

NEWS & NOTES

The Lancaster – Omaha Surgical Rotation

The rotation between surgical trainees at the Royal Lancaster Infirmary and Creighton University, Omaha, U.S.A. was conceived at a meeting in Rome in 1983. Mr. Tony Watson, Consultant Surgeon at the Royal Lancaster Infirmary, and Dr. Tom DeMeester, Head of Department of Surgery at Creighton University, Omaha, U.S.A. were both speakers at the Triennial Meeting of the International Society for Diseases of the Oesophagus. The proposal was made by Dr. DeMeester because of the shared clinical and research interests between the two respective departments and was potentially very attractive. The rotation was set up such that fourth year Surgical Residents from Creighton would come to Lancaster for clinical and technical surgical experience, which is more readily available in Lancaster than at Creighton. The other arm of the rotation would involve the surgical trainees who came to Mr. Watson's Unit for research experience to acquire their M.D. or Ch.M. thesis rotating to Creighton, where extensive research facilities, supported by generous funding, are more readily available than in Lancaster!

It took a little time to overcome the logistical problems associated with the rotation in terms of funding for salaries and accommodation and rather tedious negotiations with the General Medical Council and Medical Defence Union. The rotation commenced in 1985, since when nine Creighton trainees have acted as Mr. Watson's clinical Registrar for a period of six months each and four Research Fellows have spent between nine and twelve months at Creighton. The rotation has been an unqualified success. The Creighton residents have been a delightful group of people and a pleasure to have around. They have adapted very readily to a totally different healthcare system and have been conscientious workers who have been keen and eager to learn and all have felt more confident and competent in their clinical and surgical abilities on their return. The Lancaster Research Fellows have enjoyed the access to a large University Department of Surgery and they have benefitted immensely from the academic environment and ready availability of facilities and support services which have greatly facilitated their research. Both groups have undoubtedly benefitted from exposure to a different country with its own healthcare system and the observations of the two current participants in the rotation scheme are printed below.

The future of the rotation is somewhat uncertain with Mr. Watson's impending departure to assume the Chair of Surgery at Sydney and the possibility that Dr. DeMeester may be moving to another Chair in the United States. The funding of our Surgical Research Fellows at the Royal Lancaster Infirmary ends with Mr. Watson's departure, but the secondment of those Creighton trainees who have been promised a period of training in Lancaster will continue until June 1991, their training being supervised by Mr. Kelly.

Lancaster-Omaha exchange 1988/89

Stephen Attwood, Surgical Registrar

An annual exchange programme for surgical trainees at Lancaster has been organized by Mr. Watson, consultant surgeon. Because of Mr. Watson's interest in oesophageal diseases he has made many connections with leaders in the field of oesophageal research. One of these is Dr. Tom R. DeMeester, in Omaha Nebraska, USA.

Nebraska is right slap in the middle of the USA being 1,500 miles from the east and west coasts, and 1,000 miles from Canada to the north and the gulf to the south. Omaha is of course very different to Lancaster: old by American standards, it was founded only 150 years ago, on the banks of the Missouri river, on one of the most important trade routes for the American pioneers conquering the wild west. Today, it has a population of some 300,000 and being typically American it is built on a grid system with wide streets all running at right angles to each other. This is in dramatic contrast to the narrow winding streets of ancient Lancaster with its imposing castle.

The countryside is the flat prairie of mid-west America, with not a hill in sight for hundreds of miles in any direction. With only 1,500,000 people in Nebraska, which is 600 miles long and 300 miles wide, it is very sparsely populated; a marked contrast to crowded Britain. The climate is full of extremes – temperatures unbearably hot in the summer (thank goodness for air conditioning) and down to -20°C in the winter. But the sun shines almost every day of the year which gives the flat landscape a great feeling of openness. The occasional tornado provides a drama. During my first week a tornado struck the town – tearing a street of houses right out of the ground. No deaths – the sirens in the town and radio and TV had warned everyone to stay in their basements for safety, a system the British could learn from, considering the events of this winter.

You can imagine that there is much to learn when one arrives in this strange land – new customs, a different culture and even a new language. I had most difficulty with cars – in fact automobiles of any kind were a problem. Having to put my cases in the 'trunk', get in the wrong side, look through the 'wind-shield' over the vast 'hood' which covered the six cylinder spluttering engine which guzzled 'gas' at a phenomenal rate (admittedly at only 50p a gallon) really brought home the fact that there might be some differences between Omaha and home. Actually I tell a lie! I drove a Honda Civic.

Dr. DeMeester works at Creighton University which, although not of the same reputation as Harvard or Stanford, is nevertheless one of the leading medical schools in the USA. The institution has many marked contrasts with the Royal Lancaster Infirmary. The hospital is in a single

building, purpose built less than ten years ago. It stands on one side of the main freeway (motorway in English!); on the other is the rest of the university complex. The department of surgery occupies a vast area which includes 16 operating rooms (theatres in English), wards for cardiac surgery, urology, orthopaedics, ENT, neurosurgery and general surgery. It also houses the headquarters of the department which contains the offices of the Professor and his three secretaries (these are his personal secretary, his manuscript secretary and his wife!), and the research laboratories. My work was mostly in these laboratories – a clinical laboratory for the investigation of patients with oesophageal diseases, just like the one in the RLI, in addition to a small animal experimental operating theatre, a large animal operating theatre and a variety of analytical laboratories.

In the department there were ten research fellows – only three of whom were from Creighton University. The others were from surgical departments as far afield as New Zealand, Germany, Italy, Yugoslavia, Norway, Japan and Korea. Although we were purely involved in research activities, our offices were right beside the helicopter pilots' headquarters and the accident and emergency department, which exposed us to much of the drama of American emergency medicine!

Despite these contrasts and the obvious relative wealth of the resources in the area of health care, I was interested to see that the standard of health care was not a lot better than in the NHS here in Britain. Certainly the standard of delivery is very much more comfortable for the vast majority (with mostly single rooms for the inpatients, short waiting times both in clinics and for operations) but the medical decision-making, the standard of operating and the results achieved were comparable between the RLI and Omaha.

The work that I performed was both rewarding and educational. The training I had received in the oesophageal investigation unit at Lancaster enabled me to perform the clinical investigations with relative ease, and I found myself teaching some of the other research fellows with less experience. My research projects included both human and animal projects. On the human side I assessed the cause of complications in Barrett's oesophagus, and studied the role of surgery in this disease. The animal research was a study of factors causing the development of cancer in the oesophagus using experimental rats. We identified that duodenal juice (including bile and pancreatic enzymes) has the potential to cause adenocarcinoma in the oesophagus.

The research projects led to a number of presentations to scientific societies and subsequent publications in medical journals. These meetings were a highlight of my year as not only did they show results of my work but they allowed me to travel to a number of interesting places, such as Banff, in the snowy Canadian Rockies, the big city of Chicago, San Francisco (before the earthquake!) and the paradise islands of Hawaii.

The opportunity to travel to such exciting places, experience a new culture and work in a different and stimulating environment has been one of the high points in my career to date. Such travel does broaden your horizon, allowing you to look at problem situations with a new balance, and indeed helping you to see what is wrong with things that you may have always accepted as normal. I would recommend this form of exchange to anyone who has the opportunity to experience it.

A Comparison between American & British Surgery

Steve Tyndall, 4th Year Surgical Resident, Creighton University, Omaha, U.S.A.

From my brief experience in surgery, both here in Lancaster and in Omaha, Nebraska, I have noticed many differences in the approach to medicine and surgery. The differences seem to be driven by the restraints and pressures in each system.

In the United States litigation is very prominent and tends to contribute to the excessive use of high tech diagnostic and imagery devices. Computed tomography, magnetic resonant imaging and PET scanners are available and are encouraged to be used to eliminate the doubt of a diagnosis, and to stage a disease pre-operatively. Here in Lancaster a CT scanner is not available yet, and therefore ultrasound and barium studies are used more often. Clinical acumen is relied upon more to determine the diagnosis and subsequent treatment.

The approach to the patient is also quite different. Patients in the United States are less willing to accept the doctor's word and sometimes require a second or third opinion. Due to the probability of litigation with a potentially unhappy outcome, explicit descriptions of the disease, proposed operation and/or possible complications have to be discussed with the patient. Most patients expect to be told their diagnosis and prognosis even when the news is bad. In contrast I have found people in Lancaster still hold surgeons in high regard. The patients tend not to need details but would rather be reassured that everything will be taken care of.

In the USA we tend to be extremely aggressive with patients, even very elderly ones, with life-threatening illnesses. Unless family members express the wish not to have their relatives undergo treatment, we are obliged to press on with aggressive treatment. This includes mechanical ventilators, intravenous feeding and surgery. Patients seen here in Lancaster who have terminal disease, with an acute problem that they are unlikely to recover from, may not be kept alive by artificial means. This is not to say that aggressive treatment is not carried out in cases where the patient is salvageable, but that the doctors involved are allowed to use their judgement in giving treatment. This will let the surgical team spare patients unnecessary pain and allow them to die with some dignity without prolonging the inevitable. Obviously this places a great deal of pressure on clinicians making the decisions.

In both countries there are restraints which prevent patients from staying in hospital as long as they would like. In the USA, the government and the insurance companies place pressure on hospitals and doctors to keep costs down. There is an increasing pressure to perform procedures as an outpatient, and bring patients into the hospital for elective cases on the day of surgery. This has led to bowel preparations being performed at home, and sending home patients receiving long term intravenous feeding and antibiotics. All pre-operative tests will have been done in the

clinic or as outpatients. This leaves most hospitals with full operating schedules, but many more empty beds than in the past. In contrast, the Royal Lancaster Infirmary is usually full. This lack of beds regulates the number of elective cases that can be performed. This puts pressure on the doctors to get patients out of the hospital as quickly as they can and to perform as many tests as an outpatient as possible. I have been impressed with the district nurse concept. Their ability to dress wounds, remove sutures and generally offer support allows patients to leave the hospital sooner and relieves the surgeons of a heavy clinic schedule.

Another difference between the two systems is the way the hospital beds are arranged. In the USA most patients are in individual rooms or, at most, two patients per room. This allows patients more privacy and individual bathing facilities, but less patient-to-patient interaction. In contrast the Nightingale Wards used here make better use of hospital space. Patients have less privacy but, on the other hand, they tend to help each other. The social interactions between patients does seem to be a positive psychological factor in the healing process.

The differences seen in the two systems are a result of the restrictions placed on the surgeons practicing in each location. In America, surgical practice is being influenced by the government and third party payers who are regulating the flow of money for compensation. The high rate of litigation related to malpractice is also making most surgeons practise defensive medicine. In contrast the pressures I have observed on the surgeons here in Lancaster are slightly different. The restriction of beds and funds in the NHS have influenced medicine the most. The threat of malpractice is present but not as prominent as in the United States. I suspect this will change over the next several years. Although medicine is being practiced under different restraints, the results are quite similar.

I have found my stay here in Lancaster very enjoyable. The people here are very friendly and helpful. My operative experience has been very rewarding, especially the emergency cases. I have been exposed to many new approaches to the same old problems that I face in the United States. This experience will greatly help me in the future and it will give me an edge in my surgical career.

New Appointment

Consultant in General Surgery



Mr Trevor Leese takes up an appointment in July 1990 as Consultant in General Surgery with a special interest in Gastroenterology to replace Tony Watson. He will have clinics in Lancaster, Morecambe and the new Westmorland General Hospital.

Born in Reading in 1954, Mr Leese was brought up in south-east London where he attended Colfes' Grammar School. Preclinical studies were undertaken at St John's College Cambridge, where he met his wife. In 1976 he moved to the Westminster Hospital for clinical training where his

enthusiasm for a surgical career was fuelled by Professor Harold Ellis, for whom he subsequently worked as house surgeon and SHO. Following house jobs in 1980, he demonstrated anatomy at Cambridge University whilst working for Primary FRCS, before returning to Westminster for a two-year SHO/registrar rotation leading to the final exam.

He moved to Leicester in 1983 as surgical registrar and in 1985 became lecturer/hon. senior registrar. He developed a special interest in gastroenterology and publishes research in hepato-pancreatico-biliary pathologies. His MD thesis was in acute pancreatitis. The penultimate year as a senior registrar was spent in Paris working with Professor Henri Bismuth, who has a worldwide reputation in the field of hepato-biliary surgery. Mr Leese also made a detailed study of Paris restaurants!

He has had a broad general surgical training, but particularly enjoys surgery of the oesophagus, stomach and biliary tree. He has obtained a wide endoscopic experience, both upper GI and colonoscopy. More recently he has expanded into the field of endoscopic retrograde cholangiopancreatography (ERCP) including therapeutic endoscopic techniques such as sphincterotomy, gallstone extraction and endoprotheses for tumours. He hopes to develop these interests in Lancaster.

Mr Leese is a keen rugby player and still turns out for a game most Saturdays. He also enjoys squash, cricket and country walks. His wife, Brigitte, is French and they speak French together and with their three boys at home.

CancerCare – Slynedales



Slynedales

Slynedales, the large Victorian building behind Beaumont College and next to St. John's Hospice, was acquired for CancerCare by auction last summer for £290,000. Renovation began last month and will cost £90,000 and Slynedales will open later this year. This will be a milestone for the cancer services in North Lancashire and South Lakeland.

Slynedales will be the headquarters for CancerCare, the supportive care organization for cancer patients and families, which began in 1984 as an extension of the treatment units at

the Royal Lancaster Infirmary and Westmorland County Hospital. CancerCare started in a small way with regular group meetings in hired accommodation in Ryelands House. Its growth and development have been inspired by the patients and encouraged by the various health care professionals involved. Various complementary therapies have arisen from the obvious need for psychological and emotional support. It has become a source of factual information and advice. Recreational and creative activities have been developed. For some it is a social club. Its success comes from the continued active involvement of patients, their relatives and the bereaved. All facilities are free to patients. The budget for CancerCare last year was £45,000 and this and more was raised by donation.

In 1985, CancerCare moved its office and activities into the newly opened St. John's Hospice, thus providing a uniquely integrated supportive, palliative and terminal care service. Patients in the hospice enjoy all that CancerCare has to offer and the association of these two organizations, CancerCare and St. John's Hospice, is dynamic and strong. CancerCare has expanded, however, and has outgrown its hospice accommodation. Moreover, the hospice trustees require the office space rented by CancerCare. Slynedales, being next to the hospice, will allow this association to continue whilst giving CancerCare more space and a clearer identity.

Mr Peter Cole is Chairman of the Slynedales Appeals Committee which also includes John Whitehead who may be approaching you for covenanted contributions. The sum raised since November is £120,000. The target for the first year is £300,000. Your support would be welcome.

Lancaster and Westmorland Medical Museum

There are a great many medical articles of historic merit and interest which should be preserved. For some time Drs. Valerie Anderson and John Carne have taken a keen interest in this work, and a small group, co-ordinated by Bill Forgham, has been established to support them.

The group's main objectives are:-

- 1 to locate medical items of historical merit and interest, eg equipment, books, articles, furniture, pictures, etc.
- 2 to produce a catalogue
- 3 to arrange a permanent exhibition for the public

A number of doctors personally retain such items and will continue to do so. We would, however, be interested to hear from those of you who have such items so that a record can be made. If you no longer wish to keep any items you can donate them for safe keeping and for future exhibition.

If you would like to join the group, you would be most welcome.

Bill Forgham can be contacted via the District General Manager's office at Lancaster Moor Hospital, extension 425.

Letters to the Editor

Thrombolytic Treatment for Acute Myocardial Infarction

Sir, - The potential benefits of thrombolytic therapy in acute myocardial infarction, so clearly summarised by Dr. Brown in his article¹, are now beyond doubt and patients should receive treatment whenever possible. However, although the GISSI and ISIS 2 trials both showed impressive reduction in mortality in the treatment groups, looked at a different way it means that 100 patients must receive treatment so that 4 or 5 will live longer, even when drugs are administered under carefully controlled trial circumstances. When such potentially harmful drugs are used in less controlled circumstances, I hope we do not end up shortening or harming more lives than we prolong.

R. F. Willey
Consultant Physician
Lancaster and Kendal Hospitals

1. Brown AK. Thrombolytic Treatment for Acute Myocardial Infarction. Lancaster and Westmorland Medical Journal 1990; 1:2-4.



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S T A T E

OF THE

LANCASTER DISPENSARY

FOR THE YEAR 1805

Patients admitted from January 1st. 1805 to January 1st. 1806

1278.

D I S E A S E S

Ague	13	Female Complaints	43
Fevers	101	Epilepsy	5
Measles	100	Nervous Complaints	26
Small Pox	67	Mental Derangement	1
Cow Pox by Inoculation	35	Stomach Complaints	93
Erysipelas	5	Worms	55
Diseases of the Eyes	54	Bowel Complaints	61
Diseases of the Mouth	28	Haemorrhoids	12
Quinsy	2	Jaundice	6
Croup	4	Dropsy	17
Catarrhal Affections	133	Rickets	8
Hooping Cough	27	Scrofulous Affections.....	31
Asthma	41	Scald Head	7
Consumption	19	Ulcers &c.	39
Pleurisy	14	Cutaneous Eruptions	91
Acute Rheumatism	10	Sprains and Bruifes	56
Chronic Rheumatism	50		
Calculous Complaints	24	Total	1278

Cured	1162
Relieved	50
Died	37
Remaining	29

Total 1278



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1806

This article, which is the first of a series on clinical audit, was kindly supplied by Mr Ian Wilson, Senior Chief Medical Laboratory Scientific Officer, Department of Pathology, Lancaster Moor Hospital.

Postgraduate Centre Library Orders

October 1989

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 Progress in Obstetrics and Gynaecology. **Studd**
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February 1990

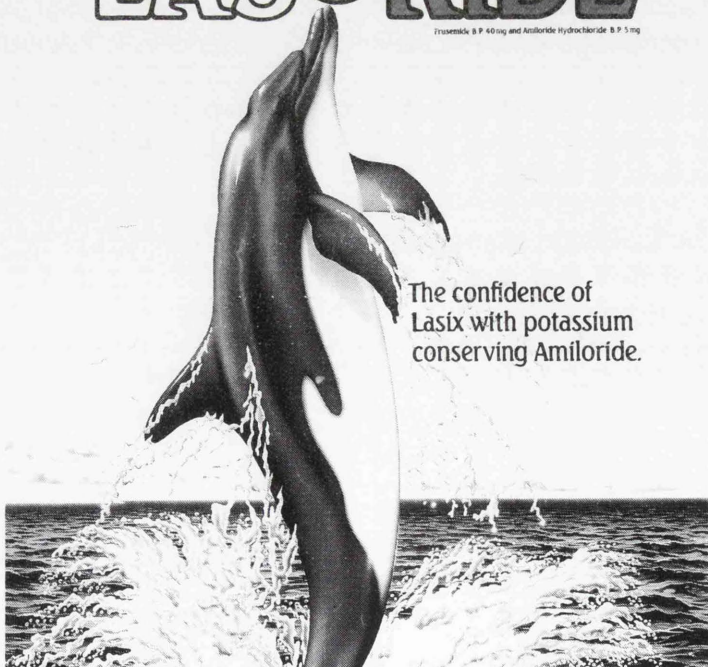
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