ELECTIVE (SSC5b) REPORT (1200 words)

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

The scope of Plastic Surgery is extensively diverse. In this specialty understanding and managing patient expectations is often as challenging as addressing the pathology itself. Clinical conditions that are managed here can be broadly divided into burns, emergency and elective procedures. During my elective period in Plastic Surgery, I was fortunate to be exposed to a wide range of conditions and procedures in clinics, wards and theatres.

Emergencies such as fractured fingers, lacerations, amputations, neurovascular or tendon injuries are triaged by the trauma team and managed appropriately based on the injury. Patients with open fractures are admitted and listed for open reduction of fracture with antibiotic cover while small lacerations are sutured in the minor injuries unit.

Patients referred for elective procedures are initially seen in the clinic as 2 week wait or routine appointments and managed as required. These may include malignant conditions such as melanomas or SCCs or more benign lesions such as lipomas or release of Dupuytrens contracture. Patients requiring procedures such as breast reconstruction may be managed electively following mastectomy and completion of radiotherapy or they are seen alongside breast oncologists.

Meticulous planning is invested into management of each patient. The surgeons work as a team with specialist nurses, psychotherapists, physiotherapists and occupatioanal therapists inorder to achieve pre-morbid functionality. Patients are reassessed at regular intervals following discharge from hospital, untill their wounds heal post-operatively and sometimes this can be for several months.

Surgical procedures performed to manage this wide scope of conditions are complex and require extensive working knowledge of surgical anatomy. Immense care is taken at every step to allow optimal neurovascular supply for tissue repair. Microscopic autograph and tissue repair techniques involve excellent hand to eye coordination. Detailed attention is given to dressing the wounds to enable healing.

Management of burns is highly specialized and in UK, this is restricted to a very few units spread accross the country, QVH Burns Unit being one such specialist centre. Currently, burns injuries are graded into different severities based on factors such as site, extent of burn etc and patients are treated in the community or burns centers or units according to the national protocol. This streamlining of management is thought to improve outcomes.

The Burns unit at QVH caters to a large area of South of England, including Kent, Sussex, Surrey and South London. It also provides outreach care for burns patients who owing to their medical comorbidities are unable to be transferred to the Burns unit.

Adult burns patients are initially assessed in emergency burns assessment centre. Patients with minor burns are managed as outpatients with dressings and if necessary, brought in for surgical intervention electively. Patients with extensive burns are admitted and resuscitated especially to maintain fluid balance and pain control. Patients with burns amounting to greater than 15% in young adults and greater than 10% in the elderly and patients with inhalation injury are admitted to ITU after discussion with Burns consultant and anaesthetic team. Full thickness burns management is

customized to each patient and involves a variety of interventions including debridement, regular dressing changes, allografts, split skin grafts and early rehabilitation. Patients with burns scars that are affecting their function adversely are seen in outpatient clinics and managed with appropriate interventions.

All patients admitted with burns are discussed in a multi disciplinary team meeting every morning. Open discussion of every aspect of each patient's care is encouraged in this meeting and every team member is allowed to contribute. A plan is agreed upon following this discussion, which is clearly documented in patient records to enable optimal patient care.

Paediatric burns patients are assessed and managed in a separate ward which also has high dependency beds. A meticulous history is taken for every paediatric burns patient on arrival to rule out non-accidental injury and risk assessment for future injuries is carried out.

Burns injuries constitute a significant percentage of trauma in United Kingdom and this reflects presentation of burns injuries worldwide. Burns have a heavy impact on patients' physical and psychosocial morbidity in the short and long terms. However, there is little evidence on longterm mortality risk associated with burns in the elderly population. As part of my elective, I participated in a study assessing mortality risk in elderly burns patients attending QVH. I was involved in reviewing literature pertinent to the study, study design and data collection. I intend to collate the data and present my findings in the next BAPRAS scientific meeting.

My experience of observing excellent clinical care, here at QVH, will have a strong influence on my future clinical practice. The knowledge gained in management of burns will be a definite advantage in my career as a foundation doctor. Effective communication and team work I experienced here will certainly add a positive impact on my career. In addition, I feel fortunate to have witnessed the importance of holistic care in patient management during my time here.