagen synthesis from the hyperplastic arachnoid cells and can be differentiated by the lack of transverse trabecular processes. The cysts are filled with a fluid similar to that of cerebrospinal fluid (CSF) although they remain separate from the ventricular system.

They account for approximately 1% of all intracranial masses. Most frequently (66%) they occur around the sylvian fissure and could be associated with underdevelopment of the underlying temporal lobe [1].

Arachnoid cysts are usually asymptomatic and remain as an incidental finding. They become symptomatic due to progressive enlargement of the cyst causing an increase in intracranial tension. Even though the exact mechanism is unclear, enlargement of the cyst occurs probably due to fluid secretion by the cyst wall or due to a one-way valve like structure causing a gradual increase in pressure due to the arterially induced pulsation of the CSF.

Enlargement of suprasellar cysts can cause endocrine dysfunction, hydrocephalus or compression of optic nerve. Occasionally even a minor trauma could cause bleeding in to the cyst which might mimic a subdural haematoma. Frequently they are seen routine imaging undertaken in patients with chronic headaches or seizures but the relationship between a non-enlarging cyst and headache or a seizure is controversial.

Arachnoid cyst could also occur in the spine as an extra-dural mass and is a rare cause of cord compression and radicular pain.

Treatment is controversial, especially whether to treat or not and the choice of intervention. Options include fenestration of the sac, insertion of a shunt into peritoneal cavity, aspiration of the cyst and radical surgical removal. Cysts treated with aspiration have a high recurrence rate. One small retrospective study showed very good long-term results following open surgery and radical removal of arachnoid cyst located at the posterior cranial fossa [2]. Advances in neurosurgical techniques favour fenestration over shunt insertion as the method of choice for decompressing symptomatic cysts. Complications of surgical intervention include hemiparesis, cerebrospinal fluid leak, hydrocephalus and subdural hygroma [3].

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Does Running cause Osteoarthritis of the knee?

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Consultant Orthopaedic Surgeon

Introduction

Why is "Running" the most popular sport of all? The simple reason is that running is free. You can do it anywhere on any types of ground. You can enjoy the fresh air and appreciate the environment. Most importantly, it burns more calories than any other mainstream exercise. You feel energised. For those, who don't like the gym or an exercise class, running provides an exercise, which can be extremely satisfying.

Running in the minds of many creates a picture of injury followed by wear and tear. This article looks at the literature and explores the effect running has on our knees.

Does running protect the knee from injury?

Research from Brigham Young University[1] suggests that it may actually prevent injuries rather than increase the risk of them.

In this study, 6 healthy runner volunteers were brought into a lab where samples of their blood and knee-joint synovial fluid (SF) were taken before (control) and after they ran for 30 minutes. Cytokine concentration was measured in SF and serum. The researchers then compared the samples with ones taken earlier when the men and women were sedentary. Ground reaction forces were measured during the run.

The cytokine GM-CSF (Granulocyte-macrophage colony-stimulating factor) decreased from pre to post-run. Interleukin-15 showed a trend for decreasing concentration pre to post-run. This was surprising, as the researchers expected to find an increase in molecules that spur inflammation, but they didn't. Instead, they found that pro-inflammatory markers had decreased.

The study also calculated the levels of COMP (Cartilage oligomeric matrix protein), which is a matrix protein currently studied as a potential serum marker for cartilage processes in osteoarthritis (OA)[2]. The results from Brigham Young University research [1] demonstrate that the control condition (rest) induced a decrease in serum COMP and an increase in synovial fluid COMP, while conversely the run induced an increase in serum COMP and a decrease in Synovial fluid COMP. This find confirmed that the marker for the osteoarthritic process in the knee synovial fluid had decreased post running.

Therefore, running appears to decrease knee intra-articular pro-inflammatory cytokine concentration and facilitates the movement of COMP from the joint space to the serum. Although it's pilot study, but the data is reassuring to indicate that running is good for your joints.

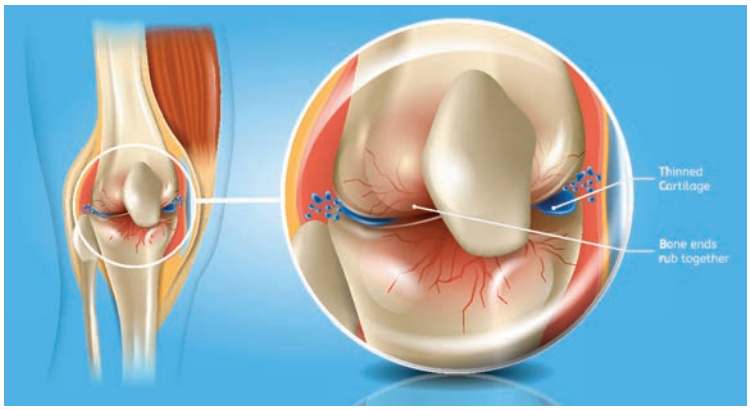
Running and Osteoarthritis

Miller et al in 2014 performed an interesting study [3] in the Human mobility Research centre, Queen's University, Canada to prove that runners do not have a high risk of osteoarthritis compared with non-runners. They compared 14 healthy adults, who walked and ran at self-selected speeds. This study compared peak and per unit distance (PUD) knee joint loads between human walking and running. Peak load has been associated with the initiation and progression of knee osteoarthritis

The results calculated that peak load was indeed three times higher in running, but the PUD load did not differ between running and walking. The reasoning behind this can be explained by understanding that that compared with walking, in running there is a relatively short duration of ground contact and the relatively long length of strides in running seem to blunt the effect of high peak joint loads, such that the PUD loads are no higher than that in walking.

This paradox suggests that running somehow blunts the effect of very high peak joint contact forces, perhaps to provide a load per unit distance (PUD) travelled that is relatively low.

Miller RH in another research study[4] at Neuroscience & Cognitive Science Program, University of Maryland concluded that runners do not have a greater prevalence of knee osteoarthritis (OA) than non-runners. He proposed two mechanisms. The first one suggests that cumulative load, which is surprisingly low in running, is more important for OA risk than peak load, and the second one is that running conditions the cartilage to acquire the unique ability to withstand the mechanical stresses of running.



An illustration of Osteoarthritis, showing thinned cartilage and bone ends rubbing together.

Athletes are more likely to sustain joint injuries compared with the average individual. In an athlete, the higher rate of loading and frequency of impact increases the amount of disruption and damage to joint cartilage. Studies have shown that for contact stressors to cause disruption to normal articular cartilage, a force of 25 MPa or more is required [5]. Activities such as running and jumping, which put mechanical stress on joints, produce force <25 Mpa, and therefore, are less likely to cause any disruption to the cartilage [5].

Running and Injuries

Estimates suggest that 79% of runners will get injured at some point, a statistic that's remained relatively stable for more than 40 years. *"Running is hard on the knees, especially if you're doing long-distance running,"* says James O'Keefe, a cardiologist at St. Luke's Mid America Heart Institute in Kansas City and a former runner [6]. *"A lot of people will break down orthopedically."* He favours light cardio workouts and suggests moderate running as 10-minute miles, two to three times per

week, for 1 to 3 miles at a time. *"Many people find that their joints feel better if they do brisk walking rather than running after age 45 or 50,"* he says. *"I do advise people over age 45 to avoid chronic very-high-intensity long-distance running, as the body is not as resilient as we get older."*

Female runners get injured more often than men. Women tend to have higher arches and point their toes out more as they run. Some experts think this increases risk of injury because of higher-impact landings. The way people's hips and knees are naturally aligned may also increase their risk. Women also tend to have less strength in their core and hips, which could affect them.

Common Running Injuries and Symptoms

1. **Runner's Knee (Anterior knee pain).** Knee pain is the most common symptom of injury in runners. The most common cause of knee pain in runners is patellofemoral pain syndrome. The hallmark of this syndrome is the gradual onset of pain in the front of the knee, near the kneecap. The pain is worse after sitting for a long time or when going up and down stairs or hills.
2. **Medial tibial stress syndrome**, also known as "shin splints." This causes pain over the shins and is more common in beginning runners.
3. **Achilles tendinitis** causes pain along the heel cord (Achilles tendon) at the back of the ankle.
4. **Stress fractures** affect long-distance runners. These result from repeated "stress" on the bone, most often in the lower leg, hip, or foot.

Conclusion

The British Heart Foundation advocates that regular running can reduce your risk of long-term illnesses, such as heart disease, type 2 diabetes and stroke. It can also boost your mood and keep your weight under control. It boosts your confidence, concentrate better and improves sleep

Runners are happier, more positive and have higher self-esteem, according to a study by Glasgow Caledonian University of more than 8,000 pavement pounders [7]. They scored 4.4 on the Oxford Happiness scale, above the average score of 4 on the method used by scientists to measure well-being.

Meanwhile, a separate study published in the American Journal of Psychiatry found that engaging in physical activity decreases people's chance of developing depression [8].

There are a lot of health benefits from running. Running and laughter have similar positive effects to the mind and confidence. The evidence strongly supports that for the common individual running for fitness is unlikely to cause osteoarthritis of the knees. However, the mechanical stresses imparted on the knees in athletes are different.

Tips for beginners

(as advocated by the NHS) [9]

- Build your fitness levels gently with our guide to walking for health before you move on to running.
- A good pair of running shoes that suit your foot type.
- Women should also consider using a sports bra.
- Start each run with a gentle warm-up of at least 5 minutes.
- Try alternating between running and walking during your session.
- Regular running for beginners means getting out at least twice a week.
- Increase your pace and distance gradually over several outings.
- Running the same route over and over again can become boring. Vary your distances, pace and routes.
- **Staying motivated. Set yourself a goal.**

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Organ Donation What is new?

Dr Satya Sharma
MBE, DL
Organ Donation Ambassador

Organ Donation (OD) and Transplantation is a UK success story. In the last decade, the UK has seen a 67% increase in deceased organ donors and a 49% increase in deceased donor transplants. Numbers on the Transplant Waiting List have fallen year on year and thousands of lives have been saved and improved through the gift of organ donation.

The organ donation is of two types:

1. **Live** – mainly from friends and family members, sometimes totally altruistic when someone gets motivated to save the life of another human being. It is restricted to kidney, liver and part of lung only. Everyone needs to go through various aspects with the help of professional support and counselling requiring time and careful consideration. It forms a small part of total OD.
2. **Deceased** – The main type is cadaver or deceased OD. Although the OD is most frequently for kidneys but many other organs such as heart, liver, lungs, pancreas, intestine and uterus can be transplanted successfully. Currently 6500 persons are waiting to receive organs and approximately 1600 (25%) are from BME communities due to prevalent illness pattern. 8% of UK population are Asians. This means the need for Asians is 3 times higher. The waiting time is 12 months longer for BAME persons.

Family matters. You must talk to your family since they can overrule your wishes. 40% white families and 60% BME families do so and many have to live with the guilt of denying others an opportunity to live.

What can be donated?

Organs: Heart, Lungs, Kidneys, Liver, Pancreas, Small and Large Bowel.

Tissues: Cornea, Skin, Heart Valves, Tendons, Ligaments, Bone. Recently Uterus and Hands transplanted successfully

WHAT IS NEW?

15.3.19 was a momentous day for organ donation as ***"Max and Keira's Law"*** achieved Royal Assent. It is also popularly called "presumed consent".

Who will the changes affect?

These changes will affect all adults in England unless they have recorded a decision not to donate or are in one of the following excluded groups:

- Those under the age of 18
- People who lack the mental capacity to understand the new arrangements and take the necessary action
- Visitors to England, and those not living here voluntarily
- People who have lived in England for less than 12 months before their death.

Key points to remember:

- From spring 2020, the law around organ and tissue donation in England is changing
- Unless you choose to opt out or are excluded, all adults in England will be considered as a possible organ donor when they die
- Adults covered by the change will still have a choice whether they want to be an organ donor and their families will still be involved before organ donation goes ahead
- Whatever your decision, make your choice clear to your family and closest friends to ensure your choice is honoured
- You can find answers to commonly asked questions on our website at: **https://www.organdonation.nhs.uk/opt-out-faq/**
- To find out more, or to register your decision to opt in or opt out, visit: **organdonation.nhs.uk**

In Wales presumed consent has been a law since 1 Dec 2015.

New figures released by the Welsh Government show for the first time a significant increase in the donation after brain stem death (DBD) consent rates in Wales (88.2%) when compared to England (73.3%). The donation after circulatory death (DCD) consent rate in Wales has also improved and is now 68% compared to England 59.8%.

Under the former 'opt-in' system, in 2012/13, 2013/14 and 2014/15 only 50.3%, 53.6% and 48.5% of families consented to deceased donation in Wales

What do the religions say?

In 1999, a conference of top religious leaders of the world involving Christians, Muslims, Hindus, Sikhs, Buddhists and other religions debated the subject. All agreed that OD is acceptable since the fundamental principle is to help others. There is more on this subject available on NHSBT website at **organdonation.nhs.uk /faq/religion/**

Conclusion:

Organ donation is a noble, most humanitarian act. All of us in the UK should be proud of the achievements, but more can and should be done by everyone.

The change in law alone is not likely to succeed unless all of us understand, remember and act.

Two actions required:

1: ***DISCUSS your wishes with family and friends, do not leave it for tomorrow.***

2: ***PASS IT ON!***

BIDA ARM Chairman's Report

Dr Jay Nankani
A.R.M. Chairman, BIDA

Dear friends,

This year's ARM/AGM was held in the Mercure Samlesbury Hotel, Preston over the weekend of 20/21/22 September 2019, hosted by Blackburn division of BIDA. My sincere thanks to Drs. Rautray, Motupalli, Rakesh Sharma and Preeti Shukla for organising this event and providing excellent hospitality on Friday evening. The evening talk on Pensions was very informative, and the entertainment/dances were brilliant.

Saturday morning started with the officers' reports followed by the motions and discussions by the delegates. The total number of motions was low this year, which were dealt with in a timely manner, leaving us about 20 minutes to discuss the future of BIDA and a brainstorming session to discuss how to strengthen BIDA in the future. A lot of good ideas were put forward by the delegates, which I am sure the EC will make a serious note of with a view to implement them. Most of the motions were either unanimously accepted or by a huge majority. A detailed account will be given in the National Secretary's report.

After the lunch break, we commenced a workshop in which we heard Prof. Iqbal Singh, Claire Light from the GMC, Cicely Cunningham from DAUK and Manda Copage from NHS Resolutions (Formerly known as NCAS) followed by a panel discussion and Q&A. This session was excellent and enjoyed and appreciated by all the Delegates.

In the evening, we had an exclusive Gala Dinner in which we heard Mr Julian Simpson, our chief guest give a brilliant account of the contribution made by overseas doctors to the NHS over the period of 1940 to 1980. Mr Simpson described the BME doctors as the architects of the NHS and praised them for their valuable contribution. He also touched upon the unfortunate discrimination that existed in that period and highlighted the fact that these doctors had very little choice in selecting the place of their work and mostly ended up in places and posts where English doctors did not wish to go.

On Sunday morning, we commenced the day with a lecture by a private company, Charles Derby on the practical aspects of NHS Pensions. This was followed by an absolutely superb talk on *"Oral manifestations of systemic diseases"* by Prof St John Crean, Pro Vice Chancellor (Clinical, Health and Research), School of Dentistry, and University of Central Lancashire.

I handed over the proceedings to the National Chairman and National President afterwards to proceed to AGM in which 3 BIDA members were awarded Fellowships. Hearty congratulations to Dr. Shamim Rose, Prof Iqbal Singh and Dr Vikram Shah on receiving the fellowship awards.

Next year's ARM/AGM will be held at Stoke on Trent. You will be notified about the dates in due course. I would urge you all to come to next year's ARM in large numbers, as each one of you do matter in making the ARM vibrant.

Hope to see you there.

Kind regards and best wishes

Dr Jay Nankani
A.R.M. Chairman, BIDA

BIDA Annual Representative's Meeting Report

The 2019 BIDA Annual Representatives Meeting was held at The Salmesbury Hotel, Salmesbury, Preston, Lancashire in September and was hosted by Blackburn Division.

The following are minutes of the ARM Meeting taken by BIDA Central Office.

Welcome by ARM Chairman

Dr J Nankani welcomed delegates to the 44th BIDA ARM and thanked Blackburn Division for hosting this years' meeting.

Proposal by BIDA General Secretary

Dr A Dhawan, General Secretary, proposed that the list of delegates be the official list of representatives to the ARM 2019. **Dr Das** seconded and delegates accepted the proposal.

Annual Report by BIDA National Chairman

Dr Kanneganti thanked Blackburn Division for their hard work in hosting this year's ARM.

Dr Kanneganti reported that the main concern for the organisation had been the Central Office, and informed the meeting that **Dr Dhawan** would discuss more about this in his National Secretary's report. It had been a difficult year for the office, but the work done by the EC and Officers remains the same. BIDA has formed a working collaborative with the Doctors Association UK who have 30,000 members across the country. **Dr. Cicely Cunningham** would be giving a talk on working together that afternoon.

Other speakers at the afternoon's workshop included **Claire Light**, Head of Equality, Diversity and Inclusion at the GMC, who planned to speak on ***'The Over Representation of BME Doctors in Regulatory Procedures'.*** The GMC have supported BIDA's conference for the last 2 years and want to carry on supporting BIDA.

Also that afternoon, **Manda Copage** of NHS Resolution would be giving a talk on ***'The NHS' Role in Supporting Doctors'***.

BIDA are working with Doctors UK "Consulting Room" online with nearly 20,000 doctors in the Group.

We continue to work with the BMA and meet **Dr. Chand Nagpaul** on a regular basis. He is looking at areas that involve medical graduate issues. There was a sexism row last year within BMA, which Dr Chand Nagpaul asked a QC to investigate. Their report will be published shortly.

Dr Kanneganti reported that BIDA still meets with RCGP leads every 3 months.

BIDA and BAPIO used to have a joint meeting with the BMA. However, the BMA are tired of being criticised by BAPIO who are going to take BMA to court over exam results. BIDA will not be supporting BAPIO in this. The BMA wish to continue working with us. **Dr S Sinha** of Wolverhampton Division represents BIDA on the BMA Council and reports back to the NEC.

Pulse magazine contacts BIDA on a regular basis for our views on certain issues and runs a list of top GPs in recognising our colleagues in the National Profile.

The guest speaker at that evening's Dinner would be **Dr Julian Simpson,** who has written an excellent book about immigration. One section of the book talks about the history of ODA and how it was formed. He is very passionate about the whole immigration debate.

The National Chairman informed the meeting that BIDA will be holding its elections next year, beginning in June. When Dr Kanneganti became Chairman he was tasked to make sure that the Organisation survived, and since then we have been raising important issues affecting International Medical Graduates and have managed to retain our profile.

Dr Kanneganti stood at his local elections in Stoke-on-Trent and was successful. He is going to stand in December's General Election for Member of Parliament and if he wins he will make sure he raises BIDA's profile.

Report by BIDA General Secretary

Dr A Dhawan welcomed delegates and asked them to observe a 30 second silence for those members who have passed away in the last year.

Feedback from last year's International Congress for which he was Convenor supported by **Dr Leena Saxena** and **Dr Sanjay Arya** proved the Congress to have been a great success. It was decided to take a break for a year. However, the NEC has discussed the next Congress and the venue will be Cambodia. We are still finalizing dates.

The Cricket Tournament as usual proved to be a very popular event followed by badminton and table tennis.

Mr A Dhawan and **Mr A Sinha** are co-editors of BIDA Journal and so far have managed to secure very good articles. However, he urged delegates to encourage their colleagues to submit articles.

Financial challenges remain. He asked delegates if they have any contacts that could help support and sponsor BIDA to let the Centre know.

Our office manager, **Alison** has been off sick for the last 3 months and **Mandy** has stepped up and done a superb job organising this conference. He urged members to be patient with Mandy whilst we secure a second member of staff.

With regards to BIDA's future he urged Divisions to continue with their activities and increase the membership.

Finally, he thanked **Blackburn Division, Mandy** and **Margaret** for their hard work.

Report by BIDA National Treasurer

Mr P Sarkar thanked Blackburn Division. He invited **Mr Zahur** of Altman Smith, the organisation's accountants to present the accounts up to 31st March 2019. This was followed by questions from the floor.

The Treasurer informed delegates that the organisation faces a difficult time ahead and the time has come to curb our spending.

Membership fees have increased and we will be informing members that their direct debits will be changing.

Mr A Sinha asked if one of the rooms in the ODA House could be sublet to create another form of income but was advised this has already been discussed by the NEC but is fraught with too many difficulties such as Health and Safety restrictions. **Mr Sarkar** has already been tasked to look into this.

Dr B Sarker suggested Senior Officers should visit the Divisions to promote the Centre and that members taking a post on the NEC should have a job description and a commitment to attend most of the meetings. **Mr A Dhawan** said the officers will take on board his advice regarding the divisions. He confirmed that the NEC have discussed NEC members' absences and it was decided that if a member misses 3 meetings, it will be communicated to them.

Dr J Nankani asked for a division to volunteer to host next years' ARM/AGM and to submit their interest before 1.00pm that day. He also asked members to put their names forward for the Agenda Committee.

MOTIONS

THE NHS

1 This meeting believes that there is no role for Private Financed Initiatives (PFIs) within the NHS and that:

(i) The government should be open on the long-term costs of using PFIs within the health and social care sector.

(ii) No further NHS contracts should be awarded to PFI companies

(iii) The ability to end PFI contracts be investigated so that the NHS is not constrained by exorbitant interest rates and fees

Passed Unanimously

2 This meeting recognises that there is an acute shortage of resources in the NHS to provide safe patient care and:-

(i) that increasing hospital waiting lists is unacceptable

(ii) waiting times at A & E are not conducive to safe patient care

(iii) waiting times for ambulances are totally unacceptable for emergency patient care

1 Abstention
Passed by Majority

3 This meeting is concerned that increasing workload and staff shortages are resulting in doctors of all grades experiencing stress and burnout and:

(i) demands that future working patterns of doctors are sustainable

(ii) demands that personal support be made to all NHS staff

(III) demands that mentoring be made available to all NHS staff

(iv) call for annual reporting of staff wellbeing, morale and burnout by all NHS bodies.

Passed Unanimously

4 That this meeting:-

(i) notes that restrictions on annual and lifetime allowances in the NHS pension scheme have had a detrimental effect on retaining doctors in the clinical practice

(ii) believes that increasing the NHS pension scheme Employer Contributions Rate to 20% will inevitably reduce the impact on any increase in NHS funding.

(iii) calls on the BMA to actively lobby the Treasury to act decisively to improve the NHS pension scheme.

Passed Unanimously

GENERAL PRACTICE

5 This meeting is dismayed by the increasing loss to the NHS caused by early retirement of GPs and Consultants and states that:-

(i) Retaining experienced doctors in the health system would be beneficial if appropriate under different contracted agreement.

(ii) Providing advice and guidance to young doctors to settle, taking up GP principal posts for continuity and patient care, holiday benefits and professional development plan.

Passed Unanimously

6 This meeting notes that CQC inspections appear to be over the board, as there is nothing medical but more about safeguarding and some of the information they are asking for is not even in the contract.

Passed Unanimously

7 This conference urges BIDA NEC to explore the possibilities of achieving a registered charity status approved by the Charity Commission UK.

1 Abstention
Passed by Majority

BIDA Annual Representative's Meeting Report

8 This RB urges BIDA central leadership to become more engaging with its divisions and the general members.

Passed Unanimously

9 The conference should support the NEC proposal that the BIDA Journal is published on-line instead of paper version and in the process support BIDA's cost saving initiatives.

Motion Lost

10 Members who have worked long term for the Association and have made significant contribution to the Association should be honoured and henceforth suggest starting "BIDA Lifetime Achievement Award".

11 If the above is agreed then we propose that the process of nomination and selecting one person amongst them should be with the Fellowship Committee.

Passed as a Reference to the NEC

12 Deprivation should be given priority as suggested by Simon Stevens but nothing has happened so far as RCGP wants rurality, should be given higher oversight.

Incompetent

13 This meeting recognises that Health and Social Care are putting a lot more pressure on GP workload services, which is already over-stretched. BIDA should put pressure on the Government to look into these issues urgently.

Passed as a Reference to the NEC

PUBLIC HEALTH

14 This meeting is seriously concerned by the increased numbers of homeless people, living and sleeping outdoors across the UK. This meeting also recognises the deleterious effects of homelessness on physical and mental health. This conference therefore calls on the Government to:-

(i) Commit additional resources and commission dedicated teams to support the primary medical care of these vulnerable people.

(ii) Ensure that no person completing a prison sentence is released to conditions of homelessness.

1 Against
Passed by Majority

COMMUNITY AND MENTAL HEALTH

15 This meeting calls upon the Department of Health and Social Care to commit to:

(i) A significant increase to mental health funding immediately and to spend a minimum 25% of the overall NHS budget by the completion of a 10 year plan to ensure funding in line with mental ill health care needs and activity.

(ii) Priority of resource access and outcome for mental and physical health services

(iii) Pressuring Public Health to allocate adequate ring-fenced funds for mental health promotion and prevention in line with the 10 year plan.

(iv) Commissioning a fundal root and branch independent review of services for people mental health crisis to develop and implement a national, integrated, easily accessible fully funded service.

Passed by Majority

MEDICAL ETHICS

16 This meeting notes the recent decision by the Royal College of Physicians to adopt a neutral position on assisted dying after surveying the view of its members and:-

(i) Supports patient' s autonomy and good quality end of life care for all patients

(ii) Recognises that not all patients suffering can be alienated

(iii) Calls on BIDA to carry out a poll of its members to ascertain their views on whether BIDA should adopt a neutral position with respect to a change in the law on assisted dying.

Passed Unanimously

ANY OTHER BUSINESS

Dr Nankani announced that Stoke-on-Trent Division has volunteered to host next years' ARM.

Dr S Sarker thanked the National Executive Committee on behalf of the members.

There being no further business the meeting closed.

AWARDS & HONOURS

FELLOWSHIP AWARDS

Dr B K Sinha invited the following members to accept Fellowship of the Association:-

Dr Ikram U Shah FRCP
Prof Iqbal Singh OBE
Dr Shamim Rose

Further details of this year's recipients can be found on page 5 of this issue.

SPORTS AWARDS

Dr B K Sinha invited **Dr R Hegde,** BIDA Sports Co-Ordinator, to present the President's Cup to this year's winners.

Dr Hegde informed the meeting that the final, between North East and Blackburn Divisions, took place on 16th August and was hosted by North East Division. Once rain had stopped play for the day, North East Division were declared the winners owing to having achieved a better run rate after 15 overs.

Dr Hegde thanked the National President and the office for all their help in organising this year's Cricket tournament.

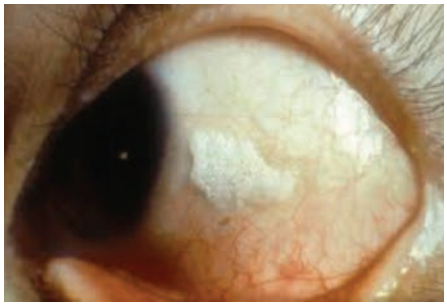
Dr Hegde also informed delegates that BIDA also had its annual Badminton and Table Tennis tournaments on 21st May hosted by NE Division. Initially 6 Divisions had entered the tournament but only 2 Divisions – Manchester and North East – ended up competing following the unfortunate withdrawal of the others.

Dr Hegde subsequently presented the winners of both BIDA's Badminton and Table Tennis Tournaments with their awards.

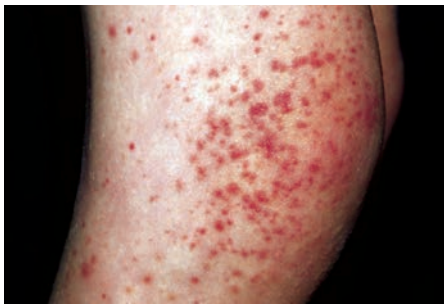
Medical Quiz

Spot the diagnosis

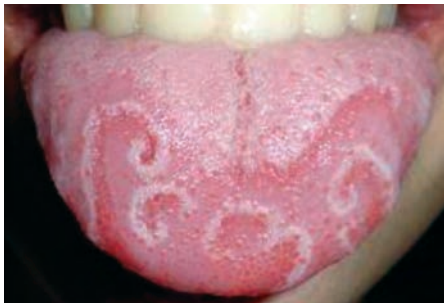
1. Spots in the eye



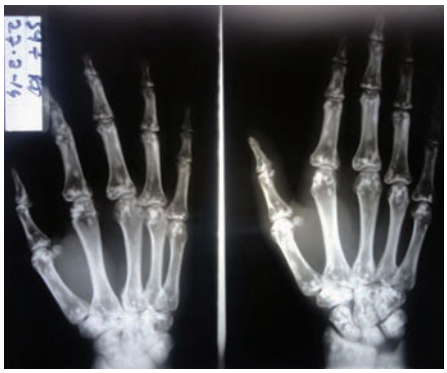
2. Spots in the leg



3. Spots on the tongue



4. Spots on bones



Answers on Page 25

Welcome

to new BIDA members

Name	Membership No.	Division
Dr M Mehta	10625	Stoke-on-Trent
Dr L Mehta	10626	Stoke-on-Trent
Dr A Jain	10627	Wigan
Dr R Jain	10628	Wigan
Dr P Ross	10629	Manchester

BIDA Members celebrating..!

Dr Leena Saxena

Congratulations to BIDA member and Wigan GP

A surprise celebration by staff, patients, and family was held for Wigan GP and BIDA member, Dr Leena Saxena, who has been working at Winstanley Medical Centre for 20 years.

A former Obstetrician and Gynaecologist based at Billinge Hospital, Leena made a change of career in 1999 and has been working as a GP ever since. She was presented with gifts, flowers and cards from her very grateful patients. Dr Saxena said she was having a marvellous time at the practice and was enjoying working as a GP. Some of her 90 year old patients also attended the celebration to tell stories about how she has been there for them and has helped them through tough times.

Leena has been a BIDA member for over 15 years. She is currently the Chair of Women Doctors Forum and also the Chair of Wigan BIDA Division. She previously held the post of Secretary for Wigan BIDA Division for more than 6 years.

Her husband Dr Sanjeev Saxena is also a GP and EC member of BIDA and her son, Dr Ishaan Saxena who recently joined as a GP in Wigan is also BIDA member, having previously been the Chair of BIDA Junior Doctors Forum.

Prof YKS Viswanath

Congratulations to **Prof YKS Viswanath** *on his appointment as Visiting Professor at Teesside University*

Professor YKS Viswanath has been a Consultant Surgeon last 18 years and an active BIDA member in the North East of England last 12 years. He has served in the executive committees and has energetically endorsed BIDA and led sporting activities successfully. He is a consultant senior surgeon with specialist interest in Upper GI and advanced Laparoscopic & Endoscopic Surgery who works at James Cook University Hospital. He is the programme director for MCh postgraduate surgical specialties and works in collaboration with Teesside University in North of England UK. He has represented regionally, nationally and internationally at various Upper GI, laparoscopic and general surgery forums since the year 2001. He is a recognised national trainer for advanced laparoscopic surgery and in the national ALSGBI council. He runs many live courses and established the National 'Endo RF anti-reflux' therapy centre in UK and carry out maximum number of these procedures per year in Europe.

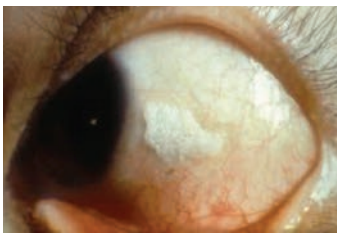
He holds a few national and international awards including 'Times NRI of the year (Professional) category 2017. He was one of the shortlisted candidate for BMJ national clinical leadership award in 2018.

The North East BIDA and National BIDA congratulate on his appointment as Visiting Professor at Teesside University. This is in recognition to his outstanding commitments and achievement towards post-graduate education and research over years.

Teesside University

Medical Quiz Answers

1. Spots in the eye

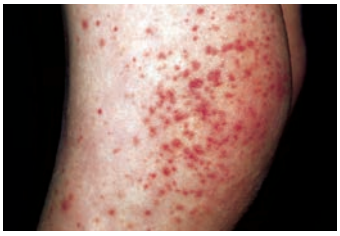


These are the buildup of keratin located superficially in the conjunctiva of human's eyes. They can be oval, triangular or irregular in shape. The spots are a sign of vitamin A deficiency and associated with drying of the cornea. Although usually a result of malnutrition, VAD can accompany malabsorption syndrome.

Bitot's spots are usually due to nutritional VAD, which is a common public health problem among preschool children in the developing world. Other conditions associated with systemic avitaminosis A may include reduced intake (alcoholism, mental illness, and dysphagia), disordered absorption (Crohn's disease, celiac sprue, pancreatic insufficiency, and short bowel syndrome), disordered transport (Abetalipoprotenemia) and reduced storage (liver disease).

The clinical detection of Bitot's spots confirms VAD. Confirmation may be done by estimation of serum retinol or retinol binding protein levels.

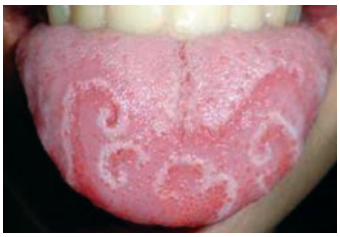
2. Henoch-Schonlein purpura (also known as IgA vasculitis)



This is a disorder that causes the small blood vessels in your skin, joints, intestines, and kidneys to become inflamed and bleed. The most striking feature of this form of vasculitis is a purplish rash, typically on the lower legs and buttocks. Henoch-Schonlein purpura can also cause abdominal pain and aching joints. Rarely, serious kidney damage can occur.

Henoch-Schonlein purpura can affect anyone, but it's most common in children between the ages of 2 and 6. The condition usually improves on its own. Medical care is generally needed if the disorder affects the kidneys.

3. Geographic tongue



This causes island-shaped lesions that give your tongue a map-like appearance. The lesions can appear on the upper surface and sides of the tongue. They look ragged and uneven, and sometimes have white borders or edges.

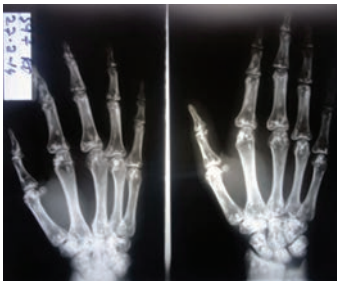
The lesions are harmless. They're not a sign of an infection, cancer, or other serious medical issue. Instead, the misshapen spots are a sign of inflammation affecting your tongue's surface.

On a healthy tongue, tiny, finger-like extensions called papillae stick up and help you eat, swallow, and taste. If you have geographic tongue, those papillae disappear, leaving behind patches of your tongue that are bald, smooth, and red.

Geographic tongue is also known as erythema migrans tongue. This is a very different condition than erythema migrans (or erythema chronicum migrans), which is a rash that appears in people who have Lyme disease.

If the map-like spots begin appearing in other parts of your mouth, such as under your tongue or on the soft palate, you may have another condition called stomatitis erythema migrans. It has the same symptoms and signs of classic geographic tongue, but the lesions have spread beyond the tongue.

4. Osteopoikilosis



The X-ray shows multiple small hyperdense oval and circular lesions scattered in all small bones of the left hand, with preservation of cortical thickness. These findings are suggestive of osteopoikilosis.

Osteopoikilosis (also called spotted bone) is a benign, possibly autosomal dominant dysplasia of bones, occurring in 1 per 50,000 people. Small bones of hand and feet, long tubular bones and pelvis are most frequently affected. The condition is asymptomatic and is diagnosed incidentally on radiographs taken for other problems. The diagnosis is straightforward based on the typical radiographic appearances of small (up to 10mm) hyperdense opacities distributed symmetrically. No further investigations or any specific treatment are indicated. Patients need to be reassured about the benign nature of radiological findings.

Did you know?

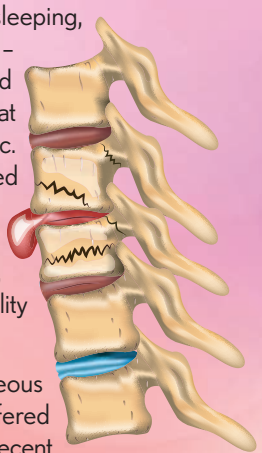
82% of post menopausal women don't know that fractures are a risk factor and sign of osteoporosis.

The risk of hip fracture rises in the decade following total knee replacements. Swedish researchers have shown based on an analysis of 3221 patients followed for 15 years that after TKRs the risk of hip fracture increased by 4% and the risk for vertebral fracture by 190% compared to the population without TKR. (Vala CH et al. Osteoporosis International Vol 27:Suppl 1: 2016).

Astronauts lose their bone mineral density during space flight.

Previous studies suggested a relationship between increased osteoclastic activity and reduced bone mineral density. As part of research, astronauts reared small freshwater fish aboard the ISS for 56 days. Their jawbones and teeth were studied. Investigators at the Tokyo Institute of Technology confirmed the previous finding. Electron microscopy studies indicated abnormality in two genes in the osteoclasts mitochondria. This was linked to the reaction of the mitochondria to microgravity.

Vertebral compression fractures associated with osteoporosis can cause acute pain. These lead to kyphosis, which causes problems with mobilisation, looking forwards, eating, sleeping, sitting and respiratory problems. Vertebroplasty – injection of acrylic bone cement into the fractured vertebral body – has become quite popular to treat pain, but has remained a controversial topic. Firanescu CE et al report a well constructed randomised trial of 180 older adults with 1-3 vertebral compression fractures of 6 – 9 weeks duration. The study measured over 12 months, showed that this procedure had no effect on quality of life or on disability.



The NICE guidelines state that percutaneous Vertebroplasty and Kyphoplasty should be offered only to people with severe on-going pain after a recent unhealed vertebral fracture despite optimal pain management. (BMJ 2018:361:k1756)

Emergency admissions to hospitals in the UK rose by 47% from 1998 to 2013, from 3.6 million to 5.3 million, with only 10% increase in population over the period.

Introduction of a primary care pay for performance scheme in England was associated with a fall in emergency admissions for incentivised ambulatory care sensitive conditions (such as epilepsy and CHF) compared with those that were not incentivised (such as cellulitis or pyelonephritis).

Divisional News

North Wales Division

Dr Yee Ping Teoh, Consultant in Chemical Pathology and Metabolic Medicine at Wrexham Maelor Hospital gave a stimulating presentation on the problems resulting from deficiency of Vitamin D. The main thrust of her presentation was to remind the audience of Vitamin D deficiency. It is a serious problem particularly in people not synthesising the vitamin naturally due to limited exposure to sun. She also reminded the audience of the importance of relating Vitamin D assessment to the time of the year. Vitamin D levels may be lower in winter months as compared to summer months and this may be an important reason to consider taking additional Vitamin D during the winter time. This was a well-attended meeting by the members of the North Wales Division.

Above: Dr Jay Nankani, Dr Yee Ping Teoh, Dr Ikram Shah and Mr Amit Sinha at BIDA North Wales Division's meeting on 24 September.

BIDA President's Cup

Cricket Final 2019

Report by **Dr Raghu Hedge**
BIDA National Sports Coordinator

For this year's Cricket tournament seven Divisions participated. The tournament went as well as expected. The final was between North East and Blackburn Divisions, which took place on the 16th of August, with the North East Division hosting the match.

It was a closely contested match, with both teams playing some excellent cricket, but unfortunately interrupted by the rain. The away team batted first and scored 179 runs in their allocated thirty overs. In reply, North East Division's innings was frequently interrupted by rain. Only fifteen overs were completed before heavy rain stopped play. According to the BIDA Cricket rules in a rain-affected match, fifteen overs is the minimum required to generate a result, with the runs scored by each side at that stage counting. In their innings, Blackburn Division had scored 64 for the loss of two wickets, while the North East Division had made 69 for no loss. Therefore North East was declared as the winner. North East Division won the trophy for the first time.

BIDA National President Dr. Birendra Sinha praised both teams for playing the match with great sportsmanship, stating that this was the principal reason that BIDA organised the tournament each year. The President then presented the trophy to the winning Captain, Prathish Thakkar, and the Runners-Up trophy to the Blackburn Division Captain, Sankesh Waghray.

Above: BIDA Sports Coordinator Dr Raghu Hedge (green top, centre) and BIDA President Dr Biru Sinha (7th right) pictured with members of the victorious North East Division team following the presentation of the President's Cup.

ACCEA

ADVISORY COMMITTEE on CLINICAL EXCELLENCE AWARDS

Dear Colleagues,

We have received the following communication from the Clinical Excellence Award Secretariat, Department of Health & Social care, an indicative timetable for the planned 2020 Awards Round. These dates shouldn't move dramatically, but are still subject to change.

2020 ACCEA Awards Round

Applications open: 6 February
Applications close: 3 April
Outcomes announced to applicants: December

The secretariat would formally announce the 2020 competition and confirm the application window dates on the website in December.

www.gov.uk/accea

Please cascade this information to your members and ensure that your own internal processes allow applicants sufficient time to complete and submit their applications to ACCEA.

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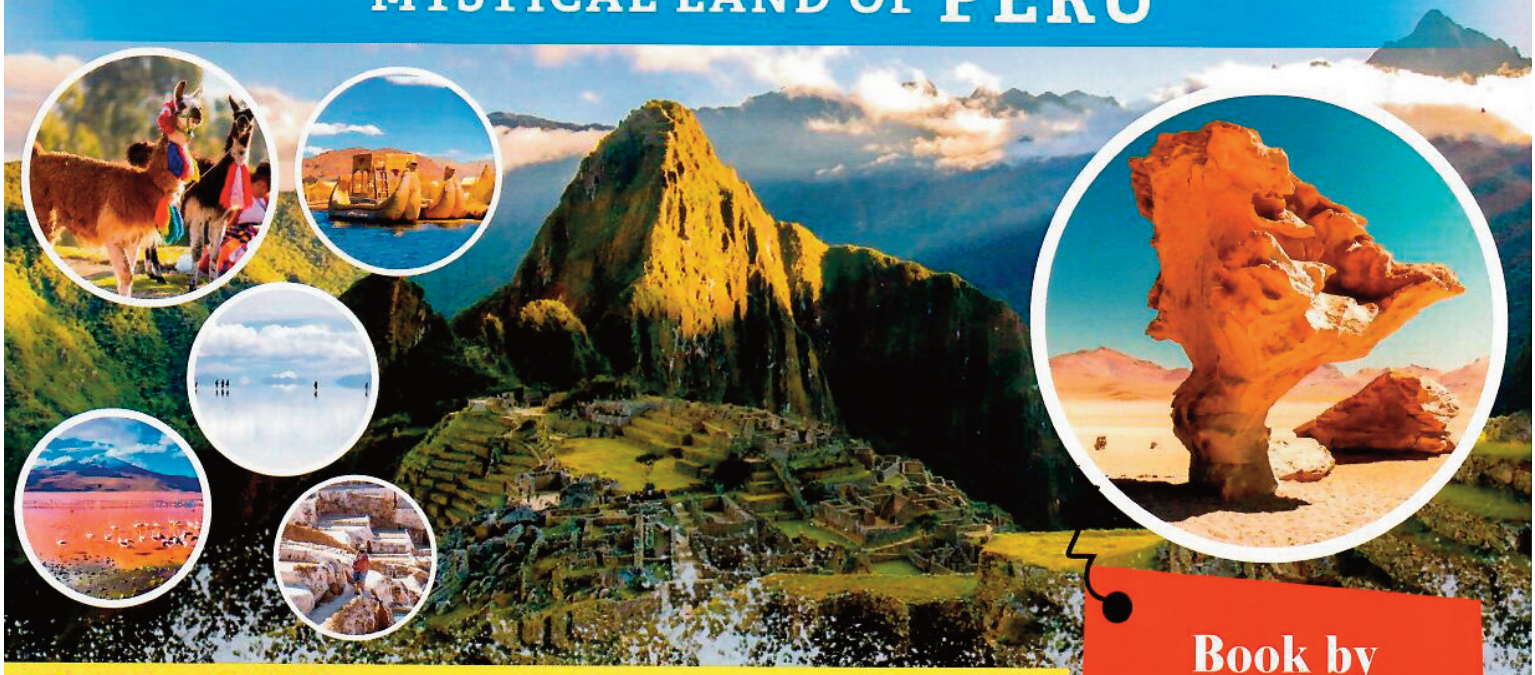

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BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

The British International Doctors Association (BIDA) is a professional doctors' association. Its sole objective is promoting ***Equality*** and ***Fairness*** for all doctors and dentists working throughout the UK.

BIDA's mission is to achieve equal treatment of all doctors and dentists based on their competence and merit, irrespective of their race, gender, sexual orientation, religion, country of origin or school of graduation.

If you believe in this mission and would like to be part of this endeavour, join us!

- You will make professional contacts, gaining the opportunity to network with people who can impact your profession, and giving you access to new opportunities, friends and information.
- *In addition to being part of a group of like-minded professionals, and having the recognition of your peers, specific member benefits include:*
- Attending BIDA-organised international, national and regional conferences, seminars, meetings, and many other educational and social activities
- Constant access to pastoral support
- Nominations for excellence awards
- BIDA Journal, our scientific journal, complete with news, interviews and much more.

If you are interested in joining BIDA, or would simply like to know more about us, please either write to **BIDA, ODA House, 316A Buxton Road, Great Moor, Stockport, Cheshire SK2 7DD, U.K.**, e-mail us at **bida@btconnect.com**, or contact us through our website at **www.bidaonline.co.uk**

We look forward to hearing from you!

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