



Medical Alumni and Faculty

Newsletter No. 13

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Diary in Pictures



Dr John McCullough; Dr Bill Cashman



Dr Pat Cogan, Dr Marion Smith



Dr Annette Dillon; Dr Timothy Jackson



Dr Gearoid Fitzgerald; Dr Rachael Cusack



Prof Cillian Twomey; Dr Patrick O'Herlihy



*Prof Katy Keohane; Dr Mary Wickham;
Dr Charlie Shanahan; Dr Mary McCarthy*



Dr Helen Hynes; Dr Aislinn Joy



Dr Diarmuid Murray; Dr Gary Lee



Introduction

Welcome

Welcome to the UCC Medical Alumni Newsletter and very best wishes for 2015. For me, the past year has been a very full one, with the opportunity and pleasure of meeting and hearing from so many recent and older Alumni. There was a great attendance at the Annual Scientific Meeting in September at Brookfield, and the increasing trend to link this event with class reunions works well. My own class of 1974 celebrated its 40th anniversary of graduation, an account of which is in the newsletter. Where did the time go!

In 2014, UCC honoured two distinguished Medical Alumni. Prof Daniel J Penny, 1986 graduate, currently Chief of Paediatric Cardiology at Texas Children's Hospital and Professor of Paediatrics at Baylor College of Medicine, was awarded the Medical School Medal for his contributions to Medicine and humanity. Dan formerly headed cardiology at the Royal Children's Hospital, Melbourne and his research involves clinical and physiological aspects of congenital heart disease. He has also been very instrumental in the planning, development and establishment of a new cardiovascular centre in Hue, Vietnam, enabling hundreds of children to be treated.

Dr John Barrett, 1969 graduate, received a Distinguished Alumnus Award. John has now retired as Chief of Trauma at Cook County Hospital, Chicago, where he developed a specialised centre, with great experience in gunshot wounds. He worked extensively with civic authorities to establish citywide access to emergency services, resulting in reduced mortality from trauma. He also worked with the police, law makers and schools to foster education and crime prevention. Cook County Hospital is very well known throughout the US and recognised worldwide, since the TV series "ER" was based on its trauma centre. See <https://www.youtube.com/watch?v=-alAQEGLDJY&list=UUftTWeXBFR577BfyPWm6atQ>

The medical School at UCC continues to expand and alumni are now actively practising in every corner of the globe. We want to hear from you, and would like to stay in touch with you all. If you are interested in being a contact person for UCC Medical Alumni in your area (especially those working overseas) please get in touch, and contribute to our website: <http://www.ucc.ie/en/medical/aboutus/medalumni/>. We are also interested in linking with Alumni in overseas Medical

Schools to foster stronger academic links at undergraduate and postgraduate level. If you can assist in this endeavour please contact me at Catherine.keohane@ucc.ie or medalumni@ucc.ie

The newsletter includes articles of interest from alumni, a synopsis of some of the ongoing projects at the Clinical Research Centre based at the Mercy University Hospital, extracts from the Scientific meeting 2014 and class reunions, and appreciations of recently deceased alumni.

The UCC Medical Alumni also administer the Professor Denis O' Sullivan Clinical Research Fellowship, the Raymond Shanahan prize, and the Ainsworth Scholarship, details of which are included. I encourage you all to attend the Scientific Conference on September 3rd 2015. Sincere thanks to the Committee and to Rachel Hyland for assistance in all matters to do with medical Alumni! ■

Katy Keohane, Chair UCC Medical Alumni Committee.

Prof Mary Horgan, Dean

Welcome

Across the world, UCC medical graduates are renowned for their clinical excellence, research skills, leadership and innovation. We continue to educate world-class doctors in our state-of-the-art facilities under the guidance of our superb clinical teachers. But educating students to become doctors is only part of our remit- we are also responsible for our graduates' lifelong learning across the continuum of medical education. This is why the College of Medicine and Health at UCC and the School of Medicine is pioneering and driving a range of Continuous Professional Development activities informed by best practice in medical education and professional and societal needs.

We are very excited by our new student exchange programmes. In January our first cohort of students began their exchange at University of Lille.

Research is top of the agenda at UCC and again this year our students have published and presented their research projects all over the world.

The School of Medicine at UCC is a dynamic and changing environment- we embrace the challenges of 21st Century Healthcare and count ourselves privileged to train world-class doctors who are proud to call UCC their Alma Mater. There are many ways you can help the medical school and we welcome

student exchanges, summer electives and post-graduate opportunities. We value your mentorship and your experience. Please keep in touch, visit our website and learn about the initiatives and opportunities available to medical students at UCC.

The best medical schools in the world are based outside capital cities. UCC is no exception.

Our warmest wishes for 2015 and we look forward to hearing from you. ■

*Professor Mary Horgan, Dean
School of Medicine UCC*





Memories are made of this

Those were the days my friends
'We thought they'd never end'

UCC Medical School 1943-1949

When I was born in Cork in 1926 my life expectancy, as an Irish male was 56 years. Yet this year I will have been sixty-five years a doctor. So I am a lucky one. But then I always was. How could I be otherwise delivered as I was by the late great "JJ" Kearney.

My years at UCC, 1943-1949, were really happy despite the relative frugality of our lives by comparison with the present. Being 'Cork' I thought that UCC was a sort of bonsai version of Harvard ('small but perfectly formed') and although Boston was reportedly bigger (actually thirty times bigger) we thought of ourselves as being more or less 'twinned' with that Hub of the Universe.

Food and clothing were rationed ("Don't you know there's a war on"); there was no travel outside the country though I did snatch a trip to London in 1947 representing the Student Council. There was still smoke coming from the bombed buildings. Even a trip to Belfast with the Philosophy in 1947, as it was then, to debate with Queen's University's 'Literific' was an exciting prospect and my first sight of police with guns. Travel within our country was uncertain; trains to Dublin often took more than twelve hours and rugby club supporters travelled (illegally) to Limerick on benches in the backs of covered lorries. Our family, mother, father and three boys cycled to Ballycotton (26 miles) for our holidays. The bike was the universal form of transport and if you were lucky you might get to bring the girl of your dreams home on the cross bar of the bike.

Entry to the medical school was easy. If you arrived with your matriculation certificate and the appropriate fee (perhaps £72 in those days) you were signed up. I was just seventeen when I started. There was an entrepreneur who told guileless rustics (anyone from west of the Straight Road) that they also needed a letter from their parish priest. If they did not have one he could provide the necessary for half a crown.

Vocation? Well yes.. Sort of. I wanted to do law but my publican father (the Hi-B Bar, still in family hands) had seen too many briefless barristers and gently but firmly advised that I accompany my best friend the late, great Jack Keane, whom he so admired, up to the College to do Medicine. My mother cried when I went

to the 'College' because she knew I would be emigrating, almost certainly permanently.

Memory plays tricks but about ninety of us started in that autumn of 1943. Premed was Physics, J J McHenry was a star. Just what we thought a professor should be, Chemistry, yes I remember who it was but he wasn't a star, but Louis Renoulf made Biology interesting. The great academic and dramatic teacher of anatomy, M A MacConnaill (Mac), dominated first and second medical. I failed anatomy in second medical because I put the oesophagus on the wrong side of the aorta in the exam. I was on a team rugby trip to Dublin when the oesophagus was discussed. Mac said "Your knowledge was like a piece of elastic: you stretched it and stretched it and eventually holes began to appear in it". I often thought of this when I was subsequently operating on perhaps sixty cases of oesophageal atresia. Physiology was taught by whispering Prof. Frank Kane, whose heart was in Howth, and he left us for the RCSI. Third medical was Pathology and Professor and Dean Billy Donovan who was a keen photographer introduced us to lectures with slides. Up to that it was 'talk and chalk'. Still looking at my old notes ...you may not believe it but I kept them for fifty years... I note that I spelt Koch's bacillus (the tuberculosis bug) as coke's



bacillus because I knew no better at that lecture. Billy subsequently became President of the IMA and when I went to him to discuss the possibility of my getting a job in Dublin in 1957 he advised me "They would kill you in Cork but they would kill you and eat you in Dublin". Another subject was taught in a monotone by a lecturer called the 'tsetse fly' that spread sleeping sickness through the class. The fourth and fifth years introduced us to two contrasting figures Paddy Kiely ('PK')

Professor of Surgery and Jimmy Donovan, Professor of Medicine. Neither had worked or studied outside Cork. Jimmy was full of erudition and common sense and had his priorities right. He went to England (always 'England' as the Germans have it: never the UK, a later invention) to 'meetings' and told us what was happening there. PK was entirely self-taught. He had an incredible memory, was a great anatomist, and knew the names of all in the class within a few days of meeting them, a daunting facility. Everything had five features, one for each of his strong fingers. This system I transferred to subsequent examinations with some success.

Tim Counihan of Killarney topped the 1947 MB graduating class and is alive and well living in Dublin's Shrewsbury Road. He and Paddy Collins (first in Surgery) of Cobh both became Professors in Dublin. It would be difficult to find two more contrasting personalities, which only goes to show that Medicine with a big M can accommodate a wide spectrum of people.

The late Denis O'Sullivan of Macroom and the late John Kiely Jr. from Cork topped the 1948 class. It had been said that if you had rubbed your behind against the bridge in Macroom it was as good as an Oxbridge education. Denis was hugely popular even then and there was great student dismay when he was passed over for the top post, house physician to Jimmy Donovan. He went immediately to Wolverhampton, England. John Kiely Jr. (PK's eldest son) was a hugely talented charming, handsome man who suffered from debilitating, devastating, asthma which may have been a factor in his premature death at about 37. Some of the clinical teaching was done in St. Finbarr's, which at that time gave us a real idea of what an eighteenth century workhouse was like. But John Kelly was there. He had trained in England and was a star teacher and surgeon. John Kiely ('K John') was the Lecturer in Surgery and was greatly loved by the students in the 110 bed North Infirmary, now closed. JJ Kearney, "J J", one of the most remarkable men who ever walked down St. Patrick's Hill taught Obstetrics. A Gold Medallist at qualification he had spent some time at the Chelsea Hospital for Women in London, his lectures were delivered from typed sheets of paper, which were guarded like original Mozart scores, or portion of the Dead Sea Scrolls. They were taken word for word from a primer of about seventy pages titled "Aids to Obstetrics" (seven shillings and sixpence) which was not on any list of recommended

books. "JJ" supplemented these talks with a series of terrifying tales of what could and did and had happened at the Obstetric coalface. Then we were taught modern Obstetrics by his son Prof. Billy Kearney who had trained at Oxford and arrived back in Cork with a much imitated accent...but he was a superb teacher. One examiner in the final med was so anxious that we should pass that he dropped heavy hints about three questions in his last clinic.

Bill Radley (a&w) from Cobh, who really finished alone in the frame he was so far ahead of the rest of us, topped the 1949 class. Second was Brendan O'Donnell who immediately went to the US (a rarity in those days) then trained in Radiology at the Mayo Clinic and is alive and well in sunny California. In third place was Jack Keane who died in New Zealand in 1993. Jack Keane a six foot red haired humourist and Gaeilgeoir, was the most popular student of his time and when, through an administrative slip up, he was called first rather than third at the graduation ceremony there was a huge cheer. There were five first class honours and four-second class honours in that June 1949 MB class of perhaps fifty, which made it probably

the best class for a long time. I was ninth and last of the second-class honours. Ninth place is hardly evidence of Newtonian intelligence but after all it is Cork we are talking of. There was tremendous intellectual synergy, even though we didn't know what that was, at all levels in that great group.

Extra curricular activities for me included the Literary and Philosophical Society (the 'Philosoph'), which provided free entertainment on Saturday nights, and rugby. I once played hooker for the College Firsts on a Saturday and two other College teams one at noon and another at three on the Sunday. Five foot seven and nine and half stone of naked aggression but I was slow, couldn't catch or kick and in general wasn't any good so no one bothered to complain. I would sometimes arrive in class on Monday morning with a pair of black eyes, not due to fights but rugby tackling. College won the rugby Bowen Shield in 1946 with international Eddie Mullane at scrum half and Captain and Jimmy Corcoran, another international in the front row of the scrum. College always had an international on the team in those days. The UCC 1947 Captain

was John Harvey, final trial full back, who said of the author "O'Donnell has great heart but he has f... all else." Close. Our trainer, the charismatic Dr. Jack Russell of Blarney, who as a second row forward had scored an unheard of two tries for Ireland in one game against Scotland at Murrayfield in 1934, saved my place. He was a converted Gaelic player and a great lineout jumper. We loved him.

About fifty of us graduated in June of that fine summer of 1949. There were perhaps five jobs between all of us in Cork. For the rest, well, we knew we were going on the "Innisfallen", the 'packet' from Cork to Fishguard and then mainly to the sooty but welcoming cities of England where we were treated with scrupulous fairness. I was gone in three weeks. And thus ended a chapter... ■

Barry O'Donnell UCC MB 1949

Past President British, Canadian and Irish Medical Associations 1976-77

President. Royal College of Surgeons in Ireland 1998-2000

Chairman, British Medical Journal 1982-88

Emeritus Professor of Paediatric Surgery RCSI

Dr Fergus Moylan

"What is Improbable is Probable." Aristotle.

Of all the innumerable lines of text I read as a medical student few have survived the passage of time. (Not surprisingly mnemonics, true to their original intent, have fared better.) But a line in "Signs and Symptoms" ("When approaching the unconscious patient one's mind may be as blank as the patient's") has stayed with me. When I first read this I realised that it was only a matter of time when it's full intent would be all too personal. So, I mentioned it to my brother Donough, who had been in practice for about ten years at the time, curious to see how he handled such medical emergencies. He gave a little self-deprecating laugh and told me of his very first experience of dealing with the unconscious patient.

The incident occurred at the Easter Monday Clonmoney point-to-point races in Co. Clare, where he found a man unconscious in a field. Being freshly qualified and of a serious scientific bent he approached the subject, his clinical skills on high alert. But, before he could

get very far in his assessment of the patient, another individual appeared on the scene and proceeded to viciously kick the subject on the ground, exhorting him to "come out of it." My brother, realising in that instant that "drink had been taken," and seeing that his services would no longer be needed, departed the scene, confident that the situation was under control and in good hands.

Humorous though the story is, it is illustrative of a fundamental fact in Medicine: the possession of accurate and significant information permits decisive and appropriate action. The question, however, remains one of how do we get from here to there?

Medical training in the 1960's was heavily grounded in the art of taking the patient's history and doing a thorough physical examination. Resources were limited. Cork was still waiting an answer to its application for an EEG machine and the world of radiographic investigation was not much more advanced than a pint glass of barium. In our final months

as Medical students we were repeatedly reminded, as if it was necessary to compensate for this lack of ancillary services, that Medicine was as much an art as a science. By the time I was doing Intensive Care the mantra had changed; if your test results did not concur with your clinical impression then you needed to change your clinical impression. In general practice I learned that this conflict between the facts and their interpretation extended to the patients, where the solidity of laboratory results had more validity than trusting to the physician's subjective interpretation. And somewhere in all of this, the facts had to be viewed within the context in which they were found. Clearly, as my brother quickly found out, clinical situations did not necessarily obligingly fall under neat chapter headings.

My first introduction to the art of eliciting a patient's medical history occurred during my Rotating Internship in Detroit in 1968. I was plodding along, methodically taking an admission history from an elderly lady when

my Pakistani supervising resident pulled back the curtain to enquire as to what was going on. In about two minutes he had the whole story and with a reassuring hand on the patient's shoulder, which was pointedly turned towards me, told her that she would be in good hands. This envious performance, I was to realise later, had been facilitated by his familiarity with the demographics of the patient population and their complaints, which made it possible for him to take a focused diagnostic approach. That said however, the hospital's heavy emphasis on investigative studies, which until a few months previously had only existed in the realm of textbooks, plunged me into a dichotomy, best illustrated by a cartoon of the time. It showed a doctor with a pile of lab reports exclaiming with obvious irritation: "All negative. I guess I am going to have to examine the patient!"

The next year I found myself doing a Paediatric residency at Bellevue Hospital in New York. Since I knew little about Paediatrics it was necessary for me to keep a low profile, stick to the basics and, hopefully, do no harm. It was in this milieu that I had my first experience of dealing with the improbable.

She arrived in the Emergency Room early one evening in status asthmaticus, a ten year old, and all too familiar, I discovered, to the staff. Before I could get a history my resident gave her a knowing look and directed me to admit her straight to the ward. She was a well-known asthmatic. ("A frequent flier" in today's parlance). Later, when I was working on the wards, she became my patient. My suspicions were first aroused when a nurse commented on how quickly she had recovered since her admission. Sure enough, there was my deadly sick patient playing with the other kids in the ward. On her next admission I waited until she had fallen asleep to re-evaluate her. To my surprise her chest was clear on auscultation. With that I asked that she be seen by the paediatric psychologist.

The psychologist in his denouement of the case showed us some drawings she had done for him. The first was of a sad lion behind bars. The second was a view from a window of children playing on the street below. The interview with the mother revealed that she had left Puerto Rico because the children's father (there was a six year old brother) had been murdered. She was now alone in New York city and terrified to let her children out to play. The little boy who was more defiant, she chained to the bed. According to the psychologist the sad lion behind bars was the patient's self-portrait, while the view from

the window indicated the outside world she craved. With appropriate family counselling the asthmatic attacks stopped.

At first blush this might seem like a perfect example of psychosomatic disease, physical symptoms precipitated by psychological stress. However, on closer inspection it might qualify as malingering. The difference between the two is that in the former the patient is unaware of the connection while in the latter the symptoms are produced for an expressed purpose; in this case, hospitalisation so she could socialise with other children. Sometimes it may be difficult to distinguish between the two. The patient who presents with such severe abdominal pain that they have difficulty getting up on the examination table and yet, when told to get dressed, hops off the table without any apparent difficulty, may or may not be conscious of the disparity in their behaviour. In the end it is less relevant as to what it is called as long as the behaviour is recognised.

Though it may be claimed that Medicine is an art, it is also a scientific discipline and as such must stand on a body of facts. These facts to be valid must be capable of withstanding statistical analysis. The great stumbling block to this in Medicine is small numbers. To circumvent this, William Sealy Gosset, an English statistician working at Guinness's Brewery in Dublin and publishing under the pseudonym of Student, developed in 1908 Student's t-test, (also referred to as the probability value or the p-value). Using the p-value as a measure of validity of correlation between facts we usually accept a p-value of 0.05 as probably significant and anything equal to or below 0.02 as definitely significant. Thus, the p-value has the imprimatur of truth, and as such it has wide and often, sadly, uncritical acceptance.

Population studies have been done to establish whether hormonal supplementation in menopausal women increases the incidence of cancer. There is a statistical significant increase. But is that statistical increase clinically significant to the individual sitting in your office? (reminds one of the comment attributed to Stalin. Two people die, it is a tragedy. Two million die, it's a statistic). An example of the unforeseen consequences of an uncritical acceptance of p-values occurred in 2000. It was shown that the use of SSRI antidepressants in teenagers (a population notorious for suicidal ideation) increased suicidal ideation. Doctors stopped prescribing SSRIs to teenagers. The suicide rate increased.

The p-value is a statistical manoeuvre to establish probability of correlation and, hopefully, causation. But there may be a quantum leap between correlation and causation. Additionally, as Aristotle recognised, the improbable also has a probability. And nowhere is that more true than in the practice of Medicine.

For me, the 1970s started out in a flurry of interest into the incidence and aetiology of Sudden Infant Death Syndrome (SIDS), a condition previously referred to as Cot Death in the UK and Crib Death in the US. I was working in Paediatric and Newborn Intensive Care at The Massachusetts General Hospital (MGH) at the time. My boss, DCS, was doing research into the control of breathing in lambs and how it might relate to infants. One morning on rounds he referred to an article which had just appeared in Paediatrics. After rounds I went back to my office to read it again and to see what was it about the article that I had failed to grasp. The author, Alfred Steinschneider, concluded from a study he had done on a small group of infants who subsequently died of SIDS, that SIDS was related to the control of breathing and that it had a genetic basis. Despite my failure to understand how he was able to come to these conclusions from the data presented, over the next 20 years the article became the opening reference to all publications on SIDS. It was viewed as a seminal moment in the understanding of the condition.

DCS, whose office adjoined mine, got on the telephone and called, at first, a few specific Paediatricians in general practice to let them know that he was studying infants who were having unexplained apnoeic spells. In no time at all he had a steady flow of patients to be evaluated in his pulmonary unit. He then hired DK, who had been one of our residents, to run the programme, evaluate the data and eventually publish. I was only peripherally involved, covering for DCS when he went on vacation, helping DK to read some of the recordings in his absence. However, I must confess that I went from believing that DCS might be in line for a Nobel Prize if his research provided the answer to the etiology of SIDS to becoming increasingly uncomfortable about the significance of the p-values. Then DCS published an article in The New England Journal of Medicine, presenting data on the relationship of the blunted response of infants with aborted SIDS to carbon dioxide inhalation. The graph presented included two infants we had treated for central hypoventilation syndrome (also referred to as Ondine's Curse; breathing ceases when

the subject falls asleep.) This seemed to me a misrepresentation of the data. But, since it wasn't my area of interest, I just moved on and moved out.

Over the next twenty years I monitored the situation by checking the review articles on the subject and registering the number of times DK/DCS articles were referenced. Their articles went from dominating the field of research to virtually disappearing for no apparent reason. However, sending babies, mostly siblings, home on monitors had become a cottage industry. There was some pushback from other researchers, mostly in the UK, to the concept that there was a genetic component to SIDS. Then an anaesthesia resident who had rotated through the Paediatric/Neonatal units at the MGH went public with his concerns that a patient who subsequently died of child abuse had been discharged from the hospital as a case of aborted SIDS. Since, it was starting to look ugly, I dropped in on DCS one day while in Boston and conveyed my concerns about how his research was being perceived. But what was apparent to me seemed to evade him. That said, however, I was totally unprepared for what happened next.

One evening in 1994, while waiting for a seat in a restaurant, the lead-off story on the evening news was the arraignment of a mother in Michigan for the second degree murder of five of her six children. These were the children who had made up the bulk of Steinschneider's original and subsequent research on SIDS. (The full story can be read in: *The Death of Innocents* by Richard Firstman and Jamie Talan). It had taken an observant lawyer to notice the pattern of deaths at a time when the infants were being studied by Steinschneider's pulmonary lab. DK travelled to the arraignment to show support for the mother (the revelations in the trial would prove nearly fatal for her). But the world of SIDS research imploded with that single announcement.

Synchronous with this thunderbolt the policy of "Back to Sleep" was introduced and within two years, the incidence of SIDS was practically halved. Despite the facts that SIDS remains the most common cause of death between the ages of one and twelve months and that it is still thought to be due to an abnormality in the control of breathing, twenty years of research was allowed to lie fallow. How all this came to pass I can only guess. I do know that a confluence of events e.g. a new book on the public health implications of SIDS, a neonatologist becoming the editor of *Pediatrics*, the sudden growth in resuscitation

and interest in the control of infant breathing, must have played a part. But, could an uncritical acceptance of p-values or falling into the trap that P. T. Barnum referred to as "emphasising what is true but irrelevant" pushed the process over the edge? Certainly, the possibility of the improbable had not been seriously entertained.

In 1951 Richard Asher, an English physician published in *The Lancet* an article describing patients who fabricate their symptoms and named it "Munchausen Syndrome" after a character in German literature famous for fabricating stories. This article and subsequent publications identified a population of patients who tended to be medically knowledgeable, to present with symptoms that were difficult to either confirm or refute e.g. fever, and that many were thought to be suffering from some sort of mood disorder.

By the mid-1970s, case reports were appearing in the Paediatric literature describing children where the mother had fabricated the child's symptoms. This was named Munchausen Syndrome by Proxy (MSbP). In 1997 an article was published on hospital room video-taping where MSbP was suspected. There were 39 cases. In 31 there was clear evidence of the mother harming the child either by suffocating with a pillow or by physical injury. One mother, enraged by a planned discharge, was seen going into the hospital room and snapping her baby's arm. The 39 patients in the group had 41 siblings. Twelve of these were discovered to be already dead. (Coincident with the publication of this report, an English au pair was being charged in a Boston court with the murder of an infant in her charge. This was a highly publicised case because of its international connotations. Many could not believe that a caregiver could do such a thing to a child. Others believed the mother, who was a paediatrician, did it because she seemed cold on the witness stand. Fortunately the jury did not agree with either view.

A 2003 survey of 451 cases of MSbP revealed considerable premeditation, unlike in "typical" child abuse where the abuse may be precipitated by the child's behaviour. Though separation of child and parent may be curative, the mother may turn her attention to a sibling, while reuniting the child and parent may be disastrous because of the 10 to 15% mortality rate. Medical investigation goes from an initial unintended facilitation of the abuse to eventual recognition but it may take several years for the improbable to enter the realm of the probable.

What is really going on in people's lives can be a mystery. Patients, presumably trying to be cooperative, tend to tell the doctor what they believe the doctor wants to know, while others leave out crucial details on the pretext that "Well, you didn't ask!" With experience the doctor develops a working strategy involving a mixture of mental reservations and pertinent questions that help to zero in on the diagnosis. In time this *modus operandi* becomes ingrained. However, it is said that if one goes through life with a hammer eventually everything begins to look like a nail. Call it tunnel vision, an inability to think outside the box, to colour outside the lines, whatever. But it is not an approach that is open to the possibility that the improbable is probable.

A few weeks before I closed my practice, I saw a teenage patient and her mother in my office. This was a family I had had considerable interaction with over the years, initially providing routine Paediatric care but as time went on and its dysfunction more disruptive, I became more involved in the management of the psychiatric issues. The problem I was struggling with on this particular visit was the child's seemingly uncontrollable anxiety, which did not seem to be responding to the standard approach (SSRIs) and was necessitating increasing doses of short acting anxiolytic agents, never the optimal approach. The situation was not made any better by the fact that the mother's mental health seemed more at issue than the patient's. Later, when I voiced my uneasiness with the situation to my office staff, a young certified nurse assistant filling in for the day said the magic words: "Maybe the mother is taking the medication."

The improbable had become probable and I had nearly missed it. Retirement could not come soon enough. Everything was beginning to look like a nail. ■

Ainsworth Scholarship



I was fortunate to be awarded the Ainsworth fellowship in 2013/14, allowing me the opportunity to pursue further specialist training & research overseas in inherited metabolic disorders and stroke medicine. As a clinical neurology specialist registrar in Ireland, I received extensive training in general neurology including diagnosis and management of all common neurological disorders.

To further my training, I pursued a fellowship incorporating relatively rare sub-specialities at the National Hospital for Neurology and Neurosurgery (NHNN), Queen Square London. Rare diseases have become increasingly recognised as important, as they have significant impact on affected individuals, as well as healthcare budgets. Some rare diseases are potentially treatable either by using well established therapies (eg. Wilson's disease or vitamin B12 and folic acid treatment in homocystinuria) or by newer targeted treatment (eg. enzyme replacement in lysosomal disorders). Many of these disorders present in adulthood.

Neurometabolic medicine is an evolving area of medicine, and dedicated adult specialist services in Ireland are a very recent development. With evolving progression in therapies for the spectrum of metabolic diseases, combined with increased recognition and identification in the population, it is important to provide expert medical care for adults with metabolic disorders. The changing ethnic composition of the Irish population and the high prevalence of neurometabolic disorders within specific ethnic groups, eg. Irish Travellers, makes this aspect of medicine and neurology of increasing importance to the Irish health service. The estimated incidence of metabolic diseases is 1 in 784 live births in a recent UK study, and over 1,000 different metabolic diseases have been identified to date.

From a patient perspective, access to clinicians with expertise in metabolic medicine is particularly important for those with less common or only recently recognised conditions, especially where there has been rapid progress in diagnostic approaches and treatment. Early recognition of rare disorders may maximise favourable outcomes in treatable conditions and minimise unnecessary investigations and delays in care.

The Charles Dent Metabolic Unit, based

at the National Hospital for Neurology and Neurosurgery (NHNN), Queen Square London, is a world renowned specialist centre. It is the only designated supra-regional centre in the UK for the investigation of neurometabolic disorders and provides a unique range of investigations and clinical advice encompassing mitochondrial, neurotransmitter, pterin and amino acid disorders and utilises state-of-the-art analytical technologies.



The multi-disciplinary team at the unit manages adult patients with inherited disorders of metabolism, including phenylketonuria, glycogen storage disorders, urea cycle defects, galactosemia, fatty acid oxidation defects, peroxisomal disorders and inherited hypophosphatemia. The unit is also a national specialised commissioning team-centre for the management of patients with lysosomal storage disorders (including, among others, Fabry disease, Pompe disease, Gaucher disease and the mucopolysaccharidoses). The recognition of novel metabolic diseases and their treatment is a specific focus of this subspecialist unit.

The further training in specialist aspects of metabolic diseases including maternal medicine and specifically peri-partum phase management has provided me with skills for future collaboration and coordination of care with relevant services.

I have had the opportunity to be a co-investigator in orphan drug trials for rare disorders as well as site investigator, including hands on recruitment of patients in acute stroke treatment clinical trials of novel treatments.

Pursuing a fellowship at NHNN allowed me the opportunity to work with a cohort of patients with Fabry's disease an X-linked lysosomal storage disease, for which an enzyme replacement therapy is available. It also gave me a unique opportunity to develop independent research & skills relating to the assessment of patients with Fabry's disease

and to gain experience and insights into cutting edge bench-to-bedside research.

This research was presented at the September 2014 Society for Study of Inherited Errors of Metabolism (SSIEM) meeting in Innsbruck, Austria at the Association of British Neurology meeting, and European Stroke conference in 2014.

The fellowship also gave me the protected time and opportunity to write grant-applications for further research funding opportunities and review papers on the topic of posterior circulation stroke, transient ischaemic attack and risk prediction & metabolic disorders, and to write 2 book chapters. Furthermore I had the chance to participate in a multi-site clinical audit across the UCL campus, in conjunction with Addenbrooke's Hospital, Cambridge and Royal Free Hospital, London. I was also given the opportunity to attend weekly joint clinical teaching sessions at the UCL Institute of Child Health, Great Ormond Street.

Additionally the fellowship provided the opportunity to receive extra training in stroke medicine and develop an extensive network of multi-specialty collaborative colleagues. Participating in the organisation and management of stroke care in a different health-care setting, has allowed me to appreciate the strengths and weaknesses of different models of care. I have gained experience in acute clinical trials including the ongoing PISTE trial, as well as exposure to neuro-ICU, hyper acute stroke care, and critical transfer of patients with acute neurological disorders. During the fellowship I also have been able to build on my teaching skills working with undergraduate and postgraduate students across academic disciplines.

The Fellowship also provided an opportunity to collaborate with colleagues in Ireland. The Queen Square Adult Leukodystrophy Group is a multi-disciplinary clinical collaboration that aims to help in the diagnosis of challenging cases, so via my role as group co-ordinator I was able to bring the skills of the Queen Square group to provide an expert opinion on a patient from Ireland

During my time in London I have had the chance to be part of the larger UCC community by having an active role as the public relations officer for the London chapter of UCC alumni. I developed the opportunity to meet other UCC medical alumni as well

as a variety of other academic backgrounds, organise networking events, a fundraising event to support the Cork Cancer Research Centre and a gala dinner.

I was delighted to be invited in spring 2014 to be a guest lecturer at Cork University Hospital (CUH) Grand Rounds and invited speaker to the neurosciences departmental meeting. This provided me the opportunity to share updates of relevance to clinical practice from the fields of inherited metabolic medicine and stroke medicine.

The Fellowship has cemented my career plans as an academic clinical neurologist and stroke physician. It has also given me a chance to be a Londoner, and enjoy the sights, sounds and tastes of multicultural London. Queen Square and UCC have one clearly tangible

and visible link – both have a large statue of a British Monarch. Queen Square is believed to be named after Queen Charlotte, wife of King George III, who was reportedly treated in a house at Queen Square. Her large statue stands in Queen Square, however unlike the statue of Queen Victoria at UCC I suspect the Queen Charlotte statue has never left 'The Square' and never will.



The Ainsworth Scholarship has provided me with transferrable skills to bring to whatever environment I may work in and is of special use in a clinical academic unit. The contact with a fantastic collaborative network of colleagues in Europe and the UK for support in current and future clinical or academic challenges is an added advantage. ■

Dr Merwick MB BAO BCh, MSc (Stroke), PhD is currently an honorary consultant neurologist at UCLH, National Hospital for Neurology and Neurosurgery, Queen Square, London, an associate researcher at UCL, and locum consultant neurologist at Chelsea and Westminster NHS Foundation Trust.

Jennings Gallery

Dr Bridget Maher



Jennings Gallery 2013/2014 Art, Science and more Art....

It's been a busy fifteen months in the Jennings Gallery – exhibitions, exhibitions, and more exhibitions! In November, 'Acquainted with the Night' featured the artworks of Grainne Tynan, Occupational Therapist. In February, the wonderful 'It's a Beautiful World' exhibition celebrated the beauty of science and nature and brought together scientists, clinicians and healthcare students at UCC to highlight the intrinsic beauty of scientific imagery.

On 2nd April, 'Celebrate Your Autism', organised by the Regional Autism Team for Cork and Kerry as part of International Autism Awareness Day, highlighted the creative talents of children on the autism spectrum. The exhibition was the result of workshops facilitated by local professional artists, as well as pieces created by children independently in clubs and schools across Cork city.

On 13th May, 'The Art of Making', a print and textile exhibition by UCC Occupational Therapy students, highlighted the importance of the relationship between the maker and the object.

'Irish Women Artists of the 20th Century' opened on 18th June 2014. The exhibition was based on the book 'Journeys through Line and Colour: Forty Irish Women Artists of the 20th Century' by medical alumnus Professor Paul Finucane and Dr. Maria Connolly. The exhibition featured stunning artworks loaned from a number of private collections and was an ideal opportunity to view the works of what are considered the best Irish female artists of the 20th century. Although under similar artistic influences, these women had very individual artistic styles.

'Portraits from the East' an exhibition of photographs by medical student Luke Feighery, opened on 12th September, 2014 and was based on Luke's travels to the Far East.

'The Legacy of Vesalius' (21st October) featured prints of Vesalius Anatomy drawings along with a display of anatomical instruments. The exhibition was organised by the Department of Anatomy and Neuroscience to mark the anniversary of Vesalius, the father of Modern Anatomy.

Finally, 'What Lies Beneath' an exhibition of drawings and pastels by Dr Maeve Doyle, Consultant Microbiologist, University Hospital Waterford opened on December 11th. Dr Doyle was illustrator of the cover of 'Modern Medicine' for many years. The exhibition features these distinctive medical drawings as well as recent work.

The Jennings Gallery is a wonderful creative space in the heart of the medical school. I am privileged to have been Director over the past fifteen months - It's been a wonderful journey through Art and Medicine, Lens and Light, Pencil and Pastel.



'Running, My Release From Reality'

Dr. Orla Crosbie

Consultant Hepatologist CUH

Two months ago Katy Keohane invited me to write an article on running for the Medical Alumni newsletter. As running is a topic very close to my heart I was flattered to be asked and delighted to agree. I'm now wondering where it all went wrong! If this was a marathon plan I would have completed the word count and spell check several times by now but instead I find myself uncharacteristically typing furiously to reach the deadline; its worse than a set of 800m intervals gone wrong on a Friday night at the Mardyke track after yet another challenging and bracing week at CUH!!

I'm not sure that Katy realises it was all her fault that I got into this dilemma in the first place. My male colleagues have long envied the get together of the XX Club, so expertly organised by Katy at the time. For obvious reasons I cannot disclose what happens at these female Consultant gatherings (sorry lads), suffice to say that after some excellent food and drink, I committed myself to a road of no return. Oonagh Gilligan was looking for some volunteers to run a leg of the Cork City marathon for the friends of Londiani, "It will only be 5 miles" she reassured me, as I enthusiastically said "I was on for it". With my one medal for a slow bicycle race at 10 years under my belt, I was confident that night that I had the required skills and qualifications for the job. But day followed night and I still remember waking up in a cold sweat the following morning and telling my husband Andrew what I had volunteered to do, but there was no going back now, I was committed and resolved to complete the challenge. The trainers were purchased, the run/walk routine began, the sweat glowed and I gradually was up and running 5 miles. The route was studied and discussed, fellow runners were consulted and a dummy run was executed until I was confident I could finish reasonably comfortably. Ten weeks later I stood at the start line and completed the 5 mile run with two other colleagues in 45 minutes, the sun was shining, the crowds cheered us on, photos were taken and we were congratulated afterwards. We received our medals and I was thrilled, dead chuffed in fact, and there was a few euro made to go to the friends of Londiani as well.

What I didn't really focus on at the time but see it more clearly now, was how much I thoroughly enjoyed the whole process. Organised by nature and reluctant to admit that I insist on being as well prepared as possible for whatever I do, I thoroughly enjoyed setting the goal, planning the training, getting motivated for the challenge, ticking off the progress and finishing the run feeling good. I had come to enjoy the freedom of running so much that after this initial challenge I have kept it up without any significant break over the last 5 years. The escape from reality, the freedom to be able to run most places at times that suit your lifestyle and the feeling of wellbeing all appealed to me. In fact I now feel I am missing out on the rare occasion I miss my daily run. Serendipitously the most valuable thing I have gained from running is a fantastic circle of friends that I rely on for support, motivation and great craic. The diversity of Runners as a group is truly amazing; from phenotypes to backgrounds and all with their own story to tell! For my story the length of this article doesn't allow me to bore you with all the details of my post 'marathon relay' running career five years ago to where I am now. Suffice to say a great friend and neighbour introduced me to the BHAA (Business House Athletic Association) races in Cork where I ran for the HSE, I joined St Finbarr's Athletic Club, had a short career in cross country (not for me sorry), progressed from 5 miles to half marathons and then the ultimate goal to date, the Marathon. This ambition requires realism and anchored to this is commitment to set training goals – see table below. My justification for the time taken is that one never regrets the time taken to do what one really loves.

As one sets more ambitious goals it unfortunately becomes inevitable that there will be disappointments and poor performances; perfect training plans and hard work don't always translate into the perfect race on the day. It's at times like this that we all help each other to share the ups and downs and realise that even the most experienced runners have had their share of off-days and got over them with the help and support of their friends. Injuries too can bring any good plan to an abrupt halt, I have been very fortunate myself on this front, so won't say much more on this dreaded matter.

I'm still not entirely sure what attracts runners to marathons but having read reviews, books,



My first Marathon, Straight Road, Cork City Marathon 2012

and anything else in fact that might mention the word I feel qualified to offer an opinion. On one hand there's the obsessive training and commitment; the mental strength and physical stamina required on the day; and also the hopeless disappointment if one small thing upsets your Plan A on the day (and it will). This is bizarrely more than offset by the undying emotional support from family and friends who will do whatever is required before and during the event to get you across the finish line in one piece (probably silently praying that you will get sense and never do another). This psychological impact often negates the fatigue and strain when faced with the 'wall' (20 mile mark), running into a headwind, not feeling well or just competing on too hot a day. I can still hear the English voice that suddenly roared from nowhere 'up the Barrs' when I hit the 7 mile mark of the London marathon this year and the lift it gave me for miles. Having trained excessively, dreamt about negative splits and eaten a meticulous diet for weeks, one turns into a complete hypochondriac in the weeks leading up to a marathon. Hypochondriasis abounds beforehand as, God forbid, you might get contaminated by any illness however small that might in your wildest dreams interfere with your performance. Forget all the logic and reasoning you were taught in UCC and on the wards of CUH; friends and family with coughs and colds are avoided, steps and cables become life-threatening obstacles, your recessive health and safety gene waves a flag at every corner, you will go to any length to get to that start line hale and hearty, carb



Therese O'Sullivan, Susan Corbett, Natasha Clarke, Orla Crosbie, Norma Scanlon, Friends from Hepatology OPD, CUH after the Ray Darcy 5km run, Lee Fields, Sep 2014.

loaded, rested and wearing the correct gear.

Now for any non-runners that don't appreciate the 'holy grail' of the Marathon, just think how nervous and excited at once you were on your wedding day, and multiply that by at least 10. The atmosphere on marathon day is electric. Months of preparation see swarms of runners like ants make their way to the bag drop area and start line. There's the frantic queuing for the loo, liberal application of Vaseline plus the loading up on gels. Then there's the silent anticipation as one waits at the start line in your time zone, distracted by occasional banter about the weather conditions and on a cool day the discarded T-shirts flying in all directions. As the time is counted down the Garmin's (running watches) are switched on and GPS's located and before you know it you are ready for the off.

I was asked specifically by Katy to mention 'the highlights of my running career' and this has been harder than I thought. It's not that there have been so many, but one is not only influenced by your time on the day, but also by how well you feel afterwards, and also on how well your friends whom you trained hard with have done. For all time success it has to be the Barcelona Marathon which I did in 3.12.21 on St Patrick's Day 2013, which was my Marathon PB (personal best). Andrew and our 2 children came over to Barcelona with me and my good friend and ex-SpR Omar did an excellent time too, beating me by 14 seconds, we were both very happy indeed. We finished off the holiday with a soccer match in Camp Nou. My son was so impressed that when he angled to get to Old Trafford the following year, he asked me "if there was any marathon in Manchester".... for another time perhaps. I was also extremely

lucky to win a team and category medal at the Dublin City Marathon in 2012 with a time of 3.14.56 and again got a medal for 3rd place in my category the following year with a time of 3.12.49.

My plans at the moment? I hope to do the Clonakilty half Marathon for the first time this December; it always feels good to try something new. All going well after that I would love to do the Tralee marathon next March, as my parents hail from Kerry and I'm well familiar with the route. I took my first steps in Kerry apparently, surely this is a good omen, or am I only fooling myself that I need encouragement!! Most of all I hope to continue to enjoy my runs and keep laughing at the ups and downs with my fantastic group of friends, some of them seen here in my selection of photos.

Appendix 1:

You know you're hooked when:

- You absent mindedly find yourself rubbing your feet with your expensive Clarins hand cream that you got as a Xmas present,
- The last two times you went shopping was to John Buckley's to buy a new pair of trainers and again 'just to have a look at his range of racers', at a time when the heel fell off the shoes you regularly wear to work (yes, on a ward round!)
- Saturday nights are for resting prior to a long run with your friends on a Sunday morning, you dread the thought of being invited to anything that might go on late and if you are and can't think of an excuse to avoid it (they will never believe I'm on call again another weekend) you insist on driving (as all alcohol is evil prior to a long run)

- When the yearly on call rota comes out you check to see if you are scheduled for the June (Cork City Marathon) and Oct (Dublin City marathon) bank holidays and the Sundays of the Ballycotton 10 in March and the Cork to Cobh race in Oct; it doesn't really matter if you are, you just need to organize a swop, as there's no way you will miss these sacred events in the Running Calendar,
- You go to the Newsagents to get the paper and automatically check to see if next month's RW (Runners World) has arrived,
- favourite website is 'Running in Cork' and looking up future races and results has become part of your normal routine,
- You drive up a hill and automatically wonder what it would be like to run up it and what pace you might do it in,
- You're secretly delighted when your husband announces he's off sailing to the Scillies with the lads again this year, as this clearly translates into the equivalent of freedom to do at least one marathon and several other smaller races,
- And yes, this did happen; I'm driving my daughter to her first day at Secondary school and have taken the day off work to make sure she gets settled in okay, she asks who's collecting her and I say it's me; "but aren't you going to work" she says; "not in my running gear surely" I reply and she just laughs at me and says "but Mum you often go to work in your running gear".

Appendix 2:

Success = Motivation x TNR *

* T=training, N= nutrition, R=rest

According to Karl Henry, and I guess he has done enough to know.

What this might look like while marathon training

TRAINING

MON: Early easy run or cross training 8pm (that would be ballroom dancing lessons with Andrew)

TUES: 7am: Hill session or intervals out straight road or tempo

WED: 7am: Easy longish run, 6-8 miles

THURS: Often my REST DAY: Why? Chaotic Hepatology clinic in morning and ERCP list in afternoon do not leave much energy for anything else....

FRI: 6pm: Tempo Session at Mardyke track with Barrs Club

SAT: Easy run or rest if have run Thursday or Gym and swim (should do this more often but don't, hate being inside in general if have option of fresh air)

SUN: Early, long run with friends, usually in direction of 'the farm' in Curraheen to run on the grass.

NUTRITION

Breakfast: Cup of tea before run (I know, should be water but much prefer Barry's) and a slice of toast; after run: Large bowl of porridge.

Lunch: (Never miss, I don't thrive on being hungry), sandwich with some protein

Dinner: As big as my husbands with lots of veg and carbs.

Evening; My downfall, as I don't get time to snack during the day, if hungry could eat anything, sandwich, cereal or both! And another cup of tea of course

Snacks: Always try to have fruit in my bag and in my office.

Liquids: Should drink more water, I try, lots of tea, some coffee, and as for alcohol, not during the week because of work, before races or long runs usually, but I do look forward to a glass of wine after I cross the finish line and don't always stop at that (please don't tell my patients!)

Supplements: Whey protein after a session or long run, in general am completely non-compliant with vitamins and iron which I occasionally convince myself I must be deficient in and buy.

REST

I like and need my sleep, lights out by 10.30 or 11pm .

Favourite rest time: Taking a leisurely breakfast after a long run, knowing I don't need to rush anywhere. ■

Flanagan Medal

A team of final year medical students from University College Cork has won the 2014 Jack Flanagan intervarsity competition in Geriatric Medicine. The group, comprising Ms. Cathie O'Mahoney, Ms. Róisín Ryan, Mr. Ronan Bluett and Mr. Ciaran Mullins was coached by Dr. Paul Gallagher (Consultant Geriatrician & Senior Lecturer in Medicine) and Dr. Amanda Lavan (Specialist Registrar in Geriatric Medicine and PhD Research Fellow, School of Medicine, UCC).

The annual clinical-pathological competition is named after Ireland's first geriatrician, Dr. Jack Flanagan, who pioneered and developed modern day geriatric medicine services in Ireland. Six of the country's medical schools were represented at this year's competition, held in RCSI Dublin on 15th October. Each team was given a complex and challenging case to review in one hour. During that time, the team had to arrive at a diagnosis, formulate a management plan and prepare a presentation for a mixed audience which addressed specific questions including ethical and legal dilemmas. The competitors were judged on their presentation skills as well as their knowledge of geriatric medicine, psychiatry and gerontology.



The UCC team was awarded the Jack Flanagan medal and a bursary of €1000. UCC will host the competition in October 2015. ■

40th Anniversary Reunion MB class of 1974 Sept 12th-14th 2014



Eugene Vaughan, Jimmy Crehan



Eileen O'Connell, Gary Lee, Fachtina Carey, Imelda Carey



Seamus Looney, Gary Lee



Debbie Vaughan, Judy Burke, Calley Kenefick, Donna Oliver



Liam Hayes



Harry Casey, Katy Keohane



Daniel Burke, Maurice Hickey



Tom Aherne, Phil Casey



Mary O'Sullivan, Jacinta Murray, Norah Murphy

There was a great turnout for the 40th anniversary of graduation of the class of 1974, which was held in conjunction with the Medical Alumni Annual Scientific Meeting on September 12th. Classmates travelled from France, from USA, United Kingdom, and all over Ireland. Some made it all the way from Bishopstown!!! A few more grey hairs all around, maybe a few more kilos on most of us, but everyone was recognisable.

Class members contributing to the meeting were Tom Aherne who spoke on the history of Cardiac Surgery in Cork, followed by a talk on the New Dementias by Katy Keohane. Gary Lee chaired the first afternoon session and there was good audience participation with a general feeling that the conference was a good focus to start the proceedings.

Many of the class attended the Gala Dinner in the Aula Max that evening which was addressed by the President of UCC Michael Murphy, who spoke on the life of George Boole and his family. UCC will commemorate Boole in 2015, to mark the 200th anniversary of his birth.

On Friday 12th many toured the main UCC

campus, guided by the Visitor Centre and kindly organised by Caroline Waters, and subsequently visited the Medical School in Brookfield and the Western Gateway Building. They were amazed by the developments since 1973, the size and scope of the school today, and plans for the future outlined by John Higgins. (Some had not returned since graduating!)

A group of 8 took the "alternate" tour around Muskerry Golf Course with the help of buggies to tackle the hills. The weather for both tours was very kind, warm and pleasant. Lunch was in the Glucksman Gallery, and the majority of people stayed in the adjacent River Lee Hotel.

The Friday evening dinner in the River Lee Hotel, attended by 51 was hugely enjoyable, and the years melted away instantly as people circulated and caught up with what was going on in each others lives. Only a few had retired, the overwhelming majority were still working full time. Messages from absent classmates who could not attend were read out and there was a fun prizegiving for the golf champions. The outright winner was Fachtina Carey from Cleveland, who achieved 39 points ...well done

Fachtina. "Diamond" Dan Burke toasted those who were no longer with us and ensured everyone present mixed well by moving tables after the main course... Maurice Hickey moved prematurely and mistakenly ate Judy Burke's duck while she had his steak. Good sport Judy!

The meal was lovely and Gary Lee entertained after dinner with memories of our time in UCC and especially of our teachers. Conversations went on well after midnight.

On Saturday morning a remembrance Mass was held in the Honan chapel for the Late Dan O'Donoghue, kindly organised by Joan Aherne, and attended by Dan's widow Anne and his brother Paul who spoke of Dan's love of Fianna Fail, Rugby, Horse racing and of course his family.

Barry and Donna Oliver gave a wonderful impromptu party on Saturday evening for the stragglers (or gluttons for punishment!!)

Those who were unable to attend missed a truly warm and delightful few days. The close links made in Medical School remained strong 40 years on. The sample photos give an indication of the great atmosphere. ■

We were saddened to learn of the death of our dear classmate Prof Benvon Cramer who with her husband Pat Parfrey hosted our 35th reunion in, St John's, Newfoundland.

Alumni Awards



President of UCC Dr Michael Murphy presenting the Distinguished Alumnus Award to Prof John Barrett. Prof Barrett received the award for his role as Chief of Trauma Services at Cook County Hospital, Chicago, USA.

Professor John Barrett

John Barrett (Mb 1969) received the College of Medicine and Health Distinguished Alumnus Award for his exceptional services to patients and to the community in his role as Chairman and Director of Trauma at Cook County Hospital, Chicago. John is a Corkman, graduated in UCC in 1969 and interned in the North Infirmary where the then Professor of Surgery "PK" Paddy Kiely encouraged him to do surgery. He qualified as a surgeon in Ireland, and was awarded MCh in 1975. He became interested in gunshot wounds during his research fellowship in Virginia and published widely on this topic and the effects of shock. He spearheaded the development of a dedicated trauma centre in Cook County Hospital, which required close co-operation with other emergency services. John and his team also worked with political and educational authorities in Chicago, to reduce crime and the use of guns. His unit became famous, not only due to the excellent outcomes, but because it was the model on which the popular TV series "ER" was based. ■



Prof John Higgins, Prof Mary Horgan, Dr Daniel Penny, Dr Liam Plant at the presentation of the Medical School Medal to Dr Penny. Dr Penny received the award for his outstanding services to paediatric cardiology in Melbourne, Vietnam and USA.

Professor Daniel J. Penny Chief of Paediatric Cardiology at the Texas Childrens' Hospital, and Professor of Paediatrics – Cardiology at Baylor College of Medicine, Houston, Texas.

Dan qualified in Medicine from UCC in 1986 and trained in Paediatrics at a number of Irish hospitals. In 1990 he was awarded a British Heart Foundation Junior Research Fellowship at the Royal Brompton Hospital in London, subsequently moving to Melbourne in 1992 as a Research Fellow in Cardiology at the Royal Childrens' Hospital Melbourne, and Monash University. In 1997 he returned to the UK, as Consultant Paediatric Cardiologist at the Royal Brompton & Harefield NHS Trust Hospital and Honorary Senior Lecturer, National Heart & Lung Institute, Imperial College of Science, Technology & Medicine, London. He was subsequently appointed Senior Lecturer in Cardiology, Institute of Child Health, and Consultant Paediatric Cardiologist-Intensivist, Great Ormond Street, London. He returned to Melbourne in 2001, as Chief of Cardiology at the Royal Childrens' Hospital Melbourne. He was a founding Director of the Australia and New Zealand Childrens' Heart Research Centre and was awarded the 'For the People's Health' medal, the highest Award for Healthcare in Vietnam for his work in an international effort to establish a top-level care facility for children and adults with cardiovascular disease in Hue City.

In 2010 he took up his current position in Houston. In February 2014, he delivered the prestigious 12th Annual William J Rashkind Lecture in Paediatric Cardiology, on a topic which encapsulates the ethos of his career: 'How to Build the Ultimate Team.' His research bridges cardiac physiology and clinical studies of congenital heart disease and he has over 100 peer-reviewed Publications. Dan Penny cares for children with complex cardiological problems and their families. He is a Clinician, Researcher and Leader in his field, who has achieved excellence in these roles on 4 continents. He is an outstanding role model for future Graduates of our Medical School, and a most deserving recipient of the 2014 UCC Medical School Medal. ■

Class of 1984 reunion

Dr Sheila Plant

The 30th anniversary reunion took place in Castlemartyr Resort on 12th and 13th September. It was fantastic to meet everyone again in a great venue! 35 of the class attended and there was plenty time to circulate over the weekend. Some went on a walk in the Comeragh hills, some played golf and some just pottered around catching up with old friends.

Perhaps every class feels a warm camaraderie about their own group, but we certainly felt it that special weekend. Sadly, we learned that Jean O'Driscoll's husband, who was at the reunion passed away a few short weeks later. May he rest in peace. ■



University College Cork
School of Medicine

MEDICAL ALUMNI & FACULTY SCIENTIFIC CONFERENCE SEPTEMBER 11, 2014 UNIVERSITY COLLEGE CORK

Brookfield Health Sciences Complex G.10

The Annual Scientific Conference is a multidisciplinary graduate meeting for all medical graduates, staff and friends of University College Cork which is organised by the Medical Alumni Committee.

APPROVED FOR 6 CONTINUING PROFESSIONAL DEVELOPMENT (CPD) POINTS

08.30	Registration	
09.00	Prof Mary Horgan	Welcome from Dean, School of Medicine
Chair:	Dr Peter Kelly (1997)	
9.15	Mr Tom Aherne (1974)	History of Cardiac Surgery in Cork
9.40	Prof Katy Keohane (1974)	The "New" Dementias.....what lies ahead?
10.05	Dr Robert Landers (1989)	Experience of Clinicians in Management
10.30	Dr Clodagh Ryan (1994)	Paediatric haematology advances
10.55	Coffee Break	
Chair:	Dr John Coulter (1989)	
11.15	Dr Raymond Hegarty (1960)	Obstetrics and Gynaecology in the 3rd World
11.40	Dr Aileen Flavin (1984)	Radiation Oncology Training in Nepal
12.05	Dr Rachael Cusack (2014)	<i>Final Year Project</i> A Follow up study of patients treated for alcohol withdrawal in an emergency setting
12.15	Dr Gearoid Fitzgerald (2014)	<i>Final Year Project</i> Antimicrobial stewardship in a Cork Hospital
12.25	Lunch	
Chair:	Dr Gary Lee (1974)	
13.30	Dr Aisling Ryan (1995)	Neuromuscular Diseases in Ireland
13.55	Dr Orla Morrissey (1992)	Safe Living Strategies for the Immunosuppressed Patient
14.20	Prof Ted Dinan (1979)	Brain-Gut-Microbiota Axis and Psychopathology
14.45	Dr Eric Kelleher (2004)	Antibody-mediated encephalitis in First Episode Psychosis
15.10	Coffee Break	
Chair:	Dr Brian Jordan (1972)	
15.30	Dr Conor Bogue (1999)	Radiation Safety in Medical Imaging
15.55	Dr Nuala O'Connor (1986)	The problem of antibiotic resistance - a GP's perspective
16.20	Dr Tony Foley (1995)	Dementia Care in General Practice - Current Challenges & Future Plans
16.55	Prof Katy Keohane (1974)	Closing Remarks
19.30	Wine Reception followed by Gala Dinner - Aula Max	

UCC Medical Alumni and Faculty Scientific Conference 2014

Brain-Gut-Microbiota Axis and Psychopathology

Prof Ted Dinan MD, PhD, DSc Department of Psychiatry and Alimentary Pharmabiotic Centre, University College Cork.

Evidence is accumulating to suggest that gut microbes (microbiota) may be involved in neural development and function, both peripherally in the enteric nervous system and centrally in the brain. There is an increasing and intense current interest in the role that gut bacteria play in maintaining the health of the host. Altogether the mass of intestinal bacteria represents a virtual inner organ with 100 times the total genetic material contained in all the cells in the human body. Surprisingly, the characterization of this extraordinarily diverse population is only just beginning, since some 60% of these microbes have never been cultured. Commensal organisms live in a state of harmonious symbiosis with each other and their host. However, a disordered balance amongst gut microbes is now thought to be an associated or even causal factor for many chronic medical conditions as varied as obesity and inflammatory bowel diseases. While evidence is still limited in psychiatric illnesses, there are rapidly coalescing clusters of evidence which point to the possibility that variations in the composition of gut microbes may be associated with changes in the normal functioning of the nervous system. Studies in germ-free animals indicate aberrant development of the brain monoaminergic system together with memory deficits and autistic patterns of behaviour. These deficits can be partially normalised if there is early gut colonisation.

Recent pre-clinical studies suggest that certain Bifidobacteria may have anxiolytic or antidepressant activity while Bifidobacterium infantis has been found effective in treating patients with irritable bowel syndrome.

Metchnikoff was the first to observe the fact that those living in a region of Bulgaria who consumed fermented food in their diet tended to live longer. He first published his observations in 1908 and this gave rise to the concept of a probiotic or bacteria with a health benefit. That bacteria might have a positive mental health benefit is now becoming clear. Such bacteria may

influence the capacity to deal with stress, reducing anxiety, perhaps positively impacting on mood and are now called psychobiotics. Whether, they are capable of acting like and in some circumstances replacing antidepressants remains to be seen. At a time when antidepressant prescribing has reached exceedingly high levels, the emergence of effective natural alternatives with less side-effects would be welcome. It will be intriguing to investigate if psychobiotics will be beneficial in other psychiatric domains. Indeed, very recently a Bacteroides fragilis given early in life was shown to correct some of the behavioural and gastrointestinal deficits in a mouse model of autism induced by maternal infection.

The mechanisms of psychobiotic action are gradually being unravelled. It has been shown that Lactobacillus rhamnosus has potent anti-anxiety effects in animals and does so by producing major changes in the expression of GABA receptors in the brain. GABA is the most important inhibitory transmitter in the human brain and these are the receptors through which benzodiazepines such as diazepam and various anaesthetic agents act. The changes in these receptors are mediated by the vagus nerve which connects the brain and gut. When this nerve is severed no effect on anxiety or on GABA receptors is seen following psychobiotic treatment. An impact on obsessive compulsive disorder type symptoms has also been reported with a similar strain of psychobiotic. Interestingly, Lactobacillus rhamnosus not only alters GABA receptors in the brain but has been shown to synthesise and release GABA. There is also evidence to support the view that gut bacteria may influence the brain in routes other than the vagus nerve, for example by immune modulation and by the manufacture of short chain fatty acids.

Communication between the brain and gut is bidirectional and complex. Increased understanding of this axis and the role of the gut microbiota may aid the development of therapies not just for functional bowel disorders but for mood disorders also. ■

Teaching Radiation Oncology in Nepal

Dr Aileen Flavin, Consultant in Radiation Oncology, Cork University Hospital

Background: Nepal is a landlocked country with a population of 29 million. It is the 13th poorest country in the world with 78% of the population living below the poverty line. Healthcare is largely self-funded. The fall in the death-rate from infectious diseases and childbirth has led to an increased life-expectancy with a rapidly increasing incidence of cancer. As in other low and middle income (LMI) countries, the commonest cancers are cervical, lung and head and neck. Unfortunately late presentation is common with 80% of cancer patients presenting with advanced disease. For this reason most radiotherapy and chemotherapy is given with palliative intent.

Access to radiotherapy is limited because of the high initial costs of setting up the infrastructure for radiotherapy delivery. There are 6 megavoltage (cobalt and linear accelerator) machines in Nepal (0.5 per million population). Ireland currently has 6 megavoltage machines per million population. As well as a lack of equipment there is a lack of trained personnel, primarily Medical Physicists and Clinical Oncologists.



Bhaktapur Cancer Hospital

My experience of teaching Oncology in Nepal dates back to 2009 when I spent 4 months there doing clinical work and teaching the residents in Oncology. They were extremely keen to be taught as "training" in Nepal is largely just getting on with doing clinical work without supervision. The routine became teaching every day when clinical work was complete. It was apparent that residents' knowledge of basic medical physics which is essential for practicing Radiation Oncology safely was very poor. In 2010 I returned to Nepal with Jim Shaw, a Medical Physicist from Liverpool and Andy Stockdale an Oncologist from Coventry. We ran a one week physics and treatment planning course in the BIR hospital in Kathmandu and in BPK

Cancer Hospital in Bharatpur respectively. Subsequently we arranged for 2 Oncologists to attend an advanced treatment planning course in Cambridge (funded by the Royal College of Radiologists in the UK) and a Medical Physicist to train in brachytherapy in Liverpool. We have made several return visits to Nepal to teach. The residents of 2009/2010 are now the Consultants.

This link with Oncology in Nepal has had benefits for all involved. For those of us working in the UK/Ireland it has made us appreciate not having to deal on a daily basis with patients who cannot afford even the most basic of treatment. The feedback from our Nepalese counterparts is that our support has helped them make some small improvements to the service. Possibly a more important thing for them seems to be a reduction in the sense of professional isolation as, although they lack facilities, they want to keep up to date with Oncology developments. The fact that all of us involved have maintained links is evidence of the satisfaction we have obtained from our involvement in Nepalese Oncology. I would strongly recommend involvement in work in LMI countries to any colleague. The HSE recently have developed a global health section. They are keen to promote twinning of healthcare institutions with those of LMI countries. The Information on these projects is available on www.esther.ie ■



Radiotherapy Department BIR Hospital Kathmandu



The residents

LMIC Missions

Dr Raymond Hegarty



Instead of "Third World" countries one now uses the term "Low and Middle Income" (LMI) countries.

Every year there are hundreds of missions of all types to LMI countries. These missions range from groups of young, motivated students to people who wish to improve the lot of their fellow man/woman, whether in erecting low-cost housing, well digging for potable water, husbandry, teaching of medical/nursing aid. Many are supported by religious denominations, so me of whom, naturally, place some emphasis on the spiritual well-being of those served.

In many cases one has to wonder whether it would be more beneficial to donate the financial costs incurred directly to those in need, keeping in mind that many NGOs have considerable cost overheads and that unscrupulous local warlords may siphon of some or all of the monies and/or supplies donated so that in some cases only a fraction of donations reach their target group.

I would like to write about medical missions in which I have been involved over the last 10 or more years, whether above the Arctic Circle, in the Caribbean or in South East Asia. Each area, obviously, is unique and presents its individual challenges and I once presented a paper on how HELLIP syndrome was managed differently according to the geography, facilities or finances available.

In the last number of years I have worked with two or three parallel groups of dedicated physicians, nurses and paramedics who care for a wide variety of mainly neglected and advanced surgical conditions. The workload is heavy and everybody pitches in. Sometimes I have been the only Gynaecologist in the group, sometimes fortunate to have one or two colleagues. We do no Obstetrics, but I generally cannot keep from poking my nose into the OB area and I generally get involved in teaching the residents who are always so keen to learn new approaches.

We work in a wide variety of locations, often in the Barrios of large and small cities, but always require hospital operating and emergency

accommodation. We bring our own equipment, supplies, medications, etc. The first day (usually Sunday) is spent unpacking and doing patient triage. The first operating day is usually chaotic!

The site is generally chose a year in advance and the local contact physician have been accumulating cases for us over that period of time. Our patients are extremely poor, cannot afford treatment and their diseases are far advanced. Many of them suffer from tuberculosis. Most are skinny which helps enormously as I remove huge ovarian and uterine tumours. Many of the hospitals in the bigger centres are teaching hospitals so there are many keen young residents anxious for surgical experience so I do a lot of teaching and frequently am the first, second or even third assistant on a case.

The hospitals are almost universally grossly overcrowded with beds lining both sides of corridors and post-operative care is carried out by family members. The wards are large with inadequate and dirty toilet facilities, no screens or curtains, narrow beds with no sheets or mattresses and minimal privacy. Patients almost invariably are up and about and eating on the morning following surgery and home second or third day postoperatively despite often major surgery.

Most of the surgeons are my vintage, old dinosaurs who are comfortable managing patients without the benefit of U/S, C/T scan or MRI. We do no laparoscopic work; everything is open surgery. We take over two operating rooms and put two tables in each, hire local anaesthetists (at \$20 per day!) and operate 10 – 12 hours each day. In the emergency department two rooms are also taken over and we put four tables in each to allow for the multitude of minor surgeries performed.

In a little over a year from now I shall be 80 years old and I'm not the oldest in any of our groups! It is difficult to recruit young physicians as they are not used to working under often primitive conditions, with minimal facilities and on advanced pathology. Also, it is quite expensive to cover the cost of travel and accommodation as well as loss of income and ongoing office overheads. So it is quite likely that our missions will cease to exist within another few years. ■

Risk of Seizure Following Symptom-Triggered Therapy Or Standard Fixed Dose Benzodiazepine Treatment For Alcohol Withdrawal In The Emergency Setting

Rachael Cusack

Symptom-triggered therapy (STT) with benzodiazepines for alcohol withdrawal syndrome (AWS) can reduce length of inpatient stay and cumulative benzodiazepine dose by comparison with conventional fixed dose schedules (FDS). This makes STT an attractive option for managing alcohol withdrawal in modern Emergency Medicine services. However, patients in acute alcohol withdrawal, if inadequately treated are at risk of seizures and re-presentation to emergency medical services. We compare the risk of re-presentation to the Emergency Department (ED) with seizure between two groups of patients treated for AWS with STT or FDS therapy.

100 patients were treated with either STT (Diazepam administered up to every 90 minutes when CIWA-Ar score > 10) or FDS (reducing dose of Chlordiazepoxide QDS). Patient manager systems in all three Cork Emergency Departments (ED) were reviewed and attendance at an ED within one week and one month of AWS treatment was recorded.

There was no difference in number of attendances between the two groups either at one week (Fisher's Exact test, 0.233; $p=0.68$) or one month (Fisher's exact test, 0.34; $p=0.76$). There were no ED presentations with seizures in any of the 100 patients within one week of index treatment.

We conclude that patients treated in the ED with STT for AWS are not at an increased risk of early re-presentation to the ED with seizure or other complication of withdrawal. This study provides further support for symptom-triggered therapy for alcohol withdrawal in the Emergency department setting. ■

The "New Dementias"

Catherine Keohane, Neuropathology Dept., Cork University Hospital.

Alzheimer's Disease is the commonest underlying pathology causing dementia in the Western World, and has several well-defined diagnostic pathologic and /or genetic types. These affect about 25% of individuals over 85 years, and the dominantly inherited types tend to have an earlier onset. However, the label of Alzheimer's disease tends to be applied to many people with dementia of unknown cause. In the past 10 years, several different "new" dementias have become recognised, most based on careful post-mortem studies of patients with atypical clinical dementia. Of course these are not really new, they are just newly recognised, because of advances in genetic investigations and development in tissue antibodies which identify cellular proteins involved in neurodegeneration. Amongst these proteins, Tau, FUS (fused in sarcoma), TDP43 (transactive response DNA binding protein) and Ubiquitin proteins are the best studied. As our ageing population increases, and as diagnostic studies improve, the less common forms of dementia have become increasingly important. Additionally, people are more curious about the underlying causes of neurodegenerative diseases (NDD), which have such a devastating effect on the individual. If successful treatments are to be devised, the basic cell abnormalities need to be understood.

Traditionally, NDD have been classified according to clinical criteria and given specific names eg Parkinson's disease, Alzheimer's disease, Motorneurone disease (MND) etc. Because diseases are individually named, we tend to think of them as specific individual entities. However, it is increasingly accepted that there are overlaps and shared features between many NDD, so these disorders are more closely related than previously thought. At a clinical level this can be reflected by different phenotypes with similar genotype, ie one individual in a family presents with features of parkinsonism, while a sibling (with the same genetic abnormality) presents with dementia, and another sibling may have motorneurone features. At a cellular level the pathological changes are identical but may be distributed more heavily in the clinically most affected region. An example of overlap is abnormal accumulation of the same protein (alpha synuclein) within

neurons or glial cells in the central nervous system in apparently different clinical diseases, eg Multiple System Atrophy, Parkinson's disease and Dementia with Lewy Bodies (DLB). Conversely, patients with clinically similar phenotypes eg a combination of parkinsonism and dementia may be due to entirely different protein accumulation, specifically tau or alpha synuclein. The recognition at post-mortem examination that TDP 43 was present in cell cytoplasm inclusions in both MND and some forms of Fronto Temporal Lobar degeneration (FTLD) led to the discovery of a genetic mutation in TDP 43 in familial MND, and is an important further example of "overlap".

Frontotemporal Dementia FTD is estimated to account for 20% of all neurodegenerative dementias. FTD is a clinical term, the main areas affected are the frontal and temporal lobes, well demonstrated by neuroimaging. FTLD describes the atrophy and may be due to different pathologic processes, all of which produce similar clinical effects and are usually indistinguishable in life.

FTLD subtypes based on pathologic features at autopsy include those associated with accumulation of tau, TDP43, and FUS, while other extremely rare types are also described. Some of these are genetically determined and may be inherited, while others are not. The first Irish cases of FUS dementia were described here in UCC/Cork University Hospital in two unrelated patients; both had progressive behavioural disturbance and dementia with early mutism.

Neuropathology has an important role in providing careful examination with close clinico-pathologic correlation in neurodegenerative diseases, using modern techniques to identify cellular changes and sampling brain tissue for genetic analysis, to provide families with accurate diagnosis. ■



Dr John Coulter; Dr Louise Nestor; Dr Rob Landers



Dr Denis O'Mahony; Dr Aileen Flavin



Dr Aidan Daly; Dr Harry Casey



Dr Pat Cogan-Tangney; Dr Eric Kelleher; Dr Corinna Sadlier



Dr Norah Murphy; Dr Joan Aherne



Dr Elizabeth Keane; Dr Paula O'Leary



Dr Clodagh Ryan; Dr Orla Healy; Dr Laura Coyle; Dr Geraldine Peterdy



Dr Joan Power; Dr Mary McLoughlin

Health Research Board Clinical Research Facility Cork (HRB-CRFC)

The ever-increasing complexity and cost of health care in what is a progressively resource constrained and cost-conscious environment has emphasised the absolute requirement for high-quality clinical research to establish the efficacy and cost-effectiveness of medical practice. This requirement extends not only to traditional pharmaceutical based research but also to the entirety of the Health Care System, including lifestyle and dietary interventions, screening programs, diagnostic test performance, medical device development and disease management pathways. It applies as much to the primary care or public health setting as to hospital practice. It is against this backdrop that the Health Research Board Clinical Research Facility at UCC (HRB CRF-C), a HRB and UCC co-funded facility, was established. The goal of the HRB CRF-C is to promote excellence in the design, conduct and analysis of patient focused research and to mitigate to the fullest extent possible all elements of risk associated with the conduct of such research. The strategic development of the CRF-C is based on 7 key objectives.

- Establishing the CRF-C as a centre for safe, high-quality integrated Patient Focused Research.
- Support the growth of a high quality, academic, Patient Focused Research agenda within each clinical speciality that is appropriate to the speciality's available resources and ambitions.
- Facilitate research in the development and commercialisation of Innovative Healthcare developments especially in area of medical devices, diagnostic testing and nutritional products.
- Provide the necessary regulatory, legal, indemnity and risk mitigation structures in a cost-effective and timely fashion so as to allow UCC to serve as legal sponsor for trials/clinical investigations being submitted to a competent authority.
- Establish CRF-C and its affiliated medical centres as a preferred site for conduct of Industry funded Stage 3 and 4 clinical trials which consistently achieve its targets and timelines.
- To integrate existing project-specific trial coordination activities into a central CRF-C supported Research Coordination and Management Unit, with a European wide reputation.
- To develop an educational and mentoring

training and teaching environment that results in a sustainable cohort of responsible, innovative, world class trialists and clinician researchers.

Infrastructure: The main unit of the CRFC is its Adult Research Unit, located in the refurbished St Anthony Ward of the Mercy University Hospital. This was opened by the Minister of Health Dr. James O'Reilly in March 2011. It consists of 2 ambulatory examination rooms, 2 dual-purpose overnight stay/ambulatory exam rooms, a procedure room, a 4 bedded observation/recovery room, phlebotomy suite, specimen processing and storage laboratory, research pharmacy and administrative offices. The facility is capable of handling over 200 comprehensive subject visits per week. We have additional administrative offices in Lancaster Hall where our data management and regulatory affairs staff are based. The CRF-C also supports a dedicated Paediatric Research Unit (the Paediatric Discovery Centre) under the direction of Prof. Jonathon Hourihan, UCC Professor of Paediatrics. This is located on the grounds of the CUH campus, providing dedicated interview and exam rooms and a suitably equipped waiting room in an appropriate child friendly environment. To support the academic activities and academic progression of its senior lecturer staff the CRF-C also has developed a Patient Focused Research Unit that is embedded within the Department of Epidemiology and Public Health. This predominantly supports the education of researchers in the conduct of patient focused research and in particular in clinical trials and is a co-applicant of the HRB Trial Methodology Research Network. The CRF-C has also successfully applied to the UCC Strategic Fund to support the development of a Biostorage Facility, to allow for the secure storage of biological specimens in a dedicated facility with appropriate backed up power and continuous temperature monitoring.

CRF-C Staff: The CRF-C provides the entire range of support services required for the planning, conduct and analysis of patient focused clinical research, including clinical trials of investigational Medicinal Products or of Medical Devices falling under remit of Health Products Regulatory Authority (previously the Irish Medicine's Board). The extent to which an individual project will require specific services varies enormously depending on the extent of the project and the nature of the sponsor.

The Facility full staff complement currently

consists of 23 full time, 9 part time staff and 8 post graduate students. The full time staff include the Clinical Director, Administrator, Business and Facilities Manager, Executive Assistant, Data Manager, Quality and Regulatory Affairs Manager, Trial Monitor, Senior Lecturer in Biostatistics, Clinical Trial Manager, Research Pharmacist, 2 Trial Coordinators, 9 Research Nurses, 2 Research Associates and a Post-Doctoral Fellow. Part time staff include Pharmacovigilance Officer, Senior Lecturer in Research Education, Regulatory Support Officer, Bioinformatics Support Officer, 2 Research Nurses, 2 Research Assistants and a Research Physician. The Facility currently supports 2 MD and 7 PhD students including a PhD scholarship awarded to Ms. Caroline Hurley by UCC's Strategic Research Fund to conduct primary research into differing strategies to monitor clinical trials.

Activities: Since the adult research unit has opened the CRF-C has supported over 51 clinicians across almost all medical specialties; it has assisted in the submission of over 28 academic grants has completed or is conducting a total of 103 projects, over half of which are clinical trials including the recently completed HARP2 trial (testing treatment in patients with acute lung injury) Site PI Dr. Dorothy Breen, Dept. of Critical Care Medicine) which was recently reported in the New England Journal of Medicine. Some studies will only require a single activity such as development of a randomisation scheme, while others require the full support of the CRF-C in all their activities.

The success of the CRF-C to date has been greatly facilitated by the support of its Management Board which oversees all elements of the work conducted and planned by the CRF-C. The Board is chaired by Prof John Higgins (Head of COMH), and includes Prof Anita Maguire (Vice President for Research and Innovation), Ms Nora Geary, (Deputy Corporate Secretary), Dr. Diarmuid Collins (UCC Bursar), and Prof Barry Plant (representing hospital based clinical investigators). The CRF-C has also benefited enormously from the advice and guidance of an Independent multi-stakeholder Advisory Committee, Chaired by Prof Liam Donnelly, former Director of An Teagasc. An interim review panel consisting of 3 international experts was convened by HRB in March 2014 to review and report on the progress made by the CRF-C as of December 2013. The interim panel congratulated the

CRF-C on the substantial progress they have made to date and recommended a further no cost extension of the original grant until July 2017.

One of the most important initiatives which the CRF-C has participated in, under the leadership of the Vice President of Research and Innovation and the Office of Corporate and Legal Affairs has been the development of UCC capacity to serve as the legal sponsor for trials falling under the remit of the 2004 EU Directive. This legislation places a wide range of obligations on both the clinician and on the sponsoring institution, obligations which neither party were historically adequately resourced to conduct. UCC is now the legal sponsor of 4 trials falling under the remit of the directive, including the RESUS-AMI trial, co-funded by HRB and SFI, under direction of Prof. Noel Caplice, examining an innovative adjuvant therapy at time of coronary angioplasty; and ANSWER, under direction of Prof Geraldine Boylan, aimed at providing an automated system to facilitate seizure detection in neonates. In addition, UCC is about to sponsor its first national multicentre trial, 'STRIDER' (PI Prof Louise Kenny, Sponsor HRB) Sildenafil Therapy In Dismal prognosis Early-onset intrauterine growth Restriction.

The CRF-C works closely with several other UCC research initiatives and groups including the UCC Department of Epidemiology and Public Health, Department of General Practice, the Alimentary Pharmacobiotic Centre and the Health Innovation Hub. The Health Innovation

Hub is co-founded by the Department of Health and the Department of Jobs, Enterprise and Innovation and provides a novel and unique conduit to deliver innovative ideas, products and systems into the HSE, with the CRF-C supporting a range of studies aimed at reducing hospital acquired infections. Several of the above mentioned staff are seconded to and support the day to day work of different research groups within UCC, such as the HRB Oncology Clinical Trials unit, the HIP consortium and Eldermet study, and thereby indirectly support these initiatives.

The CRF-C is also contributing to several European 'Framework programme' multinational consortia, including The TRUST (Treatment Results of Uterine Sparing Technologies) study and NILVAD (trial of nilvadipine therapy in Alzheimer's disease), while two such consortia are based within and are directly coordinated by the CRF-C staff: Senator and CFMatters.

SENATOR is led by Dr. Denis O'Mahony, consultant geriatrician Cork University Hospital. The aim of this ambitious project is to develop a robust and efficient software engine (SENATOR) capable of individually screening the clinical status and pharmacological and non-pharmacological therapy of older people with multimorbidity in order to define optimal drug therapy, highlight adverse drug reaction (ADR) risk, indicate best value drug brand for selection and provide advice on appropriate non-pharmacological therapy. The 5 year grant of almost 6 million euros includes partners in

9 EU countries.

CF Matters, led by Prof Barry Plant (Consultant Respiratory Physician) will undertake a randomized multi-national clinical trial across 6 countries to quantify the benefits of microbiome-derived antimicrobial treatments versus current empirical therapy of infectious exacerbations in patients with cystic fibrosis. Simultaneously parallel human host-pathogen interaction studies in sputa, human gut microflora analysis and evaluation of murine exacerbation models will be performed.

Conclusion: the tremendous progress made by the CRF-C over the last 3 years is a testament to the hard work and dedication of numerous clinicians, researchers and academic staff within and affiliated with UCC and of the financial investment by the HRB within this area. These initiatives by improving the health of our sickest patients will improve the health of the population. The future has never been brighter for Patient Focused Research in Cork.

Note to editor: "The Health Research Board (HRB) supports excellent research that improves people's health, patient care and health service delivery. We aim to ensure that new knowledge is created and then used in policy and practise. In doing so, we support health system innovation and create new enterprise opportunities." ■



SENATOR Consortium



Dr Sheila Boland nee O'Connell UCC 1969



It was with great sadness that the news filtered through on July 5th that Sheila passed away after a short illness which she had borne with courage, dignity, and fortitude. Her

faith and strength in this time of adversity was an example to all of us that visited her in those final days. Her good humour and cheerfulness shone through as she tried to console those she loved whom she knew she was leaving on her final journey.

Sheila was the fourth eldest of seven children of Jack and Eileen O'Connell of O'Connell Avenue, Ballinacurra, Limerick. The O'Connell's were a famous sporting and scholarly family steeped in Gaelic tradition and love of music. In her early days Sheila attended Laurel Hill Convent and was awarded a scholarship to UCC where she studied medicine, joining her sister Kathleen and, later, Patricia.

Sheila excelled academically in UCC, graduating with honours. Having interned in St Finbarr's Hospital, she progressed to post of Cardiology Registrar where a serious academic career was beckoning but Sheila chose to return to Limerick and pursued her career in Paediatrics before becoming a Public Health specialist with the Mid Western Health Board. Here she met and married Gerard Boland, a young chartered accountant, who won her heart and with whom she spent 40 joyous years. It is poignant that Sheila was not present to see Gerard conferred with an honorary Doctorate from the University of Limerick in November for his outstanding work and her unstinting support in making Limerick a better place.

Their lives were filled with excitement, challenge, fulfilment and much love. Two of their four children entered the medical field - Gillian a GP in Limerick, and Yvonne a pharmacist in Kilkenny. Her sons John, also a chartered accountant, and Stephen, a videographer live abroad. Throughout her career, she enjoyed the professionalism, kinship and friendship of her many colleagues. She was a wonderful doctor and touched the lives of all those lucky enough to encounter her care.

In her college days she was known as a great beauty, refined and elegant, with a ready wit

and a lovely winning smile. Sheila was a very gentle and kind person and was unassuming despite her many talents; playing the piano at any social occasion, a brilliant seamstress, homemaker, and an accomplished tennis player - she was the proud winner of the 2nd Med tennis trophy. Sheila was a quiet competitor as anyone who played golf against her soon realised once they saw the determination on her face when she sank an 8 foot putt! Sheila had a great love for music and came from a family of talented musicians where family gatherings invariably featured wonderful performances of music and song.

The O'Connell family are eternally indebted to Sheila for the care she bestowed on her parents Jack and Eileen in their declining years. She devoted herself selflessly and entirely to their care for over 10 years and was the keystone in the organisation of her siblings to enable her parents to remain in their own homes.

Sheila spent a lot of time in Kilkee where she was the centre of family fun, musical gatherings and many happy memories. She leaves a deep hollow in the hearts of those who knew and loved her that will be very hard to fill. Sheila is sadly missed by her family and many friends and colleagues. Her memory will be forever cherished.

Hilda O'Shea

Peter Cauty 1942-2014



Peter was born in Cork on July 27, 1942. He attended Primary School at CBC, Cork from where five classmates reunited as medical students, after different secondary schools.

Peter went to boarding school in Castleknock. He entered UCC in 1960 and graduated in 1966. Peter was kept under the watchful eye of his aunt, Dr O'Connor, Senior Lecturer in Ophthalmology during his years in college. She got to know many of his classmates and soon became affectionately known to all as "Auntie Ina". His family moved to Schull as his father was posted there as Manager of the Munster and Leinster Bank. Peter retained a great affection for West Cork and was able later in life to buy a cottage overlooking Schull harbour.

Peter had extraordinary determination and resilience. After graduation he chose surgery

and subsequently settled on the subspecialty of Otorhinolaryngology. He was admitted to the training programme at the Manchester Royal Infirmary in 1970, and was successful in the FRCS (Edinburgh and London) in 1974. Peter's training culminated in his appointment to the MRI as Consultant ENT Surgeon in 1979. His smooth progress was all the more remarkable given that the seventies was a decade of IRA mayhem in Britain. He took his turn as Clinical Director of the service and the Unit developed an outstanding reputation in patient care and surgical training, Peter became a very sought after clinician with a great reputation that extended to Old Trafford. That was a great boon to visiting friends who found themselves watching Manchester United from excellent stand seats.

Peter had a special talent for friendship and he will be missed greatly, of course within his family, but also by a wide circle of friends. His company always lit up a gathering with good humour and a great way of relating to the world. He maintained contact with his college friends, many of whom were entertained in Manchester by Petr and his wife Mary Conroy, who is also a UCC graduate.

In 1998 he retired from the NHS but continued in private practice until 2006. In retirement he was able to spend more time in his beloved Schull. He was a keen follower of rugby and was a regular at Sale, Munster and Irish International games. In 2011 he was diagnosed with cancer but with the help of Mary, remained socially engaged right up to the end, despite many hospital admissions. He died surrounded by this family on June 7, 2014. He would have been very proud of his eldest son's oration at the funeral mass, which was full of humour, affection and sadness for a much loved husband, father, grandfather and friend.

Peter is survived by Mary, his sister Ruth, sons Stephen and Edward, their wives and 6 grandchildren.

John Curtin

We have sadly learned of the deaths of Dr Geraldine O'Sullivan (1975), Prof Benvon Cramer (1974), and Dr Martin Haugh (1957).

International expert on marine safety and survival at sea

Frank Golden: June 5th, 1936-January 5th, 2014



Frank Golden, who has died aged 77, was a Cork-born doctor who became a leading international expert on marine safety and survival at sea.

The sixth of seven children of Henry and Nora (née Murphy) Golden, he was educated at Presentation Brothers College, ("Pres") and University College Cork, a stone's throw from his home on Magazine Road.

At Pres and later at UCC he was a regular on the rugby first XV.

Standing six foot, four inches, he was a lineout specialist and captained UCC to win the Cork Charity Cup in 1960. His undergraduate career was academically unexceptional, in contrast to his postgraduate achievements, which can only be described as stellar.

After internship in Cork, Golden became an assistant in general practice in the UK, where he met his future wife, Jenny Beard.

After a couple of years he joined the Royal Navy on a short-term commission, a decision he said was taken on the advice of his bank manager.

An early posting was as medical officer on HMS Jaguar, a frigate engaged in a courtesy voyage around the world.

He liked to recall a friendly rugby match in Kenya in which he went to the aid of a shipmate outnumbered in an "altercation" and was sent off.

The following day he was reprimanded by his commanding officer for "conduct unbecoming to a gentleman and an officer in Her Majesty's Navy".

He observed later that neither the referee nor the commanding officer knew anything of the etiquette of Munster Cup rugby, where he had cut his teeth.

At the naval air station in Culdrose in Cornwall he became involved in air sea rescues – the Torrey Canyon supertanker grounding in 1967 being one such event. He was frustrated by the lack of medical knowledge

relating to the urgent management of survivors, who frequently succumbed while being winched up to the helicopter or died shortly afterwards in the aircraft.

He enrolled for a PhD in applied physiology at Leeds University, studying the effects of cold immersion on the body. The results of his research helped provide lifesaving strategies for seamen, including development and testing of protective equipment.

He came to be recognised as a worldwide authority on sea survival and was invited to lecture in a multitude of countries to naval, aviation, scientific and recreational groups.

Undoubtedly, the lives of many seafarers have been saved as a result of his energy and application. He retired from the navy in 1993 with the rank of surgeon rear admiral but went on to lecture and continue his research at Portsmouth University alongside Prof Michael Tipton, with whom he wrote *Essentials of Sea Survival* in 2002.

He received multiple awards, including an OBE, and held many honorary appointments – physician to her majesty the queen, lecturer in applied physiology at the Universities of Leeds, Sheffield and Portsmouth, Consultant to several UK government departments and to the RAF, Fellow of the Nautical Institute and Brother of the Order of St John.

He appeared as a guest expert on the BBC, ITV and Discovery channels.

He died peacefully at home in Gosport, Hampshire, after a period of illness borne with fortitude and resignation. He is survived by his wife Jenny, sister Catherine, brother Finbarr, sons Dominic and Damien, daughter Clare, daughter-in-law Maxine, son-in-law Tim, and by his five grandchildren.



Matt Hickey

Matthias C Hickey was appointed to St. Finbarr's Hospital, Cork, as radiologist with a special interest in neuroradiology in 1976 and transferred to the new, then named, Cork Regional Hospital when it

opened in 1979. He worked as a full time neuroradiologist at CRH, subsequently Cork University Hospital, up to his retirement. He was a deeply committed family man and his passing in 2012 after a difficult illness followed an all too short retirement with his wife, Anna and children Oonagh, Conor and Eadine.

Matt, a Cork man, was schooled at Rochestown College and graduated in Medicine from UCC in 1968. While working in Bantry hospital he met his wife Anna, a radiographer. With her encouragement, he decided to pursue a career in the newly developing discipline of neuroradiology. He did his training in Britain, mostly in the North Staffordshire Hospitals Group. This group had at the time a very active neuroscience division and was developing the first post graduate centre outside the Hammersmith Hospital. Matt was appointed consultant at the young age of 29 years. He was very involved in the commissioning of one of the early British CT brain scanners in the North Staffordshire Royal Infirmary. He also worked periods as a consultant in the Netherlands, an experience he enjoyed and fondly remembered.

Things were difficult in Cork in his early years. It was a time of austerity and savage cutbacks, the autonomy of neuroradiology within the wider specialty wasn't recognised. Matt soldiered on and was clinical lead when CT scanning was introduced to Cork. Things became easier when Dermot Ryder was appointed as a second neuroradiologist in 1982. This extra appointment and financial easing allowed an orderly development of the unit. Matt was proud to have been involved in a cross city radiology group that brought MRI scanning to Cork as a public/private enterprise. He regarded a high spot of his career an Irish Neurological Association meeting in Kinsale in 1998. He arranged it with aplomb, down to the highlight when the group was led by a piper from Acton's Hotel to a civic reception in the Town Hall. The troubles in the north were in full spate at the time and one of the delegates from Belfast, a committed Orangeman, wryly commented that he never thought that he would see the day when he had to travel south to march!

Matt was immensely proud of a long association with the Royal National Lifeboat Institute. He served as coxswain to RNLI and put to sea on many rescue missions with the Courtmacsherry lifeboat, often in treacherous conditions. He had many other interests. He had a fine tenor voice and sang in a family barber shop quartet. He was an enthusiastic dancer even as far as line dancing in a powder

blue Stetson hat. He wrote poetry and painted and loved Courtmacsherry. He was at his happiest sitting quietly in his boat out by Horse Rock. In his last years he spent a lot of time with his four grand children and used to lead them on Patrick's day romps around the house while playing the piano accordion.

He was one of a kind. Ar dheis De go raibh a anam.

Michael O'Shea



Michael O'Shea was Cork's first gastroenterologist, appointed to the Bon Secours hospital in 1967. He introduced the gastroscope to Cork and UCC.

Following his school days at the Glasheen National School, Presentation College and Mount Mellery he proceeded to UCC in 1951 and graduated in 1957. He was Auditor of the Medical Society. Following graduation he interned in the North Infirmary.

He was then faced with the choice of returning to Dungarvan to lead the family Tanning business after the premature death of his Uncle, Dr. Austin Casey. However he opted to continue his medical career, and proceeded to house jobs in the Richmond Hospital and Crumlin and on to a residency in George Washington University Hospital in Washington DC. He returned to the Mater Hospital in Dublin, as registrar to Dr. Bryan Alton. He specialised in Gastroenterology and it was in the Mater that the seeds were set for his life long interest in good food and wine at the feet of Dublin's outstanding medical 'bon vivant' and raconteur. In 1965 he obtained a visiting fellowship at Edinburgh Western General Infirmary and in 1968 proceeded to MD in UCD. In 1967 he was appointed General Physician and Consultant Gastroenterologist to the Bon Secours Hospital in Cork. He was also soon appointed as tutor in physiology in UCC and visiting Physician to the Military Hospital, at the Collins Barracks in Cork. He was an active member of the Irish Society of Gastroenterology from its foundation.

He retired in 2005 after 38 years. He was renowned for his good clinical judgement, and a never ending sense of good humour.

In 1969 he married Hilda Fennell, a UCC medical graduate of that year. They were

blessed with 5 daughters, Carol-Ann, Hilda-Clare, Catherine, Sofie and Michelle, and 8 grandchildren.

His non medical interests were many and eclectic, good food and wine, all sports but especially horse racing, opera and music, reading, art and antiques, cooking and travel. Michael had boundless energy and enthusiasm and right to the end enjoyed life to the full. He was great fun; no-one could spin a story like him. At many meetings or receptions colleagues and friends drifted towards Michael's corner of the room to be entertained by his stories, the telling accompanied by so much side splitting laughter and merriment.

Will Fennell

Joan O'Sullivan



Joan O'Sullivan, nee Brown, late of Baltimore, County Cork, was the widow of Emeritus Professor Denis O'Sullivan and mother of Donal, Sheila, Sean, Fergus, Siobhan and Denis.

She was born in Leamington Spa, England. An only child, during WW2 she lived on a farm for a prolonged period, which she loved. Joan O'Sullivan led a full, busy and interesting life. She qualified as an almoner, and in her early twenties while working in Gulson Hospital, England, she met Denis, then a young doctor from Carrigadrohid, Co Cork. They married in 1953.

On moving to Cork in 1962, Joan enduringly helped Denis in vital practical ways in his role as Professor of Medicine, University College, Cork, and in the huge work load which led to Cork Regional Hospital opening in 1978. In spite of his famously long working hours, both loved a good party and Joan was known to be an acute, funny host, as well as being a reader, a gardener and a friend who would step in during an emergency. She was a volunteer with the Citizens Advice Bureau and also worked as a psychiatric social worker.

It showed something of Joan's personality that she actually enjoyed the year she spent in Baghdad with Denis after his retirement, during the height of Saddam Hussein's rule and the First Iraq War. They retired to the West

Cork village of Baltimore in 1992.

Denis' death in December 2010 was a heavy blow, but Joan's resilience, her love of her six children and 13 grandchildren, and such things as her coffee mornings and book club in Baltimore, allowed her to continue to love life. She died in Bantry Hospital, after a short illness, on 23rd July, 2014.

Tim O'Connell

Dr Paul B O Donovan MB 1962

RIP 26/9/2014

Paul O Donovan a graduate of UCC, was born in Dublin but the family moved to Cork where he attended UCC and met his first wife Mona, with whom he shared a great love of opera. They moved to Rochester Minnesota, where Paul did a residency at the Mayo Clinic, subsequently being appointed to the clinical and teaching staff at the Mayo. Due to his interest in physics and working on a research programme with NASA, he had a lifelong interest in medical technology and community education. He moved to Chicago in 1976, joining the staff at Little Company of Mary Hospital and a private practice group with other Mayo Clinic Alumni. He also served on the staff at Northwestern Memorial Hospital and Rush Presbyterian St Luke's Hospital. His life was driven by excellence progress and service to others, but he was an unassuming gracious man who was known to be an expert negotiator and a great thinker. He served as President of the Chicago Heart Association, the South Cook County Heart Association, the Mayo Clinic Global Alumni Association, and was a partner and Fundraiser for the Irish Heart Association. In addition he was a sponsor and designer of the heart exhibit at the Museum of Science and Industry in Chicago and an advocate for equality in health care, serving underprivileged neighbourhoods in Chicago. He published many research papers.

Paul learned to sail on the Lake Isle of Inisfree, sailed regularly on Lake Michigan, and won the Verve cup on his yacht, Fastnet. With his wife Mona, he was a patron of the Chicago Symphony orchestra and Lyric Opera of Chicago. After Mona's death in 1998, he married Carol Rauner, another music lover, and they enjoyed concerts and travel until her death in 2013. In his final years, Paul spent his time visiting the families of his children Hugh, Cliona, Maeve and Emer and his 5 grandchildren. Many people will also know his sister Judy O' Hare, a fellow UCC Medical Alumnus.

AINSWORTH SCHOLARSHIPS SESSION 2015/16



Applications for the above postgraduate Scholarships are invited, from doctors who intend to practise their profession in Ireland, primarily those who are medical graduates of University College Cork.

Full particulars of the Scholarships and of their award may be viewed at:

<http://www.ucc.ie/calendar/scholarship/sch004.html>
(Postgraduate Scholarship section of the College Calendar). Further details may be obtained from Professor Catherine Keohane, School of Medicine, Brookfield Health Sciences Complex, College Road, catherine.keohane@ucc.ie who may be contacted for informal discussion.

The latest date for the receipt of applications is Friday, 20th February 2015.

UCC042 Ainsworth Scholarship 13x2 IMN

PROFESSOR DENIS O'SULLIVAN CLINICAL RESEARCH FELLOWSHIP



Applications are invited for the above Fellowship, open to NCHD-grade doctors and tenable in a clinical department of any teaching hospital of University College Cork.

The Fellowship is for one year from July 2015. It is expected that an applicant will have a specific research proposal, prepared in collaboration with his/her nominated department. Collaboration with basic science and other departments within the University will be encouraged.

Applications will consist of the research proposal, Curriculum Vitae and two references. Applicants should submit six copies of each to:

**Prof. Catherine Keohane, School of Medicine,
Brookfield Health Sciences Complex,
University College Cork, College Road, Cork**

from whom further details may be obtained, and who may be contacted for informal discussion.

**Tel: 021-4901587; Fax: 021-4901594;
E-mail: catherine.keohane@ucc.ie**

Closing Date: January 27, 2015

University College Cork is an equal opportunities employer



**UCC Medical Alumni
Annual Scientific Conference
September 3, 2015
Contact: Rachel Hyland
021 4901587 / r.hyland@ucc.ie**

Contact Details:

Ms. Rachel Hyland, Medical Alumni Association,
Brookfield Health Sciences Complex, College Rd, Cork.

**Tel: +353 (0)21 4901 587 Email: medalumni@ucc.ie
www.ucc.ie/medschool**

Please send us your email address to update our files.

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