

## **ELECTIVE (SSC5b) REPORT (1200 words)**

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

**During the time course of my placement one of the most common presentations during ward cover was conditions and acute management relating to alcoholic liver disease (ALD). This was in contrast of expecting to observe a predominant caseload relating to IBD which during this short time frame appeared less frequent. Speaking with the wider team they stated that over this time period this did not fully portray an accurate representation of their daily work/caseload management. However, it proved insightful to discuss with the team as to why this trend is becoming apparent. One reason for the increased disease burden relating to ALD at the hospital could be the vast catchment area in which it covers. This was highlighted during a consultant clinic I attended whereby numerous patients would travel in excess of 1h to attend, one specific case travelling over 1.5h from another city who was then subsequently admitted for detox. A valid argument for cases like this to be treated more locally to the individual would be that they are closer to family, support networks and ongoing rehab units which could seek to distribute the disease burden more evenly; although this equally highlights regional disparities in what services are offered. Other causes discussed for the use of increased ETOH consumption was the wider demographics of the surrounding regions e.g. indigenous populations reporting a higher intake and also lower socio-economic classes from refugee backgrounds which is comparable to the UK.**

**In some of the cases of IBD that I was able to observe it was interesting to see how the management differed vs the UK. Mostly the medication management appears equivaquol other than most things in Australia being quoted as the brand name. Subsequently I was told that it was more for patient ease vs generics not being available however, interestingly this is something we are fiercly taught not to do during our training. Another interesting difference in the role of management was the practicalities of scoping patients whereby common practice here is to sedate all patients for endoscopy which is not routinely done in the UK practice I have observed. On further discussion with a consultant in endoscopy this appeared to be a cultural preference for the patient and the clinician. Equally we were able to discuss the pros and cons to the differing practices relating weighing up the risk of complications when sedation is used but equally the increase in completion rates.**

**In terms of the junior doctor structure this appeared very comparable to the UK. My team within gastroenterology displayed good team working skills and emphasized the key point of keeping up with jobs throughout the ward rounds to help facilitate more rapid and seamless forward planning in relation to procedures and discharges. Communication across the team was vital throughout the day which enabled effective management of the patients whereby often the team would split during ward round and would always prioritise seeing potential discharges first to aid bed pressures. Another key feature was that the workload was fairly shared between team members within their clinical capabilities. This often helped to ensure rounds were not too long and would often enable the team to have small tutorials led by the registrar. One registrar in particular provided concise but very informative tutorials on a variety of topics including renal medicine, TB and causes/management of ascites which was a useful test of my knowledge post finals and pre foundation.**

**During one of my sessions in endoscopy I was able to discuss some of the current research and trials taking place at SVHM in the remit of inflammatory bowel disease. One of particular interest is the**

ongoing STRIDENT study which we discussed which aims to address issues of stricture development during the disease course and seeking optimal treatments to prevent this complication utilising biological therapies - anti TNFs . We also discussed some of the new imaging modalities being used throughout this trial assessing the use of intestinal ultrasound scanning as a non-invasive measure of inflammation. We were also able to discuss the evolving disease profile in epidemiological terms whereby Australia sees high immigration from now developed Asian countries which have seen dramatic increases in IBD incidence rates whereby the unit is seeking to conduct epi studies to help acquire a better understanding as to why this shift has occurred.

As part of my attachment I have been able to attend case discussions regarding ongoing patient care and also observe a weekly forum whereby the MDT and lead consultants in gastroenterology, psychiatry and psychologists discuss complex cases. This principally addresses patients that attend the functional gut clinic whereby there is an array of input from the MDT helping to manage these patients. I found this of particular interest as this drew on my experience as a gastro dietitian and also my time working with patient's with diagnosed eating disorders. This appeared to be an invaluable opportunity for members of the team to discuss current patients and how to best progress their care/management whilst also serving as an informative learning opportunity for the junior doctors and all those involved.