South Warwickshire NHS Foundation Trust

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Acute Medicine Educational Newsletter

March 2023 | Edition 5

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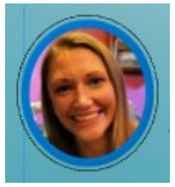
Editor
Angela Perrett | Acute Medicine ACP



Editors Update

Angela Perrett | ACP Acute Medicine

Welcome back to another edition of the Acute Medicine Educational Newsletter (AMEN). I am excited to finally get this edition out, with a new design, and I am hoping to increase the frequency of these educational newsletters to quarterly. I am very keen for everyone to get involved, so please do let me know if you have any interesting reflections, research, clinical cases or anything else you wish to be included — this resource is for everyone. Equally, I welcome any feedback or suggestions to help improve the Newsletter.

Since the last edition we have had Acute Medicine Awareness day. A huge thank you to those that organised the cake sale.

We have had the Samba report, which is included in this newsletter and this proved what an amazing service we have at Warwick hospital. Everyone works so tirelessly, especially during the winter pressures and I personally am proud to work with such a wonderful multidisciplinary team.

Have you all seen the guess the baby competition on the wall at the entrance to Oken / AEC? Can you guess them all yet?

01 Meet the Team: GP Liaison Team

Katy McDonnell, Kam Kaur, Celine Lepretre-Granet, Kelly Mukundu | GP Liaison Team

Katy McDonnell

Having started my nursing career on Oken Ward in October 2014, I feel such a baptism of fire provided a fantastic learning platform due to the varied exposure to acute medicine & the benefit of working alongside such experienced healthcare professionals. Thus, I soon felt ready to progress onto a Sister's role managing a medical discharge ward.

As I gained knowledge of clinical management I discovered that my true interests lie more towards clinical care & a wish to acquire advanced clinical skills. I was then pleased to move into a Medical Nurse Practitioner position with the Frailty Team, which provided the opportunity to return to University & complete a Post-Reg MSc in Health Assessment followed by an Independent Prescriber module.

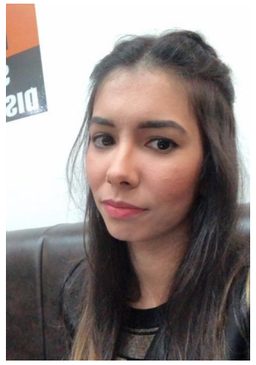
As my clinical knowledge expanded through rapid assessment and acute service selection I became more confident with my clinical decision making & clinical critique. Thus lead me towards a more autonomous role, and I welcomed the new role of GP Liaison Practitioner in March 2021. I felt in a fine position to recognise considerations for new models of triage & referral pathways, and I embraced the support I experience upon my return to acute medicine (back to my roots;).

What was once a solo role has now expanded to a team of four Medical Flow Practitioners ☺ which has enabled us to provide our primary care colleagues with a weekday telephone triage service, alongside providing our acute medical team with a 7-day support service in A&E. I'm loving the new dimension that this team expansion has introduced, mainly due to the need for front-door

clinical assessment and the increased opportunity for hands-on patient care.

Kam Kaur

I am originally from India but moved to Italy at a young age and studied nursing there. After receiving my nursing degree, I have decided to move to England to practise nursing. A great opportunity came up for me to be recruited by SWFT as a band 5 nurse for the Haematology ward (Farries ward).



There have been lots of challenges on arrival to England, from not knowing the language to being alone in a country without my parents. Thanks to the support of my colleagues, managers and relatives, I have been able to `Fit in` the team very well.

SWFT has given me the opportunity to study and develop my career, from in hospital training to academic level studies, from having experience in different wards and specialities. I have made lots of friends here as well.

I am currently a Band 7 GP Liaison/ Flow practitioner nurse with previous experience in Haematology, Care of elderly and acute medicine. I am very satisfied about the progression I have made so far and my family are proud. I am always looking for opportunities to develop myself and my career and hopefully something good will be in future but for now, I am very happy with my current job role and I have beautiful, wonderful and supportive colleagues.

Celine Lepretre-Granet

I was working as a clinical sister at Worcester A&E prior to this role. The majority of my nursing career to date has been spent in A&E departments. I also have held various other nursing positions that include trauma and orthopaedics and cardio thoracic. Acute medicine is fairly new to me ☺ I am excited to see how this role evolves.

Kelly Hope Mukundu

Prior to this GP Liaison/Flow Practitioner role I was a Clinical Site Manager at MID & South Essex NHS Foundation Trust.

My clinical experience includes Acute Medicine, Oncology & Haematology – Palliative Care and Chemotherapy.

This role encourages me to utilise both my clinical and non-clinical skills.

I am fairly new to the team and look forward to see how this role will evolve.

GP Liaison

Our service offers a single point of contact for emergency medical referrals and ensures that GPs are provided with the most appropriate pathway for their patients.

We aim to provide efficient and effective communication with all GPs/ ACPs, 111 and WMAS staff

The benefits of the service include:

- A dedicated single point of contact for GP emergency medical referrals
- An improved direct phone line for communicating patient details
- Email facility (to allow referral details/patient summaries to be sent to)
- Time saving in establishing contact with the on-call doctor
- Redirection to appropriate specialist services and fast-track clinics

Admission to the hospital's Emergency Department / Acute Decisions Unit (ADU) may not always be the most direct route for patients to receive the care they need. The hospital is continually striving to improve access to its services and have created some fast-track clinics to enable patients to be seen as soon as possible by the most relevant specialty.

The GP Liaison Nurse can advise on, and facilitate admission to the most appropriate specialist service according to individual patient needs.

In this way the GP Liaison service aims to reduce inappropriate emergency admissions and ensures that GPs have access to specialist services and fast track clinics, in addition to the hospital's Emergency Department /ADU.

The service is available Monday to Friday 8am-7pm. Please contact Katy McDonnell, Kam Kaur, Celine Lepretre -Granet and Kelly Mukundu GP Liaison Nurses:

- Telephone: 07979705360
- Office Ex. 6939
- Email: ambulatory.care@nhs.net

Flow Practitioner

This role has been up and running since summer 2022. We are now a fully established team of 4 band 7 nurses. We aim to provide cover within our ED department 7 days a week. When there are gaps in our rota, due to annual leave, we will not have cover in ED on Wednesdays and Thursdays, please bare this in mind. Dr Elliott is looking at recruiting another part time member to support our rota gaps.

In a nutshell, the flow practitioner role aims to:

- Identify and stream medical patients within ED to the most appropriate clinical area (right patient, right place, first time), increasing utilisation of AEC where appropriate

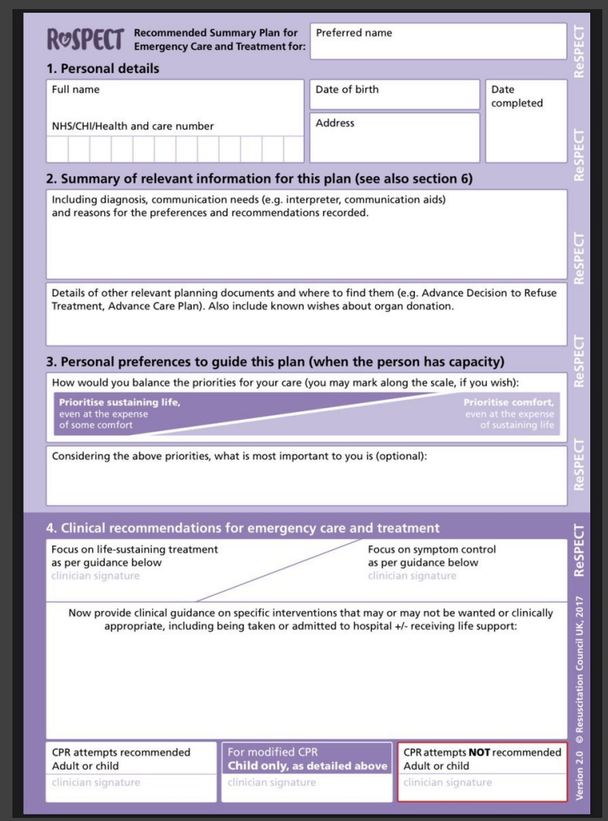
- Improve patient flow from ED by facilitating prompt triage / assessment, clinical decision-making and expediting transfer / discharge
- Enhance communication, handover and team-working between ED, the on-call medical team and medical assessment areas
- Provide continuity of care during the busiest periods in the evening and reduce the number of patients handed over to be seen by the night team
- Improve patient safety and experience.

ReSPECT

Have you had the conversation?

Everybody has the right to be treated with dignity and respect!!

Recommended Summary Plan for Emergency Care and Treatment



02 Acute Kidney Injury Part 1

Dr Claire Winterbottom | Consultant

An introduction to AKI – 5 Important Questions

What is Acute Kidney Injury (AKI)?

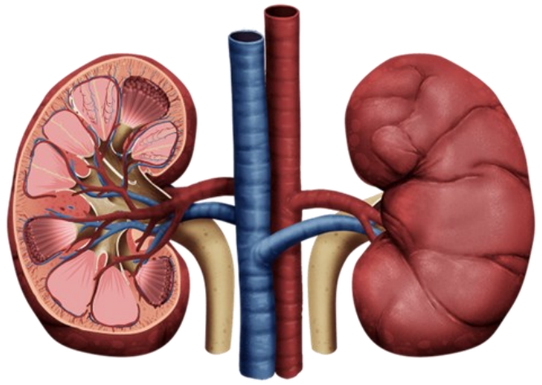
AKI stands for acute kidney injury and is defined as a sudden reduction in kidney function over a period of hours to days leading to a rise in serum creatinine and/or a fall in urine output. It commonly occurs in patients with intercurrent illness.

Why is it important?

AKI is common

- Approximately 1/5 people admitted to hospital each year as an emergency have an AKI
- About 65% of AKI starts in the community

And is associated with considerable harm



- In the UK up to 100,000 deaths each year in hospital are associated with AKI
- Inpatient mortality of >20% (increasing to 35% with stage 3 AKI)

The development and course of AKI is modifiable

- Early recognition and appropriate management is important to reduce progression of AKI
- Care bundles are proven to improve outcomes

Who is at risk?

- All acutely unwell patients
- > 65 years age
- Patients with pre-existing kidney disease or previous episodes of AKI
- Comorbidities – diabetes, heart failure, liver disease
- If you're taking certain medications – NSAIDs, ACEi, diuretics, immune check point inhibitors, aminoglycosides, PPIs

How do we recognise it?

AKI is recognised by a change in creatinine or urine output and is staged using the KDIGO staging system (see below). Biochemical alerts are generated by the lab and are automatically uploaded to ICE.

Increasing stage of AKI is associated with increased risk of death, ICU admission and increased hospital length of stay.

Stage	Serum creatinine	Urine output
1	1.5–1.9 times baseline OR ⩾0.3 mg/dl (⩾26.5 μmol/l) increase	<0.5 ml/kg/h for 6–12 hours
2	2.0–2.9 times baseline	<0.5 ml/kg/h for ⩾12 hours
3	3.0 times baseline OR Increase in serum creatinine to ⩾4.0 mg/dl (⩾353.6 μmol/l) OR Initiation of renal replacement therapy OR, In patients <18 years, decrease in eGFR to <35 ml/min per 1.73 m^2	<0.3 ml/kg/h for ⩾24 hours OR Anuria for ⩾12 hours

What do we need to do?

- Assess the patient and complete all the minimum steps of the AKI care bundle
- Document urine dip clearly in the medical notes
- Consider the need to refer to SWFT ICU team or UHCW renal team
- Complete for all stages of AKI

	Review →	Respond →
Complete for all AKI Stages	☐ ABCDE Assessment ☐ Observations check MEWS score ☐ Look for signs of sepsis	☐ Call for help to resuscitate if patient critical ☐ Prompt treatment of sepsis *(Start Sepsis six care bundle if signs of sepsis)*
	☐ Volume status assessment ☐ Fluid balance chart	☐ Fluid challenges if hypovolaemic/hypotensive
	☐ Abdominal palpation looking for full bladder *or* perform bladder scan	☐ Relieve obstruction
	☐ Medication review	☐ If BP low hold BP lowering medication ☐ Consider stopping nephrotoxics (e.g. *NSAIDs, ACE Inhibitors, Diuretics, Angiotensin receptor blockers, Gentamicin, PPI)* ☐ Check for dose adjustment in AKI
	☐ Urine Dipstick *(Document full result in notes)*	☐ Send Urine ACR if proteinuria ☐ Send Urine MC+S if haematuria, suspicion of crystalluria or infection ☐ Consider vasculitis / renal screen if haematuria or proteinuria *(ANA, ANCA, antiGBM, complement C3/C4, Immunoglobulins, serum & urine electrophoresis)*

Useful resources

AKI Care Bundle.pdf (warwickacutemedicine.co.uk)

AKI Home - Acute Kidney Injury (thinkkidneys.nhs.uk)

Acute kidney injury - Symptoms, diagnosis and treatment | BMJ Best Practice

03 Clinical Incident: Learning Points for all

Molly Bowler | Sister Oken Ward

Background

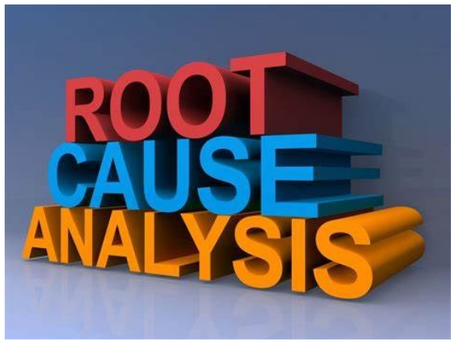
Within the past three months on AMU we have had three serious incidents where patients have developed pressure damage. All incidents were investigated and determined to be avoidable, had hospital policy been adhered too.

For each of the incidents one of the sisters on AMU had to fill out an incident document where all of the patient's notes had to be detailed to investigate omissions in care. After this was completed the case was then presented at a Pressure Ulcer Review Group (PURG).

PURG is used by the trust to investigate whether harm was caused to the patient, and therefore how this can be prevented in the future. It is not used to point fingers at individuals but to recognise lessons learnt and create an action plan on how we can prevent omissions in care happening again. Members at PURG include: the patient safety team, the head of nursing, a member of the CCG, Tissue Viability Lead Nurse and other teams which maybe relevant to that case. Below is a brief outline of one of the investigations that occurred.

Incident

A patient was admitted with chest and urine sepsis and was bedbound from traumatic brain injury. The patient was quadriplegic and had been on an Invacare® mattress without a pump since admission. On admission they had a skin assessment which stated the patients' skin was intact, however, two days later it was documented as discoloured across his sacrum area which was an STDI.



Contributing Factors

1. Waterlow was assessed as 14 on admission however patient was bedbound and couldn't reposition self. Patient was on an Invacare mattress however there was no pump applied. Waterlow was reassessed two days later and determined as 28.
2. No pressure ulcer care plan completed until the patient was transferred to a different ward.
3. Patient had private carers who were helping with ADL's, however this meant that no documentation was being completed and pressure damage wasn't identified early enough.
4. There was a complete lack of documentation on the rounding charts, on one day there were no turns or skin checks documented from 06:00 until 21:30.
5. The patient was a bedbound, quadriplegic who was NBM for a lot of his time on AMU and therefore was high risk of developing a pressure ulcer however not put on an air mattress until the STDI was discovered.
6. 0% of RN's and HCA's had completed the mandatory pressure ulcer training on ESR.

Conclusion

It was concluded by PURG that the pressure ulcer was caused by omissions in care by the nursing team. Poor repositioning by nursing staff directly caused a patient to gain an ungradable pressure ulcer.

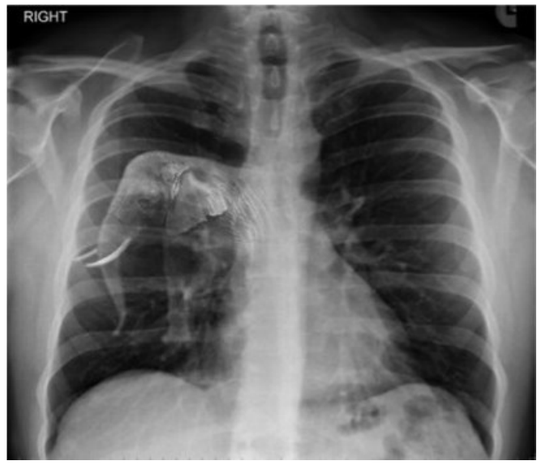
Lessons learnt

- Patients must have accurate initial assessments to be able to nurse them with the correct equipment.
- Even when patients have private carers who help with personal care, nurses must still be completing skin checks and documenting when the patient is repositioned.
- More training is needed for our staff to identify high risk patients and the importance of documentation.
- Pressure ulcer prevention equipment has now been ordered for the ward.

04 Simple Chest Xray Interpretation

Angela Perrett | Acute Medicine ACP

How would you interpret this Xray?

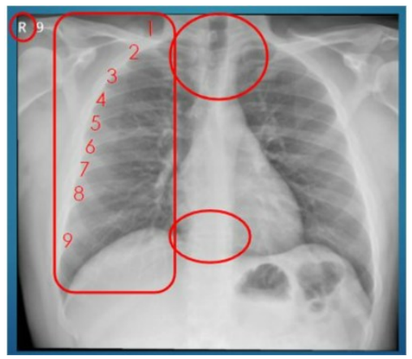


Use a systematic approach:

⇒ Technical
⇒ A
⇒ B
⇒ C
⇒ D
⇒ E / F
⇒ G

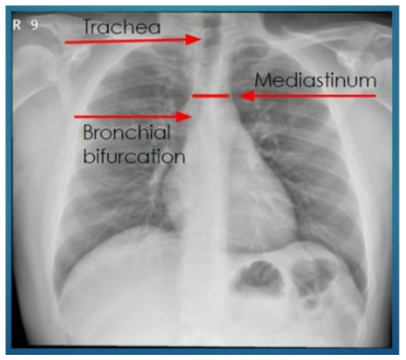
Technical

Correct patient and date, Orientation, Position (supine/erect, PA/AP) Rotation, Inhalation, Exposure.



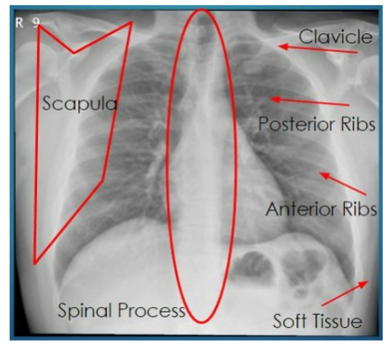
Airway

Trachea, mediastinum, bronchial bifurcation



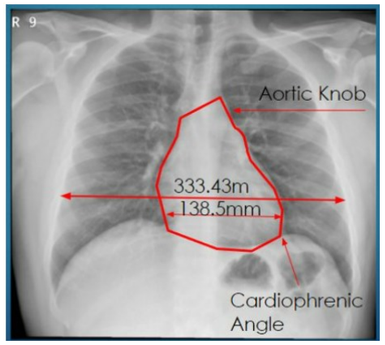
Bone and Soft Tissue

Clavicle, Anterior (6) and Posterior (9) ribs, Scapula, Spinal Process



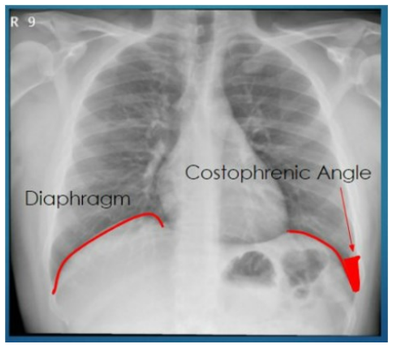
Cardiac Shadow

The cardiac silhouette is considered enlarged if the cardiothoracic ratio is greater than 50% on a PA view of the chest



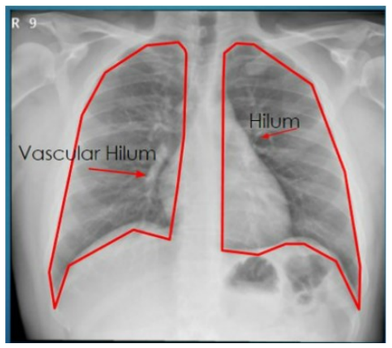
Diaphragm

Costophrenic angle, pneumoperitoneum



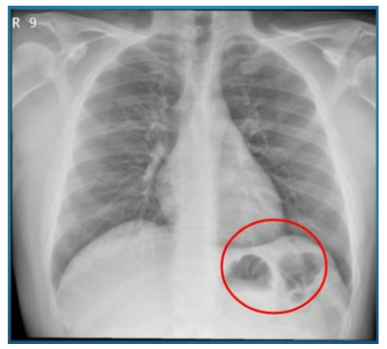
Equal Lung Fields

Compare upper, middle and lower lung zones,. Abnormalities include consolidation, masses, pneumothorax, pleural effusion



Gastric Bubble

Round / ovoid shape under left hemidiaphragm is normal. However, a thickened hemidiaphragm with gas underneath could indicate a perforation



05 Not another blood test!?

Serum Osmolality, Urine Sodium / Osmolality

Sadie Davies | ACP Acute Medicine

Serum = a portion of plasma remaining after coagulation of blood

Osmolality = a measure of the concentration of particles dissolved in a kilogram of fluid

Sodium = salt

Hyponatraemia is when the serum sodium is <135mmol/L

So what? ....

Serum osmolality along with urine sodium and osmolality are needed when a patient is diagnosed with the electrolyte disorder hyponatraemia; to ascertain the cause in order to guide treatment.

The Test....

2 parts to it - Blood and urine tests to be performed simultaneously and at least within 30 minutes of each other to enhance accuracy of results.

1. White top bottle for urine osmolality and urine sodium to be sent to biochemistry.

2. Yellow bottle for sodium and serum osmolality to be sent to biochemistry.

The measurement.....

Measuring osmolality in serum and urine assesses water balance to check if the body response is appropriate.

Serum electrolytes: identifies hyponatraemia

Serum osmolality: to exclude 'hidden' osmolality: glucose, urea, triglycerides and proteins in plasma.

Results....

If ↓ sodium and serum osmolality is ↓ then genuine hyponatraemia

If ↓ sodium and serum osmolality is ↔ then pseudo hyponatraemia

If ↓ sodium and ↑ serum osmolality is a condition known as hyperosmolar hyperglycemic state (HSS)

Causes....

Reduced concentration of sodium in the urine **or** excess fluid in the blood-stream, either by excessive drinking or fluid retention.

1. Too much water coming in....

This would have a dilutional effect, excess water causes an increase in the reabsorption of water by the kidneys. This is achieved by anti-diuretic hormone (ADH) secreted from the posterior pituitary which acts upon the collecting ducts of the kidney, leading to an increase of water reabsorption into the blood. If a patient has, 'Syndrome of Inappropriate Antidiuretic Hormone' (SIADH) too much ADH is released leading to too much water being reabsorbed.

2. Too much water going out....

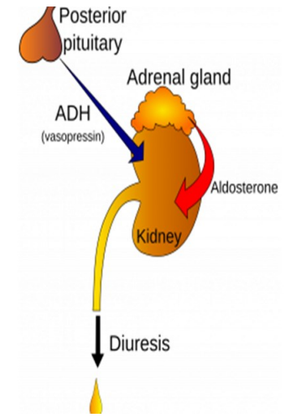
Can be through sweating, increased oral intake, increased levels of osmotically active agent, vomiting, diarrhoea, burns or inappropriate action of ADH.

Reduced urine output

Inappropriate response to dehydration, reduced blood flow from the kidneys, damage to tubular cells.

A shortage of steroid hormones, namely; aldosterone and cortisol which cause sodium reabsorption in the kidneys.

Increased plasma osmolality, caused by dehydration, increased glucose in diabetic mellitus, ingestion of toxins, diabetic insipidus.



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Nov 2020 https://cks.nice.org.uk/topics/hyponatraemia/

06 Reflection on Practice

Kathryn Marlow | MNP Ambulatory Care Team

What was the nature of the CPD activity and/or practice-related feedback and/or event experience in your practice?

A younger adult patient attended the GP practice for the results of some blood tests with regards to her diabetic care. From a previous appointment and discussion with the patient, it had been established that the patients diet was poor and they did very little exercise. The patient did not seem to want to acknowledge their diagnosis. of diabetes and they did not want to engage with a change in their lifestyle and diet advice that I was giving to them.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

Type II diabetes use to be thought of as a disease of older adults but the

age of diagnosis is falling and it is becoming increasingly more common in adolescence and young adults. Being diagnosed with type II diabetes at a young age can be a very traumatic life event as it can be associated with sigma. These individuals are likely to be obese and live a sedentary life. Reflecting on my experience in advising younger people with a chronic disease, I can see that they are more likely to neglect (or even try to ignore) their condition and as a result, suffer more acute complications.

My experience has shown that younger patients pose a real challenge in helping themselves self manage their condition. There is a real need for specialist input in terms of structured education, counselling and clinic support to help this group of people, independently manage their condition.

How did you change or improve your practice as a result?

I put the time aside to gain more in-depth training in diabetes and diabetes in young adults regarding their education and life-style choices. I also spoke to the specialist diabetes nurse. I learned that listening carefully to the patient is as valuable in their diabetes management as a clinical or advice approach. I feel that this knowledge can be used in my future practice wherever I work.

How is this relevant to the Code?

This reflection is relevant to me for practicing effectively in caring for young adult diabetic patients and promoting professionalism and trust, enhancing my knowledge of the care of diabetic patients. I must listen to their needs and gain their trust in order for them to manage their own care more proactively, thus preserving their safety and provide safe and effective care.

07 Focus on Heart Failure: Part 4

Natalie Barber | Cardiology ACP

This is the 4th and final instalment to Focus on Heart Failure. These articles have been extremely informative, thank you to Natalie Barber.

Discharge Home

Patients should be discharged only when stable off of intravenous diuretics. NICE (2018) state that all patients should have heart failure follow up within two weeks of discharge, there is a weekly post discharge heart failure clinic run by the cardiology ACP's at Warwick Hospital. Patient should be educated to monitor their weight following discharge and signs and symptoms of heart failure.

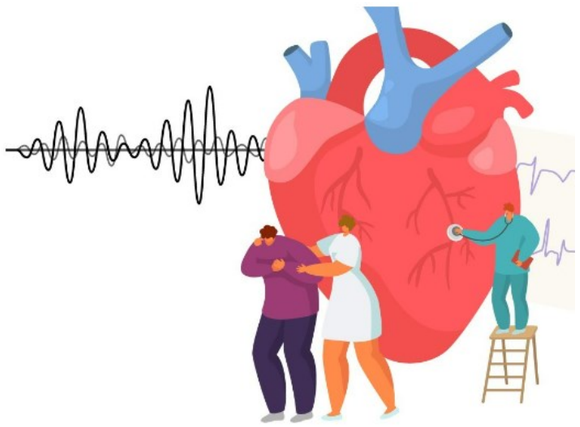
Discharge letters should include as much information as possible including:

- Who the patient's Cardiologist is, if HFREF or HFPEF, date and findings of latest Echocardiogram. Aetiology of heart failure if this is unknown, plans to investigate further.
- If palliative care/end of life conversations took place what the outcome was. If the patient has a respect form at the point of discharge.
- ECG findings. If a device has been implanted or previously implanted when it was last checked and the outcome.
- Discharging observations, BP, pulse. Blood test results including Hb, Renal function and BNP. If HFREF latest Iron studies and if IV Iron was given whilst in hospital.
- Weight on admission: weight on discharge: Dry weight.
- Inpatient heart failure treatment: what was started, how many days of IV diuretic therapy was required. If inotropic support or CPAP required. Any medication stopped and why.
- Discharge plan: outline if drugs should be titrated or reintroduced and the follow up planned by the hospital. When bloods should be repeated.

The integrated Heart Failure Nursing service

We were very fortunate at the end of 2020 the heart failure specialist nursing service was able to expand from 1 nurse to now 4 nurses in post. Based at Cape Road Clinic in Warwick they provide support for patients with HFREF (Ejection fraction of ≤ 40%) registered with a south Warwickshire GP. This ensures patients have access to medication and treatments focused at prolonging life and improving symptoms. The heart failure team along with the community practitioners work hard at admission prevention for those with known heart failure and will increase medication and closely monitor patients with the aim to avoid hospital admission. They run Heart Failure Clinics in a variety of locations and also visit more frail patients at home.

All community services can be accessed via the Integrated Single Point of Access (iSpPA) via telephone 01926 600818 or email ISPA@swft.nhs.uk. But we ask that all heart failure patients are referred through the Cardiology Inpatient Referral Service as we link in with the Integrated Heart Failure Nursing Service, there are plans that the heart failure team will provide inpatient support in reviewing patients on non-Cardiology Wards.



Heart Failure Key Points

- Please refer early to the Cardiology Inpatient Referral Service via bleep 2134 (Monday—Friday 8am—6pm)
- There is a post discharge heart failure clinic every Monday morning in the Keith lee Suite for early review of patient within two weeks of discharge. Discuss with the inpatient team to arrange.
- Carefully monitoring weight on a daily basis, analyse the trend. Medication can be adjusted accordingly.
- If you have stopped key heart failure medication for other reasons such as an acute kidney injury please ensure there is a plan to the GP in the discharge letter about when to reintroduce and monitoring required. Speak to the cardiology Inpatient team if in doubt.

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08 Samba 22 Local Report

Dr Rachel Dancer | Consultant Acute Medicine

The Society of Acute Medicine Benchmarking Audit 2022 (SAMBA22) took place on 23rd June 2022. This is a National Audit and provides information about individual unit performance against SAM's clinical quality indicators. Here is an overview of the findings for Warwick Hospital.

Patient Population

116 participating units included some patients that were planned returners through Same Day Emergency Care (SDEC) or equivalent services. 36 units had no patients who were planned returners.

Percentage of unplanned admissions with NEWS2 score of 3 or more Average: 29% Your unit: 30%

Percentage of unplanned admissions aged 70 years or older Average: 50% Your unit: 46%

Referral source for unplanned admissions: Average percentage GP referrals: 20% Your unit: 41%

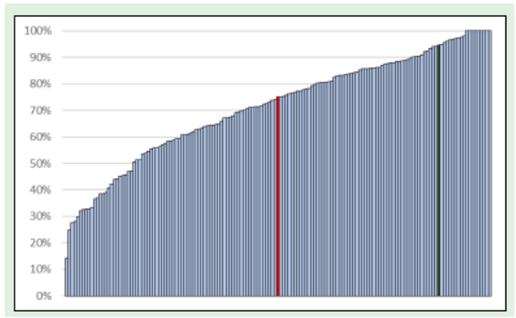
Percentage of unplanned admissions who had been in hospital in prior 30 days Average: 20% Your unit: 16% .

Clinical Indicators

EARLY WARNING SCORES

Percentage of unplanned admissions with Early Warning Score recorded within 30 minutes of hospital arrival. Median unit performance: 75% Your unit: 95% Performance depending on initial assessment location (by any clinician) in your unit:

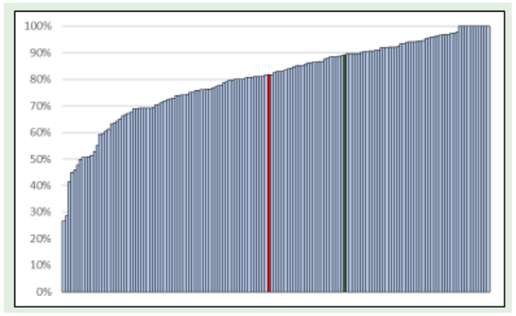
- Initial assessment in ED: 96%
- Initial assessment in AMU: 100%
- Initial assessment in SDEC: 90%



FIRST CLINICIAN REVIEW

Percentage of unplanned admissions reviewed by a competent clinical decision maker within 4 hours of hospital arrival. Median unit performance: 82% Your unit: 89% Performance depending on initial assessment location (by any clinician) in your unit:

- Initial assessment in ED: 96%
  Initial assessment in AMU: 50%
- Initial assessment in SDEC: 90%

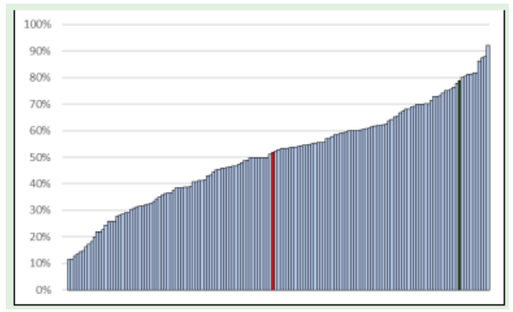


CONSULTANT REVIEW

OVERALL

Percentage of unplanned admissions with consultant review (if required) within the target time Median unit performance: 52% Your unit: 79% Performance depending on initial assessment location (by any clinician) in your unit:

- Initial assessment in ED: 81%
- Initial assessment in AMU: 50%



- Initial assessment in SDEC: 88%

DAYTIME

Percentage of unplanned admissions arriving during the daytime (08:00-20:00) with consultant review within the target time (6 hours): Median unit performance: 41% Your unit: 70%

OVERNIGHT

Percentage of unplanned admissions arriving overnight (20:00-08:00) with consultant review within the target time (14 hours): Median unit performance: 80% Your unit: 100%

In the SAMBA22 Warwick Hospital performed better than the average unit in every area.

For more information, see the full SAMBA 2022 report.

Reduce the risk of hospital-acquired VTE

All medical patients should be assessed to identify the risk of VTE and bleeding by the time of the first consultant review … OKEN is only achieving 78.6%!!!

We need to improve … how can you help?

Medical champions:

Daily checks of ALL drug charts on Oken and ADU

Nursing Champions:

During drug rounds please highlight any assessments that are not completed

Pharmacy Champions:

Please inform the doctors directly of any VTE assessments not completed

Ward performance by week no	2023	Areas for concern this week (No. VTE missing)
Week No	6	
Avon Ward	100.00%	
Castle Ward	100.00%	
CCU	62.50%	3
Farries Ward	100.00%	
Malins Ward	81.80%	2
Oken ward	78.60%	3
Fairfax ward	100.00%	
Mary Ward	80.00%	2
Nicholas Ward	100.00%	
Beaumont Ward	75.00%	2
23 Hr	100.00%	
Hatton ward	60.00%	2
Charlecote Ward	100.00%	
Thomas Ward	100.00%	
Beauchamp ward	100.00%	
Greville Ward	100.00%	
Willoughby Ward	100.00%	
Victoria Ward	100.00%	
Day surgery	100.00%	
Trust performance for Week	93.00%	

Together we can get 100%

09 Drug of the Month: Naproxen

Harriet Meakin | Acute Medicine ACP

What is it?

Non Steroidal Anti-Inflammatory Drug (NSAID). Used for variety of different conditions including rheumatic disease, acute gout, acute pain and musculoskeletal disorders and acute migraine (unlicenced).

How does it work?

NSAIDS reduce production of prostaglandin by inhibiting COX-2 enzyme. This reduces gastro-intestinal protection leading to side effects such as GORD, acute GI bleeding and ulcers.

Side effect

Common side effects: Alopecia, EO asthma, angioedema, confusion, constipation, GI disorders and discomfort, female infertility, muscle weakness, myalgia, papilloedema, pulmonary oedema, pulmonary oedema, renal failure, sleep disorders, thirst, skin reactions,

nausea, vasculitis, vertigo, photosensitivity.

Dosage

Oral form dose 750mg-1g max 24 hours- Naproxen usually better tolerated lower incidence of side effects compared to Ibuprofen.

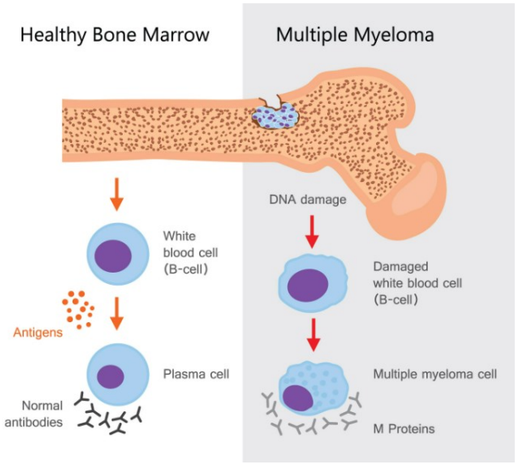
Case Study:

62 year old man with knee OA has been admitted with deranged U&Es by the GP. Creatinine 275 Urea 22.1 last checked 3 years ago normal baseline- creatinine 80. His GP prescribed Naproxen 500mg BD 18 months ago which significantly helped with his pain. After stopping Naproxen his U&Es only improved marginally. He was referred to the renal team as an outpatient. Monitoring is essential!

10 Condition of the issue: Multiple Myeloma

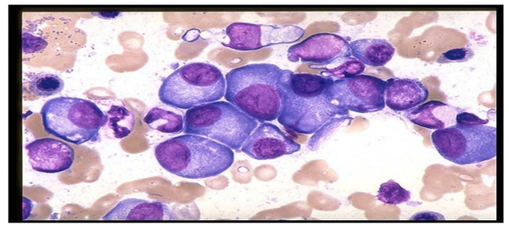
Emma Byrne | Acute Medicine ACP
Siham Hassan | Student Nurse

Multiple myeloma also known as myeloma is a cancer of plasma cells. Plasma cells, which are a type of white blood cell, are produced in the bone marrow and are a crucial part of the immune system which is made up of multiple cells that contribute to fighting infections. The cancerous cells multiply, overcrowding the bone marrow, preventing the production of healthy blood cells.



Causes

It's not exactly known what causes multiple myeloma. However, there is



a correlation between multiple myeloma and Monoclonal Gammopathy of Unknown Significance (MGUS). Statistically, 1 in every 100 people with MGUS go on to develop myeloma annually. Unfortunately, there is no way to prevent this, so individuals with MGUS will have to go for frequent check-up to detect possible cancer early.

Risk Factors

- If you are a male
- If you are over 60
- If you are of African heritage
- If you have any past medical history of MGUS

Signs and Symptoms of Multiple Myeloma:

- A persistent bone pain, typically in the back, hip or ribs.
- Tiredness, weakness and shortness of breath that's caused by anaemia
- High levels of calcium in the blood
- Kidney problems
- Weight loss
- Blurred vision or dizziness
- Bruising or unusual bleeding such as frequent heavy periods

Think CRAB

Calcium: hypercalcaemia is a common effect for 1 in 4 people with myeloma.

Renal impairment: the kidneys become damaged as a result of the high levels of abnormal protein cells.

Anaemia: reduced production of red blood cells.

Bone pain: due to the destruction of the bones caused by the production of the myeloma cells, sometimes leading to: bone lesions; spinal cord compression; fractures and bone thinning.

Investigations

Blood tests. M proteins are produced by myeloma cells. Another abnormal protein produced by myeloma cells — called beta-2-microglobulin — may be detected.

(Bloods including: kidney function, blood cell counts, calcium levels and uric acid levels, LDH, Ig A/G/M and serum free light chains; all helpful for haematology.)

Urine tests. Analysis of your urine may show M proteins, which are referred to as Bence Jones proteins when they're detected in urine (used less and less).

Examination of the bone marrow. Bone marrow aspiration and biopsy.

Imaging tests. Imaging tests may be recommended to detect bone problems associated with multiple myeloma. Tests may include an X-ray, MRI, CT or Positron Emission Tomography (PET scan).

Treatment

Targeted therapy. Targeted drug treatments focus on specific weaknesses present within cancer cells. By blocking these abnormalities, targeted drug treatments can cause cancer cells to die.

Immunotherapy. Immunotherapy uses your immune system to fight cancer. Your body's disease-fighting immune system may not attack your cancer because the cancer cells produce proteins that help them hide from the immune system cells. Immunotherapy works by interfering with that process.

Chemotherapy. Chemotherapy uses drugs to kill cancer cells. The drugs kill fast-growing cells, including myeloma cells. High doses of chemotherapy drugs are used before a bone marrow transplant.

Corticosteroids. Corticosteroid medications regulate the immune system to control inflammation in the body. They are also active against myeloma cells.

Bone marrow transplant. A bone marrow transplant, also known as a stem cell transplant, is a procedure to replace your diseased bone marrow with healthy bone marrow. Before a bone marrow transplant, blood-forming stem cells are collected from your blood. You then receive high doses of chemotherapy to destroy your diseased bone marrow. Then your stem cells are infused into your body, where they travel to your bones and begin rebuilding your bone marrow.

Radiation therapy. Radiation therapy uses high-powered energy beams from sources such as X-rays and protons to kill cancer cells. It may be used to quickly shrink myeloma cells in a specific area — for instance, when a collection of abnormal plasma cells form a tumour (plasmacytoma) that's causing pain or destroying a bone.

References

https://themmrf.org/multiple-myeloma/

https://www.nhs.uk/conditions/multiple-myeloma/

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Symptoms & complications - Myeloma UK

South Warwickshire NHS
NHS Foundation Trust

Trusted to provide inclusive safe effective compassionate care

Acute Medicine Educational Newsletter

Thank you to all the staff that have provided articles for this newsletter. Please contact me via teams or email if you would like to be a part of the next edition.

For any queries contact angela.perrett@swft.nhs.uk