

Ulster Society of Internal Medicine 91st (Spring) Meeting Friday 23rd May 2014

Craigavon Area Hospital



PROGRAMME:

- 2.00 pm **An unusual case of wrist pain.** D McCormick, R Stewart, M Neill, C Donnelly, H McCormick, M Mchenry. Rheumatology department, MPH, Orthopaedic department, RVH, Infectious diseases department, RVH. Microbiology department, RVH.
- 2.15 pm **The use of novel oral-anticoagulants in the prophylaxis of stroke in non-valvular atrial fibrillation. A review of prescribing practise and outcomes in the Belfast HSC Trust.** M Monaghan, K Goodwin, B Proctor, C Monteith, M Jackson, G Manoharan. Cardiology Department, Belfast Health & Social Care Trust.
- 2.30 pm **Auditing the Launch of Formal Oxygen Prescribing Practice.** G Patterson, S Graham, E McRory, R Convery. Respiratory Medicine, Craigavon Area Hospital.
- 2.45 pm **Guest Lecture: "The initial assessment of Syncope."** **Dr. John Purvis, Consultant Cardiologist, Western HSC Trust.**
- 3.15 pm Afternoon Tea.
- 3.40 pm **Grand Rounds: Cases from Craigavon Area Hospital Facilitator: Dr Rory Convery, Consultant Respiratory Physician, Southern HSC Trust.**
- 4.10 pm **Swollen legs, a common presentation with an unusual cause.** E Teague, R Ali, E Campbell, A Hameed, Acute Medical Unit, Altnagelvin Area Hospital, Western HSC Trust.
- 4.25 pm **Learning from an uncommon cause of a common presentation – autoimmune encephalitis on the acute medical ward.** G McCluskey, G Lewis, P Gardiner and M McCarron. Department of Medicine, Altnagelvin Area Hospital, Western HSC Trust.
- 4.40 pm Presentation of prize for the best abstract.
- 4.45 pm **Guest Lecture: "ACS and provision of 24/7 primary PCI in Northern Ireland."** **Dr Michael Moore, Consultant in Invasive Cardiology, Western HSC Trust.**

AN UNUSUAL CASE OF WRIST PAIN

D McCormick¹, R Stewart¹, M Neill², C Donnelly³, H McCormick⁴, M Mchenry¹.

1. Rheumatology department, Musgrave park hospital. 2. Orthopaedic department, Royal Victoria hospital. 3. Infectious diseases department, Royal Victoria hospital. 4. Microbiology department, Royal Victoria hospital

66 year old gentleman with a significant past medical history including autoimmune hepatitis requiring Immunosuppression with azathioprine and low dose prednisolone, previous deep venous thrombosis and atrial fibrillation requiring warfarinisation, pulmonary fibrosis, gout and osteoarthritis.

Presented to rheumatology service with monoarthropathy of right wrist in April 2013. Joint injection provided minimal benefit. Symptoms progressed over the following six months with increased pain and diffuse swelling of distal forearm and hand. Wrist aspirate in August suggested calcium pyrophosphate crystals but also cultured candida albicans on enrichment which was felt to be a contaminant. Further wrist aspirate in October, however, again cultured candida albicans.

MRI of wrist showed gross tenosynovitis of extensor and flexor tendons as well as synovitis and effusion in wrist. A low grade inflammatory process was suspected likely secondary to candida. Aspirate from olecranon bursa swelling also cultured Candida albicans.

There was no evidence of systemic candidiasis and the source of infection is unclear but case reports suggest rose thorns as a potential route of entry.

Despite 2 weeks of intravenous anti-fungal therapy, repeat joint aspirates continued to culture candida.

Repeat MRI scan showed further progression and suggested osteomyelitis of carpal bones. MRI elbow showed a large distended olecranon bursa as well as likely osteomyelitis of the olecranon.

Failure of conservative management of this rare and complex condition prompted transfer to orthopaedics where he has subsequently undergone endoscopic olecranon bursectomy and at a later date tenosynovectomy and ultimately may require amputation.

We await the outcome of this unfortunate gentleman.

THE USE OF NOVEL ORAL-ANTICOAGULANTS (NOACS) IN THE PROPHYLAXIS OF STROKE IN NON-VALVULAR ATRIAL FIBRILLATION (NVAF). A REVIEW OF PRESCRIBING PRACTISE AND OUTCOMES IN THE BELFAST HEALTH & SOCIAL CARE TRUST.

M Monaghan, K Goodwin, B Proctor, C Monteith, M Jackson, G Manoharan.

Cardiology Department, Belfast Health & Social Care Trust, The Royal Hospitals, 274 Grosvenor Road, Belfast BT12 6BA.

Atrial fibrillation (AF) is the most common arrhythmia with a prevalence of 1.5-2% of the population. AF is associated with increased mortality, a three-fold increase in congestive cardiac failure and a five-fold increase in incidence of stroke.¹ The ESC advise that stroke risk should be assessed using the CHA2DS2VASC scoring system and oral anticoagulation commenced in patients that score 1 or more.

Until recently, VKAs (Warfarin) were the only oral-anticoagulants available for the prophylaxis of stroke in patients with NVAF. The NOACs can be classified into: the direct thrombin inhibitors (e.g. Dabigatran) and direct factor Xa inhibitors (e.g. Rivaroxaban, Apixaban).

A retrospective study was undertaken to investigate the prescribing of NOACs across the Belfast Trust from November 2012 to November 2013. 367 patients (Male 50%) with an average age of 70 years (+/- 17 years SD) were identified: (157 (42%) Dabigatran), (119 (32%) Rivaroxaban); (89 (24%) Apixaban). The average CHA2DS2VASC was calculated as 4 (+/- 2SD) with hypertension (51%), stroke or TIA (40%) and vascular disease (35%) identified as the most commonly occurring risk factors for stroke.

21 (5.7%) patients were admitted with bleeding predominantly from a gastrointestinal source(8, 2%), intracranial (4, 1.0%) or haematuria (4, 1.3%). One patient required blood transfusion. 6 patients (1.6%) were admitted with cerebral infarction. NOACs were discontinued in 4 (1%) patients. All-cause mortality was calculated at 6.8% with no patients dying from bleeding.

NOAC prescribing represents 9% of the total percentage of patients receiving oral anticoagulants. This study has shown that NOACs are generally well tolerated, safe and not associated with life-threatening bleeds.

REFERENCES

1. 2012 focused update of the ESC Guidelines for the management of atrial fibrillation. An update of the 2010 ESC Guidelines for the management of atrial fibrillation. Developed with the special contribution of the European Heart Rhythm Association. *Eur Heart J* 2012;**33**:2719–2747.

AUDITING THE LAUNCH OF FORMAL OXYGEN PRESCRIBING PRACTICE

G Patterson, S Graham, E McRory, R Convery

Respiratory Medicine, Craigavon Area Hospital, Portadown, County Armagh

The 2008 British Thoracic Society (BTS) guidelines on the use of oxygen were published to ensure that oxygen was prescribed

according to a target saturation range, rather than device and flow rate. In response, we conducted an audit on the prescription of oxygen in Craigavon Area Hospital (CAH).

Using the BTS Emergency Oxygen Audit 2012 template, we conducted an initial and subsequent re-audit, following MDT oxygen training sessions conducted by ourselves, during May and July 2013 respectively. We collected data from 10 wards auditing kardexes of patients who were on oxygen at the time of data collection.

In the first audit 38/287 patients were on oxygen at the time of data collection. 9/38 (24%) were prescribed oxygen on their kardex; 2/9 (22%) of these patients had oxygen correctly signed for on medication rounds. On re-auditing following staff training, we saw an 11% increase in the number of patients prescribed oxygen, and a 7% improvement in the number of kardexes signed.

This audit has shown that with appropriate education, formal oxygen prescribing practice has improved in CAH. As a result we have facilitated a move towards better oxygen prescribing amongst the oxygen sensitive population, in keeping with BTS guidelines.

REFERENCES

1. O'Driscoll, B.R., Howard, L.S., Davison, A.G. (2008) 'British thoracic society guideline for emergency oxygen use in adult patients', *Thorax*, **63**(6), pp. 1-68.

SWOLLEN LEGS, A COMMON PRESENTATION WITH AN UNUSUAL CAUSE.

E Teague, R Ali, E Campbell, A Hameed, Acute Medical Unit, Altnagelvin Area Hospital, Londonderry.

We present the case of a previously fit and well 32 year old man with a 10 day history of left flank pain and bilateral leg swelling. On examination he had pitting oedema to the groins bilaterally and dilated abdominal wall veins. Investigations revealed a d-dimer of 4.6mg/L (normal reference range <0.5) and ultrasound Doppler of lower limb veins revealed occlusive deep venous thrombosis (DVT) in the common femoral, femoral and popliteal veins bilaterally. A computerised tomography scan of abdomen was performed and this showed an abnormal mid inferior vena cava (IVC) thought to represent congenital aplasia of the IVC. The patient was treated with low molecular weight heparin and warfarin. He was fitted with compression stockings and referred to the regional vascular surgery centre who recommended continuing with conservative management and seeking haematology advice regarding the duration of anticoagulation required. His leg swelling improved considerably and he remains on anticoagulation indefinitely.

Congenital IVC malformation is a rare vascular defect that is found in almost 5% of unprovoked DVTS in patients under 30 years old¹. It is more common in men. The associated DVT can be unilateral but is more commonly bilateral. It can be diagnosed with CT scanning and is managed as outlined above. The necessary duration of anticoagulation has yet to be established as patients with this anomaly and thrombosis can be at increased risk of recurrent DVT².

We believe that this case promotes the need to consider further investigation of young patients presenting with unprovoked DVT.

REFERENCES

1. Lambert et al, Inferior vena cava agenesis and deep vein thrombosis: 10 patients and review of the literature *Vasc Med* 2010 Dec: **15(6)**:451-9
2. Obsenoster et al, Anomalies of the inferior vena cava in patients with ileac vein thrombosis *Ann Intern Med* 2002 Jan 1: **136(1)**:37-41

LEARNING FROM AN UNCOMMON CAUSE OF A COMMON PRESENTATION – AUTOIMMUNE ENCEPHALITIS ON THE ACUTE MEDICAL WARD.

G McCluskey, G Lewis, P Gardiner and M McCarron

Department of Medicine, Altnagelvin Area Hospital, Derry, Northern Ireland

Acute confusion and hyponatraemia in the elderly commonly present to acute physicians. This case report describes a 72 year old female who presented following a fall and a 3 week history of confusion and memory impairment. She was found to be severely

hyponatraemic at 108 mmol/L (normal range 133-145) and was initially treated with hypertonic saline. Once her serum sodium reached 120 she was fluid restricted as serum and urine osmolality were typical of SIADH. MRI brain revealed encephalitis, presumably from a viral cause, although CSF analysis did not show any organisms. The patient developed tonic clonic seizures and required HDU admission for 7 days. An autoimmune screen was sent and showed markedly raised titres of voltage gated potassium complex (VGKC) antibodies at 1144 pM (normal range <100). She was treated with corticosteroids and began to show improvement in her confusion and memory. Her serum sodium also returned to within the normal range. This case highlights the importance of fully investigating for uncommon causes of confusion and hyponatraemia. VGKC antibodies have been given recognition in recent years as a potentially reversible cause of encephalitis, making it essential that they are part of the differential diagnosis in patients who present encephalitis, especially if no viral organism is identified.