# Oral Surgery Club of Great Britain

## Guildford meeting on 10th November 2023

The Autumn Meeting of the OSCGB was held in Guildford under the presidency of Steve Walsh. An interesting programme of talks was presented, principally by members of the local medical establishment.

The first presentation was on **enhanced recovery from major joint arthroplasty** by Dr Cathryn Eitel, Consultant Anaesthetist at St Richards Hospital, Chichester. She outlined a project to reduce inpatient stays for hip and knee replacements from 6.5 to 3 days by following an evidence-based approach to all aspects of care directed at minimising the stress response to enable a quick return to function. One of the principal factors in delayed discharge was use of lines such as for catheterisation, transfusion, or morphine PCA. A large team, including members of all clinical teams involved, developed a standardised protocol of perioperative care including pre-op; assessment, information (verbal and written) and nutrition, anaesthetic protocol: including pain control with blocks and local infiltration, tranexamic acid, antibiotics and anaesthetic technique and standardised surgical technique. Post-op care focussed on minimising catheter use and transfusion with early mobilisation. The complete protocol was adopted by all teams on the same day after detailed explanations and education. The aim of halving in-patient stays was achieved within six months. However, covid gave a national impetus to try to move to day-case arthroplasty treatment. Patient selection, an expectation of same day discharge, avoiding use of beds (trolleys and chairs), twilight physiotherapy, direct routes of readmission and good follow up were added to the protocol. Once established, 54% day-case discharge was achieved with over 99% being discharged on the first post-operative day. The potential for roll out to maxillofacial procedures was discussed with bimaxillary osteotomies and certain head and neck procedures being the likely targets in the future.

**Day-case thyroid and para-thyroid surgery** was the topic explored by Peyman Alam, Consultant Maxillofacial Surgeon, discussing his experience in Chichester. Most thyroid cases present with a solitary nodule with a range of benign to malignant diagnoses. High risk indicators include size, speed of growth, childhood radiotherapy, altered voice and family history. Special investigations include FNAC and imaging and appropriate patients are discussed by an MDT for treatment decisions. Parathyroid disease is a natural companion with hyperparathyroidism from all causes assessed for treatment, primary hyperparathyroidism being the main disease requiring surgical treatment. The meticulous surgical technique was outlined with focus on control of bleeding, recurrent laryngeal nerve identification and removing all suspect thyroid tissue. The variable sites of parathyroid tissue requires careful imaging to aid localisation and removal. With careful patient preparation and treatment day-case rates of 70% for thyroid surgery and 92.5% for parathyroid surgery have been achieved.

Mr James Hicks, Consultant Urological Surgeon at St Richards Hospital, Chichester discussed current approaches to **prostate cancer** care. Prostate cancer accounts for 27% of all cancers in men and its incidence is increasing, due to increased survival and awareness, but mortality is decreasing. The average age at diagnosis is 65 years which means that there are

a lot of men in their 50's with prostate cancer. Risk factors include increasing age, family history and African-Caribbean heritage and there are no modifiable factors. PSA works well as a risk indicator rather than a diagnostic aid. Investigations have been helped by imaging and trans-perineal, as opposed to trans-faecal, biopsies. The progress of the disease is related to its grade and staging and a low grade, low volume disease may only require active surveillance. Robot assisted radical prostatectomy has transformed surgery with much improved recovery and reduced morbidity. Radiotherapy, brachytherapy, and modern hormone treatment provide options for combination treatments, especially for high risk or metastatic disease. Survival is good with nearly 100% 5-year survival, only falling to 91% by 15 years. Therefore, prognosis is good for patients in their 70's, who will probably die with their disease although it is more guarded for patients in their 50's. Screening is challenging as the PSA test is not ideal but the best available. One would have to screen 1500 men and treat 50 of them, with all the attendant potential complications, to save one life. PSA may be of more use in men in their 50's to help identify aggressive cancers early where treatment would be more effective.

After coffee Jenny Sutcliffe, a Human Factors Specialist at the Royal Surrey County hospital, outlined facts and fallacies of **human factors in surgery**. The opening premise was that human errors were rarely due to individual failures but often the outcome of humans working with a poorly designed system. As many systems are poorly resourced or designed, individuals under pressure try to manage as best as possible. In doing so, they will follow the easiest path even if it isn't the prescribed path. Training, policies, and reminders have limited effect in changing the behaviour of an individual struggling with a poor system. However, the effectiveness of the individual and system can be optimised if the system is improved by introducing standardisation, automation and forcing functions. Most workplace endeavours work well and are generally ignored, and exceptional performance is gratefully accepted but not utilised to guide others. If things go wrong, the focus is just on the reasons for failure and any measures taken can design out the things that go well. A broader view is required to reduce the opportunity for errors. An understanding of human factors helps put that thinking into practice.

**The relevance of margins in early oral cancer** was the subject of a presentation by Mr Mandeep Bajwa, Clinical Senior Lecturer in Head and Neck Surgical Oncology at the University of Surrey. Surgery for early oral cancer as the only modality offers the best chance of cure as in late-stage disease the margin is often limited by anatomy and a multi-modality approach will often be required. When is a surgical margin close enough to warrant adjuvant therapy? Conventionally, a margin of less than 1mm is regarded as involved, 1.0-4.9mm as close and over 5mm as clear. However, experience shows that close margins have similar outcomes to clear margins and research at the Sloane-Kettering Institute recommends that 2.2mm is the cut off for considering adjuvant treatment. Just as important is the tumour biology and host interaction, with a dyscohesive invasive front, perineural invasion and nodal disease, especially with extra-capsular spread, being poor predictors and likely to trigger adjuvant therapy. Unsurprisingly, the best outcomes are seen with clear margins and no nodal disease. Implications for treatment include enhancing margin control with measures such as fluorescence guided surgery and efforts to improve tumour biology with measures such as neoadjuvant immunotherapy.

Professor Jag Dhanda, Consultant Oral and Maxillofacial Surgeon at East Grinstead, joined us online from Australia to discuss **extended reality in surgical education: its scientific evaluation and its application in Global Health**. He outlined the work of a non-profit academic group in evaluating extended reality; online delivery of interactive muti-view training videos using the ubiquitous mobile phone as a 'headset', in healthcare education – in particular for low to middle income countries. The training events include medical simulations, live surgery, use of equipment, and mandatory training including basic life support. As courses are rolled out they are recorded, building up a library of techniques and procedures. Using 'camera in camera' displays, more than one viewpoint can be available on the screen. It is envisaged that such extended reality could play a role in medical education in the future.

After lunch Will Gardner, a change consultant, posed the question; **can business be a force for good in the world?** He outlined the history of business, starting with the meaning of company; 'with bread' a group of people with a common purpose with whom you would share bread. In the 8$^{th}$ century BC Indian Guilds developed, in the 10$^{th}$ Century AD the Song Dynasty established shareholders and in the 1800's the Industrial Revolution in Britain and elsewhere transformed the world. However, there have been problems – initially with working conditions which enlightened industrialists such as Lever and Cadbury addressed, together with legislation. But now increasing population growth and resource usage are producing greenhouse gases and adversely affecting the worlds biomes together with inequality of benefits of all this activity. A shift in attitudes and activity is required to change an unsustainable market economy to a sustainable market economy. Purpose driven businesses are required working towards positive and sustainable outcomes with willing engagement of their workforce. Examples of companies embarking on this path were given. Orsted is an energy generating company whose stated purpose is to help create a world that runs entirely on green energy. To this end, over a ten-year period they changed from 85% energy generation from fossil fuels to 85% from green technologies. Patagonia has been using second hand clothing to produce recycled materials to make new products. Interface has been buying discarded fishing nets, a source of pollution, in the third world to turn into carpet tiles. Overall, Will believes that this approach brings improved meaning to work and motivates employees therefore helping companies recruit and retain the best talent. In addition, this can enhance relations with customers and win trust from regulators and society in general.

Next David Grimes, a Consultant OMFS and Cleft Surgeon at the Evelina London Children's Hospital, reviewed progress in **cleft surgery** in the UK. He reminded us of the Eurocleft Study and CSAG reports in the 1990's which highlighted the poor outcomes in the UK in relation to Europe. Subsequent changes in the UK included centralisation of cleft services, fewer surgeons, and enhanced training with a follow up review in 2006-7 showing improved facial growth and speech, although no improvement in dental health. The Cleft Training Interface Group controls entry to training for primary cleft surgeons and there are currently 23 plastic, 10 maxillofacial and 1 ENT surgeons. Technological improvements include 3D photography and machine learning to enhance craniofacial diagnosis, the use of transoral robotic surgery and 3D imaging and printing to improve planning, model production and surgical device manufacture.

The next speaker was Jeremy Collyer who gave a very personal account of **keeping moving for health and managing Parkinson's disease**. As a point of interest, he had reviewed his handwritten notes between 2008 and 2010 and had found increasing micrographia although his Parkinson's disease was not diagnosed until 2012. He noted that the incidence of Parkinson's disease was increasing with 18,000 new diagnoses per year currently. There are a variety of signs and symptoms but only motor effects respond to medication that increase dopamine availability. Medication doesn't affect the progress of the disease and deep brain stimulation surgery has been used on occasion. Exercise may help mitigate the effects although this is variable. He was a strong advocate for exercise and recommended getting coaching and participating in classes to enhance normal interactions. Over the years he had taken up windsurfing, although difficulties in maintaining posture hampered this, cycling – now using an e-bike to even out the leg strain, boxing and tennis.

Following a coffee break, Ash Messiah addressed the question **'TMJ Arthroscopy – Voodoo or evidence based?'**. The history of the technique was outlined with the first reported case in 1975, the publication of a large series by McCain in 1985, and the associated use of therapeutic agents in 1986. The technique was described with the diagnostic sweep through the 7 points of arthroscopy used to confirm normal anatomy and identify abnormalities. Use following failure of conservative measures was discussed with mention of potential complications including inadvertent entry to the middle cranial fossa. The array of potential therapeutic agents was outlined including local anaesthetic, opioids, steroids and plasma rich growth factor. Ash had built up a case load of 250 operations to date in order to try to provide an evidence base for TMJ arthroscopy. However, he acknowledged that an evidence base was essential to overcome the associated factors of ritual, use of sharp instruments, scepticism and variable outcome that also accompany Voodoo.

Finally, Steve Walsh used rhetoric and You Tube videos to demonstrate the attractions of Dublin and Ireland to encourage participation in his Spring Meeting in Dublin.

Members then sought suitable refreshments in the bar whilst reflecting on the very informative day and proceeded to the Prelude Suite of the conference hotel for a reception and the Club Dinner.

Jon Hayter
Honorary Secretary