The goal of measuring patient satisfaction in this review was to ensure that the benefits on efficiency and physician satisfaction did not come at the expense of patient experience, as this could have major implications for patient outcomes. Overall, patient satisfaction remained unchanged, and in some cases improved, indicating human scribes are viable from a patient's perspective.

Conclusions: Incorporation of medical scribes is associated with increased physician efficiency and reduced documentation time. Medical scribes may mitigate the need for increased numbers of physicians to cover current gaps in care seen in Canada, while also playing a protective role for physician mental health.

Keywords: medical scribe; physician efficiency; administrative burden; physician satisfaction; burnout

Echocardiographic hemodynamic outcomes and prosthesis–patient mismatch after transcatheter aortic valve implantation in patients with class III obesity: a province-wide retrospective cohort

A. Kamal, O. Elkhateeb

Background and Objectives: Class III obesity (BMI ≥40 kg/m^2) is increasingly common among patients undergoing transcatheter aortic valve implantation (TAVI), yet post-procedural hemodynamics and prosthesis–patient mismatch (PPM) are poorly characterized in this population. Because PPM is graded by indexing effective orifice area (EOA) to body-surface area (BSA), adiposity may inflate its apparent prevalence. We aimed to characterize within-patient hemodynamic change and its durability after TAVI, and to determine how PPM prevalence depends on its definition.

Methods: Retrospective cohort of 84 consecutive patients with BMI ≥40 undergoing TAVI at the QEII Health Sciences Centre between 2013 and 2025. All echocardiograms performed across the Nova Scotia provincial system (11 hospitals) were reviewed and 828 studies extracted. Analyses used standard resting transthoracic studies; valve-in-valve procedures (n=12) were excluded, leaving 72 patients. Within-patient change in mean and peak aortic gradient and dimensionless velocity index (DVI) was assessed from the closest pre-TAVI baseline to the earliest post-TAVI study, and durability from earliest to last post-TAVI study (Wilcoxon signed-rank). PPM was classified using measured EOA (continuity equation) and predicted EOA (published core-laboratory reference values for the implanted valve model and size), each indexed to pre-TAVI BSA, under conventional (≤0.85/≤0.65 cm^2/m^2) and obesity-adjusted (≤0.70/≤0.55 cm^2/m^2) thresholds.

Results: A pre-TAVI baseline was available in 71 of 72 patients (median follow-up 2.1 years). From baseline to earliest post-TAVI study, mean gradient fell from 41.8 to 11.7 mmHg (median change −29.2 mmHg [IQR −37.8, −21.7]; n=70), peak gradient fell by 50.8 mmHg [−63.6, −36.1] (n=68), and DVI rose from 0.25 to 0.52 (+0.25 [+0.22, +0.35]; n=51); all p<0.001. Among patients with two or more post-TAVI studies, mean gradient was unchanged between early and last studies (+1.3 mmHg, p=0.31), with minor changes in peak gradient (+4.0 mmHg, p=0.02) and DVI (−0.05, p<0.001). At last follow-up, paravalvular regurgitation (graded in 39 patients) was absent in 13, trace in 13 and mild in 13; total aortic regurgitation (n=71) was absent in 41, trace in 23 and mild in 7, none was moderate or greater. Six of 72 patients (8%) met the VARC-3 gradient criterion for moderate hemodynamic valve deterioration. By measured EOA (n=49), moderate-or-severe PPM was present in 51% (severe 29%) by conventional and 35% (severe 14%) by obesity-adjusted thresholds. By predicted EOA (n=67), corresponding rates were 70% (severe 7%) and 13% (severe 0%). Self-expanding valves had larger predicted indexed EOA than balloon-expandable valves (median 0.87 vs 0.76 cm^2/m^2, p<0.001).

Discussion: Post-TAVI gradients fell within published normal ranges, yet PPM prevalence depended on its definition: by conventional measured criteria, severe PPM was over twice the STS/ACC TVT Registry rate (12%), but this excess largely resolved with obesity-adjusted thresholds and predicted EOA. Apparent PPM despite low gradients suggests over-indexation, as adipose tissue inflates BSA without proportionate flow demand.

Conclusions: TAVI provides effective, durable hemodynamic relief in class III obesity. PPM prevalence varies several-fold with its definition, and conventional criteria classify many patients with normal gradients as mismatched. Correlating each PPM definition with clinical outcomes is the next step to establish which is prognostically meaningful.

Keywords: transcatheter aortic valve implantation; class III obesity; prosthesis–patient mismatch

Long-term Outcomes of Non-Operative Management for Achilles Tendon Ruptures: A >10-Year Follow-Up

A. Marshall, E. Liu, B. Burgeson, J. Morash, M. Glazebrook

Background and Objectives: Achilles tendon rupture (ATR) incidence is rising, and non-operative management is increasingly favored given comparable short- and mid-term outcomes to surgical repair with fewer risks. However, data beyond 10 years remain limited. This study evaluated long-term function, satisfaction, symptoms, and re-rupture rates in patients treated non-operatively for acute ATR injuries more than 10 years prior and compared long-term function to previously documented 1-year outcomes.

Methods: This retrospective cohort study identified 69 patients treated non-operatively for an acute ATR at the Halifax Infirmary (QEII Health Sciences Centre) between 2011 and 2015, all with documented 1-year follow-up. Long-term outcomes were collected via structured telephone interview at a minimum of 10 years post-injury. Assessments included evaluation of the Achilles Tendon Total Rupture Score (ATRS), patient satisfaction, reported pain, rates of re-rupture, and return to pre-injury activity.

Results: 34 of 69 patients (53%) completed long-term follow-up, with 23 male respondents (67.6%) and 11 females (32.3%). The mean age of patients was 42.5 years at the time of injury, with an average follow-up time of 12.8 years post-injury. The majority (85%) of injuries were sport related. Two re-ruptures occurred (5.9%), both traumatic and both within the first post-injury year, with none thereafter. ATRS improved from 83.9 at 1-year to 92.4 at long-term follow-up (mean difference +6.8, $p=0.0066$). Patients with lower 1-year scores showed the greatest further gains ($p<0.0001$), indicating that improvement was not limited to patients who were already doing well at 1 year. Long-term ATRS correlated strongly with satisfaction ($r=0.76$, $p<0.0001$), which averaged 8.8/10 overall. 11.8% of patients indicated they still experience persistent pain, although the reported pain levels were low (<5/10 for all participants, with an overall mean pain score of 0.3/10), and 70.6% returned to their pre-injury activity level. Patients reporting persistent weakness had significantly lower long-term ATRS (86.4 vs 96.2, $p=0.042$) and satisfaction (7.8 vs 9.4, $p=0.042$) than those without weakness.

Discussion: The functional recovery of ATR patients treated non-operatively continued to improve beyond 1-year post-injury, challenging the assumption that recovery plateaus at that point. Re-rupture risk was confined to the early post-injury period, with no late failures after more than a decade, supporting tendon durability once healed. Although approximately one-third of patients did not return to pre-injury activity, high satisfaction and low pain persisted, suggesting factors beyond tendon function, such as age, confidence, and lifestyle, may drive activity decisions more than physical limitation. These findings extend non-operative outcomes well beyond the short- and mid-term horizon reported in most existing literature.

Conclusions: Non-operative management of acute ATR provides durable functional benefit beyond 10 years, with low pain, high satisfaction, and re-rupture risk isolated to the first year after injury. These findings support non-operative treatment as a safe and effective long-term management strategy for most patients with acute ATR.

Keywords: Achilles tendon rupture; non-operative management; long-term outcomes

Pregnant and early postpartum individuals' perceptions of gestational weight gain interventions: a systematic review of qualitative evidence

C. Cameron-Hamilton, H. Piccinini-Vallis

Background and Objectives: Current guidelines for gestational weight gain (GWG) are based on pre-pregnancy body mass index. Guideline-discordant GWG is associated with adverse outcomes for mother and baby during pregnancy, delivery and beyond. Excess GWG is common, affecting 37-51% of pregnancies globally. Numerous interventions have been designed to address excess GWG, with mixed results. It is evident that interventions must be aligned with a holistic approach, be equitable, accessible, relevant, and non-stigmatising. This study aimed to explore pregnant peoples' perceptions of interventions designed to curb GWG through a systematic review of qualitative research to inform future intervention design.

Methods: Data were collected via systematic search of Medline via Ovid, CINAHL, PsycInfo, and Embase. Title and abstract screening, followed by full text review with predetermined inclusion and exclusion criteria, were conducted by two independent reviewers using Covidence. The Mixed Methods Appraisal Tool was used for critical appraisal. Data were extracted deductively using the COM-B (capability, opportunity, motivation) model as a guiding framework and categorizing into factors that encourage intervention participation (facilitators) and factors that challenge intervention participation (barriers). Inductive themes were then generated within each COM-B domain.

Results: The initial search yielded 6,378 records. After removal of duplicates, title and abstract screening, full text review, and quality appraisal, thirty-five studies remained for data extraction. The included studies covered a range of intervention types, delivery methods, and participant contexts.

Participant perceptions involved factors mapping to all domains of the COM-B model that acted as barriers and facilitators. Opportunity and reflective motivation factors were significant. Capability was less present throughout participant data, although physical capability barriers appeared to strongly influence participant engagement.

Discussion: The uneven distribution of factors is likely multifactorial. It is possible that capability factors are underrepresented due to primary studies focusing on reflections pertaining to the intervention and not participant capacity. Likewise, motivation plays a unique role in behaviour during pregnancy, and many interventions used motivation-based techniques such as goal setting. Thus, data from primary studies may reflect this intentional focus. However, it appears that motivation factors alone are not sufficient to drive behaviour.

Within the opportunity domain, barriers and facilitators notably referenced the patient-provider relationship across multiple themes, highlighting the importance of this relationship in supporting pregnancy. Across all domains, but particularly within opportunity, facilitators were not always simple inverses of barriers, suggesting that optimisation requires more than removing constraints.

Conclusions: Interventions to address excess GWG are highly heterogenous, and participant experiences vary widely yet reflect discrete themes. The COM-B model is a useful framework for understanding GWG intervention experience across intervention types. Future intervention designs should account for the range of COM-B factors identified and work towards actively incorporating facilitating factors, not simply removing barriers.

Keywords: pregnancy; gestational weight gain; systematic review