

Association of Paediatric Anaesthetists of Great Britain & Ireland

43rd APA ANNUAL SCIENTIFIC MEETING

4th–6th May 2016

Belfast Waterfront

www.apagbi2016.co.uk

Programme

Welcome

The Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) cordially invite you to their 43rd Annual meeting in Belfast. Belfast lays claim to a unique history. Once the home of the Irish linen industry, tobacco production and the world famous Harland and Wolff shipbuilders, it is now home to many world famous golf courses and the "Game of Thrones".

We will welcome delegates to a great scientific and social programme in the award winning Belfast Waterfront Hall. The Waterfront is now one of the world's leading conference centres. It is co-located with the conference hotel, the Belfast Hilton. The scientific meeting is preceded by a half-day trainee symposium, which is free to trainees who register for the whole meeting. The scientific programme includes sessions on 'state of the art' topics, 'Risky Business', new drugs in paediatrics and developments in fluid management.

The meeting opens with a reception at the historic McHughs pub. Dating back to 1711 and located beside Custom House Square, McHughs is the oldest surviving building in Belfast. In a city famous for hospitality, McHughs offers a classic warm Irish welcome. The popular annual dinner is to be held at the impressive City Hall. This Portland stone and copper-domed building was completed in 1906 as a symbol of Belfast's new city status granted by Queen Victoria. The splendour and grandeur created by the craftsmen of Belfast in the interiors of City Hall, was reflected in the impressive public rooms on board Titanic.

Belfast is a busy city served by two airports, with excellent rail, bus and road links to Dublin, as well as regular ferries to Scotland and England. There are a number of attractions within the city, not least the Titanic Exhibition, and there are still remnants of Belfast's historic quarters – Cathedral, Queen's,

Titanic and Gaeltacht Quarters. All four are rich in history, culture and full of local 'craic' (or 'good times' to the uninitiated)! The beauty of the surrounding countryside is famous, not least the remarkable Giant's Causeway which is one of only two UNESCO natural world heritage sites situated in the UK and Ireland.

Belfast may be a small city but don't let the size fool you – because we're big on excitement. There's something for everyone to love from shopping, tours, world-class dining to lively arts and music scene, you name it – we've got it. So dig a little deeper and start planning your Belfast adventure!

Céad míle fáilte.

Prof Andrew Wolf, *President, APAGBI*

Dr Keith Bailie, *Chair, APA 2016 Local Organising Committee*

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This meeting has been approved by the Royal College of Anaesthetists for the purposes of continuing professional development. Claim up to 5 points for each day. 1 CPD point is equivalent to 1 hour of learning.



1015-1055	Registration/Tea & Coffee	
1055-1100	Welcome by Prof Andrew Wolf, President, APAGBI	
1100-1230	Session 1: Difficult circumstances	Chair: Dr Siobhan Cavanagh, Belfast
1100-1130	Non cardiac anaesthesia for the cardiac patient 2C04, 3G00	Dr Sinead Harte, Dublin
1130-1200	Stabilisation, transport and treatment of neurological injuries 2D01, 2F01, 3F00	Dr Mark Terris, Belfast
1200-1230	Anaesthesia for the upper airway problem – Bronchoscopy 2A01, 2D02	Dr Keith Bailie, Belfast
1230-1330	Lunch	
1330-1500	Session 2: Routine care	Chair: Dr Elin Jones, Trainee Member, APAGBI
1330-1400	The preoperative visit 2A03, 2A07	Dr Mark Thomas, London
1400-1430	Recognising the critically ill child 2D01, 2D03	Dr Julie Richardson, Belfast
1430-1500	Post-operative analgesia 2D05, 2E01	Dr Simon Courtman, Plymouth
1500-1530	Tea & coffee	
1530-1630	Session 3: The virtual list	Chair: Dr Alison Cooke, Belfast
	The unoperated AV canal with incarcerated hernia 2C04, 3G00	Dr Sinead Harte, Dublin
	Neck stabilisation and difficult intubation 2D01, 2F01, 3F00	Dr Mark Terris, Belfast
	The shocked patient with appendicitis 2C02, 2D01, 2D03	Dr Simon Courtman, Plymouth
	Retrieval of an endotracheal foreign body 2A01, 2D02	Dr Keith Bailie, Belfast
	Anterior mediastinal mass 2A03, 2A07	Dr Mark Thomas, London
1630	Close of meeting	

0800-0900	Registration/Tea & Coffee/Exhibition		
	STREAM 1		STREAM 2
0900-1030	Session 1a: Respiration 2016 Chair: Prof Andrew Wolf, President APAGBI		Session 1b: Drugs in anaesthesia 2016 Chair: Dr Jeremy Lyons, Belfast
0900-0930	Obstructive sleep apnoea 2A03, 3A02 Dr Peter Stoddart, Bristol		Sugammadex 1A02 Dr Martin Shields, Belfast
0930-1000	Tracheostomy in children 1C02, 2A01 Mr Keith Trimble, Consultant Paediatric Otolaryngologist, Belfast		Dexmedetomidine 1A02 Dr Gill Lauder, Vancouver, Canada
1000-1030	Airway algorithm for the difficult airway 2A01 Dr Thomas Engelhardt, Aberdeen		Why isn't TIVA more popular? 1A02, 3I00 Dr Alistair Baxter, Edinburgh
1030-1100	Tea & Coffee/Exhibition		
1100-1225	Session 2a: 'State of the art' Chair: Dr Sam Lamont, Belfast	1100-1225	Session 2b: The preoperative visit and the unexpected outcome Chair: Dr Aideen Kearney, Belfast
1100-1145	State of the art: Local anaesthetics 1A02 Dr Suellen Walker, London	1100-1115	What does the patient want? 3A03 Mr John Hitchman, Durham
1145-1225	Debate: The T piece – 'gone, but not forgotten' 3D00 Pro: Dr Frank Potter, Liverpool Con: Dr Jason Maynes, Toronto	1115-1130	What does the anaesthetist want? 3A03 Dr Jonathan Smith, London
		1130-1145	Dealing with a child's bad prior experience of anaesthesia 3A03 Dr Colin Dryden, Liverpool
		1145-1200	Debriefing the team after bad outcomes 1I02, 1I03 Prof Andrew Wolf, Bristol
		1200-1225	Discussion
1230-1330	Session 3: APA AGM		
1330-1430	Lunch/Tea & Coffee/Exhibition		

Scientific Programme

Thursday 5th May

	STREAM 1	STREAM 2
1430-1600	Session 4a: Computers and anaesthesia Chair: Dr Charles Philpott, Belfast	Session 4b: Risky business Chair: Dr Allan Goldman, London
1430-1500	Going paperless - The Addenbrookes experience 1G01 Dr Vaithy Mani, Cambridge	Lessons from other high risk industries 1I03 Dr Allan Goldman, London
1500-1530	What the APA and the website can do for you 1G01 Dr Mark Thomas, London & Dr Simon Courtman, Plymouth	Culture and power gradients in the cockpit, can these human factor lessons be translated into the operating room 1I03 Dr/Capt Steve Scott, Aviation Psychologist, Coventry
1530-1600	Data mining in the OR, noticing important changes 1G01 Dr Gill Lauder, Vancouver, Canada	Taking risks for peace: Breaking the fast with the world's most wanted 1I03 Prof Beverley Milton-Edwards, Professor of Politics, International Studies and Philosophy, Belfast
1600-1630	Tea & Coffee/Exhibition	
1630-1645	Session 5: APA Awards & Citations Chair: Prof Andrew Wolf, President, APAGBI	
1645-1730	Session 6: Jackson Rees Lecture Chair: Prof Andrew Wolf, President, APAGBI	
	Protocols in professional practice – Prospects and pitfalls Prof Brian Kavanagh, Toronto, Canada	

Friday 6th May

	STREAM 1	STREAM 2
0830-0900	Registration/Tea & Coffee/Exhibition	
0900-1030	Session 7: Scientific Abstracts 1F05, 1G02 Chairs: Drs Suellen Walker & Jon Smith, APA scientific committee	

	STREAM 1	STREAM 2
1030-1100	Tea & Coffee/Exhibition	
1100-1230	Session 8a: Fluid therapy Chair: Dr Peter Crean, Local Organising Committee, Belfast	Session 8b: New technology Chair: Dr Stephen Robinson, Belfast
1100-1130	The NICE guidelines 2A05 Dr Chris Gildersleve, Cardiff	NAVA and the anaesthetist 2A04, 2C02 Prof Javier García Fernández, Madrid
1130-1200	The problems with fluids 2A05 Dr Terence Montague, Dublin	ECMO and the anaesthetist 2C04, 2C07 Dr Jon Smith, Newcastle
1200-1230	Blood and other products 2A05 Dr Philip Arnold, Liverpool	Best ventilation in the OR – Ventilate an isolated lung 2A04, 2C02 Prof Javier García Fernández, Madrid
1230-1330	Lunch/Tea & Coffee/Exhibition	
1330-1500	Session 9a: ‘State of the art 2’ Chair: Dr Bob Bingham, London	Session 9b: Maquet workshops Chairs: Drs Stewart Reid & Keith Bailie, Belfast
1330-1415	State of the art: Drug development in anaesthesia 1A02 Dr Jason Maynes, Toronto	Group 1 – Low flow anaesthesia & AGC (45 minutes) 2A04, 2C02
1415-1500	Multicentre studies in paediatric anaesthesia 1G02, 1I05 Prof Walid Habre, Geneva	Group 2 – Lung recruitment with an isolated lung model (45 minutes) 2A04, 2C02
1500-1530	Tea & Coffee/Exhibition	
1530-1630	Session 10: The President’s Session Chair: Dr Chris Gildersleve, Honorary Secretary, APAGBI Dr Gill Lauder, Vancouver Dr Jason Maynes, Toronto Dr Stephen Robinson, Belfast Prof Andrew Wolf, President, APAGBI	
1630	Close of APA 2016 Meeting	

Workshop Descriptions

If you have registered to attend, your name will be displayed in the APA registration area. If you would like to register, please come to the APA registration desk to check availability. A fee of £65 is payable for each workshop in addition to the registration fees.

Airway

A review of current advanced techniques in paediatric and neonatal difficult airway management covering intubation with a variety of indirect video laryngoscopes and fibre-optic laryngoscope guided techniques and an interactive scenario-based discussion.

Expertise will be delivered by the course directors and faculty members of the Oxford Paediatric Difficult Airway Workshop.

TIVA

This complements the lecture "Why is TIVA not more popular in children". A practical seminar on the use of TIVA in the paediatric population that will include suggestions and recipes that could change your view of the use of TIVA in children and give you ideas of how to do it.

It will be delivered by experienced practitioners (from the TIVA for TOTS group) and concentrate more on the clinical situation than the pharmacological backdrop.

SPONSOR & EXHIBITOR THANK YOU

The APAGBI would like to thank all industry exhibitors who attended the conference and would like to include a special mention of **Maquet Ltd** for their sponsorship of the meeting.

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Session 1

Non cardiac anaesthesia for the cardiac patient (2C04, 3G00)

Dr Sinead Harte, Dublin

This talk will provide the learner with information to allow a better understanding of the challenges and complexity associated with providing anaesthesia for children with congenital cardiac disease for non-cardiac surgery. The opportunities to look after these children as they grow into adulthood are increasing as outcomes improve and the number of procedures which they require are often higher than their non-cardiac counterparts.

Learning outcomes:

1. Pre-op assessment and planning for children with CHD for nono-cardiac surgery
2. Identification of high risk children
3. Anaesthesia techniques: brief R/V of physiology and pharmacology
4. Monitoring for CHD children
5. Team work: deciding what to do, where

Stabilisation, transport and treatment of neurological injuries (2D01, 2F01, 3F00)

Dr Mark Terris, Belfast

Neurological injury can arise through a variety of mechanisms. Perhaps the best understood approach to such cases comes from Traumatic Brain Injury. Whilst trauma remains one of the leading causes of death in children across the world it is infrequently encountered by the majority of Anaesthetists in their day-to-day practice. Initial management involves a multidisciplinary team approach and is aimed at rapid stabilization to reduce associated morbidity or even mortality. The same approach may be broadly suitable for a wider range of causes of paediatric neurological injury.

Commonly following neurological injury children will require transport, either within hospital to allow imaging, or between hospitals to allow access to PICU. In the case of neurologically injured patients this may be a time-critical move and so may not allow the use of a dedicated paediatric transport service.

During this talk I aim to cover the initial stabilization, transfer and treatment of neurological injuries and in particular highlight

- Relevant worldwide guidelines available
- Issues relating to potential associated spinal injuries
- Practical aspects of transporting such patients

Anaesthesia for the upper airway problem – Bronchoscopy (2A01, 2D02)

Dr Keith Bailie, Belfast

Paediatric airway cases are often a cause for anxiety amongst anaesthetists. During this talk I aim to outline how recognition of the stages of anaesthesia can be used to proceed confidently.

The causes of an obstructed upper airway can be acute or chronic, and vary in nature. Despite the differing aetiologies, the conduct of anaesthesia for the obstructed upper airway should proceed in a similar fashion.

Commonly a paediatric ENT surgeon will be in attendance and it is essential before commencing anaesthesia that an agreed airway management plan A,B and C are in place. Team working and communication are crucial to successful airway maintenance.

Various techniques can be employed to maintain the airway while preparing to handover for bronchoscopy. Adjuncts such as an oro- or nasopharyngeal airway may be employed in conjunction with simple airway manoeuvres. Videolaryngoscopes, fiberoptic laryngoscopes and other difficult airway devices should be available. Jet ventilation is uncommon in paediatric practice.

It is essential that the anaesthetist is experienced in recognising the depth of anaesthesia whether this be inhalational anaesthesia or total intravenous anaesthesia as early airway intervention may precipitate laryngospasm and loss of an already compromised airway. This experience is not limited to paediatric anaesthetists and is applicable to all areas of anaesthesia.

Learning outcomes:

1. Understanding of Airway Management
2. Recognition of depth of Anaesthesia

Session 2

The preoperative visit (2A03, 2A07)

Dr Mark Thomas, London

This talk, aimed at trainees, will cover the purpose of the visit, how to conduct a fruitful visit and what the parent and child should expect of a well conducted visit. Some hints and tips regarding common pitfalls and challenging parental questions will also be covered. Specific areas covered will include: professionalism, discussion of risk, interaction with the reticent child and the provision of written information.

Learning outcomes:

1. Feel better prepared to conduct a fruitful visit
2. Be equipped with some answers to challenging parental questions
3. Have some information about common anaesthetic procedures to provide parents and older children

Recognising the critically ill child (2D01, 2D03)

Dr Julie Richardson, Belfast

Learning outcomes:

1. Increase confidence in identification and assessment of the sick child
2. Revise indications of intraosseous access

Post-operative analgesia (2D05, 2E01)

Dr Simon Courtman, Plymouth

This lecture will cover the essentials of post-operative analgesia and consider pain assessment, simple analgesia and some advanced techniques for commoner procedures such as nerve blocks, caudals/epidurals and PCA/NCA. It will also highlight recent changes in analgesia in response to national recommendations.

Learning points:

1. Understand the challenges of pain assessment and management in children.
2. Awareness of analgesic strategies for both daycase work and more complex surgery.
3. Be aware of recent national recommendations.

Session 3

The unoperated AV canal with incarcerated hernia (2C04, 3G00)

Dr Sinead Harte, Dublin

Neck stabilisation and difficult intubation (2D01, 2F01, 3F00)

Dr Mark Terris, Belfast

Session 3

The shocked patient with appendicitis (2C02, 2D01, 2D03)

Dr Simon Courtman, Plymouth

This lecture will look at the perioperative care of the commonest surgical emergency in children and look at the importance of recognising the sick child preoperatively and the subsequent stabilisation and intraoperative care. It will also discuss some of the challenges to deliver high quality care in all non-specialist centres.

Learning points:

1. Recognising and managing the sick child preoperatively.
2. Analgesia for laparotomies pre and post-operatively.
3. Optimising good outcomes.

Retrieval of an endotracheal foreign body (2A01, 2D02)

Dr Keith Bailie, Belfast

This will be an interactive case discussion around airway foreign bodies and the principles of airway management.

Session 3

Anterior mediastinal mass (2A03, 2A07)

Dr Mark Thomas, London

These cases represent a real challenge to the anaesthetist. The assessment, both clinical and investigative will be discussed.

Management strategies will also be debated and potential rescue measures in the event of a crisis will be covered. Some references for further reading will be provided.

Learning outcomes

1. List the risk factors for higher risk cases and be able to recognise these
2. Present a reasoned plan of management to senior colleagues
3. Know of at least two good reference articles to quote on this subject

Session 1a

Obstructive sleep apnoea (2A03, 3A02)

Dr Peter Stoddart, Bristol

Obstructive sleep apnoea (OSA), a syndrome that includes a range of sleep disordered breathing patterns from simple snoring to life-threatening airway occlusion, may be associated with significant respiratory, cardiovascular, behavioural, cognitive and even metabolic dysfunction. Paediatric anaesthetists are increasingly seeing the label OSA in the notes of their patients. Should we be concerned?

These children may challenge our clinical skills and acumen but many don't. Consensus statements define the diagnosis and guide the treatment of OSA and where children should be managed. However these are not universally followed.

In this presentation I aim to:

1. Describe the syndrome and the diagnostic criteria
2. Discuss the management of OSA
3. Discuss the challenges for anaesthesia and analgesia

Tracheostomy in children (1C02, 2A01)

Mr Keith Trimble, Consultant Paediatric Otolaryngologist, Belfast

Indications for tracheostomy in children has moved from infective causes to airway obstruction and congenital anomalies, long-term ventilation and underlying neuromuscular or respiratory problems. Modern paediatric tracheostomy care involves a multidisciplinary clinic to supervise use of speaking valves, avoidance of long-term complications and de-cannulation where practical. Tracheostomy technique has been modified to include stomal maturation sutures to avoid the catastrophe of early accidental decannulation. The Global Tracheostomy Collaborative launched in 2014 to improve quality of care in paediatric tracheostomy and to disseminate best practices and improve outcomes. The UK National Tracheostomy Safety Project is adapting paediatric emergency algorithms. Clinical decision making in life-limited children can require presentation to the hospital ethics committee.

Learning Objectives

1. Appreciate shift in indications for paediatric tracheostomy
2. Familiarisation with NTSP paediatric emergency algorithm and bedhead signage
3. Top Tips for safe surgical tracheostomy technique in children

Session 1a

Airway algorithm for the difficult airway (2A01)

Dr Thomas Engelhardt, Aberdeen

Airway problems remain a leading cause of perioperative morbidity and mortality in children.

Proficiency and expertise in airway management are key elements for the safe conduct of paediatric anaesthesia. Clear strategies must be in place to successfully manage children with a normal, acutely impaired and expected difficult airway. Simple, forward only, easy to memorize and easy to practice open algorithms are essential in preparation for the unexpected difficult paediatric airway. The child with the acutely impaired normal airway and known difficult airway are the domain of the experienced anaesthetist in an appropriately staffed and equipped paediatric setting.

Learning points

1. Recognition and treatment of anatomical and functional airway obstructions
2. Simple, forward only, easy to memorize and practice open algorithms are essential
3. Children with an impaired normal or a known difficult airway are the domain of the experienced anaesthetist in a paediatric hospital setting

Session 1b

Sugammadex (1A02)

Dr Martin Shields, Belfast

Sugammadex is a γ -cyclodextrin that was first synthesised in the late 1990s. 15 years later the true value of sugammadex in modern clinical practice is still debated, mostly due to financial reasons. Sugammadex will reverse the neuromuscular blocking effects of all aminosteroidal neuromuscular blocking drugs from any depth of paralysis. In contrast, neostigmine will reverse paralysis effectively, but only when a substantial degree of muscle function has started to recover spontaneously. This has rekindled an examination of the potential benefits to surgeons of using deeper levels of paralysis to facilitate a quiet surgical field and also the possible benefit to patients, with less residual post-operative curarisation.

Another value has been the ability to use non-depolarising muscle relaxants safely in patients with conditions affecting nerves and muscles where they might previously have been avoided. These include myasthenia gravis, muscular dystrophies and spinal muscular atrophy. Side effects of sugammadex are quite rare. There have been cases of type-1 hyper sensitivity reactions to this drug however given that millions of patients have now received the drug worldwide the pattern of allergic anaphylaxis is similar to majority of drugs anaesthetists administer on a daily basis.

Learning objectives

1. Evaluate the cost benefit analysis for sugammadex.
2. Understand the role sugammadex may have in delivering anaesthesia safely to special paediatric populations.
3. Understand the side effect profile of sugammadex especially in relation to hypersensitivity reactions.

Dexmedetomidine (1A02)

Dr Gill Lauder, Vancouver, Canada

Key points

- Dexmedetomidine is a selective alpha-2 receptor agonist that confers sedation, anxiolysis, sympatholysis and analgesia with anaesthetic/analgesic-sparing effects (Su et al., 2011; El-Rahmaw et al., 2013; Abdallah et al., 2013).
- Dexmedetomidine is relatively free from respiratory depressive effects and has neuroprotective effects on the brain (Brissaud et al., 2013).
- These favourable physiological effects combined with a limited adverse effect profile make dexmedetomidine an attractive adjunct for paediatric anaesthesia (general and regional) and analgesia.
- In children haemodynamic changes occur which are related to the serum concentration of dexmedetomidine (Petroz et al., 2006).

Learning objectives

1. Summarise relevant current evidence for dexmedetomidine in pediatric anaesthesia and analgesia.
2. Outline BC Children's Hospital (BCCH) experience with dexmedetomidine in anaesthesia, the acute pain service and intensive care.
3. Describe clinical situations where dexmedetomidine has been particularly effective.
4. Discuss the contra-indications and limitations of this therapy.

Session 1b

Why isn't TIVA more popular? (1A02, 3I00)

Dr Alistair Baxter, Edinburgh

It is now 25 years since Dr Brian Marsh and colleagues published their work on the use of a pharmacokinetic model for paediatric total intra venous anaesthesia (1). However, a survey of paediatric anaesthetists in 2008 and later the NAP5 report suggested that only a small fraction of paediatric anaesthetics are delivered by this method.

There may be a number of reasons for this including:

1. Limited availability of suitable algorithms and pumps
2. Pain on injection and necessity for intra venous access prior to induction
3. Anxiety over propofol infusion syndrome
4. Reliance on and experience with volatile anaesthesia.

In recent years, research into pharmacological modelling and development of suitable programmable infusion devices aligned with a greater understanding of the mechanisms behind propofol infusion syndrome, has resulted in an increase in the use of propofol for TIVA in children (2&3).

However, the benefits of TIVA of children are similar to those seen in adults, namely decrease postoperative nausea and vomiting, rapid and smooth recovery without emergence delirium often seen with volatile anaesthesia and decreased environmental (and operative field) pollution. (3)

This talk will focus on how these advances have been used to target specific areas of paediatric practice that may benefit from the use of TIVA. It also discusses the problems associated with the lack of analgesic activity of propofol, and how this can be overcome without compromising the benefits of TIVA (4&5).

Examples of TIVA in action in children will be discussed and future developments that may increase the use of TIVA in children.

- (1) Marsh, B. et al. "Pharmacokinetic model driven infusion of propofol in children". BJA, (1991) 67(1). 41-8.
- (2) McCormack, J.G. "Total intravenous anaesthesia in children". Current Anaesthesia and Critical Care(2008) 30, 1-6
- (3) Loh, N.-H., Nair,P., "Propofol infusion syndrome". Continuing Education in Anaesthesia, Critical Care & Pain, (2013).
- (4) Milne,S.E., et al. "Propofol sparing effects of remifentanyl using closed-loop anaesthesia". BJA (2003) 90 (5). 623-9
- (5) Malherbe, S. et al "Total intravenous anaesthesia and spontaneous respiration for airway endoscopy in children-a prospective evaluation" Pediatric Anesthesia (2010). 20. 434-438.

Session 2a

State of the art: Local anaesthetics (1A02)

Dr Suellen Walker, London

An ideal local anaesthetic has a long list of desirable properties: effective; rapid onset and adequate duration; reversible; dose response with selective sensory block or minimal motor block; lack of local and systemic toxicity; low allergy risk; stable and able to be sterilised; effective topically; minimal interaction with other drugs; and low cost.

Approaches to develop more 'ideal' local anaesthetics include:

- I. formulations that prolong the duration of action of existing drugs, such as liposomes (1) and microspheres (2);
- II. improving selectivity and prolonging duration by restricting access of the local anaesthetic to sensory fibres eg. quaternary lidocaine (QX-314) (3, 4);
- III. more selectively targeting sodium channels, eg. neosaxitoxin which binds to the outer pore (5, 6) or targeting specific subtypes of voltage-gated sodium channels.(7)

Learning objectives

4. understand the physiology of voltage gated sodium channels as relevant to the action of local anaesthetics
5. be aware of current efficacy and safety data for new local anaesthetic preparations

Debate: The T piece – 'gone, but not forgotten' (3D00)

Pro: Dr Frank Potter, Liverpool

Con: Dr Jason Maynes, Toronto

Session 2b

What does the patient want? (3A03)

Mr John Hitchman, Durham

The pre-operative visit may occupy the shortest time of the peri-operative pathway for children, but the success or otherwise of the visit will determine the overall experience for both children and parents.

While a busy ward and a couple of minutes for the visit may be inappropriate. Change is highly unlikely in a time impoverished NHS.

In the short time available the anaesthetist needs to identify the expectations of the child and parents. A snap decision needs to be taken as whether to focus on the worries of the child or the parents. It may seem obvious to focus on the child, but often the worries of parents are transmitted through to a child who otherwise might be happy to go with the flow. Parents write the feedback!

In delivering last minute information the anaesthetist needs to be aware that people, and especially children, are good at detecting when they are receiving information by rote. At this stressful time children and parents need to be inspired by a professional who is aware of their individual circumstances, even if those circumstances are not unusual.

With a good pre-assessment from an anaesthetist led pre-assessment team the pre-operative visit is likely to provide essential information in a reassuring way.

What does the anaesthetist want? (3A03)

Dr Jonathan Smith, London

Dealing with a child's bad prior experience of anaesthesia (3A03)

Dr Colin Dryden, Liverpool

Most children have a positive experience of anaesthesia, helped by friendly surroundings, sympathetic staff and technological developments such as topical local anaesthesia. However, a number of children will have a bad experience of anaesthesia whether that is down to the child's natural anxiety, learning difficulties, system failures on the day of the procedure, technical difficulties, or simply bad luck. The consequences of a bad experience include nightmares, anxiety, increased levels of pain and requirement for medication, and reluctance to mobilise and return to usual routine.

With the inexorable move towards day surgery where possible, or otherwise to admission on the day of surgery, the opportunities for staff to anticipate issues such as anxiety and to build a rapport with the child are extremely limited. Preadmission telephone consultation can be very helpful in identifying predictable issues and indicating the need for a plan tailored to the specific needs of the child. A walk-through of the process and meeting the staff who will be involved in the child's procedure are very useful in alleviating anxiety in the child and the parents, and gives an opportunity for distraction techniques or sedative premedication to be discussed.

Learning points:

1. Means of identifying and highlighting children at risk of a bad experience
2. Developing links with other healthcare workers with an interest in optimising a child's experience of anaesthesia
3. Strategies for handling highlighted children.

Debriefing the team after bad outcomes (1102, 1103)

Prof Andrew Wolf, Bristol

During the course of a career, almost all anaesthetists will experience an unanticipated serious adverse event related to a surgical/ anaesthetic procedure that will result in death or major injury to a patient. Injuries involving a child carry greater emotive weight for the individuals involved, the families and the hospital. Efforts to avoid and manage critical incidents are vital, but bad outcomes happen, and attention needs to be paid in learning how to deal effectively with the wide reaching aftermath of such an event.

While the debrief is an expected part of management, there is limited data on best practice. Currently, its application is inconsistent and sometimes not even undertaken. This talk will discuss from personal experience the necessary goals of the debrief, and how to avoid some of the pitfalls. The underlying principle is to maintain open consistent communication with all groups involved: the families, the team and the hospital. Debriefing is not an event but a process that needs to support all the members of the team. The guilt, anxiety and perseverance associated with the event are handled differently by individuals, and for some, recovery and resolution may take a considerable time.

Session 4a

Going paperless – The Addenbrookes experience (1G01)

Dr Vaithy Mani, Cambridge

Electronic health records improve the quality of care as well as improve the convenience of accessing the records for both the providers and patients. In 2013, Health Secretary challenged the whole NHS to go paperless by 2018, substantiated by a report submitted by Pricewaterhouse Coopers (PwC), which estimated a potential £4.4 billion per year could be reinvested in improving care by making better use of information and technology.

Cambridge University Hospitals implemented the electronic health care software "EPIC" in October 2014. We had implemented this across all parts of the hospital. We did have a difficult start to the implementation, which was not completely unexpected. But, since then, the EPIC system has improved a lot and there is scope to improve further. We have seen lots of benefits to both providers and patients.

Learning points

1. Planning the implementation of electronic health records (EHR)
2. Benefits of EHR
3. Disadvantages of EHR

References

1. NHS Challenged to go paperless by 2018 – DoH document
2. A review of the potential benefits from the better use of information and technology in health and social care – PwC report Feb 2013.
3. EPIC Health care record software – www.Epic.com

What the APA and the website can do for you (1G01)

Dr Mark Thomas, London &
Dr Simon Courtman, Plymouth

We will cover the work of the APA, including new initiatives and how to get actively involved as a member.

A tour of the website will demonstrate its functionality and also its resources, many of which may be a pleasant surprise! We will also look at the uses of social media

Invitations to get involved at council or other levels will be actively sought and feedback/suggestions welcomed on how to further improve the services we provide.

Learning outcomes

1. Have a better understanding of the work the APA undertakes
2. Know how to get involved and who to contact
3. Feel encouraged to apply for formal roles

Data mining in the OR, noticing important changes (1G01)

Dr Gill Lauder, Vancouver, Canada

Key Points

- Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Good quality audit requires accurate measurement. We are fortunate to have a way to measure intra-operative vital signs every 5 seconds in all the operating rooms of our surgical suite.

- This intra-operative vital sign data has been used to drive quality improvement projects at BC Children's hospital (BCCH).
- "Big Data" involves applying mathematical algorithms to huge quantities of data in order to infer probabilities from linear and non-linear relationships. This requires a change in focus to correlations and not to causation.
- "Big Data" has potential to fuel a renaissance in medical artificial intelligence in terms of alarms, prediction, policing (computer critic or helper) to aid quality improvements in a different way to audit.
- "Big Data" value needs to be considered in terms of all the possible ways it can be employed in the future. Many aspects of our world will be augmented or replaced by computer systems that today are the sole purview of human judgment.

Learning objectives

1. Outline BCCH experience with data mining from anesthesia monitors in the pediatric anaesthesia OR suite.
2. Outline BCCH involvement with the Paediatric National Surgical Quality Improvement Project (P-NSQIP).
3. Describe "Big Data"
4. Explain why current hospital based hypothesis driven audit does not represent "Big Data"

Session 4b

Lessons from other high risk industries (1103)

Dr Allan Goldman, London

Culture and power gradients in the cockpit, can these human factor lessons be translated into the operating room (1103)

Dr/Capt Steve Scott, Aviation Psychologist, Coventry

The presentation is about research completed involving the effects of culture/hierarchy on the flight deck.

Learning objectives:

1. Culture/hierarchy attributes can be both positive and negative.
2. Decision-making varies between peoples of different cultures/hierarchy.
3. Understanding the self is the first step to working more effectively with others.
4. Learning about others can help understand how they may differ from you.

Taking risks for peace: Breaking the fast with the world's most wanted (1103)

Prof Beverley Milton-Edwards, Professor of Politics, International Studies and Philosophy, Belfast

This talk, will focus on the risks for peace in negotiating with some of the world's most wanted terrorists and why such risks would be taken.

Focussing on the themes of risk, knowledge, diversity and dialogue some perspectives are offered on the wider issues as they pertain to how professionals must tackle sensitive, often confidential and challenging interactions.

Learning outcomes

1. Understand risk behaviour and link to knowledge
2. See the big picture from one small interaction
3. Scale risk to the task

Session 6

Protocols in professional practice – Prospects and pitfalls

Prof Brian Kavanagh, Toronto, Canada

Guidelines, protocols, and checklists (together called "protocols") can be immensely helpful in the clinical arena. However, clinicians and health care systems relying on protocols must assess whether benefits are being accrued, whether such "benefits" are real, and whether harm can be detected. These concerns are important because protocols (as opposed to drugs or other interventions) are seldom subjected to rigorous testing; instead, they are often implemented on the basis of belief or the results of simplistic "before and after" studies. We describe two concepts, "protocol misalignment" and "protocol misattribution," and discuss how understanding these concepts might help improve outcome and prevent unanticipated harm. Ultimately, applying protocols to the same standards of proof as other interventions might increase insight and help ensure "true" patient benefit.

Learning objectives

1. To understand the difference between protocols, guidelines and checklists
2. To review how protocols can be beneficial
3. To understand how protocols can have unintended consequences
4. To review how to optimize care using protocols

Session 8a

The NICE guidelines (2A05)

Dr Chris Gildersleve, Cardiff

Accepted current practice in intravenous fluid therapy for children has its roots in the mid-20th century. More precisely, almost 60 years ago, in the 1957 treatise by Holliday and Segar: *"The maintenance need for water in parenteral fluid therapy"*, published in the journal Pediatrics. Using this as a reference point this lecture traces a path from the early 2000s via alerts of the danger of using hypotonic intravenous solutions in children, through the release of the APA Consensus guidelines on the perioperative fluid management of children in 2007 to the present day with the publication, in December 2015, of the NICE Guideline: Intravenous fluid therapy in children and young people in hospital.

Learning objectives

Following this lecture delegates should:

1. Have an awareness of the historical background of intravenous fluid management in children.
2. Understand the scope, aims and development of the NICE guideline: IV fluid therapy in children and young people in hospital.
3. Appreciate that development of the guideline is based on both evidence and consensus and that:
4. Isotonic solution should be the initial treatment for resuscitation, replacement and redistribution, and routine maintenance.
5. There is no evidence for the routine use of glucose in most children outside the neonatal age group.
6. The appointment of an IV fluids lead is crucial for hospital/trust wide implementation of fluid guidelines.

The problems with fluids (2A05)

Dr Terence Montague, Dublin

Blood and other products (2A05)

Dr Philip Arnold, Liverpool

Most articles on transfusion will begin with a sentence to the effect of: 'transfusion is a vital and at times lifesaving intervention, but...'

Following the 'but' will be a discussion of risks related to transfusion and the need to make the best use of a limited resource.

This talk will aim to discuss both the benefits and risks of transfusion in children undergoing surgery. Reference will be made to a number of recent guidelines, including recent NICE guidance (on transfusion in adults and children over the age of 1 year). Despite the importance of this intervention, there is generally a lack of evidence to support either existing or evolving practice. Much of what we do in children is, by necessity, an extrapolation of adult practice and most adult practice is extrapolated from basic science. More recently, there has been an attempt to question some historical practices and some evidence has emerged.

Topics covered in this talk will include:

- Brief overview of current guidance on transfusion and children
- Blood conservation
- Management of bleeding
- Current trends in practice and research

Session 8b

NAVA and the anaesthetist (2A04, 2C02)

Prof Javier García Fernández, Madrid

Session 8b

ECMO and the anaesthetist (2C04, 2C07)

Dr Jon Smith, Newcastle

Extracorporeal Membrane oxygenation (ECMO) was first used for clinical care in 1971 and used later that decade in children. There has been further rapid development in the last 10 years. My talk will review the argument for the use of this technique and the relevant physiology. I will talk about the development of the newer ECMO circuits and their advantages. I will review the studies that were instrumental in bringing ECMO into the mainstream¹⁻⁴. I will discuss the problems that the anaesthetist might have with ECMO; logistics, bleeding and anaesthesia and how these can best be dealt with. I will talk about the outcomes of ECMO in the current era⁵ in both respiratory failure^{6,7} and cardiac disease.

1. UK collaborative randomised trial of neonatal extracorporeal membrane oxygenation. *Lancet* 1996; vol. 348 pp. 75-82.
2. Peek GJ, Mugford M, Tiruvoipati R et al. CESAR: a multicentre randomised controlled trial. *The Lancet*. vol. 374pp. 1351-63 2009
3. Noah MA, Peek GJ, Finney SJ et al. Referral to an ECMO center and mortality among patients with influenza A(H1N1). *JAMA*. 2011;306:1659-1668.
4. Macrae DJ, Field DJ. Our study 20 years on: Intensive Care Med. 2016;42:841-843.
5. Iguchi A, Ridout DA, Galan S et al. Long-term survival outcomes and causes of late death etc. *Pediatr Crit Care Med*. 2013;14:580-586.
6. Nijhuis-van der Sanden M, van der Cammen-van Zijp M, Janssen A et al. Motor performance in five-year-old ECMO survivors: *Critical Care*. 2009;13:R47.
7. Madderom MJ, Reuser JJ, Utens EM et al. Neurodevelopmental, educational and behavioral outcome at 8 years after neonatal ECMO: *Intensive Care Med*. 2013;39:1584-1593.

Session 8b

Best ventilation in the OR – Ventilate an isolated lung (2A04, 2C02)

Prof Javier García Fernández, Madrid

Guidelines, protocols, and checklists (together called “protocols”) can be immensely helpful in the clinical arena. However, clinicians and health care systems relying on protocols must assess whether benefits are being accrued, whether such “benefits” are real, and whether harm can be detected. These concerns are important because protocols (as opposed to drugs or other interventions) are seldom subjected to rigorous testing; instead, they are often implemented on the basis of belief or the results of simplistic “before and after” studies. We describe two concepts, “protocol misalignment” and “protocol misattribution,” and discuss how understanding these concepts might help improve outcome and prevent unanticipated harm. Ultimately, applying protocols to the same standards of proof as other interventions might increase insight and help ensure “true” patient benefit.

Learning objectives

1. To understand the difference between protocols, guidelines and checklists
2. To review how protocols can be beneficial
3. To understand how protocols can have unintended consequences
4. To review how to optimize care using protocols

Session 9a

State of the art: Drug development in anaesthesia (1A02)

Dr Jason Maynes, Toronto

Genetic, epigenetic and environmental factors influence the effect that pharmaceuticals have on a patient, including efficacy for a given clinical indication or potential toxicity. Population-based values, like expected drug effect, do not predict whether a drug will work in a particular patient, and are not useful for the discovery of new drugs that may only work in a subset of the patient population. The new ability to model a particular patient, or subgroup of patients, using human stem-cell derived tissue facilitates the testing of pharmaceuticals for clinical effect and toxicity, allowing for targeted therapy. Among the currently available types that can be generated, cardiac and neuronal tissues are particularly relevant to anaesthesia and pain medicine. We will illustrate how patient-derived cardiac tissue can be used to discover new therapies for heart failure, model chemotherapy-induced organ damage and screen for mitigating compounds that can be used to preserve heart function. We will show how local anesthetic toxicity can be modeled, revealing a novel mechanism by which arrhythmia is induced, and provide evidence for a new cardioprotective strategy. Stem cell-derived tissues provide a vehicle for individualized patient treatment, ensuring that the right drug is given to the right patient.

Learning objectives

1. To understand how stem cell-derived tissue can be used to model disease
2. To understand how “personalized” tissue can be used to determine patient-drug interactions
3. To learn how tissue can be constructed with multiple cell types to discover new targeted therapies

Multicentre studies in paediatric anaesthesia (1G02, 1I05)

Prof Walid Habre, Geneva

Session 9b

This workshop will have two rotations:

- 1. Low flow anaesthesia & AGC** – The benefits and clinical risks of low flow anaesthesia – why do we need automated low flow?
- 2. Lung recruitment with an isolated lung model**
– In this section you can visualise in a real isolated lung model.

Social Programme

If you would like to register for any of the social events, please visit the APA registration desk



Evening Social Reception

Wednesday 4th May, 1900–2100

Price: £10 per ticket

The meeting opens with a reception at the historic McHughs bar. Dating back to 1711 and located beside Custom House Square, McHughs is the oldest surviving building in Belfast.

In a city famous for hospitality, McHughs offers a classic warm Irish welcome. There will be drinks and canapés served throughout the evening along with Irish entertainment.



Annual Dinner

Thursday 5th May, 1930–2359

Dress code: Dress smart (black tie optional)

Price: £65 per ticket

The popular annual dinner is to be held at the impressive City Hall. This Portland stone and copper-domed building was completed in 1906 as a symbol of Belfast's new city status granted by Queen Victoria. The splendour and grandeur created by the craftsmen of Belfast in the interiors of City Hall, was reflected in the impressive public rooms on board the Titanic. There will be a drinks reception followed by a 3 course dinner & wine, complete with Irish entertainment.

Oral Presentations

No.	Author	Co-Authors	Title
001	P Asimakopoulos	D Pennell, C Mamais, D Veitch, S Stafrace, T Engelhardt	The use of ultrasound in assessing tonsillar size in children
002	M Bloor	A Snoek, M Catolico, J Navaratnarajah, J Herod	Anaesthetic perioperative management of vein of Galen malformation: a review of 192 anaesthetics
003	B von Ungern-Sternberg	L Cheung, S Salman, M Nguyen, L-Y Lim	A pilot randomised open-label taste-testing study to evaluate the acceptability of chocolate-based midazolam in children
004	R Cowen	S Lane, P Arnold	Stating the 'Bleeding Obvious': Association Between Increased Transfusion and Mortality during Paediatric Heart Surgery at Alder Hey Children's Hospital
005	C Raistrick	C Kelly, R Perkins	Paediatric Emergency Laparotomy Audit (PELA)
006	L McNulty	P Crean, R Haughey	Post Operative Analgesia in Tonsillectomy and Adenotonsillectomy: In the Wake of Withdrawal of Codeine from Paediatric Practice, How Effectively is this Being Managed?
007	D Fancourt	S Baltzer Nielsen, S Capps, C Lee, P Brooks	RELAX Anaesthetics: the effect of a bespoke distraction app on anxiety levels in children undergoing anaesthesia

Poster Prizes

No.	Author	Co-Authors	Title
008	S Black	L Tooke	A QUALITY IMPROVEMENT PROJECT IN CAN THO, VIETNAM: 'S.A.FE SBAR'- Designing and Introducing a Checklist to Improve Anaesthetic Handover from Theatre to Recovery
009	S Black	I Barker, D DeBeer, K-B Ong	A QUALITY IMPROVEMENT PROJECT: Improving Theatre Recovery Throughput in Elective Craniofacial Paediatric Surgical Patients
010	E Sharkey	M Cohen, E Haque, N Dobby	A service review of Baxter and Primal Sevoflurane
011	J Erskine	S Hickey, T Moores	What do trainees REALLY think of training in paediatric anaesthesia in a tertiary centre? A novel approach to assessing the training experience
012	C Waugh		Reducing Error in Paediatric Anaesthetic Emergencies
013	AM Dolan	K O'Brien, F Kirby	The usefulness of the modified Yale preoperative anxiety scale and other qualitative markers for induction of anaesthesia in paediatric patients
014	M Haque	E Sharkey, N Dobby, H Hume-Smith	Pharmacoeconomics of Sevoflurane
015	I Ioannou	D De Beer	Prevalence of Preoperative Anaemia in the Paediatric Population
058	A Hutton	M Arrica, K Wilkinson	Paediatric Cardiac Arrest...Who should make the call? A survey of multi-disciplinary opinions regarding decision-making in termination of paediatric cardiac arrest
079	M Salman	C Matava	Factors predicting impact of 711 pediatric anesthesia case reports
080	S Monks	M Sadadcharam, C Doherty, B McGrath, R Neal	Use of simulated scenarios to assess effectiveness of emergency paediatric tracheostomy emergency algorithms and training
081	R Ayyash	M Clement	A Needs-based Assessment of Paediatric Pain Management Teaching for UK Anaesthetic Trainees
090	A Keith		Comparison of invasive and non-invasive blood pressure measurement in children undergoing cardiac catheterisation

Posters

No.	Author	Co-Authors	Title
016	M Bloor	C Stendall	Great Ormond Street Preoperative Assessment Clinic: a patient's perspective
017	R Cowen	P Arnold	Observational analysis of the use of fibrinogen concentrate (RiaSTAP) in paediatric cardiac surgery
018	V Raman	G Argote-Romero, C Burrier, J Uffman, J Tobia	Patient Satisfaction Improvement after post-operative standardized video in Adenoidectomy patients
019	A Miskovic	H Robinson, T Webster, V Guruswamy	Analgesia for tibia-fibula external fixation in children
020	B Stahl	M Walters	Introducing paediatric TIVA in a district general hospital. Quality improvement or not?
021	D Newby	S Shafeek	An Audit into the Perioperative Care of Paediatric Type-One Diabetic Patients Presenting for Elective and Emergency Surgery at a District General Hospital
022	R Campbell	S King	Improving quality and safety for cardiac children presenting for non cardiac surgery
023	S Gallagher	R Clerkin	Determining Relative INtaKes before Surgery (DRINKS) Audit
024	R Danha	A Nowicka, S Bullock, S Chari	An audit of the distribution of the paediatric anaesthesia workload at the University Hospital Coventry
025	B O'Sullivan	K Thomas	Cochlear Implants as Day Case Surgery: Implementation, A Retrospective Study of Techniques Employed and Production of a Day Case Surgery Protocol
026	P Giri	S Alva	Comparison of tablets to other conventional distraction methods during anaesthetic induction in children
027	B-L Tingle	R Wilde	Introduction of Buccal Midazolam for Pre-medication and Procedural Sedation in Children at Oxford University Hospital NHS Foundation Trust: a quality improvement initiative
028	E Jones	Z Harclerode	PATRN - Setting up a trainee research network
029	S Monks	T Mount, L Hartley	A Pilot of Excellence Reporting in theatres in the Royal Manchester Children's Hospital
030	K Robinson	N Shaw	A Snapshot of Induction Practice in the Paediatric Theatre, Ninewells Teaching Hospital
031	H Lonsdale	H Neary	Quality Improvement through reverse innovation: Re-assessing NCA use for post-operative pain following cranial surgery

Posters

No.	Author	Co-Authors	Title
032	P Giri	P Sodhi	Audit on unplanned hospital admissions following day case surgery in pediatric patients.
033	E Blythe	J Short	The Changing Face of Operating at Sheffield Children's Hospital 1947–2015
034	B-L Tingle	T Whittington	Tracheo-Bronchial Topicalisation in Paediatric Medical Bronchoscopies - A Unique Anaesthetic Technique at Oxford University Hospital NHS Foundation Trust
035	L Talbot	Z Kulcsar, C O'Donnell, J Rajan	Post-thoracotomy analgesia – an audit of clinical practice
036	AM Dolan	K O'Brien	Anaesthesia Exposure of Children under 12 months of age at Temple Street Children's University hospital, Dublin, characteristics and complexities
037	A Callaghan	A Cooke	The Preparation of Anaesthetic Emergency drugs in Paediatric Theatres: a survey of practice
038	R Wilde	N Taylor, K Ng	Improving the Safety of Post-Anaesthesia Paediatric Handover
039	S Ritchie-McLean	J Neeley, M Cole, D Banni, H Underhill	A completed audit cycle of parental satisfaction with the paediatric anaesthetic service in our hospital
040	A Jaspal-Mander	K Cruickshank, T Moores	Peri-operative paracetamol prescribing in a Tertiary Paediatric teaching hospital
041	K Wood	V Barlow, J Diacono, M Abdelrahman	The Impact of a New Consultant Led Pre-Operative Assessment Service at Royal Manchester Children's Hospital
042	C O'Donnell	N Hyndman	Safety and Improvement in Allergy Documentation and Identification in the Royal Belfast Hospital for Sick Children
043	M Redmond	M Khater	Facilitating timely non-elective surgical intervention in children – full cycle clinical audit and recommendations
044	C Pocknall	K Nicholson, A Katana, G Lee, T Quintana, Y Cousins, R Pegg	Peri-operative neonatal temperature control – a quality improvement project
045	V Marshall	A Keaney, L McDonald, P Coulter	Weighing Children, A Heavy Burden?
046	S Poulouse	J Armstrong	AUDIT OF PAEDIATRIC MICRO-CUFF ENDOTRACHEAL TUBE USE – IS THE PRESSURE ON?
047	R Saini	S Jaggar	Analgesia Post Paediatric Pacemaker Insertion

Posters

No.	Author	Co-Authors	Title
048	M Gandhi	N Hall	Paediatric emergency surgery: Do we time it well? Paediatric emergency theatre list efficiency at Great North Children's Hospital, Newcastle upon Tyne
049	G Fitzpatrick	J Smith	Fresh frozen plasma repletion on bypass as a management for high risk paediatric and congenital cardiac surgery
050	V Adiga	D De Beer	An Evaluation of the pain management of patients undergoing major craniofacial surgery in a tertiary children's hospital
051	G Devoy		Handovers to a paediatric post anaesthesia care unit: a pilot audit
052	AM Dolan	F Kirby	Analgesia given to patients under 12 months of age who require general anaesthesia and turnaround time in recovery with a nurse led extubation policy
053	L Lavery	K Bailie	An Audit of Preoperative Pain Management in Paediatric Appendicitis
054	B O'Sullivan	R Lin, H Cathie, B Lambert	Paediatric Recovery Times: A Tale of Two Tertiary Referral Centres
055	H Muir	V Guruswamy, R Barbour, R Subramaniam, A Turner	Anaesthetic implications of robotic urology surgery in children
056	D Marriott	K Peiris	Transversus Abdominis Plane Catheters: The New Epidural. A Comparison on Analgesic Techniques for Paediatric Laparotomies in our Centre
057	K Smallshaw	M Clement, S Punj, A O'Neill	Pain Management for Appendicectomy in children: Does use of morphine nurse or patient controlled analgesia increase morbidity?
059	C Perry	M Gandhi	Use of additives in paediatric epidurals: a nationwide survey of practice guiding development of a local service
060	T Mahendrayogam	S Shafeek	A NATIONAL APAGBI SURVEY OF TIME-CRITICAL PAEDIATRIC TRANSFERS
061	Z Harclerode	E Jones	Post-operative Tonsillectomy Analgesia after discharge: A UK practice survey
062	S Nour		Parental survey of paediatric day surgery
063	GB Crapelli	SI Jaggat	Monitoring awareness in the paediatric cardiac catheter laboratories
064	M Thomas	D Willdrige, R Newton	A national survey of paediatric pre-operative fluid fasting

Posters

No.	Author	Co-Authors	Title
065	S Gallagher	Z Nawoor, B Lyons	Patients with cardiac disease for noncardiac procedures
066	D Greaney	D Mullane, M Bourke	"I hate treating a sick kid" - Confidence in paediatric anaesthesia before and after dedicated paediatric training
067	G Fitzpatrick	K Baillie	A survey of post operative analgesia for day case orchidopexy
068	A Mohabir	B Tingle, C Morris	HALT - Are we putting the theory into our practice?
069	N Karunasekara	B Lambert	Harlequin Ichthyosis: Costume of Arlecchino
070	S Monks	V Barlow, C Doherty, I Bruce, N Bateman	Generating an educational tool and guideline for an EXIT (Ex-utero, intrapartum treatment) procedure
071	L Dyal	J Stansfield	The Case of the Chesty Child
072	K Blyth		Fulminant rheumatic fever causing severe mitral and aortic regurgitation
073	S Ritchie-McLean	M Kanagarathnam	Tumour lysis syndrome triggered by anaesthesia in a child with B-Cell Non-Hodgkin's Lymphoma
074	S Poulouse	P Sudarshan	Hyper-metabolic Response to Inhalational Anaesthetics: Case series
075	A Mesbah	K Thies	Anaesthetic Management of Laparoscopic Nissen Fundoplication in a Child with MEGDEL Syndrome
076	G Malhi	C Pruefer	Congenital central hypoventilation syndrome (Ondine's curse) and the anaesthetist
077	A Snoek	E Saffer	Accuracy of a formula to predict optimal oesophageal temperature probe position in children
078	M Worrall	G Bell, M Buchner, E Fulton, E Cole	Improving the use of paediatric clinical guidelines with a new information delivery platform
082	D Marriott	K Peiris	Clearing the Mist: Introduction of Paediatric Bronchospasm and Anaphylaxis Guideline Boxes at a University Teaching Hospital
083	A Barrow	W Fisher	Survey of paediatric difficult airway management practice at a district general hospital and production of a training video utilising locally available equipment
084	R Ridgway	S Bew, H Shore, J Wolfe-Barry	The Leeds Neonatal Airway Training (NAT) course – a fresh approach to training and cross speciality networks

Posters

No.	Author	Co-Authors	Title
085	J Scheffczik		Low Quality of Evidence for Standards: Should We Use It For Audit?
086	N Woodman	M George, J Smith	Educational videos using a head-mounted device to gain expert perspective in complex neonatal and paediatric procedures
087	M Same	A Sogbodjor	Improving performance: Format and feedback from a Paediatric Anaesthesia FRCA Study Day
088	A Mohabir	B Tingle, A Choi	Neonatal Difficult Airway Algorithm
089	V Mann	D Kelly	A Plastic-Fantastic Solution... In-Situ Recovery Simulation
091	V Raman	M Kamada, J Tobias, T Englehardt	Ultrasound Evaluation for the Pediatric Upper Airway
092	C Raistrick	R Walker, R Hawkes	Abnormalities of the trachea in Mucopolysaccharidoses patients
093	R Cowen	J McHugh	The Functional Impacts of Paediatric Chronic Pain
094	R Cowen	J McHugh	Demographics of Patients Referred to Paediatric Chronic Pain Clinic
095	P Cowie	J Dickson	Paediatric Ear Reconstruction – An Analgesic Problem



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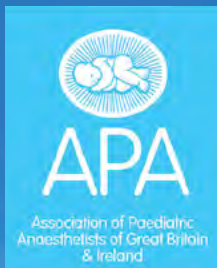
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