

# Game Changers

## THE EMERGENCY SURGICAL UNIT (EMSU) – REVOLUTIONISING UNSCHEDULED CARE IN SURGICAL PATIENTS

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Recent recommendations<sup>1,2</sup> have fuelled a trend towards the segregation of elective and emergency surgical services. Belfast is no different having gone live with the EmSU in June 2013.

The “General Surgeon” in recent times has been under threat of extinction as a paradigm shift towards ‘Specialist training’ has compromised this identity.

The surgeons’ workload encompasses four primary domains;

1. Specialist Cancer (resectional) surgery
2. Complex Specialist Elective Benign disease
3. High volume low tariff surgery, suitable for Day Case
4. General Surgical Emergencies (accounting for >60% of finished consultant episodes)

Unscheduled care, historically, has played a supporting role but never the lead. Surgery out of hours being delivered by surgeons in training with consultants ‘plate spinning’, spreading themselves thinly between their speciality and the general ‘take-in’.

With the evolution of the EmSU ‘unscheduled care’ is delivered 24/7 by Consultants specialising in Upper and Lower GI surgery. Consultants see patients expediently, exercise experienced clinical judgement, implement streamlined management plans and ultimately deliver timely surgery on protected lists. These are the hallmarks of the EmSU affording the highest quality of care.

Pre EmSU <5% of all Laparoscopic Cholecystectomies were performed on the index admission, this figure has risen > 50%. Time to surgery has fallen by 50% and approximately 8000 patient/bed days are saved annually. Mortality and ‘readmission rates’ are also well below the National average.

We strive to improve quality and efficiency through radical changes in our working dynamic, culture and behaviour. The ‘Son of EmSU’ will be an Ambulatory Surgical Service with rapid access to Consultant assessment, imaging and labs with the majority of care afforded in an outpatient setting.

Long live the General Surgeon!

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## PET RESCUE

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In Northern Ireland we have been fortunate to have access to PET scanning so readily. The Royal Victoria Hospital was only the fifth location in Europe to have such technology when it began operation in 2002. In Head & Neck Cancer this has been a great tool for both diagnosis and disease recurrence surveillance. PET is performed in conjunction with CT to provide detailed merged images.

Metastatic SCC of the neck is frequently seen, however occasionally the primary site is not identified. Gone are the days of the ‘blanket biopsy’ of tonsil, tongue base, larynx, bronchus and oesophagus. Although PET can aid in pinpointing the primary tumour location, there still exist a number of patients with a true ‘unknown primary’. Part of any cancer service is follow-up, after treatment, to monitor for recurrence. This is a challenge if you don’t know where it started in the first place. Indeed, these patients will invariably receive significant radiation to their head and neck.

Radiotherapy changes and tumour recurrence are not always easy to discern during follow up. False positives are possible due to inflammation, but PET has undoubtedly proved valuable.<sup>1</sup> Various studies have shown its strength over traditional imaging and clinical findings.<sup>2</sup> Its use will continue to improve care in Head & Neck Cancer.

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## ENDO-PROSTHETIC REPLACEMENT IN THE MANAGEMENT OF COMPLEX DISTAL FEMORAL FRACTURES IN THE ELDERLY

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Over recent years there have been an increasing number of elderly patients admitted to the Royal Victoria Hospital trauma unit with complex, osteoporotic fractures involving



the distal femur. These patients often have multiple medical comorbidities and a poor pre-injury mobility status akin to patients with fracture neck of femur. The common treatment for these fracture include locking plates, or intramedullary nails. A stable reduction is not always possible and early weight bearing is restricted. Fractures can develop non-union in 18% of cases, with subsequent implant failure<sup>1</sup>. These require further surgery with repeat fixation and bone grafting, with some progressing on to multiple surgeries. This carries with it increased morbidity and mortality for patients.

Endo-prosthetic replacements were initially developed for use in major bone loss associated with oncological bone disease, and have evolved significantly in recent years. They are now also being used as a salvage procedure in revision arthroplasty, non-union and infection.

Recent literature has presented evidence that endo-prosthetic replacement as a first line surgical treatment has a role in elderly patients with complex, intra-articular distal femoral fractures<sup>2,3</sup>. Use of these implants addresses the aims of

fracture management, which are to produce a stable construct and allow early weight bearing and active mobilisation of the involved limb. This can enhance recovery and shorten hospital stays. Although not without risk, the use of endo-prosthetic replacement does offer a useful alternative to internal fixation for this group of patients.

Within our unit this is a treatment strategy that we have adopted and we are currently assessing the short to mid term outcomes for these patients.

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