Elective in Gastroenterology: A BSG Bursary Report

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My elective at the Szpital w Ostródzie (Ostróda Hospital) in Poland, from 14/07/2025 to 13/08/2025, was driven by a strong interest in gastroenterology and a desire to explore it as a future career. I was keen to see first-hand how the specialty requires a blend of deep specialist knowledge and broad general medical skills, being aware that UK gastroenterology training is dual accredited with General Internal Medicine. I was also eager to use this opportunity to strengthen my foundational skills in acute medicine. My goal was to bridge the gap between textbook knowledge and the practical realities of diagnosing and managing complex GI pathology in an acute setting.

This elective was on an internal medicine unit with a cardiology focus, though in practice it mirrored the highly busy, varied caseload of a UK Acute Medical Unit (AMU). The experience was invaluable, helping me to understand that excellence in gastroenterology and medicine requires a synthesis of diagnostic interpretation, risk stratification, and a deep knowledge of medical and interventional therapies, especially when managing diseases at their most critical stages.

A pivotal case discussion involved an elderly, frail patient (high ASA grade) with what initially appeared to be simple cholecystitis. However, a deeper analysis of the ultrasound revealed a more dangerous picture: echogenic debris consistent with an empyema and, critically, reduced doppler flow to the gallbladder wall, a sign of potential gangrenous change. This interpretation immediately changed the management. Recognising the prohibitive surgical risk, I was involved in a discussion where I learned of advanced, non-operative source control options like percutaneous cholecystostomy or EUS-guided transmural drainage. This case cemented my understanding that the future of gastroenterology and general surgery involves mastering these minimally invasive techniques to provide life-saving care to patients previously considered untreatable or inoperable.

My time on the acute medical unit also provided a stark look at the life-threatening nature of IBD, moving it from the chronic outpatient condition to a time-critical emergency.

I was involved in the care of a patient presenting with severe bloody diarrhoea and significant anaemia. Calculating the severity from the Truelove and Witts' criteria helped justify the immediate need for admission, IV corticosteroids, and vital VTE prophylaxis as IBD is a pro-thrombotic state. This situation underscored the need for rapid escalation to "rescue therapy" if first-line treatment fails and the essential collaboration between gastroenterology and colorectal surgery from day one if needed.

In another patient with known UC, the presentation of abdominal pain with absent bowel sounds was an ominous sign of a paralytic ileus. In this context, this is the possible foreshadowing of toxic megacolon, a surgical emergency. This experience

taught me to recognise the subtle but critical differences that dictate whether a patient needs conservative management or an immediate surgical review.

I also assisted in the assessment of an elderly lady who developed an acutely painful abdomen. My examination findings of absent bowel sounds on auscultation contributed to the high suspicion of a surgical emergency. This was quickly confirmed by a CT scan which revealed a perforation, and the patient was taken for emergency surgery.

Another theme of the elective was the critical interplay between gastroenterology and cardiology. A powerful example was a case of ischaemic colitis, where the underlying cause was a thromboembolism from atrial fibrillation, highlighting how a primary cardiovascular condition can present as an acute GI emergency. This theme of managing systemic complications also extended to critically unwell patients from any cause. The ability to manage these was tested when I performed my first synchronised cardioversion under direct observation on a patient, a skill essential for any physician managing acute emergencies or as part of their general ‘toolkit’. This approach also extended to nuanced prescribing, where we discussed evidence-based approaches, referencing trials indicating a more favourable GI bleeding profile for apixaban over rivaroxaban, another key interface between these two specialties.

Comparing the Polish healthcare system with the NHS provided a fascinating perspective on clinical practice. One of the most critical practical lessons was the importance of vigilance with international lab conventions. Recognising that Haemoglobin is measured in g/dL in Poland versus g/L in the UK is crucial for avoiding serious clinical error.

Beyond lab values, there were other subtle but important differences in the clinical approaches. For instance, the biomarker Procalcitonin (PCT) was frequently used in Poland to help differentiate bacterial from viral infections and to support clinical decision-making in suspected sepsis. This contrasts with the more conservative UK (NICE) approach, which limits its routine use for these purposes. Another interesting difference was in renal medicine, where I noted that dialysis initiation in Poland was often strongly anchored to the eGFR value, whereas UK (NICE) guidance is more explicitly symptom led.

Finally, this elective deepened my biochemical knowledge in a GI/Endocrine context. For example, understanding that iron deficiency anaemia from a slow GI bleed can falsely elevate HbA1c, preventing a misdiagnosis of diabetes. Conversely, in a patient with haemolysis secondary to Wilson's disease, I knew the HbA1c would be falsely low. This level of biochemical insight is crucial for accurate management.

Beyond the hospital, living in Ostróda was a wonderful experience. I took the opportunity to explore the city's rich history, from the Teutonic Castle to the beautiful lake. I was able to reconnect with my Polish heritage and practise my medical Polish.

I would like to extend my sincerest gratitude to the British Society of Gastroenterology for the generous undergraduate elective grant. This financial support was instrumental

in enabling me to undertake this immersive placement. This elective, made possible by your support, transitioned from being a valuable experience into an even greater opportunity for deep, focused immersion in the specialty. It provided an unparalleled platform to develop the clinical reasoning and practical insights detailed in this report, and for that, I am exceptionally grateful.

This elective has greatly strengthened my interest in gastroenterology and helped me understand the qualities I hope to develop as a future doctor. It highlighted the importance of striving to become:

A skilled diagnostician and clinician, comfortable with the cutting-edge techniques needed to treat complex patients.

A holistic physician, who has the general medical skills to manage the systemic nature of digestive diseases.

A critical and evidence-based thinker, who applies a deep pathophysiological understanding to every clinical decision.

I am excited to continue learning and hope to one day contribute to this challenging and rewarding field, providing the best possible care for patients.