At the end of their training the number of the house officers who acquired the confidence to carry out the procedures independently is shown in the Table. The two procedures that all of them felt confident carrying it out independently were passing a catheter and surgical scrubbing. Except for one all the others felt confident in independently passing a Naso-Gastric tube and interpreting a Chest X-ray. In case of Cardiopulmonary resuscitation (CPR) (12/30) and recording an ECG (11/30) the majority did not feel confident to perform it independently. For the other six procedures, the doctors feeling confident varied between 22/30 to 27/30.

Conclusion

It was assumed that by the end of their 12 month training, all house officers would have acquired the confidence to carry out the specific procedures independently. The list of procedures and the expected competency was given to house officers at the start of their job. The limitation of house officers to do these procedural skills points out the deficiency to monitor their learning in the house job programme which needs the attention of the trainers.

CPR is a life saving skill that all house officers are required to learn during their 12 month of house job. Being deficient in this skill can have serious outcome when managing patients. The hospital has a well equipped skills laboratory with a CPR mannequin. Hence incompetency in carrying out the procedure of CPR indicates that the skill lab has not been availed to its full capacity. The supervisors need to determine the reason/s why some house officers have not acquired the required confidence in these basic skills.

Recommendations

1. All institutions offering house jobs should prepare a list of the procedures that the house officers are expected to learn during their training. It should also mention the level of competency the trainees are required to achieve.

2. All new house officers should be tested for their level of competency at the start of the programme. For the supervisors this will provide information about areas which need attention. It will also help them identify individual trainees who need more attention in respect to specified skills.

3. A log book listing all the procedures the trainees are required to learn should be provided to all new trainees. This should be monitored regularly, so that remedial action can be taken in time.

4. At the end of the year trainees should be asked to again fill up the questionnaire that they filled on joining. This will, as this study has shown, help the supervisors in planning future programmes.

References


Case Report

Gangliouneuma of the Neck

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Abstract

Gangliouneuma (GN) has a neuroectodermic origin and is localized along the sympathetic trunk. GN of the neck is a rare tumour and due to proximity to the thyroid gland, clinically and radiologically, these lesions can be mistaken as thyroid swellings. Definite diagnosis only can be suspected after surgical exploration and complete surgical excision is the treatment of choice, as it will ensure thorough sampling of the tumour and cure.

Introduction

Gangliouneuma (GN) of the neck is a rare tumour that most commonly presents as an enlarging neck mass.1,2 In the neck due to proximity to the thyroid gland, clinically and radiologically, these lesions can be mistaken as thyroid swellings (i.e. goiter)3 and diagnosis only can be suspected after surgical exploration as in the
enophthalmos and absence of ciliospinal reflex) (Fig. 3). He underwent a Fasanella Savant procedure for correction of left ptosis and is doing well at follow up.

**Discussion**

Tumours of sympathetic nervous system (neuroblastoma, ganglioneuroblastoma and ganglioneuroma) are derived from neural crest cells. Histological differentiation of these tumours are directly related to their clinical behaviour. Ganglioneuroma consists of mature Schwann cells and ganglion cells. Neuroblastoma and ganglioblastoma are malignant and the proportion of neuroblastoma element determines the histological grading and prognosis.\textsuperscript{4,5}
Ganglioneuroma is a benign tumour. Ganglioneuroma usually occurs in older population and in literature contrary to our case there is a slight female predominance. The most common locations for GN to occur are the posterior mediastinum, retro peritoneum, adrenal gland, and neck (8%) respectively. Unusual sites include the spermatic cord, heart, bone, and intestine. In the neck it is sometime confused with other neck swellings i.e. thyroid swellings. Complete surgical excision is the treatment of choice, as it will ensure thorough sampling of the tumor and cure.

References

Case Report

Recurrent priapism in Sickle Cell Trait with Protein S deficiency
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Abstract
We report the case of a young Omani man, a regular blood donor, who presented twice in two months, with painful penile erection lasting more than 12 hours. The patient is known to have sickle cell trait [HbS 34.6%]. Although the first episode of penile erection settled with aspiration of blood and local injection of epinephrine, on the second occasion necessitated cavernosal glandular shunting. A subsequent investigation revealed a mild protein S deficiency. Although priapism is known to occur in sickle cell disease, it is unusual in sickle cell trait. Association of mild protein S deficiency with erythrocytosis could have precipitated the onset of priapism.

Introduction
Priapism is defined as prolonged and persistent erection of the penis without sexual stimulation. It is seen in a number of conditions that cause disturbance of blood flow to penis such as in ischaemic vessel disease, elevated white blood cells (WBC), polycythemia, essential thrombocythaemia and sickle cell disease. Priapism can also be caused by haematologic malignancies associated with hypercoagulation, metastatic disease involving the corpora cavernosa with thrombosis of the venous outflow from the penis, or fat embolism, or rarely from intracavernous injections of papaverine and phenolamine used for the treatment of impotence. Rarely, it is also seen in patients receiving drugs like oral anticoagulants, LMWH, cocaine and sildenafil. Although sickle cell disease is a recognized cause of priapism, sickle cell trait (SCT) is not known to cause it per se. Incidentally, while searching for an underlying cause the patient was also found to have protein S deficiency.

Case report
A 28 year old healthy Omani male presented with a history of penile erection of 12 hours duration. He denied history of any unusual sexual activity, perineal trauma or straddle injury or drug abuse like sildenafil or cocaine prior to the onset of the episode. Physical examination was unremarkable except for the tender penile erection. His initial investigations showed a haemoglobin of 15.2 g/dl with a haematocrit of 0.46 L/L, red blood cell count was 5.32 x10^{12}/l, WBC was 9.91 x10^{9}/l, with a normal differential, and platelet count was 256 x10^{9}/l. Sickle cell screening test was positive and HPLC showed HbS level of 34.6%, with a HbA of 55%, HbA2 of 3.9%, and HbF of 0.3% suggestive of SCT. Routine biochemical investigations were normal. Penile aspiration was done by removing 20ml of blood from the corpus cavernosum.