# bida Journal

## RCS Edinburgh
## Bullying & Undermining Campaign
#let'sremoveit

## Maternal Sudden Death in Pregnancy
*due to Cardiac Causes*

## PCSK9 Inhibitors
*What do they do and do they work?*

## BIDA A.R.M. / A.G.M. 2018
*Full Report and Images*

## Pelvic Tumour
*A Case History*

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***Editorial Committee:***

*Co-Editors*
Mr A. Sinha
Dr Ashish Dhawan

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Dr Sanjay Arya
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Dr P. Sarkar
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Prof. S. Senapati
Dr B K Sinha
Mrs K. Upadhyay

*Secretary:* Mrs Margaret Barron



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***Editorial Address:***
The Co-Editors, BIDA Journal,
ODA House, 316A Buxton Rd.
Great Moor, Stockport, Cheshire SK2 7DD
*E-mail:* amitani2000@yahoo.co.in
bida@btconnect.com
*Website:* www.bidaonline.co.uk

Produced on behalf of the British International Doctors' Association by:

***Graphic Design & Digital Artwork:***
**Nick Sample** D&AD INFP
8 Fairways, Appleton, Cheshire WA4 5HA
*Phone:* 07950 332 645
*E-mail:* njcsample1@me.com
*Website:* www.nicksample.com

***Printed by:***
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King William House, 202 Manchester Road,
Bolton, Lancashire BL3 2QS
*Phone:* 01204 397522
*E-mail:* info@minervaprint.com
*Website:* www.minervaprint.com


# bida Journal
# Editorial


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



**Dr. Ashish Dhawan**
*MD, MRCP*
Co-Editor, BIDA Journal.
Consultant Cardiologist &
Cardiac Electro Physiologist,
Wigan Royal Infirmary


**The government has outlined the main focus for the long-term 10 year plan to deliver world class healthcare with a budget, which would rise to £20 billion a year above inflation by 2023. Pledges on maternity care, mental health, elderly support and earlier detection and prevention of diseases will be included in the plan. In spite of these positive decisions, we would question, "Is the funding sufficient and where is the staffing?"**

Many frontline staff are used to seeing a lack of investment in workforce, equipment and buildings in their workplace. However, it is ironic and incomprehensible to see that it's acceptable for the NHS management to hand over at least £26 million from the NHS budgets to private consultancy firms to reorganise the health service. This leads to hundreds of new managerial and administrative posts. The private consultancy forms have made lots of money with questionable value for the money they have received for the services they have given to the NHS. Would our government ever realise that this money has in most cases gone down the drain?

Workforce is the main priority in most hospitals leading to rota gaps and variability in the respective teams. Recruitment agencies and MTI or Fellowship programmes have attempted to bridge the gap. One decision by the government has been positive "Removal of cap on skilled visa for doctors and nurses outside the EU", which is now permanent. Is this enough? The issue of Brexit has worsened the situation.

BIDA has remained in the forefront to raise the various issues affecting the international medical doctors. Our President, Dr B K Sinha sends a message and outlines our various activities.

We remain concerned about the gradual decline in GP partnerships. BIDA GP forum chairman, Dr P Shukla is disappointed about the introduction of state indemnity scheme in April 2019. The announcement by the government that state indemnity scheme is going to be funded from existing GP resources. This would reduce their finances and deter fresh and newly qualified doctors to join GP partnerships.

We present a variety of extremely interesting and thought provoking articles in this edition. Central to our concerns is "Bullying in NHS". Olivia McBride and her team from the Royal College of Edinburgh present their "LetsRemoveit" campaign. Their resources are a must read for all (www.rcsed.ac.uk/bullying). They have teamed with the GMC and the Royal College of Obstetrics & Gynaecology to produce an e-learning module. The Scottish government has recently announced an independent inquiry into alleged bullying in the NHS Highland region, which will be carried out by John Sturrock QC.

We should make you aware that bullying at workplace affects the mind and body alike. A recent prospective study published in the European Heart Journal established that people who are bullied or experience violence at work had a higher risk of cardiovascular disease. It is now the responsibility of every NHS worker to be aware of this issue and promote an environment of civility.

Mr Sarkar updates us about cardiac deaths during pregnancy, which remain a serious clinical challenge to the professionals. The condition of Sudden Arrhythmic Death Syndrome has only recently been recognised and more than 50% of these individuals have a normal heart. McConnel & Dhawan present their experience using Alirocumab (PCSK9) a lipid-lowering agent. We have the ARM/AGM reports as well as the abstracts of the BIDA International Congress 2018.

We deeply regret the loss of one of our senior colleagues. Dr Vidya Prasad was a close friend and an active BIDA member of the North Wales Division in the early years. His warm personality and a quiet smile embodied a wealth of wisdom and knowledge. His daughters learnt from his teachings and followed his footsteps. He will be deeply missed. Mahatma Gandhi's words are most appropriate:

***"You must be the change you wish to see in this world."***

Best wishes

**Ashish Dhawan & Amit Sinha**
*Co-Editors, BIDA Journal.*

# BIDA National President's Report

**Dr Birendra Sinha**
*National President, BIDA*

Dear Members,

First of all, I would like to start by wishing all BIDA members and their families a happy, healthy and prosperous new year for 2019. In the last 12 months BIDA has played a very proactive role in British medical politics, which was dominated by the Bawa Garba case. I'm pleased to report that BIDA played an important and appropriate role in this case. On behalf of all BIDA members I would like to thank our National Chairman Dr Chandra Kanneganti who has worked tirelessly to highlight the issues faced by BME Doctors on various fronts. Last year we had a very successful International Congress in Jakarta, Indonesia. This is down to the hard work of Dr Ashish Dhawan, our National Secretary and Congress Convenor and to his Co Convenor, Dr Leena Saxena (Chair, BIDA Women Doctor's Forum). As usual, the scientific sessions were highly educational and productive for BIDA members and all the credit for this goes to Dr Sanjay Arya, Chairman of the scientific committee and Dr Vinod Gadiyar, Co Chairman. One important question that is persistently raised by various divisions and BIDA grass roots members 'what does BIDA do for it's members?'. With the help of Central Office, we have summarised some of the important actions and activities BIDA has been involved with in the last 12months.

I would like to finish by wishing you all the best for 2019 and thank you all for supporting BIDA.

**Dr Birendra Sinha**
*National President, BIDA*

# What does BIDA do for its members?

- BIDA is fully engaged with all major stakeholders in British Medical politics:
  - General Practice Committee (GPC) of BMA
  - Consultants Committee, BMA
  - BME Council of GMC
  - RCGP, involved in various committees of GMC
  - CQC
- BIDA is a nominating body for the ACCEA awards
- BIDA played a major role in the campaign to secure justice for Dr Bawa Garba
- BIDA Actively campaigned to resolve the recent visa issues for overseas Doctors who had already been appointed and willing to come and work in the UK.
- BIDA has been calling for CQC to investigate the link between ethnicity and practice ratings.
- BIDA has many successful national meetings per year including: Annual Oncology conference, Obesity conference and National Doctors update meeting, along with frequent local divisional educational meetings.
- BIDA also organises International Congresses on a regular basis and also National sporting activities, including cricket, table tennis and badminton.
- BIDA holds an annual ARM/AGM. The format for the last 3 year's ARM has been changed to include a workshop on the Saturday afternoon. This has proved to be hugely popular. This year the theme was Gross Negligence Manslaughter / Culpable homicide. Esteemed guests included Dr Jenny Vaughan, Consultant neurologist and BME (Black, Minority & Ethnic) campaigner; Dr David Sellu, Campaigner and Consultant colorectal surgeon, convicted for gross negligent manslaughter, which has now been quashed and Dr Jonathan Leach, Medical Director and Vice Chair, RCGP. Our Chief Guest was Mr Leslie Hamilton, Chair independent review of GNM/CH (Gross Negligence Manslaughter/Culpable homicide).
- BIDA offers a mentoring programme for Doctors' who need guidance.

# BIDA National Chairman's Report

**Dr Chandra Kanneganti**
*National Chairman, BIDA*

**Dear Colleagues,**

It was busy last few weeks for the BIDA Executive committee.

I attended the appeal court judgment few weeks, which reinstated Dr. Hadiza Bawa Garba to practice again as MPTS recommendations. I have been interviewed by number of press colleagues and my comments along with BIDA's views about this are issue are publishes in number of national news papers. The victory for Hadiza is a victory for patient safety. We will continue to work with GMC and other stakeholders to work on the clinical negligence cases treated as GNM. BIDA has responded to Independent review commissioned by GMC on GNM led by Dr. Leslie Hamilton.

We had an excellent Annual AGM/ARM held at the Daresbury Park Hotel, Warrington, Cheshire WA4 4BB from October 12th-14th 2018 .We had an excellent program for this. Thanks to Merseyside and Cheshire division for organising this year's ARM and it was a huge success. Our chief guest for the occasion was Dr. Leslie Hamilton, Independent review lead on GNM who spoke about his review work and has responded to delegates' queries. We had inspirative speeches from Dr. Jennie Vaughan, Dr. David Sellu and Dr. Jonathan Leach. The panel discussion was very thought provoking and I am grateful to all delegates who participated in the event and made the event huge success. BIDA is proud to announce and award Jenny Vaughan for her enormous contribution in supporting international doctors. I am looking forward to our next year AGM in Blackburn.

BIDA International Congress was also a huge success in October 2018 in Jakarta and Bali. Thanks to Dr. Ashish Dhawan who has organised the event and Dr.Sanjay Arya who has compiled an excellent scientific conference for this. We would like to give our special thanks to Bolton Travels, who made the event a huge success.

BIDA has joined other like-minded organisations in 'Learn Not Blame' Campaign, which was launched in the House of Commons in November 2018, which I attended. BIDA is also proud to be part of 2 Facebook groups which we moderate with other organisations; "Learn Not Blame Group" and "The Consulting Room". Please join these groups.

**Dr Chandra Kanneganti**
*National Chairman, BIDA*

# BIDA National Secretary's Report

**Dr Ashish Dhawan**
*National Secretary, BIDA*

**Dear Friends,**

I would like to start by wishing you and your loved ones a happy and prosperous 2019. As the country enters into the New Year, the NHS keeps on struggling with the same old issues of staffing and funding. The latest 20 billion boost for NHS might be helpful in ecuring the future of the NHS in the short term.

2018 has been another very productive and year for BIDA. We had many Divisional and National meetings. The Annual ARM/AGM meeting hosted by Liverpool and Merseyside Division in October was once again very well attended. The weekend was packed with lots of interesting talks and workshops covering wide variety of topics. We discussed many relevant current resolutions that will be taken forward this year. Dr Biplab Das and his team deserve all the credit for putting up an excellent show.

We also hosted the 13th BIDA International Congress at Jakarta, Indonesia. This was attended by many members and once again proved to be one of the most popular events on 2018 calendar. I would like to take this opportunity to thank my Co-Convener, Dr Leena Saxena and Dr Sanjay Arya, Chairman of the Scientific Committee, for all their effort and hard work towards this Congress

The backbone of any organization lies in its members and the same holds true for BIDA. Myself and all members of BIDA EC strive to strengthen our organization by ensuring that our divisions are thriving and our membership keeps going upwards.

Finally, I would like to thank our Central Office staff Alison and Mandy for their hard work in keeping the office running smoothly.

Best wishes,

**Dr Ashish Dhawan**
*National Secretary, BIDA*

# BIDA National Treasurer's Report

**Mr Pranab K Sarkar**
*National Treasurer, BIDA*

**Dear Members,**

I would like to take this opportunity to wish you all a Very Happy and Prosperous New Year.

I would also take this opportunity to congratulate Dr Biplab Das and Dr Biru Sinha, Divisional President of Mersey & Cheshire Division for hosting a very successful AGM/ARM in October 2018.

In my previous report in this Journal, I indicated that in the financial interest of our organisation, it would be necessary to increase our annual membership subscription due to the fact that our annual income from our membership subscription showing a downward trend during the past few years while our expenditure has been gradually going up at the same. Following a careful assessment of our current financial circumstances, the members of the National Finance Committee and NEC supported this proposal. The delegates attending the last ARM/AGM approved that the annual membership subscriptions in all categories will be increased by 10% and to be effective from 1 October 2019. I am grateful to all the delegates, and the NEC Members for this supporting important proposal. I am confident that all our members will support and cooperate with the implementation of this important decision, as in absence of any 'reliable' income from external sources (donations or sponsorships), our other option would have been to 'cut' some of our services and activities in order to remain financially stable. Last time we increased our annual membership subscriptions was in 2013 at Glasgow ARM/AGM.

I am pleased to inform you that the NEC has approved to financially support the publications of BIDA Journal and updating cost of BIDA website. We are also committed to provide financial support to various educational meetings, professional activities and annual sporting activities e.g. BIDA President's Cup Cricket Tournament and Annual Badminton/TT Competition with a view to fulfilling our main objective to raise BIDA's profile regionally and nationally.

At the last NEC meeting, the members agreed that we would continue to reimburse delegates attending AGM/ARM and refund 10% of divisional membership subscriptions contributions from the central fund. In order to facilitate annual account preparation, I would advise the Divisional Treasurers or Secretaries to submit the claim to the central office by 28th February 2019. It may not be possible to process the claim after this date.

Our financial goal is quite straightforward – to Keep our finances in good health. This can be challenging when we are faced with a declining income and rising expenditure. As the National Treasurer, I feel that, in the interest of our organisation, we should have a money management strategy that would take into consideration that our expenditure does not exceed our overall income.

Finally, just when I have been thinking about efficient money management, I must thank Alison and Mandy at our central office, who have been trying their level best to keep our administrative expenditure under tight control by looking out for competitive and cost-effective contracts for running our business.

**Mr Pranab K Sarkar**
*National Treasurer, BIDA*

# BIDA GP Forum Chairperson's Report

**Dr Preeti Shukla**
*G.P. Forum Chairperson, BIDA*

**Dear Members,**

I hope everyone had a lovely break over the festive period and you are ready to face the challenges of the New Year.

As GP's we were hoping to get some relief from the introduction of state indemnity scheme in April 2019 but the announcement by government that state indemnity scheme is going to be funded from existing GP resources turned it to dust. The fact that GP partners would have to bear the cost of the scheme would add fuel to fire and more GP's will opt out of partnership. The numbers of partners have slumped by more than 4% from 19,576 to 19,342 according to recent figures.

To this effect I spoke in LMC conference in favour of the emergency motion that state indemnity should be funded by new money and no GP should be disadvantaged by this scheme, which was agreed unanimously by the delegates.

Another issue very close to my heart is 'last man standing scenario ' and I spoke on how it's stopping young GP's to take partnerships and forcing experienced GPs to opt for early retirement. This needs urgent remedial action as GPs who finds themselves in this situation run the risk of becoming bankrupt as they are responsible for settling the debts of the practice including but not limited to staff redundancies, premises cost & other financial liabilities. I hope that 'partnership review' led by Nigel Watson would offer solutions to this ludicrous scenario.

As always would continue to raise my voice for issues affecting general practice and thanks for all your support, really appreciate it.

**Dr Preeti Shukla**
*G.P. Forum Chairperson, BIDA*

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

**Miss Olivia McBride**
*Royal College of Surgeons, Nicolson Street, Edinburgh EH8 9DW*
**A Hartley, C Sanderson, D Riding, S Backhouse, J Evans, V Srinivasan**

# Bullying and Undermining Programme

*#LetsRemoveIt*

The link between undermining and bullying behaviour and patient safety has become clearer and less contentious over the past few years. Evidence that these behaviours have a negative impact on the workings of a team or unit are growing.[1] Whilst undermining and bullying extend beyond the specialty of surgery, it is important to recognise that being a surgeon requires far more than just technical expertise, but also the behaviours required to work with and lead a team. How we behave shapes the culture we work in, those we train and the profession as a whole.

In order to instigate change, one must define and understand the problem. Whilst numerous definitions of bullying and undermining exist, the core principles remain. A widely accepted definition is provided by the Advisory, Conciliation and Arbitration Service (ACAS); Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.[2] Undermining describes behaviour that has undermined professional confidence of self-esteem. According to the Equality Act 2010, harassment is defined as 'unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual'.

The problem of bullying, undermining and harassment is not isolated to surgery. The 2017 NHS England Staff Survey reported that 24.3% of all NHS staff had experienced these behaviours, equating to over a quarter of a million people.[3] In 2016, the Royal College of Obstetrics and Gynaecology (RCOG) provided their members and fellows with initiatives to tackle bullying. This was in response to almost half of surveyed Consultants reporting persistent bullying and a third labelling this as severe.[4] Furthermore, these problems are worldwide. In 2015, the President of the Royal Australasian College of Surgeons issued a public apology for the level of bullying, harassment and sexual discrimination that had been identified in surgical practice in Australia and New Zealand. This then led to the launch of their "Let's Operate with Respect" campaign.[5,6]

A survey of the Royal College of Surgeons of Edinburgh (RCSEd) own membership demonstrated the scale of the problem, with almost 40% of respondents reporting that they had experienced or witnessed such behaviour. The monetary cost of this behaviour to the NHS is overwhelming, with reports estimating this at £13.75 billion annually.[7] More importantly, the effect on patient safety is startling with one report attributing disruptive behaviour in the peri-operative area to 67% of adverse events, 71% of medical errors and 27% of perioperative deaths.[8]

The RCSEd have developed a comprehensive set of resources that are freely available for all healthcare professionals (www.rcsed.ac.uk/bullying). A CPD accredited e-learning module has also been developed, giving individuals more confidence in identifying and managing incidents of bullying, undermining or harassment. The #LetsRemoveIt Campaign has a significant web presence with almost 18,000 visits to the Bullying and Undermining section of the RCSEd website. Notably, the most visited elements on the website are "Resources to help change the culture" and "Are you a bully?". The commitment of the RCSEd to deliver the highest standards of education has led to the development of workshops on conflict resolution and bullying and undermining behaviours. A collaboration with the General Medical Council and the Royal College of Obstetricians and Gynaecologists has resulted in a joint learning module that will be delivered across the UK over the coming year.

To disseminate a positive message to members, fellows and the wider healthcare community, the RCSEd has set professional standards with regards to conduct in the workplace. Individuals are expected to:

1. Demonstrate exemplary professional behaviour in ensuring that they do not bully or undermine colleagues, either deliberately or inadvertently;
2. Adopt a zero-tolerance approach to bullying and undermining behaviour; and demonstrate to their colleagues that undermining and bullying is unacceptable when encountered;
3. Challenge and report bullying and undermining behaviour appropriately, whenever it is experienced or observed;
4. Identify, report and in if in a leadership role, where possible investigate allegations of bullying or undermining behaviour.
5. Ensure all colleagues are informed to identify and report undermining and bullying behaviour, both as a victim and an observer.
6. Contribute to or conduct investigations into allegations of bullying and undermining behaviour without prejudice to either the alleged victim or perpetrator, and must raise concerns about the conduct of such investigations if they are perceived to be prejudiced, compromised or insufficiently robust;
7. Demonstrate leadership by contributing to the development of local reporting systems that are effective and have the confidence of colleagues.

The RCSEd are committed to meeting the challenges facing our profession, to change the culture within surgery and build a safer, more respectful workplace that will be beneficial for patients, trainees and all our colleagues. The RCSEd are acutely aware that they cannot achieve these changes alone. Change will neither be immediate nor easy to achieve. A long-term coordinated set of collaborations will be required to deliver this impact.

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# Bullying in the NHS

## *From the Editor's Desk*

As a NHS worker have you asked yourself the question, ***"Do I feel valued as a human being working in the NHS?"*** A recent staff engagement survey shows it all: Private sector 90% said Yes, whereas in the NHS only 65% did.

Bullying is one of the major factors responsible for this perception. One in four experienced it last year, says the national staff survey. In turn it has an impact on sickness absenteeism, productivity and employment relations. When staff continue to work while being bullied they are more prone to making mistakes. Many decide to leave their jobs. Some cases lead to litigation and compensation.

A recent research using data from NHS Digital to gauge the impact of bullying estimated £2.28 bn as the cost to the NHS England. Cost is an obvious end result due to the consequences of bullying. One must try to understand the types of behaviours interpreted as bullying and monitor how staff feel about procedures in place to tackle the problems.

Dido Harding, Chair of NHS Improvement believes that, the high levels of bullying seen in the health service arise from shortcomings in management skills across the NHS. *"I suspect it's a real indication of an immaturity in the whole system in what good management looks like"*. She says, *"Good management isn't soft and fluffy – good management is about giving or having honest adult conversations. Bad management can often be interpreted as bullying."*

It's heartening to see that some steps have been taken to tackle it. There are pockets of good practice. Besides the Royal Colleges and the BMA almost all the Trust hospitals and Health Boards have set up their awareness programmes. It is essential for each NHS member, both in the medical and management teams, to remain civil to every other NHS worker. Penny Hurst and Joe Farmer's campaign "Civility Saves lives" preaches to practice this. Rudeness at work not only hits recipients but everyone around them. We must wholeheartedly support "#LetsRemoveit" campaign as advocated by the RCSEd.

**Amit Sinha**

*Co-Editor, BIDA Journal*

# PCSK9 Inhibitors

## *What do they do and do they work?*

**Dr. Oliver McConnell**
*Trainee SpR, Cardiology*
*North West Deanery*

**Dr. Ashish Dhawan**
*MD, MRCP*
*Co-Editor, BIDA Journal.*
*Consultant Cardiologist &*
*Cardiac Electro Physiologist,*
*Wigan Royal Infirmary*

**Hyperlipidaemia is a well-established risk factor for developing cardiovascular disease. Multiple randomized controlled trials have shown that lowering LDL levels correlates with reduced cardiovascular events. Currently statins are the cornerstone of treatment for lipid lowering but some patients continue to have events on maximal doses and others develop side effects that limit statin use. PCSK9 inhibitors are leading a new era of lipid lowering therapies.**

### *What is PCSK9?*

Proprotein convertase subtilisin / kexin type 9 (PCSK9) is an enzyme encoded by the PCSK9 gene on chromosome 1.

This protein plays a major regulatory role in cholesterol homeostasis, mainly by reducing LDL receptor (LDLR) levels on the plasma membrane. Reduced LDLR levels results in decreased metabolism of LDL-particles, which can lead to hypercholesterolemia.

### *Are there any other effects of PCSK9?*

PCSK9 is highly expressed in arterial walls such as endothelium, smooth muscle cells, and macrophages, with a local effect that can regulate vascular homeostasis and atherosclerosis.[1]

It is well known that PCSK9 is pro-atherosclerotic in its regulatory effects of lipids.

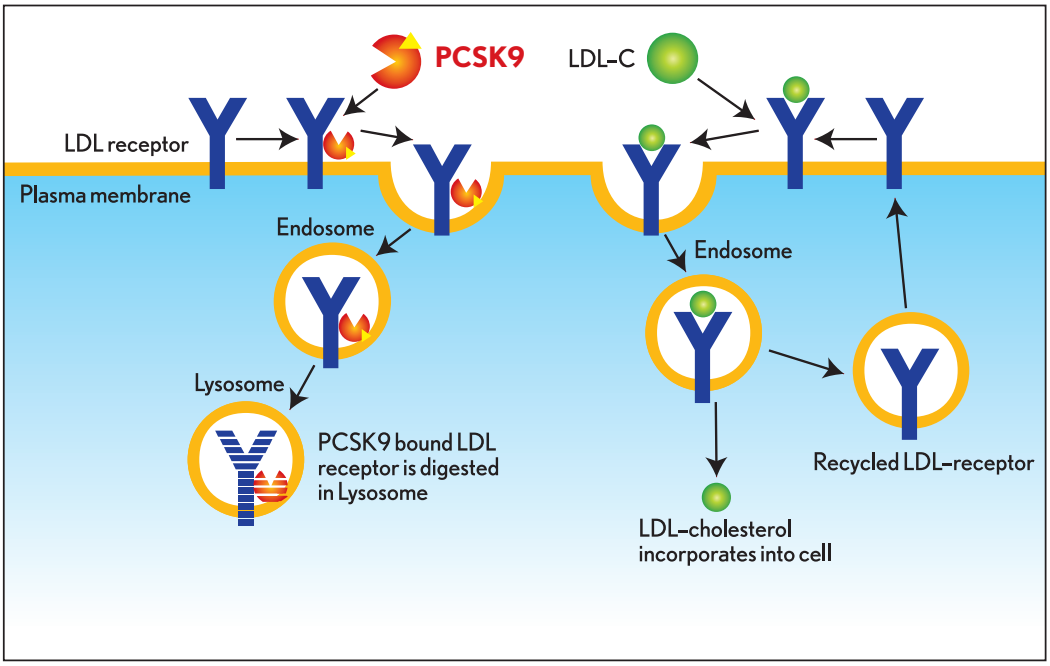
In addition to its lipoprotein synthetic and pro-atherosclerotic effects, PCSK9 is involved in glucose metabolism and obesity, [2] regulation of re-absorption of sodium in the kidney which is relevant in hypertension. [3] PCSK9 is also thought to be involved in both bacterial and viral infections and sepsis. [4] In the brain the role of PCSK9 is still controversial and may be either pro-apoptotic or protective in the development of the nervous system. [5]

### *How do PCSK9 inhibitors work?*

LDL-particles are removed from the blood when they bind to LDLR on the surface of cells. When PCSK9 binds to an LDLR, the receptor is destroyed along with the LDL particle. PCSK9 degrades LDLR by preventing the hairpin conformational change of LDLR.[6] If PCSK9 does not bind, the receptor will return to the surface of the cell and can continue to remove LDL-particles from the bloodstream.[7]

Hence inhibition of PCSK9 will allow LDLR to be recycled to the cell surface and continue to remove LDL cholesterol.

PCSK9 inhibitors are monoclonal antibodies that are given by subcutaneous injection every 2 weeks. They are delivered to patients' homes directly and they self administer the injections with regular follow up and monitoring of lipids.




### *Clinical trials*

The ODYSSEY LONG TERM trial [9] was published in the New England Journal of Medicine in April 2015 . The trial was designed to obtain longer-term data on safety and reduction in LDL cholesterol levels. It also looked at post hoc analysis of cardiovascular events.

The PCSK9 inhibitor in this series was alirocumab. The trial assigned 2341 high-risk patients to either the PCSK9 inhibitor alirocumab or placebo. As compared with placebo, alirocumab reduced LDL cholesterol levels by 62% at 24 weeks, with a consistent reduction over a period of 78 weeks of treatment. In a post hoc analysis, there was evidence of a reduction in cardiovascular events with alirocumab.

# PCSK9 Inhibitors

## *What do they do and do they work?* (Continued)

### *NICE Guidelines*

The national institute for clinical excellence (NICE) have put strict controls on the criteria for prescribing of PCSK9 inhibitors in view of their high cost. NICE have estimated annual cost of treatment per patient is £4,383. The have created the following treatment recommendation: -

| | Without CVD | With CVD | |
|---|---|---|---|
| | | High Risk of CVD[A] | Very High Risk of CVD[B] |
| **Primary non-familial hypercholesterolaemia or mixed dyslipidaemia** | Not recommended at any LDL-C concentration | Recommended only if LDL-C concentration is persistently above 4.0 mmol/litre | Recommended only if LDL-C concentration is persistently above 3.5 mmol/litre |
| **Primary heterozygous-familial hypercholesterolaemia** | Recommended only if LDL-C concentration is persistently above 5.0 mmol/litre | Recommended only if LDL-C concentration is persistently above 3.5 mmol/litre | |

[A]High risk of CVD is defined as a history of any of the following: acute coronary syndrome (such as myocardial infarction or unstable angina needing hospitalisation); coronary or other arterial revascularisation procedures; chronic heart disease; ischaemic stroke; peripheral arterial disease.

[B]Very high risk of CVD is defined as recurrent cardiovascular events or cardiovascular events in more than 1 vascular bed (that is, polyvascular disease).

Abbreviations: CVD, cardiovascular disease; LDL-C, low-density lipoprotein cholesterol.

*Above: A table showing NICE's treatment recommendation.*

### *Real world experience of PCSK9 inhibitors*

Our experience of PCSK9 inhibitors was with in a district general hospital which runs a regional lipid clinic for challenging hyper-lipidaemia and FH patients. This serves a population of around 1,000,000 in the north west of England. Patients who met the criteria for PCSK 9 inhibitors were prescribed alirocumab.

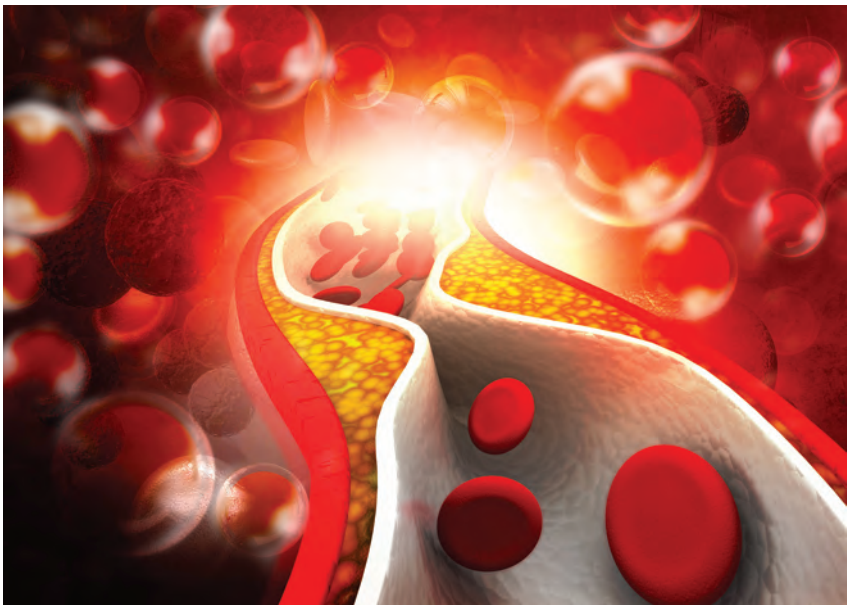
In total 24 patients were successfully started on alirocumab over a 12 month period.

The average age of patients was 57. 54% of patients were male. 30% of the FH patients had previously had a cardiovascular event at initiation of treatment. All patients were on the maximum tolerated dose of lipid lowering therapy (LLT).

Of those started on alirocumab, 63% of were intolerant to high dose statins with 46% being intolerant to all statins.

Three people discontinued the drug due to intolerance. However, there was an average 49% reduction in low density lipoprotein (LDL) cholesterol levels from baseline on maximal tolerated dose of LLT.

In our experience, the reduction in LDL seen in a real world setting with alirocumab mirrored that of the reductions seen in the clinical trials. It proved to be a well-tolerated, effective method of reducing LDL cholesterol along-side maximum tolerated doses of lipid lowering therapies.



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# Maternal Sudden Death in Pregnancy due to Cardiac causes – are they preventable?

**Mr Pranab K Sarkar**
*MBBS, MRCOG, MOG, FRCOG*
*Consultant Obstetrician & Gynaecologist*
*Blackburn, Lancashire*

## Introduction

**Over the past decades, a steady decline in maternal mortality among women of reproductive age has been observed in the western world [1]. However, despite significant improvements in the standards of care for women during the antepartum, intrapartum and postpartum period, this tragic event continues to remain a serious clinical challenge to the professionals.**

In recent years cardiovascular disease has emerged as the leading cause of maternal death during pregnancy and in the postpartum period both in the developing and developed countries [2]. The latest confidential enquiries into maternal deaths report in the United Kingdom and Ireland, the fourth in the annual report format, and the first to repeat the 3 yearly thermic cycle, published in December 2017 includes surveillance and confidential enquiries covering the period 2013-15 [3]. This topic specific review report into the care of women who died from haemorrhage, amniotic fluid embolism, sepsis, anaesthetic complications, neurological conditions and other surgical and medical conditions revealed that although overall there was no change in the maternal death rate in the UK between 2010-12 and 2013-15, which is now 8.76 per 100 000 maternities (95% confidence interval 7.59-10.05), the cardiac disease was found to be the leading cause of indirect maternal death during or up to 6 weeks after the end of pregnancy with a rate of 2.34 per 100 000 maternities (95% CI 1.76-3.06). The previous MBRRACE UK report 2016, the 3rd of CEMD annual reports which included data on surveillance of maternal deaths between 2012-2014 did show similar picture in that the cardiovascular disease was found to be the leading causes of indirect maternal death during or up to 6 weeks after the end of pregnancy with overall no statistically significant decrease in the Maternal death rate in the UK between 2009-2001 and 2012 -2014. A retrospective review of maternal deaths while pregnant or within 1 year of pregnancy between 2002 and 2006 in the USA also revealed that a significant proportion (25 %) of all maternal deaths was attributed to cardiovascular disease [4].

Most recently Sudden Arrhythmic Deaths syndrome (SADS) has been identified as the main cause of maternal sudden death in pregnancy or in the postpartum period [5]. In this study, 50% deaths were during pregnancy and 50% were postpartum. The main cause of death was sudden cardiac death with a morphologically normal heart in 43 out of 80 cases (53.75%), followed by cardiomyopathies in 11 patients (13.80%) (table 1).

| Cause of death | Total | % Cohort |
|---|---|---|
| Morphological normal heart | 43 | 53.75 |
| Cardiomyopathy | 11 | 13.80 |
| Dissection of aorta or its branches | 7 | 8.75 |
| Congenital heart disease | 2 | 2.50 |
| Valvular diseases | 3 | 3.75 |
| Floppy mitral valve | 2 | 2.50 |
| Mitral stenosis | 1 | 1.25 |
| Miscellaneous causes | 14 | 17.50 |

*Table 1: Cardiovascular causes of maternal death (Krexi and Shephard, 2017)*

## Patients' characteristic and Risk factor for SADS

Significant risk factors of maternal death due to cardiac disease are older age, high BMI and family history. These risk factors should be taken into consideration in clinical obstetric practice [5]. Sudden cardiac death is more likely to happen in older female especially women older than 35 years rather than in the younger women [5,6]. High BMI (obese or overweight) is a risk factor for maternal sudden cardiac death and this should be taken into account in clinical practice. High percentage of obese pregnant women (59.18 percent) has been found to suffer sudden cardiac death. High BMI, as a risk factor, has not been associated with the age of the woman.

A history of sudden young female death in the family is very important. Women with such history would need for family screening until proven otherwise as channelopathies have been identified in up to 50% of families [7].

Circumstances leading to maternal death were interesting in that majority of death occurred mainly at rest (71.30 %) and the rest in sleep (12.5%). Women who died in sleep were under 35 years old [5].

Symptoms suggestive of cardiac disease were noted in cases immediately prior to death. A significant proportion of women (37.50%) were symptomatic with one or more cardiac symptoms which were chest pain, shortness of breath, syncope/collapse, dizziness and palpitations [5].

## Discussion

***Maternal Mortality (MM)*** is defined by the WHO (2004) as the death of a woman while pregnant or within 42 days of end of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (from direct or indirect obstetric death) but not from accidental or incidental causes.

***Direct MM*** is defined as a maternal death resulting from obstetric complications of the

# Maternal Sudden Death in Pregnancy due to Cardiac causes – **are they preventable?**

pregnancy state (pregnancy or labour or puerperium) from their interventions, omissions, incorrect treatment of from a chain of events resulting from any of above.

Whereas, ***Indirect MM*** is defined as a pregnancy related death in a female patient resulting from with a pre-existing disease or a disease that newly developed during pregnancy and which was not due to the direct obstetric causes, but which was aggravated by the physiologic effect of pregnancy. ***Maternal mortality rate (MMR)*** is defined as the annual number of woman's deaths per 100,000 live births from any causes related to or aggravated by pregnancy or its management excluding accidental or incidental causes.

Cardiovascular disease has now been established as an important contributor to maternal mortality worldwide. In the UK, maternal cardiac deaths are due mainly to SADS which as an important cause of maternal death has only recently been recognised. Maternal deaths due to SADS, however, may not be so rare as successive confidential enquires into maternal death in the UK in recent years have reported cases of SADS as the cause of death since this was first reported in 2002. An electrical disturbance in the channelopathies in a morphologically normal heart has been suggested as the possibility of death in women who died of SADS [8].

It has been suggested that some of these deaths are preventable if diagnosed early. Therefore, there is now a compelling reason for the professionals to be more aware of the risks of sudden maternal deaths due to cardiac diseases and pay particular attention to the risk of cardiac conditions that may contribute to maternal deaths.

Caring for women with cardiac disease in pregnancy can be challenging. Considering the gradual rate of decline, achieving the government's aspiration of reducing maternal death by 50% by 2030 will be a big challenge for UK health services, requiring coordinated action across multiple specialities.

It has been concluded that 'there remain multiple opportunities to reduce women's risk of complications in pregnancy through early and forward planning of the care of women with known risk factors. Provision of appropriate advice and referral early in pregnancy for appropriate specialist advice concerning risks, the need of cardiological screening of the family as a result of the diagnosis and planning for future pregnancies are the key improvements needed to prevent women dying needlessly or having severe complications in the future [3]'.

## *Lessons on cardiovascular disease from MBRRACE-UK (Maternal and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Update*

The latest UK and Ireland confidential enquires into maternal death and morbidity (MBRRACE-UK 2017) report has highlighted the following lessons learnt from the investigation;

### *Interdisciplinary Team Work and Inadequate Communication*

Lack of co-location of obstetric and cardiac services jeopardises interdisciplinary working and communication. Measures such as joint obstetric clinics, multidisciplinary care plans, copying letters to the woman and all clinicians involved in her care as well as staff from all specialities writing in the woman's hand-held notes may mitigate against the inherent risk of inadequate communication between specialities.

### *Multidisciplinary Involvement*

Early involvement of senior clinicians from the obstetric and cardiology multidisciplinary team is vitally important, whether a pregnant or postpartum woman presents with suspected cardiac disease, but particularly if she presents to the emergency department.

### *Clinical Awareness*

Staff should be aware that a raised respiratory rate, chest pain, persistent tachycardia and orthopnoea are important signs and symptoms which should always be fully investigated. The emphasis should be on making a diagnosis, not simply excluding a diagnosis. A normal ECG and or a negative

Troponin does not exclude the diagnosis of an acute coronary syndrome.

### *Family screening*

Women who die from sudden cardiac arrest and who have a morphologically normal heart should have molecular studies at post-mortem with the potential for family screening. Future sudden deaths amongst relatives may then be prevented.

### *Counselling*

Pre-pregnancy counselling should be available both within the paediatric transition service and to women of childbearing age with known cardiac disease. This should include appropriate contraceptive service advice. The need for more effective pre- or postpartum counselling of women is high-lighted.

## *Key topic specific messages for care:*

Health professional involved in maternity care should be aware that there may be a sign of an underlying problem in women with cardiac disease.

Obstetric community should be aware of SADS and the increased risks during pregnancy and afterwards.

Women with cardiac disorders with or without risk factors should have a clear care plan for an appropriate schedule of checks with more clinic visits than those for low risk pregnant women.

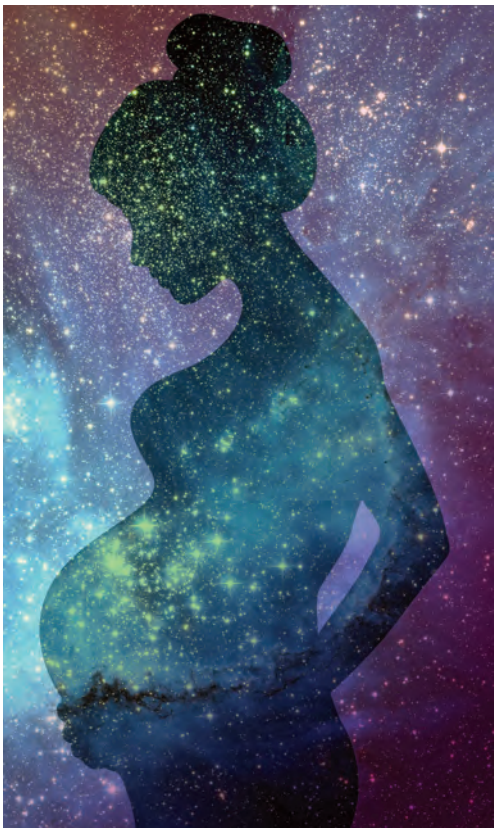
Women with prosthetic valves in pregnancy are at extremely high risk and should be referred to specialist centres early. They need an expert obstetrician, haematologist, cardiologist and anaesthetist input.

New onset of symptoms suggestive of cardiac diseases should be considered for prompt referral to a consultant unit for urgent assessment and treatment with clear communication between health professionals.

Pregnancy may precipitate the first presentation of cardiac arrythmia and point to an underlying channelopathy or the patient may already be aware of such a diagnosis in herself or other family members.

All consultant led maternity unit should have ready access to an ECG machine and someone who can interpret ECGs. Similarly, Echocardiogram, performed by a competent practitioner should be available 7 days a week.

A history of sudden young death in the family is very important. The risk of pregnancy must be considered, and obstetricians are made aware of the family history or previous diagnosis. Arrhythmias in pregnancy or post-



partum period, may be a recurrence of a previously diagnosed arrhythmia, but there may be no previous history of arrhythmia or a diagnosis of a channelopathies [9]. Women with risk factors need cardiac screening by a cardiologist with special interest in electrophysiology. A detailed past family history of sudden deaths or cardiac arrhythmias is essential and screening of other family members is indicated to avoid further deaths since these entities are commonly inherited.

When delivery is planned, for foetal reasons, in a different unit to where women received their usual antenatal care, women's own health issues were often overlooked. In pregnant or postpartum women with complex cardiac problems involving multiple specialities, their responsible consultant obstetrician or cardiologist must show clear leadership and be responsible for coordinating care and liaising with anaesthetists, midwives, other physicians and obstetricians, and all other professional who need to be involved in the care of these women.

These women may require additional care following discharge from hospital and There is a need for senior review prior to discharge, with a clear plan for the postnatal period. The senior review should include input from obstetricians and all relevant colleagues.

After pregnancy, care should be clearly handed over to women's GPs.

Service delivery issue in particular staffing and workload imbalance has been implicated as possible contributing factor to maternal deaths. However, an impact of this on women's deaths yet to be to be established.

## *Conclusions*

The latest research evidence has revealed cardiac disease as the leading cause of Indirect maternal death during or up to 6 weeks after the end of pregnancy in the United Kingdom [3]. Recently, Sudden Arrhythmic Death Syndrome (SADS) has also been recognised as the main cause of maternal sudden cardiac death in pregnancy or in the postpartum period [4]. It has been suggested that maternal deaths due to cardiac disease may be preventable if diagnosed early or may be avoided by better care [4]. In this respect identification of a number of significant risk factors and a strong family history closely linked to maternal sudden cardiac deaths (SADS) can be extremely valuable in caring for pregnant women. Accordingly, it cannot be over-emphasized that there is an urgent need for raising professional awareness of this frequently under-diagnosed clinical condition leading to sudden cardiac death in women during pregnancy and postpartum.

The epidemiological evidence of a declining trend in the overall maternal death in the UK is encouraging and is a testimony to the high standard of care provided by the healthcare professionals. Although the situation has been improving, more needed to be done in order to prevent the recurrences of tragic deaths from cardiac disease which in recent years has emerged as the leading cause of maternal death in pregnancy.

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# 13th BIDA International Scientific Congress

## 22nd & 23rd October 2018, Jakarta, Indonesia

**Dr Sanjay Arya**
*Chairman, Scientific Committee,*
*13th BIDA International Congress*
*Consultant Cardiologist & Medical Director*
*Wrightington, Wigan & Leigh NHS Foundation Trust*

*Dear Colleagues*

The 13th BIDA International Congress was successfully held in Jakarta, Indonesia on the 22nd and 23rd October 2018. The Scientific Congress was approved by the Federation of the Royal Colleges of Physicians of the United Kingdom for 9 category 1 (external) CPD credits.

BIDA International Congress has been very popular among our members. It is an important event in the diary of our organisation and has always been oversubscribed. We had a high-quality two day scientific programme covering major topics in health-care. The conference gave us the opportunity to interact with speakers who are experts in their own fields. It enabled the health-care professionals to keep up-to-date with important research, learn directly from experiences of the specialists, share best practices and develop new skills and techniques. I am sure this will have a direct impact on our daily clinical practice, helping us to deliver high quality and safe care to our patients.

I would like to express my gratitude to the distinguished speakers and the chairpersons for their contribution to the Scientific Congress. My special thanks to Biro Sinha, National President, Chandra Kanneganti, National Chairman, Ash Dhawan, National Secretary & Convenor, Leena Saxena, Chairperson Women's Doctors Forum & Co-Convenor and Vinod Gadiyar, Chairman Hospital Doctors Forum & Co-Chairman of the Scientific Congress for their support in laying out the agenda for the Scientific Congress.

Hope to see you all at the next BIDA International Congress in 2019.

**Dr Sanjay Arya**

*Chairman, Scientific Committee,*
*13th BIDA International Congress*


# Abstract Presentations

## Mr Amit Sinha

Consultant Orthopaedic Surgeon, Spire Yale Hospital, Wrexham

### Clinical dilemmas: Can somebody help me, please?

Are there times when it is acceptable to cover up or avoid revealing a mistake if that mistake would not cause harm to the patient? What if the mistake is potentially or likely to cause harm to the patient? Would you wait until the danger period passed away or reveal your mistake early on and cause unnecessary emotional upset to the patient and the whole family. A "Wait and watch approach" may be considered by some. Others would have a dogmatic view that "Covering is lying". What is yours?

Ethical dilemmas around medical information frequently involve conflicts between the duty to inform and to respect patients' rights to autonomy. When more people, in particular the partner or the family or the parents of a sick child have a say in medical issues, conflicts regarding solutions of complex medical problems obviously become more frequent. Information should be seen as a vital part of patient care, but similar to a drug it should be individualised and handled with competency.

In our day-to-day professional career, we come across situations, which are unique and complex enough to create an atmosphere of uncertainty. In these situations lack of communication, missing clear signals, wrong clinical judgements, attempts to hide relevant facts quite often leads to disastrous consequences. This talk presents a series of medico-legal/ethical dilemmas for all of us to understand, discuss and make appropriate decisions, which would be considered safe and appropriate for our patients.

## Dr Shikha Pitalia

General Practitioner, Director SSP Health.

### The changing face of General Practice

On the 70th anniversary of the NHS, General Practice, its traditional 'gatekeeper', remains the strongest link in robust healthcare. However, Primary Care is transforming into a new entity. What options are there for the traditional model of General Practice to remain viable in this current environment - Integrated care, Accountable care organisations, Federations, Super-practices? Where does the future lie?

Dr Pitalia is Director of SSP Health, leading the largest corporate practice in the North West England, working across 10 CCGs and 4 NHS England teams, caring for circa 140,000 patients. Founded in 2002, SSP Health has led the evolution of one of the most successful models for sustainable General Practice. How can embracing change support practices to meet the challenges of the 24/7 demands of our patients and commissioners?

In an arena of complex co-morbidities, polypharmacy and an increasingly elderly population, we have a workforce crisis and financial pressures from all directions. Dr Pitalia will share some examples of how General Practice can work differently and survive this onslaught of ever-increasing demands. Simple yet innovative solutions of working together can improve access, help achieve targets, reduce costs and hopefully improve your work: life balance!

## Dr Birendra Jha

Associate Specialist, Care of the Elderly, Upton Hospital, Slough

### Polypharmacy in the Elderly

Polypharmacy, defined as prescription and administration of more than five medications at the same time, first appeared in medical literature more than 150 years ago. In the past ten years the average number of prescription for each person per year increased by 53.8% from 11.9% in 2001 to 18.3% in 2011.

A study of more than 300,000 patients found that between 1995 and 2010 the proportion of patients receiving five or more drugs increased from 12% to 22% and proportion receiving 10 or more drugs rose from 1.9% to 5.8%. Figures are higher in the elderly with one in six patients over the age of 65 receiving 10 or more drugs.

Polypharmacy can lead to serious adverse events. 5 to 17% of hospital admissions are caused by adverse drug reactions. The physiological and pathological changes of ageing put elderly patients at a much higher risk of multimorbidity and treatment related complications. Polypharmacy particularly affects those with poor communication, cognitive issues, deafness, poor eye sight, over the counter medications and multiple prescribers.

Aarson et al have proposed the term appropriate polypharmacy and problematic polypharmacy. This classification distinguishes the sides of the same coin. Polypharmacy on one hand has the potential to be beneficial for some patients but can also prove harmful if poorly managed. There is lack of pharmacokinetics and pharmacodynamics data from drug trial in the elderly.

Drugs that have been started in hospital should be reviewed regularly by the whole MDT and not only by pharmacists to avoid sending patients home on unnecessary medications. It is difficult to foresee the drug-drug interactions and adverse drug reactions. It is important to identify Polypharmacy so that patients and their caregivers can be given better information, so as to increase awareness of the dangers of polypharmacy without deterring compliance.

De-prescribing is challenging and needs a multidisciplinary effort. In some circumstances polypharmacy can be appropriate, but needs concerted management such as regular laboratory tests. In many circumstances the involvement of clinical pharmacists is key. Whereas some degree of adverse effects may be unavoidable, their severity or incidence can be significantly reduced through regular intervention and educating patients. De-prescribing is a happiness pill for the doctor and patient.

## Dr Ashish Sukthankar

Consultant in Genitourinary Medicine, Manchester Royal Infirmary.
Manchester University Hospitals NHS Foundation Trust.

### HIV and the Primary Care Physician

Over the past 30 years HIV Medicine has evolved dramatically. The epidemiology in the world and in the UK has shown significant changes resulting in paradigm shift not only in the diagnosis and treatment but also in prevention strategies. The British HIV Association has recently published the findings from the Primary Care Project which investigated the role of the Primary Care Physician in the delivery of high-quality healthcare for people living with HIV and the integration of care across both primary and specialist services.

There is increasing emphasis on reducing late diagnosis by increasing HIV testing in various healthcare settings including primary care. It is also important to understand the changes in risk behaviour resulting in HIV transmission such as chemsex. This talk will focus on these challenges and how the primary care physician can adapt their practice to improve diagnosis, stay abreast of advances in prevention (Pre and post exposure prophylaxis against HIV infection) and develop their knowledge of current HIV treatment modalities/strategies and understand their role in the shared care of HIV positive patients.

There are around 104,000 people living with HIV in the UK and over half of these are now over the age of 45. The holistic care of these patients involves close communication between the specialists and primary care physicians with particular emphasis on drug interactions, mental health, screening for cancers, poly-pharmacy and management of co-morbidities such as diabetes, hypertension & hyperlipidaemia. This talk will also explore the importance of reducing stigma and overcoming barriers such as concerns about confidentiality in primary care.

## Dr Sayeed Ahmed

Consultant Anaesthetist, Intensive Care Unit, Wrightington Wigan & Leigh NHS Foundation Trust

### ICU Survivors in the Community

Admission to the ICU is one of the most traumatic/stressful events in life. Patients who are admitted to ICU and discharged into the community most often face a very difficult and long journey. The period of recovery and rehabilitation after discharge can be protracted and most often the family bear a significant proportion of the burden as they readjust to their life in the community. Dealing with such changes and adapting to facilitate day to day activities can be tough.

Patient Support Groups can help with the transition by providing advice, support and lessening the load. Patient Support groups are vital for providing continuing support for patients and relatives but do not necessarily receive funding or support from ICUs. There does not appear to be one model which meets all the needs so what has emerged is guidance on a range of common components or elements that can assist in the establishment of a Support Group which can be tailored to meet local circumstances and needs.

This talk looks at the real life experiences of these patients in the community post discharge. The aim is to shed some light about the problems and support that the community based services such as the Support groups and GP services can provide to this group of patients. It is hoped that advertising / education within GP surgeries may potentially increase uptake of the service.

## Dr Ram Karan Singh

Consultant Anaesthetist, Queen Elizabeth Hospital, Gateshead, NE9 6SX

### Prehabilitation- preparing patients for surgery

Nearly 10 million surgeries are performed in the UK per year of which 15% belong to high-risk categories, contributing to 85% of surgical mortalities. Major surgery can be compared with running a marathon since both are risky and require a lot of preparation for a good outcome.

Prehabilitation is the process of enhancing a patient's functional capacity to enable them to withstand a forthcoming stressful event, e.g. major surgery. It is multimodal in its approach and includes pre-operative physical exercise, nutritional support, psychological support, lifestyle choices (smoking, alcohol intake, weight optimisation) and medical optimisation of morbidities such as diabetes, heart failure, anaemia, COPD, hypertension etc.

An exercise programme could be tailored to the patient's physical ability and could be home-based or hospital-based depending on resource availability or the patient's convenience. Telephonic encouragement is the key to success of the programme. Frailty and malnutrition delay wound healing and increase risks of infection, and proper nutritional support is required for good surgical outcome.

The Physician's involvement is paramount in optimising pre-operative morbidities such as diabetes, anaemia, heart conditions and chest problems. They also play a very important role in diagnosing and treating post-operative complications. Anxiety and depression are not uncommon before surgery and require good explanation, an approach with empathy and sometimes a psychiatrist's help.

Prehabilitation is an upcoming paradigm. Evidence is emerging in support for this programme. However, there is a paucity of resources in the stretched NHS. Additionally, we need to learn how best to use this tool for best outcome. Hopefully prehabilitation may play a significant role in future in the management of high risk patients.

# Abstract Presentations

## Dr Veena Jha

General Practitioner, Glossop & Hadfield, Manchester

### Primary and Secondary Care Interface – The Challenges

Good medical practice dictates that primary and secondary care clinicians communicate clearly and effectively with each other to provide a seamless and high quality care to their patients.

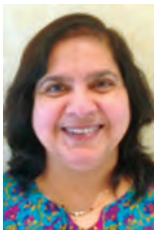
Due to the involvement of multiple healthcare professionals and healthcare agencies in the transmission of the information from the secondary care to the primary care clinicians, it is immensely important that fail-safe systems are put in place to prevent any gap in information or any misinformation.

Effective communication between the two clinicians, either following acute admissions or following routine outpatient appointment is essential as inadequate information, misinformation or lack of information can lead to unintended harm to patients which may be irreversible and serious at times.

I worked in secondary care for many years before moving into in general practice fifteen years ago. I feel that I have an insight into working in both healthcare settings. I would like to present some real but anonymised cases to the audience consisting of colleagues from both primary and secondary care. This will give us an opportunity to discuss how these cases could have been managed differently to achieve better clinical outcomes for these individual patients.

I would expect a brainstorming session between the Primary and Secondary care clinicians which will not only smoothen the interface but also help us achieve a common goal of providing the best care to our patients.

## Dr Shaila Sukthankar



Consultant Paediatrician, Royal Manchester Children's Hospital.

### Easily Missed, Pitfalls in Paediatrics

In this session, we will visit common presentations of symptoms and signs in children that may sometimes indicate rare yet life threatening conditions, and how we could avoid situations of misdiagnosis or missing the diagnoses - Noddy's guide to detecting the red flag clinically critical signs for timely intervention and referral.

Common presentations of illness in infants and young children include cough, cold, shortness of breath, vomiting +/ - diarrhoea, reduced feeding/ refusal to feed, irritability and excessive crying, rashes, fever with undefined focus, and fits, faints and funny turns. In older children, the common presentations include headaches, lethargy, loss of appetite/weight, aches and pains, lumps and bumps and fever. Most clinicians are familiar with common life-threatening paediatric conditions like Meningococcal sepsis, DKA, status asthmaticus and status epilepticus etc.

Rare conditions are defined by their incidence, which may be based on the geographical location and population demographics. Their definition may also reflect personal experience, interests and patient cohort being treated within regular practice. Rare but not life-threatening conditions such as progressive neurodegenerative diseases, some endocrine, metabolic or MSK disorders often do not warrant urgent intervention and there is often enough time to think and consult with the specialists for best way to investigate and manage.

However, the focus of this talk is on "how to survive, not sink"! We will have a clinical case-based discussion and illustration of pitfalls to avoid when faced with rare and yet serious medical and surgical conditions in children. We will discuss differential diagnosis, symptom characteristics and clinical signs that will help our audience to consider life threatening and / or urgent paediatric pathology requiring prompt intervention and referral to hospital. These conditions include surgical abdomen, orthopaedic emergencies, and rare medical diagnoses that warrant prompt recognition and management in both primary and secondary settings.

## Dr Anita Sanghi

Consultant Obstetrician & Gynaecologist. Divisional Director Womens' & Children, Royal London Hospital, Whitechapel, Caldicott Guardian Barts Health NHS Trust

### The Management of Heavy Menstrual Bleeding

Heavy Menstrual bleeding (HMB) is defined as "excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It can occur alone or in combination with other symptoms". HMB is one of the most common reasons for gynaecological consultations in both primary and secondary care. About 1 in 20 women aged between 30 and 49 years consult their GP each year because of heavy periods or menstrual problems, and menstrual disorders comprise 12% of all referrals to gynaecology services. In the UK 20% of women have hysterectomy before the age of 60, mainly to alleviate heavy bleeding.

The prevalence of menorrhagia increases with age, peaking in women aged 30–49 years. The aetiology, diagnosis and treatment will be discussed. Many women presenting to primary care with HMB will only ever require simple treatment without the need for further investigations. However, some women with HMB may have an underlying pathology, which is often not apparent from the woman's history or examination and further investigations to identify the cause may be needed. The aim of investigation is to identify structural abnormalities such as submucosal fibroids, larger fibroids or adenomyosis, and to also detect rare and potentially serious pathologies such as endometrial hyperplasia or carcinoma.

The recommendations of NICE guideline (March 2018): Heavy menstrual bleeding - assessment and management" (NG88) and how this differs from previous NICE guideline will be discussed. The guideline is a partial update of the 2007 NICE guideline (CG 44) on Heavy Menstrual Bleeding: assessment and management. The guideline's main aim is to help healthcare professionals to advise each woman with HMB about the treatments that are right for her, with a clear focus on the woman's choice.

Some interesting case studies will be presented.

## Dr Pamadeth Shobha MBBS MRCPsych

Consultant Psychiatrist, Kent Institute of Medicine and Surgery, Maidstone, Kent.
Royal College MRCPsych Examiner & Consultants Appraiser

### Anxiety Disorders - Management and Treatment

Anxiety disorders are the most common type of mental health disorders. Overall about 10 to 20% patients presenting to primary care will have symptoms of anxiety disorders. Anxiety disorders are more common in females. The common anxiety disorders include generalised anxiety disorder, panic disorder, OCD, phobias and post traumatic stress disorder. Anxiety disorders are associated with a wide range of psychiatric and medical disorders as a co-morbid condition.

Despite the high prevalence rates, anxiety disorders are often under-recognised and untreated. Anxiety disorders have been associated with significant long term disability with relapse and remissions leading to not only a substantial burden for the patients and families but also a huge economic burden to the Society.

Recovery is possible with appropriate treatment which usually consists of a combination of pharmacological management and / or psychological intervention. A range of additional anxiety management techniques are also found to be helpful.

The choice of drug treatment or psychotherapy depends on several factors including patient choice and motivation, the skills and expertise of the treating clinician, the availability of local resources and the presence of co- morbid medical or psychiatric conditions.

In terms of pharmacological treatment, SSRIs and SNRIs are the most commonly recommended drug treatment followed by Tricyclics. Benzodiazepines are only recommended as a very short term treatment for acute anxiety state. Pregabalin and Buspirone have also been found to be effective in some patients. Psychological management include Cognitive behavioural therapy (CBT), inter personal therapy and supportive therapy. CBT is the most recommended evidence based treatment.

## Mr Mukesh Hemmady

Consultant Orthopaedic Surgeon, Wrightington, Wigan & Leigh NHS Foundation Trust

### The Management of Hip Pain in Adults in General Practice

Hip pain is one of the most common musculoskeletal problems encountered in primary care. In adults this can be in the acute setting or indeed seen as a chronic problem. Whilst fractures of the proximal femur generally present to the A&E, undisplaced stress or pathological fractures may present to the GP as ongoing hip pain.

Although primary osteoarthritis of the hip is by far the commonest cause of adult hip pain, conditions like femoroacetabular impingement is being increasingly seen in young active adults like runners, footballers etc. This may present either as a labral tear or as a cam/pincer type impingement which after clinical diagnosis will need special investigations for confirmation of diagnosis and treatment may involve hip arthroscopy.

Another group of conditions that present commonly in general practice are under the umbrella diagnosis of lateral hip pain which includes trochanteric bursitis, abductor tendinopathy, IT band syndrome etc. If physiotherapy and analgesics fail to improve the situation then the patient may have to be referred to secondary care for shock wave therapy. Other conditions which are not that frequently seen in primary care like AVN of the femoral head, metastatic disease etc will also be discussed in this presentation.

## Dr Uday Kanitkar

General Practitioner. Undregraduate Tutor and GP ST Trainer, Leyland, Preston

### Managing Shoulder Pain in General Practice

Shoulder pain is the third most common site of pain after back and knee. In any one year, one in 40 people will consult their GP with shoulder pain. Shoulder pain often significantly interferes with sleep, work, sports and daily activities and can be significantly persistent. Pain is often accompanied by a restricted range of movement. In about 1 in 20 people the pain is actually coming from neck and not the shoulder or patients are worried it could be from the heart or maybe a referred pain. It is also important to recognise when the shoulder pain maybe serious particularly cancer deposits i.e. with red flags. GPs can initially investigate with X-ray or US scan and offer treatment in the form of NSAID medication, steroid injection or a referral to physiotherapy. One in 4 or 5 may need referral to secondary care for problems such as instability, presence of red flags, diagnostic uncertainty or if they need surgical treatment.

Hawkins test is essential to differentiate between frozen shoulder, sub-acromial impingement and rotator cuff tear. Surgery has a place in the management and can offer arthroscopic decompressions for persistent sub acromial impingement with rotator cuff disease. It helps to relieve pain and restoring function in patients who have failed conservative treatment. Controversy exists regarding management of small rotor cuff tear. Arguably small tears should be repaired to relieve symptoms and to prevent progression to larger tears. For resistant acromio-clavicular joint pain, an arthroscopic excision of lateral end of clavicle may be effective.

Surgery remains mainstay of treatment for most cases of recurrent shoulder instability. The management of Osteoarthritis and Rheumatoid arthritis has improved with joint replacement surgery as with other joints providing relief of pain for end stage disease.

# Abstract Presentations

## Prof Videsh Raut

Consultant Orthopaedic Surgeon, Wrightington Hospital & Lancashire Teaching Hospital
Honorary Professor, Edge Hill University

### Knee Replacement (TKR) for osteoarthritis with knock-kneed (valgus) deformity – Outcome of my personally developed technique

Knock-Kneed (valgus) deformity of the knee is uncommon (<20%). It is physiological in children and can persist into adulthood. There are however other causes of Knock knees. Valgus mal-alignment is an important cause of symptoms affecting the outer half of the knee, either meniscal damage or degeneration and progressive arthritis in the outer half of the knee.

Valgus knees with severe arthritis pose difficult problems for the arthroplasty surgeon as the medial structures are stretched and lateral structures are contracted. Often, these patients are obese and it is therefore a challenge to correct the deformity and at the same time achieve good balance of the soft tissues. Hence most surgeons commonly use constrained prosthesis for knee replacements in these patients.

Unconstrained- TKR for valgus deformity is rarely used. I have been performing this technique since 2001 and now have a series of 109 knees that have been reviewed at an average follow-up of 5.5 years (maximum FU 14.5 years). This is the biggest series in world literature on the subject.

Staged soft tissue release laterally was performed correcting valgus deformity before implantation of Knee prosthesis. My personally developed technique of release of the lateral ligament complex (Sliver Femoral Osteotomy) was needed for severely deformed knees (15 knees). Mean improvement in the valgus angle was 14 degrees. No patient had stiffness after surgery. None of the components have been revised so far. No instability was noted in any of the patient. Two patients had persistent pain, but investigation has not shown any cause.

An Unconstrained TKR can therefore be successfully implanted in a Valgus Knee. In our series, at an average of 5.5 years, there was 100% survival. This technique helps preserve patient's bone stock for any future revision surgery.

## Dr Vinod Gadiyar

Consultant in Anaesthesia and Pain Medicine, Bury and Rochdale Care Organisation.
Northern Care Alliance, Manchester.

### A Tale of Two Plants

During my presentation, I shall be concentrating on the two plants, Cannabis and Opium in relation to pain management under various circumstances.

Cannabis has been in the news recently in relation to its medical use and how it is managed in various countries in the world. Cannabis has been used for medicinal purposes since fourth century. Analgesic effect of Cannabis was first introduced to western world in 1893. UK banned Cannabis in 1928 but it remained clinically available till 1971. UK is the world's largest producer of medicinal cannabis. There are more than 400 compounds in the cannabis plant. Two main compounds include THC (Tetrahydrocannabinol), a primary psychoactive compound and CBD (Cannabidiol) which is non psychoactive. In pain clinics across Canada, use of Cannabis based medicine (CBM) is around 12%. These medicines can be inhaled, smoked and ingested. It can also be used rectally, sublingually, trans-dermally and intravenously. There is good and moderate evidence for efficacy of cannabis for pain in various formulations.

Opium has been used since ancient times. Opioids are very useful in acute pain settings and have been used extensively. They are extensively used in palliative care. Use of opioids in long-term non-cancer pain has increased in the last few decades. Its common side effects include nausea, vomiting, sedation, constipation and respiratory depression. However, long term use can cause dependence, opioid induced hyperalgesia, depression of pituitary adrenal axis making one vulnerable to infections. Opioids are used and misused and was responsible for 63,000 deaths in the USA in 2016 and of these 40% was attributed to prescription opioids. Faculty of Pain Medicine at the Royal College of Anaesthetists (Opioids Aware) recommends that more than 120 mg of oral morphine equivalent per day of any opioids will cause more harm than benefit.

## Dr Ashish Dhawan

Consultant Cardiologist, Wrightington, Wigan and Leigh NHS Foundation Trust.

### Advances in the Management of Heart Failure

It is estimated that there are 26 million patients worldwide with heart failure (HF) with more than half a million people living with this condition in the United Kingdom. 1-2% of the NHS budget is estimated to be spent on heart failure, with 60-70% related to the costs of hospitalisation.

Over time, there has been a considerable progress in the management of chronic HF with the availability of drugs such as angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), beta-blockers, and mineralocorticoid receptor antagonist (MRA). These drugs have conventionally been the mainstay of treatment for heart failure. Although these drugs have reduced mortality and morbidity significantly, this has still remained alarmingly high. For patients with more advanced HF which is characterised by significantly impaired cardiac function and symptomatic limitation, despite best medical therapy, survival and prognosis has remained very poor.

Recent advances in the management of heart failure include use of promising new drugs to treat such patients, namely Ivabradine and Sacubitril/Valsartan. In addition, some of the newer agents in testing offer the potential for significant progress. Complex Devices including Implantable cardioverter defibrillator (ICD) and Cardiac resynchronisation therapy (CRT) has played an important role in the management of patients with advanced heart failure by treating life-threatening arrhythmias, and improving morbidity and survival.

## Dr Sanjay Arya

Consultant Cardiologist and Medical Director,
Wrightington, Wigan and Leigh NHS Foundation Trust.

### Sex and the Heart

Erectile Dysfunction (ED) provides early warning signs for cardiovascular disease (CVD). It is therefore important that cardiac risk factors are assessed in all patients presenting with ED. Coronary artery disease and ED share the same risk factors and commonly coexist, with atherosclerosis being common pathophysiology to both. The number of men with ED will increase from 152 million men in 1995 to 322 million men by 2025, with over 50% of these men under 55yrs of age.

Only a third of patients with myocardial infarction resume sexual activity after the cardiac event. There are myths and fears in patients and their partners and doctors are reluctant to address the issue. Resuming sexual activity is an important part of getting life back to normal. Proactive and sensitive questioning about a patient's sexual relationship should form an integral part of routine consultation in patients with cardiac illnesses

It is safe for cardiac patients to have sex if the patient is able to walk a mile in 20 min or walk up and down 13 steps in 10 sec or able to walk for 4 min on the tread mill. Provided they are used correctly, treatment with PDE5 Inhibitor does not increase the overall cardiovascular risk in patients with diagnosed CVD.

## Dr Swati Raut

Artistic Director, Swati Dance Company. Principal Teacher, Milap Art School.

### Bharatanatyam – Art or Science?

Acharya Ratna, Dr Swati Raut talks about her practise, her passion and the science behind the delivery of this beautiful Art Form, which like all Classical Arts has stood the test of time. The physical demands of Bharatanatyam are very high on the dancers' body both for correctness of delivery and for the longevity of the dancers' performing career. The most important being muscle strength and core stability which in turn prevents injury to vital joints such as knees and ankles.

The physical and mental benefits of the regular practise of Bharatanatyam are documented in journals and are not anecdotal and definitely not fictional. It improves stamina, strength, concentration, balance and co-ordination. It definitely decreases negative emotions, relieves stress, reduces anxiety and depression, improves cognitive skills and lowers the risk of dementia.

'Half of Me' is Swati Dance Company's most recent work based on the emotional implications of young people coming of age born through ART (Assisted Reproductive Therapy). The idea behind this work will be discussed briefly. The talk will be in the format of a lecture demonstration.

# 13th BIDA International Scientific Congress Delegates

| Name | Division |
|---|---|
| Dr Kailash Agarwal | Blackburn |
| Dr Aftab Ahmed | Scottish |
| Dr Sheik Sayeed Ahmed | Wigan |
| Dr Satish Ahuja | Wigan |
| Dr Ravindranath Arepalli | Stoke |
| Dr Sanjay Arya | Wigan |
| Dr Maitrayee Arya | Wigan |
| Dr Ashok Atrey | Wigan |
| Dr Neela Atrey | Wigan |
| Dr Anwer Azam | Bradford |
| Dr Jahan Azam | Bradford |
| Dr Tej Bahadur | Kent |
| Dr Ravi Bajaj | Merseyside |
| Dr Harish Borse | Stoke on Trent |
| Dr Shashank Chattree | Blackburn |
| Dr Sunita Chattree | Blackburn |
| Dr Raksha Chopra | Wolverhampton |
| Dr Ashish Dhawan | Wigan |
| Dr Shalini Gadiyar | Rochdale & Bury |
| Dr Vinod Gadiyar | Rochdale & Bury |
| Dr Ajeet Gupta | Blackburn |
| Dr Parshottam Das Gupta | Wolverhampton |
| Dr Raj Kishore Gupta | Kent |
| Dr Virendra Gupta | Merseyside |
| Mr Mukesh Hemmady | Wigan |
| Dr Birendra Kumar Jha | Merseyside |
| Dr Ram Jha | Rochdale & Bury |
| Dr Veena Jha | Rochdale & Bury |
| Dr Priyadarshan Joshi | Manchester |
| Dr Vaishali Joshi | Manchester |
| Dr Rajshree Kantikar | Preston |
| Dr Uday Kantikar | Preston |
| Dr Chandra Kanneganti | Stoke-on-Trent |
| Dr Chandra Khatri | Wigan |
| Dr Krishna Khatri | Wigan |
| Dr Chander Khemani | Kent |
| Dr Anil Kumar Kohli | Wolverhampton |
| Dr Binoy Kumar | Preston |
| Dr Surendra Kumar | Merseyside |
| Dr George Kuruvilla | Merseyside |
| Dr Susan Kuruvilla | Merseyside |
| Dr Govind Lall | Kent |
| Dr Vasantka Maheepathi | Stoke-on-Trent |
| Dr Meenakshi Malhotra | Wigan |
| Dr Micky Malhotra | Wigan |
| Dr Chinta Mani | Scottish |
| Dr Nirmala Nagpal | Blackburn |
| Dr Satish Nagpal | Blackburn |
| Mr John O'Loan | Merseyside |
| Dr Sukhbir Parihar | Manchester |
| Dr Sanjay Pitalia | Wigan |
| Dr Shikha Pitalia | Wigan |
| Dr Arun Rai | Scottish |
| Dr Sidhanaidu Ramamurthy | Merseyside |
| Dr Tej Rastogi | Merseyside |
| Dr Swati Raut | Wigan |
| Prof Videsh Raut | Wigan |
| Dr Jyoti Ray | Merseyside |
| Dr Sudheera Reddy | Wigan |
| Dr Harcharan Sahni | Wolverhampton |
| Dr Parmindar Sahni | Wolverhampton |
| Dr Alia Saleem | Merseyside |
| Dr Anita Sanghi | Essex |
| Dr Pradeep Sanghi | Essex |
| Dr Sunil Sapre | Merseyside |
| Dr Leena Saxena | Wigan |
| Dr Sanjeev Saxena | Wigan |
| Dr Bharat Sharma | Kent |
| Dr Pamadeth Shobha | Kent |
| Dr Bijendra Singh | Kent |
| Dr Jenifer Singh | Wigan |
| Dr O M Singh | Kent |
| Dr Shashi Singh | Kent |
| Dr Surendra Singh | Merseyside |
| Mr Amit Sinha | North Wales |
| Dr Ashok K Sinha | Stoke-on-Trent |
| Dr Birendra Sinha | Merseyside |
| Dr Ashish Sukthankar | Wigan |
| Dr Shaila Sukthankar | Wigan |
| Dr Devamani Thimmaiah | Merseyside |
| Dr Alka Trivedi | Wigan |
| Mr Nanikram Vaswani | Merseyside |
| Dr Aruna Vij | Wolverhampton |
| Dr Sunhash Vij | Wolverhampton |

# Child with a painless limp - An unusual presentation of a **Pelvic Tumour**

A CASE REPORT

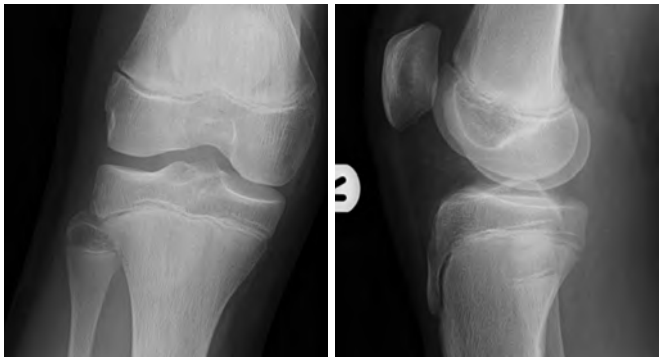
**Jayadeep Jayachandran**
*SAS Doctor Orthopaedics*
*Department of Trauma and Orthopaedics*
*Glan Clwyd Hospital Rhyl*

**Lewys Peters**
*FY2 Orthopaedics*
*Department of Trauma and Orthopaedics*
*Glan Clwyd Hospital Rhyl*

## Background

The presence of any disease process often presents with symptoms which are characteristic to that disease. Broad differentials are mperative when considering any disease processes. When the obvious diagnosis is not picked up with the clinical and diagnostic modalities the general practitioner should refer the case for specialist opinion.

We report a case of a child with a painless limp which the diagnosis was delayed as the initial investigation modality failed to diagnose a lesion in the affected pelvis.

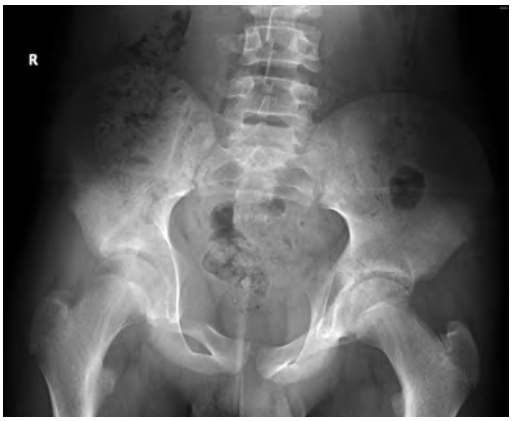


*Pic 1 Knee radiographs AP and lateral*

## Case presentation

A fit and well 12-year-old boy, with no history of any metabolic disorders or trauma had presented to the general practitioner with a limp which had been there for a few weeks. The parents had attributed this to increased sporting activity and had rested him for a week and when the symptoms failed to settle sought the GP consultation.

The GP after clinical evaluation requested a radiograph of the knee, as the knee was thought to be the culprit. The radiograph had been reported as normal. The GP had advised reduction of activity and analgesics. As the symptoms failed to settle, further review at the practice at about 2 months of the initial presentation was arranged,




*Pic 2 Pelvis radiograph*

At this stage a pelvic radiograph was performed and as this was reported as suspicious and the patient was referred to our Paediatric unit. Orthopaedic opinion was sought as a routine by the Paediatric team.

## Investigations

On examination he had a painless gait with no pain on palpation around the hip and abdomen, full range of movements of the hip.

Blood and urine tests were performed and did not reveal any abnormalities.

The radiographs were reviewed with a radiologist with special interest in musculo skeletal conditions. As the symptoms persisted, we made a provisional diagnosis of a 'possible' early slip capital epiphysis and requested an urgent MRI scan of the hip joint.

MRI of the hip revealed a large expansile lesion on the quadrilateral plate of the iliac bone.

## Management

Patient was referred to the Bone tumor unit in Birmingham. After a multi-disciplinary review the decision was made to perform a biopsy to confirm the diagnosis. He underwent a biopsy via a limited anterior approach.

The biopsy revealed the tumour as a giant cell tumour and further surgery was deemed to be appropriate in view of the child's age and location of the lesion.

The tumour unit has arranged regular review of the patient and plans to deal with appropriately with serial clinical examination and imaging.

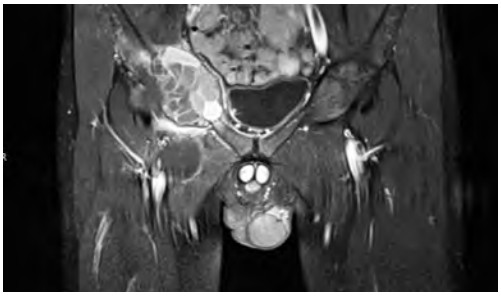
## Differential Diagnosis

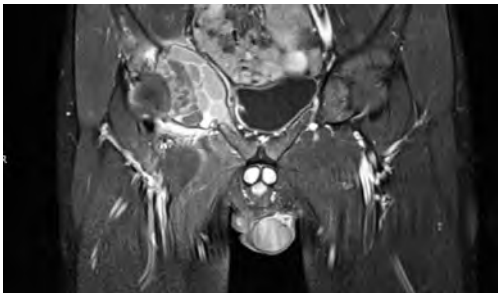
Painful limp in the age group commonly is attributed to either a slipped capital femoral epiphysis or late onset Perthes disease. Tumours are very rare and almost seldom in the differentials entertained. Lesions at this age group are usually aneurysmal bone cyst, with giant cell tumour and Ewing's Sarcoma as differentials.

## Discussion

Limping child is a fairly common presentation in the paediatric patients and is usually due to transient synovitis. It is important to consider all possibilities and evaluate with MRI scans when the clinical and radiologic investigations are unremarkable and symptoms do not resolve in a few weeks.

GCT in the pelvis in paediatric age group is a rare occurrence. As a primary bone tumour GCT occurs in 5 % of cases and 20% of benign skeletal tumours. The prevalence of GCT is maximum in the third decade and about 80 % occurs in the age group 30 to 50. Less than 3 % of GCT occur in patients under 14.





*Pic 3 and 4 Pelvis MR with contrast*

## References:

M. Campanacci, A. Giunti, and R. Olmi, "Metaphyseal and diaphyseal localization of giant cell tumors," La Chirurgia Degli Organi di Movimento, vol. 62, no. 1, pp. 29-34, 1975.

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R. R. Goldenberg, C. J. Campbell, and M. Bonfiglio, "Giant-cell tumor of bone. An analysis of two hundred and eighteen cases," The Journal of Bone & Joint Surgery–American Volume, vol. 52, no. 4, pp. 619-664, 1970.

# BIDA Annual Representative's Meeting Report

**Dr Jay Nankani**
*ARM Chairman, BIDA*

***The 2018 Annual Representatives Meeting was held at The Daresbury Park Hotel, Warrington, Cheshire in October and was hosted by Merseyside and Cheshire Division.***

**Welcome** by ARM Chairman

**Dr J Nankani** welcomed delegates to ARM 2018.

**Proposal** by BIDA General Secretary

**Dr A Dhawan**, General Secretary, proposed and **Dr T Rastogi** seconded, to accept the list of representatives as the official representative to the ARM 2018. **Dr Nankani** invited the Main Officers of BIDA to submit their reports.

**Annual Report** by BIDA National Chairman

**Dr Kanneganti** informed delegates it is now 4 years since he took on the role of National Chairman and the organisation continues to fight for equality for international doctors. It is recognised by many of the stakeholders that we should be involved in discussions involving the NHS. A lot has changed in the NHS under this Health Secretary. The recent Dr. Bawa Gaba case prompted the press to contact us for our opinion. What happened to her was the result of systemic failure. We met with **Charlie Massey** of the GMC to voice our concerns and made an appeal for her to be reinstated. GMC went to court to have her name erased but the Judge disagreed with GMC and said she should be re-instated. This is a victory for all doctors. Doctors had become afraid to report patient safety issues.

We have organised important workshops this afternoon with topics including clinical negligence and Dr Kanneganti has personally invited **Dr David Sellu** who spent time in prison for the very same, to come and tell his story. He was treated appallingly because of hospital failures. **Dr Jenny Vaughan**, Consultant and Medical law campaigner runs a web site to help people caught up in manslaughter cases. She is coming along today and we are hoping to have good discussions about gross negligence and manslaughter for the benefit of patient safety.

GMC have supported this conference. It is very important that we work with them to bring about the reforms that are needed. We have worked very closely with **Dr Chand Nagpaul**, BMA Chairman who invited us to be part of the racial equality discussions. We have made a case to all organisations how important it is for them to engage with us and work with our members to have equality and justice for all doctors in the NHS.

**Dr Kanneganti** urged all delegates to come back this afternoon and take part in the discussions.

**Report** by BIDA General Secretary

**Dr A Dhawan** welcomed delegates. He thanked the host division, Cheshire and Merseyside for all their efforts in organising this conference.

A lot of activities have taken place over the last 12months. BIDA stands for the best of BME doctors. We are liaising with the Department of Health, General Medical Council, British Medical Association, BAPIO, fighting for the rights of overseas doctors and were successful in the case of doctors being challenged about visas.

With regards to the educational side we held our Oncology Conference which was organised by **Professor Senapati** earlier on this year. We also held a very successful meeting to discuss "Protecting Patients, Supporting Doctors" which was organised by **Dr Gadiyar**.

The International Congress has become an annual affair which is hugely successful. Last year's was organised by **Dr Bachi Sarker** and himself. This year we are heading to Jakarta for our 13th international conference. **Dr Dhawan** is Convenor and **Dr Sanjay Arya** is looking after the Scientific Programme.

Going forward, what does the future hold for BIDA.? There are challenges but BIDA's strength lies in its membership. He encouraged delegates to encourage young doctors to become members. A third of our Divisions are not very active and it is up to us to try and help to revive those divisions.

**Report** by BIDA National Treasurer

**Mr P Sarkar** thanked **Dr B Das** and **Dr B K Sinha** of Merseyside and Cheshire Division for hosting this year's ARM/AGM. His first year as Treasurer has been challenging. He thanked his predecessor **Dr Sinha** for his financial acumen.

**Mr Sarkar** invited **Mr Zahur** of Altman Smith to present BIDA's accounts for the year up to 31st March 2018.

**Mr Sarkar** asked that any division wishing to claim a 10% refund should do so before 31st March 2019.

**Mr Sarkar** thanked **Mr Zahur** and his son **Amir** for all their hard work in keeping the accounts.

**Dr Kanneganti** informed delegates that he has spoken to the BMA Treasurer and we will need to send a copy of our proceedings to the BMA.

# BIDA Annual Representative's Meeting Report Saturday 13th October 2018

## ARM 2018

One minute's silence was held in memory of **Dr Venugopal**, founding member of BIDA, then known as Overseas Doctors' Association (ODA)

## MOTIONS

### NHS

1P *This RB finds it appalling that patients are being assessed and treated in hospital corridors Due to acute shortage of beds. It seems that it is not the "winter pressure" but "all year" pressure. This has affected the care of patients and also significantly compromised the confidentiality and privacy of patients and urges BIDA Executive Committee to discuss with Secretary of State for Health.*

***Passed Unanimously***

3P *This meeting advises that Doctors in the NHS need a universal support mechanism for every doctor regardless of age and speciality while workload soars and thousands of doctors are stressed, burnt out and sometimes suicidal.*

***Passed Unanimously***

4P *This meeting believes that doctors and other staff are stressed out and being pushed to the brink due to unsafe workload burden. Doctors are concerned about the difficulties and pressure they are facing daily in an underfunded and under-resourced NHS. Doctors are working beyond their capacity and safe limits which also compromises standard of patient care. This RB urges BIDA EC to engage with NHS management to take robust measures for recruitment and retention of health-care professionals and also work towards safe workload for doctors.*

***Passed Unanimously***

5P *This meeting believes NHS contract with Capita is a failure causing a lot of anxiety and disruption to the Medical profession, causing patient safety risk issues and it should be terminated with immediate effect.*

***Passed Unanimously*** as a Reference to the NEC

7P *BIDA urges the DHSC to address the problems and in particular seek to retain senior doctors across the primary and secondary care since these doctors have considerable contributions to make to NHS clinical activities, teaching, research and leadership at a time when services are under great stress.*

***4 Abstentions 4 Against***
***Passed by a Majority***

### GMC

9P *In the light of despicable conduct of the GMC in the Bawa Garba case and its impact on doctors' morale and culture of NHS, this meeting declares that BIDA has no confidence in the GMC as professional regulatory body. The conduct of GMC to appeal against the decision of its own disciplinary panel (MPT) is really abhorrent*

***20 For 4 Against 4 Abstentions***
***Passed by Majority***

11P *This RB welcomes the new guidance from GMC advocating safe reflective processes however we should ask for full legal protection for reflective practice notes. Reflection is a vital tool in all doctors' professional development and allows them to look back at events good and bad so they can improve their practice and care for their patients. The reflections should always before learning and not for blame.*

***Passed Unanimously***

### BREXIT

12P *BIDA should support BMA to oppose Brexit "as a whole" and call for public final say, it is a major threat to health and industry.*

***Passed by a Majority***

### BIDA ORGANISATION

13P *BIDA EC proposes that Clause 5 in the membership section of the BIDA Constitution (page7) any medical and dental practitioner who supports the objective of the Association shall subject to the approval of the Executive Committee be eligible as an ordinary member of the Association. The mode and conditions of election to membership shall be determined by or in accordance with the By-Laws' should be removed.*

***Passed Unanimously***

14P *This meeting calls for BIDA to review its working system and structure to attract the young medical graduates and strengthen the divisions so that they can serve the grass root members in a much more robust way. Membership is a strength of any organisation and we must endeavour to increase our membership which needs urgent attention.*

***Passed Unanimously***

15P *This meeting should recommend a separate forum for retired members of BIDA in view of the fact a large number of BIDA members have retired and they are keen to continue their long association with BIDA.*

***4 Against 2 Abstentions***
***Passed by a Majority***

16P *BIDA NEC urges the conference to approve the Executive Committee proposal that the current Annual membership subscription is increased by 10% in all categories of membership and is made effective from 1st October 2019.*

***2 Against 1 Abstention***
***Passed by a Majority***

## WORKSHOPS

2:00-3:00pm. Chaired by **Dr Jay Nankani**.

### Agenda Committee

Dr Nankani announced the names of the new Agenda Committee members: - **Dr Jay Nankani, Dr Birendra Sinha, Dr Chandra Kanneganti, Mr PK Sarkar, Dr Ashish Dhawan, Dr TK Rastogi, Dr Alka Trivedi, Dr Vinod Gadiyar, Dr Leena Saxena, Dr Suresh Chandran** and **Mr Amit Sinha.**

Dr Kanneganti welcomed **Mr Leslie Hamilton**, Lead of GMC Review Panel, **Dr Jenny Vaughan**, Medical Law campaigner, **Mr David Sellu** and **Dr Jonathan Leach**, Vice Chair RCGP, and then invited them to give their presentations. These were followed by a Q & A session.

In the evening we held our Gala Dinner. **Dr Arya** was the MC and our Chief Guest this year was **Mr Leslie Hamilton**, who gave an excellent speech.

# BIDA Annual General Meeting Report

Sunday 14th October 2018

## INTRODUCTION

**Dr Nankani** Chaired the Sunday and welcomed delegates.

**Dr Das** introduced **Christopher Crichton-Rankin**, Financial Advisor, Ludlow Financial Services who gave a talk on Inheritance Tax followed by a Q & A session.

**Dr S Arya** invited **Mr David Sellu**, Senior Consultant Surgeon from St Marks Hospital, London to address the meeting with his talk on ***"Lessons from my manslaughter conviction"*** followed by questions and answers.

## ANNUAL GENERAL MEETING

**Welcome and Opening Remarks** by BIDA National Chairman,

**Dr Kanneganti** reported that this year we have had very good speakers at the ARM, speaking on topics that are current. ARM motions went very well, and everyone contributed to the discussions and got involved. He thanked the office staff, **Alison, Mandy** and **Margaret** for their support.

He asked delegates what they would like the organisation to do over the next 12 months.

BAPIO want to hold their conference the same weekend as BIDA's conference next year. Do we think about holding ours on a different date? It is not easy getting speakers when 2 organisations are holding their conferences at the same time. Next year's ARM is planned for September in Blackburn. Dr Sharma from Blackburn Division is looking into venues etc.

Members have remarked that the ARM and International Congress are held too close together and perhaps we should not be too rigid in our plans.

The GMC have given a limited sum of money to investigate BME doctors' issues. We feel they could have asked us to do this, we are best placed and ready to do research.

We should investigate the availability of Educational Grants from the GMC.

Delegates put forward their thoughts and suggestion on how we might improve the Association's profile and attract younger members. We have discussed running courses for junior doctors in the past. **Dr Kanneganti** is a PLAB examiner for the RCGP and has supported this in the past, but found that junior doctors were just coming for the courses and were not interested in joining BIDA.

We should hold more educational activities. We have a lot of very knowledgeable members with good skills.

**Dr A Trivedi** from Wigan Division has always believed in the personal approach. When she meets juniors in clinical meeting she invites them to Divisional activities. Wigan Division has a lot of younger members.

Suggestions for attracting juniors included, training, education, job prospects, sporting activities.

**Dr Arya** said that in his Trust they have a process in place for anyone waiting to do PLAB and wants a clinical attachment. Please guide anyone wanting the same to Dr Arya.

**Dr Das** commented that the guests from Liverpool CCG at this year's ARM were completely sympathetic to BIDA's cause.

**Dr Kanneganti** will propose holding a brain-storming meeting at the next Executive Committee to discuss reviving divisions who are struggling to remain active.

**Dr Kanneganti** invited a colleague to give an obituary for **Dr Maheswaran** of North East Division who sadly passed away on Thursday 11th October 2018.

**Review of Proceedings and Resolutions of the ARM** by the BIDA General Secretary

**Dr A Dhawan** welcomed everyone to the AGM and summarised the weekend. We had an excellent educational meeting on Friday followed by an informal dinner organised by Merseyside and Cheshire Division.

12 motions were discussed at the ARM yesterday morning. 6 motions were passed unanimously, 5 by majority and 1 was passed as a reference to the NEC.

We had really interesting, interactive and informative workshops involving **Dr Jenny Vaughan, Mr Leslie Hamilton** and **Dr David Sellu** and **Jonathan Leach**, followed by a Dinner where we welcomed our guests. The day was mentally stimulating. He thanked Merseyside and Cheshire Division for hosting and the delegates for sending in motions and taking part in deliberations.

**Presentation of Treasurer's Report & Approval of Accounts**
by the BIDA National Treasurer

**Mr P Sarkar** informed the meeting that the accounts had been scrutinised at the ARM yesterday.

**Dr S Sarker** proposed, **Dr A Trivedi** seconded and delegates agreed to accept the accounts of BIDA to 31st March 2018.

**Election of Association's Auditors and Solicitors** for the Ensuing Year

BIDA National President, **Dr B K Sinha**, thanked **Mr Zahur** and his son for their hard work in looking after the Association's accounts for the last year. **Dr B K Sinha** proposed, **Dr S Saxena** seconded, and delegates agreed to appoint Altman Smith as the Associations auditors for the ensuing year.

# BIDA Annual General Meeting Report

Sunday 14th October 2018

## Awards and Honours

### Fellowship Awards

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

**Professor Siba Senapati** *Manchester Division*
**Dr S Sathiyaseelan** *North Wales Division*
**Dr Sudhir Handa** *Wolverhampton Division*

**Professor Siba Senapati** has contributed enormously to BIDA. He was Hospital Doctors' Forum Chairman from 2014-2017, has organised 4 successful BIDA Oncology Meetings and 2 BIDA Obesity Study Days. Professor Senapati was the organiser and speaker at the 11th BIDA International Congress, and has also helped to rejuvenate the Manchester Division.

**Dr S Sathiyaseelan** was the founder member of the BIDA (ODA) Warrington Division, and established the Division very successfully for about 10 years until his retirement from General Practice. He was in the posts of both Divisional Secretary and Chairman for many years. Warrington hosted the BIDA AGM / ARM once during his tenure. He also served as EC member in the centre in the past. As a General Practitioner, Dr Sathiyaseelan worked as member of the PCG and PCT of Warrington and also served as a Warrington LMC member.

**Dr Sudir Handa** has been a long-term serving and active BIDA member since 1990. He has contributed as an LMC member since 1991 and been the Vice-chair 2011–13. He has been a GPC member 2011 - 14 and played an essential role in PCG, PCT and CCG governing board.

### 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 7 divisions entered the Cricket Tournament which started mid-June. The final between Wigan and Blackburn was held in August and was hosted by Wigan Division.

BIDA National President **Dr B K Sinha**, Immediate Past President **Dr S Sarker,** National Chairman **Dr Chandra Kanneganti** and Sports Co-ordinator, **Dr Hegde**, all attended the final. Wigan won by 50 runs.

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

Vice Captain of Wigan Division, **Mr Mukesh Hammady**, accepted the President's Cricket Cup on behalf of the Cricket team.

**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 entered the tournament but only 2 divisions competed, Manchester and North East divisions. 4 divisions withdrew.

*Above, left to right: 2018 BIDA Scientific Congress Co-Ordinator Dr Sanjay Arya, BIDA National Chairman Dr Chandra Kanneganti, BIDA National Secretary Dr Ashish Dhawan, BIDA National President Dr Biru Sinha alongside Dr S Sathiyaseelan and Professor Siba Senapati following their elevation to the Fellowship of BIDA, along with (pictured right) Dr Sudir Handa.*

**Dr Hegde** presented the winners of both tournaments with their awards.

For future reference delegates were advised that anyone wishing to compete in the Cricket Tournament should be approved by the Centre.

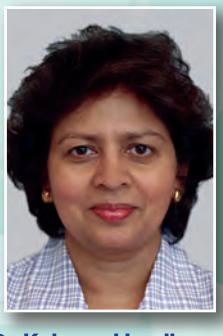
*BIDA A.R.M. 2018 Executive Officers, Guests and Delegates.*

# Welcome
## to new BIDA members

| Name | Membership No. | Division |
|---|---|---|
| Mr David Sellu | 10591 *(Life Member)* | London Metropolitan |
| Dr R Singh | 10592 | North Wales |
| Dr A K Bansal | 10593 | Wigan |
| Dr S Ahmadi | 10594 | Essex |
| Dr Puskar Bura | 10595 | North Wales |
| Dr D Prasad | 10596 | Huddersfield |
| Dr M Dhall | 10597 | Blackburn |



# Medical Quiz



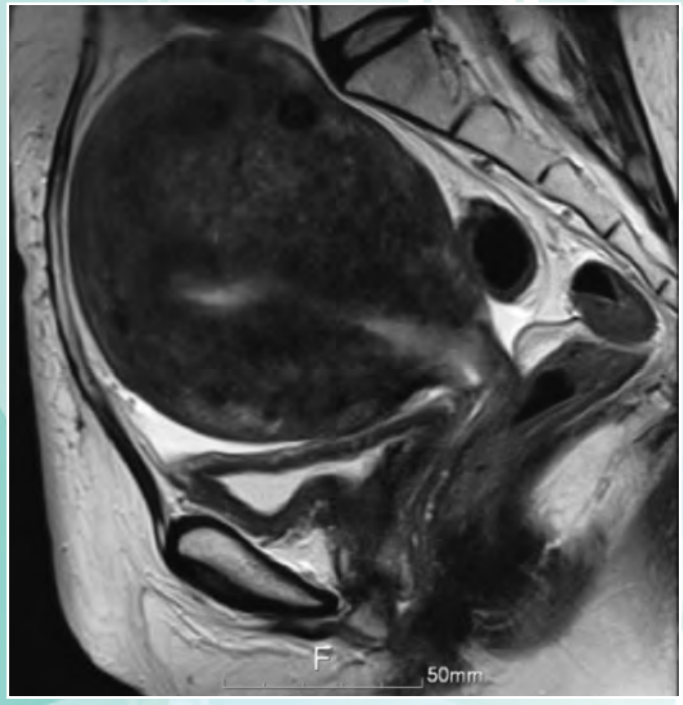

**Dr Kalpana Upadhyay**
MRCOG
*Consultant in Obstetrics And Gynaecology, Wrexham Maelor Hospital, BCUHB, North Wales*


A 40 year old woman presents with a supra pubic abdominal mass up to the umbilicus associated with symptoms of urinary retention, constipation and bloating. Her periods are regular but heavy.

Routine blood investigations reveal haemoglobin of 101gm/l, normal renal and liver function tests.

CA 125 levels were within normal range.

An MRI pelvis and abdomen scan shows the following:




Please choose the most likely diagnosis from the list below and four possible differential diagnoses:

A) Distended bladder
B) Solid ovarian tumour
C) Colorectal carcinoma
D) Uterine fibroid
E) Leiomyosarcoma
F) Tumour of the fallopian tube
G) Cervical neoplasm
H) Angiosarcoma
I) Rhabdomyosarcoma

*Answers on Page 26*

# OBITUARY

## Dr Vidyanand Prasad

### 6th January 1948 – 10th November 2018

Vidyanand was born in Asansol, West Bengal, India in 1948. He was a self made man. His father told him early on that all this efforts were going into running the small family business and if Vidyanand wanted to achieve, he'd have to use his own initiative and hard work. He attended the local government school, excelled academically and gained a place at the Nilratan Sarkar Medical College, Kolkata (1966-1972). Those were amongst his most memorable years. He completed his MD in Dermatology and Venereology at Patna University in 1979.

He made a huge impact right from the start as a Junior Doctor. One of his early posts was as the sole doctor in a village government hospital. The clinic was extremely quiet, which puzzled Vidyanand, as he knew there was a huge healthcare need in the area. His staff informed him that the doctor who previously held his position only treated those who would pay fees even though this was supposed to be a government funded clinic. Vidyanand petitioned the local officials for basic X-ray equipment, dressings and medicines. The official sensed that he was genuine and supplied all that was requested. Within weeks, the clinic became busy. He was providing outpatient care and also had set up some inpatient beds. The community treasured him and brought what they could for Dr Saab to show their gratitude including farm produce and home cooked meals. He made a real difference to so many lives right at the start of his medical career and never succumbed to the financial corruption that was endemic at the time. The experience of learning how kindness can impact on your fellow man stayed with him and he practiced this all his life.

Another position he took up was on a merchant ship. His weekly pay was more than his monthly pay had been on shore. He was living in the officer's quarters and dined at the Captain's table. However, he was served western food and at the time this was alien and unpalatable to him. A worker on the ship offered to take him to the ordinary workers' dining room. There he ate freshly made puris and sabji. The workers were happy to welcome Dr Saab into their dining quarters. However, after a few days he still had not found his sea legs and at his request the crew reluctantly put him into a boat for shore. Later in life he loved cruising and sailed in the Caribbean, Scandinavia, Europe, and the Far East. His last cruise was in Easter 2018.

He married Rita in 1974. They went onto have 3 girls; Seema, Rachana and Pallavi. In 1979, he made the bold decision to move to the UK, where he thought he would be able to provide a better life for his family. He arrived with £79 in his pocket and a suitcase. He worked tirelessly and sent money home and also saved for a deposit on a house. Within 2 years he had bought a home and furnished it. In 1981 he called his wife and children over and they went straight from the airport to their new comfortable home.

He was always a dedicated family man. He worked tirelessly to provide for his family. It's only later that we realised what sacrifices he and mum had made to provide for us.

He did his Registrar training in Manchester and then went onto be a General Practitioner in Winsford, Cheshire where he practiced for 28 years before retiring in 2014. He always practiced holistically and would try to steer patients to non-drug therapies whenever the evidence base allowed. He was very conscientious in his continued medical education and always read the medical literature widely. He subscribed to many medical journals and his study at home was full of interesting articles he would cut from the journals and file. He also practiced as a specialty doctor in sexually transmitted disease and HIV in Leighton Hospital, Crewe.

He was always brave and courageous. He had had rheumatic fever as a child and in his early 40s became increasingly symptomatic. He had been a medical registrar at Manchester Royal Infirmary and went back to see his previous Consultants there, this time as a patient. He had a Mitral Valve replacement, which was the first of many treatments and surgeries, which he faced with fight and steel.

Vidyanand had a love for foreign travel. He had subscriptions to numerous travel magazines and was always jet setting around the globe. He travelled in Europe, North America, Russia, Middle East, Far East and North Africa by land, sea and air. He also was very much into politics and current affairs and monitored UK, International and Indian news.

His pride in his girls was always evident. He always impressed upon us the importance of reading widely and focussing on our education. He used to say, "always behave with integrity". We all followed in his footsteps. Seema is now an Orthopaedic surgeon, Rachana is a Cardiologist and Pallavi is a Paediatric Nephrologist. We know that what we have achieved is down to Dad and Mum's guidance, education and hard work. If we are making a difference to people lives through our work today, it is because Dad enabled us to do so.

After my fathers death I rummaged through his papers in his study and came across this analysis my Father had written about a Kabir verse.

"Guru Govind dono khade kake lagu paay

Balihari Guru aapki Govind diyo batay." [Sant Kabir]

Kabir wrote this verse to sing the glory of Guru, without whose help one cannot cross this ocean of worldly life. He asks, "If both Guru and God in the form of Govind were to appear at the door, whose feet will I worship first?" He answers, "It has to be the Guru's feet first, because without him, how would I have recognised God?"

For us, our Father was our ultimate guru and we will continue to worship him for all the teachings and guidance he gave us.

**Seema, Rachana and Pallavi.**

# Divisional News

## North East Division *AGM*

The AGM was held on 4th November 2018 at Le Raaj Sedgfield. We paid tribute to Mr. Maheswaran who died on 10/10/18. Mr. Vishvanathan was congratulated on him being honoured with Professorship from Teesside University. Dr. Ambu Patel presented the accounts of the division and was accepted. The winners of the National BIDA - Badminton and Table Tennis players were given the trophies.

Badminton Singles winner - Dr. Chakrapani Kalluri

Badminton Doubles winner - Dr. Chakrapani Kalluri and Mr. Jaganath Chakravathi.

Table Tennis Doubles winner – Dr. Chakrapani Kalluri and Dr. Vikram Narula

## North Wales Division *Educational Meeting*

North Wales Division held an extremely successful Educational Meeting on 24th October 2018, which was well attended.

*Pictured: (Left to right): Drs P S Anandaram; Peter Saul, Joint Chair of RCGP Wales; Bernhard Frank, Consultant Pain Specialist from Walton Neurology centre and Guest Speaker; Raj Avula.*

# OBITUARY

## Dr Ghulam Rasool Nahami

### 1st January 1938 – 28th April 2015

Dr Nahami was born in Srinagar, Kashmir. India. He was born to Ali Mohammed Nahami and Jana Nahami. He was married to his beloved Fatima and had four children. Dr Nahami had a passion for life and was always there helping those around him. From the very childhood he had deep interest in treating animals. This led to his aim to become a doctor from an early age. With a humble family background, when education was not for the masses, through hard work and immense determination he managed to qualify to the medical school in Srinagar. Having worked in many remote villages he always helped those in most need and was popular with the masses that most needed medical assistance.

He migrated to the UK in 1974, a wish he longed for. In Sheffield, he finally settled as a GP where he was popular with his patients. Soon after retirement, health issues followed and finally he passed away in 2015 at St Lukes Hospice, Sheffield surrounded by his family. His departure has left a void amongst his family and friends. For his family he was a strong pillar of strength. A man of immense passion for knowledge, travel and intellect he continues to be missed. A man of courage and wisdom he lived his life to the full and achieved so much.

# Divisional News

## Merseyside & Cheshire Division

### New Year Function

The BIDA Merseyside and Cheshire Division held their New Year Function on 6th January 2018 at the Mayur Restaurant in Liverpool. The function was opened by Dr Biplab Das, Merseyside & Cheshire Divisional Chairman who welcomed all the guests. They had an excellent programme and entertainment with dance, song and dinner. Approximately 70 BIDA members, including guests from CCG, LMC and Indian High Commission attended and we have had lots of very positive feedback. The event was also attended by several BIDA National officers including Dr Birendra Sinha, BIDA National President and Dr TK Rastogi, BIDA ARM Vice Chairman. All guests enjoyed the evening.

### New Divisional Secretary

It was announced with great pleasure that Dr Rakesh Parikh, Consultant Anaesthetist, Royal Liverpool University Hospital & Womens Hospital, has taken over the post of Secretary of Merseyside and Cheshire Division. Dr Biplab Das, Divisional Chairman, said that he had no doubt that the Division will continue to flourish with his contribution.

*Right: Dr Rakesh Parikh.*
*Above and right: Guests enjoying the New Year function at the Mayur Restaurant.*

# Medical Quiz Answers

**Answer: D (Uterine fibroid)**

These are the most common benign tumours of female genital tract during reproductive years. The incidence is 25-30% in women between 35 -50 years. They are classified according to the site of development (sub serosal which may be pedunculated; intramural which are the commonest; sub mucous which lie partly or completely in the uterine cavity and rarer types like cervical and intraligamentry). Most common presentation is heavy menstrual bleeding, pressure symptoms, pain and discomfort. Management depends on age, symptoms, fertility, size and number of fibroids and possibility of malignancy. Treatment choices include pharmacological, surgical, intervention radiology and focussed ultrasound.

**Differential Diagnosis:**

1. **Distended bladder:** The appearance will be different on imaging both with ultrasound and MRI. If in doubt, draining the bladder with catheter will reveal the correct diagnosis.
2. **Solid ovarian tumour:** Can be benign i.e. Dermoid or malignant. Ultrasound and MRI are useful in detecting type of ovarian tumour. Tumour marker like CA 125 will be raised in malignant ovarian tumours.
3. **Malignant tumour of uterus:** Leiomyosarcoma. Although the incidence of sarcomatous change in a leiomyoma is very low (0.2%) but any rapid enlargement in the size of a fibroid along with pain, vaginal bleeding and malaise should raise the index of suspicion.
4. **Colorectal cancer:** It is the second most common visceral cancer with a lifetime risk of 5.9% in the general population. Symptoms include bleeding per rectum and change in bowel habits. Imaging techniques like MRI can help confirm the diagnosis.

# VIETNAM

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# TOGETHER, WE ARE STRONGER

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!

**www.bidaonline.co.uk**