pulsetoday.co.uk

PULSE

18.07.12
Issue 25 | Volume 72

BriefingMedia

At the heart of general practice since 1960

GPs outnumbered on nearly half of CCG boards

Just one in five board members a GP in some areas amid mounting concern over costs

EXCLUSIVE
By Gareth Iacobucci

GPs have taken less than half of the seats on the new boards of CCGs, and in some parts of the country make up just a fifth of board members, a Pulse investigation reveals.

Our analysis of more than 1,300 board positions, based on data released under the Freedom of Information Act from 100 CCGs, shows practices risk being forced out of the commissioning process as CCGs struggle to keep down costs, minimise conflicts of interest and engage grassroots GPs. In some areas, financial restraints have forced CCGs to actively cut the number of GPs on their boards, despite health secretary Andrew Lansley's insistence that it is GPs who are 'best placed' to improve NHS commissioning.

EDITORIAL ▶
GPs must sit in the driving seat 17

The analysis is the most comprehensive to date of the leadership of CCGs, which will assume responsibility for commissioning from April 2013. It reveals the full impact of the 'pause' in the health bill's passage through Parliament, when CCGs were told to include more non-GPs.

Overall, responses from 100 CCGs showed that GPs held 645 out of 1,325 board positions (49%), with five CCGs unable to confirm their board's composition. Managers and finance officers accounted for some 267 positions, alongside 140 lay members, 65 nurses, 50 public health representatives, 46 from local authorities, 42 practice managers and 70 other members. In some areas, GP representation reached as high as 88%, but on 44% of CCG boards fewer than half of members were GPs. Across the country, just a third of CCGs' accountable officers were GPs.

Dr Guy Mansford: smaller CCGs forced to reduce GPs on board to cut costs

CCGs with the lowest proportion of GPs included Nottingham West, which had two GPs (20%); Bury, with three GPs (21%); and Newcastle, also with three GPs (21%). In contrast, Medway, Sandwell and West Birmingham CCGs each had GPs in at least 75% of board seats.

Dr Guy Mansford, clinical lead and deputy chair of Nottingham West CCG, told Pulse practices in his area had agreed to cut the number of GP board members from five to two to reduce costs and the likelihood of the board being accused of having a conflict of interest: 'With a large board there is a massive workload for governance, and innovation was just going out of the window. For small CCGs trying to live within the £25 per head budget, it is very hard to do everything.'

Bob Senior, head of medical services at RSM Tenon and chair of the Association of Independent Specialist Medical Accountants, said the £25 management allowance was a factor in the composition of many boards: 'The economies of scale don't work so smaller [CCGs] are having to use that money judiciously, which means you can't have quite as big an involvement from GPs.'

But Dr George Rae, secretary of Newcastle and North Tyneside LMC, said the balance had swung too far: 'If it is GP-led commissioning, the correct balance isn't GPs in the minority. There are other people who have to have input, but we must not sell ourselves short.'

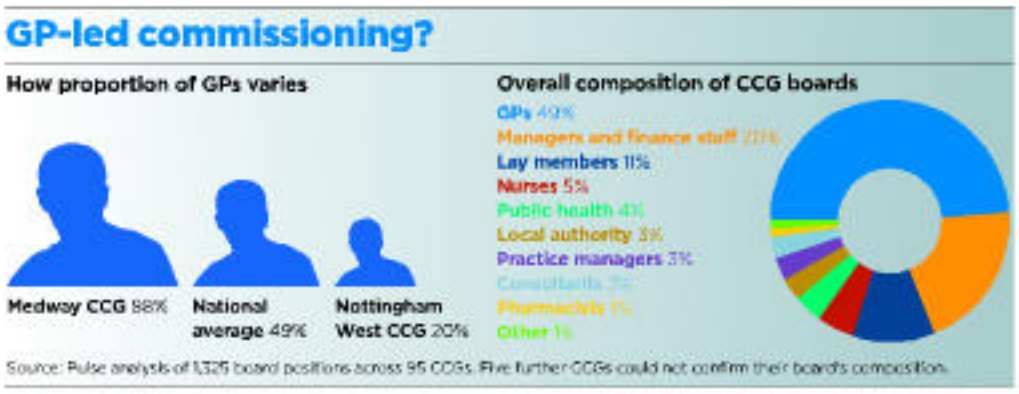
GPC negotiator Dr Chaand Nagpaul said: 'We have seen the failings of diminishing the GP presence on boards with PCTs. We need to learn the lessons and ensure the GP presence isn't being diluted.'

A Department of Health spokesperson said: 'Beyond the core requirements set out in regulations, it is up to GP practices to decide on the composition of their CCG's governing body.'

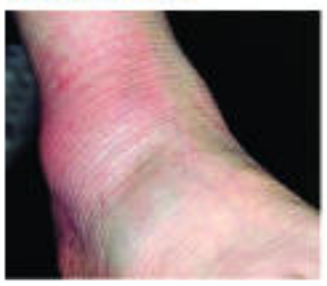
@garethiacobucci

▶ Full analysis on pages 2-3 and online at pulsetoday.co.uk/ccgboards

GP-led commissioning?



Source: Pulse analysis of 1,325 board positions across 95 CCGs. Five further CCGs could not confirm their boards composition.



The week in general practice

INSIDE

MORE ONLINE

▶ pulsetoday.co.uk/news

Older GPs could be shunted into 'back-office' roles under plans tabled by the Government to reduce the impact of its pension reforms

▶ pulsetoday.co.uk/practicenews

CCG investigation

Use our interactive map to see who's heading up CCGs near you

▶ pulsetoday.co.uk/ccgboards

Video of the week

Watch our video on preparing an emergency kit for your surgery

▶ pulsetoday.co.uk/videos

PULSENEWSEXTRA
CCG INVESTIGATION

ELECTIONS

CCG leaders won't face new elections

Most CCGs to ignore GPC demand for fresh elections

EXCLUSIVE

By Gareth Iacobucci

Most GPs will be denied the chance to re-elect their representatives on their CCG board before it takes on commissioning responsibility, Pulse's investigation has found.

Our analysis of 100 CCGs gathered data on the appointment process for 480 GP board positions and found more than three-quarters have been subject to elections to date.

But just a third of these positions will be put up for re-election once CCGs are fully authorised, despite the GPC's insistence that fresh elections are necessary to ensure CCGs have a proper democratic mandate before they become statutory bodies.

GPC chair Dr Laurence Buckman warned in April that GPs on shadow CCG boards should not be automatically transferred to CCG boards.

The figures, obtained through the Freedom of Information Act, show that 75% of GPs currently on CCG governing bodies have been elected, although two-thirds stood unopposed.

But only 25% will face re-election once authorised, with the remaining CCGs having no plans to re-elect board members before April 2013.

Dr Nigel Watson, chair of the GPC's commissioning and service development subcommittee and chief executive of Wessex LMCs, said shadow board members must be re-elected: 'People have been appointed into shadow roles. These may be the right people, but they can't take that for granted. We don't see how people can assume they will become the statutory representatives.'

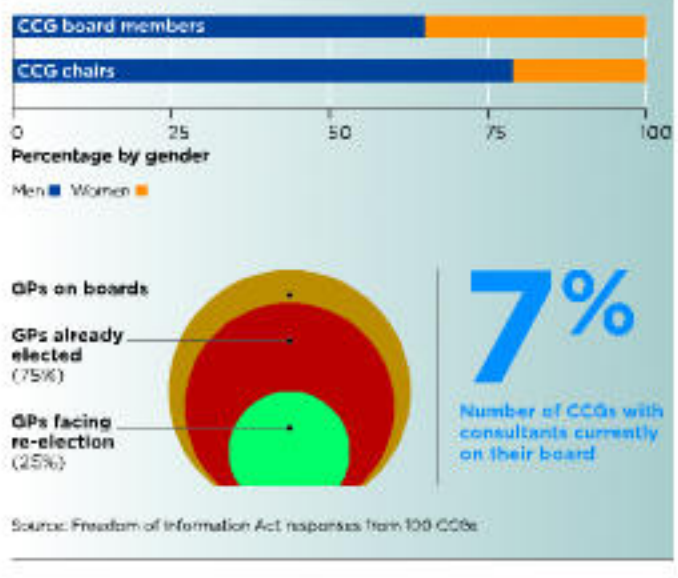
Dr Watson added it was up to LMCs and practices to make sure CCGs were established on firm democratic footings.

Dr Sarah Schofield, chair of West Hampshire CCG, said: 'My CCG has made it clear we were elected in shadow form and had to go back to the electorate. I think the membership organisations will need to decide the difference between shadow and live boards.'

But Dr Catti Moss, a GP in Guilsborough, Northamptonshire, said: 'With our local CCG the board members were appointed in a shadow role, but it was clearly with the intention they should continue. You do need some continuity.'

@ggarethiacobucci

Who's sitting on CCG boards?



BMA to consider 'all

BMA Council members have insisted 'all options' for future industrial action are still on the table as the union battles to maintain the momentum of its campaign against the Government's pension reforms.

Ahead of this week's crucial council meeting in Edinburgh, BMA Council members said they were determined to keep up the pressure on ministers, but admitted there were 'mixed views' on whether to take more action.

The meeting will decide the next steps for the BMA, with council members due to consider feedback on last month's 'day of action'. But it comes after the Treasury announced it was to press ahead with legislation to implement the pensions deal.

BMA council member and GPC deputy chair Dr Richard

Dr Sarah Schofield: shadow CCG board will face re-election

GPs reject new boundaries

EXCLUSIVE

By Madlen Davies

Scores of practices are refusing to extend the outer boundary of their catchment area by using a loophole in the Government's scheme to increase patient choice, Pulse can reveal.

PCT figures show many practices have opted not to alter their catchment areas, despite the Department of Health insisting they can only do this in 'exceptional circumstances'.

A further three-quarters of PCTs failed to agree outer boundaries with GP practices by the DH's 1 July deadline.

The figures come as the latest blow to the Government's scheme to allow patients a greater choice of GP practice, with Pulse revealing last month that only 12 patients had decided to register out of their area under pilots in three cities.

All practices in England were required under the 2012/13 GP contract to agree an outer boundary with their PCT by the beginning of this month. However, DH guidelines allowed practices with large boundary areas to exempt themselves, but only in 'exceptional circumstances'.

Information from 25 PCTs responsible for 1,700 GP practices shows a fifth (21%) have agreed an outer boundary, while almost three-quarters (73%) have still not reached agreement.

To date, 81 practices (5%) have asked for an exemption on a new outer boundary for their surgery, although in some areas they are coming under pressure to reconsider.

In Leeds, 18 practices have refused to provide a new outer boundary and 46 are still negotiating with the PCT, while in Dudley seven practices have declined to extend their catchment area.

A spokesperson for NHS Dudley said: 'The PCT is reviewing these practices, which will involve further discussions with GPs. If there was a difference of opinion, it would be escalated to the Black Country Cluster functions committee for further decisions.'

'Practices have more important things to do at the moment' Dr Richard Vautrey

Dr Tim Horsburgh, medical secretary of Dudley LMC, told Pulse practices had valid concerns about a possible rise in workload: 'Expanding the outer boundary isn't just a fuzzy extension to incorporate existing patients, they're actually just expanding GP practice boundaries. Suddenly they'll have thousands of new patients with no provision or planning on how they're going to provide the extra service.'

Dr Richard Vautrey, GPC deputy chair, said it was not surprising so few practices had fulfilled the DH's request: 'Both practices and PCTs have more important things to be doing at the moment, and so agreeing an outer boundary is not seen as a priority. It is no surprise that many have yet to do this.'

A DH spokesperson said: 'GP practices and PCTs should have discussed and agreed outer boundary areas by now.'

@madlendavies

CONSULTANTS

Consultant posts vacant

Only 7% of CCGs have appointed a secondary care consultant to their board, amid signs they are struggling to meet the Department of Health's requirement for each board to include a consultant.

The stipulation came after pressure from secondary care to have a greater say in how services are commissioned, with ministers insisting consultants must come from outside CCGs' boundaries to avoid conflicts of interest.

But only 36 out of 100 CCGs have reserved a position for a secondary care doctor – and just seven of these positions have been filled.

Dr Chaand Nagpaul, GPC negotiator, said the restriction on local consultants 'didn't make logical sense': 'There is little incentive for a consultant to be travelling across the country to provide advice to PCTs, whereas there would be every reason why a local consultant would want to work with local GPs to improve health services. Even PCTs had local consultants on their boards.'

But a DH spokesperson said: 'The non-GP members of the governing body are there to provide an independent perspective and help ensure good governance. SHA and PCT clusters are supporting CCGs in identifying candidates for these important roles.'

GENDER

Third of leaders women

Only a third of CCG board members – and just a fifth of GPs on boards – are women, according to Pulse's analysis.

Our investigation found a clear majority of CCG board seats are currently occupied by men, with just 35% of 1,153 identifiable board positions held by women, and only 21% of chair posts. In total, the 100 CCG boards analysed were comprised of 398 women and 755 men.

Among GPs, the disparity was even more marked, with just 21% of GP board positions taken by women.

Dr Clare Gerada, RCGP chair and a GP in Lambeth, south London, said: 'It is the usual issues. I suspect a lot of boards are taken up by the old guard, and the old guard were predominantly men. It may also be, of course, that the women prefer to stay in the surgery and see patients.'

MORE ONLINE
Full investigation results
pulsetoday.co.uk/ccgboards

options' on pensions

Vautrey said: 'We will assess the issues at the meeting. All options [for action] are still there.'

Dr Peter Holden, BMA council member and GPC negotiator, said: 'For a long time, doctors have not taken industrial action. This reminded [the Government] we can't be taken for granted. There are mixed views [on whether to repeat it], so we need to see sampling and reports.'

New BMA chair Dr Mark Porter was due to meet health secretary Andrew Lansley before the meeting, but the Department of Health said it was an introductory meeting and there would be no negotiations on pensions.

MORE ONLINE
For the latest on what the BMA decides, go to
pulsetoday.co.uk/news

Revalidation is a reality GPs must accept
▶ page 21

GPs to screen over-40s for diabetes

NICE guidance asks GPs to identify pre-diabetes and prescribe metformin if lifestyle change doesn't work

By Sofia Lind

GPs will be expected to identify all patients over 40 with pre-diabetes and offer them intensive lifestyle-change programmes plus annual follow-up to track progress, under NICE guidance published last week.

Those whose HbA_1c or fasting blood glucose has not improved should then be offered metformin, currently unlicensed for impaired glucose tolerance.

The NICE public health guidance – criticised as 'beyond the capability' of most practices – recommends GPs use an electronic risk-assessment tool to identify anyone over 40 at risk of developing diabetes and call them in for a fasting blood glucose or HbA_1c test. Anyone over 25 in certain risk groups should be called in (see box, below right).

Those with an HbA_1c under 42mmol/l (6%) should be advised about risk modification and offered access to support services – then reassessed at three years.

Patients with an HbA_1c of between 42-47mmol/l (6-6.4%) should be referred for an intensive lifestyle-change programme, based in groups that should meet at least eight times over up to 18 months, with a total of 16 hours' contact time.

Metformin should be considered for those whose HbA_1c does not improve – with benefit assessed every three months.

Professor Kamlesh Khunti, professor of primary care diabetes at the University of Leicester and chair of the programme development group at NICE, said: 'Evidence has shown an intensive lifestyle programme, where patients make simple changes – like changing their diet – can help prevent onset of diabetes.'

NICE said the guidance should complement the NHS HealthCheck programme, but GP leaders warned it would have huge financial implications for practices.

Dr Laurence Buckman, GPC chair, said: 'These plans call for resources that are currently beyond the capability of most practices. If we are to make this a reality, the Government will need to commit significant extra resources.'

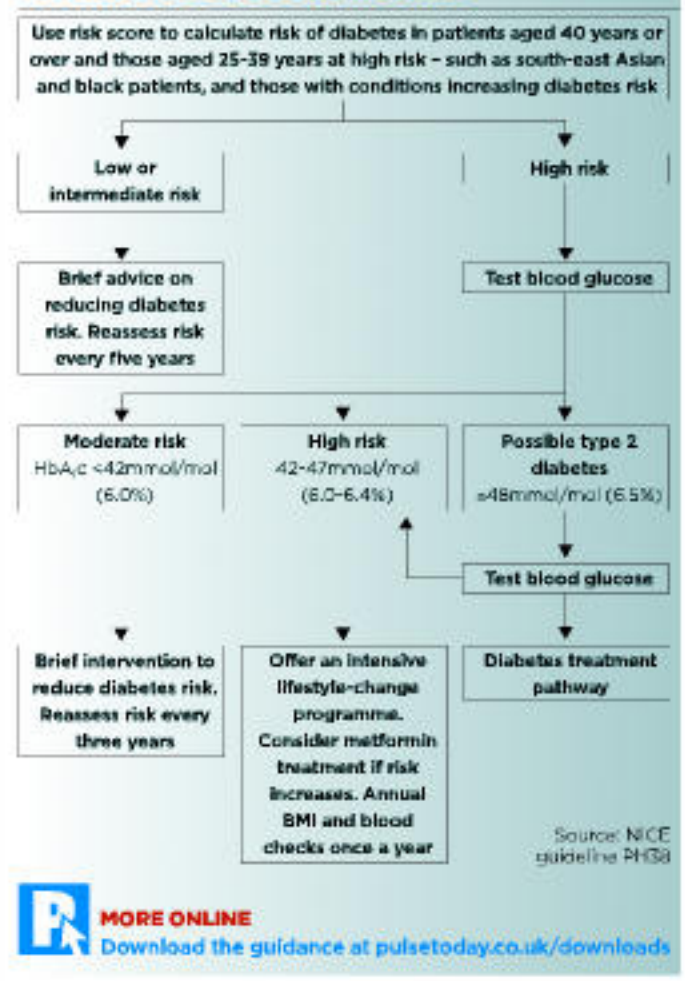
GPC negotiator Dr Peter Holden added: 'If they are not willing to resource it, I am not willing to do it. GPs are already squeezed to the point where there is no more to squeeze.'

Dr Alan Begg, a GP in Montrose, Scotland and co-editor of the journal *Practical Diabetes*, said: 'Metformin has an evidence base for preventing diabetes but is not licensed for it. So there may be reluctance to prescribe it, but we do have a precedent in that we use it in patients with polycystic ovaries.'

@sofialind_Pulse

Anyone at risk of diabetes should have a blood test

What NICE recommends



Source: NICE guideline PH38

MORE ONLINE
Download the guidance at pulsetoday.co.uk/downloads

Attend child protection meetings, says GMC

GPs must record concerns promptly and should attend all child protection conferences and case reviews in person, says new GMC guidance on child protection.

The guidance urges all GPs to 'co-operate fully' with child-protection procedures and to attend meetings, even if they are arranged at short notice.

It says despite the inconvenience of rescheduling appointments or finding a locum, GPs can share unique insights into a child and their family.

The guidance reads: 'If you are asked to take part in child-protection procedures, you must co-operate fully... If meetings are called at short notice or inconvenient times, you should still try to go.'

It adds: 'If this is not possible, you must try to provide relevant information about the child or young person and their family to the meeting, either through a telephone or video conference, in a written report, or by discussing the information with another professional.'

Dr Tim Robson, a GP in Watford, said: 'GP input can be very valuable, but the time commitment involved is huge.'

MORE ONLINE
Download the guidance
pulsetoday.co.uk/downloads

1 in 4

of your adult patients could develop shingles in their lifetime if they are among the 90% that have had chickenpox[1,2]

ZOSTAVAX®▼

Shingles (herpes zoster) vaccine (live)

Prevention of shingles and post-herpetic neuralgia – 1 dose* for adults aged 50+[3]

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® powder and solvent for suspension for injection [shingles (herpes zoster) vaccine (live)] *Refer to Summary of Product Characteristics for full product information.*

Presentation: Vial containing a lyophilised preparation of live attenuated varicella-zoster virus (Oka/Merck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque-forming units) varicella-zoster virus (Oka/Merck strain). **Indications:** Active immunisation for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN) in individuals 50 years of age and older. **Dosage and administration:** A single dose should be administered by subcutaneous injection, preferably in the deltoid region. **Contraindications:** Hypersensitivity to the vaccine or any of its components (including neomycin). Individuals receiving immunosuppressive therapy (including high-dose corticosteroids) or who have a primary or acquired immunodeficiency. Individuals with active untreated tuberculosis. Pregnancy. **Warnings and precautions:** Appropriate facilities and medication should be available in the rare event of anaphylaxis. Deferral of vaccination should be considered in the presence of fever. In clinical trials with Zostavax, transmission of the vaccine virus has not been reported. However, post-marketing experience with varicella vaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varicella-zoster virus (VZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zostavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zostavax may not result in protection in all vaccine recipients. **Pregnancy and lactation:** Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Caution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. **Undesirable effects:** Very common side effects include: pain/tenderness, erythema, swelling and pruritus at the injection site. Common side effects include warmth, haematoma and induration at the injection site, pain in extremity, and headache. Post marketing use has shown hypersensitivity reactions including anaphylactic reactions, joint and muscle pain, fever, swollen glands, rash, skin lumps and rash at the injection site. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic cost:** Vial and pre-filled syringe with two separate needles. The cost of this vaccine is £99.96. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 Rue Jonas Salk, F-69007 Lyon, France **Marketing authorisation number:** EU/1/06/341/011 **Legal category:** POM ® Registered trademark **Date of last review:** June 2012

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Sanofi Pasteur MSD, telephone number 01628 785291.

References: 1. Miller E, Marshall R, Vudien J. Epidemiology, outcome and control of varicella-zoster infection. *Rev Med Microbiol* 1993; 4: 222-30. **2.** Bowsher D. The lifetime occurrence of Herpes zoster and prevalence of post-herpetic neuralgia: A retrospective survey in an elderly population. *Eur J Pain* 1999; 3: 335-42. **3.** ZOSTAVAX® SmPC.

* The need for a second dose is currently unknown

Scan the QR code with your smartphone to access www.shinglesaware.co.uk

UK15206a c 06/12

sanofi pasteur MSD
vaccines for life

Key questions: ankle and knee injuries
▶ page 22

CQC will access patient records

Regulator reveals pilots will allow inspectors to review GP records without obtaining patient consent

By Sofia Lind

GP records are to be routinely accessed without patient consent by the Care Quality Commission as part of a pilot scheme to test the regulator's practice inspections, Pulse can reveal.

The pilots will see non-medically qualified inspectors routinely looking at patient records, although inspectors will let practices select which patient records they wish them to review.

The CQC said the results of the pilots in 40 practices will be published in September and were designed to 'identify any issues' in its approach to inspecting practices.

The GPC warned patient records should not be routinely accessed without patient consent, but the CQC argued it was legally able to do so under the Health and Social Care Act 2008 on the grounds there is a 'public interest' in accessing the confidential data.

Pulse revealed in April that the CQC will inspect GP practices every two years, with visits lasting between half a day and a full day likely to include interviews with practice staff and patients.

Patients' records will be routinely accessed by CQC inspectors

A spokesperson for the CQC said its approach to reviewing GP records more widely from April 2013 would depend on the outcome of the pilots: 'The pilot inspections will include testing the CQC's approach to reviewing patient records.

'However, inspectors will let the service select which records to review. If a GP knows a patient would not wish their records to be shared, our inspectors will honour that wish. All information gathered will remain confidential.'

But GPC deputy chair Dr Richard Vautrey said the CQC should gain consent from patients before accessing their records.

He said: 'There is a question mark over whether it is appropriate for them to access patient files in the pilot because they are not yet accredited inspectors. They really should get patient consent at the moment.'

Dr Grant Ingrams, a GP in Coventry, said: 'Sometimes inspectors will need access to patient files, but it should not be routine and the CQC should have to state why it needs to see the files.

'There should be more strict guidelines to go with it. As it stands, CQC inspectors have carte blanche access to everything.'

@sofialind_Pulse

Countdown to CQC registration

JUL 2012	SEPT 2012	DEC 2012	APR 2013
CQC begins pilot inspections of 40 GP practices	CQC to conclude inspections pilot and publish results	Deadline for filing registration applications to the CQC	All practices registered; CQC to begin inspections

GPs wrongly told to ditch toys

GPs have been wrongly urged by PCT infection control leads to cut down on the number of toys in their waiting room and remove soft furnishings to prepare for Care Quality Commission registration.

The CQC has asked GPs to report any NHS managers overzealously applying infection control guidelines, after a GP practice in Surrey was urged to reduce the number of toys in its waiting room and clean those it kept every day.

The CQC said it was aware a number of PCTs had said similar things to GP practices, and insisted rumours that toys would have to be removed and only hard chairs would be allowed in waiting rooms were 'absolutely false'.

Dr Martin Brunet, a GP in Godalming, Surrey, said his practice had been visited by an infection control nurse who had claimed CQC requirements would include removing and cleaning toys.

But Yong Tan, infection control lead nurse at NHS Surrey, said the advice had been 'only a recommendation'.

A CQC spokesperson said: 'This and other rumours such as carpets and soft furnishings in waiting rooms having to be removed due to infection issues are absolutely false.'

BMA suspends retired GP for questioning campaign

A retired GP has been suspended from the BMA Welsh Council until 2014 after he questioned the evidence behind the BMA's campaign to ban smoking in vehicles in a radio interview.

Dr Brendan O'Reilly, a retired GP, has also had his BMA membership suspended until he provides 'an acceptable written apology' to four named BMA members.

At a hearing last week, a BMA Council panel said it had considered the language Dr O'Reilly had used when describing his opposition to the BMA's use of statistics on the risks of passive smoking in cars as 'unacceptable'. But Dr O'Reilly said he was being 'harangued' by the BMA for simply expressing a difference of opinion.

Dr O'Reilly questioned the BMA's claim that children in cars are exposed to 23 times more toxins than people in a smoky bar on the Jason Mohammod BBC Radio Wales show.

The BMA admitted it did have to later publicly revise some of the data in its briefing paper *Smoking in vehicles*. But it said Dr O'Reilly's use of the term 'manipulation' was 'detrimental to the honour and interest of the BMA'.

Simplify the data. Complete the picture.

Bayer's new CONTOUR® NEXT USB meter helps patients organise their diabetes information quickly and easily

- Captures blood glucose results, with optional carbohydrate and insulin logging, for a more complete picture of control
- Helps patients make the connection between actions and results, for better self-management
- No set-up requirements – easy-to-use and learn, and easy for you to teach
- Data is simple to see and share, directly on the meter, or plugged into any computer
- Uses Bayer's new CONTOUR® NEXT test strip to deliver advanced accuracy[1]

High-performance accuracy and precision
– 'Second chance' technology allows blood to be reapplied to the same test strip, if necessary

Contour next

Speak to your Bayer representative to find out more

Reference: 1. Harrison B, Schachner HC, Brown D. Accurate assessment of the blood glucose meter CONTOUR® NEXT USB. Poster presented at: Annual Meeting of the German Diabetes Association; May 16-19, 2012; Stuttgart, Germany (nm600).

Contour next USB
Blood Glucose Monitoring System

PPIs should be used 'more prudently' after data shows they increase risk of *C. difficile*-associated diarrhoea

GASTROENTEROLOGY

PPIs raise *C. difficile* risk by 70%

By David Swan

Proton pump inhibitors raise the risk of *Clostridium difficile*-associated diarrhoea by over two-thirds and should be used 'more prudently' to prevent gastric ulcers, a new analysis suggests.

Although antibiotic use remains the biggest risk factor for *C. difficile*-associated disease, this is the first large analysis suggesting PPI use is also a risk factor, possibly because *C. difficile* spores are more likely to survive at higher pHs.

The result comes after several warnings over the use of PPIs, with the MHRA warning that the drugs are associated with the development of fractures and hypomagnesaemia.

The authors analysed 23 studies with data from 289,000 hospital patients that looked at the increased risk of *C. difficile*-associated diarrhoea in patients taking PPIs for at least three months. When data from all studies was included, patients on PPIs had a significant 69% increase in risk of contracting *C. difficile*-associated diarrhoea, compared with matched controls, or for cohort studies when adjusted for confounding factors.

When these studies were split up into subgroups based on their design – either cohort or case-control – the risk increase remained high at 66% and 65% when adjusted for confounders, or compared with controls. Performing a sensitivity analysis to account for publication bias saw the risk fall to 26%, but this association between PPIs and *C. difficile*-associated diarrhoea was still significant compared with matched controls or after adjustment for confounders.

The researchers – from Harper University Hospital in Michigan and the University of Utah School of Medicine – said their study showed a new guideline for PPI use was needed: 'We recommend that the routine use of PPIs for gastric ulcer prophylaxis should be more prudent.

'Establishing a guideline for the use of PPIs may help in the future.'

Dr Michael Cohen, a GP in Bristol and member of the committee for the Primary Care Society for Gastroenterology, felt GPs should be aware that PPIs are a risk factor for *C. difficile*-associated diarrhoea, but disagreed with the call for a new guideline: 'I think GPs are "guidelined out" and am not sure another would be of any benefit here.'

He added that more information from the study would have been useful: 'The dose and duration of the therapy was not defined in many studies, which is a shame.'

An MHRA spokesperson said there were already warnings about the risk of gastrointestinal infection with PPIs, but they would look at the data and 'will consider any regulatory action that may be necessary'.

Risk of *C. difficile*-associated diarrhoea

69%
Overall relative risk increase

3
Months PPI use minimum

Am J Gastroenterol 2012, online 19 June

***Am J Gastroenterol* 2012, online 19 June**

david.swan@pulsetoday.co.uk

STROKE

Elderly able to self-manage anticoagulants

Self-management in elderly patients taking anticoagulation therapy is associated with improved quality of life, compared with routine care.

German researchers followed 195 patients, with a mean age of over 69 years, who were undergoing long-term warfarin therapy for conditions such as atrial fibrillation. Patients were randomised to routine care or self-management, where they were trained to monitor their own INRs and adjust anticoagulant dose as needed.

Treatment-related quality of life was assessed at baseline and during a final follow-up visit using a validated questionnaire. The biggest improvement was found in general treatment satisfaction for those in the self-management group, compared with no increase for the routine care group. Self-management also outperformed routine care on the other questionnaire scales – such as general psychological distress, daily hassles and impaired social life.

The researchers, from Goethe University in Germany, concluded: 'The benefits of self-management of oral anticoagulation can be achieved without negatively affecting quality of life.'

***Thromb Res* 2012, online 1 July**

No extra cash

By Sofia Lind

The NHS will have to use existing funds to roll out local telehealth initiatives, as there will be no additional money to bankroll the Government's commitment to expanding the use of new technology in the NHS, says the Department of Health.

A senior DH official said it was looking at how tariffs could be altered and incentives introduced to commission telehealth and telecare services, but this would have to come from existing funds. The development comes after experts expressed doubts about the results of the Government's £30m Whole Systems Demonstrator pilot programme.

A study on the pilot published earlier this month found a significant impact on mortality and hospital admissions, but not on costs.

Speaking at the Westminster Health Forum, Stephen Johnson, deputy director and head of long-term conditions at the DH, argued there was a business case for rolling out the services – which see patients with long-term conditions monitored re-

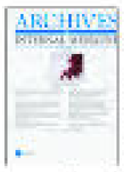
It's about finding the right patient and right time to use telehealth
Dr Andrew Innes

Sudden death in young athletes
▶ page 27

GPs have been advised to be 'more prudent' about use of PPIs

CVD

No statin benefits in women



Statins have no significant effect on all-cause mortality and the risk of recurrent stroke in women with cardiovascular disease, concludes a meta-analysis.

The US researchers pooled 11 secondary prevention trials with statins that had a minimum follow-up of 16 weeks and involved 43,191 patients with pre-existing cardiovascular disease.

They found that statin treatment significantly reduced the risk of all-cause mortality in men by 21% compared with those on placebo, but in women the reduction was only 8% and was non-significant. A similar disparity was also found in stroke recurrence risk – a significant 18% reduction in men, but a non-significant 8% in women.

The researchers concluded: 'Public policies addressing sex-specific differences in cardiovascular health are encouraged.'

Arch Intern Med 2012, online 25 June

GUIDANCE ROUND-UP

Prevent vascular events with aspirin

GPs should use low-dose aspirin for secondary prevention of vascular events in patients with upper gastrointestinal bleeding in whom haemostasis has been achieved, according to the latest NICE guidelines. The guidelines also recommend that NSAIDs should be stopped during the acute phase of bleeding.

NICE clinical guideline CG141

Heparin for patients with DVT

Low-molecular weight heparin should be offered to patients with a confirmed proximal deep vein thrombosis or a pulmonary embolism, say new guidelines.

NICE clinical guideline CG144

List complications on discharge

All discharge summaries should contain descriptions of complications experienced by the patient during their hospital stay and a list of all investigations performed, say new Scottish guidelines.

SIGN guideline No. 128

OSTEOARTHRITIS

Viscosupplementation increases adverse events

GPs should be 'discouraged' from recommending viscosupplementation in patients with knee osteoarthritis due to an increased risk of adverse events, concludes a new review.

European researchers investigated the efficacy of the treatment by pooling 89 trials that compared viscosupplementation with placebo or no intervention, using knee pain as a primary outcome and a flare-up in the injected knee as a primary safety outcome.

They predefined a clinically important difference of -0.37 in the effect size for knee pain. Although the overall meta-analysis found that viscosupplementation had an effect size of -0.37 compared with placebo, a clinically important difference. It was also associated with a 51% increase in risk for flare-ups in the injected knee.

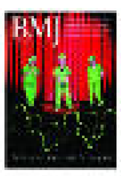
The risk of serious and local adverse events also increased in the viscosupplementation group compared with placebo, with rates of 41% and 34% respectively.

The researchers concluded: 'The increased risk in serious adverse events associated with viscosupplementation is concerning.'

Ann Intern Med 2012, online 12 June

DOMESTIC VIOLENCE

GP domestic violence training 'cost-effective'



A domestic violence training and support programme for primary care is cost-effective for GP practices to implement, conclude UK researchers.

Their research into 143,868 women found the Identification and Referral to Improve Safety (IRIS) programme saved £37 per woman registered at a practice – in both societal and health costs – compared with practices not receiving the programme.

The IRIS programme consisted of two training sessions for clinical staff aiming to improve their response to women who experience abuse, led by an advocate educator and either a clinical psychologist or an academic GP. When wider non-healthcare costs were set aside and only NHS costs for medical attention and mental health were considered, it produced a saving of £1.07 per woman per year, equivalent to £3,155 per practice each year.

Researchers from the London School of Medicine and the University of Bristol concluded: 'The analysis is evidence of cost-effectiveness, which can inform the commissioning of the IRIS programme in the context of primary healthcare services.'

BMJ Open 2012, online 22 June

for telehealth

motely – despite the findings.

Asked whether the Government would provide additional funding for the rollout, he said: 'Generally, no. It is about building a sustainable model. Let us see what solutions people can come up with and see what we can do, including tariffs and incentives in commissioning.'

The Government's '3million-lives' campaign has set a target to improve the quality of life for three million patients with long-term conditions through telehealth, with an expected cost-saving of £1.2bn.

A DH spokesperson added: 'The point of "3millionlives" is that we need to understand better how to overcome any barriers to use and we will be looking at these, including how the money flows.

'As for Government funding, we have said all along that this is not about putting more money into the NHS, it is about finding ways of using the money more effectively.'

But GPs said there were still unanswered questions around the wider telehealth rollout.

Dr Andrew Innes, a GP in East Riding, east Yorkshire, and a telehealth researcher at the University of Hull, said: 'We need to find the conditions that benefit from the use of telehealth. It is about cost efficiency, clinical effectiveness, finding the right patient and the right time to use telehealth.'

@sofialind_Pulse

CPD TIP OF THE WEEK

Gastroprotection in patients taking clopidogrel

Advice from the MHRA on gastroprotection in patients taking clopidogrel has recently changed, according to our new CPD module on antiplatelet therapy.

The agency states that previous advice to avoid all PPIs is probably unnecessary, but that omeprazole and esomeprazole should be avoided with clopidogrel. Also, the H2-receptor antagonist cimetidine should not be used as it also inhibits cytochrome p450.

Other PPIs or H2-receptor antagonists should be considered – but there is more limited evidence for using an H2-receptor antagonist for this use, and it should be prescribed at twice the normal dose.

ONLINE CPD
See the Hot topics in antiplatelet therapy module at pulse-learning.co.uk

MOVICOL® and MOVICOL® Liquid Orange Flavour, concentrate for oral solution. Abbreviated Prescribing Information. REFER TO FULL SUMMARY OF PRODUCT CHARACTERISTICS (SMPC) BEFORE PRESCRIBING. **MOVICOL Liquid is not recommended for faecal impaction. Presentation:** MOVICOL Sachet of white powder which dissolves in about 125ml (approximately ½ glassful) water to make a lemon/lime flavoured drink. Each sachet contains: 13.125g macrogol (polyethylene glycol) 3350, 178.5mg sodium hydrogen carbonate, 350.7mg sodium chloride and 46.6mg potassium chloride. MOVICOL Liquid A clear concentrated liquid, which is diluted in water to make an orange flavoured drink. Each 25 ml of MOVICOL Liquid is diluted in 100 ml of water before use and contains the following active ingredients: 13.125 g macrogol (polyethylene glycol) 3350, 178.5 mg sodium hydrogen carbonate, 350.7 mg sodium chloride and 46.6mg potassium chloride. **Uses:** Treatment of chronic constipation. **Dosage and administration:** MOVICOL Adults, adolescents and the elderly: 1-3 sachets daily in divided doses, according to individual response. For extended use: adjust dose down to 1 or 2 sachets. Extended use may be necessary in patients with severe chronic or resistant constipation, secondary to multiple sclerosis or Parkinson's Disease, or induced by regular constipating medicine, in particular opioids and antimuscarinics. A course of MOVICOL treatment does not normally exceed 2 weeks, but can be repeated if required. MOVICOL Liquid Adults, adolescents and the elderly: 25 ml diluted in 100 ml of water 1-3 times daily in divided doses, according to individual response. For extended use, the dose can be adjusted down to 1 or 2 doses per day, each consisting of 25 ml diluted in 100 ml of water. Extended use may be necessary in patients with severe chronic or resistant constipation, secondary to multiple sclerosis or Parkinson's Disease, or induced by regular constipating medicine, in particular opioids and antimuscarinics. A course of MOVICOL Liquid treatment does not normally exceed 2 weeks, but can be repeated if required. MOVICOL and MOVICOL Liquid are not recommended for children below 12 years. See MOVICOL Paediatric Plain. Contra-indications: Intestinal perforation or obstruction due to structural or functional disorders of the gut wall, ileus, severe inflammatory conditions of the intestinal tract, such as Crohn's disease, ulcerative colitis and toxic megacolon. Hypersensitivity to the active substances or any of the excipients. Warnings and precautions for use: If patients develop any symptoms indicating shifts of fluids/electrolytes treatment should be stopped immediately. MOVICOL Liquid contains 8.125 mmol of sodium in each diluted dose of 125 ml and should be considered when administered to patients on a controlled sodium diet. MOVICOL Liquid contains benzyl alcohol. Do not exceed the maximum recommended daily dose. Interactions: There is a possibility that the absorption of concomitantly administered medication could be transiently reduced. Pregnancy and lactation: There is insufficient data on use in pregnancy and lactation, and should only be used if considered essential. Undesirable effects: Reactions related to the gastrointestinal tract are the most common and include: abdominal pain, abdominal distension, nausea, dyspepsia, vomiting, diarrhoea, flatulence, borborygmi and anal discomfort. Allergic reactions, including anaphylactic reaction, angioedema, dyspnoea and skin reactions can occur. Other effects can include electrolyte disturbances, headache and peripheral oedema. **Legal category:** P. **Cost and MA number:** MOVICOL 20 sachets £4.45, 30 sachets £6.68, 50 sachets £11.13. **MA number:** PL 00322/0070. MOVICOL Liquid **Cost:** 500ml £4.45. **MA number:** PL20011/0007. **For further information contact:** Norgine Pharmaceuticals Limited, Norgine House, Moorhall Road, Harefield, Middlesex UB9 6NS. Telephone: 01895 826606. E-mail:medinfo@norgine.com MOVICOL® is a registered trademark of the NORGINE® group of companies. **Date of preparation/revision:** MO/2954/JUN/12

Adverse events should be reported. Reporting forms and information can be found at http://www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals Ltd on 01895 826606.

References:
1. Attar A *et al.* Gut 1999; **44**: 226-230.
2. Gruss HJ, Teucher T. Gen Pract 1999; **21**(16): 1342-1350.
3. MOVICOL® Summary of Product Characteristics.

MO/2978/JUL/12

NORGINE

www.MOVICOL.co.uk

Effective

MOVICOL® is superior to lactulose[1]

Well tolerated

Tolerability rated highly by both doctors and patients[2]

Broad patient suitability

Versatile

Tailor to individual patient's needs[3]

MOVICOL®

macrogol 3350, sodium bicarbonate, sodium chloride, potassium chloride

Blends proven efficacy[1] with fast-mix convenience

For the treatment of chronic constipation

MOVICOL® LIQUID

macrogol 3350, sodium hydrogen carbonate, sodium chloride, potassium chloride

Copperfield: computer says go – now
▶ page 21

GPs told to 'track' Ca referrals

London practices asked to review referrals after hospital loses information on hundreds of patients

By Madlen Davies

GPs have been told to 'proactively track' all urgent referrals for suspected cancer after information regarding hundreds of patients was lost by the UK's largest hospital trust.

NHS managers in London have written to GP practices to ask them to review all their two-week referrals for cancer over the past six months, and introduce a 'safe system' to ensure they track all future referrals.

The advice from NHS North West London comes after 'data reporting' errors at Imperial College Healthcare NHS Trust resulted in incomplete records for patients referred under the two-week pathway.

Pulse first revealed in May that Imperial College Healthcare NHS Trust had been forced to write to GPs to ask for their help in tracking down patients urgently referred for cancer tests, after records detailing whether 1,023 patients still required treatment were found to be incomplete.

> GPs should review all two-week referrals over the last six months, and consider the systems used by your practice to proactively track these particular referrals. We will work with the LMC to describe safe systems you may wish to adopt.
>
> Source: NHS North West London

NHS North West London subsequently wrote to all GP practices asking for them to share responsibility for ensuring patients referred for an urgent cancer diagnosis were seen.

The letter said: 'The North West London Clinical Executive Committee has recommended that all practices review systems and processes associated with cancer referrals.'

It added that GPs should 'consider the systems used by your practice to proactively track these particular referrals. We will continue to work with the LMC to describe safe systems that you may wish to adopt.'

A spokesperson for NHS North West London confirmed that as a 'safety net', the PCT cluster was encouraging GPs to track urgent referrals made to secondary care.

He said: 'We have been working with the LMC to ensure the system provides an additional safety net for the process and a good level of support for patients, without increasing the workload in general practice.'

However, Dr Tony Grewal, medical director of Londonwide LMCs, said the failures of a hospital trust should not result in burdensome systems being imposed on GPs.

'It would be dangerous to divert the responsibility in the referral pathway from the trust that is being referred to,' he said.

'If a trust can't run its own referral pathway, then it's not fit for purpose. GPs have got enough work to do.'

@madlendavies

A tour of sporting pathology
▶ page 24

GPs have been told to 'track' progress of their cancer referrals

Welsh practices to open on Saturdays from 2014

GP practices in Wales will start routinely opening on Saturdays from 2014, but only if there is demand from patients, the Welsh Government has announced.

Welsh health minister Lesley Griffiths set out the new targets for extended access earlier this month, including plans to end in-hours closing and for half of all practices to open late in the evenings.

But the shake-up in GP opening hours has been condemned by GPC Wales, who said the move would lead to cutbacks in other areas of the health service, given it is attached to no new money.

Ms Griffiths has given health boards in Wales a target for 50% of practices to stay open past 6.30pm within the next two years.

The Welsh Government has also commissioned a review – led by Dr Chris Jones, a GP in Taff Vale and chair of Cwm Taf Health Board – to develop a new model for access to services at the weekend to begin during 2014/15.

However, the Government said there would be no firm target for this and it would be determined by patient demand.

GPC Wales chair Dr David Bailey said: 'If they move more money into this, then they have to take it from somewhere else.'

IN BRIEF

GPs miss QOF payments

GPs may be missing out on valuable QOF payments by not recording the presence of proteinuria in patients with chronic kidney disease, an NHS audit has concluded.

Full story ▶ pulsetoday.co.uk/practicenews

Report whooping cough

GPs have been urged by the HPA to report cases of whooping cough quickly as the number of cases continues to rise.

Full story ▶ pulsetoday.co.uk/clinicalnews

Shared care agreements

GPs have been urged to ensure all patients on shared care have written agreements in place, after rising numbers of 'informal' requests for the prescribing of specialist drugs.

Full story ▶ pulsetoday.co.uk/practicenews

Ten top tips for commissioning GI services
▶ page 35

GP commissioners warn plans to expand scheme come before any evidence from pilots is published

NHS MANDATE

Wider rollout for personal budgets

By Emma Wilkinson

Patients are to be given a 'right to ask' for a personal health budget under plans to extend choice and control for patients set out in the Government's draft mandate for the NHS.

The plans will see a massive extension to the scheme – currently still being piloted – with patients given a cash budget by the NHS to spend on whatever they choose, subject to approval.

But GP commissioners raised concerns that the wider rollout of personal health budgets had been decided upon before evidence on their effectiveness has been published.

The plans were outlined in a draft version of the first annual mandate to be given to the NHS Commissioning Board by health secretary Andrew Lansley.

The mandate for 2013 also revealed the quality premium for GP practices will be funded from NHS administration costs and tied the board to various targets, such as treating patients within 18 weeks and improving dementia care.

NHS Mandate: key points

- Gives patients a right to a personal health budget
- Alternative providers to treat patients who miss 18-week target
- Quality premium funded from administration budget

MORE ONLINE
Read the full NHS Mandate at pulsetoday.co.uk/downloads

Among the 22 objectives the board was charged to deliver was a drive to extend choice and control for patients. The mandate said this would include giving patients receiving NHS Continuing Healthcare and parents of children with special educational needs or disabilities the right to a personal budget spanning health, social care and education from April 2014.

The document added: 'The aim is to create a right to ask for a personal health budget for all those who would benefit from one.'

Pulse reported last month that the budgets have been used to buy items such as theatre tickets, frozen meals and complementary therapies in pilots.

Mr Lansley said: 'The launch of these care objectives underlines my ambition to improve outcomes for patients and place patients right at the heart of everything the NHS does.'

But Dr David Jenner, interim chair of Northern, Eastern and Western Devon CCG, said: 'The pilots are yet to report, so as a commissioner I would be waiting to see the results.'

And Dr Johnny Marshall, interim project manager of NHS Clinical Commissioners, said: 'How will the effectiveness of personal health budgets be assessed? This doesn't answer any questions.'

feedback@pulsetoday.co.uk

Dr David Jenner: rollout should wait for pilot results

ANALYSIS

Not perfect, but a start

The Government's mandate is essential in ensuring the new NHS delivers a locally determined and sensitive health system.

The draft proposals are not perfect. It could be viewed as a lost opportunity to restate clearly the differences in functions and governance between the old and new NHS. But it is a start.

The most important bit of the mandate is the duty of the board to promote the autonomy of commissioners and providers. This is a major change. CCGs are in the best place to make decisions and they need space to develop and succeed.

But we are no clearer on what proportion of the administrative budget will be developed to the quality premium, or how the NHS Commissioning Board will performance manage practices.

Some of the ideas on extending patient choice are interesting, but it is unclear how they can be applied in practice.

Dr Charles Alessi is chair of the NAPC

NHS CONSTITUTION

Constitution has 'no teeth'

The GP charged with leading the reshaping of the NHS Constitution has warned the document is seen as having 'fine words, but no teeth'.

Professor Steve Field, chair of the NHS Future Forum and a GP in Birmingham, said the document needed to be beefed up 'not only in its content, but also in its application'.

In a letter to health secretary Andrew Lansley, Professor Field said: 'More than any other view expressed, it has been put to us forcibly that the constitution amounts to "fine words, but no teeth".'

'Where the rights it contains are not lived up to, there must be an understandable, accessible and effective means of challenge and redress.'

In an interview with Pulse, Professor Field said GPs' awareness of the constitution was increasing, but added it was important that all NHS staff and patients saw it as 'a living document'.

He said: 'How do we strengthen it, so everyone really understands it, and patients and staff really use it as living document?'

MORE ONLINE
Watch the full interview with Professor Field
pulsetoday.co.uk/videos

A world of knowledge about allergy MEDA

MEDA is one of the fastest growing Pharmaceutical companies in the world, with a global presence in over 120 countries and a current UK portfolio of over 70 products.

With a team of dedicated specialists, we are committed to supporting healthcare professionals and patients in the treatment of allergy - now and for years to come.

So as you can see we are covering a lot of ground.

medapharma.co.uk

UK/GEN/12/0015 June 2012

GPs must sit in the driving seat

With just nine months to go until the demise of PCTs, the structure of Andrew Lansley's brave new NHS is gradually taking shape – and Pulse's investigation this week puts names and faces to the leaders of the revolution.

While pretty much every practice is now a signed-up member of a CCG, the mere fact of membership does not – despite ministers' protestations to the contrary – equate to any particular enthusiasm for the NHS reforms. Nor does there appear to be a groundswell of GPs desperate to take on a leadership role, given that two-thirds of GPs elected to a CCG board faced no competition.

Instead, grassroots GPs seem mostly happy to keep their heads down and let CCGs just get on with it. And so our analysis of more than 1,300 board positions across 100 CCGs offers a fascinating snapshot of commissioning's emerging officer class.

There is a stark gender divide, with women clearly under-represented. The Department of Health's insistence that every board should include a hospital consultant does not appear to have translated into reality – just seven CCGs surveyed had one. Likewise the GPC's demand for CCGs to hold fresh elections before assuming commissioning responsibility – around one in three will do so.

But most striking of all is the extent to which GPs appear to be losing their grip on the organisations they were meant to lead.

Overall, GPs make up less than half of CCG board members, and in some areas are outnumbered four to one by managers, nurses, councillors and others.

Alarmingly, some small CCGs have actually been forced to shed GP board members on the grounds that they are simply too expensive to backfill.

Steve Nowottny
Acting editor

It is right that other disciplines should be represented, and this time last year the NHS Future Forum acknowledged as much when its report recommended the term 'GP commissioning' should be replaced with 'clinical commissioning'.

But that report also warned against compulsory board places for consultants, and added: 'We recognise the unique role of GPs who are tied in through their practice contracts to commissioning consortia, and who therefore will have overall accountability for the decisions made.'

With hindsight, the NHS Future Forum was spot on. If commissioning is to work, it must not be simply about a minority of keen GPs redrawing a few care pathways. CCGs must not water down the power of GPs to the extent that they end up recreating PCTs.

Ultimately, it is GPs who will be held responsible for the success or failure of their CCG, contractually, financially and in the public eye. And, of course, beyond commissioning CCGs will wield enormous power over their constituent practices – over prescribing, referrals and performance management.

GPs should be keen to ensure they and their colleagues retain the balance of power. If they let it slip, they may regret it.

Do you agree? Let us know by emailing Steve at editor@pulsetoday.co.uk

How to contact Pulse

General editorial enquiries 020 7332 2904
News desk 020 7332 2904
Classified advertising 020 7332 2924
Display advertising 020 7332 2928
pulsetoday.co.uk 020 7332 2938
Email pulse@pulsetoday.co.uk

Address (editorial) Pulse, Briefing Media, 3rd Floor Mermaid House, 2 Puddle Dock, London EC4V 3DB
Delivery and subscription Medical Reader, c/o BHP, 2-3 Commercial Way, Christy Close, Southfields, Basildon SS15 6EF
Free circulation: Call 0845 1369316 or email medicalreader@binleys.com
Paid subscription: Call 01858 438893

Group editor Jo Haynes
Acting editor Steve Nowottny
Group clinical editor Adam Legge
Acting deputy editor Nigel Praities
Chief reporter Gareth Iacobucci
Reporter Sofia Lind
News intern Madlen Davies
Online producer Jessica Baron
Online intern Hannah Bass
Deputy clinical editor Rhiannon Smith
Assistant clinical editor David Swan
Assistant features editor Ellie Broughton
Art director Ravi Naidoo

Art editor James Depree
Senior sub editor Brooke Balza
Events and business editor Lisa Thomlinson
Editorial adviser Dr Keith Hopcroft
General practice adviser Dr Alistair Moulds
Production controller Phil Taylor
Advertising executive Cliff Brown
Head of events Stephen Knowles
Projects director Paul Barressam
Associate publisher Sanjay Chudasama
CEO, Briefing Media Neil Thackray
CMO, Briefing Media Rory Brown

PULSE BriefingMedia recycle

Information for Care. Everywhere.

Advanced
Health & Care

Advanced Health & Care

Intelligent systems cut costs

Do you know how you will deliver more, with less?

Advanced Health & Care is a leading supplier of IT management systems for:

- **Urgent & unplanned care**
- **NHS 111**
- **Community services**
- **Mobile information for community clinicians & care workers**
- **Homecare**
- **Residential care**
- **Hospices**
- **Local authorities & care providers**

Working with partners in the NHS, local government and the private sector, Advanced delivers IT solutions in support of safe, efficient care with integrated management information. Advanced has a range of integrated care solutions offering visibility of information for both the commissioner and care provider.

The Advanced Health & Care suite of products includes: Adastra, Adastra 111, Advanced Community, iNurse, Crosscare, StaffPlan, iConnect and CareSys

To find out more or book an appointment to see us, please call 01233 722670 or visit www.advancedcomputersoftware.com/ahc

Unit 4 Eurogate Business Park | Ashford | Kent | TN24 8SB
w: www.advancedcomputersoftware.com/ahc e: ahcmarketing@advancedcomputersoftware.com

adastra adastra 111 Advanced Community iNurse Crosscare staffplan iConnect CareSys

PULSE VIEWS LETTERS

We want to hear your views

Post your letters online at pulsetoday.co.uk/feedback. Email letters@pulsetoday.co.uk

Write to Pulse, Briefing Media, 3rd Floor, Mermaid House, 2 Puddle Dock, London EC4V 3DS. Let us know where your practice is situated. Feedback may be edited

Cancer tsar is wrong on awareness campaigns

LETTER OF THE WEEK

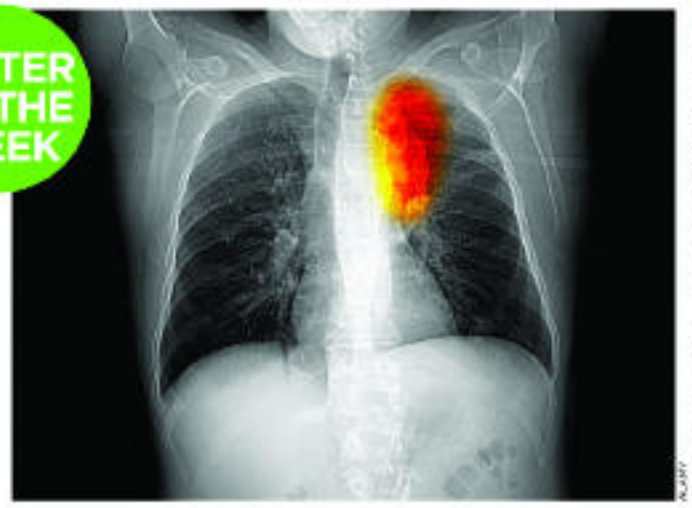
From Dr Ted Willis
Brigg, Lincolnshire

Professor Mike Richards, national clinical director for cancer, is about as wrong as it is possible to be on cancer diagnosis ('Cancer awareness campaigns are essential to tackle late diagnosis', pulsetoday.co.uk/opinion).

He says 'there is broad agreement... that late diagnosis is a major factor in differences in cancer survival between countries'. In fact, there is little evidence for this and our experience as GPs suggests that it is unlikely. Cancers are a heterogeneous group of diseases and one cannot simply compare different countries' cancers as if they were brands of car.

Most GPs' experience is that some patients have aggressive cancers with short histories that are incurable from the word 'go', while others are very treatable.

Other cancers still, including many found by screening, are not really life-threatening at all, but diagnosing them – causing nothing but distress and danger to the patient – does wonders for statistical measures of survival rates. Surely we have learned to be wary of epidemiological associations, which time and again have been shown to be just that – association, not causation?



Do cancer awareness campaigns really improve care?

Professor Richards should be testing the hypothesis – because that is all it is. Cancer awareness campaigns are great for raising money for charities and boosting the profile of back-room generals like Professor Richards, but do a lot of harm to the rest of us. The harm comes from raising anxieties, increasing the burden of dealing with the 'worried well' that keeps us away from genuinely suffering patients, and above all from reducing morale among GPs.

There is much that Professor Richards could be doing to improve care for patients with cancer – for example, the biggest problem for my patients is a long wait from initial diagnosis to treatment plan. But nagging GPs and patients is not the way to do it.

In defence of the NDA

From Dr Roger Gadsby
GP clinical lead for the National Diabetes Audit

Dr Bill Beeby's analysis piece on the proposed revamp of diabetes QOF indicators makes one suspect it's the NICE standards, not the National Diabetes Audit (NDA), that he objects to ('Flawed audit is no basis for altering GP pay', pulsetoday.co.uk/analysis).

QOF is a payment mechanism – the NDA is a clinical audit that assesses compliance with NICE guidance. So it is hardly surprising that the NDA and QOF headline results look so different. At 95% of available points for diabetes, QOF indicators mean the negotiated 'achievable performance' was attained in 95% of cases – by contrast, the NDA's bundle completion is based on all NICE-specified checks being carried out in every patient.

The bundle completion figure of 54.3% doesn't mean that 45.7% of patients are receiving unsatisfactory care. Indeed, the NDA shows that when individual tests are considered, each is completed in at least 80% of patients.

The NDA tries to keep in synch with QOF, but its code set is slightly smaller due to strict alignment with NICE standards. Far from being flawed, the NDA is the reliable method for ascertaining overall compliance with NICE recommendations. Hopefully it will continue to support and chart continuing improvement.

How to win on pensions

From Dr Geoff Davies
Shrewsbury, Shropshire

Sun Tzu tells us the most important aspect of war is to know your enemy. But our enemy isn't Andrew Lansley, and it isn't even David Cameron. No, it's George Osborne. And he is after your money.

The only effective action now is to cut off the supply of money. If all doctors suspend their NHS contributions, the £2bn surplus disappears and the Treasury will panic – and if you suspend your contribution now, you can rejoin within five years under the same conditions. The only effective action revolves around money – anything else will fail.

Has it really come to this?

From Dr FV Griffiths
Chelsea, west London

As a semi-retired GP, I am writing to express my shock that further industrial action is being contemplated. What happened to the Hippocratic Oath? Perhaps you should publish it as a reminder if we are to remain a profession, rather than a trade union.

The PM's verdict on pensions

From Dr Tom Robinson
Sully, South Glamorgan

Dear Andrew,

The poor turnout for the strike will be regarded by yourself as a personal triumph. There are few better ways to ingratiate yourself with the party faithful than by smashing a union.

You now need to offer an olive branch. The BMA is an old and cherished institution, and has one overwhelming quality: it is crap at industrial action.

But beware the many intelligent, young doctors, disillusioned with the BMA, who have lots of practical ideas. The last thing we want is to see them organise. So get the negotiators back. We have some rather nasty surprises planned – act now to keep opposition ineffectual.

All the best, David

NEW

Trajenta®

(linagliptin) 5mg film-coated tablets

ONE DOSE ONCE DAILY 5mg

Control and care matter

***Trajenta®* (linagliptin)** *is suitable for your hyperglycaemic adult type 2 diabetes patients as monotherapy in metformin-inappropriate patients and add-on to metformin alone or metformin + a sulphonylurea*[1]

Efficacy

- significant HbA_{1c} reductions vs placebo[2–4]
- HbA_{1c} reduction sustained over 102 weeks as add-on to metformin + a sulphonylurea in the completer population (319 patients out of 544 enrolled patients)[5]

Generally well tolerated

- Trajenta® (linagliptin) has an overall incidence of adverse events that is similar to placebo[1]

Different

- the first one dose, once-daily DPP-4 inhibitor excreted primarily via the bile requiring no dose adjustment[1,6–11]

Prescribing Information (UK) ▼ **TRAJENTA® 5 mg film-coated tablets**
Film-coated tablets containing 5 mg linagliptin. **Indications:** Trajenta is indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults: as monotherapy - in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to intolerance, or contraindicated due to renal impairment; as combination therapy: - in combination with metformin when diet and exercise plus metformin alone do not provide adequate glycaemic control; - in combination with a sulphonylurea and metformin when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control. **Dose and Administration:** 5 mg once daily. If added to metformin, the dose of metformin should be maintained and linagliptin administered concomitantly. When used in combination with a sulphonylurea, a lower dose of the sulphonylurea may be considered to reduce the risk of hypoglycaemia. Patients with renal impairment: no dose adjustment required. Pharmacokinetic studies suggest that no dose adjustment is required for patients with hepatic impairment but clinical experience in such patients is lacking. Elderly: no dose adjustment is necessary based on age however, clinical experience in patients > 75 years of age is limited. The safety and efficacy of linagliptin in children and adolescents has not yet been established. No data are available. Trajenta can be taken with or without a meal at any time of the day. If a dose is missed, it should be taken as soon as possible but a double dose should not be taken on the same day. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and Precautions:** Trajenta should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Caution is advised when linagliptin is used in combination with a sulphonylurea; a dose reduction of the sulphonylurea may be considered. **Interactions:** Linagliptin is a weak competitive and a weak to moderate mechanism-based inhibitor of CYP isozyme CYP3A4, but does not inhibit other CYP isozymes. It is not an inducer of CYP isozymes. Linagliptin is a P-glycoprotein substrate and inhibits P-glycoprotein mediated transport of digoxin with low potency. Based on these results and *in vivo* interaction studies, linagliptin is considered unlikely to cause interactions with other P-gp substrates. The risk for clinically meaningful interactions by other medicinal products on linagliptin is low and in clinical studies linagliptin had no clinically relevant effect on the pharmacokinetics of metformin, glyburide, simvastatin, warfarin, digoxin or oral contraceptives (please refer to Summary of Product Characteristics for information on clinical data). **Fertility, pregnancy and lactation:** Avoid use during pregnancy. A risk to the breast-fed child cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/ abstain from Trajenta therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. No studies on the effect on human fertility have been conducted for Trajenta. **Undesirable effects:** Adverse reactions reported in patients who received linagliptin 5 mg daily as monotherapy or as add-on therapies (pooled analyses of placebo-controlled studies). The adverse reactions are listed by absolute frequency. Frequencies are defined as: very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), or very rare (<1/10,000), not known (cannot be estimated from the available data). Very common: hypoglycaemia (combination with/add on to metformin and sulphonylurea). Uncommon: nasopharyngitis (monotherapy; combination with/add on to metformin); hypersensitivity (combination with/add on to metformin); cough (monotherapy; combination with/ add on to metformin). Not known: nasopharyngitis (combination with/add on to metformin and sulphonylurea); hypersensitivity (monotherapy; combination with/add on to metformin and sulphonylurea); cough (combination with/add on to metformin and sulphonylurea); pancreatitis (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylurea). Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** 28 tablets £33.26. **Legal category:** POM. **MA number:** EU/1/11/707/003. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared** in September 2011.

Adverse events should be reported. Reporting forms and information can be found at http://yellowcard.mhra.gov.uk/. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

References: 1. Trajenta® Summary of Product Characteristics, August 2011. **2.** Barnett AH et al. Poster No. 1021-P. The European Association for the Study of Diabetes 46th Annual Meeting, 20–24 September 2010, Stockholm, Sweden. **3.** Taskinen M-R *et al. Diabetes Obes Metab* 2011; 13:65–74. **4.** Owens DR et al. *Diabet Med* 2011;28:1352–61. **5.** Boehringer Ingelheim, data on file UM11-086a. **6.** Vincent SH et al. *Drug Metab Dispos* 2007;35:533–538. **7.** Januvia (sitagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/19609/SPC/JANUVIA+100mg+film-coated+tablets/ (accessed May 2012). **8.** Galvus (vildagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22734/SPC/Galvus+50+mg+Tablets/ (accessed May 2012). **9.** Onglyza (saxagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22315/SPC/Onglyza+2.5mg+%26+5mg+film-coated+tablets/ (accessed May 2012). **10.** Deacon CF. *Diabetes Obes Metab* 2011;13:7–18. **11.** Blech S et al. *Drug Metab Dispos* 2010;38:667–678.

UK/TRJ/0008a Date of preparation: May 2012

Boehringer Ingelheim

Lilly

Computer says go – right now

ILLUSTRATION: JIM KAY

Copperfield might just win an award for his new plan to get patients out of the consulting room

I don't mean to brag, but if there was a Nobel prize for primary care, I could be a contender. As it goes, there isn't – so I'll have to make do with one of those awards with 'innovation' in the title that I'm dimly aware of and which I suspect are presented in a desolate hotel somewhere attended by almost nobody. Because I've had An Idea. And it's the result of the coincidence of a number of events, which, I believe, was how penicillin was discovered. Specifically:

1 We've just had a new computer system installed. For the first week, it sent us into meltdown, prompting my registrar to say, memorably: 'The new system's fine, it's when you add patients into the mix that it becomes intolerable.' By the end of week two, we've tamed it and are in awe – a system that seemed to do nothing we wanted will now do anything we ask, and probably make coffee.

2 A young female patient paused a consultation mid-discussion of her acne to take a text message. 'Is Dundee in Scotland?' she asked, as she scrutinised her iPhone. I replied that it was. She texted her reply, and we continued in the direction of oxytetracycline as though nothing had happened.

3 I had a discussion with a poor, naive pharmacist who couldn't believe two things. First, that a third of prescriptions we write don't even make it to the pharmacy. And second, that this is because we GPs sometimes write unnecessary scripts as a way of terminating the consultation.

4 I'm suffering an epidemic of patients presenting with chilling opening statements like 'I don't know where to start' and 'I really need sorting out'. Inevitably, there comes a point in these interactions where I want to scream: 'For f**'s sake, don't you realise I've only got 10 minutes?' So I do. This shocks the patient: not the screaming and swearing, which they expect, but the constraint of time.

No, the patient does not suddenly fall into a pit of vipers

So, let's put all this together. My consultations are too long. We need a legitimate way of terminating them. Patients are blissfully ignorant of our time pressures. They are perfectly happy to accept and respond to text messages during the consultation. We have a fabulous new computer system which is capable of anything.

Bleedin' obvious, isn't it? As soon as I press, 'consult' on my computer, a software clock starts ticking.

And as it reaches 10 minutes, something wonderful happens. No, an ejector seat doesn't spring into life, the patient doesn't fall into a pit of vipers, I don't pull out a Kalashnikov, nor any of the other wacky and hilarious consultation-ending ploys I've described in previous columns, wacky and hilarious though they are.

No. What happens is, my computer texts the patient a message. It says: 'Your 10-minute consultation is over. Now just go.'

It's genius. And if any naysayer out there says computers can't send texts, I say, oh yes, my new one can. I think.

Or, if it can't, find a way. There's a day out to a desolate hotel in it for you.

Dr Tony Copperfield is a GP in Essex. You can email him at tonycopperfield@hotmail.com

More online

Can't wait for your next dose of the world according to Copperfield? Read his blog at pulsetoday.co.uk/copperfield or follow him on Twitter @doccopperfield.

OPINION

Revalidation is a reality GPs must accept

Revalidation will benefit both patients and the profession, writes **Professor Mike Pringle,** president-elect of the RCGP

Last month I was elected to succeed Dr Iona Heath as president of the RCGP from November. As president, I will be representing the views of members within the college and ensuring they are heard.

Many members – and non-members – will be fearful of the arrival of revalidation and will need support through its early years. Some may be confused at its imposition, seeing it as unnecessary and de-professionalising.

I am currently the college's clinical lead for revalidation, and I've spent the past few years planning the implementation of revalidation. How can I square these two circles?

We could continue to question whether revalidation is necessary, but the debate is becoming increasingly redundant. Revalidation is about to happen.

I believe it will restore public trust in doctors and that it is a necessary step to ensure all doctors remain up to date and fit to practise.

Without revalidation, we will be mired in the spiral of mistrust that has already tainted our relationship with politicians, colleagues, NHS managers and, to an extent, our patients.

My role in revalidation has been two-fold. First, I have been working to make the process practical and non-threatening for all good GPs. And second, I have been ensuring a level playing field for all doctors so that GPs are treated no better or worse than our consultant colleagues.

The supporting information we must provide in our appraisals is, with one important exception, information that we should have readily to hand.

We should be recording our CPD. We should be doing an occasional audit and considering significant events. Almost all of us survey our patients from time to time. For some GPs, a colleague survey may be a new idea, but now a majority of GPs I speak to have done one.

Appraisal should continue to be a supportive opportunity to review your year and plan the next. Most GPs already share information with their appraiser that they can build into a revalidation portfolio, and your appraiser will only need to make sure all areas are covered.

Ensuring patient safety

But the new dimension is the one that sits behind the appraisal: the appraiser needs to reassure your responsible officer that you are on track for revalidation. If concerns are raised, your responsible officer must address them. This is a key part of ensuring patient safety in all settings, including general practice.

All doctors will be expected to provide similar supporting information. The portfolios of a dermatologist, cardiac surgeon, psychiatrist or GP will be populated by the same types of information.

Each of the royal colleges has published a similar core document, with only minor modifications that can be justified by the circumstances of that specialty.

Surgeons, for example, will be expected to provide hard outcomes data personal to them – GPs cannot provide data on outcomes specific to themselves, so are not expected to do so.

The RCGP's *Guide to revalidation* takes into account pilot studies involving locums, out-of-hours GPs, prison doctors, GPs with a special interest, non-clinical GPs, rural GPs and so on. We are a diverse group, and the flexibility over the supporting information required for GPs reflects that complexity.

I have seen part of my role as representing the views of all GPs in my revalidation work. I have also been aware of the need to listen to patients and respect their opinions and needs.

I think revalidation will achieve a good balance between professional and patient priorities, and will be fit for purpose. It will raise standards, protect patients, enhance the quality of appraisals and minimise disruption for doctors. Revalidation should be seen as a positive process for doctors.

If a case is made for refining revalidation, I'll ensure that whoever leads revalidation is made aware of it and, if anomalies arise, the advice given to responsible officers must be adapted.

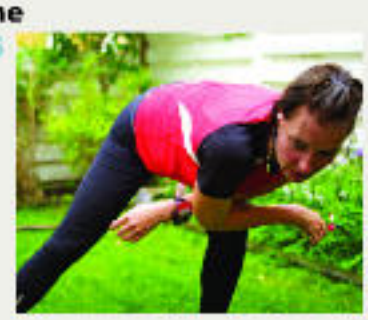
I hope that over the next few years, you will see my aspirations put into practice. My evolution from revalidation lead to president feels a natural one. In my view, placing patients and GPs at the heart of the college, and representing their interests, are complementary activities.

Professor Mike Pringle is president-elect of the RCGP and its clinical lead on revalidation

Pulse Plus

Our monthly CPD section provides an in-depth update on a clinical area, allowing you to earn credits for appraisal by answering questions online

In this issue



More online

Pulse Learning
▶ pulse-learning.co.uk

Hot topics in antiplatelet prescribing 2 CPD hours
The latest on their role in primary and secondary prevention of CVD

Understanding pigmented lesions 1 CPD hour
Our latest video module

PulseToday
▶ pulsetoday.co.uk

Joint injections
How to inject the acromioclavicular joint – with useful pictures and diagrams

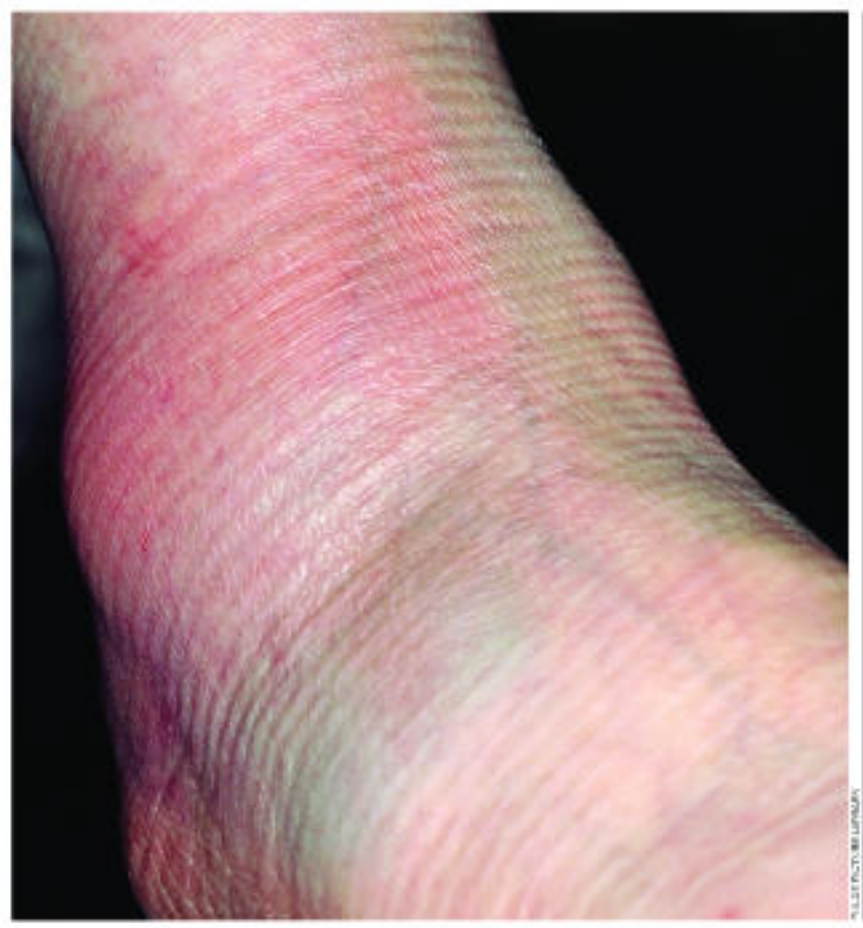
Resource of the week
New guidance on identifying eye problems in people with learning disabilities

Sports medicine

Key questions

Ankle and knee injuries

Dr John Outhwaite, orthopaedic medicine physician, and **Mr Sean Curry**, consultant orthopaedic and trauma surgeon, tackle questions on examination and management from GP **Dr Melanie Wynne-Jones**



Swollen and inflamed sprained ankle

1 How often does actual ligament rupture occur with ankle sprains? How can we recognise it and how should it be treated?

Whether actual ligament rupture occurs depends entirely on the force of the injury.

As a rough guide, if the bruising and swelling is in the malleolus and associated mid-foot, then ligament injury is probably not too severe.

If the swelling goes up as far as the mid calf, then there is probably complete rupture of the ligament. Traditionally ligament rupture is treated with immobilisation, icing and physical therapy.

Many of the ligaments will heal with time – although significant sprains may take as long as six to nine months to heal. Very few will need surgical reconstruction.

2 How can we tell the difference between an ankle sprain and possible fracture? When should we arrange an X-ray?

Severe in-turning or out-turning of the foot relative to the ankle stretches the ligaments beyond their normal length. Most injuries are inversion injuries divided into three types:

- grade 1 sprain with some slight stretching of the fibres
- grade 2 sprain with partial tearing of the ligaments
- grade 3 sprain with complete tearing of the ligaments.

In a grade 1 sprain, the patient will still have full range of motion, which is reduced in grade 2 and 3 sprains. But these are difficult to distinguish clinically because pain and spasm will cause the patient to guard the ankle, and the amount of movement is not easily distinguished.

Alternatively there may be fibula or malleolar fractures or talar dome fractures. Again, classical examination techniques may be unhelpful in distinguishing sprains and fractures, because of patients guarding the injury, or because adrenaline or alcohol may obscure the pain.

A patient who is unable to weight bear – particularly immediately after the injury – warrants an X-ray. But the opposite is not true – ability to weight bear doesn't exclude a fracture. I would always have a relatively low threshold for X-raying these injuries. Grade 2 and 3 sprains should be referred for physiotherapy as soon as possible.

The Ottawa ankle rules are useful for determining which patients should have an X-ray – these can be viewed on pulsetoday.co.uk/tools-and-resources.

PULSE Learning

3 CPD hours

The five articles that make up this PulsePlus CPD module, worth 3 credits, will be available free to all members of Pulse Learning until 1 August 2012
▶ pulse-learning.co.uk

3 Which injuries or complications present as a persistently troublesome ankle some time after an apparently simple sprain? How can we recognise and manage these?

In severe ankle inversion injuries, talar dome fractures are relatively common and difficult to spot on initial X-rays. In any patient with persistent pain or swelling after four to six weeks, an MRI scan should be undertaken to evaluate injury to the mortice joint and persistent injury in the ligaments and tendons around the ankle. A simple sprain should be significantly better in this time frame.

Calf muscles often heal short and eccentric after a severe ankle sprain, and this can cause front loading of the foot and excessive strain on the peroneal tendon and tibialis posterior tendon, causing further pain. Complex regional pain syndrome and other neuropathic pain problems can also occur after a simple sprain. Excessive vasomotor irritability in the skin, allodynia and swelling distal to the area of the original injury are helpful signs of complex regional pain syndrome.

4 Is strapping a sprained ankle helpful?
This really depends on the degree of swelling and pain in the ankle. In a patient with a very swollen, painful ankle, strapping may not be useful.

But later on when the swelling has settled, strapping can be helpful if the ankle is unstable. There are now a range of ankle braces designed for sports use, but which can also be applicable for general use, and these can be extremely helpful for providing stability in the short term.

Immobilisation with an air splint (an ankle brace with air pockets) or Beckham boot (a rigid plastic support similar to a ski boot) may also be helpful.

5 Which symptoms and signs warrant same-day referral after a knee injury?
I would recommend a same-day referral for any knee where there is an inability to weight bear or redness and swelling.

In particular, referral is indicated if swelling occurs immediately after injury (within seconds or minutes), as this indicates severe injury or fracture. Same-day referral is also necessary when there is an open wound. Although these can sometimes be left overnight, the patient would still need to be in hospital.

Locked knees used to be considered an emergency, but now it is thought that – while a locked knee needs to be operated on early – it doesn't need intervention within 24 hours.

6 We often see patients with persistent pain and swelling a week or two after a knee injury; they've usually tried RICE and NSAIDs. If there are no red flags, how long should we wait for symptoms to settle before referral? What exercises should we teach them if physiotherapy isn't quickly available?
The base unit of orthopaedic counting is six weeks, and orthopaedic appointments tend to be in multiples of this number. This is because most soft-tissue injuries take about this long to settle on their own.

The usual picture for a simple knee sprain is a slow, steady improvement over about six weeks. If the patient fits this pattern, a 'watch and wait' approach is acceptable. But any patient whose symptoms are getting worse should be referred urgently (but not same day), as should anyone with persistent swelling beyond four weeks or anyone who cannot fully straighten their knee.

Physiotherapy can start as soon as the patient can tolerate it, but if there is going to be a delay in accessing physiotherapy, the patient can start static quads exercises – where they try to straighten the knee as much as they can by tensing the quadriceps muscles. Go to pulsetoday.co.uk/tools-and-resources for a link to a video demonstrating this exercise.

Once they can do static quads exercises, they can add in a straight leg raise and slowly work on regaining flexion as well. This is usually enough to prevent significant deterioration before physiotherapy begins.

7 While most cruciate ligament injuries are dramatic and present to A&E, some can be more subtle, or are missed at first presentation and present later to the GP. What symptoms and signs should make us consider cruciate ligament injury?
Any history of giving way or instability should raise the suspicion of a ligament injury. Sometimes the language a patient uses can vary and while they might not describe their knee giving way, if you ask them if they ever get a 'wobble' from the knee, a lot of patients will know what you are talking about.

The most sensitive test for an anterior cruciate ligament injury is the Lachman test, but this is difficult to perform and requires a lot of experience to get right. A simpler test is the dynamic extension test.[1] The leg is flexed to about 30° over a bolster and the patient is asked to lift their heel off the bed. If there is damage to the anterior cruciate ligament, the tibia just below the knee is seen to translate forwards before the knee extends. This can be accentuated by resisting movement if you place a hand on the front of the ankle.

This test can also be done in the swollen, painful knee. It does have a false positive rate for posterior cruciate ligament injuries as well as posterolateral corner injuries, but as both require a specialist opinion, it can be safely used to decide whether to refer.

8 When is an MRI scan indicated, and should GPs be able to request them? Is an MRI always requested nowadays before considering arthroscopy?
An MRI scan is done where there is concern about a meniscal injury, ligament injury or articular cartilage damage. Any patient with persistent swelling of the knee, catching, locking or giving way warrants an MRI. Physical signs such as joint-line tenderness or demonstrable instability reinforce the diagnosis, but often the decision to scan is made on symptoms.

I have no problem with GPs requesting MRIs, but if they aren't happy with the reliability of the reporting or interpreting the report, a referral to a knee specialist may be required. I like to see the images from a knee scan with the patient anyway, as decisions on intervention are based on matching symptoms and physical signs with the images. Some pathology can be safely ignored if asymptomatic.

Sometimes the decision to operate can be made without an MRI, but an MRI is useful to pick up secondary injuries and can help in counselling the patient about ongoing symptoms, particularly if there is a meniscal tear with degenerative change. So I recommend an MRI prior to surgery.[2]

Dr John Outhwaite is a consultant orthopaedic medicine physician at the Nuffield Orthopaedic Centre, Oxford, and The London Orthopaedic Clinic
Mr Sean Curry is a consultant orthopaedic and trauma surgeon specialising in knee and hip problems at The London Orthopaedic Clinic
Dr Melanie Wynne-Jones is a GP trainer in Stockport, Cheshire

For more information about The London Orthopaedic Clinic go to londonorthopaedic.com

+SUPPORTING YOU WITH CPD

▶ pulse-learning.co.uk

Go online to read an extended version of this article, with Dr Outhwaite and Mr Curry answering questions on meniscal tears, knee supports and recurrent knee dislocation

References

1 Cross M, Schmidt D and Mackie I. A no-touch test for the anterior cruciate ligament. *J Bone Joint Surgery* 1987. tinyurl.com/notouchACL (accessed 25 June 2012)
2 Boeree N, Watkinson A, Ackroyd C et al. Magnetic resonance imaging of meniscal and cruciate injuries of the knee. *J Bone Joint Surg Br* 1991;73:452-7

Further reading

NHS Choices. *Sprains and strains*. nhs.uk/conditions/sprains (accessed 25 June 2012)

Promoting physical activity

GP and sports medicine consultant Dr Pete Bailey on pragmatic advice for sedentary patients

The aim of this article is to provide guidance on how to offer routine advice and encouragement to adults around physical activity. But it doesn't cover the more extended, individually focused interventions, further details of which are covered in the recent Department of Health *Start Active, Stay Active* guidance.[1]

+WHAT TO SAY TO PATIENTS IF YOU ONLY HAVE 30 SECONDS

- **Doing regular physical activity and trying not to sit for long periods of time will benefit your health, make you feel better and help maintain your body weight.**
- **You should do at least 30 minutes of moderate-intensity physical activity above what you're already doing at work or home on at least five days of the week – enough to raise your heart beat and break into a sweat.**
- **If you're already overweight or obese, then you should aim to do between 60 and 90 minutes of exercise, five days a week – but you can do shorter bouts of 10 or 15 minutes throughout the day.**
- **Walking briskly is an easy way to get started. Slowly increase the length of each walk, and then think about trying other activities – include some stretching and resistance exercises.**

Recommended levels of physical activity

The DH revised its recommendations in 2011, and for adults they are:

- Aim to be active daily. Over a week, activity should add up to at least 150 minutes of moderate-intensity activity in bouts of at least 10 minutes – for example, 30 minutes on at least five days a week.
- Comparable benefits can be achieved through 75 minutes of vigorous-intensity activity spread across the week or a combination of moderate- and vigorous-intensity activity.[1]

Moderate-intensity activity means you're working hard enough to raise your heart rate and break a sweat. Vigorous-intensity activity means you're breathing hard and fast, and your heart rate has gone up quite a bit. You won't be able to say more than a few words without pausing for a breath.

The guidance also states adults should do some muscle strengthening activity at least twice a week and minimise the amount of time they spend sitting.

What works in primary care

Physical activity interventions that are effective and cost-effective in primary care can be broadly classified into advice or counselling and exercise referral.

Advice and counselling

Brief advice from a GP – backed up by information the patient can take away – has been shown to have a moderate short-term effect on physical activity, which lasts six to 12 months. In fact, brief counselling – lasting three to 10 minutes – was as effective as lengthier counselling.[2]

Factors which are known to maximise short-term improvements include assessing a patient's readiness to exercise and discussing which type of exercise might suit them best.

The impact of brief advice from a GP is similar to that seen with smoking cessation, and even though it's a relatively small effect it can have an important effect if applied to a large enough population. Even if you only have 30 seconds to promote physical activity, it's worth doing (see box, above).

For longer sessions, it's worth honing in on reasons for being active that promote individual wellbeing – often more immediate and tangible to the patient – than on improvements in physical health. Emphasise that people who become physically active tend to:

- feel better in terms of enhanced wellbeing, improved mood, life satisfaction, quality of life and energy
- feel better about themselves through improved physical self-perception and improved self-esteem
- be able to concentrate better
- sleep longer and deeper
- feel more generally relaxed and better able to deal with stressful situations (especially useful if patients are also trying to give up smoking).

Exercise referral schemes

Exercise referral schemes involve GPs sending sedentary adults to a leisure centre for an initial assessment, a tailored programme of exercise, and regular monitoring and supervision by an exercise professional. The evidence suggests this produces a small but statistically significant increase in the number of people becoming active.

The latest study into the effectiveness of these programmes – comparing exercise referral schemes with usual care – found a 16% increase in the number of participants who achieved 90-150 minutes of physical activity of at least moderate intensity per week, but no consistent evidence of an increase in the amount of physical activity of moderate or vigorous intensity performed per week.[3]

A failure to properly address long-term behaviour change was identified as a key failing of the schemes analysed – with less than half of participants completing a full course of sessions – and that may be worth considering when evaluating local schemes. The British Heart Foundation has developed a useful exercise referral toolkit (see resources).

Dr Pete Bailey is a GP in Glasgow and a consultant in sports medicine

References

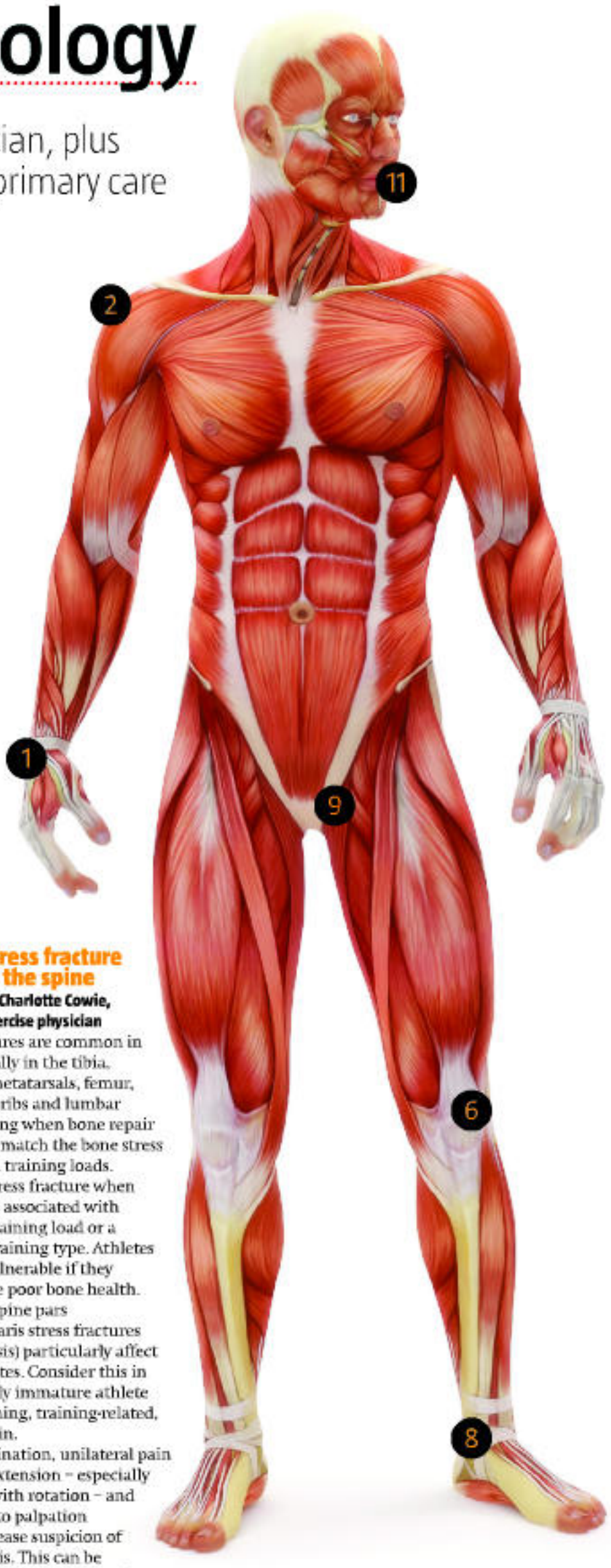
1 Department of Health. *Start Active, Stay Active – a report on physical activity for health from the four home countries' chief medical officers*. July 2011
2 Hillsdon M, Foster C, Naidoo B and Crombie H. *The effectiveness of public health interventions for increasing physical activity among adults: a review of reviews*. NHS Health Development Agency, 2004
3 Pavey T, Taylor A, Fox K et al. Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: systematic review and meta-analysis. BMJ 2011;343:d6462

Resources

- The British Heart Foundation National Centre for Physical Activity and Health Exercise Referral Toolkit. bhfactive.org.uk/exercisereferral/index.html
- NHS Scotland. *Energising lives: a guide to promoting physical activity in primary care*. NHS Scotland 2008. healthscotland.com/documents/2759.aspx

A tour of sporting pathology

Dr Roger Hawkes, consultant sport and exercise physician, plus colleagues give an overview of sporting injuries seen in primary care



1 Scaphoid fracture

Mr Mike Hayton, consultant orthopaedic hand and wrist surgeon

Trauma is required to fracture a scaphoid bone – commonly a fall onto outstretched hands or a goalkeeper blocking a powerful shot. Pain is the most common presenting complaint and is localised to the radial (thumb) side of the wrist, with tenderness in the anatomical snuff box. Telescoping the thumb into the hand may cause pain.

Loss of wrist extension is a sensitive sign. Ask your patient to extend both wrists together with the hands in front of them in a prayer position. A loss of wrist extension should raise the suspicion of a serious intra-articular injury such as a fracture or ligament rupture. If you suspect a scaphoid fracture, refer.

Occasionally, initial X-rays do not show the fracture. GPs may also see patients a week or so after the injury – with scophoid pain and reduced extension. I would advise an urgent fracture clinic appointment in these patients. MRI scanning is the most sensitive method of detecting a scaphoid fracture and will give an immediate diagnosis.

Treatment depends on where the fracture is – the more proximal the fracture, the greater the risk of non-union. All displaced scaphoid fractures should be fixed. In my opinion, all proximal pole fractures should be fixed – even undisplaced ones – because of the high non-union rate. The patient can return to sports after around eight weeks, when bony union has occurred.

2 Subacromial impingement

Professor Len Funk, consultant shoulder and upper limb surgeon

Subacromial impingement is the mechanical compression of subacromial structures between the coracoacromial arch and the humerus during active elevation of the arm above shoulder level. The process is probably multifactorial and not just caused by an acromial spur, particularly in athletes.

In young patients with impingement, consider subclinical instability with possible capsule and labral pathology. Scapular muscle problems are also common. In athletes older than about 50, the causes of impingement are often degenerate and related to an acromial spur, acromioclavicular joint arthritis and rotator cuff tendonopathy or tears.

Younger patients usually present after trauma – either single acute or repetitive. Try physiotherapy first, and failing this consider referring to a specialist for injections.

MR arthrogram is the preferred investigation in younger patients. X-ray, ultrasound and MRI scan is preferred in older patients.

Initial treatment involves rest and rehabilitation addressing posture, scapular, rotator cuff and core stability. Steroid injections can help by addressing the bursitis. Surgery is indicated where two to three months of appropriate and sports-specific rehabilitation has failed.

Surgery in the younger patient involves capsular labral reconstruction with or without subacromial decompression. Surgery in the older patient involves subacromial decompression with or without acromioclavicular joint excision and rotator cuff debridement or repair.

3 Tennis elbow

Mr Adam Watts, consultant elbow and upper limb surgeon

Tennis elbow is the most common cause of lateral-sided elbow pain. It is characterised by micro-tears – in the absence of inflammation – of the deep extensor carpi radialis brevis tendon as it arises from the lateral epicondyle. The diagnosis is often clinical, with a history of localised lateral elbow pain, made worse by resisted wrist extension. Non-operative treatment includes activity modification, rest, physiotherapy and local steroid injection.

There is reasonable evidence that local steroid injection can improve pain symptoms short term. But in up to 40% of patients, symptoms can recur at six to 12 weeks after injection, and at 12 months the patient is more likely to be asymptomatic if they didn't have a steroid injection.

Platelet-rich plasma injection is not widely available in primary care, but has been gaining interest as a treatment – with trials of platelet-rich plasma versus local steroid injection in recalcitrant tennis elbow reporting superior outcomes. Physiotherapy, including eccentric loading exercises, should be started a week after injection and continued until symptoms have resolved.

4 Golfer's wrist

Dr Roger Hawkes, consultant sport and exercise physician

Golfers are prone to wrist injuries, generally in the leading wrist, because of the number of shots played, the divots they take to control the ball and when they hit an unexpected object such as a root.

The movement of the leading wrist is mainly in the coronal plane with radial to ulnar deviation, and so can lead to de Quervain's tenosynovitis – or, on the ulnar side of the wrist, tenosynovitis of extensor carpi ulnaris with tenderness and pain over this cord-like structure just distal to the ulnar styloid. Pain that gets worse with activity suggests stress reactions in the carpal bones. Most occur on the ulnar side of the leading wrist and can be diagnosed by MRI. Try rest for a couple of weeks and then gradually reintroduce playing. If the pain returns, refer to a sports physician.

Fractures of the hook of the hamate are rare, but 35% of these occur in golfers – acutely when the butt of the club compresses the hook or its associated ligament.

It can also present with more chronic pain as a stress reaction in the bone and should be considered with all players complaining of palmar, ulnar-sided pain in the leading wrist. Because of risk of injury to the adjacent ulnar nerve and artery, suspected cases should be referred.

5 Stress fracture of the spine

Dr Charlotte Cowie, sport and exercise physician

Stress fractures are common in sport – usually in the tibia, navicular, metatarsals, femur, pubic rami, ribs and lumbar spine – arising when bone repair is unable to match the bone stress of increased training loads. Suspect a stress fracture when bony pain is associated with increased training load or a change in training type. Athletes are more vulnerable if they already have poor bone health.

Lumbar spine pars interarticularis stress fractures (spondylolysis) particularly affect young athletes. Consider this in any skeletally immature athlete with worsening, training-related, low back pain.

On examination, unilateral pain with back extension – especially combined with rotation – and tenderness to palpation should increase suspicion of spondylolysis. This can be shown on an X-ray of the lumbar spine, but oblique X-rays should be requested in addition to the usual anteroposterior and lateral views.

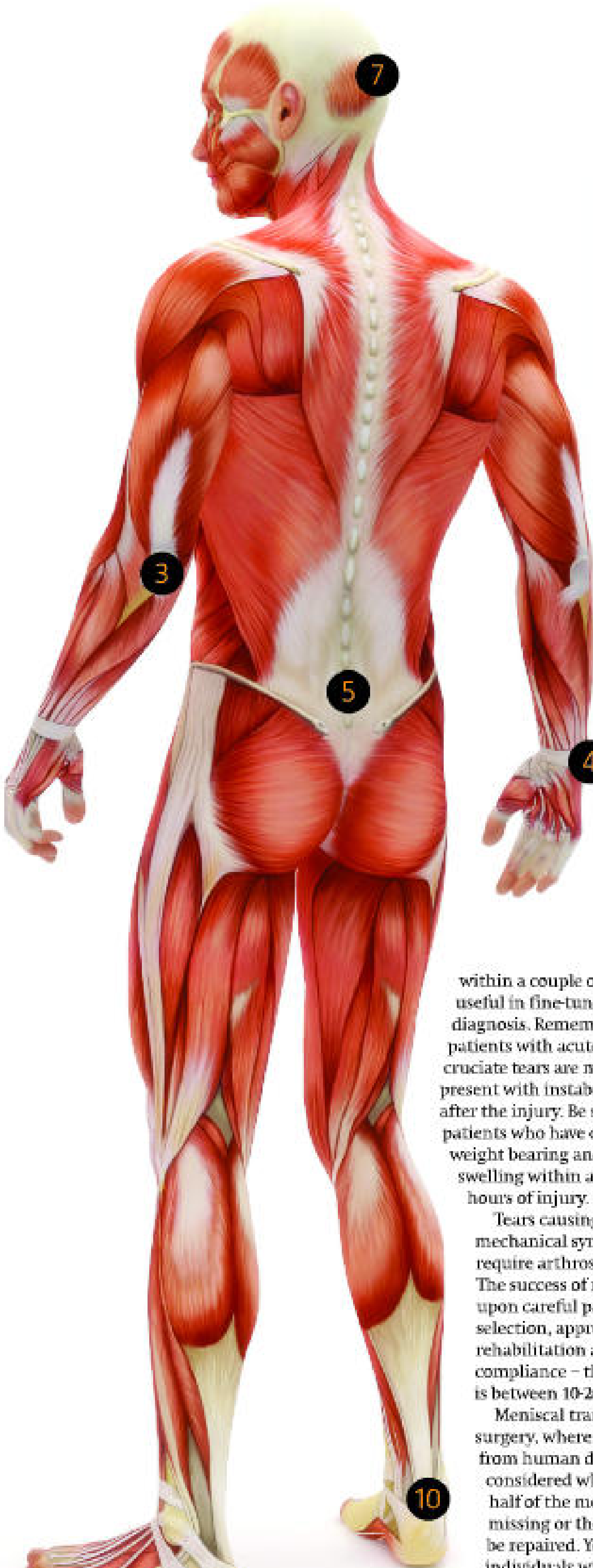
A normal X-ray does not exclude a stress fracture and a definitive diagnosis is made with a radio-isotope bone, CT or MRI scan. Treatment usually involves rest from training and monitoring progress symptomatically. For undisplaced fractures the prognosis is very good.

However, if a bilateral spondylolysis fails to unite, it can result in a spondylolisthesis – one vertebra slipping forward on its distal neighbour – risking long-term pain and instability.

6 Meniscal tears

Mr Ashvin Pimpalnerkar, consultant knee, shoulder and sports surgeon

Meniscal tears often result from twisting



injuries, and occur in all age groups. Patients present with either acute pain immediately or gradual-onset pain and swelling. They lack confidence on twisting and pivoting and can have difficulty squatting or crouching. They may have clicking, giving way and sometimes locking of the knee. In severe cases where the tear is displaced, patients may present with a locked knee. This requires urgent referral – within a couple of days. MRI is useful in fine-tuning the diagnosis. Remember, many patients with acute anterior cruciate tears are missed and present with instability months after the injury. Be suspicious of patients who have difficulty weight bearing and have swelling within a couple of hours of injury.

Tears causing true mechanical symptoms require arthroscopic surgery. The success of repair depends upon careful patient selection, appropriate rehabilitation and patient compliance – the failure rate is between 10-20%.

Meniscal transplant surgery, where tissue is taken from human donors, is considered when more than half of the meniscus is missing or the tear cannot be repaired. Young, active individuals with persistent pain and minimal degenerative knee changes are ideal candidates.

7 Concussion

Dr Mike Loosemore, consultant sport and exercise physician

If a patient presents following a blow to the head, they do not have to have been knocked out to have concussion.[1]

Concussion is diagnosed on:

- presenting symptoms including somatic (headache), cognitive (feeling like they are in a fog) or emotional (lability)
- physical signs (loss of consciousness or amnesia)
- behavioural changes (irritability)
- cognitive impairment (slowed reaction times)
- sleep disturbance (drowsiness).

If one or more of these components is present, suspect concussion. Concussions in children should be taken seriously – seek a neurological opinion if symptoms don't improve in a few days.

Once the diagnosis is made, the patient should rest until symptoms resolve. This includes physical and mental rest – for example, not playing computer games – to allow the brain to recover. Avoid activities which risk further blows to the head.

Once the symptoms have declined, test the recovery by exercising the patient. If the symptoms return, more rest is required. If the patient remains symptom free they are fit to return to sport – moving from light exercise to full contact over about one week.

8 Ankle injuries

Dr Jo Larkin, specialist trainee in sport and exercise medicine

The ankle is one of the most common joints to be injured in professional and recreational football in all age groups – though the rate increases with age. A sudden change in direction can cause an inversion or eversion twisting injury – a fracture or sprain – typically involving the lateral ligament. Ankle injuries can also cause chronic instability resulting from significant ligament damage, delayed presentation, poor rehabilitation or syndesmosis injury (ligaments between the tibia and fibula). This type of injury requires intense rehabilitation and possibly surgery.

It can be hard to differentiate between a fracture and severe sprain. A validated set of rules – the Ottawa rules – are a good guide. An X-ray is indicated if there is any pain and tenderness over the posterior edge or tip of the lateral malleolus, or tenderness over the fifth metatarsal, or if the patient is unable to weight bear. Go to pulsetoday.co.uk/tools-and-resources to view the Ottawa rules.

Ankle injuries can result in significant time away from training and competition, and this is linked to both the frequency and risk of re-injury.

9 Groin injuries

Dr Bryan English, consultant sport and exercise physician

Groin injuries in sport are often secondary to a problem elsewhere, such as mechanical problems of the spine or pelvis, or weakness of the hip extensors. The adductors are stabilising muscles and are important for power, especially in football and ice hockey.

Insufficiency groin injuries, such as the posterior abdominal wall with the so-called sportsman's hernia, occur more commonly in men than women and can be remedied by an alteration in sporting activity – not rest – for a short time. Minimal invasive surgery can be done if the issue becomes chronic.

Other injuries – such as stress fracture of the pelvis, disruption of the integrity of the mechanics of the hip, and dysfunction of the sacroiliac joint – can also lead to groin pain. Differentiation of these can be difficult, so you may need to refer to a sports physician.

Injuries between the umbilicus and the mid thigh can often be complex and multifactorial. But a detailed history, examination and good strength and conditioning help diagnosis and hopefully prevent recurrence of injury.

10 Achilles tendinosis

Dr Kim Gregory, specialty registrar in sport and exercise medicine

Tendon overloading is the key underlying reason for the pain, so reducing aggravating activity levels is critical. Start a graded eccentric heel-drop exercise programme early. But warn the patient that it will cause discomfort – ensure they have adequate analgesia to maintain compliance. If the pain is localised at the insertion, ultrasound-guided steroid injection into the bursa may help.

Consider contributing factors – does the patient have poor calf muscle flexibility, restricted ankle movements or significant over-pronation?

Physiotherapy and orthotic support can help minimise recurrence. Newer treatments include dry needling, platelet-rich plasma or autologous blood injections, high-volume injections and shock wave therapy. Surgery is a last resort.

Tendinopathies can easily become chronic. Return to activity should be gradual and guided by pain. Excluding a significant tendon tear early is critical by palpation of a gap or 'step' in the tendon or a positive Simmonds's calf squeeze test (lack of ankle plantar flexion when the calf muscle is squeezed).

11 Doping in sport

Dr Roger Hawkes and Michele Verroken, anti-doping adviser

Familiarise yourself with the anti-doping regulatory framework. Athletes are responsible for checking medications and avoiding treatments involving prohibited substances.

If this is not possible, they must apply for a Therapeutic Use Exemption to use these medications with approval. This includes, for example, oral, intravenous, intramuscular or rectal applications of steroids, insulin, growth hormone or testosterone. Diagnostic evidence must be included in their application.

You can check the anti-doping regulations 'prohibited list' online.[2] Eirpharm.com is also a good source of information about products and lists by medical conditions.

Encourage athletes to be cautious when using unregulated supplements as they can be contaminated.

This article was overseen by Dr Roger Hawkes, consultant sport and exercise physician and medical director of the physiotherapy and orthopaedic medicine NHS services in South Staffordshire PCT, and chief medical officer of the PGA European Golf Tour, and Mr Mike Hayton, consultant orthopaedic hand and wrist surgeon at Wrightington, Wigan and Leigh NHS Foundation Trust

Professor Len Funk, Mr Adam Watts and Mr Ashwin Pimpalnerkar, are surgeons with a special interest in sport. Dr Bryan English, Dr Charlotte Cowie and Dr Mike Loosemore are consultant sport and exercise physicians. Dr Jo Larkin and Dr Kim Gregory are ST6 trainees in sport and exercise medicine. Michele Verroken is the anti-doping adviser to the International Golf Federation and the European Tour (golf).

References

1 McCrory P, Meeuwisse W, Johnston K et al. *Consensus statement on concussion in sport*. Third International Conference on Concussion in Sport, November 2008
2 World Anti-Doping Agency Prohibited list. wada-ama.org/en/World-Anti-Doping-Program/Sports-and-Anti-Doping-Organizations/International-Standards/Prohibited-List/ (accessed 25 June 2012)

Further reading

- Woods C, Hawkins R, Hulse M and Hodson A. The Football Association medical research programme: an audit of injuries in professional football: an analysis of ankle sprains. *Br J Sports Med* 2003;37:233-8
- Cloke DJ, Ansell P, Avery P and Deehan D. Ankle injuries in football academies: a three-centre prospective study. *Br J Sports Med* 2011;45:702-708

Controversies in sports medicine

Cardiology GPSI and sports health adviser **Dr Matt Hughes**'s guide to the evidence behind five controversies

Does stretching before exercise reduce injury?
Probably not – though this is one of the most quoted golden rules of exercise. There is evidence to show stretching may be useful in reducing soreness after exercise, and limited evidence that it might reduce the risk of tendon and ligament damage, but not enough to make firm recommendations.

The most recent study on the subject found stretching produces a 3% – not statistically significant – reduction in all-injury risk, but does reduce the risk of soreness afterwards by 31%. Although stretching reduced the risk of injuries to ligaments and tendons, the reduction was small and was a secondary outcome of the trial.[1] More recently, a study of 2,700 runners looking specifically at stretching before a run found similar injury rates – about 16% over three months – among the group asked to stretch for five minutes before their run and the group asked not to.[2] Those who enjoy stretching or feel it reduces soreness shouldn't be advised against doing so. Those who don't should balance the risk of minimising soreness and a small reduction in the risk of tendon and ligament injury against the time and motivation it takes to stretch.

But a personal worry of mine is that people who weight train heavily – either for bodybuilding or just seeking to increase muscle mass – are poorly represented in the trial data (just 5% of the 2010 study mentioned above). But they are arguably at risk of greater damage than most, because of the extreme forces they place on their joints and large muscle groups. There are certainly enough anecdotal stories of torn biceps and rotator cuffs to persuade me to recommend a warm-up for this particular group.

Is there a value in the warm-down?
Gentle exercise after vigorous exercise – a cool-down, but also called warm-down or active recovery – is often recommended with the claim that it helps speed up the removal of lactic acid and prevents soreness. But since delayed-onset muscle soreness is now known not to be caused by an accumulation of lactic acid, this is questionable advice.

A small, but fairly robust, Australian study from 2007 looked at the effect on muscle soreness in four groups of people: warm-up/cool-down, warm-up only, cool-down only or neither. Its strength was that all participants did a specific exercise designed to induce muscle soreness: walking backwards downhill on a 13° incline treadmill for 30 minutes at 35 steps per minute, leading with the right leg. Muscle soreness was then assessed in the right leg and the researchers found warm-up reduced perceived muscle soreness 48 hours after exercise, but cool-down had no apparent effect.[3]

This study looked at a specific end-point of a very specific activity, and the results echo those of the 2010 study quoted above. But the cool-down has entered the canon of sports training advice on the basis of anecdote, and there's arguably little point in actively advising against it.

Do creatine supplements work? Are they safe?
In the past two decades the use of creatine supplements has rocketed, making it the most widely used sports supplement. Creatine is involved in the regulation of cell energy demand via adenosine triphosphate production, so there's a plausible physiological rationale for claims it aids endurance. And many studies have demonstrated that oral creatine can maximise muscle creatine levels via a 'loading' dose of 20g/day for five days followed by a 'maintenance dose' of 2-3g/day for up to 30 days. These regimes lead to improved performance of repeated high-intensity exercise, increased strength and lean body mass and enhanced fatigue resistance for exercise tasks lasting 30 seconds or less, particularly when combined with progressive resistance training – explaining their popularity among weight trainers.[4] There were reports in 1998 of renal impairment associated with oral creatine, but subsequent studies have shown no impact on eGFR. But I'd recommend a cautious approach and advise anyone with impaired renal function, diabetes or hypertension not to use creatine.

Are post-match ice baths of any help?
A cautious, qualified yes for this one. Cold-water immersion, less than 15°C, is another of the strategies used for preventing or minimising delayed-onset muscle soreness and fatigue after exercise. This is most popular at football and rugby clubs, and among tennis players and runners.

A recent Cochrane report analysed 17 small trials – involving a total of 366 participants – but the overall trial quality was low. The temperature, duration and frequency of immersion varied as did the sports and settings. Fourteen studies compared cold-water immersion with rest or no specific intervention. Pooled data showed a statistically significant effect on muscle soreness 24, 48, 72 and even 96 hours after exercise, and some trials showed less fatigue and improved perceived performance.[5] More rigorous research might better justify the discomfort and even pain.

Are 'sports drinks' worth the money?
If you exercise moderately hard, then the answer is yes – unless you can be bothered to make your own. If you exercise less intensively, then water will do just fine.

A sports drink is defined as containing:
- carbohydrate – between 4-8g/100ml, sometimes a single sugar and sometimes a glucose/fructose combination
- electrolytes – usually 10-30mmol/l sodium, but other electrolytes like magnesium, potassium and calcium are sometimes included.

Sports drinks also containing protein are beginning to appear. The case for consuming protein during recovery after exercise is strong, and protein shakes and supplements are popular – although actual food works too. But claims that consuming protein during exercise improves performance are contentious. The key points on sports drinks are that you need to start exercising properly hydrated, drink as much as you feel you need during training and replace the water and electrolytes after. What you should drink depends on the length and level of exercise intensity.
- For low to moderate intensity exercise that lasts less than an hour, water will do.
- For moderate to hard sessions that last longer than one hour (with significant sweat loss), a commercial isotonic sports drink will help. A homemade version can be made with 200ml squash, 800ml water and a large pinch of salt.[6]

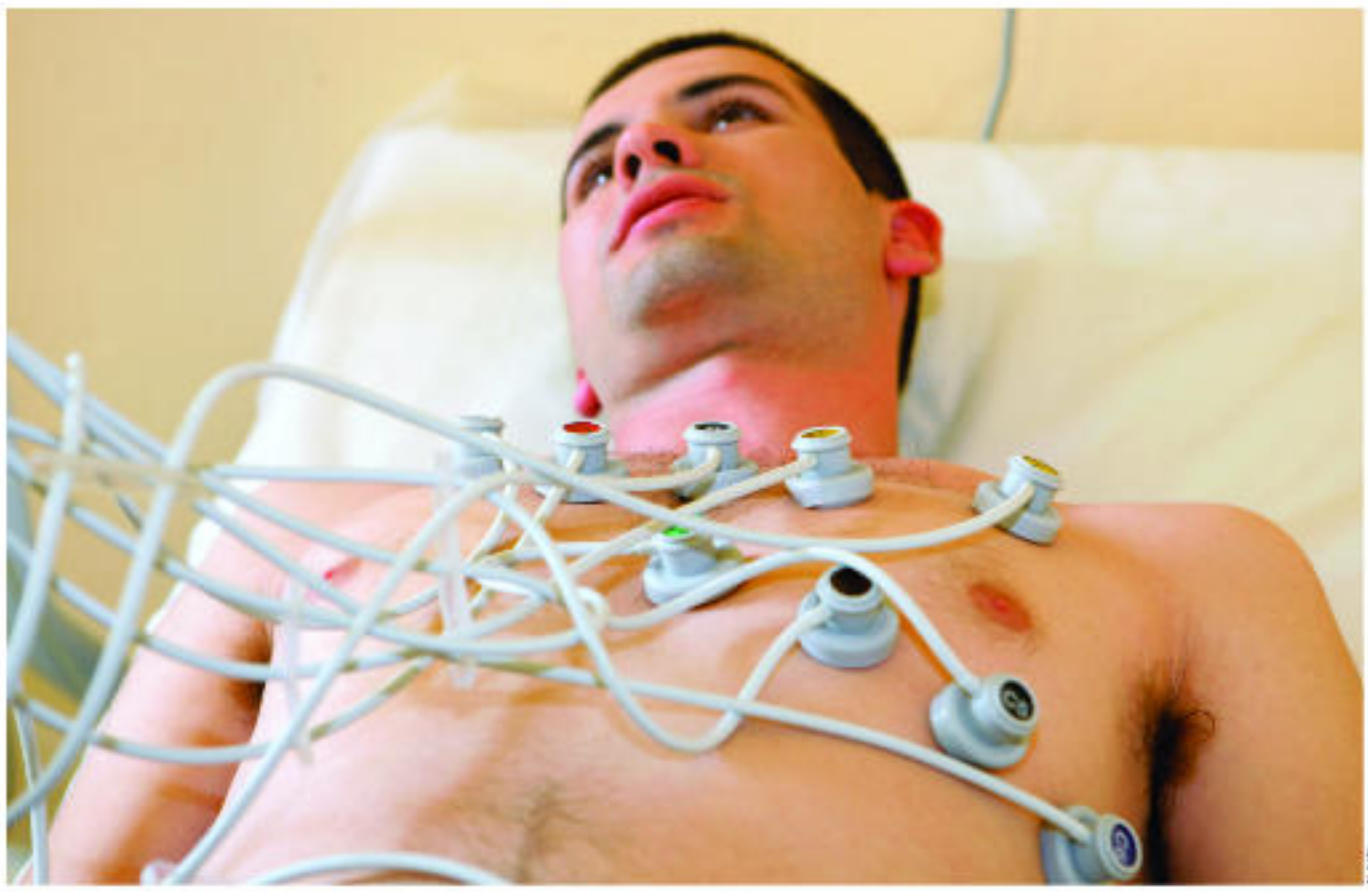
Dr Matt Hughes is a GP and hospital practitioner in cardiology in Cardiff and acts as a medical consultant to a range of gyms in south Wales

References

1 Jamtvedt G, Herbert R and Flottorp S et al. A pragmatic randomised trial of stretching before and after physical activity to prevent injury and soreness. *Br J Sports Med* 2010;44:1002-9
2 Pereles L. American Academy of Orthopaedic Surgeons annual meeting 2011. Abstract P648
3 Law R and Herbert R. Warm-up reduces delayed-onset muscle soreness but cool-down does not: a randomised controlled trial. *Aust J Physiother* 2007; 53:91-5
4 Poortmans J, Rawson E, Burke R et al. A–Z of nutritional supplements: dietary supplements, sports nutrition foods and ergogenic aids for health and performance Part 11. *Br J Sports Med* 2010;44:765-6
5 Bleakley C, McDonough S, Gardner E et al. Cold-water immersion (cryotherapy) for preventing and treating muscle soreness after exercise. *Cochrane Database Syst Rev* 2012;CD008262
6 The British Dietetic Association. Food fact sheet: sports. bda.uk.com

Sudden death in young athletes

Cardiologists **Dr Michael Papadakis** and **Professor Sanjay Sharma** discuss causes of sudden cardiac death and who to screen



Initial assessment in an athlete with worrying symptoms will include a 12-lead ECG

Occasionally a young, apparently healthy, athletic individual suffers sudden cardiac death. Many of these deaths may be preventable and the devastating impact of a missed opportunity to save a young life cannot be underestimated. The nature of these deaths attract a lot of media attention and often lead to a wave of enquiries for GPs from individuals about their or their families' risk. This article summarises the relevant cardiac pathologies, potential red flags, investigations, management and preventive strategies.

Sudden death in young athletes (under 35) is rare – the estimated yearly incidence is four per 100,000 – with male to female ratio of 9:1. Most of these deaths occur during or shortly after exercise – most are reported in football and basketball (high rates of participation provide the most plausible explanation for this). The mean age of sudden cardiac death ranges from 17 to 23 years.[1,2,3]

What is the likely cause of sudden cardiac death in young athletes?

Inherited cardiomyopathies are the most common cause of sudden cardiac death – hypertrophic cardiomyopathy accounts for over one-third of cases in athletes in US studies and arrhythmogenic right ventricular cardiomyopathy predominates in Italian and UK studies. Congenital coronary artery anomalies and premature atherosclerosis account for almost 20% of sudden cardiac deaths. But in many cases, an obvious cause cannot be identified. These are classified as sudden arrhythmic death syndrome and are usually due to inherited electrical abnormalities with a predilection to fatal arrhythmias.[3]

Are there any warning symptoms or signs?

Around a third of victims report warning cardiac symptoms and almost 30% of patients with hypertrophic cardiomyopathy exhibit dynamic left ventricular outflow tract obstruction at rest, resulting in an ejection systolic murmur. So a targeted history and cardiovascular assessment are important when assessing a young athlete.

Symptoms such as palpitations, shortness of breath, chest pain, pre-syncope and syncope are fairly common in the general population. But symptoms that should raise concern of underlying cardiac pathology and prompt further evaluation are:

- syncope with no prodromal symptoms
- syncope resulting in injury
- new onset seizures
- new onset exertional symptoms
- symptoms in the context of a family history of cardiac disease or premature sudden death (younger than 40).

During cardiovascular examination, look for stigmata of connective tissue disease such as Marfan's syndrome, which can be associated with sudden cardiac death because of valvular lesions or aortic dissection or rupture. Assess the rate, rhythm and character of the pulse and measure blood pressure on both arms. Radio-radial or radio-femoral delay, or significant blood pressure difference between arms, may be an indication of undetected coarctation of the aorta, which can be associated with sudden death because of congestive heart failure, dissection or rupture.

Also auscultate for any murmurs. In contrast to the ejection systolic murmur associated with aortic valve stenosis, hypertrophic cardiomyopathy may be associated with a murmur that increases in intensity during valsalva and when the patient stands upright from a supine position.

What investigations are needed in an athlete with worrying symptoms or signs?

Young athletes with symptoms or signs suggestive of underlying cardiac pathology should ideally be referred to a cardiologist with expertise in sports cardiology.

GPs may wish to preform initial investigations such as a 12-lead ECG or echocardiogram – but it's important to remember that interpretation of the results can be challenging (see below).

Once referred, the athlete may undergo initial assessment with a 12-lead ECG, transthoracic echocardiogram, cardiopulmonary exercise tolerance testing and cardiac monitor.

Further investigations will depend on initial results. Interventions vary from simple lifestyle modification advice, including abstinence from competitive sport, to the implantation of an intracardiac defibrillator.

Should we screen for conditions predisposing to sudden death in young athletes?

Current strategies to prevent sudden cardiac death include:

- targeted screening of high-risk people, such as relatives of anyone who experienced sudden cardiac death

28

◄ 27
● cardiovascular evaluation of individuals with symptoms suggesting cardiovascular disease, a family history of inherited cardiac disease or premature sudden cardiac death
● putting automated external defibrillators in public and athletics venues.

However, these strategies only prevent a minority of sudden cardiac deaths in the young, since sudden cardiac death is usually the first presentation of quiescent cardiac disease and the efficacy of external defibrillators is limited in the context of extreme exercise.[1]

A number of scientific and sporting bodies recommend pre-participation cardiac evaluation with a 12-lead ECG. This is a highly sensitive tool for identifying quiescent cardiomyopathies – 95% of individuals with hypertrophic cardiomyopathy and 80% of individuals with arrhythmogenic right ventricular cardiomyopathy exhibit ECG abnormalities.

The most compelling evidence that screening with a 12-lead ECG reduces sudden cardiac death in sport is from a prospective study showing that after screening was introduced in Italy, the incidence rate of sudden cardiac death decreased from 3.6 per 100,000 person-years to 0.4 per 100,000 person-years – a 90% reduction in mortality.

What are the potential pitfalls of ECG screening in athletes?

An ECG cannot identify all athletes at risk of sudden cardiac death. In particular, it fails to identify athletes with atherosclerotic coronary artery disease and congenital coronary anomalies, and given the high prevalence of unsuspected atherosclerosis in athletes aged over 35 years, its efficiency is limited in older people.

Concerns about ECG screening in young athletes are mostly because of potential false positives leading to unnecessary investigations or even disqualification of athletes.

But in the UK, screening has a false-positive rate of 3.7% using history, physical examination and ECG, with only 1.9% of false positives from ECG alone.

Physical conditioning is associated with ECG changes that may overlap with changes observed in cardiomyopathies. So pre-participation screening should be performed by cardiologists or other clinicians with an interest in cardiovascular adaptation to exercise.

To aid your interpretation of the 12-lead ECG in athletes, the sports cardiology section of the European Association for Cardiovascular Prevention and Rehabilitation has produced guidelines on differentiating training-related ECG changes from underlying cardiac pathology.

Should GPs give young patients 'checks'?

In the UK, there is no state-funded cardiovascular pre-participation evaluation. The charity Cardiac Risk in the Young (CRY) subsidises cardiovascular evaluations for several elite sporting organisations that self-fund evaluations for recruits competing at regional, national or international level.

CRY also advocates screening for all individuals who wish to be tested for self-protection, aged 14 to 35 years, irrespective of athletic status. All evaluations are supervised by cardiologists with expertise in cardiovascular adaptation to exercise and conditions predisposing to sudden cardiac death.

What about screening in those with a family history of sudden cardiac death?

As most conditions predisposing to sudden cardiac death in the young are inherited, the UK Government commissioned the 8th chapter of the National Service Framework for heart disease to facilitate early identification of individuals at risk of sudden cardiac death.[4] All first-degree relatives of individuals with a potentially inherited cardiac condition predisposing to sudden cardiac death, premature sudden cardiac death (younger than 40), sudden cardiac death from a potentially inherited cardiac pathology or unexplained sudden death should be referred for detailed cardiovascular screening to a tertiary cardiogenetics clinic with expertise in the diagnosis and management of inherited cardiac conditions.

Current literature suggests that approximately 50% of families where the deceased's post-mortem examination failed to identify any cardiac pathology demonstrate evidence of an ion-channel disorder following clinical assessment.[5]

These relatives will receive treatment to prevent sudden death – ranging from lifestyle modification advice to implantation of a permanent pacemaker system or intracardiac cardioverter defibrillator.

Dr Michael Papadakis is a clinical lecturer in cardiology at St George's University of London and member of the sports cardiology nucleus of the European Association for Cardiovascular Prevention and Rehabilitation (EACPR)

Professor Sanjay Sharma is professor of clinical cardiology at St George's University of London, medical director to the London Marathon and president-elect of the sports cardiology nucleus of the EACPR

Visit c-r-y.org.uk for more information about cardiac screening, sports cardiology and inherited cardiac conditions. To book a place on the Cardiac Risk in the Young annual conferences, or to view past presentations, go to c-r-y.org.uk/conferences.htm.

References

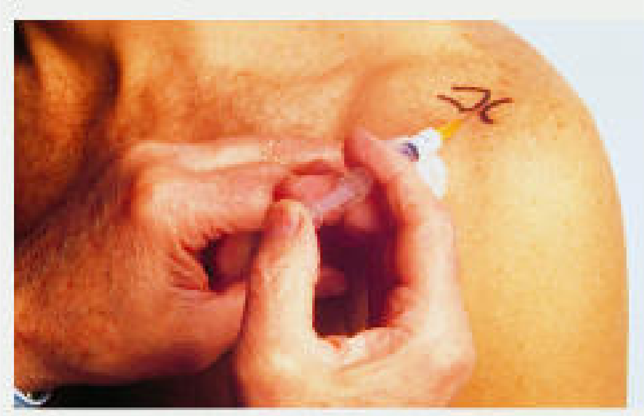
1 Papadakis M and Sharma S. Electrocardiographic screening in athletes: the time is now for universal screening. Br J Sports Med 2009;43:663-8
2 Papadakis M and Sharma S. Sudden cardiac death. Medicine 2010;38:502-6
3 Papadakis M, Sharma S, Cox S et al. The magnitude of sudden cardiac death in the young: a death certificate-based review in England and Wales. Europace 2009;11:1353-8
4 Department of Health coronary heart disease team. National Service Framework for coronary heart disease. Chapter 8: Arrhythmias and Sudden Cardiac Death. tinyurl.com/nsfsuddencardiac (accessed 12 January 2011)
5 Behr ER, Dalageorgou C, Christiansen M et al. Sudden arrhythmic death syndrome: familial evaluation identifies inheritable heart disease in the majority of families. Eur Heart J. 2008;29:1670-80

Further reading

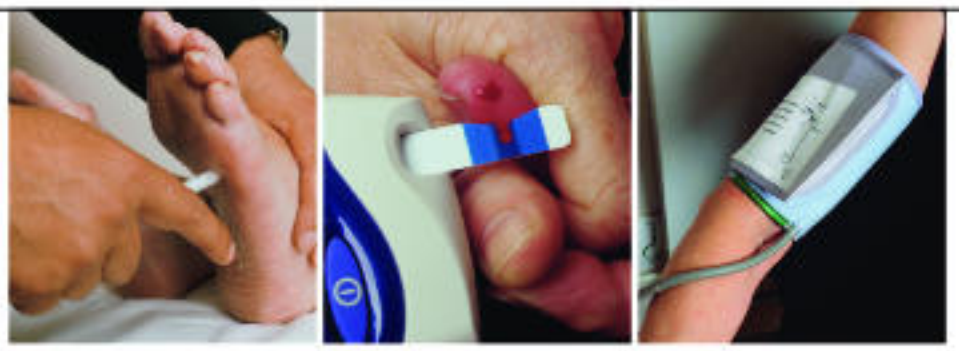
● European Society of Cardiology sportscardiology.eu (accessed 27 June 2012)

New online series

▶ pulsetoday.co.uk/joint-injections



Go online to see our new series of articles on joint and soft tissue injections, with useful pictures and diagrams to guide you.



6 CPD hours

PULSE Clinical Seminars

Diabetes and CVD Update 2012

Extended early bird rate
Save £50
Book before 24 August

Wednesday 26 September, central London

Five reasons why you must attend this event:

- Cut through the controversies about the latest NICE guidance on preventing type 2 diabetes
- Explore realistic and cost-effective strategies to implement the NICE hypertension guidelines in your practice
- Share a masterclass on the pros and cons of new versus older diabetes drugs
- Establish when and how to use the new anticoagulants in atrial fibrillation
- Examine what's new in the QOF and how this can boost income
- Tackle diabetes complications case-by-case

Book Now

Register today at www.pulse-seminars.com

t 020 7332 2934

In association with

GPSI

education for health

Media partner

PCCJ

PULSE Clinical Update

Free-to-attend half-day seminars

Lower GI update

Focusing on accurate diagnosis and effective management of irritable bowel syndrome and lower gastrointestinal symptoms

Choose from two venues in 2012
27 September *Crowne Plaza, Manchester*
11 October *King's Fund, London*

Don't miss this essential afternoon seminar:

- Sharpen your diagnostic skills in lower GI disorders to avoid unnecessary testing and reduce costs
- Establish how to tailor first- and second-line management options to meet individual needs
- Hear expert insight on patient perspectives to maximise the effectiveness of your consultations

BOOK NOW
LIMITED FREE PLACES

Register your free place online **pulsetoday.co.uk/lower-gi-2012**

Supported and initiated by

DANONE

PCSG

In association with

PULSE

PULSE
3 CPD hours
Attending this seminar is worth 3 CPD credits towards the 50 annual credits you must build up for appraisal

30 PULSESERVICES
TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Destination	Hepatitis A & Typhoid	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B & Rabies	Yellow fever	Tick-borne encephalitis	Japanese encephalitis/ Meningo/ACWY	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards	Alternative regimen
Abu Dhabi	S	R			S		S	S			No			Le
Afghanistan	R	R	S	R	R	S	S	S	C		Yes, below 2,000m, May-Nov	ME or DO or MON	PC	Le
Albania	S	R					S	S	C		No			Le
Algeria	R	R			S	S	S	S	C		Yes, area around Biskra	W		Sh Le
Angola	R	R	S	R	R	S	S	S	M		Yes, high risk	ME or DO or MON	PC	Sh Ts
Antigua & Barbuda		S					S		C		No			
Argentina	S	R					S	S	S		Yes, rural areas near ME border with Bolivia and NW border with Brazil and Paraguay	C	P	
											Other areas very low	W		
Armenia	S	R			S	S	S	S			No	W		
Australia									C	S	No			
Austria										S	No			
Azerbaijan	S	R				S	S	S		S	Variable risk at SW border Jun-Oct	C	P	Le
Bahamas		R					S		C		No			
Bahrain	S	R				S	S	S	C		No			Le
Bali	R	R			R	S	S	S	C	S	Yes, low risk	W		
Bangladesh	R	R	S		R	S	S	S	C	S	Yes, SE and Chittagong Hill Tracts. Elsewhere, low risk	ME or DO or MON	PC	Le
												W		
Barbados		S			S		S		C		No			
Belarus		R			S	S	S	S			No			
Belize	S	R				S	S	S	C		Variable risk in south, low risk Belize City	C	P	
Benin Republic	R	R	S	R	S	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC	Sh Le
Bermuda		S					S				No			
Bhutan	R	R	S			S	S	S	C	S	Yes, southern districts	ME or DO or MON	DIF	Le
Bolivia	R	R			R	S	S	S	R		Yes, high risk in Amazon basin. Variable risk on Paraguayan and Argentine borders	ME or DO or MON	PC	
												PC	DIF	
Borneo	R	R	S		S	S	S	S	C	S	Low risk, coastal areas of Malaysian Sarawak and Sabah. Indonesian Kalimantan, high risk all areas	W		
												ME or DO or MON	PC	
												PC	PC	
Bosnia		R			S	S	S	S			No			Le
Botswana	R	R	S		S	S	S	S	C		Yes, northern half only Nov-June	ME or DO or MON	PC	Sh Ts
Brazil	S	R			S	S	S	S	R		High risk in NW half in Amazonia states. Elsewhere, very low	ME or DO or MON	PC	Sh Le Tc
												W		
Brunei		R				S	S	S	C	S	No			
Bulgaria		R				S	S	S		S	No			
Burkina Faso	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC	Sh Le Ta
Burundi	R	R	S			S	S	S	M		Yes, high risk	ME or DO or MON	PC	Sh Ts
Cambodia	R	R	S		R	S	S	S	C	S	Yes	DO or MON	PC	
											Yes, significant risk elsewhere. Minimal risk Phnom Penh, Angkor Wat, Siem Reap	ME or DO or MON	PC	
												W		
Cameroon	R	R	S		R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC	Sh Ta
Canada											No			
Cape Verde Islands	R	R			S	S	S	S	C		Yes, very low risk May-Nov	W		Le
Cayman Islands		S					S				No			
Central African Rep.	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC	Sh Ts
Chad	R	R	S	R	R	S	S	S	R	S	Yes, high risk	ME or DO or MON	PC	Sh Ta
Chile	S	R					S	S			No			Tc
China (Mainland)	S	R	S	R		S	S	S	C		S	S	Yes, in Yunnan and inland Hainan. Elsewhere, very low/no risk	ME or DO or MON	PC	Sh
												W		
China (Hong Kong)		R				S	S				No			
China (Macao)		R				S	S	S		S	No			
Colombia	S	R					S	S	R		Yes, high Eastern half	ME or DO or MON	PC	Le Ta
											Variable risk elsewhere <1,600m	PC	DIF	
											Very low around Medellin, Bogotá & Cartagena	W		
Comoros	R	R	S		S	S	S	S			Yes, high risk	ME or DO or MON	PC	Le
Congo	R	R	S	R	R	S	S	S	M		Yes, high risk	ME or DO or MON	PC	Sh Ts
Congo Dem. Rep.	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC	Sh Ts
Cook Islands		R					S				No			
Costa Rica		R			S		S	S	C		Small variable risk area on East coast. Rest of country, low risk	C	P	Le Tc
												W		
Croatia		S					S	S			S	No		Le
Cuba		R					S	S			No			
Cyprus		S									No			Le
Czech Republic		S					S				S	No		
Djibouti	R	R	S		S	S	S	S	C			Yes, high risk	ME or DO or MON	PC	Sh Le
Dominican Republic	R	R	S		R	S	S	S				Yes, high risk along Haitian border, variable risk elsewhere	C	P	Sh Le
Dubai	S	R			S		S	S				No		Le
East Timor (Timor Leste)	R	R			S	S	S	S	C	S		Yes, high risk	ME or DO or MON	PC	Le
Ecuador	R	R				S	S	S	R			Yes, high risk Esmeraldas and rainforest/aerial rim bordering Colombia and Peru. Elsewhere low risk	ME or DO or MON	PC	Tc
													W		
Egypt	R	R					S	S	C			No			
El Salvador	R	R					S	S	C			Yes, low risk	W		
Equatorial Guinea	R	R	S		R	S	S	S	R			Yes, high risk	ME or DO or MON	PC	Sh Ta
Eritrea	R	R	S		R	S	S	S	C	S		Yes, high risk (no risk in Asmara)	ME or DO or MON	PC	Sh Le
Estonia		S					S	S		S		No			
Ethiopia	R	R	S		R	S	S	S	R	S		Yes, high risk below 2,000m (low risk in Addis Ababa)	ME or DO or MON	PC	Sh
Falklands (Tristan da C.)												No			
Fiji	S	R			R		S		C			No			
Finland										S		No			
France										S		No			Le
French Guiana	S	R			S	S	S	S	M			High risk inland and border areas, coast and islands, low no risk	ME or DO or MON	PC	Sh Tc
French Polynesia		R					S					No			
Gabon	R	R	S	R	R	S	S	S	M			Yes, high risk	ME or DO or MON	PC	Sh
Gambia	R	R				S	S	S	R	S		Yes, high risk	ME or DO or MON	PC	Sh Ta
Georgia	S	R				S	S	S			S	Yes, v. low risk SE villages Jul-Oct	W		
Germany										S		No			
Ghana	R	R	S		R	S	S	S	M	S		Yes, high risk	ME or DO or MON	PC	Sh Ta
Goa	R	R		R	R	S	S	S	C	S		Yes, variable risk	PC	DIF	Le
Greece and Islands		S					S			S		No			Le
Greenland		R			S		S	S				No			
Grenada		S					S	S	C			No			
Guadeloupe		S				S	S		C			No			
Guam		R				S	S					No			
Guatemala	S	R				S	S	S	C			Yes, some risk below 1,500m	C	P	
Guinea	R	R	S	R	R	S	S	S	R	S		Yes, high risk	ME or DO or MON	PC	Sh Ta
Guinea Bissau	R	R	S		S	S	S	S	M	S		Yes, high risk	ME or DO or MON	PC	Sh Ta
Guyana	S	R				S	S	S	R			Yes, high risk all areas except coastal strip	ME or DO or MON	PC	Sh
Haiti	R	R	S		R	S	S	S	C			Yes, high risk throughout country	ME or DO or MON	PC	
Hawaii							S					No			
Honduras	R	R				S	S	S	C			Yes, risk variable	C	P	Le
Hungary							S			S		No			
India	R	R	S	R	R	S	S	S	C	S		Yes, high risk Assam	ME or DO or MON	PC	Le
												Yes, low risk in southern states, Delhi, Jaipur, Agra, Mumbai	W		
												Yes, elsewhere	PC	DIF	
Indonesia	R	R	S		R	S	S	S	C	S		Yes, high risk Lombok	ME or DO or MON	PC	Sh
												Very low risk Bali and cities	W		
												Yes, variable elsewhere	PC	DIF	
Iran	S	R	S		S		S	S	C			Yes, rural SE provinces Mar-Nov	ME or DO or MON	PC	Sh Le
Iraq	R	R	S		R	S	S	S	C			Yes, v. low risk rural north May-Nov	W	P	Sh Le
Israel		R					S	S				No			Le
Italy		S					S			S		No			Le
Ivory Coast	R	R	S	R	R	S	S	S	M	S		Yes, high risk	ME or DO or MON	PC	Ta
Jamaica		R			S		S		C			No			
Japan							S			S	S	No			Sh
Jordan	S	R					S	S	C			No			Le
Kazakhstan		R			R	S	S	S	C		S	No			Le
Kenya	R	R	S	R	R	S	S	S	R	S		Yes, high risk (Nairobi and highlands low risk)	ME or DO or MON	PC	Sh Le Ta
Kiribati	S	R			S	S	S		C			No			
Korea (North)	R	R			S	S	S	S	C		S	Yes, limited risk extreme south	W		
Korea (South)	S	R				S	S				S	Yes, limited risk extreme north	W		
Kosovo		R				S	S	S			S	No			Le
Kuwait	S	R			R		S					No			
Kyrgyzstan	S	R		R	R	S	S	S			S	Yes, low risk some S to W areas	W		Le
Laos	R	R	S		R	S	S	S	C		S	Yes, high risk (minimal risk Vientiane)	ME or DO or MON	PC	
Latvia	S	S			S	S	S	S			S	No			

Key

- **M** = immunisation mandatory
- **R** = immunisation recommended as risk of infection is substantial
- **S** = immunisation sometimes recommended:
  - for more than three visits in a one-year period
  - a stay of more than three months in a rural area
  - for high-risk occupational groups
  - for backpackers staying more than one month
  - when entering the limited geographical risk area for the target disease
- **C** = See Yellow fever, next column

Where **S** appears for cholera, it indicates that only high-risk travellers, usually healthcare workers in areas of known epidemics, should be immunised.

Vaccinations information

Tetanus
Five tetanus doses are considered protective for life by the DH, although there is no evidence base for this. Travellers at risk of tetanus-prone wounds should be given 10-yearly boosters if they are going to poorer countries in Africa, Asia and South America where specific immunoglobulin may be unavailable.

Polio
All travellers should have completed the British vaccination schedule for polio immunisation in childhood or as adults.

Yellow fever
● An international certificate of vaccination may be required for those entering from, or transiting through airports in YF endemic countries where **C**, **S**, **R** or **M** appears indicated in the yellow fever column. For details consult: http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-3-infectious-diseases-related-to-travel/yellow-fever-and-malaria-information-by-country.htm#seldyfm298

● **M** = Mandatory generally indicates that all travellers aged >12 months should carry an international certificate of vaccination. Country specific ages are indicated in the web site above.

Information source and updates
This chart is based on information from the UK TRAVAX website and other databases. TRAVAX is an information service provided by Health Protection Scotland (www.travax.scot.nhs.uk; telephone 0141 300 1130).

The chart is updated regularly. Readers are advised to use the latest chart only, to ensure that their practice reflects the most recent advice.

Travel vaccinations and malaria information author
Dr Michael Jones, consultant physician, Regional Infectious Disease Unit, Western General Hospital, Edinburgh

Parasitic infections

Short-term travellers staying in good conditions are usually at low risk of acquiring parasitic infections. Schistosomiasis is common and potentially serious. Leishmaniasis and trypanosomiasis are less common but potentially lethal. Expatriates in remote areas at risk of other rare diseases are not shown in this chart.

Sh = schistosomiasis. Travellers should avoid swimming in freshwater lakes and rivers in endemic areas.

Ta = African trypanosomiasis (sleeping sickness). Transmitted by tse-tse flies, and a risk in some African game parks and rural areas. Travellers should use insect repellents, close windows if fly swarms approach and seek medical attention for any signs of infection around bites one to three weeks later.

Tc = South American trypanosomiasis (Chagas' disease). Transmitted by reduvid bugs that feed at night and reside in the thatch and crevices of rural dwellings. Travellers should avoid sleeping in huts.

Le = leishmaniasis. Transmitted by sandflies in arid areas (including Mediterranean coastal areas), mostly at night. Travellers should use insecticide-impregnated mosquito nets and insect repellent.

Travel medicine update

Measles in Ukraine and Russian Federation
By the end of May, 10,000 cases of measles had been reported in Ukraine, most in the western regions bordering Poland, but also in the Russian Federation – where since the start of 2012, the incidence of measles has increased over 22 times compared with the same time period in 2011. In Russia, this is mostly in the Central, Southern and Northern Caucasus federal districts. GPs should be aware of the increased risk to unimmunised travellers, particularly football fans returning from Euro 2012. Any unimmunised adults born since 1970 planning travel should be offered two doses of MMR vaccine.

Leptospirosis in Thailand
Leptospirosis has long been a particular risk for travellers venturing into the forests of Malaysia and Thailand. Health officials in north-east Thailand have reported an outbreak of leptospirosis during this rainy season, and since January over 700 cases, causing 17 deaths, were recorded. Leptospirosis is caused by contact with fresh water, wet soil or vegetation that has been contaminated by urine, often from rats, but also dogs, cattle and pigs. An additional benefit of doxycycline antimalarial prophylaxis, where indicated, is its action preventing leptospirosis.

Cholera in the Philippines
An outbreak of cholera in the province of Catanduanes in the Philippines has been declared, with over 1,300 cases and eight cholera-related deaths recorded since January 2012. The worst-affected area is the town of Virac, with 748 cases and six deaths reported. Travellers should maintain a high standard of food, water and personal hygiene. The oral vaccine may be considered for those likely to be in direct contact with cholera cases or who cannot maintain safe food and water precautions.

Source
travax.nhs.uk

Specialist advice

For advice on complex itineraries and other queries, use the following helplines:
Birmingham **0121 424 0357/ 3354/2357**
Edinburgh, Western General Hospital **0131 537 2822**
National Travel Health Network and Centre (Monday to Friday, 9am-12pm, 2pm-4.30pm) **0845 602 6712** (local call rate)

PULSE

Updated: July 2012

Destination	Hepatitis A	Typhoid	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningitis/ACWY	Japanese enceph	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Lebanon	S	R			S		S	S	C				No			Le
Lesotho	R	R	S		S	S	S	S	C				No			Sh
Liberia	R	R	S	R	S	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Libya	S	R			S	S	S	S	C				No risk			Le
Liechtenstein		S					S					S	No			
Lithuania		S				S	S	S				S	No			
Macedonia		R					S	S				S	No			Le
Madagascar	R	R			S	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh
Madeira		S					S						No			
Malawi	R	R	S			S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Malaysia	R	R	S		S	S	S	S	C		S		Yes, high risk Sabah and deep forests of peninsular Malaysia	ME or DO or MON	PC	
Maldives	R	R				S	S	S	C				No			
Mali	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Ta
Malta and Gozo		S					S		C				No			Le
Martinique		S				S	S		C				No			Sh
Mauritania	R	R	S	R	R	S	S	S	R	S			Yes, high risk all year in south Low risk in far north	ME or DO or MON	PC	Sh Le
Mauritius		R					S		C				No	W		
Mayotte	R	R				S	S	S	C				Yes, high risk	ME or DO or MON	PC	Le
Mexico	R	R					S	S					Yes, southern rural areas only Elsewhere and tourist areas	C W	P	Tc
Moldova	S	R			S	S	S	S				S	No			
Mongolia	S	R				S	S	S				S	No			
Montenegro		R				S	S	S				S	No			Le
Montserrat		S					S		C				No			
Morocco	R	R				S	S	S					No	W		Le
Mozambique	R	R	S		R	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Myanmar (Burma)	R	R	S		R	S	S	S	C		S		Yes, Kayin and East Shan state Yes, elsewhere Low/no risk Mandalay & Rangoon	DO or MON ME or DO or MON W	PC PC	
Namibia	R	R	S		S	S	S	S	C				Yes, northeast third only Yes, all year – along Kavango and Kunene Rivers	ME or DO or MON	PC	Sh
Nepal	R	R	S	R	R	S	S	S	C		S		Yes, below 1,500m (no risk in Kathmandu)	PC	DRF	Le
Neth Antilles		S					S		C				No			
Netherlands													No			
New Caledonia	S	R					S		C				No			
New Zealand													No			
Nicaragua	R	R				S	S	S	C				Yes, variable risk in north, low risk in south	C	P	Le Tc
Niger	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Nigeria	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Norway		S										S	No			
Oman	S	R					S	S	C				Sporadic imported risk	W		Sh Le
Pakistan	R	R	S	R	R	S	S	S	C		S		Yes, significant below 2,000m	ME or DO or MON	PC	PC
Panama	R	R			S	S	S	S	R				Yes, high risk NE coast & Colombia border Variable risk east & west of Canal	ME or DO or MON C	PC P	
Papua New Guinea	R	R	S		R	S	S	S	C		S		Yes, high risk below 1,800m	ME or DO or MON	PC	
Paraguay	R	R			S	S	S	S	R				Yes, extreme eastern areas, Oct-May	C	P	Le Tc
Peru	R	R				S	S	S	R				Yes, high risk in Amazonian Loreto Dept. Variable risk SE area bordering Brazil & Bolivia, and around Tumbes & Piura	ME or DO or MON C	PC P	Le Tc
Philippines	R	R	S		S	S	S	S	C		S		Yes, many rural areas below 600m No risk – Cebu, Bohol, Catanduanes	PC W	DRF	Sh
Poland		S					S	S				S	No			
Portugal		S					S						No			
Puerto Rico		R			S		S	S					No			Sh Le
Qatar	S	R				S	S	S					No			Le
Reunion		R				S	S		C				No			Sh
Romania	S	R				S	S	S				S	No			
Russian Federation	S	R			S	S	S	S	C		S	S	No			
Rwanda	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Sabah	R	R	S		S	S	S	S	C		S		Yes, high risk inland Low risk coastal area and Kota Kinabalu	ME or DO or MON W	PC	
Samoa	S	R			S		S	S	C				No			
Sao Tome	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Le
Saudi Arabia	S	R			R		S	S	C	S M			Yes, SW region, rural areas of W region Elsewhere (no risk Mecca, Medina)	ME or DO or MON W	PC	Sh Le
Senegal	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Serbia		R				S	S	S				S	No			Le
Seychelles	S	R				S	S		C				No			
Sierra Leone	R	R	S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Singapore		S					S		C		S		No			
Slovakia		S					S	S				S	No			
Slovenia		S					S	S				S	No			
Solomon Islands	R	R			S	S	S		C				Yes, high risk	ME or DO or MON	PC	
Somalia	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Le
South Africa	S	R	S		S	S	S	S	C				Yes, NE rim bordering Zimbabwe, Mozambique & Eastern Swaziland, including Kruger, Kosi Bay & Jozini	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			Le
Sri Lanka	R	R				S	S	S	C		S		Yes, far north and NE, north of Anuradhapura & Polonnaruwa Elsewhere	PC W	ME, DO DRF	
St Helena & Ascension		S							C				No			
St Kitts & Nevis		S					S		C				No			
St Lucia		S					S		C				No			
St Vincent & Grenadines		S					S		C				No			
Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
South Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
Surinam	S	R			S	S	S	S	R				Yes (except Paramaribo and coast)	ME or DO or MON	PC	Sh Le
Swaziland	R	R	S		S	S	S	S	C				Yes, high risk, eastern areas	ME or DO or MON	PC	Sh
Sweden		S										S	No			
Switzerland		S										S	No			
Syria	S	R			S		S	S	C				No			Sh Le
Taiwan		R				S	S				S		No			
Tajikistan	R	R	S			S	S	S				S	Yes, Jun-Oct variable on NW & SW borders	PC	ME, DO or MON	
Tanzania	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Ta
Thailand	S	R	S		S	S	S	S	C		S		Yes, on extreme fringe of international borders Elsewhere	DO or MON W		
Tibet	S	R	S	R	R	S	S	S	C		S		No			
Tobago		S			S		S	S	C				No			Tc
Togo	R	R	S		S	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Trinidad		S			S		S	S	R				No			Tc
Tunisia	R	R					S	S	C				No			Le
Turkey	S	R					S	S					Yes, Syria border May-Oct Elsewhere	C W	P	Le
Turkmenistan		R			S	S	S	S				S	No			
Uganda	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Ukraine	S	R			R	S	S	S				S	No			
United Arab Emirates	S	R			S		S	S					No			Le
Uruguay		R					S	S	C				No			Tc
USA													No			
Uzbekistan	S	R				S	S	S				S	Yes, very low risk extreme SE	W		Le
Vanuatu	S	R			S	S	S						Yes, high risk	ME or DO or MON	PC	
Venezuela	S	R			S		S	S	R				Yes, high risk to south of Orinoco River Variable/low risk north of Orinoco No risk Caracas or Margarita	ME or DO or MON C W	PC P	Le Tc
Vietnam	R	R	S		S	S	S	S	C		S		Low risk in cities, coast between Ho Chi Minh & Hanoi, Mekong Delta Elsewhere	W ME or DO or MON	PC	
Virgin Islands		S					S						No			
West Papua (formerly Irian Jaya)	R	R			R	S	S	S	C		S		Yes, high risk below 1800m	ME or DO or MON	PC	Sh Ta
Yemen	R	R	S		R	S	S	S	C				Yes, but no risk in Sana'a city	PC	DRF	Sh Le
Zambia	R	R	S		S	S	S	S	S				Yes, high risk	ME or DO or MON	PC	Sh Ta
Zimbabwe	R	R	S		S	S	S	S	C				Yes, high risk Zambezi valley Yes, elsewhere below 1,200m Nov-Jun Negligible risk Harare and Bulawayo	ME or DO or MON ME or DO or MON W	PC PC	Sh Ta

Key to malaria prophylaxis regimens

Regimen MON
Malarone (atovaquone/proguanil), one tablet daily. Begin 1-2 days before departure, continue while in malarious area and for 7 days after return. ACMP suggest Malarone is safe for periods in continuous use of at least 1 year and possibly longer. Safety in pregnancy has not been established, and use in pregnancy should only be considered if benefit to the mother outweighs risk to foetus. Children use paediatric tablets.

Regimen PC
Proguanil (Paludrine) 200mg daily plus chloroquine 300mg or 310mg base weekly (=Avloclor 2x250mg). Begin 1 week before travel and continue for 4 weeks after return.

Regimen ME
Mefloquine, 1x250mg tablet weekly. ACMP suggest it is safe in continuous use for periods of at least 3 years. Begin at least 21/2 weeks before travel (at least 3 doses before arriving in malarious area). Avoid in first trimester of pregnancy and do not start pregnancy until 3 months after stopping mefloquine. Inadvertent use in first trimester is not an indication for termination. If pregnant women must travel to chloroquine-resistant falciparum area, seek expert advice and conduct careful risk-benefit analysis. Use in any trimester may be justified.

Regimen C
Chloroquine 300mg or 310mg base weekly (=Avloclor 2x250mg). Begin 1 week before travel and continue for 4 weeks after return.

Regimen P
Proguanil (Paludrine) 200mg daily. Begin 1-2 days before travel and continue for 4 weeks after return.

Regimen W
No chemoprophylaxis but be aware of risk. Avoid mosquito bites and carry standby treatment if going to be far from medical facilities.

Regimen DO
Doxycycline, 1 tablet of 100mg daily. Begin 1-2 days before travel and continue for 4 weeks after return. Not for children or pregnant women. Be aware of oesophageal ulceration, photosensitivity and very rare intracranial hypertension risk. Take with food or milk and avoid ingestion in late evening.

Regimen DRF
In the alternative regimen column, **DRF** is Drug-Resistant-Falciparum regimen. **DRF = ME** or **DO** or **MON**

Primaquine
A causal prophylactic that may be used when G6PD deficiency has been excluded in travellers with contra-indications to other anti-malarials. Active against all species. Adult dose 30mg daily. Start 1-2 days before departure and continue for 7 days after return.

Children's doses of antimalarial prophylactics

Weight in kg	Chloroquine Proguanil	Mefloquine	Age
Under 6.0	0.125 adult dose ¼ tablet	not recommended	term to 12 weeks
6.0 to 9.9	0.25 adult dose ½ tablet	0.25 adult dose ¼ tablet	3 months to 11 months
10.0 to 15.9	0.375 adult dose ¾ tablet	0.25 adult dose ¼ tablet	1 year to 3 years 11 months
16.0 to 24.9	0.5 adult dose 1 tablet	0.5 adult dose ½ tablet	4 years to 7 years 11 months
25.0 to 44.9	0.75 adult dose 1½ tablets	0.75 adult dose ¾ tablet	8 years to 12 years 11 months
45kg and over	Adult dose 2 tablets	Adult dose 1 tablet	13 years and over

Doxycycline only above 12 years and the adult dose is given

Children's doses

Paediatric malarone for prophylaxis

Weight in kg	Number of tablets daily
11-20	1 paediatric tablet
21-30	2 paediatric tablets
31-40	3 paediatric tablets
Above 40	1 adult tablet

Specialist advice

For malaria advice
Malaria Reference Laboratory 020 7636 3924 (health professionals only)
Birmingham 0121 424 0357/ 3354/2357
Edinburgh 0131 537 2822
Glasgow 0141 300 1130
Liverpool 0151 708 9393
Oxford 01865 225 214

TIP OF THE MONTH

A new quadrivalent menigococcal conjugate vaccine

GSK have just launched Nimenrix, a new quadrivalent conjugate meningococcal vaccine that also protects against invasive meningococcal disease caused by serogroups A, C, W-135 and Y. It can be given to individuals from 12 months of age, including those who may have previously received meningococcal ACWY polysaccharide (ACWY-PS) vaccine. The licence for Menveo, another quadrivalent conjugate meningococcal vaccine that launched two years ago, is for active immunisation of adolescents from 11 years of age and adults. The Joint Committee on Vaccination and Immunisation decided to recommend off-label use of Menveo, specifically in that a conjugate vaccine is recommended in preference to a plain vaccine in children under five years of age.

The data sheet for Nimenrix describes the trials supporting the licence application and indicates that this vaccine is non-inferior to ACWY-PS vaccines, and produces a better antibody response in young children. Responses for serogroup C are non-inferior to monovalent Men C conjugate vaccine. No side-by-side randomised controlled trials have yet been reported comparing Nimenrix with Menveo or Menactra, and these are eagerly awaited. Although we await further comment from JCVI, we now have a conjugate vaccine which is fully approved for use in small children travelling to areas where the quadrivalent vaccine is indicated.

References
1 dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133117.pdf
2 medicines.org.uk/EMC/medicine/26514/SPC/Nimenrix/

Pulse Business & Commissioning

Practice Business

IN THIS ISSUE

MORE ONLINE

pulsetoday.co.uk/practice

Six steps to making your practice website safer How to offer a secure online service

Is your practice disability-friendly? Four tips from an award-winning practice

Commissioning

IN THIS ISSUE

MORE ONLINE

pulsetoday.co.uk/commissioning

Evidence-based care for patients with GI problems or liver disease A resource to accompany the CPD module

What impact does telehealth have on hospital use? Analysis from the Nuffield Trust

Managing employees on long-term sick leave

Solicitor **Victoria Patterson** advises GPs on how to deal with prolonged absences from staff members

HAVING AN EMPLOYEE ON LONG-TERM SICK LEAVE is not in the interests of either party. It can be damaging to the employee's long-term health and future career prospects, but the practice can also suffer in terms of additional costs and administration, staff morale and possibly productivity levels, depending on what cover can be arranged. Even with the best policy in the world, instances of long-term sick leave are unavoidable – so how do you deal with it? The simple answer is to be proactive.

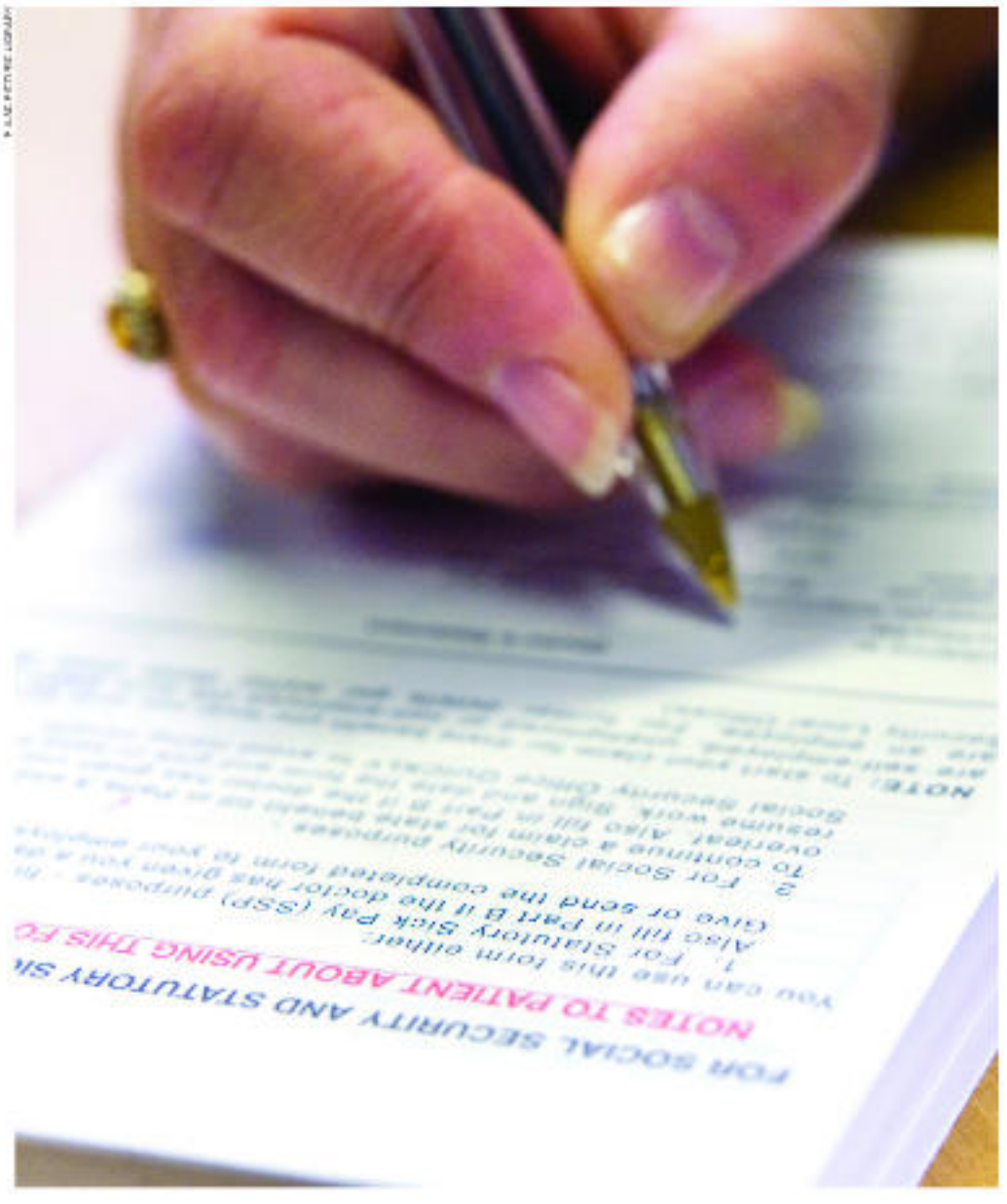
Have a sick leave policy

Impose and follow a sickness absence policy. Have clear rules about reporting, providing evidence and return-to-work meetings. It is important that everyone knows the policy and that the practice acts consistently when dealing with employees to avoid potential discrimination claims. Long-term sick leave may result in one of three outcomes: resignation, a phased return to work or – in more serious cases – a dismissal on the grounds of capability. While a lack of capability can be grounds for dismissal, you must follow a fair procedure and should seek advice before starting this process.

Seek specialist assessment

Before you consider changing an employee's

You should seek advice before looking to dismiss



duties or job role, or terminating their employment, you must have independent medical evidence on which to base your decision. The employee may have a disability, so it is important that this is assessed early to avoid any disability discrimination claim and to alert you to any additional steps you may need to take in terms of reasonable adjustments.

If you are considering changing duties or job roles, this could cause the employee to resign and claim constructive unfair dismissal – so consult with them before making any changes.

To assess an employee's condition and plan a return to work, you will need medical evidence from an independent third party, such as an occupational health specialist. With the consent of the employee, a medical assessment should be arranged at an early stage. You should ask the specialist to focus their report on:

- the employee's health
- what medical treatment is needed
- how long symptoms are likely to last
- the likely date of return to work
- whether there are any reasonable adjustments which the practice should make to accommodate the employee's return to work.

It may help the specialist to see the employee's GP records in order to know more about their medical history, but if the employee is registered at your practice, you must obtain consent from the patient in order to share their records.

Communication is key

Once you have this report, you will be able to decide what to do. Are there any changes you could make to the employee's duties? Is there the potential to dismiss them on capability grounds? Often employers feel it would not be appropriate to contact an employee on sick leave, but you still have responsibilities and duties towards your employee and you should communicate with them regularly. Once you have the occupational health specialist's report, hold a meeting to discuss its recommendations and seek a way forward.

Victoria Patterson
is a solicitor at Veale Wasbrough Vizards

Documenting third-party rent

Creating formal arrangements for the occupation of rooms on your premises will prevent disputes later

DOCUMENTING THE OCCUPATION OF ROOMS in your practice premises ensures the rights and obligations of both parties are discussed and agreed, and set out in writing. The written agreement you produce should identify the space to be occupied, any rent or licence fee, any services to be provided, the rules and regulations as to use, the period of occupation and the basis upon which the agreement can be terminated.

Picking the right agreement

The most common ways to document occupation are by using a licence to occupy or a lease.

- **A licence to occupy** is a less formal arrangement and grants a personal right for the licensee to use the property. It does not grant a legal interest in the property that can be transferred to someone else, and is suitable for occasional or short-term use of space and where flexibility is required. The licence may be for a fixed period of time or could run until terminated, and will often reserve the right for the practice to relocate the licensee to another room. A licence to occupy would be appropriate either for arrangements of less than six months or flexible arrangements – for instance, non-GP clinics – where rooms are used on certain days at certain times. Examples of the kind of third parties who would benefit from a licence to occupy include occupational health visitors, midwives, district nurses and osteopaths.
- Where space is occupied exclusively for more than six months, a **lease** would be more appropriate. A lease grants a legal interest in the space occupied for a certain period of time and at an agreed rent. It can also be transferred to someone else, subject to the landlord's consent. The tenant would usually be expected to take on more responsibility for the property and make a financial contribution towards repair, maintenance, cleaning and insurance. A lease would be appropriate where rooms are used for a longer term and for permanent arrangements where nobody else uses the area other than the third party. Examples include dentists, pharmacists and the PCT or CCG.

You should also establish a formal notice procedure before the lease is granted, in order to avoid giving tenants 'security of tenure' over the space.

Rebecca Beardsley is an associate at Veale Wasbrough Vizards

Ten top tips for commissioning GI services

Dr John O'Malley offers 'quick wins' for commissioners to improve treatment of gastrointestinal and liver disorders

DESPITE THEIR IMPORTANCE, gastrointestinal (GI) and liver disorders have received less attention than other, less prevalent, conditions. GI disorders constitute a major part of NHS work, both in primary and secondary care, and a GP will find between 10% and 15% of consultations involve gastroenterology.

GI disorders are also an important cause of morbidity and mortality in the UK. Deaths from liver disease reached record levels in the UK this year, rising by 25% in less than a decade.[1,2] Commissioners should make GI disease a priority both in terms of its cost and its impact on patients. The British Society of Gastroenterology's guidance on the subject aligns itself with the five domains of the NHS Outcomes Framework (see box, below).[3] This article walks through 10 'quick wins' commissioners can begin with, based on the document's recommendations.

1 Catch alcohol problems early

Domains: ● ● ● ● ●

Alcohol-related admissions are costly, with such patients often entering a 'revolving door' of frequent readmissions. NICE reports that only 6% of patients with alcohol problems in England receive treatment for them.[4] Pilot studies and modelling exercises have shown that increasing access for patients to community care and detoxification, improving primary care early detection and advice and providing rapid and good community outreach and psychiatric care can all reduce the cost of the consequences of alcohol misuse.

2 Target obesity and hepatitis

Domains: ● ●

Alcohol is not the only cause of liver disease – obesity and viral hepatitis are both putting pressure on budgets. Half of all liver transplantations are accounted for by chronic viral hepatitis, despite cost-effective treatments being available. NICE has shown the appropriate use of antivirals leads to substantial savings in the medium term.[5] Commissioners should work with secondary care to set up methods for early recognition and treatment. One approach would be targeted screening in high-risk groups in primary care, by way of the new patient medical.

3 Reduce the burden on secondary care

Domains: ● ●

Many GI patients with functional disorders do not need to be seen in secondary care. Good interface services for primary care clinicians – either through Choose and Book's 'advice and guidance', or by secure email or telephone helplines – would enable assessment of potential referrals and advice on how to care for patients more cost-effectively. Management plans and mutually agreed referral strategies could also reduce the load.

4 Monitor immunosuppressant prescribing

Domains: ● ● ●

Large amounts of money are spent in secondary care on monitoring immunosuppressant drugs used in the treatment of inflammatory bowel disease (IBD) and autoimmune hepatitis. Local clinical governance processes could be created to support prescribing, organise community blood testing and establish secure IT links so that results can be reviewed and acted upon. Governance issues about clinical responsibility, especially for prescribing off-label, need to be resolved by CCGs.

5 Reduce the cost of follow-up and readmission

Domains: ● ●

New-to-follow-up ratios fail to reflect the chronicity and needs of patients in some areas of gastroenterology. Patients with IBD and chronic liver disease can now be given long-term specialist follow-up more cheaply with new methods of access such as virtual clinics, telephone consultations and a more flexible approach to the timing of outpatient follow-up appointments. Integrated planning with secondary care would result in many patients with irritable bowel syndrome (IBS), coeliac disease and well-controlled IBD being able to manage their own conditions with less reliance on primary and secondary care.

6 Scrutinise endoscopy use

Domains: ● ●

At present we have a growing need for additional lower GI investigations, such as colonoscopy and flexible sigmoidoscopy, and a growing demand for upper GI endoscopy from primary care. This mismatch cannot continue. Commissioners and secondary care should work together to see how the best can be gained from such investigations. Commissioners also need to insist on properly validated surveillance lists for endoscopy in secondary care and named consultant lists, rather than pooling.

7 Offer a one-stop service

Domains: ● ● ●

Patients want rapid, safe assessment and treatment. One-stop services providing for the diagnosis of rectal bleeding, for example, will be more patient-friendly and cost-effective. The principle could be extended to IBS assessment and treatment, investigation of iron deficiency anaemia and other areas. What is important is to resource these services appropriately so tariffs will be negotiated to reflect the changed service.

8 Cut IBD spending

Domains: ● ● ● ●

More cost-effective recognition and treatment of IBD must start in primary care. Many patients are referred unnecessarily with a primary care concern related to possible IBD, and end up not having IBD diagnosed until they reach secondary care.

Conversely, many patients with IBD are misdiagnosed and treated for IBS for years, thus delaying proper treatment, which increases costs through subsequent need for surgery and years of chronic ill health.

Pre-screening by faecal calprotectin in primary care would lead to these patients being identified earlier, and at the same time reduce inappropriate referrals and investigation.

There is potential for patients with well-controlled IBD to be seen in the community, and an expanded community role for nurses would help facilitate this.

9 Educate and feed back to clinicians

Domains: ● ● ● ● ●

Primary and secondary care need to work together to act on outmoded thinking that reduces care quality and cost efficiency. But nothing will change unless primary and secondary care produce and enforce local algorithms, which give honest feedback to those who over-use upper GI endoscopy. Education opportunities to highlight alternative management following such referrals could be useful.

10 Address 'hidden' problems

Domains: ● ● ● ●

Faecal incontinence can affect up to 10% of adults, with a 10th of those being disabled enough for their quality of life to be affected. There are costs involved with continence products, together with the costs of hospital admission, primary care consultations and community care. But often, good care with the proper use of laxatives, specialist continence units and nurse follow-up in primary care would reduce spending in this area.

Dr John O'Malley is secretary of the Primary Care Society for Gastroenterology and a GP in Manchester

The five NHS Outcomes Framework domains

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment

References

1 National End Of Life Care Intelligence Network. *Deaths from Liver Disease*. March 2012. tinyurl.com/cbe8fax
2 Sheron N, Hawkey C and Gilmore I. Projections of alcohol deaths – a wake-up call. *Lancet* 2011;377:1297-9. tinyurl.com/66klll8
3 British Society of Gastroenterology. *Commissioning evidence-based care for patients with gastrointestinal and liver disease*. 2012. tinyurl.com/cr8rnx8
4 NICE. *Alcohol-use disorders*. 2011. tinyurl.com/7vmg6ft
5 NICE. Hepatitis C TA200; Hepatitis B TA153 and TA173

Contact
Cliff Brown
Advertisement executive
020 7332 2924
For a quote send adverts to:
clifford.brown@briefingmedia.com

Rates
£18.00 - £26.00 per single column centimetre.
Colour rates available on request

Issue date/Copy deadline
Publication date Wednesday.
Booking deadline Thursday 4pm preceeding publication date.
Copy deadline Friday noon preceeding publication date

By post
Briefing Media
3rd Floor, Mermaid House
Puddle Dock
London, EC4V 3DB

Website
pulsetoday.co.uk

DOCTORS/GPS REQUIRED

EASTBOURNE G.P. PARTNERSHIP

Here at Princes Park Health Centre, we are a friendly, hardworking, high earning PMS training practice situated on the South – East coast. We are now looking to employ a full time GP to join the practice with a six month period of mutual assessment.

Occupying 2000 sq - meters of purpose built medical premises (on one site) our 9 Doctor Team provides a wide range of services to its 14500 patients.

The facilities that we offer, which includes onsite X – ray, MRI and DXA scanning, make us stand out as a progressive practice. We also provide a wide range of Enhanced services and Nurse lead clinics.

The Practice also has close links with Brighton and Sussex Medical School and is actively involved in teaching Medical students at all levels; together with being an established Training Practice with ST3 Doctors working with us.

For more information please go to www.princesparkhealthcentre.co.uk

If you are a well-motivated, enthusiastic and committed GP and this unique opportunity interests you, then please contact:

Mr Graham Willoughby (Practice Manager)
Graham.willoughby@nhs.net
Dr Stockton and Partners
Princes Park Health Centre
Wartling Road, Eastbourne, East Sussex BN22 7PG
01323 744644

Closing date:17th August

GP Required

in Waltham Abbey for 6-8 sessions per week from September 2012

Market Square Surgery in Waltham Abbey Health Centre requires a GP to work 6-8 sessions per week from September 2012.

Initially this is a 6-8 months locum position to cover a partner's leave, but is likely to be extended to a long term position after that if the practice and the locum GP are mutually satisfied with each other.

Remuneration and working hours are negotiable. We are easily accessible by M25 (junction 26). We are located in a modern purpose built health centre and use SystmOne.

Please could interested applicants send a CV to the practice manager by e-mail at shobha.dhawan@nhs.net or by post to Market Square Surgery, Waltham Abbey Health Centre, 13 Sewardstone Road, Waltham Abbey, Essex, EN9 1NP

SALARIED GP

With possible partnership opportunity
Norheads Lane Surgery,
14 a Norheads Lane, Biggin Hill, Kent, TN16 3XS

- **4-5 sessions /flexible from October 2012**
- **Friendly, efficient Practice**
- **Excellent nursing and admin support**
- **High QOF achievement**
- **Just moved to EMIS web [ample opportunity available for training]**

Please send CV by e-mail to Lisa.dilling@nhs.net
For further information please contact:
Lisa Dilling, Practice Manager, 01959 574188

Associate General Practitioner

Job Location North West
Salary Dependant on experience
Contract Type Permanent
Recruiter Darwen Healthcare

Further information
8 Session Associate General Practitioner
Darwen Healthcare, Darwen, Lancashire

Darwen Healthcare is a general practice with a list of 12600 patients specialising in high quality care. We are a friendly, innovative training practice with a reputation for providing good patient care, having major links with the local community and being a strong, supportive team with an established team of doctors, nursing staff and administration support. We are seeking to recruit an additional 8 session associate general practitioner to join our practice. This is a fantastic opportunity for a motivated general practitioner to join a team with outstanding facilities, a fantastic team atmosphere and contribute to the excellent patient experience which the practice provides.

Apply by email with accompanying CV and covering letter to:
Richard Halstead, Business Manager
Email: richard.halstead@nhs.net
Telephone 01254 226710

Closing Date 27th July 2012
Start Date September 2012

The Lowry Medical Practice

Dr's Ballin, Begum, Ahmed, Bishop & Corkindale.

PENDLEBURY, GREATER MANCHESTER
PARTNERSHIP VACANCY

Replacement partner required for a five partner teaching practice High standard forward thinking doctor wanted to help maintain top quality indicators.
Six - seven sessions per week.

We are a GMS practice with a list size of 6900 in a small urban practice area.

- *In-Practice Systems system – paperless practice.*
- *Health Centre*
- *Immediate parity*
- *Established teaching practice.*
- *No OOH*
- *Shared extended hours*
- *Excellent practice and attached staff*

To apply for this vacancy please email your CV with a covering letter to :- Miss Jacqueline Rivers,
Deputy Practice Manager, Lowry Medical Practice,
Pendlebury Health Centre, 659, Bolton Road,
Pendlebury, Manchester, M27 8HP
Tel no: 0161 212 6565, E-mail:- Jacqueline.rivers@nhs.net
Website:- www.pendleburyhealthcentre.co.uk

Closing Date:- 15th August

Winch Lane Surgery
Haverfordwest, Pembrokeshire, West Wales

FULL-TIME SALARIED GP (8 SESSIONS)

- *14000 patients with "Personal List" system*
- *Teaching Practice - GP Trainees, Medical Students, Further Training*
- *Paperless, EMIS LV and High QOF Scores*
- *Modern, purpose-built premises*
- *Nine GPs and two Nurse Practitioners*
- *Excellent Nursing, Admin and Reception Teams*
- *Flexible start-date and prepared to wait for right candidate*

Please apply in writing with a CV to:

Michael McManus, Practice Manager
Winch Lane Surgery, Haverfordwest, Pembrokeshire SA61 1RN

For an informal chat or to arrange a visit please contact Dr David Davies
or
Michael McManus on 01437 762333

Closing Date: Wednesday 5th September 2012

SALARIED GP

With a view to Partnership
8 sessions per week
Salary Negotiable

Mayfield Medical Centre, 4 Glenholme Park, Clayton, Bradford, BD14 6NF

We are a friendly, supportive and forward thinking training practice with an established team of Doctors, nursing and admin support.

The practice comprises of a wide reaching skill mix and we would welcome anyone who wishes to develop a special interest.

Practice features:- Teaching practice, list size is 6,700 approx, three Partners and 2 Advanced Nurse Practitioners, Patient Reference Group, Enhanced in house services, high QOF achievers, SystmOne clinical system, protected clinical meetings.
We have also recently achieved the RCGP Quality Practice Award.

Our closing date for the application is Friday 27th July 2012

Please send a CV with a covering letter to:
Mrs Sharon Barraclough, Business Development, Enterprise and Finance Manager, Mayfield Medical Centre, 4 Glenholme Park, Clayton, Bradford, BD14 6NF
Email: Sharon.barraclough@bradford.nhs.uk
Website: www.mayfieldmedicalcentre.com

The GLEBE PRACTICE
85 SYKES LANE
SAXILBY
LINCOLN
LN1 2NU

Dr's Ash, Azar, Gopee and Satyam are seeking Salaried GP for up to 6 sessions over a 3 – 5 day week on a negotiable salary.

Practice is a 2 site semi rural PMS dispensing practice utilising Emis web to manage 8,000 patients. Benefits from purpose built buildings, F2 doctors and an 8 strong nursing team alongside admin and dispensing staff.

Informal visits welcome, contact one of the management team on 01522 706900/706901 to arrange.

Further details can be obtained from Dr Ash on 0844 477 3462

Applications by CV for the attention of Dr Ash.

An established friendly PMS Practice is seeking 2 Salaried GPs with a view to partnership.

Full or Part Time considered.

Newark Road Surgery, Lincoln, Lincolnshire, LN6 8RT

University and Cathedral city with excellent local schools

- *6000 List Size*
- *Quality Focus*
- *Providing comprehensive enhanced services*
- *Nurse Practitioner and friendly, experienced clinical and admin support team*
- *Committed to clinical excellence*
- *Specialist Interest encouraged*
- *Multi-Professional Learning Organisation*
- *Mentorship Support*
- *SystemOne Clinical System*
- *High QOF achievement*
- *Member of Optimus, a Federation of 6 practices.*

For further information about us visit: newarkroadsurgery.co.uk or contact Dr Jane Marshall or Chris Symonds, Practice Manager on 01522 537844 or e-mail: christopher.symonds@lpct.nhs.uk

Apply by CV and covering letter to Practice Manager by 31 July 2012.

DOCTORS/GPS REQUIRED

Are you looking for a GP practice with INSTANT Equitable decision opportunities, equitable work load and are remunerated fairly?

Are you looking for a friendly, forward-thinking practice with experienced and approachable GPs?

Willow Bank Surgery

We are currently 4 full-time and 1 half time Salaried GPs team looking for 1 full time or 2 part time salaried GPs for our progressive practice.

- Almost 7,500 patients and continuing to grow
- Teaching Keele Medical Students (with the view to teaching GP registrar in the future)
- Local CCG involvement
- Good QOF and QIF achievement
- Weekly clinical meetings and team meetings
- 2 Sites – Longton & Meir
  (Meir's site opening times are 8.00am to 8.00pm plus Saturday mornings)
- EMIS PCS but will be upgrading to EMIS WEB in the near future.
  - *In house minor surgery clinic*
  - *Shared Care Substance Misuse service at both sites*
  - *In surgery Alcohol Intervention clinic*
  - *Leaders in community hepatitis C screening project in Stoke-on-Trent*
- Excellent nursing team with Nurse Practitioners and Practice Nurses currently training on Warwick University diabetes course.
- We also have a Nurse Practitioner who works primarily in the Community providing care and visits for the housebound and those in nursing and residential homes.

Salary is £75,000 for a full-time GP with experience but with the opportunity to earn more for taking on additional responsibilities or doing additional clinical work. GMC and MDU fees paid for.

Full time (7 sessions face-to-face consultations with administration and CPD / PDP sessions)

Hours of work open for negotiation. Teaching or course fees open for negotiation

Your enthusiasm and ideas matter to us. If you are curious about this then why not speak to Dr Paul Roberts (03001231467) or Dr Richard Aw (03001235002)

If you're interested enough to want to apply then please email us for further details at recruit@willowbankcic.org

The Limes

SALARIED GP VACANCY

The Limes Medical Centre, 65 Leicester Road, Narborough, Leicester LE19 2DU

We are seeking a Salaried GP to join our progressive Practice team to work 6 sessions per week over 3 days.

Practice information:

- *Long established clinical and support teams including 5 GP Partners and 4 Salaried GPs*
- *Large nursing team including Nurse Practitioners*
- *Teaching Practice with strong links to the Deanery*
- *Tailored clinical development and speciality training for Salaried staff*
- *Extensive range of private clinics including offshore medicals, cosmetic services and travel health*
- *Active participants with the CCG, providing supporting clinical and managerial representation for the Locality*
- *High QOF, Enhanced Services and Locality Scheme achievement*
- *14,500 patients, System1, PMS, additional city based Practice*

If you have enthusiasm, commitment, excellent clinical skills and a focus on quality, then we are seeking to invest in you to continue the long term growth, development and strong reputation of The Limes.

If you wish to discuss this unique opportunity, or to visit the Practice to find out more, then please email Nina.phipps@gp-c82055.nhs.uk who will organise this for you.

Alternatively send your CV and supporting letter for the personal attention of:
Dr GDW Prowse MA. MBBS. DRCOG. FRCGP. DMJ. MFFLM.
The Limes Medical Centre
65 Leicester Road
Narborough, Leicester LE19 2DU

Closing date for applications: 24th August 2012
Interviews will be held between 17th & 28th September 2012

Leeds Community Healthcare NHS
NHS Trust

Salaried General Practitioner

York Street Health Practice, LS9

£53,781 up to £81,158 per annum **Reference: 833-TP-SP-249-12**

Part Time – 4 sessions per week – Permanent contract

Leeds Community Healthcare NHS Trust are seeking to appoint a part time GP for 4 Sessions (2 days) to work in our dynamic York St Health Practice. The practice population is for Vulnerably Transient People which include those who are homeless and/or vulnerably housed, rough sleeping and seeking asylum, presenting with complex needs including alcohol and drug dependency, offending behaviours and mental health issues.

The practice is part of the award winning Vulnerable Groups Services and as such GPs will have the opportunity to work with colleagues to deliver services to those most in need in the Leeds area.

We have an extremely experienced, dedicated and supportive multi-disciplinary team comprising Mental Health Nurse/Support Workers, Drug Therapists, Practice Nurses, Nurse Practitioner, Client Support Workers and are well supported by administrative staff.

We are also developing our expertise in alcohol and introducing Improving Access to Psychological Therapies (IAPT) posts.

It is expected that you will have or be willing to work towards the RCGP Certificate in Substance Misuse parts 1 and 2. You will be well supported personally and professionally both at York St and Trust levels. Admin/ development time will be offered with the role including protected time to meet the requirements of annual appraisals.

This post is a four session contract, worked over 2 days, to complement existing GP service provision.

Contact Catherine Hall, Head of Service – 07960 727165, or Dr Eleanor Willman, General Practitioner – 0113 295 4840.

Apply online at www.jobs.nhs.uk/in/LCH

Closing date: 1 August 2012.

The Health Foundation Inspiring Improvement | Quality Improvement Fellowships

Wanted: champions* for healthcare improvement…

…to become Health Foundation Quality Improvement Fellows.

We want talented and committed clinically-qualified leaders to join our Quality Improvement Fellowships.

Our fellows spend a fully-funded year at the Institute for Healthcare Improvement in the US, where they combine academic and practical learning in quality improvement.

Find out more at **www.health.org.uk/qif**

Or email **qif@health.org.uk**

Now open for applications

Applications close on Tuesday 9 October 2012

**open not embedded*

DOCTORS/GPS REQUIRED

PART TIME SALARIED GP
KETTERING NORTHANTS

Due to an increasing patient list size, a vacancy has arisen for the post of salaried GP at Weavers Medical.

- 6 – 8 sessions per week
- Core working days Tuesday, Wednesday & Thursday
- To start as soon as possible
- 15,800 patients, town centre practice
- Long established training practice
- GMS, heavily involved with PBC & Nene Commissioning
- New purpose-built premises shared with one other practice & a range of ancillary services
- Full complement of staff including strong nurse team leading LTC clinics & minor illness clinics, multi-skilled 20+ strong admin team
- Team approach to workload, forward-thinking, friendly, inclusive, supportive, open & honest ethos, consistently high GPAQ survey results
- Dedicated time for peer-review of clinical work to support revalidation & best-practice, we consider ourselves a 'learning practice'
- Systmone, very paperlight & maximum use of IT within practice
- Consistently high achievements in QoF, full portfolio of ESC & full participation in other local contracts

www.weaversmedical.co.uk
www.prospect-house.co.uk

Please send full CV with covering letter and names of two referees (one from current place of work). Please include details of sickness absence in last two years and statement of health.

Closing date for applications: 31.07.12

For further information or an informal chat contact: Dr John McManus on 01536 513494. Previous applicants need not apply.

Maternity Locum Required
with Possible View to Partnership

Bethesda Surgery, Gwynedd
Tel: 01248 600212

Locum required between October 2012 and end of March 2013 to cover full time position, however, hours are negotiable.

Part time partner required from April 2013, hours between 0.5 and 0.75 FTE negotiable.

- List size 6,000
- 3 full time and one part time partners
- New premises

Informal visits and enquiries welcome for either position or send CV with covering letter to; Mr J Hayes
Yr Hen Orsaf, Station Rd., Bethesda, Gwynedd LL57 3NE

Tel: 01248 600212
email: john.hayes@gp-w94028.wales.nhs.uk

Closing date end of July 2012

Doctors required UK-Wide for insurance medicals.

dc life

...is growing. Join our panel of doctors who provide Insurance Medicals.

● Adhoc or sessional work ● Training provided
● Excellent remuneration ● Full administrative support

This is a unique opportunity to be part of our team. If you are interested please send a copy of your CV to:

info@dclife.co.uk Tel: 0845 140 3000

HARLEY STREET DOCTORS LTD.

Doctors required UK-wide for mobile insurance medicals, especially in the following areas:
London, Bournemouth, Southend, Chelmsford, Reading, Southampton, Leics., Lincs., Cambs., Herts., Dorset, Dundee, Aberdeen & Dublin

Please email your CV to: peter@harleystreetgroup.co.uk or call on 020 7224 0030

6 session Partner or salaried with a view to Partnership

The Grovehurst Surgery, Sittinghourne, is seeking an additional 6 session GP to join its enthusiastic and friendly team.

We are offering an opportunity to become the 5th Partner of a forward thinking 5 doctor partnership:

- Full complement of administrative and nursing staff
- 7000 patient list.
- Very high achieving QOF Practice offering a range of Enhanced Services.
- EMIS PCS (moving to EMIS web) and paper light.
- Purpose built premises.
- Actively involved in CCG.

Detailed information is available on request and we would welcome informal visits from interested colleagues.

To apply please send your CV and covering letter to Mr Geoff Eaton, Practice Manager, The Grovehurst Surgery, Grovehurst Road, Kemsley, Sittingbourne, Kent, ME10 2ST.

Tel: 01795 431399
Email: g.eaton@nhs.net
www.thegrovehurstsurgery.nhs.uk

Closing date for applications 10th August 2012

ST MARYS SURGERY, SOUTHAMPTON

GP VACANCY

We are a friendly and dynamic inner-city practice with an expanding patient list, and we are looking for an enthusiastic, hard-working salaried doctor to join our growing clinical team.

This new post is for 6 – 7 sessions per week and will include responsibility for a small patient list.

We are an innovative PMS training practice, working from two, purpose-built premises in the centre of Southampton City.

To find out more about our practice, you can visit our website at www.StMarysHealth.co.uk.

Please contact our practice manager on 023 8021 0292 or email to barbara.clark1@nhs.net for more information, or to arrange an informal visit.

Please send a letter of application and your C.V. to Barbara Clark, St Marys Surgery, 1 Johnson Street, Southampton, SO14 1LT

The Consulting Rooms, Watford
www.theconsultingroomssouthoxhey.co.uk

FULL TIME PARTNER (nine sessions)

We are seeking a committed and enthusiastic full time GP to join our progressive practice.

- Nine sessions a week over five days
- 7250 patients
- Recently refurbished partner owned surgery
- Friendly management and support team
- High QOF achievers
- Beautiful area and excellent schools
- We aim for a good work/life balance
- London 20 minutes away

For an informal visit or to apply please contact Paul Drinkwater, Practice manager on 08084212142 or email paul.drinkwater@nhs.net

Brewood Medical Practice Staffordshire

Salaried GP

with a view to partnership

Full-time

We are looking for an enthusiastic, highly motivated G.P. to join our friendly semi-rural, part-dispensing practice.

- Training Practice
- Ennis Web/Docman/Paperlight
- 10,500 patients
- Well Organised Team
- High QOF achievers

For more information or to arrange an informal visit – please contact:
Gill Bowers – Practice Manager
Please apply in writing with your CV by 31st July 2012 to:
The Surgery, Sandy Lane, Brewood, Stafford, ST19 9ES
Direct line to Practice Manager – 01902 850900
Email: gill.bowers@nhs.net

SUFFOLK
Framfield House Surgery, Woodbridge
www.framfieldhouse.com

FULL TIME PARTNER (eight sessions)
(Retirement Vacancy)

We are seeking a committed and enthusiastic full time GP (or combination of part time GPs) to join our progressive semi-rural training practice.

- Eight sessions a week over four days
- 11,500 patients
- Fabulous partner owned new medical centre with further development potential
- In house separate pharmacy company which you will be invited to join subject to satisfactory mutual assessment period
- Excellent practice team including nurse practitioners
- High QOF achievers
- VTS training practice and University undergraduate teaching practice
- Beautiful area and excellent schools
- We aim for a good work/life balance
- London 1hr 10, Cambridge 1hr, Norwich 1hr

For an informal visit or to apply please contact Carole Edwards, Business Manager 01394 615500 or email carol.edwards@gp-d83057.nhs.uk

Closing date for applications July 31st 2012

The London Road Surgery
Wickford, Essex.

SALARIED GP

Friendly, busy and patient focussed GP Practice in Wickford are looking for dynamic salaried GP(s).
Up to 10 sessions a week available.
Full Time or Job Share considered.

Competitive Salary including Professional Fees paid pro-rata.

Please send your CV with a covering letter to Ms Kim Hookings, Practice Manager, The London Road Surgery, 64 London Road, Wickford, Essex. SS12 0AH
Or via email: practice.managerF81041@nhs.net

Closing date for applications: 5pm 31st August 2012

GP's required
for part time medico-legal work.

Leading medico-legal reporting business require GP's in Wales and West / South West England for part time sessional work.

We pay a fixed fee per session and take care of all the administration.

All our GP partners have to do is to carry out medical examinations / interviews in accordance with our procedures at one of our designated locations local to you.

Interested GP's should send their cv stating the area(s) you are interested in covering to Derek Stephens at info@promedicalreports.co.uk

NOTTINGHAM – ST LUKES SURGERY, RADFORD NG7 3GW

SALARY - NEGOTIABLE

ENERGETIC, ENTHUSIASTIC, PART TIME PARTNER REQUIRED FOR INNER CITY MULTI CULTURAL, GP PRACTICE.

- GMS/EMIS PRACTICE
- LIST SIZE 3400
- HIGH QOF ACHIEVERS
- NO OOH COMMITMENTS
- 4-6 SESSIONS
- FRIENDLY, DEDICATED TEAM

Pre-arranged informal visits are welcome.
For further information please forward covering letter & CV to:
Mrs Collette Saxon – PM
St Luke's Surgery, Ilkeston Road, Radford, Nottingham NG7 3GW
Tel: 0115 9784374/0834125
Email: collette.saxon@gp-e84136.nhs.uk

CLOSING DATE: 3rd August 2012
INTERVIEW DATE: 8th August 2012 but negotiable for appropriate candidates.

DOCTORS/GPS REQUIRED

CIRCUIT LANE SURGERY, READING

GENERAL PRACTITIONER

We are a long established, well-respected, busy practice. Due to the forthcoming departure of a full-time partner, and the imminent retirement of our senior partner, we are looking for full/part-time/job-share partners but would consider making salaried appointments.

- 7 partners, 5.5wte, with a list of 10,500
- .4wte salaried doctor
- Well organised, fully computerised and paper light using the iSoft Synergy package
- nPMS with high level of aspiration/ achievement
- Excellent nursing, reception and administrative support
- Located in an area which has an expanding local population
- Planned premises development
- Friendly and supportive PHCT
- Active member of North & West Reading Clinical Commissioning Group
- OOH cover provided by Westcall

Please visit our website:
www.circuitlanesurgery.co.uk

For further information please contact:
Mrs Jenny Marnock, Practice Manager, 0118 9582537
Or Email: jennymarnock@nhs.net

Start dates: September 2012 and March 2013

BRYNTIRION SURGERY
BARGOED (SOUTH WALES)

FULL TIME SALARIED GP
(WITH POTENTIAL PARTNERSHIP OPPORTUNITY)

- Purpose built, well maintained premises
- Vision Computer Software
- List size: 10,700 (operating from two sites)
- Consistently high QOF points
- Opportunity to develop special interests and roles
- Full complement of attached staff

Please apply in writing with CV to: Miss Jayne Billington, Bryntirion Surgery, West Street, Bargoed, Mid Glamorgan CF81 8SA.

Email: Jayne.Billington@wales.nhs.uk

Closing date:	Willing to wait for the appropriate candidate
Region:	South Wales
Job Type:	Salaried GP

We are looking for a salaried GP to work 4-5 sessions per week in a busy surgery in Southall.

Wages will be negotiable according to experience.

Please email CV to salujaball y@hotmail.com

PRIVATE GP

Mayfair Practice, London requires a full time Private GP to start as soon as possible. Please contact Dr J J Masani

Tel: 020 7408 1164
Email: jmasani@me.com
www.mayfairpractice.com

Malling Health

Malling Health has GP vacancies both for full-time and part-time positions in a GP owned organisation, we offer competitive salary and NHS Pension; for further information and details of our vacancies please visit www.mallinghealth.co.uk

---

Full Time GP required. £90,000 p/a. 9 sessions and 2 on calls per week. Immediate start. Bradford area.

E mail CV to: drmhkhan@aol.com

Bungay Medical Practice

Salaried GP

Norfolk/Suffolk Border

This well organised, thriving and friendly practice situated in a market town has a vacancy for one and a half GPs. They would be joining a team of nine – a mixture of salaried GPs and partners (many of whom were previously salaried in the practice).

- Modern purpose-built premises with dispensary
- Personalised patient lists (total list size 10,500)
- Community Hospital
- Teaching medical students, F2s and GP Trainees
- Research Practice
- High QOF achiever

Practice details can be viewed on our website:
www.bungaymedical.co.uk

For more information, or to arrange an informal visit, contact Sarah Harris, Practice Manager, Bungay Medical Practice, 28 St John's Road, Bungay, Suffolk NR35 1LP.
Telephone 01986 891727 or email sarah.harris2@nhs.net

Alizonne

Fully registered medical doctor required
for sessional work in our well-established private London clinic providing an exclusive, highly successful, non surgical body contouring weight reduction treatment programme.

Exceptional opportunity to work in the private sector and to develop skills in this field.

Excellent working conditions, remuneration and job satisfaction. Negotiable hours.

General practice background ideal but not essential as full training will be given.

Keen interest and the necessary inter-personal skills to work successfully in the private sector are very important.

More details of our clinics are available at:
www.alizonne.co.uk
For further details regarding this vacancy please contact Anne Welford on 0113 2822266 or e-mail awelford@alizonne.co.uk

LOCUM AGENCIES

---

dr-locums

Earn £1000* per day

Recruiting across the UK :-

London * Sussex * Essex * Suffolk * Midlands * North England * Wales

Walk In Centres
Out of Hours
Prisons (RCGP1 trained)
GP surgeries

Call 020 7498 7999
www.drlocums.com
gp@drlocums.com

Cimarron

Established and unique GP Locum Agency, offering a professional, efficient service for all GPs.

URGENTLY REQUIRED
Primary Care and Substance Misuse GPs required for prison work in; Chelmsford, Manchester, Peterborough and Middlesex

Contact us today and see the Difference!
Phone 01206 274174
Email: enquiries@cimarron-uk.com

REC Recruitment & Employment Confederation

COURSES & CONFERENCES

PREMISES

RELEASE YOUR SURGERY EQUITY OR DEVELOP YOUR NEW SURGERY

Medical Centre Developments Ltd

We are specialist developers and funders.
Talk to us about your requirements.

Contact: Christopher Hobden
54 Weymouth Street, London W1G 6NU
020 7935 5042
Email: joan.elms@medicalcentres.co.uk
www.medicalcentres.co.uk

OVERSEAS

@pulsetoday The best of what's online this week at pulsetoday.co.uk

EDITOR'S CHOICE

A deficiency of evidence

Britain is obsessed with its low vitamin D levels, says Dr Shaba Nabi – but is it a problem we really need to fix?

When I was working as a senior home officer in psychiatry in 1993, I looked after a man in his early 40s.

He was admitted under the Mental Health Act as it was felt he was a risk to his health – he had a bizarre, restrictive diet and rarely left his squalid house. His severe muscle wasting was thought to be due to a combination of lack of exercise and malnutrition. It wasn't until his admission – when bloods revealed a low calcium and phosphate coupled with a high alkaline phosphatase – that a diagnosis of severe osteomalacia was made.

I was fascinated by the case. It was a pivotal factor in me changing career direction and working in general medicine for a few years before becoming a GP.

I have not seen another case of osteomalacia since, despite having a heightened awareness of it. Yet after moving to Bristol in 2007 to work as a GP in a multicultural inner-city practice, I find the terms 'vitamin D deficiency' and 'osteomalacia' are used interchangeably and treated as one condition.

Almost every everyone seems to be campaigning about the population's collective vitamin D deficiency and demanding something be done.

So what are the facts? The truth is, we don't know. There is little high-quality evidence, and patients present daily demanding their vitamin D levels are checked on the basis of a wide variety of non-specific symptoms. Their levels are low, so they feel there must be a causal relationship.

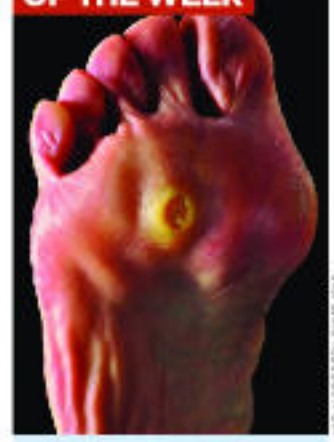
But for years, many healthy, asymptomatic populations have had 'deficient' levels of vitamin D without any consequences. Surely if virtually the entire population is labelled as being deficient, there must be something wrong with the parameters?

Dr Shaba Nabi: patients demand checks on a daily basis

Dr Shaba Nabi is a GP in Bristol

MORE ONLINE
Read the full article
pulsetoday.co.uk/opinion

CLINICAL PICTURE OF THE WEEK



Our clinical picture of the week archive has been updated, with pictures from the Institute of Medical Illustrators awards over the past three years. A slideshow of all the images is also available.

▶ pulsetoday.co.uk/clinical-picture-of-the-week

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"It's common in Africa. Google it."
... on Copperfield's head-scratcher of an exotic disease

"Big mistake – the BMA will need all the members it can get in the future."
... on a retired GP being suspended from the BMA for questioning its stance on smoking

"Can I spend mine on a trip to the casino?"
... on patients getting the 'right to ask' for a personal health budget

BOOK REVIEW

The latest wonder drug?

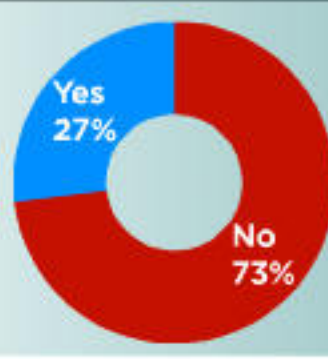
Dr Natalie Smith, a GP registrar in Oxford, has reviewed *An aspirin a day: the wonder drug that could save your life* by Dr Keith Souter. Find out why she thinks that 'reading this book will leave you believing that aspirin really is a wonder drug'.

MORE ONLINE
Read Dr Smith's review and more at pulsetoday.co.uk/book-reviews

THIS WEEK'S POLL

Should all CCG boards have a GP majority?
Vote at ▶ pulsetoday.co.uk/polls

Last issue's poll
Will a composite QOF indicator improve diabetes care?



Turn inside for this week's shot of the world according to Copperfield
▶ page 21