ELECTIVE (SSC5b) REPORT (1200 words)

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

I spent two weeks in Respiratory Medicine at Poole Hospital. This included attending ward rounds, clinics, procedures, such as bronchoscopy and thoracoscopy, and observing and assisting with suitable procedures on the wards, such as chest drains. This was an excellent opportunity to see good practice in preparation for my FY1 job in Respiratory medicine next year.

What are the characteristics of respiratory patients in Poole? What are the key comparison points with East London?

Attending the ward rounds and clinics at Poole gave a good impression of the variety of patients and presentations. The majority of patients were older people, but I was interested at the variety of patients and presentations. I saw several patients with bronchiectasis and lung fibrosis, which were conditions where I was glad to improve my clinical experience. I was also interested to learn about lung cancers from patients in clinic, which I had little clinical experience of despite being the second or third most common cancer in the UK, after breast and prostate.

I completed my last Respiratory medicine placement in Newham in East London. Newham differs from Poole in that it has a majority young migrant population, with a census average age of 30. The conditions I saw most commonly while in Newham were COPD exacerbation, asthma and tuberculosis. Newham has the highest rates of tuberculosis in the UK. There is social stigma around tuberculosis, and I have heard it called Koch's disease by a Doctor, to avoid the stigma. This could be why treatment completion rates in Newham are below average for London, and 1 in 10 patients are lost to followup. I was aware of two cases of suspected new tuberculosis on the ward while I was there, which were not thought to be TB on review. This indicated the importance of a high index of suspicion for TB as it is an infectious disease.

How are the services provided in respiratory medicine in Poole? How similar is the provision to East London?

The respratory ward (B4 Arne ward) in Poole was a large acute medical ward of about 28 beds in bays and side rooms. Additional respiratory patients, or outliers, are located elsewhere in the hospital. I attended the consultant ward round twicea week, and junior Doctors completed ward rounds on the other days. These were a good opportunity to see patients with a range of respiratory conditions, and learn about their management. It was also a chance to learn from observing good practice and prepare for FY1 work in August.

Endoscopic procedures were once a week or fourtnight, and I attended a thoracoscopy list, and broncoscopy list. Thoracoscopy involved endoscopic visualisation of the pleaural space, with tissue samples taken for diagnosis, and therapeutic drainage of effusion. This was followed by pleurodeisis where the viceral and parietal pleura were encouraged to adhere together by an inflammatory reaction to talc, with the goal of preventing further effusion. The broncoscopy list included an endobronchial ultrasound (EBUS) where lymphnode biopsies were taken under ultrasound guidance, and bronchial washings for culture in bronchiectasis. I had not seen either of these procedures before, so was glad to have the opportunity.

There were Respiratory clinics several times a week, with a variety of patients attending. I saw patients coming for appointments to review chronic conditions, such as asthma, as well as breaking bad news to patients with lung cancer.

What are the characteristics of the respiratory patients in Poole in terms of complexity, multimorbidity and polypharmacy?

Many of the patients on the ward and in clinic were older people, and included those with multiple conditions, and social care needs. Some of these patients had respiratory conditions as a result of systemic illnesses, such as vasculitis, or in addition to other unrelated conditions. Patients with multiple conditions reminded me that it is possible to present with more than one problem at any one time. Patients with a longer medical history tended to take more medications, but there were patients who attended clinic or on the ward who took no medications previously.

What are the characteristics of work in respiratory medicine and how to they correspond to my strengths and weaknesses? How has this helped me prepare for FY1?

I was glad to have the chance to practice examination skills, particularly lung auscultation, under the supervision of Dr Crowther. This was an area that I was able to develop in terms of precision in describing crackles by their nature and timing. I listened to the late inspiratory crackles of fibrosis, and coarse crackles of bronchiectasis. These were both conditions where I was glad to develop my understanding and clinical experience.

I was interested to learn about how respiratory function tests were used in distinguishing lung disease and assessing severity. Although I had a basic understanding of obstructive and restrictive conditions defined by the FVC and FEV1 values and ratio, more subtle inferences based on airflow in small airways (PEF), and gas transfer factors were interesting to learn about.

I saw chest drains being inserted using the seldinger technique involving a needle, guidewire, dilator and drain, and was lucky to be present while an FY1 was taught and supervised to complete a chest drain. This reminded me of how it is importaint to plan educational opportunities to develop skills and competencies, and that this is an ongoing process. I was particularly glad to practice the organisational elements of an FY1, such as annotating the list, writing in the notes, and making a jobs list from handover and management plans. I think this will be of great value on starting work in August.

https://www.newham.gov.uk/Pages/News/Residents-urged-to-help-win-fight-against-TB.aspx

http://www.newham.info/factsandfigures

http://www.healthwatchnewham.co.uk/sites/default/files/tb_report.pdf

http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/common-cancers-compared#heading-Zero