

Letters

TEACHING RADIOLOGICAL ANATOMY

Editor

Utilising postgraduate trainees to deliver undergraduate teaching is a logical and well established practice. Undergraduate cadaveric anatomy, once the exclusive domain of the surgical demonstrator, has in many institutions dissected itself out of existence. The rationale, if subjected to the same dissection, was in essence too many facts and too costly when software simulation is too sexy to withstand. The consequences, whilst debated in many learned papers are sublimely demonstrated in a BBC documentary “Where’s the femur?” (first broadcast Radio 4 Jan 2008), the title referring to a witnessed exchange between two junior doctors. Populism aside, renewed emphasis on basic science is returning to the undergraduate curriculum and fortunately Queens University Belfast has kept it’s dissection module intact. Notwithstanding there is laudable enthusiasm for multimodality input and potential for symbiotic learning across the perceived ‘MB’ divide.

In response an Applied Anatomy class was introduced at the completion of each anatomical module for the academic year of 2011/2012 (first and second year students). Links between clinical radiologists and anatomy departments are well documented, as is the impression of symbiotic mutualism for student and post graduate trainee, which although rational, is difficult to prove. The format over a two hour class involved dividing the students into 7 to 8 groups and rotating them around a matching number of ‘stations’ at 8 minute intervals. The stations were taught by first year Radiology Registrars preparing for their own FRCR anatomy exam, each addressing different imaging modalities/anatomical regions. On reflection I felt it would be churlish to restrict teaching material to radiological imaging when the students could feast upon the relative technicolor of endoscopy or handle some of the Orthopods expensive hardware – live clinical anatomy. Registrars from Neurosurgery, Cardiology, Respiratory medicine, Orthopaedics and Vascular surgery were thus coerced to attend relevant sessions. Whilst not guaranteeing an additional transfer of anatomical knowledge, at least encountering an endovascular stent, footage of a bronchoscopy, a ventricular shunt or a hip prosthesis etc confirmed relevance of the subject beyond the next exam. Happily the Radiology Registrars all passed their exam and unofficial feedback from the students was favourable, so at worst we have observed commensalism, at best mutualism.

The venue of the anatomy speed dating sessions were in the Dissection Room, which I think is important. The cadavers bear witness to forms of enlightenment which can only be gained via their recent exploration. Ofcourse similar unique perspectives are gained by the contemporary medical imagery surrounding them and many centres are opting for ‘simulation

only teaching’. I feel the latter is misguided; illuminating difficult concepts from different angles frequently diminishes confusion. Other exclusive benefits of the dissection room are an introduction to the essential clinical paradox of desensitisation and humanity. Anonymous 3D images do not have the physical impact factor or the realisation that this aorta or this hand were used by an individual when they decided to afford the student the present learning experience.

The aim of the current module was to present some relevant clinical ‘coat hangers’ for the students newly purchased anatomical clothes. At this stage they have an impressive wardrobe, although as all previous generations can testify this diminishes with the wear and tear of time. If in the future all that remains is some well worn underwear and an odd sock at least the Queen’s student won’t be completely naked.

Mark Worthington

Imaging Department, Royal Victoria Hospital, Grosvenor Road, BT12 6BA.

Correspondence to: Mark Worthington

Mark.Worthington@belfasttrust.hscni.net

TWO CASES OF IMPORTATION OF NEW DELHI METALLO- β -LACTAMASE 1 INTO NORTHERN IRELAND

Editor,

Multi-drug-resistant Gram-negative pathogens are increasingly isolated at hospitals around the world. We report two cases of colonisation and infection with *Enterobacter cloacae* strains producing New Delhi Metallo- β -lactamase 1 (NDM-1), not previously reported in Northern Ireland.

Case 1: A 6 year-old-boy on holiday in India suffered electrical burns to 60% of his body. On day 10 he was airlifted back to the regional paediatric ICU. On day 20 both a swab of burns on his left leg and the tip of a femoral line removed that day, grew multi-resistant *E. cloacae*. Both *E. cloacae* isolates were retested at the Health Protection Agency (HPA) Antibiotic Resistance Monitoring and Reference Laboratory (ARMRL) which found carbapenem resistance in the leg isolate (Table 1). This isolate was positive by PCR for *bla*_{NDM-1} encoding NDM-1 β -lactamase. The femoral line isolate lacked NDM-1 enzyme, but had an extended-spectrum β -lactamase (ESBL). Pulsed-field gel electrophoresis showed that these *E. cloacae* were distinct strains. Thankfully, the patient did not require antimicrobial treatment for these *E. cloacae* strains, and was discharged on day 91.

Case 2: A 46 year-old man presented with a wound infection a month after external fixation of a fracture of the 4th and 5th metatarsals of the right foot following a road traffic accident in India. Bone samples taken during debridement in theatre on day 7 grew *Pseudomonas aeruginosa* and *E. cloacae*, both multi-resistant. At ARMRL the *P. aeruginosa* was positive by