AUSTRALASIAN BRONCHOSCOPIC TRAINING AND MAINTENANCE OF COMPETENCY ARE INCONSISTENT WITH GUIDELINE RECOMMENDATIONS.

E DABSCHECK¹,², M HEW¹, L IRVING¹, D STEINFORT¹
¹ Department of Respiratory and Sleep Medicine, Royal Melbourne Hospital, VIC, 3050; ² Allergy Immunology and Respiratory Medicine, Alfred Hospital, VIC, 3185

Introduction: The Australasian practise and training of bronchoscopy is not standardized and has not previously been reported. We examined adherence to previously published Australian guidelines for flexible bronchoscopy.

Methods: All adult physician and trainee members of the Thoracic Society of Australia New Zealand (TSANZ) were e-mailed a web-link to an online survey. Survey responses were benchmarked against TSANZ guidelines.

Results: The response rate was forty two percent (217 out of a total of 517 specialists and trainees). Response rate amongst trainees was higher at seventy eight percent (46 of 59). Forty-nine percent respondents performed less than the guideline-recommended ideal 50 procedures per year. Sixty percent of trainees are unlikely to achieve the guideline-recommended 200 supervised bronchoscopies.

Conclusions: Significant gaps between bronchoscopy guidelines and practice of bronchoscopy in Australasia exist. Trainees may not be completing sufficient procedure volumes to achieve competency and a majority of consultant bronchoscopists may not be maintaining proficiency. We suggest that the TSANZ position paper should be reviewed and updated. Alternatives to the current volume-based approach to achieving and maintaining of competence should be considered.


Conflict of Interest: none to declare
Introduction: The Australasian practise and training of conventional transbronchial needle aspiration (TBNA) and endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is not standardized and has not previously been reported. We examined adherence to previously published international guidelines.

Methods: All adult physician and trainee members of the Thoracic Society of Australia New Zealand (TSANZ) were e-mailed a web-link to an online survey. Survey responses were benchmarked against relevant international guidelines.

Results: The response rate was 42% (217 out of a total of 517 specialists and trainees). Response rate amongst trainees was higher at 78% (46 of 59). Less than 20% of trainees receive adequate training in transbronchial lymph node aspiration. The majority of consultant physicians performing such techniques are not performing sufficient numbers to maintain competency as per guideline recommendations.

Conclusion: Significant gaps exist between TBNA guidelines and the practice of TBNA in Australasia. Trainees may not be completing sufficient procedure volumes to achieve competency and a majority of consultant bronchoscopists may not be maintaining proficiency. We suggest that the TSANZ position paper should be reviewed and updated. Alternatives to the current volume-based approach to achieving and maintaining of competence should be considered.


Conflict of interest: none to declare
Aim. To test the feasibility of incorporating objective testing of bronchoscopy skills following hands on training courses.

Methods. Two courses were run- a 4 day Advanced EBUS skills course and a 1 day introductory training course for first year trainees starting bronchoscopy training. Simulated training was with video bronchoscopes and dedicated EBUS TBNA and guide sheath (Koken) models, Accutouch high fidelity EBUS TBNA simulator, Dexter and Bronchoboy training models. Post course testing used the following 100 point objective testing instruments: Bronchus STAT (for basic bronchoscopy), EBUS STAT (for EBUS TBNA), and a modified Bronchus STAT for EBUS Guide sheath testing. Timed scope navigation test was done on a Dexter.

Results. There were 23 attendees for the EBUS course and 5 for the introductory course. All skills were testable on the models, in particular the endobronchial biopsy, brush and TBNA skills were possible on the Accutouch. Approximate hands-on testing times for the STAT tests were 20 minutes. Dexter testing took 3-8 minutes. Mean results for EBUS STAT and Guide sheath STAT were 83.4(SD7.8) and 81.3(6.8). For Bronchus STAT mean results were 89.2(1.1). All of these results were in the high Intermediate range, with results >90 indicating Advanced skill. Dexter testing of a navigation route was 2.8 (1.5) minutes in the advanced group and 3.4(1.0) in the introductory group, p = NS. Independent course rating by attendees for the EBUS group on a 7 point likert scale was 6.6 (0.6), and all Introductory attendees rated the course 5/5.

Conclusions. Objective testing after training courses was easily achieved. All course attendees rated well compared to published scales. Good dexterity scores were achieved by the novice group. Such testing was well accepted by attendees and may have overall increased course satisfaction.


Supported by Olympus Australia.

Nomination Nil

Conflict of interest Nil
BD Dougherty  
Dept. of Thoracic Medicine, Royal Adelaide Hospital, South Australia, 5000

Introduction: When do trainees gain experience in pleural procedures? Who teaches the trainees? How many procedures should be performed to be deemed competent?

Methods: An online questionnaire was sent to all advanced trainees in respiratory medicine in South Australia in 2010.

Results: 8/9 (89%) of trainees responded; 2 (22%) were Australian graduates, 6 (78%) from overseas. Overseas graduates had performed a mean 38.4 pleural taps, 31.6 seldinger and 8.4 large bore chest drains prior to entering Australia. Australian trainees had performed a mean 12.2 pleural taps and 1 chest drain before advanced training. Advanced trainees had performed a mean 29.71 pleural taps, 19.51 seldinger and 8.16 large bore chest drains, and 3.3 closed pleural biopsies. 60.8% of these procedures were taught by a more senior registrar, 18.1% by a consultant physician, 7.25% by a peer doctor, 4.6% in a skills lab, 2.78% by an ED physician and 6.55% self taught. All trainees self rated as competent to perform all pleural procedures unsupervised, except closed pleural biopsy. Trainees thought performing 26.6 pleural taps, 31.88 seldinger drains, 15.88 large drains and 9.38 closed pleural biopsies would demonstrate procedural competency.

Discussion: SA overseas trainees have significant procedural experience prior to Australian training. Local graduates have minimal procedural experience prior to advanced training. The respiratory STC recommends 20 chest drains and 20 closed pleural biopsies during advanced training. SA trainees had performed adequate numbers of chest drains and too few closed pleural biopsies by these standards.

Conclusion: Overseas graduates are experienced in pleural procedures before advanced training, Australian graduates gain experience during advanced training. SA trainees have good pleural procedural experience, and their opinions should be used to inform STC recommendations.

Conflict of interest The author is an advanced trainee from South Australia.
AN AUDIT OF WARD-BASED CHEST-TUBE INSERTION AT A TERTIARY TEACHING HOSPITAL.

Nicole Lafontaine Bedecarratz, Simon Joosten, Louis Irving, Mark Hew
Department of Respiratory & Sleep Medicine, Royal Melbourne Hospital, VIC 3050, Australia

Aim: To review the adherence of ward-based chest tube insertion at the Royal Melbourne Hospital (RMH) to consensus guidelines.

Method: Patients who underwent chest tube placement between 1/9/2010 – 28/2/2011 were identified by a key-word search of the radiology database at RMH. Patients who underwent tube insertion in Emergency, Intensive Care, Theatre and Radiology were excluded. A retrospective chart review was performed to identify indications, method of insertion, tube bore, experience of the operator, utilisation of ultrasound guidance, complications and pathology investigations requested. Practice and outcomes were benchmarked against the British Thoracic Society consensus guidelines published in 2010 prior to the audit period.

Results: 29 cases were identified. Of these, 25 had histories available. From the histories examined, chest tubes where generally inserted where indicated. Only 44% had written consent, 56% had adequate documentation, 64% were inserted in-hours, 35% used a small-bore tube, 52% had appropriate investigation of pleural fluid as recommended by the guidelines and 44% used ultrasound guidance. The complication rate was about 10%.

Conclusion: Chest tube insertion at RMH was poorly adherent to consensus guidelines. Key concerns focused on lack of consent, documentation, standardization and inadequate use of ultrasound. Consequently, a two-stage quality improvement project was implemented and practice will be subject to re-audit.

Conflict of interest: No
TO-046
THORACIC ULTRASOUND IN ACUTE RESPIRATORY PATIENTS: THE ‘C3PO’ PROTOCOL

SIMON JOOSTEN, PETER WALLBRIDGE, LIAM HANNAN, JEREMY GOLDIN, LOU IRVING, MARK HEW
Department of Respiratory and Sleep Medicine, Royal Melbourne Hospital, Victoria 3050, Australia.

Introduction: Chest ultrasound has excellent test characteristics for diagnosing alveolar and interstitial lung syndromes as well as pleural disease. We examined the utility of lung ultrasound when integrated into the routine care of patients admitted to a respiratory high dependency unit.

Methods: Patients admitted in-hours to the respiratory HDU of our university teaching hospital underwent bedside thoracic ultrasound by one of 5 clinicians within 24hrs of admission. A standardized protocol was applied with the acronym ‘C3PO’, documenting the presence of ‘Comets’, Consolidation, CVP elevation, Pleural effusion or ‘O’ (Zero findings suggestive of pulmonary embolus or pure ventilatory failure). This was compared with the clinical assessment and available radiology. Clinicians were asked if the ultrasound results influenced their confidence of the primary diagnosis or changed subsequent management.

Results: 50 patients were assessed over 6 months. Ultrasound assessment took an average of 18 minutes. The clinical diagnoses included: chronic obstructive pulmonary disease (COPD), right heart failure, left heart failure, bi-ventricular failure, interstitial lung disease, pleural effusion and pneumonia.

Chest ultrasound increased diagnostic confidence in 44%. New or additional diagnoses were made in 28%. Ultrasound changed clinical management in 30%.

Conclusions: When incorporated into the routine assessment of patients admitted to respiratory high dependency, structured chest ultrasound is both feasible and clinically useful.

Conflict of Interest: MH convenes a Chest Ultrasound Course which receives sponsorship from Sonosite, Astra Zeneca and Cook Medical.