Spring Academic Sessions
Sunday 5th May 2019

# SLMDA

## Programme and Abstracts

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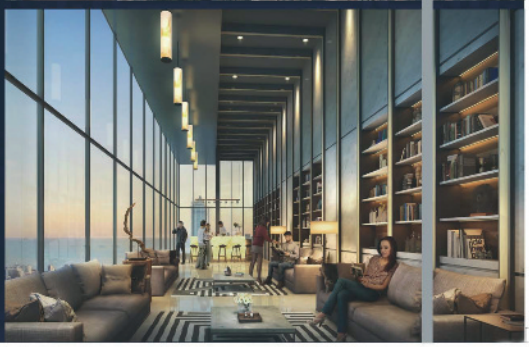

**Sri Lankan Medical and Dental Association in the UK**

**Annual Spring Meeting 2019 - Scientific sessions**

## Welcome Message from the Scientific Organising Committee

Dear Colleagues and Friends,

We wish to extend a warm welcome to you to the Annual Spring Scientific Sessions of the Sri Lankan Medical and Dental Association. We have gathered an array of distinguished speakers today and would like to express our sincere thanks to them for their time and effort.

These sessions as always, afford an excellent opportunity for current and aspiring young doctors and dentists early in their careers, to present well-prepared papers and posters. It gives us a great deal of satisfaction to see them taking advantage of this opportunity. We are confident that you will find their work to be of high calibre, and both useful and exciting. We like to congratulate them on their hard work, and we are confident that this experience will help them to further their careers. We wish them well.

We would also like to invite you to please take time to view the posters and discuss them with the presenters as this will mean a lot to them.

The committee has done its best to make this meeting to be of high scientific value, and we do hope that you will find the sessions both enjoyable and educationally stimulating.

*Supul Hennayake, Mahesh Nirmalan, Rasieka Jayatunga,*
*Mahendra Gonsalkorale, Sita Nanayakkara*

# SLMDA Scientific Sessions Programme

**Sunday 5th May 2019**
**Three Rivers Golf Club and Resort, Purleigh, Essex, CM3 6RR**

**08:30 - 08:55** Registration and coffee
**08:55 - 09:00** President's welcome

**Session 1 - 09:00 -10:10**
**Chair:** *Dr Saman Perera and Mr Ajantha Jayatunga*
09:00 - 09:20 **Chronic Pain - a disease in its own right?**
**Dr Victor Mendis**, Consultant in Pain Medicine and Anaesthesia, Mid Essex NHST

09:20 - 09:35 Trainee Presentation 1
**Centre of Mass- Variation of centre of mass in humans**
Charutha Senaratne,Year 2 Student, Nottingham Medical school

09:35 - 09:50 Trainee Presentation 2
**Capsule Endoscopy - A Clearer Window into the Small Bowel?**
Sherwin Fernando, 4th Year Medical Student at Barts and The London School of Medicine

09:50 - 10:10 **Liver - Friend or Foe of the Surgeon?**
**Prof Aloka Pathirana**, Professor of Surgery, Faculty of Medical Sciences, University of Sri Jayewardenepura, Sri Lanka

**Session 2 - 10:10 - 11:05**
**Chair:** *Dr Janaka Silva and Dr Melanie Weerasuriya*
10:10 - 10:30 **Pivotal role of the Histopathologist in patient care**
**Dr Ayoma Attygalle**, Consultant Histopathologist, Royal Marsden NHS FT

10:30 - 10:45 Trainee Presentation 3
**What are the indirect mechanisms through which armed conflict impacts health? A case study of the Iraq war**

*Sandali Wickrama*
Year 4 medical student, Barts and the London School of Medicine and Dentistry

10:45 - 11:05 **Genomics and Clinical Medicine**
**Prof Suranjith Seneviratne**, Professor and Consultant in Clinical Immunology and Allergy, Royal Free London NHS Foundation trust

**11:05 - 11:35 - Tea and Poster Viewing**

**Session 3 - 11:35 - 12:45**
**Chair:** *Dr Ruwan De Soysa and Dr Elaine Mendis*
11:35 - 11:55 **Current concepts of managing chronic cough**
**Dr Keith Hatthotuwa**, Consultant Physician and Senior Lecturer in Respiratory Medicine, Broomfield Hospital, Chelmsford

11:55 - 12:10 Trainee Presentations 4
**Stigma surrounding cancer within the South Asian Community**
Dr Kanchana De Abrew,Haematology Registrar, Salisbury District Hospital

12:10 -12:25 Trainee Presentation 5
**New Technique of ACL Reconstruction. Anatomic medial portal vs all inside arthroscopic ACL reconstruction: a randomised controlled trial comparing hamstring strength and functional outcome: ongoing**
Dr Shanaka Senevirathna, Fellowship trainee in Sports Knee Surgery- Trauma & Orthopaedics, Robert Jones & Agnes Hunt NHS trust

12:25 - 12:45 **The changing face of upper GI Surgery - Is Robotic surgery the future?** - **Mr Sritharan Kadirkamanathan**, Consultant Upper GI Surgeon and Clinical Director of Surgery, Mid Essex NHST

**Session 4 - 12:45 - 13:30**
**Chair:** *Dr Sita Nanayakkara and Dr Mahadeva Manohar*
12:45 - 13:00 Trainee Presentation 6
**Costs of care at the end of life**
Dr Wikum Jayatunga,
Public Health Registrar ST4, UCL Institute of Health Informatics

13:00 -13:30 - **SLMDA ORATION**
**Preventing deaths from pesticide poisoning in the North Central Province of Sri Lanka**
**Professor Michael Philip Eddleston**, Professor of Clinical Toxicology, Centre for cardiovascular science (Pharmacology, Toxicology and Therapeutics), University of Edinburgh

**13:30 - 13:40 - Awards and closing**

**13:40 - 14:15 - Lunch and more poster viewing**

**14:15** - **Annual General Meeting (Members only)**

**DATES FOR YOUR DIARY**

JULY 13th Saturday LAW MEDICAL MATCH

OCTOBER 12th Saturday SLMDA AUTUMN BALL,

Stock Brook Country Club, Billericay, Essex CM1 0SP

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**BIOGRAPHIES AND ABSTRACTS OF MAIN SPEAKER PRESENTATIONS**
**(in order of appearance)**

## Chronic Pain - a Disease in its own right?

**Dr Victor Mendis** MD, FRCA, FFPMRCA, FFARCS
Consultant in Pain Medicine and Anaesthetics, Mid Essex NHS Trust

**Biography:** Graduated with a first class degree from the Vinnitsa Medical Academy in Ukraine in 1990 and obtained an MD Anaesthesia in 1998 from the University of Colombo. He Completed his Specialist Training in Anaesthesia at Barts and The London Hospitals, obtaining the Certificate of Completion of Specialist Training (CCST) in 2005. During his training he undertook a year of Advanced Pain Training in London. He was appointed a Consultant in Pain Medicine and Anaesthetics at Mid Essex NHS Trust in 2005.

He was the Local Pain Medicine Educational Supervisor for the Trust and in 2010 was elected as the Regional Advisor in Pain Medicine (London) for The Royal College of Anaesthetists. In 2017 he was elected chair of the Regional Advisors in Pain Medicine in the UK. In 2014 he was appointed to the board of examiners for the Faculty of Pain Medicine, Royal College of Anaesthetists. He is a College Assessor and an executive member of the Training and Assessment Committee of the Faculty of Pain Medicine, Royal College of Anaesthetists. In 2018 he was appointed as the Pain lead for the Medical Training Initiative of the Royal College of Anaesthetists. He sits on the London Pain Training Advisory Group and on various International Advisory Boards for Pain Medicine and has been a guest speaker at many International Scientific Meetings. He was the recipient of the Bangladesh Friendship award in 2018 for his continued commitment to pain training in Bangladesh. He was the Principal Investigator for a Pan-European drug trial and has many publications to his credit.

**Abstract:** Understanding pain has been one of the oldest challenges in the history of medicine. The European Federation of the International Association for the Study of Pain, declared that chronic and recurrent pain is a specific healthcare problem and a disease in its own right. According to a 2014 global study on the global burden of chronic pain, at least 10% of the world's population is affected by a chronic pain condition, and every year, an additional 1 in 10 people develop chronic pain. Chronic pain is a disabling condition, and, as reported by Turk et al, affects every aspect of a patient's life, contributing to a loss of both physical and emotional function and affecting a patient's level of activity. Primary care settings in Asia, Africa, Europe, and the Americas had patients reporting a persistent-pain prevalence of 10 to 25%. Consistent estimates of chronic-pain prevalence in the US range from 11-40% and prevalence of 20% has been noted in Europe.

Dr John Bonica, the father of pain medicine wrote "in its late phases, when it becomes intractable, it no longer serves an useful purpose and then becomes, through its mental and physical effects, a destructive force". In the last decade, significant progress has been made, thanks to the contribution from neuroimaging studies with evidence of functional, structural and chemical changes occurring in the brain that has led to greater understanding of neuroplasticity.

## Liver – Friend or Foe of the Surgeon

**Aloka Pathirana** MS, FRCS(Eng), FRCS(Edin)
Professor in Surgery, Faculty of Medical Sciences
University of Sri Jayewardenepura, Sri Lanka

**Biography:** Qualified in 1991 from the University of Colombo and obtained his MS in 1997 and FRCS degree in 1998. Awarded the Rockwood Gold Medal for Surgery – obtaining the highest marks for surgery at the Final MBBS, University of Colombo, 1991, Dr P R Anthonis Gold Medal for Basic Sciences in Surgery – for obtaining the highest marks at the MS (Surgery) Part I examination, and The Milroy Paul Gold Medal for Clinical Surgery -for

obtaining the highest marks for clinicals, at the MS (Surgery) Part II examination. He also won the President's Award for Scientific Publication in 2018.

He has published widely in Journals and books on a range of surgical topics including Hepatobiliary Surgery, Benign oesophageal obstruction, Endoscopic treatment Endotherapy, Gastrointestinal tract infections, Management of wounds, ulcers, burns and abscesses. He has presented well over a 100 research papers and posters at Sceintific meetings. He is a much sort after examiner for many qualifications including MD (Surgery), MRCS, MD, Diploma in sports medicine, Final MBBS and MPhil (Anatomy).

Apart from his clinical duties, Prof Pathirana undertakes a host of Administrative responsibilities, such as being Trainer, National Trauma Management Course (NTMC), International Association for Trauma Surgery and Intensive Care, Convener – MCQ Core Group for MD Surgery part II, Postgraduate Institute of Medicine, University of Colombo Sri Lanka, Member, Editorial Board, Sri Lanka Journal of Surgery (2012-2014), Member, Editorial Board, Journal of the Postgraduate Institute of Medicine.

**Abstract:** Liver, the largest organ, has fascinated mankind for many years. It has many surgeon-friendly features that none of the other organs of the human body has and continues to fascinate us from time immemorial. The anatomy of the liver guided rulers of Mesopotamia even 5000 years ago. Its rapid regenerating ability was well known to the Greeks. Though shielded by the rib cage, it's the commonest organ to get injured in abdominal trauma, but most resolve spontaneously, only rarely necessitating surgical intervention.

Its unique dual blood supply allows the surgeon to block one system in order to control haemorrhage and also to cause hypertrophy of the contralateral liver. The segmental anatomy which is similar to the lung helps to resect tumours with minimal blood loss.

The liver has a significant reserve functional capability allowing up to 80% of the volume to be resected and is the only human organ with the capability of true regeneration, allowing resection of large volumes. Acting as a filter of the gut, it's the commonest site of metastases from gut malignancies. Knowledge of this has helped in screening and successful/effective therapy.

Being a "vital organ" it needs to be transplanted when failure sets in. However, when compared to other organs which are transplanted, the liver is rejected less commonly and immunosuppression can be withdrawn completely in some.

## Pivotal role of the Histopathologist in patient care

**Dr Ayoma Attygalle**. MBBS, FRCPath, PhD
Consultant Histopathologist, Royal Marsden NHSFTrust, London

B**iography:** She qualified in 1992 from the All India Institute of Medical Sciences, New Delhi, and subsequently obtained a Diploma in Pathology and MD in histopathology from Sri Lanka. She became a Fellow of the Royal College of Pathologists in 2005 and completed a PhD at the University of London by submitting a thesis on Angioimmunoblastic t-cell lymphoma: histologic immunophenotype and molecular genetic characterisation of the disease, in 2016.

Her specialist areas of interest are Haematopathology with subspecialist interest and international expertise in angioimmunoblastic T-cell lymphomas and other nodal lymphomas of T-follicular helper cell origin and in Gynaecological tumour pathology. Has over 40 publications in reputed International journals and has delivered many lectures in her chosen areas at National and International meetings. She is the Educational lead.

**Abstract:** Who is a Histopathologist? The general public, our patients or potential patients ask - *'The sort of pathologist in "Silent Witness"?', 'A type*

*of technician?', 'You work in a lab, right?'* What about to the General Practitioner and Hospital Clinician? What exactly is our role? Is it a cushy 9-5 job with long lunch and coffee breaks? Do we actually make a difference in how you manage a given patient? Is it a minor role or is it pivotal?

Today's Histopathologist is an essential part of the multidisciplinary team (MDT), a required presence for MDT meetings to be quorate. He/she is not just an ornament who provides a break in the monotony by showing colourful histology slides that nobody understands, but is involved in active discussion and provides important information regarding diagnosis, tumour characteristics, dimensions and margins, all of which determine the therapeutic option selected and agreed on collectively. We actively contribute to the implementation of personalised medicine. Histopathologists play a crucial role in clinical trials and translational research. We request, interpret the significance of, and integrate results of ancillary tests including relevant genetics tests in order to make the correct diagnosis and predict prognosis and potential response to a given therapy. We are also detectives, who at times have to seek out clues in order to piece together crucial clinical information that is inadvertently withheld from us by requesting clinicians. If we get it wrong, the Clinician will get it wrong! How much more pivotal could our role be?

## Genomics and Clinical Medicine

**Professor Suranjith Seneviratne,** DPhil(Oxon), MBBS, MD, DPath, MRCPath, MRCP, FRCP, FRCPath, FCCP
Professor and Consultant in Clinical Immunology and Allergy

**Biography:** Currently at the Institute of Immunity and Transplantation, Royal Free Hospital and University College London, UK and the Department of Surgery, Faculty of Medicine, University of Colombo, Sri Lanka. Completed his basic Medical Degree at the Faculty of Medicine, University of Colombo with First Class Honours, eight distinctions and ten Gold medals and was

placed first in his year. He completed his MD in Internal Medicine and trained in Clinical Immunology and Allergy at the John Radcliffe Hospital in Oxford. He completed a Doctor of Philosophy in Molecular Medicine at the Weatherall Institute of Molecular Medicine, University of Oxford as a Commonwealth Scholar. So far, he has authored 212 journal publications and has published in Journals such as: *Science, Nature Medicine, Blood*, *American Journal of Medical Genetics, American Journal of Human Genetics, Journal of Experimental Medicine and Journal of Allergy and Clinical Immunology*. Professor Seneviratne is an International expert in Immunodeficiency, Autoimmune, Allergic/Mast Cell disorders and Immunogenetics. He is the Director of the Centre for Mast Cell Disorders and the President of the UK-Sri Lanka Immunology Foundation, an organisation that contributes to Immunology, Allergy and Immunogenetics education in Sri Lanka.

**Abstract:** The fields of Genomics and Immunogenetics have seen massive advances during the past few years. Important new findings in these fields are continuing to have a major translational impact in all areas of Clinical Medicine. Precision or Personalised Medicine has rapidly taken centre stage in both Clinical diagnostics and therapeutics. My talk would outline the important recent advances in Genomics and Immunogenetics and its influence on the prediction, diagnosis and management of Cancer, Infectious Diseases and Immunodeficiency, Neurology, Cardiovascular disorders.

## Current concepts of managing chronic cough

**Dr Keith Hattotuwa.** FRCP
Senior Lecturer in Respiratory Medicine
Queen Mary University London, Broomfield Hospital

**Biography:** Consultant in Respiratory medicne and General internal medicine with acute on-call for over ten years now. He is a Senior Lecturer in Respiratory Medicine and Academic Sub-Dean at Queen Mary Westfield College, as well as Foundation Year Programme Director, Broomfield

Hospital. He specialises in Respiratory Medicine including sleep disorders, cough, COPD, pleural disease, lung disease, TB and lung cancer. His special interests include Airways diseases, Pulmonary Fibrosis, Sleep, Chronic cough, Pulmonary Hypertension,Un-explained Breathlessness. He has more than 7 peer reviewed articles and many cited. He has presented numerous abstracts and posters at National and International meetings.

**Abstract:** The management of chronic cough presents a challenge for the clinician. Chronic cough (defined as persisting more than 8 weeks) is estimated to occur in up to 40% of the population. Cough however, is a protective reflex serving a normal physiological function of clearing the airway be it debris generated from the airway or from outside the airway. The reflex has an afferent sensory limb,a central processing centre and finally an efferent motor limb. The workup of a chronic cough is discussed. The aetiology of a chronic cough can be extremely challenging to dignose. Equally often, treatments may not be effective. The author will aim to go over the current concepts of chronic cough management and aim to discuss future challenges.

## The changing face of upper GI Surgery - Is Robotic surgery the future?

**Mr Sritharan Kadirkamanathan** FRCS
Consultant Upper GI Surgeon, Clinical Director of Surgery, Mid Essex NHST

**Biography:** He held many clinical and academic positions in the filed of GI surgery including Visiting Consultant Surgeon. Great Ormond Street Children's Hospital, London, Lead clinician Essex wide cancer network for oesophageal and gastric cancers 2005- 2010, Special Advisor to NICE on Interventional procedures, Clinical Lead and course organiser and Examiner– Master of Surgery course in minimally Invasive and Robotic Surgery – Anglia Ruskin University, Chelmsford, Reviewer – NIHR Grant Applications.

His clinical interests include gastric pacing / Gastric Electrical Stimulation for gastroparesis, Physiology of the stomach and oesophagus, capsule

endoscopy (He is a part of the team that invented capsule endoscopy at the Royal London Hospital), oesophageal and gastric cancer, Advanced Laparoscopic and Robotic Surgery. Endoluminal surgery is a special area of interest and he is part of a group that pioneered surgical techniques that have become routine practice in the past 12 years.

He has a host of publications in peer reviewed journals and over 150 national and International presentations. He has delivered lectures at both National and International meetings, including lectures in Hungary, France, Japan, Sri Lanka and Canada.

He is an active researcher and was the Principal Investigator - STAT-ROC Trial on oesophageal cancer, Chief Investigator of the on going Medtronic PSR-GES European Registry Study and Principal Investigator - RLM-MD-01/02/03/04 studies – European studies (on going). He is very proud of the fact that he has raised over £2 Million for Broomfield Hospital.

**Abstract:** The future of surgery is exciting and full of change, and it will continue to need to attract talented, innovative and compassionate individuals. Digital technologies and robotics could enable more types of routine surgery to be delivered locally if resources are available. I shall expand on this theme in my presentation.

## THE SLMDA ORATION

**Preventing deaths from pesticide poisoning in the North Central Province of Sri Lanka**

**Professor Michael Philip Eddleston** ScD FRCP(Edin) FEAPCCT FBPhS 1
Professor of Clinical Toxicology, Centre for cardiovascular science (Pharmacology, Toxicology and Therapeutics), University of Edinburgh

**Biography:** Prof Eddlestone graduated with a BA 1st Class Honours from the University of Cambridge in 1990, and did his PhD at the Scripps Research Institute, La Jolla, USA and University of Cambridge, 1994. He then went on to Oxford and obtained his BM, BChir in July 1998, and his MRCP in 2001. He

became FRCP (Edin) in 2010. He was awarded the prestgious ScD from Cambridge University in 2014.

He describes his research aims as follows: “My work’s major aim is to reduce deaths from pesticide and plant self-poisoning in rural Asia, a cause of over 200,000 premature deaths each year and a key global means of suicide. To do this, I perform clinical trials in Sri Lankan and other South Asian district hospitals to better understand the pharmacology and effectiveness of antidotes and community-based controlled trials to identify effective public health interventions. This work is complemented by translational studies of antidotes in minipig models of poisoning in a large animal critical care laboratory that I have established in Edinburgh, work with sociologists and anthropologists to better understand the meaning of self-harm, and work with the World Health Organisation and Food and Agriculture Organisation to aid implementation. I also perform clinical and animal research in Edinburgh to improve treatment of other forms of poisoning”.

**Abstract:** Since the Green Revolution placed highly hazardous pesticides such as parathion into rural households, 15 million people have died globally from pesticide suicides. Unfortunately, this problem has been long neglected. Prevention will require a multi-faceted approach, improving medical management, reducing the use of pesticides in these rural communities, and most importantly removing the most dangerous pesticides from agriculture through government regulation. Sri Lanka has been at the forefront of addressing this problem, while bringing down the total national suicide rate to the lowest it has been for 40 years. This talk will review the processes and research that has brought Sri Lanka to this position of leadership, which should better known and celebrated.

**INDEX OF TRAINEE ORAL ABSTRACTS**

## INDEX OF POSTER ABSTRACTS

## JUNIOR FORUM - ORAL PRESENTATIONS

**Abstract O1: Experimental study (pilot)**
**Title:** Centre of Mass- Variation of centre of mass in humans
**Presenter:** ***Charutha Senaratne***, Year 2, Nottingham Medical school
**Introduction:** Centre of mass is the single theoretical point where the mass of an object can be assumed to be concentrated, and when said object is within a uniform gravitational field, the single point from which the weight of an object can be thought to act. Centre of mass of the human body impacts its motion and balance and has numerous applications, some of which are medical. Thus, variation of the location of the centre of mass within the population is of interest.
**Method:** This pilot study examines the variation of the location of centre of mass with height, BMI and gender within a sample population (n = 30) of 18-25 year olds
**Results and Discussion:** Data is presented that there is a positive linear correlation between height and the location of the centre of mass; that there is a negative linear correlation between BMI and the centre of mass location to height ratio (x/h); and that x/h for both males and females is normally distributed, with the peak of the male distribution having a greater value of x/h. Properly determined trends such as these for the whole population / various population segments has applications predictively within sports medicine, physiotherapy, assessment of falls risk, amputees/prosthesis design etc. This study demonstrates the existence of these trends, forming the basis of further research.

**Abstract O2: Audit**
**Title:** Capsule Endoscopy: A Clearer Window into the Small Bowel?
**Presenter:** ***Sherwin Fernando***, 4th Year Medical Student at Barts and The London School of Medicine. *Priyantha Siriwardana Rasika Bulathsinghela and Sritharan Kadirkamanathan*
**Introduction/Background:** Imaging Techniques such as barium follow-through and CT/MR enterography are used to indirectly visualise the small bowel. Small Bowel Capsule Endoscopy (SBCE) directly visualises the small

bowel, hence led to significant changes in the management of small bowel diseases such as obscure bleeds, Crohn's disease (CD), etc.

**Aims and Objectives:** Aim was to evaluate diagnostic yield and outcomes of SBCE performed at MEHT compared to; NICE*, BSG* and ESGE* guidelines with obscure GI bleed; 31-76% positive predictive value (PPV) and suspected CD; 43-71% PPV.

**Materials and methods:** Designed as a retrospective analysis of all SBCE at MEHT from October 2012 to September 2015. Demographics, clinical presentation, investigations and outcomes were assessed.

**Results and Discussion:** 136 patients (60.3% female) with median age of 62 (range 17-97) underwent an SBCE. 84.6% presented with anaemia with iron deficiency anaemia (IDA) being the most common specific presenting complaint (38.2%). 98.2% with anaemia had an oesophago-gastroduodenoscopy (OGD), and 85% a colonoscopy before SBCE. 5 patients were referred for suspected CD of which all had small bowel imaging before SBCE. The study was incomplete in 20 patients with 1 suffering capsule retention. A cause of obscure GI bleeding was established in 77.6%. Of those referred with CD, 38.5% had SBCE evidence of the disease.

**Conclusion:** Outcome data from MEHT are within the audit standards of NICE, BSG and ESGE guidelines. SBCE is a useful investigative tool for small bowel pathology and shows a good diagnostic yield, particularly in anaemia. SBCE can also be a useful tool for diagnosing and assessing CD.

**References:**

1) Apostolopoulos P et al. The role of wireless capsule endoscopy in investigating unexplained iron deficiency anaemia after negative endoscopic evaluation of the upper and lower gastrointestinal tract. *Endoscopy. 2006 ;38:1127-32.*

2) Patel et al. A Review of Small Bowel Capsule Endoscopy Performed At Darent Valley Hospital. *The Online Journal of Clinical Audits. 2011; Vol 3*.

NICE* National Institute for Clinical Excellence, BSG* British Society of Gastroenterology and ESGE* European Society of Gastrointestinal Endoscopy.

**Abstract O3: Case study**

**Title:** What are the indirect mechanisms through which armed conflict impacts health? A case study of the Iraq war

**Presenter:** ***Sandali Wickrama***, Year 4 medical student, Barts and the London School of Medicine and Dentistry*, Jonathan Kennedy*

**Introduction/Background:** Armed conflict has deleterious effects on health, predominantly through indirect mechanisms, however it is a largely understudied area of research [1]. The aim of this paper was to fill a gap in the literature by assessing a crucial case – Iraq. In the past few decades, Iraqi civilians have been affected by a series of international and civil conflicts, yet, the majority of research focuses primarily on military personnel [2].

**Methods:** A search for qualitative, quantitative and grey literature was conducted on a series of databases, relevant websites and major news outlets. A set of inclusion and exclusion criteria was applied, and selected data was analysed using a mixed methods appraisal tool to assess overall quality and common results were aggregated. Finally, a systematic narrative review was conducted to make overall conclusions.

**Results:** Six primary themes highlighting the ways in which conflict indirectly affected health in Iraq were identified. These were: the deterioration of the healthcare system; toxification of the environment; rise in communicable disease; rise in non-communicable disease; poor reproductive health outcomes; and adverse paediatric health outcomes.

**Conclusions:** The overall findings indicate the health implications of conflict in Iraq has extended far beyond the immediate effects of combat related civilian death or injury which dominates the current literature and has resulted in adverse health outcomes which may persist for decades.

**References:**

1) Ghobarah HA, Huth P, Russett B. The post-war public health effects of civil conflict. Soc Sci Med. 2004;59(4):869-84.

2) Levy BS, Sidel VW. Adverse health consequences of the Iraq War. Lancet. 2013;381(9870):949-58.

**Abstract O4: Reflective study**

**Title:** Stigma surrounding cancer within the South Asian Community

**Presenter:** ***Dr Kanchana De Abrew***, Haematology Registrar, Salisbury District Hospital

**Introduction/ Background**: Stigma to mental health is well documented across all cultures, particularly within the South Asian community. Stigma to cancer is also highly prevalent among the South Asian demographic, in contrast to the Western world where cancer is perceived as a misfortune that needs to be fought.

**Objectives:** To discuss the root of stigma and its subsequent effects

**Materials and Methods:** A reflection based on personal experiences within the Srilankan community

**Results:** "Blame" is common, partly resulting from interpretation of Buddhism and Hinduism philosophies together with the hierarchical caste system. A simplistic interpretation is that suffering is a direct result of karma or fate, resulting in a deep sense of shame or guilt.

A similar attitude can also be seen in Christianity and Islam in traditional societies, where illness is seen as "God's will". Within Christianity, particularly Catholicism, illness can be seen as "punishment for sins".

**Discussion:** Patients subsequently "hide" an illness from close friends/ extended family. This can occur vice versa with collusion, causing distrust and emotional distress following inadequate communication. Another major consequence of stigma is isolation, leaving patients and their carers vulnerable to depression and anxiety.

**Conclusions:** Culture plays an important role, whether influenced by religion or not in this stigma. One way to reduce stigma is through education; that cancer arises from mutations. We should focus on programmes to raise awareness and understanding of the causes of disease. By reducing stigma, we can boost psychological support and wellbeing for the affected patient and their close loved ones.

**References:**

1) Chaturvedi SK. Psychiatric oncology: Cancer in mind. Indian Journal of Psychiatry. 2012;54(2):111-118. doi:10.4103/0019-5545.99529.

**2)** Chaturvedi SK, Loiselle CG, Chandra PS. Communication with Relatives and Collusion in Palliative Care: A Cross-Cultural Perspective. Indian Journal of Palliative Care. 2009;15(1):2-9. doi:10.4103/0973-1075.53485.

3) Chandra PS, Chaturvedi SK, Kumar A, Kumar S, Subbakrishna DK, Channabasavanna SM, et al. Awareness of diagnosis and psychiatric morbidity among cancer patients: A study from South India. J Psychosom Res. 1998;45:257–62
4) Sharma H, Jagdish V, Anusha P, Bharti S. End-of-life care: Indian perspective. Indian Journal of Psychiatry. 2013;55(Suppl 2):S293-S298. doi:10.4103/0019-5545.105554.
5) Chaturvedi SK, Strohschein FJ, Saraf G, Loiselle CG. Communication in cancer care: psycho-social, interactional, and cultural issues. A general overview and the example of India. Frontiers in Psychology. 2014;5:1332. doi:10.3389/fpsyg.2014.01332.

**Abstract O5: Randomised control trial**

**Title:** New Technique of ACL Reconstruction.
Anatomic medial portal vs all inside arthroscopic ACL reconstruction: a randomised controlled trial comparing hamstring strength and functional outcome: ongoing

**Presenter:** ***Dr Shanaka Senevirathna***, Fellowship trainee in Sports Knee Surgery- Trauma & Orthopaedics, Robert Jones & Agnes Hunt NHS trust.
*Tanweer Ashraf*.

**Introduction/Background:** ACL reconstruction is a commonly performed procedure by knee surgeons across the world. All inside ACL reconstruction technique is a new development which is getting more popular due to its unique features of closed socket tunnels, dual suspensory graft fixation, decreased bone removal and smaller skin incisions [1]

As per recent studies all-inside ACLR appears to have similar overall results on subjective and objective outcomes studies compared to standard medial portal ACLR techniques and may be associated with decreased post-operative pain[1].No significant difference found between the two groups for IKDC, VAS pain score, Lysholm and Tegner scores at two years of follow up [2]

The all-inside ACL technique typically utilises a single quadruple semitendinosus tendon autograft, in contrast to standard medial portal ACL technique which typically utilize both semitendinosus-gracilis (S-G) tendon autograft. Since closed femoral and tibial sockets are drilled rather than full tunnels, a decreased graft length is necessary for the all-inside ACL technique. Therefore, a single hamstring tendon harvest provides sufficient length to serve as the autograft when quadrupled [1].

**Objectives:** The hamstring muscles act as agonists to the ACL by resisting the anterior tibial displacement that result from quadriceps muscle forces at the knee. Neuromuscular imbalance with low hamstring to quadriceps (H:Q) strength ratio has been identified as a risk factor for ACL graft re rupture [3].

Harvest of a single hamstring tendon for reconstruction with the all-inside ACL technique should potentially cause less functional deficits than harvest of both S-G hamstring tendons in standard ACL technique. Therefore difference of H:Q strength ratio should remain low following all inside ACLR in comparison to standard technique, which may enable early return to sports and reduce the risk of graft re rupture

Since there remains a need for a methodologically sound RCT, we have decided to conduct the current trial to compare difference in the Hamstring to Quadriceps strength ratio in these two groups of patients.

**Material and Methods:** Study design is randomised control with the following *Inclusion Criteria*: All patients aged between 18 to 50 years of age who underwent ACLR following traumatic injuries, and as Exclusion *Criteria*: Multiligamentous injury, patient declines participation, patients lacking capacity, pregnant women, and prisoners. Patients randomised into two groups using a computer based randomisation technique.

**Discussion:** The hypothesis is that bilateral difference of hamstring to quadriceps to strength ratio should be similar in both groups. The Primary Objective is to determine whether there is a significant difference in hamstring to quadriceps strength ratio following all inside ACL reconstruction compared to standard medial portal ACL reconstruction using hamstring grafts. *The Primary outcome measure* is the H:Q strength ratio determined by Isokinetic dynamometer measurement.

*Secondary Objectives* are to compare the functional outcome with IKDC scores and RSI scores. (Return to sports Index Questioner), Hop Testing: single hop distance, triple hop distance and cross over hop distance, Limb symmetry Index (LSI) and hip muscle strength and stability.

Patients following ACL reconstructions are followed up by the operating surgeons at 6 weeks, 3 months, 9 months and 18 months. IKDC score and RSI score will be performed at each follow-up visit. They will have isokinetic dynamometer measurements to assess H:Q strength ratio and hip muscle strength after 6 months following surgery under musculo-skeletal physiotherapist, and Hop testing after 6 months. Target number of patients: 30. (15 patients in each group). Expected Duration of Study: 15 months

**References:**

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3. Likelihood of ACL graft rupture: not meeting six clinical discharge criteria before return to sport is associated with a four times greater risk of rupture. *Kyritsis P1, Bahr R2, Landreau P1, Miladi R1, Witvrouw E3. Br J Sports Med. 2016 Aug;50(15):946-51. doi: 10.1136/bjsports-2015-095908*

**Abstract 06: Research**

**Title:** Costs of care at the end of life

**Presenter:** ***Dr Wikum Jayatunga***, Public Health Registrar ST4, UCL Institute of Health Informatics. *Dan Lewer, Jenny Shand, Jessica Sheringham, Stephen Morris, Julie George*

**Introduction/ Background**: Per capita health care costs increase with age, and this has led to concerns of ever-increasing healthcare costs with an aging population. However, the cost increase could relate to proximity to death rather than age per se. We investigated the system-wide costs associated with the end of life across different health and social care settings.

**Materials and Methods:** We performed cross-sectional analysis of linked electronic health records of residents aged over 50 in the London Borough of Barking and Dagenham between 2011 and 2017. Those who died during the study period were matched to survivors on age group, gender, deprivation, number of long term conditions and time period. Mean care costs were calculated by care setting, age, and months to death**.**

**Results:** Across 8920 matched patients, the final year of life was associated with an increase in mean costs of £7359 (95% CI £7012 – 7720, $p < 0.001$), 57% of which was due to non-elective hospital care. Healthcare costs were more strongly influenced by proximity to death than age, while the opposite was true for social care costs.

**Conclusions:** A large proportion of costs at the end of life relate to non-elective care, and might be reduced through better end of life planning directing care towards more appropriate settings. Healthcare expenditure associated with population aging may have been overstated, but social care demands may well increase with an aging population

## JUNIOR FORUM - POSTER PRESENTATIONS

**Abstract P1: Audit – Descriptive and retrospective study**

**Title:** Assessment of the Referral to Treatment pathway of Primary hyperparathyroidism at the Sherwood Forest Hospitals, NHS Foundation Trust: A Retrospective study

**Presenter**: ***Dr Imesh Prathapasinghe,*** International Medical Research Fellow and Medical Administrator, NHS – Sherwood Forest Hospital foundation Trust, *Fernando DJS, Venoden D, Somaratne CJK, Abhishek VYAS, Win K, Akthar I*

**Introduction:** Referral to Treatment (RTT) pathway, which is specified as the right of the patient in the NHS constitution[1], shouldn't be longer than 18 weeks, and prolongation beyond 52 weeks lead to financial penalties to the provider.[2]

Diagnosis of primary hyperparathyroidism is confirmed by demonstrating hypercalcaemia together with an elevated serum parathyroid hormone concentration.[3]

**Objectives:** To assess the RTT pathway of the treatment of Primary hyperparathyroidism (PHPT) at the Sherwood Forest Hospitals (SFH).

**Materials and methods:** All 25 cases referred for the treatment of PHPT to SFH were analysed retrospectively from January 2018 to August 2018.

**Results:** Out of 25 patients 21 were referred by the General Practitioners (GP), and the rest were from wards of the hospital. Among the patients referred by the GP, RTT target of 18 weeks were met only in 2 patients (9.5%) and four patients had to wait more than 52 (19%) weeks for treatment. Out of 4 hospital referred patients 3 were treated within 18 weeks. Following referral from endocrinology department, 22 out of 25 (88%) patients had to wait more than four weeks for surgery.

**Conclusions:** RTT target was met in only in 8.5% of the patients treated for PHPT. Referring patients with required investigations to establish PHPT and increasing the day surgical case capacity could improve this situation.

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**Abstract P2: Audit**

**Title:** Back to Basics – Increasing the use of Posteroanterior Chest Radiograph to Aid Assessment of Chest Pain for Aortic Dissection

**Presenter:** ***Dr Sachintha Perera,*** FY2 St Georges University Hospital NHS Foundation Trust, Tooting

**Introduction/Background:** Aortic dissection is severe and potentially fatal. 60-90% of aortic dissections demonstrate mediastinal widening on chest radiograph (CXR)[1]. Specialty guidelines recommend CXR for intermediate and low risk dissection patients[2]. Posteroanterior (PA) orientation is considered superior to anteroposterior (AP).

**Objectives:** The first audit cycle aimed to evaluate the proportion of PA chest radiographs being performed for Emergency Department (ED) patients presenting with chest pain. The second cycle aimed to increase this proportion**.**

**Materials and Methods:** A cross sectional study reviewing ED records identified 80 patients presenting with chest pain, their age and CXR orientation. To increase PA CXR performance, we adopted a two-pronged intervention. 1) Radiographer education, and signs encouraging performance of PA radiographs and documentation justifying why PA radiographs were not performed. 2) Signs requesting ED doctors to specify "PA CXR" and patient ability to stand safely on request forms. Performance was re-audited on 73 patients

**Results:** The proportion of PA radiographs increased from 50±10.96% to 83.6±8.50%, $Z = -4.3776$, $p < 0.001$. Mean age of PA radiographs in first and second cycles was 54.6 and 53.1 respectively, with AP being 71 and 70.8 respectively. 16.7% of AP erect radiographs had documentation justifying why PA was not performed.

**Discussion:** PA CXR has an important role in aortic dissection investigation in low and intermediate risk cases. Although few guidelines state PA orientation specifically is required, increasing the proportion of PA films

performed may help reduce missed aortic dissection, as PA orientation is more sensitive and specific for increased mediastinal width[3], arguably the major CXR abnormality.

**Conclusions:** Implementing our changes caused a significant increase in PA proportion, suggesting improved communication between the doctors and radiographers reduces the number of inappropriately performed AP radiographs.

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**Abstract P3: Literature review**

**Title:** Specialist physician productivity: An effective measure for NHS

**Presenter:** ***Dr Janaka Somaratne,*** International Medical Research Fellow and Medical Administrator, NHS – Sherwood Forest Hospital foundation Trust, *Venoden D, Prathapasinghe ID, Fernando DJS.*

**Introduction/Background:** The founding principles of the NHS were provision of comprehensive, universal healthcare which is free at the point of delivery without based on the ability to pay.[1,2] Specialist physician productivity, a determinant of overall healthcare productivity, is the level of healthcare output produced by the physicians for a given level of inputs.[3,4]

**Objective:** To review the literature on Specialist physician productivity measures in outpatient care services for proposing an effective measure for the NHS.

**Materials and methods:** Journals and articles on physician productivity measures were reviewed. Articles on current productivity measures of NHS physician productivity were explored and critically analysed.

**Results:** Physician productivity was measured in different ways based on the objectives of the health systems[5]. In the United States it was measured in terms of financial output of the physician. In the NHS trusts, it was measured using new to follow up ratio; a proxy financial output measure.[6]

**Discussion:** Being a health system which provide free health services to patients at the point of delivery and paying fixed salaries to physicians, NHS shouldn't rely only on financial terms in measuring physician productivity[7]. This could risk compromising the quality and safety of patient care. Trusts, which currently function in a competitive internal market environment, however, require financial measures for ensuring operational profit.

**Conclusions:** NHS trusts measure physician productivity in financial terms using new to follow up ratio. Adding quality measures such as patient, staff satisfaction and revisit rate along with new to follow up ratio could measure physician productivity in an effective manner.

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**Abstract P4: Best practice**

**Title:** Use of Doppler Ultrasound in Stroke Management'

**Presenter:** ***Dr Sachintha Perera***, FY2 University Hospital NHS Foundation Trust, Tooting, *Dr Saman Perera*

**Introduction/ Background:** Stroke is a leading cause of death and disability in the UK. Doppler ultrasound is a valuable noninvasive technique in the investigation and initial management of ischaemic stroke and transient ischaemic attacks (TIA). It is particularly useful in characterising atherosclerotic plaques in the extra cranial carotid circulation and in identifying significant arterial stenosis which would benefit from carotid endarterectomy or stent placement.

**Objectives:** To survey the current usage of Doppler ultrasound; its technique, normal and abnormal appearances of extracranial carotid circulation, criteria for intervention and potential pitfalls.

**Materials and Methods:** Use of ultrasound in a clinical setting and accepted standards of imaging and velocity measurement.

**Results:** This is a survey of a technique and its accepted usage.

**Discussion:** Doppler Ultrasound is an important, well established method of investigating the possible causes of ischaemic stroke. It is often the first imaging investigation in stroke patients to identify those who could benefit from surgery or Radiological intervention.

**Conclusions:** As above

**References:**

1) Lee W. General principles of carotid Doppler ultrasonography. *Ultrasonography. 2014 Jan; 33(1):11-17.*

2) Hamid R. Tahmasebpour, Anne R. Buckley, Peter L. Cooperberg, Cathy H. Fix. Sonographic Examination of the Carotid Arteries: *Radiographics. 2015, Nov. Vol 5, No 6.*

**Abstract P5: Literature review**

**Title:** How has the government of Sri Lanka addressed the high suicide rates in its civilian population following the end of the civil war?

**Presenter:** ***Tharanika Ahillan***, Year 4 Medical Student, University College London. Acknowledge help from my supervisor Dr Rodney Reynolds

**Introduction/Background:** Suicide is a global health problem, particularly in low-and middle-income countries. Sri Lanka has experienced one of the highest suicide rates following the end of the civil war in 2009.

**Objectives:** I conducted a literature review to examine how the Government of Sri Lanka has addressed the high suicide rates after the civil war. I aimed to inspect the mental health needs related to suicide in the country, wider mental health care and the specific interventions by the government.

**Materials and Methods:** I conducted a literature review using PubMed, OVID Global Health, PsycArticles, Google Scholar and Sri Lanka Journals Online, which was supplemented with grey literature including reports and policies from the Sri Lankan Ministry of Health, the National Institute of Mental Health, WHO and any related news articles. The key concepts in the question were “Sri Lanka”, “mental health disease”, “suicide”, “mental health care” and “civil war” which were used in various combinations to maximise the results.

**Results/Discussion:** There was limited official governmental data but I reviewed estimates from many studies. I identified the existence of a unique ‘conflict culture’ in Sri Lanka as a mental health need, which contributed to impulsive acts of suicide, greater suicide rates in young women and was linked to community mental health and the civil war. Government interventions were centred on restricting access to pesticides and improving mental healthcare, with limited success. Government mental healthcare has shifted towards community-based care, but increased integration with traditional care was identified for future policies.

**Conclusion:** While the findings cannot be generalisable to all low- and middle-income countries due to unique socioeconomic factors, it highlighted the prominent role of culture in suicide prevention, and the limitations to using westernised models in such policies and interventions.

**References:** See poster

**Abstract P6: Audit**

**Title:** Hyponatremia after primary hip and knee arthroplasty: Audit on incidence, severity, associated risk factors and management

**Presenter:** ***Dr Shanaka Senevirathna***, Fellowship trainee in Sports Knee Surgery- Trauma & Orthopaedics, Robert Jones & Agnes Hunt NHS trust.
*Stephanie Chianda, Sanjiv Chugh*

**Introduction/Background:** Post-operative hyponatraemia, (Na<135mmol/L), in the elective arthroplasty setting is the commonest electrolyte abnormality which could lead to life-threatening complications and causes significant delays in patient discharge.

**Objectives:** An audit was carried out to determine the causes, associated risk factors, severity of the problem and its implications.

**Materials and Methods:** A retrospective review of 50 consecutive primary THR and TKR notes were scrutinised for symptoms, associated risk factors, medications, fluid-intake, anaesthesia, pre & post- op Sodium levels, management and the duration of stay.

**Results:** Hyponatraemia was diagnosed in 26/50. (4- moderate, 22-Mild).
Moderate hyponatraemia was treated with fluid restriction and mild hyponatraemia resolved spontaneously. 9 out of 20 patients who became hyponatraemic on day 1, had normal sodium levels on day 2,9 out of 12 with nausea & vomiting were hyponatraemic. Only 6/26 were fluid restricted.
NO AKI in any of the patients. Average length of stay (ALOS) in hyponatraemic patients- 5 days(3-11) and non-hyponatraemic patients- 5.2 days. ALOS in moderate hyponatraemic group (4) - 6.25 days and ALOS in restricted group (6) - 6 days.
The commonest co-morbidity was hypertension (20% on thiazide diuretic and 30% were on PPI). The average est. total fluid (PO+IV) intake in the first 12 hours post-operatively: 2950ml in the hyponatraemic group vs 2625ml in non-hyponatraemics.

**Discussion and Recommendations:** Mild hyponatraemia resolves spontaneously. Majority of these cases are iatrogenic and could be prevented. No new attributable cause was found. However, careful fluid balance is advised avoiding overzealous fluid prescription.
Identification of patient sub-groups at risk may help to reduce its incidence.

**References:**

1.Hyponatremia after primary hip and knee arthroplasty: incidence and associated risk factors. *Sah AP1. Am J Orthop (Belle Mead NJ). 2014 Apr;43(4):E69-73.*

2. Hyponatraemia after orthopaedic surgery. *Nick Lane, Kathryn Allen BMJ. 1999 May 22; 318(7195): 1363–1364*

**Abstract P7: Case report**

**Title:** Isolated hypoglossal nerve palsy presenting as a stroke mimic

**Presenter:** ***Dr Nihara De Silva***, FY1, Luton and Dunstable Hospital

**Introduction/ Background:** Isolated hypoglossal nerve palsy (HNP) is rare compared to the simultaneous involvement of multiple cranial nerves [1]. A common cause of this finding is metastasis [1]. We describe hypoglossal nerve compression caused by metastasis from a probable thyroid primary.

**Objectives:** We describe a 72-year-old gentleman presenting with left-sided occipital headache and slurred speech. Clinical examination found mild dysarthria, left-sided tongue weakness and neck pain, and tongue deviation to the left on protrusion. He was initially managed as a stroke patient and started on dual anti-platelets. Computed tomography (CT), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) revealed no stroke or dissection. MRI with contrast showed bony metastases spreading to the clivus and left hypoglossal canal. A thyroid nodule was identified as the possible primary tumour.

**Methods:** Case report of a patient presenting with left HNP and a literature search of PubMed using the term 'isolated hypoglossal nerve palsy'.

**Results and Discussion:** The hypoglossal nerve provides motor innervation of the tongue. Causes of HNP have commonly been subdivided to follow the anatomical course of the nerve [2]. Literature review revealed primary malignancy and skull base metastases as widely reported causes. This phenomenon is uncommon in stroke, but internal carotid and vertebral artery dissections can present with the symptoms seen in our patient [1].

**Conclusions:** In patients with isolated HNP, malignancy should remain at the forefront of differential diagnoses; stroke is a rare cause. Metastasis from a primary thyroid cancer causing HNP has been previously described [3].

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**Abstract P8: Retrospective cohort study**

**Title:** The value of routine intraoperative cholangiogram in patients with normal liver function tests and common bile duct diameter - A single unit experience

**Presenter:** ***U S Medagodahetti,*** Senior Clinical Fellow in General Surgery, Russell's Hall Hospital, Dudley, West Midlands. *N Lal, S J D Wickramarathna, E Palmer, A H Khan and S C Sellahewa.*

**Introduction/ Background:** The use of routine versus selective intra-operative cholangiogram (IOC) in laparoscopic cholecystectomy (LC) remains an area of debate, and its value in detecting residual stones in patients with normal liver function tests (LFTs) and normal common bile duct (CBD) diameter is considered an unresolved issue.[1,2]

**Objectives:** 1.To investigate the effectiveness of routine IOC in detecting residual stones in patients undergoing LC. 2.To assess the relationship between residual CBD stones with preoperative LFTs and CBD diameter.

**Material and Methods:** Between January 2015 and March 2019 all patients who had LC with successful IOC, performed by one upper GI consultant at Russell's Hall Hospital (Dudley), were recruited for the study. Data collected retrospectively using the hospital electronic system and operation notes.

**Results and Discussion:** We identified 582 patients who underwent LC and IOC, of whom 425 (73.02%) were female. 35 (6.01%) patients had filling defects noted on IOC. 27 (77.14%) of these patients proceeded to ERCP, of whom 19 (70.37%) were found to have CBD stones. Of those with CBD stones, 14 (73.68%) had normal preoperative alkaline phosphatase (ALP) levels and 19 (100%) had normal serum bilirubin. 12 (63.15%) had non-dilated CBD in preoperative imaging. 8 (42.11%) had ALP, bilirubin and CBD diameter all normal.

**Discussion:** This study demonstrates that routine IOC was effective in detecting residual CBD stones in this cohort. These incidental stones could potentially cause symptoms if left untreated. A significant proportion of patients with CBD stones had normal preoperative LFTs and CBD diameter.

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1) Iranmanesh P, Tobler O, De Sousa S, Andres A, Frossard J-L, Morel P, et al. (2018) Feasibility, benefit and risk of systematic intraoperative cholangiogram in patients undergoing emergency cholecystectomy. PLoS ONE 13(6): e0199147. https://doi.org/10.1371/ journal.pone.0199147

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