Perioperative care for older people
What we need to know and do

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Guy's and St Thomas' NHS Foundation Trust
Deputy Director, Centre for Perioperative Care
President Elect, British Geriatrics Society
Professor of Geriatric Medicine, Kings College London
We have MDTs and so we get the decisions right, don’t we?
- 1 in 7 patients regret undergoing major surgery

Surgery is really safe, isn’t it?
In theatre mortality is 1 in 100,000 (0.01%), but...
- crude 30/7 mortality after major surgery 0.5-5%
- 25% of patients have inpatient complications
- 50% of adverse events in hospital relate to surgical care
- 50% of surgery related harm is preventable

Of all patients in hospital today, how many will have died by 1 year?
- 30% seen across specialties (CLI, EGS, NOF, CUR etc)
The success of health and social care...
...but this means more surgical pathology...

Degenerative
Neoplastic
Vascular

Peripheral vascular disease
...and that means more surgery in older people...

Figure 2: Hospital admissions (finished consultant episodes – a continuous period of care under one consultant) by age and sex, 2018/19

Source: NHS Digital (2020)**

Fowler et al, BJS 2019: 1012-1018 & GIRFT 2022
...so you will be seeing more older people in your clinics...
...and they will have ‘non-surgical’ issues...

Physiological status

Multimorbidity

Unrecognised disease/syndromes

Patient

Behaviour, social & environment

Frailty

Disability

Social network
Clinician reported outcomes
  Morbidity
  Mortality

Patient reported outcomes
  Recovery
  Experience, satisfaction

Process related outcomes
  Harm and complaints
  LOS, readmissions
  Cost

...that mean they are at higher risk of adverse outcome
<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Medical Issues</th>
<th>Lab Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>78 yrs old F</td>
<td>Living alone</td>
<td>No surgery</td>
</tr>
<tr>
<td>Living alone</td>
<td>No support</td>
<td>HbA1c 8.2%</td>
</tr>
<tr>
<td>No support</td>
<td>‘Difficult’ historian</td>
<td>BP 170/88</td>
</tr>
<tr>
<td>‘Difficult’ historian</td>
<td>Osteoarthritis</td>
<td>ECG/CXR NAD</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>Diabetes</td>
<td>Hb 100g/l</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Hypertension</td>
<td>Fatigued</td>
</tr>
<tr>
<td>Hypertension</td>
<td>SOB ?cause</td>
<td>Slow on feet</td>
</tr>
<tr>
<td>SOB ?cause</td>
<td>Anaemia</td>
<td>Slow walking</td>
</tr>
<tr>
<td>Anaemia</td>
<td></td>
<td>Poor strength</td>
</tr>
</tbody>
</table>

**Elective/emergency vascular surgery**

(orthopaedic/vascular/gynae/any)
...and this means she has those worrying issues...

**Poor physiological status**
- Flights of stairs
- DASI
- Gait speed/CPET

**Social determinants/lifestyle**
- Education level/housing
- Overweight
- Minimal physical activity

- 18% of >65 yrs live in poverty
- 70% of >65 yrs overweight or obese
What is a long term condition?

- lasts a year or more
- requires ongoing medical attention and/or limits activities of daily living

Multimorbidity is two or more concurrent chronic conditions

- collectively have an adverse effect on health status, function or quality of life
- require complex healthcare management, decision-making and/or coordination

Why do people get MLTC?

- A common biological aetiology e.g. smoking, lung cancer & IHD
- One can be caused by the other e.g. diabetes & chronic kidney disease
- An association exists e.g. dementia with PD
- Clustering with SE deprivation
...which isn’t surprising, but is harmful...

Harm related to:
- Side effects
- Interactions
- Non-concordance

British Journal of Anaesthesia 2022 128333-342DOI: (10.1016/j.bja.2021.11.011)
Frailty is a **distinctive** health state related to the ageing process in which **multiple** body systems gradually lose their in-built **reserves**.

### Criteria that define frailty

- Weight loss
- Reduced grip strength
- Slow walking speed
- Low level of activity
- Exhaustion

*Fit for Frailty, British Geriatrics Society 2014 A Clegg, Lancet 2013*
...like many of the older surgical population...

20% CFS ≥5

19% REFS ≥7
...and we know that’s bad for you...

- **Clinicin outcomes**
  - Mortality
  - Morbidity

- **Patient reported outcomes**
  - Dependency
  - Experience
  - Quality of life

- **Process related outcomes**
  - LOS, readmissions
  - Financial cost - formal and informal
...across all surgical populations
While there is overlap between frailty and multimorbidity, they are distinct issues.

7 of 10 patients with frailty have MLTC.
3 of 10 patients with MLTC are frail.

Maria is worrying...

Physiological status
Multimorbidity

Patient
Unrecognised disease/syndromes

Behaviour, social & environment
Frailty

Social network Disability

Performance of cardiopulmonary exercise testing for the prediction of post-operative complications in non-cardiopulmonary surgery: A systematic review

Daniel J. Stubbs. Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Validation, Writing – original draft. Writing – review & editing: Lisa A. Groves. Data curation, Formal analysis, Project administration, Writing – review & editing, and An Ecrote. Conceptualization, Project administration, Supervision, Validation, Writing – review & editing.

Gabor Kovacs, Editor

PMCID: PMC6966804
PMID: 3232168
…and what do we know happens to people like Maria?

Declines surgery
- Understanding - Info poorly communicated
- Understanding – Sensory/cognitive impairment
- Health literacy – life expectancy, risk/benefit
- Burden of intervention

Referred for medical opinion
- Anaemia
- Diabetes
- Shortness of breath

Cancelled on day of surgery
- Not followed fasting/medicines instructions
- Concern about medical status (anaemia, SOB)
Or maybe she gets great care (prehab and/or ERAS)...

Prehabilitation; smoking, alcohol, exercise, nutrition counselling

Enhanced care/HDU/ITU
...but back on the ward, this still happens

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Opiates</td>
</tr>
<tr>
<td>Post-op nausea/ileus</td>
<td>On/off ‘sliding scale’</td>
</tr>
<tr>
<td>Hypovolaemic (AKI)</td>
<td>Fluids</td>
</tr>
<tr>
<td>Anaemia</td>
<td>Blood</td>
</tr>
<tr>
<td>Peripheral oedema</td>
<td>Diuretics</td>
</tr>
<tr>
<td>Apathy (Hypoactive delirium)</td>
<td>Anti-depressants</td>
</tr>
<tr>
<td>Functional decline</td>
<td>Carers (Rehab)</td>
</tr>
</tbody>
</table>
What do we need to do differently?

- Screen
- Assess/diagnose/evaluate
- Optimise
- Plan
- Follow through/Hands on care

SDM

The Perioperative Medicine Programme
Adverse postop outcome

Complexity of patient

Complexity of pathway

Paucity of evidence

Outdated funding structures

Traditional attitudes & behaviours

Unprepared workforce

Poor translation
Changing our approach in POA

The question
- Is the patient fit for anaesthetic?
- Is the patient sorted enough to get the best possible outcome?

To get the best possible outcome
Screening in older people in POA

Frailty Cognition MLTC CFS 4AT >8meds
Why bother screening?

Multidomain
Multidisciplinary
Objective tools
Optimisation thro’ hands
on care & follow through

30% higher chance of being alive and in own home
NNT 13 (OR 1.31, CI 1.15-1.49)

https://www.bgs.org.uk/resources/
Using CGA in the perioperative setting...

The POPS Model

Nurse delivered preoperative assessment clinic

Preoperative Anesthetist Clinic

Surgical Outpatient Clinic

Referral based on:
- Surgical complexity
- Multimorbidity
- Geriatric syndromes (e.g., frailty, cognitive disorders)
- Limited functional status
- Difficult decision making

POPS Preoperative clinic
- Multidisciplinary CGA and optimisation
- Prediction of perioperative complications
- Perioperative management plan
- Liaison with surgeons, anaesthetics, primary care and all AHPs involved in pathway

Surgical Admission
- Joint POPS – surgical ward rounds
- POPS CGA and optimisation
- Ward Based MDTMs
- Rehabilitation goal setting
- Discharge Planning
- Family meetings

Emergency Department

Surgical Assessment

Screening through:
- CEPD handover
- Board round
- Structured ward round
- Referrals

Discharge home/rehabilitation unit/care home
- Signposting to primary care / other services

Discharge to Amputee rehabilitation unit
- POPS ward round and MDTMs
...where CGA prompts interventions...

<table>
<thead>
<tr>
<th>Component of care</th>
<th>Proportion of patients (n=500)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>2/3 new diagnosis</td>
</tr>
<tr>
<td>Optimisation</td>
<td>1/2 lifestyle advice</td>
</tr>
<tr>
<td></td>
<td>3/4 meds changed</td>
</tr>
<tr>
<td></td>
<td>1/4 therapy interventions (diet/exercise)</td>
</tr>
<tr>
<td>Communication</td>
<td>1/5 multispecialty discussion</td>
</tr>
<tr>
<td></td>
<td>4/5 anticipation of postoperative complications</td>
</tr>
<tr>
<td>Referral</td>
<td>1/7 preoperative investigations</td>
</tr>
<tr>
<td></td>
<td>1/10 anaesthetic input</td>
</tr>
<tr>
<td></td>
<td>1/20 organ specialty advice</td>
</tr>
<tr>
<td>Anticipatory care planning</td>
<td>1/10 anticipatory care planning</td>
</tr>
<tr>
<td>Long term condition mx</td>
<td>1/3 LTC management referral</td>
</tr>
<tr>
<td>SDM</td>
<td>Documented in 98%</td>
</tr>
</tbody>
</table>

Shahab & Lochrie, JAMDA 2022
15% of patients do not proceed with the surgery initially proposed

23% of our AAA population

TEPs and ACPs

Acknowledgement – Modarai & Tyrell, GSTT
## Perioperative CGA & optimisation for Maria... (multimorbidity, frailty, cog impairment)

<table>
<thead>
<tr>
<th>OA</th>
<th>Pain</th>
<th>Assess/Treat (meds/physio)</th>
<th>NICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>HbA1c 8.2%</td>
<td>Assess/Treat/plan/refer</td>
<td>CPOC</td>
</tr>
<tr>
<td>HTN</td>
<td>BP 170/88</td>
<td>Assess - ABPM/treat</td>
<td>AAGBI</td>
</tr>
<tr>
<td>SOB?cause</td>
<td>Ischaemic ECG</td>
<td>Assess/optimise/refer</td>
<td>ESC</td>
</tr>
<tr>
<td></td>
<td>Anaemia</td>
<td>Diagnose/Iv iron</td>
<td>CPOC</td>
</tr>
<tr>
<td></td>
<td>Deconditioning</td>
<td>Diagnose/Tx/Physio/OT</td>
<td>Nutrition Exercise</td>
</tr>
<tr>
<td>‘Difficult’ historian</td>
<td>Cog impair’t</td>
<td>Diag/assess/plan/long term</td>
<td>NICE, SIGN</td>
</tr>
<tr>
<td></td>
<td>Social issues</td>
<td>Equipment/POC</td>
<td>BGS, CGA toolkit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychological support</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge planning</td>
<td></td>
</tr>
</tbody>
</table>
...supports quality postoperative management...

**Mechanisms**
- POPS Letter
- Nursing handover
- Surgical handover
- Joint ward rounds
- MDTMs
- Physical presence

**Continuity of postoperative care**
- Medical management
- Rehabilitation
- Discharge planning
  - POC, ICT, care home
- Communication
  - Patient
  - Family/carers
  - Primary/community care

- Planned individualised intraop care
- Proactive standardised mx of bowel, delirium, diabetes, fluid balance
- Effective rehabilitation
- Appropriate discharge plans

- Detailed info to anaesthetist
- Admission on day of surgery
For example; whole pathway approach; prevention/management of delirium

- **Identify delirium risk factors**
  - No consensus on prediction tool in surgical setting.
  - Strong evidence for targeting modifiable factors to reduce delirium incidence.

- **BIS monitoring**
  - Targeting a BIS of 40-60 may reduce incidence of delirium.

- **Avoid benzodiazepines**
  - 2-5x increase in delirium incidence when benzodiazepines used peri-operatively.

- **Multi-component interventions**
  - Strong evidence base but implementation gap.
  - Getting the basics right: orientation mobilisation; visual and hearing aids; sleep promotion; bowel function; minimisation of catheters/cannulae; MDT working.

- **Regional anaesthesia**
  - Fascia iliaca blocks in neck of femur patients can reduce delirium incidence.
  - Otherwise, no evidence RA causes less delirium than GA.

- **TIVA**
  - Low certainty evidence that TIVA reduces postoperative cognitive dysfunction.
  - Studies ongoing.

- **Melatonin**
  - Despite a lack of evidence for reducing delirium incidence, likelihood of harm is low.

- **Depth of sedation**
  - Lighter sedation with RA is not proven to reduce delirium incidence.

- **Dexmedetomidine**
  - Attenuating inflammation, likely to reduce incidence.
  - Not widely adopted, limited by the practicalities of applying ICU practice to surgical patients.

- **Treat pain**
  - Pain is likely to be a more potent trigger for delirium than opioids. A multimodal pain management strategy should be employed.

- **Steroids**
  - Limited and inconclusive evidence in delirium prevention.

- **Cholinergic stimulation**
  - Theoretical basis for effect but no conclusive evidence of cholinergic stimulation on reduced delirium incidence. Studies ongoing.

Figure 1 Strategies for reducing postoperative delirium incidence: evidence-based recommendations and areas of ongoing research. BIS, bispectral index; TIVA, total intravenous anaesthesia; RA, regional anaesthesia; MDT, multidisciplinary team; GA, general anaesthesia.

Anaesthesia 2022, 77
(Suppl. 1), 92–101
doi:10.1111/anae.15607
POPS provided across emergency and elective surgery across specialties

**ELECTIVE**
1600 PATIENTS P/A

- Nurse delivered preoperative assessment clinic
- Preoperative Anesthetist Clinic
- Surgical Outpatient Clinic

**Referral based on:**
- Surgical complexity
- Multimorbidity
- Geriatric syndromes (e.g., frailty, cognitive disorders)
- Limited functional status
- Difficult decision making

**POPS Preoperative clinic**
- Multidisciplinary CGA and optimisation
- Prediction of perioperative complications
- Perioperative management plan
- Liaison with surgeons, anaesthetics, primary care and all AHPs involved in pathway

**Discharge home/rehabilitation unit/care home**
- Signposting to primary care / other services

**EMERGENCY**
2400-3000 PATIENTS P/A

- Emergency Department
- Surgical Assessment

**Screening through:**
- CEPOD handover
- Board round
- Structured ward round referrals

**Surgical Admission**
- Joint POPS – surgical ward rounds
- POPS CGA and optimisation
- Ward-Based MDTMs
- Rehabilitation goal setting
- Discharge Planning
- Family meetings

**Discharge to:**
- Amputee rehabilitation unit
- POPS ward round and MDTMs
Factors contributing to poor outcomes

- Complexity of patient
- Complexity of pathway
- Paucity of evidence
- Outdated funding structures
- Traditional attitudes and behaviours
- Unprepared workforce
- Poor translation
- Adverse postop outcome
The evidence...

Year | What happened?
--- | ---
2003 | Start of charity funded project
2005 | (BP) Mainstream funding for POPS service
2008 | (BP) Funding for additional CNS and consultant (2009)
2010 | Used remaining grant funding to secure 1 year research SpR
2011 | Research grant for POPS Vascular RCT
2012 | FY2 became deanery funded, rebadged money for OOPE
2013 | (BP) 3 PAs for the amputee rehab unit
2014 | (BP) Funding for 4 PAs = WTE Gynae POPS CNS
2014 | (BP) 7 Pas for vascular POPS consultant (2015)
2015 | FY programme (with funding for 2 cons but 2 OOPE, 1 cons)
2016 | Vanguard funding for translation to DVH
2018 | (BP) 3 PAs for orthogeriatrics expansion
2019 | (BP) 5 PAs for cardiac surgery
2019 | Funding for POPS@EKHUT
...also in terms of postoperative ward care ...

- Reductions in hospital-acquired geriatric syndromes
  - Delirium
  - Cardiac complications
  - Infective complications
- Benefits also demonstrated in frail subgroup
Organisational factors and mortality after an emergency laparotomy

Oliver et al, BJA 2018

Postoperative geriatric medicine review was associated with substantially lower mortality in older patients

OR 0.35; 95% CI: 0.29-0.42

...now supported by big data studies
Prehabilitation in older people...

Rehabilitation for the Frailty Syndrome: Improving Outcomes for Our Most Vulnerable Patients

Norris, Christina M. MBBS\^1, Close, Jacqueline C. T. MD\^1

Author Information

Anesthesia & Analgesia: June 2020 - Volume 130 - Issue 6 - p 1524-1533
doi: 10.1213/ANE.0000000000004785

Prehabilitation in adult patients undergoing surgery: an umbrella review of systematic reviews

Daniel I. McIsaac\^1,2,3, Marlyn Gill\^1, Laura Boland\^1, Brian Hutton\^1, Karina S. Johnson\^1, Julia Shaw\^1,2, Alexa L. Gudzinski\^1, Natasha Barone\^1, Chelsia Gillis\^1 on behalf of the Prehabilitation Knowledge Network\^1

Preoperative exercise training for adults undergoing elective major vascular surgery: A systematic review

Garry A. Tim, Kim Casey, Gerard Canisut

Published, January 26, 2022 • https://doi.org/10.1371/journal.pone.0290090

Home-based prehabilitation with exercise to improve postoperative recovery for older adults with frailty having cancer surgery: the PREHAB randomised clinical trial

Daniel I. McIsaac, Emily Haidewicz, Gregory L. Bryson, ... Carl van Walraven, Colin J.L. McCartney, Monica Talia

Published: May 17, 2022 • DOI: https://doi.org/10.1016/j.bja.2022.04.006
...maybe missing a critical component?

CGA
Medical, functional, social, psychological

Prehab
Factors contributing to poor outcomes

Complexity of patient
Complexity of pathway
Paucity of evidence
Poor translation
Outdated funding structures
Unprepared workforce
Traditional attitudes & behaviours

Adverse postop outcome
“we want to but it can’t be done at a DGH, because we don’t have…
- the money
- the workforce”

Figure 1. Features of perioperative services provided by geriatric medicine in the UK.

Partridge, Age and Ageing 2014
The money

Preoperative
- Reduced out patient referrals (often to multiple specialties/unnecessary tests)
- Improved shared decision making (less surgery?)
- Better use of workforce – reduced need for parallel services
- Reduced late cancellations
- Increased appropriate day surgery

Inpatient
- Improved quality, reduced medical complications
- Reduced need for level 2/3
- Reduced need for organ specialties & general medical SpRs
- Reduced LOS
- Better use of community services – Virtual wards, Hospital at home, Rehab

Post discharge
- Reduced readmissions across the hospital (heart, lungs, kidneys, brain
- Reduced postoperative referrals to surgery and medicine
- Reduced long term complications
- Better recovery/rehabilitation
The money; academic literature...

Preoperative

- Reduced outpatient referrals (often to multiple specialties/unecessary tests)
- Improved shared decision making (less surgery?)
- Better use of workforce – reduced need for parallel services
- Reduced late cancellations
- Increased appropriate day surgery

Inpatient

- Improved quality, reduced medical complications
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Post discharge

- Reduced readmissions across the hospital (heart, lungs, kidneys, brain)
- Reduced postoperative referrals to surgery and medicine
- Reduced long term complications
- Better recovery/rehabilitation

CGA after hip fracture showed reduced total cost

CGA is a cost-effective substitute for standard preoperative care in elective arterial surgery
Mean total pre- and postoperative healthcare utilisation costs ~£1,165 lower for CGA patients


Preoperative comprehensive geriatric assessment and optimisation prior to elective arterial vascular surgery: a health economic analysis

Judith S L Partridge 1,2, Andrew Healey 3, Bijan Modarai 4,5, Danielle Harari 1,2, Finbarr C Martin 2, Jugdeep K Dhesi 1,2,6

Affiliations + expand
PMID: 34120179 DOI: 10.1093/ageing/afab094

Cochrane Library
Cochrane Database of Systematic Reviews

Comprehensive geriatric assessment for older people admitted to a surgical service (Review)
Eamer G, Taheri A, Chen SS, Daviduck Q, Chambers T, Shi X, Khadaroo RG
Length of stay (mean 13 median 9)(↓ 4 days)
30 day readmission rate (↓ 13.2%)
Consults (↓ 18%)
Medication reviews (↑ 51%)
Coding/recognition complications
Coding comorbidities ↑

The workforce

AHPs
- Curriculum, Competency framework
- E-learning & face to face
- LSBU MSc

FY
- Modular training programme
- From contemplation to recovery

Specialist
- Curriculum
- OOPE/T
- Darzi fellows

National/International
- E-learning modules
- MSc
- POPS conferences
Translation is happening...

- Response rate 127 of 152 NHS hospitals (88%)
- Preoperative clinics = 37
  20 existing clinics
  14 dedicated ger med
  3 jt clinics (anaes & ger med)
- Increase in
  - joint meetings
  - joint guidelines
  - surgical directorate funding

Joughin et al Age & Ageing 2019
Translation is happening, supported through NHS Elect POPS@ network

Provision of
- Toolkit (all resources)
- Coaching and mentoring
- Support with measurement for improvement

Focus on
- Establishing early adopters
- Developing regional centres
- Ensuring sustainability
- Providing forum for health services research

And internationally!

<table>
<thead>
<tr>
<th>Cohort 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Addenbrooke’s Hospital, Cambridge</td>
</tr>
<tr>
<td>2. Darent Valley Hospital, Dartford</td>
</tr>
<tr>
<td>3. Frimley Park Hospital, Frimley</td>
</tr>
<tr>
<td>4. Northwick Park Hospital, London</td>
</tr>
<tr>
<td>5. University Hospital of Wales, Cardiff</td>
</tr>
<tr>
<td>6. Wirral University Teaching Hospital, Birkenhead</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cohort 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. King’s College Hospital, London</td>
</tr>
<tr>
<td>2. Morriston Hospital, Swansea</td>
</tr>
<tr>
<td>3. Royal Devon and Exeter Hospital, Exeter</td>
</tr>
<tr>
<td>4. University College Hospital, London</td>
</tr>
<tr>
<td>5. University Hospital Lewisham, London</td>
</tr>
<tr>
<td>6. West Suffolk Hospital, Bury St Edmunds</td>
</tr>
<tr>
<td>7. Whips Cross University Hospital, London</td>
</tr>
</tbody>
</table>
The need for cultural and policy change
Improving care from moment of contemplation of surgery until recovery...
...needs integration of all forms of evidence based practice & implementation
Improving outcomes for older/high risk surgical patients requires a multimodal approach.

- Addressing complexity of patients
- Developing pathways
- Producing evidence
- Ensuring translation
- Preparing the workforce
- Changing attitudes and behaviours
- Integrating funding structures

Improved postop outcome
Resources

- British Geriatrics Society POPS SIG [www.bgs.org.uk](http://www.bgs.org.uk)
- CPOC (@CPOCnews [www.c poc.org.uk](http://www.c poc.org.uk) )
- CPOC/BGS periop guidelines [www.bgs.org.uk](http://www.bgs.org.uk)
- Frailty, delirium and POPS eLearning module [www.bgs.org.uk](http://www.bgs.org.uk)
- UCL Perioperative Medicine MSc
- NHS Elect POPS network jugdeep.dhesi@gstt.nhs.uk
- NHFD, NELA
- POPS, CPOC, EBPOM, RCoA conferences

jugdeep.dhesi@gstt.nhs.uk
@JKDhesi
@POPS_GSTT
@CPOC_News