Medical Trainees Conference - On Call Conundrums
Answered Slido Questions

Tricky Troponins – Dr Javed Iqbal

Q: Are we relying too much on biochemical and radiological tests in these situations? Could thorough history & clinical examinations pick up some of these earlier?

A: Cannot agree more. History and clinical examination are important aspects of patient's assessment. Biochemical and radiological results should be taken in context of clinical history and examination.

Hiding in Plain Sight - Unmissable X-rays – Dr Joanne Sharkey

Q: If we are missing so many lung cancers should cxr screening be introduced in at risk individuals?

A: Yes, this would pick up more cancer and although cost benefit analysis suggests screening is viable, there are currently no firm plans for this in Scotland.
Until this time, I would reiterate that a 'normal' CXR does not exclude lung cancer and if that is the concern, the patient needs CT imaging.

Q: When should we order a lateral CXR?

A: This is generally a problem solving tool for radiologists. Historically laterals were useful in localising lesions or collapse, although now cross sectional imaging is typically requested instead. I still find them useful when assessing the left base (if obscured by the heart/ epicardial fat pads), assessing an abnormal hilum (is there a structure behind or in front of the hilum causing increased density or enlargement on the PA CXR), assessing mediastinal lesions (is it anterior or posterior), assessing the vertebrae, or looking for small effusions (a lateral CXR will pick up a smaller volume of fluid than a PA). That said, I rarely suggest getting a lateral unless my level of concern of significant pathology is low - if I have significant concerns on the PA CXR, I would request CT.

Q: Is there still any role for lateral films in chest x ray imaging? If so when should that be considered in acute chest presentations?

A: As above. Sometimes collapse is easier to localise with a lateral in the acute setting (esp. RML collapse) but if you are considering more imaging to help you interpret the PA CXR, that is usually a signal that the imaging needs a radiologist opinion where possible cross sectional imaging can be arranged as appropriate.

Q: If unsure regarding RML collapse on AP xray, would you recommend then getting a lateral view film?

A: An AP film often distorts the mediastinum and its contours. As RML collapse can be subtle at the best of times, a PA CXR would be advised in the first instance and if getting that anyway, it wouldn't be unreasonable to request a lateral CXR at the same time if you had a strong suspicion of this. Again, a radiologist could help your interpretation of this.

Q: Sorry if stupid question: if we're asking a radiographer for a lateral chest Xray to help us when we suspect lobar collapse, do we need to specify the side we're interested in?

A: No need to specify the side for collapse. But please read above, if you are considering collapse on the PA view, speak to a radiologist who may feel there is either sufficient evidence to go to CT if convincing enough collapse, or reassure you that there is no evidence of collapse.

Recording of consultations – important part of the future of the NHS – Professor Sue Carr

Q: You mentioned that patients want remote consultations. What I have encountered is generally a lot of resentment from most of my patients that they are accessing less face to face care, particularly in primary care. What is it evidence that patients want remote consultations?

A: While we can't provide an overview of research, we're aware of evidence that some (but not all) patients find remote consultations useful and convenient – this is certainly my experience as a clinician working in outpatient clinics too. For instance, in 2020 Healthwatch, Traverse and National Voices found this in their research report, 'The doctor will zoom you now: getting the most out of the virtual health and care experience'. However, the same report emphasised that there is no 'one size that fits all solution' and the right approach to consultations should be based on individual needs and circumstances.

Similarly, in our Prescribing guidance we recognise that patients may prefer to access healthcare services face-to-face or through remote consultations via telephone, video-link or online, depending on their individual needs and circumstances. Where different options exist, and when it is within their power, doctors should agree with the patient which mode of consultation is most suitable for them (paragraph 21). Doctors must also consider the suitability of the mode of consultation they're using, for example face to face or remote, taking account of any need for physical examination or other assessments (paragraph 20a)."

Q: How do we balance the workload with primary care with remote consultations with simple investigations such as blood tests - if the patient has to come to secondary care already for blood tests, they may as well come to clinic. If we ask GPs - this is adding to an already huge workload.

A: I don't think is something GMC can specifically comment on.

Q: Which programmes do people rate better than others e.g. accurx? I found in community palliative care this worked really well when relative or district nurse or GP were present during consultation and would encourage hospital docs to consider this for outpatients with complex issues who cannot travel

A: We can't comment on specific software or platforms for remote consultations.

Q: What about the role of a Telemedicine consult in Palliative medicine where most of the patients are expected to have complex care needs? Do standards governing a tele-consult change at that time?

A: We understand this question is asking whether our standards in relation to remote consultations change if doctors are practising in palliative medicine where patients may have complex care needs.

Our guidance on the professional standards expected of doctors is necessarily high-level so it can be widely applicable to all doctors in the UK, regardless of their specialty, grade and area of work. As it can't cover all the situations they might face in practice, we expect doctors to use their professional judgment to apply the principles in our guidance. In other words, the standards we set out in relevant guidance such as Good medical practice and Good practice in prescribing and managing medicines and devices remain the same. But we expect doctors to apply the principles to the specific situation they're facing. We also provide helpful advice on our ethical hub to help doctors put our guidance into practice. This includes our page on remote consultations, which includes a useful flowchart to help doctors consider when a face-to-face consultation may be more appropriate than a remote one.

Acute symptom management in Palliative Care – Dr Abigail Walton

Q: Do you support a mechanistic or empiric approach to treatment of Vomiting? Does your preference depend upon the stage of the Patient's illness (within the disease trajectory) - early palliative or end of life setting?

A: I would tend to use the mechanistic approach especially in the earlier phases of someone's disease. For patients with slow gut transit there is benefit to early rationalisation of medication, reduction in constipating medications and initiation of prokinetics (as long as no contraindications), laxatives etc. Later on in someone's illness, especially nearer end of life it is sometimes more difficult to work through a mechanistic approach and often a broad spectrum antiemetic is of more value in targeting symptoms that may arise including terminal agitation.

Q: How do we confirm slow gut transit?

A: Understand the patient's individual pathology as to whether they are high risk of slow gut transit. The pattern of nausea and vomiting will often be one of early satiety, bloating, belching, indigestion, intermittent vomiting and improvement of nausea after vomiting and constipation. These things would lead you towards presuming they have some degree of reduced gut transit.

Q: How common are side effects with metoclopramide and what route is best for optimal symptom relief with minimal side effects (e.g. PO, IV, s/c)?

A: Side effects can be significant with metoclopramide - primarily dopamine blockade side effects - ie movement disorders etc. Higher risk pts are young females and so particular caution should be used in these patients. Similarly there should be caution used in a bowel that is on the verge of obstruction - advice should be sought about whether to use prokinetics in these patients as the decision is often very nuanced. Caution should be given to using metoclopramide and other antiemetics in patients without a palliative diagnosis as the benefit/ risk profile may be different.
If you see a palliative pt who would benefit from a prokinetic - early use is good and may be able to be oral before symptoms become established. Unfortunately however the N&V may develop in a way that makes oral route

unviable and we would often then suggest parenteral routes. IV tds administration may cause a peak/ trough of medication and we often prefer a continous sc infusion if not improving.

Q: What is your experience with the use of NK1 Antagonists and cannabinoids for the management vomiting in advanced cancer?

A: I don't have much experience with NK1 antagonists mainly because their licensing sits mainly in oncology and I don't work in the cancer centre. I think there is evidence of benefit in certain chemo-induced N&V but not much out with that even though NK1 receps sit at numerous points within the emetogenic pathways.
Similarly with cannabinoids - I have only used them in complex pain pts on a named patient basis. I think there are still trials ongoing for cannabinoids in nausea but we do not see them used widely in palliative care at the moment.

Q: What pattern of n&v makes you suspect slow gastric emptying?

A: Early satiety, belching, indigestion, constipation, build up of nausea with eventual vomiting (potentially after a few days of worsening nausea) and then relief of nausea after vomiting. Also a knowledge of their pathology to suggest that there is disease (often peritoneal/ omental) that may suggest an impact on the gut.

Detecting decompensation in chronic liver disease – Dr Jude Morris

Q: Should rifaximin be only started by gastroenterologist? Or can it be started on acute take?

Answer: Any one can start this! It is recommended after one episode of encephalopathy. 550mg BD alongside
Its usage for other indications (e.g. primary prophylaxis of SBP) is more nuanced and for that I would discuss with GI

Q: How do we differentiate drug induced drowsiness vs hepatic encephalopathy in ALD patient on benzodiazepine?

A: Good question! It's not always easy. Often they co-exist. Look for flap and foetor in HE. In both we would want to remove the BZD- or use a shorter acting one like lorazepam, rehydrate treat triggers. A serum ammonia is not routinely recommended.