ELECTIVE (SSC5c) REPORT (1200 words)

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

1. What are the most common reasons for paediatric admission at Newham General?

The most common conditions admitted include viral-induced wheeze, sepsis, bronchitis, febrile seizures, and exacerbation of asthma. The ward also has an observation unit that monitors children with ENT conditions, dental conditions, and transfusions. Children with long term conditions can be fast-tracked from A&E to the ward. This includes patients with global developmental delay presenting with acute infections e.g. chest, children with reflux presenting with vomiting, and children with epilepsy presenting with seizures.

I saw many interesting cases on the ward that I know I will remember during my career. An example was a case of Addisonian crisis in a patient with congenital adrenal hyperplasia. I had not seen this before and I found it really interesting to hear the patient's history, as well as recap my knowledge of the condition through discussions with Dr Anjum and the other students. Other interesting cases I saw were hydrocephalus in a child with beta mannosidase deficiency, LOC after head trauma, febrile seizure, and a patient with nephrotic syndrome and renal transplant. I found the cases at the Rainbow ward to be extremely interesting and educational.

2. Describe the management available at Newham General for acute asthma and compare this to that available in other areas of the UK

As with other acute scenarios, there is a protocol that is followed in the paediatrics A&E for managing acute asthma. I was able to get a copy of the guidelines used in Newham, as well as research on the information that this guideline was based on – the Children's Acute Transport Service (CATS) Clinical Guidelines for Acute Severe Asthma (attached).

In summary, the guidelines outline the features to look out for when classifying an acute asthma exacerbation into moderate, severe, or life-threatening, and then provides clear and detailed information for its management.

A basic overview of the protocol for severe asthma is that patients should first be given high flow oxygen if SpO2 is <92%, and then back to back doses of nebulised bronchodilators (salbutamol 2.5-5mg with 250 mcg of ipratropium bromide). The next step up from this, if symptoms are not improving, is to administer IV hydrocortisone 4 hourly, after which IV salbutamol (max 250 mcg) can be tried. Further options then include giving IV aminophylline, or a slow infusion of IV magnesium sulphate.

I decided to look at the guidelines used to treat acute asthma in Scotland (attached) to compare it to the one used at Newham General. I was surprised to see that, while elements of the SIGN guideline (Scottish Intercollegiate Guidelines Network) were quite similar, there were some small differences in the management that is advised.

Firstly, it did not mention the administering of oxygen in its flow chart. Secondly it advocates the use of magnesium sulphate with the nebuliser. The other difference I noticed was that, where CATS tell us to give steroid therapy intravenously, SIGN advises to use oral steroids. The final difference was that

giving an infusion of magnesium sulphate was not clearly indicated at the end of the flowchart, as 'its place in the management is not yet established).

I'm glad I had a look at the SIGN guidelines- it was interesting to see the small differences in the treatment of acute asthma between the one employed by staff at Newham, and the one used in a different part of the UK, i.e. Scotland.

3. Describe examples of good clinical practice that I have observed in paediatric management at Newham

During my time at Newham, I sat in for a number of clinics, during which I was able to learn a lot about how different doctors approach their patients. Regardless of how different one doctor was to the next, I realised that, through years of experience, they had each perfected their own manner and method for communicating with and treating their patients. They all made the care of their patient their first concern, and had extensive, up to date knowledge in their field. They also maintained the safety, dignity and comfort of their patients. Confidentiality was always upheld and patients were treated as individuals whose opinion was valued in the partnership that was created when deciding on management.

An example of a case that interested me was of an eight year old boy with sickle cell anaemia. I saw him during a haematology clinic at Ark outpatients and a discussion was had between the consultant and the patient's parents in regards to bone marrow transplant, due to the patient suffering from frequent crises in the past. After extensive discussion, a decision was made, in light of the fact that in the last six months the patient had been in good health with no crises occurring, to wait until the child was older. When the child reaches adulthood and is able to understand the implications of a bone marrow transplant (e.g. probable infertility), he can make a decision to go ahead with the transplant or not. If however the child does become unwell again, the option for bone marrow transplanting was always there, especially since his stem cells had already been saved.

I observed how both the child's parents and the consultant were equally as concerned for his safety and good health, as well as wanting to give him the opportunity to make his own informed decision regarding his health and management.

4. Overall reflection on my elective placement and explore paediatrics as a potential career path

The last six weeks spent on this elective has been enjoyable as well as educational. I was given the opportunity to make my own decisions about my education and experience here, while being offered a range of activities and tasks to take part in. These included bedside teaching, teaching sessions, ward rounds, shadowing on the ward and in A&E, and attending outpatients' clinics. I opted to mainly attend bedside teaching, scheduled teaching sessions, ward rounds, and outpatients' clinics.

The ward rounds I attended were really interesting. The staff were passionate about their work and held great relationships with their patients as well as the patients' families. They were also very helpful explaining things, quizzing me and giving me tips for when I start working.

I found the bedside teaching sessions to be very useful, especially after having attended the ward round prior to them. It gave me further insight into the patients as well as being taught more about history taking and examining. The scheduled teaching sessions were also very useful. Even though I

had already sat in for them in previous years, I still found it a good revision and I know it will be useful for when I start working as an FY1.

During outpatients' clinics, while there were some conditions that were more common than others, I was still able to see a wide range of conditions. The consultants I sat in with were friendly and knowledgeable, and taught me a lot about how to communicate with patients and their families.

Overall this elective has been a very enjoyable experience, and I know I have built on my knowledge to take away with me for work. Paediatrics has always been of interest to me and I would definitely enjoy it as a career. I think, however, my heart leans more towards working as a GP. But I know that even as a GP, a large proportion of my patients will be children so I am glad that I have been able to partake in this elective and spend time with the staff here.