Tips for GP trainees working in general surgery

INTRODUCTION

General surgery may seem a daunting prospect for many trainees without background experience in its practice. It may also feel alien to your final career path, especially at the sharp end, in theatre itself. On the other hand there are many trainees who develop a taste for 'the cutting' and will go on to run their own minor surgery list in primary care.

Whatever your feelings on the matter, an attachment in general surgery will offer any trainee a wealth of experience across a broad range of settings — be that elective theatre time, trauma and resuscitation scenarios, dealing with post-operative complications, and the assessment of the acute abdomen; or urology, oncology, vascular, paediatric, and endocrine practice; or the investigation of dozens of chronic conditions in the out-patient clinic. General surgery is anything but a narrow field, and the transferable skills that can be learnt during your attachment will certainly prove valuable in the future.

It is also true that as a senior house officer, the job is not all that complex. Ward rounds will generally be registrar lead, on-calls are busy (but not on a scale with medicine), and 99% of problems will be avoided through a conscientious focus on getting the basics right.

The most concerning issue is that at times you are relatively unsupported due to seniors being scrubbed in theatre or in clinic. The key to dealing with any problem is knowing what you can do yourself in the interim, versus when you need to gatecrash whatever they're up to and call in the cavalry. Hopefully these tips will be useful.

1. Try to see everything in theatre at least once, it will give you more insight into what your patients are going through in the community.
2. Even if you hate surgery, the team will appreciate you being the 'medical

opinion', so think about the whole patient.

3. Try to get an idea of your registrar and consultant's timetables early on, in other words, 'when can I call and actually get an answer?'
4. Unsurprisingly, surgeons want to know the past surgical history and who did the operation.
5. On a ward round think tubes (nasogastric, drain, catheter, i.v). What's going in? What's coming out? Which can come out?
6. Post-operative diet is usually increased in a stepwise manner: sips, clear fluid, free fluids, soft diet, full diet. If patients are not tolerating increases, step them back. Consider total parenteral nutrition if patients are unlikely to have oral intake for 5 days or more. NB: some patients may be on an enhanced recovery programme and be on full diets much earlier — best check local protocol and with your boss.
7. Prior to an operating list see the patients and know why they need the operation. Learning to consent patients is an important skill in hospital and will aid you in answering questions on these procedures in primary care.
8. If you are doing colorectal, learn your consultant's bowel prep preferences for each operation.
9. A pyrexia within 24 hours of surgery is most often due to atelectasis not sepsis, think: sit up, humidified oxygen, good analgesia, encourage coughing, and chest physiotherapy before knee-jerk antibiotics.
10. Do a per rectum (PR) examination. Only exceptions being patient refusal, a child, it has already been done, or you can think of a really good reason not to. You can't PR a stoma ... but you should per stoma it.

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11. Always examine for an abdominal aortic aneurysm (AAA) (bilateral renal colic is an AAA until proven otherwise).
12. Morphine doesn't mask peritonism. Useful distraction techniques include pressing the abdomen with the stethoscope while auscultating, asking the patient to cough or sit up, and asking kids to hop on the spot.
13. Perforations need i.v access, fluids, antibiotics, and if it's possibly an ulcer, i.v protein pump inhibitors before theatre.
14. Make all new admissions nil-by-mouth pending senior review.
15. If unsure whether an erect chest X-ray and abdominal X-ray is warranted, get one anyway.
16. 'Everyone' gets an amylase.
17. All females of childbearing age get a beta-human chorionic gonadotropin (BHCG) test.
18. Immediately postpartum females should always be seen by a gynecologist.
19. On this topic, don't enter into debate with other specialities about the ownership of patients. Discuss it with your senior and let them sort it out.
20. If you are worried, do a blood gas — venous is fine initially to establish if there's a problem.
21. Know the local antibiotic policy. The days of 'cef and met' are long gone.
22. Metoclopramide is a prokinetic, therefore, don't use it in obstructed patients (increased risk of perforation) but fire away if they have an ileus.
23. Don't give stimulant laxatives or enemas to patients with an anastomosis.
24. Pancreatitis: know how to score patients, ensure they've got a catheter, and fluid, fluid, fluid. If they are not responding to the first 2–3 litres, call the high dependency unit, the intensive treatment unit, and your boss.
25. Bowel obstruction = drip and suck (nasogastric tube, fluids, and catheter).
26. Small bowel obstruction = abdominal distension and vomiting.
27. Large bowel obstruction = abdominal distension and constipation.
28. Bowel obstruction is painful, ileus is not, even though they both look the same on X-ray.
29. Acute limb ischaemia is an emergency, you have 4–6 hours to intervene. If they are without contraindications, heparinise, then call the boss ASAP. If they don't answer, find them!
30. PR bleeds can be investigated as an out-patient if the patient is well. Admission is desirable where bleeding is heavy or there is haemodynamic compromise.
31. Right iliac fossa pain is not always an appendicitis. Think about the differentials and exclude testicular torsion or a septic hip.
32. Abscesses need a knife not antibiotics. However, a groin abscess is a femoral artery aneurysm until proven otherwise.
33. At trauma calls, stand back, let accident and emergency run it, and step in to deal with the abdomen.
34. Every patient gets deep vein thrombosis prophylaxis unless they're a child or objectively contraindicated.
35. Pyelonephritis is only a urological condition if the patient has stones.
36. It's amazing how many patients get admitted to hospital with a perfectly normal suprapubic catheter that just needed to be tugged on a bit more to get it out and changed. Try to see this procedure done so you can get confident in doing it.
37. Neither a negative kidney/ureter/bladder X-ray, nor absence of haematuria exclude renal calculi — go with the clinical history, discuss with a senior, and consider a CT.
38. Urinary retentions of roughly greater than 800 ml need admission to make sure they don't begin diuresing.
39. Never use a catheter introducer! Only the registrar gets to play with them.
40. Remember — if uncertain what to do with a patient with abdominal pain get an amylase, liver function tests, a troponin, a BHCG, an electrocardiogram, an erect chest X-ray and abdomen X-ray, an arterial blood gas, and do a PR exam ... you'll have covered your bases every time.

Provenance

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