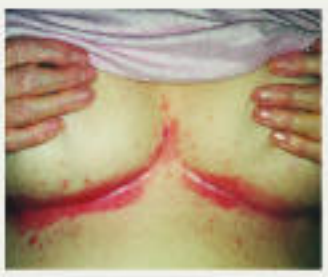

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PULSE

04.07.12
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BriefingMedia

At the heart of general practice since 1960

DH to ramp up QOF diabetes workload

Proposed 'composite indicator' would require GPs to run nine checks for every patient

EXCLUSIVE
By Madlen Davies

GPs will be forced to conduct nine separate checks in each patient with diabetes under Department of Health plans to create a single diabetes QOF indicator worth over £5,000, Pulse can reveal.

The DH is also pushing for a change in thresholds along with the 'composite indicator', which would include HbA1c, cholesterol, blood pressure and foot checks, in an attempt to boost achievement in the routine assessment of patients with diabetes.

The move comes after a national audit suggested only half of patients with diabetes were receiving all nine checks – a result described as 'appalling' by patient groups.

But the findings of the National Diabetes Audit for 2010/11, published last month, have been plunged into controversy after the GPC filed a complaint to the NHS Information Centre over the data used in the audit.

The DH has launched an investigation into the GPC's complaint, which is due to report in September. In the meantime, it has written to NICE, asking it to look at bundling all the nine checks – currently separate indicators worth 39 points (equivalent to £5,217 per year for an average practice) – into one single indicator.

NHS medical director Sir Bruce Keogh wrote to NICE last month asking it to consider 'replacing the current QOF indicators relating to the nine processes for diabetes with a composite indicator measuring the proportion of patients who received all nine of the processes'.

In the letter, he also asked NICE to review 'the range of target measurements and associated payment thresholds'.

If successful, the new indicator could be included in the 2015 QOF.

But GPs warned the changes could mean much more work for practices and potentially lost income, and the GPC said the profession was being 'unfairly criticised' because of the National Diabetes Audit's findings.

Dr Bill Beeby, chair of the GPC's clinical and prescribing subcommittee, told Pulse the figures from the national audit were 'incomparable' to the achievement recorded in the QOF: 'GPs are not putting in the codes that the National Diabetes Audit looks for, because they're not being asked to.

'If you look for the wrong thing you won't find it. Some areas are being unfairly criticised as a result.'

GPC negotiator Dr Beth McCarron-Nash said the proposed changes would be considered as part of the normal negotiation process, but added: 'GPs asked for stability in the QOF and we are mindful of that.'

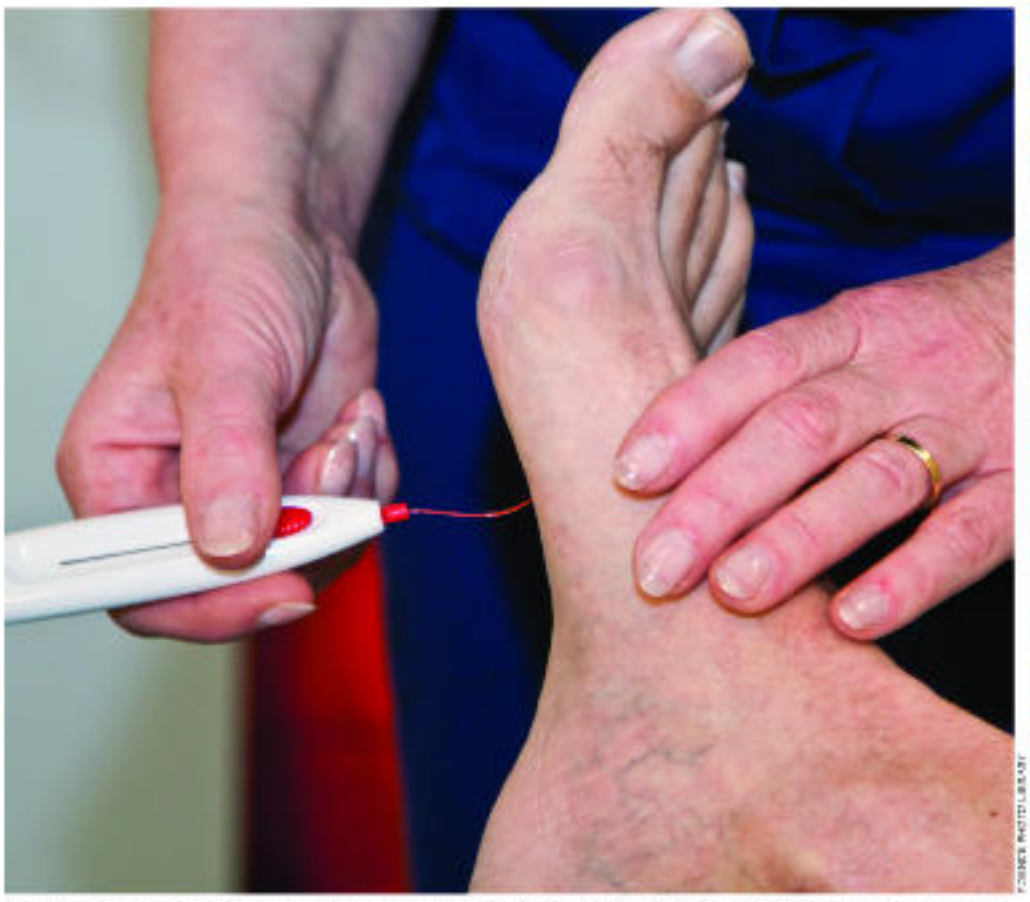
Dr Stephen Mann, a GP in Stourbridge in the West Midlands, said the change could have a drastic impact on practice income, with the increased number of checks likely to hit uptake: 'You'll get patients who won't comply, won't turn up, won't want to be monitored.

'GPs will have to jump through hoops, and if they miss one thing they'll fail.'

Dr Paul Conley, a GP in Basingstoke, said: 'GPs ensure high-level care for patients with diabetes already, and we've had so many changes to the QOF. This extreme micromanaging of complex clinical processes can have the opposite effect, and GPs feel demoralised.'

A spokesperson for the DH said: 'We hope to work together [with NICE] and with the BMA and other stakeholders to improve the QOF and support ongoing improvements in quality and outcomes for patients.'

@madlendavies



Foot examinations – one of nine checks GPs will need to perform under the 'composite indicator'

Which indicators could be bundled together?

BMI check
DM2 (1 point)

Checking HbA1c levels
No equivalent indicator currently in QOF

Retinal screening
DM21 (5 points)

Foot examinations
DM29 (4 points)

Measuring blood pressure
No equivalent indicator currently in QOF

Urinary albumin test
DM13 (3 points)

Creatinine test
DM22 (1 point)

Measuring cholesterol levels
No equivalent indicator currently in QOF

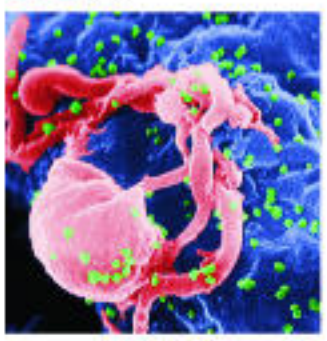
Recording smoking status
Smoking 5 (25 points)

Source: Department of Health

Analysis

Dr Bill Beeby on the proposed QOF changes

pulsetoday.co.uk/analysis



The week in general practice

INSIDE

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New NHS guidance has set out how CCGs should manage conflicts of interest
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Download of the week
Read Dr Hamish Meldrum's farewell speech to the BMA
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Video of the week
Watch Dr Peter Swinyard, chair of the Family Doctor Association, talk about where the profession goes next on pensions
▶ pulsetoday.co.uk/videos

PULSENEWS

Treasury to force through reform of pensions

Controversial changes will be formally unveiled before BMA decides on further industrial action

EXCLUSIVE
By Jaimie Kaffash

The Government is to push through its controversial reforms to GPs' pensions before the BMA has a chance to decide whether to take further industrial action, Pulse understands.

A source close to health secretary Andrew Lansley told Pulse the Treasury is set to formally announce the reforms before parliamentary recess in mid-July, ahead of the next meeting of BMA Council on 18 July, where it will decide what action to take next.

Mr Lansley last week wrote to Unison, which is co-ordinating the NHS-staff side of the pensions negotiations, suggesting the overall package – which will lead to higher contributions from GPs and a pension age of 68 – will be formalised imminently.

'The battle is never over until it is won'
Dr Peter Swinyard

The Treasury announcement will end all talks on higher contribution rates for GPs post-2015, and a move to career-average revalued earnings for salaried NHS staff. Mr Lansley said there were two outstanding issues to resolve – the contribution rate for 2013 and 2014, and the arrangements for NHS staff who felt unable to sustain their current role until the age of 68.

The source told Pulse these issues would not need to be resolved before the Treasury announcement.

The news comes after a disappointing turnout for the BMA's day of action last month. Despite this, the BMA's Annual Representative Meeting passed motions last week calling on BMA Council to consider further industrial action including a boycott of the commissioning process, separate actions for different branches of practice and further days of action.

At the end of the conference in Bournemouth, BMA Council elected as its new chair Dr Mark Porter (see above). However, the meeting did not discuss whether to take further industrial action.

Immediately after his election, Dr Porter said he would seek an 'urgent meeting' with Mr Lansley to discuss pensions. But the Department of Health said any negotiations would have to be through the official trades union talks.

Rachael Maskell, the head of healthcare at Unite, said the Government was willing to discuss limited changes, but seemed determined to force through the major thrust of the reforms:

List cleansing

EXCLUSIVE
By Madlen Davies

As many as one in three foreign nationals is being de-registered as part of increasingly tough list-cleansing drives, far exceeding projected numbers and raising fears that genuine patients may be left without a GP.

Figures obtained by Pulse show that many more patients have been removed than anticipated as part of PCTs' drive to wipe so-called 'ghost patients' from practice lists.

PCTs are scrambling to meet the Department of Health's target to identify and remove 2.5 million extra patients by next April.

But LMC leaders claimed the list validation exercises were removing genuine patients, and said the policy was discriminating against vulnerable patients who were unable to respond to letters or were confused by the process.

In Buckingham and Oxfordshire, 32% of foreign nationals reviewed – some 18,400 patients – were removed from practice lists in 2011/12, despite initial projections suggesting just 10% of patients would be deregistered.

NHS Surrey said it had removed more than a third of patients, including some foreign

Proportion of patients removed from lists

34%
NHS Surrey

32%
NHS Buckinghamshire and Oxfordshire

26%
NHS Berkshire

BMA elects new chair

The newly elected chair of the BMA, Dr Mark Porter, has warned doctors face a 'particularly challenging time' as the financial squeeze intensifies in the NHS.

The warning comes after Dr Porter was elected by BMA Council to replace GP Dr Hamish Meldrum as chair of the organisation. Dr Porter is a consultant anaesthetist at University Hospitals Coventry and Warwickshire NHS Trust, and was previously chair of the BMA's consultants committee.

Dr Porter said: 'I'm excited and privileged to be taking on this role at what is a particularly challenging time for the NHS and the medical profession.

'The BMA will continue to work to help its members do the best for patients.'

▶ Editorial, page 14

BMA: Lansley should resign

BMA representatives have defied their leadership in calling for the health secretary to resign in a vote of no confidence at the Annual Representative Meeting in Bournemouth.

The no confidence vote in Andrew Lansley was carried by 158 votes to 124, despite outgoing BMA chair Dr Hamish Meldrum calling on delegates to reject the motion.

Presenting the motion at the conference, Dr Gary Marlowe, a GP from Hackney, east London, said Mr Lansley's NHS and pension reforms meant he should no longer continue as health secretary.

He said: 'I've heard the argument that we cannot ask someone to resign if we have to negotiate with them tomorrow, but he doesn't listen. He sticks his fingers in his ears. Trust lies at the heart of everything we do. I do not trust this man.'

However, Dr Meldrum said that it 'was not about one man' and the BMA should continue to campaign against policies, not personalities.

He warned it would be harder to negotiate with the Government if the conference passed the motion: 'I've got to negotiate with him, and it's awkward to say: "Here's your P45 – let's talk."'

'This wasn't about one man, there was a whole Government, a Liberal Democrat coalition, that supported it and others that helped it through.'

GPC negotiator Dr Peter Holden said: 'Resignation's too good for Lansley. Cameron should sack him.'

Next steps in pensions battle

28 JUNE 2012	17 JULY 2012	18 JULY 2012	2015
BMA Council elects Dr Mark Porter as new chair	End of parliamentary term, by which time Treasury statement is expected	Next BMA Council meeting to discuss possible further action	Changes to NHS pensions due to be implemented

busts targets

nationals, since April this year, with 363 of the 1,058 patients identified as possible 'ghost patients' taken off lists.

In Berkshire, 26% of the foreign nationals checked were de-registered, with 10,800 patients removed.

The Thames Valley Primary Care Agency, responsible for carrying out the drive, had projected a removal rate of just 10%.

Dr Paul Roblin, chief executive of Berkshire, Buckinghamshire and Oxfordshire LMCs, said patients whose first language is not English were being de-registered, and that students who remained in the area had been knocked off lists after letters were sent to student halls where they no longer lived.

Dr Roblin said: 'The DH sends down diktats that the local NHS has to follow, and there are unforeseen consequences.'

Dr Harry Yoxall, medical secretary of Somerset LMC, told Pulse there were concerns in his area that members of the Polish and Portuguese communities would not respond to letters sent out by the PCT: 'The formal letter is written in quite complex and bureaucratic English.'

Dr Marine Ullah, a GP in Maidenhead, Berkshire, claimed a number of current patients had been de-registered, and two such patients had left her practice as they were angry at their GP.

'Understandably, we're not very happy about this,' she said. 'Patients come back in quite angry with GPs. It reflects badly on the practice.'

A spokesperson for the Thames Valley Primary Care Agency said it worked 'closely' with GP practices 'to ensure the right people remain on lists'.

'Patients are written to and if they fail to respond within two months the practice has to show they are still registered and using services, or they are removed from the list after six months,' the spokesperson said.

@maellendavies

sharing agreement reached in 2008, which said that the staff side will bear any future cost.'

Dr Peter Swinyard, chair of the Family Doctor Association, said: 'The battle is never over until it is won.'

VIDEO
Dr Peter Swinyard discusses pensions action
pulsetoday.co.uk/videos

GPs denied dementia options

Limited fall in antipsychotic prescribing as investigation reveals patchy access to treatment alternatives

EXCLUSIVE

By Pat Anderson

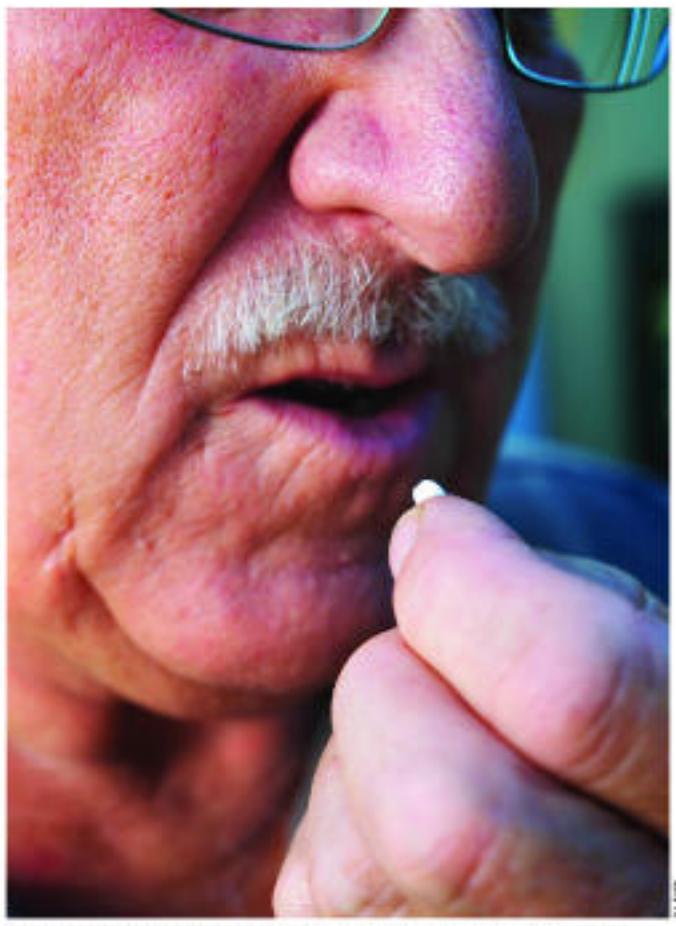
The Government's dementia drive has had little effect on antipsychotic prescribing, with GPs continuing to lack access to treatment alternatives, a Pulse investigation has found.

One in 10 PCTs does not commission any alternative dementia treatments for GPs to refer to, while in other areas waits can be up to six months.

Figures obtained by Pulse reveal that since the Government issued a call to reduce NHS prescribing of antipsychotics in dementia patients by two-thirds, there has been only a 16% reduction in GP prescribing of the drugs.

Prescribing figures extrapolated by healthcare market research agency Cegedim Strategic Data from 150 practices show an estimated 43,584 patients with a dementia diagnosis received a GP prescription for an antipsychotic in May.

This is a reduction from a peak of 55,616 patients taking the drugs in March 2009. But since November 2010, when the Government set its target of reducing prescribing by two-thirds, the fall has been just 16% in primary care.



Antipsychotic prescribing has fallen, but not to target levels

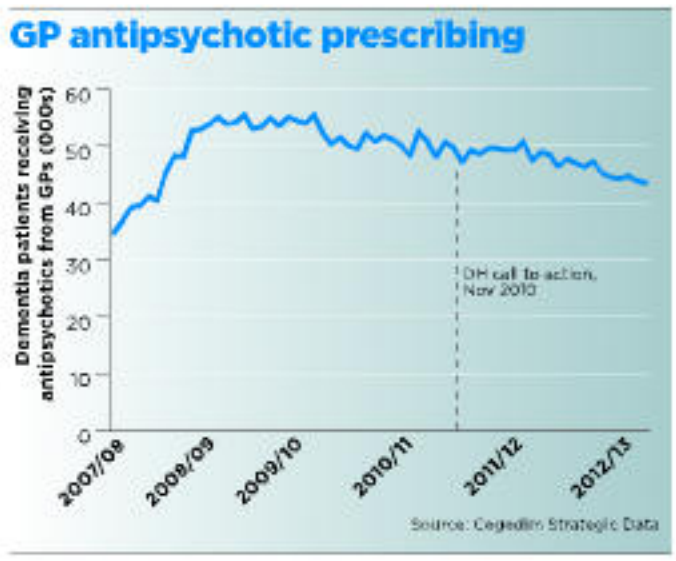
As part of the 'Prime Minister's challenge on dementia', launched last year, GPs were asked to review all patients on antipsychotics and explore NICE-approved alternatives, such as aromatherapy, multisensory stimulation or massage.

But a Pulse survey of 82 PCTs in England shows 11% do not commission any alternative therapies.

Of those who do, only 13% allow GP referrals and waiting times ranged from three weeks to six months.

Responding to Pulse's investigation, RCGP chair Dr Clare Gerada said although GPs should be cutting down on antipsychotic use, it was essential the provision of memory clinics and community psychiatric services was expanded.

She said: 'We are going to end up with patients, families and carers without support, and that's the worst possible scenario.'



Professor Steve Iliffe, a GP in north-west London and professor of primary care for older people at University College London, said GPs were often faced with an urgent situation as the ability of care home staff and carers at home to deal with behavioural problems was 'limited', and added: 'It makes no sense to say "stop using this treatment" if alternatives are not available.'

Dr Simon Ruffle, a GP in Twyford, Berkshire, said: 'Some [patients] are terrified, see things and smear faeces on the wall – we are supposed to stand back and allow this?'

A spokesperson for the DH said it remained committed to reducing inappropriate prescribing.

feedback@pulsetoday.co.uk

ANALYSIS

The whole system needs to change

Nigel Praities
Acting deputy editor

A call to reduce the prescribing of any drug in the NHS by two-thirds is ambitious, but the case for doing this with antipsychotics in dementia is overwhelming.

Study after study has shown a substantially raised risk of mortality in dementia patients taking the drugs, and in a report published in 2009 the drugs were linked with an extra 1,800 deaths a year in the NHS.

On the back of this, the Government issued an immediate review of care home prescribing, and followed this up with a 'call to action' in 2010 and the 'Prime Minister's challenge on dementia' last year to ensure all patients were reviewed and alternatives to antipsychotics were considered.

A health minister even made a threat of legal action under the Mental Capacity Act for prescribers who did not seek special permission to use the drugs.

Has all of this activity made a difference? Our investigation shows levels of antipsychotic prescribing by GPs are coming down slowly, which should be welcomed, but the overall rate remains relatively high.

Speak to GPs and they will tell you the system is struggling to cope. Care homes and carers have very little capacity to handle aggression in a patient with dementia. GPs are often called only when the situation is urgent and, as our investigation reveals, their access to alternative treatments is, at best, patchy.

Antipsychotic prescribing in dementia is a rare example of experts, NICE, ministers and GP leaders agreeing what needs to be done. But institutional barriers continue to prevent the rapid improvement everyone wants to see.

GPs hit by benefits overhaul

The GPC has complained to the Government over its drive to reassess everyone on incapacity benefit, warning practices are facing rising numbers of patients requesting 'fit notes' while their cases are reviewed.

The move comes as BMA leaders voted to scrap the Work Capability Assessment scheme, which they said 'has little regard for the nature or complexity of the needs of the long-term sick and disabled'.

Dr Deborah Colvin, chair of City and Hackney LMC, said each of the 10 GPs at her practice now sees three to four patients a week requesting a sick note while they appeal the decision to withdraw their benefits, when it used to be an occasional occurrence: 'I can't bear seeing patients with major disabilities being told they can go to work when there are no jobs to be had. What do [the Department for Work and Pensions] expect us to do? Are we supposed to leave people with nothing?'

I can't bear seeing disabled patients being told they can go to work

Dr Deborah Colvin

Dr John Canning, chair of the GPC's Professional Fees Committee, said he had raised the rise in fit note requests with the DWP: 'The DWP have undertaken to address the issue. I will not let this rest.'

The BMA's Annual Representative Meeting in Bournemouth last week voted for the scheme to be replaced with a 'rigorous and safe' system that 'does not cause unavoidable harm' to the weakest in society.

A DWP spokesperson said: 'GPs should only issue a fit note if a patient has a health condition that impacts on their fitness for work, whether they are appealing any DWP decision or not.'

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Contra-indications: Hypersensitivity to any of the ingredients. **Side-effects:** Skin reactions including pruritus, rash, erythema, skin exfoliation, burning sensation, hypersensitivity, pain, dry skin and bullous dermatitis have been reported with product use. **Package Quantities:** Cream: 50g tubes, 500g pump dispensers; Ointment: 50g tubes, 500g jar. **Basic NHS Costs:** Cream: £1.28 (50g), £6.32 (500g); Ointment: £1.28 (50g), £5.99 (500g). **Legal Category:** GSL. **Marketing Authorisation Numbers:** Cream: PL 00025/0057; Ointment: PL 00025/0574. **Marketing Authorisation Holder:** Merck Sharp & Dohme Limited, Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU, UK. **Date of Revision:** February 2012.

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Key questions: HIV
▶ page 20

The campaign had little effect on bowel cancer referrals

Cancer drive 'has no impact on diagnoses'

Pilots of DH awareness campaign find no significant rise in detections

By Emma Wilkinson

A major Department of Health publicity campaign urging patients to see their GP earlier if they have symptoms of breast, lung or bowel cancer is unlikely to have any significant impact on the number of cancer referrals or diagnoses, official figures suggest.

A DH evaluation reveals its £9m national awareness campaign was based on pilots that showed no significant increase in the numbers of cancers detected, compared with areas where there was no campaign.

The 'Be Clear on Cancer' awareness campaign was launched by the DH in January, and includes adverts running on billboards, buses and in local newspapers urging patients to present to their GP if they have symptoms including a cough lasting three weeks or 'louse poo', but has been criticised by some cancer leads as unhelpful.

Data from pilots taking place in 76 PCTs in 2010/11 showed a non-significant 9% increase in two-week wait referrals for lung cancer, compared with a 7% rise in referrals over the same period in 73 'control' areas where the publicity campaign was not run.

With bowel cancer, there was a non-significant 16% rise in the 77 PCTs with local awareness campaigns, compared with a 13% rise in the 74 control areas.

The awareness campaigns also had no significant effect on the number of cancers detected.

There was a 6% rise in bowel cancers and a 4% rise in lung cancers detected in areas with the awareness campaign, but these were not statistically significant increases compared with control areas. Figures for the breast cancer awareness campaign were not calculated.

The report concluded: 'The data appear to show no significant impact on the number of cancers diagnosed via the two-week wait or the percentage conversions.'

Dr Kiran Singh, GP cancer lead for NHS Warwickshire – one of the areas that trialled the publicity campaign – said: 'I am surprised it didn't make a difference [to cancer referrals]. The general feeling among clinicians is that we do see an increase after such campaigns.'

But Dr Dermot Ryan, a GPSI in endoscopy in Loughborough, Leicestershire, said: 'I have patients who are referred with absolutely no likelihood of cancer, and all it does is clog up the two-week wait.'

A DH spokesperson said: 'This initial evaluation is from only the first year of the programme, and we have always anticipated that full impact will be seen after a few years.'

feedback@pulsetoday.co.uk

Does the cancer campaign work?

Lung cancer

- **Non-significant 4% rise in cancer diagnoses in campaign areas, compared with a 1% rise in control areas.**

Bowel cancer

- **Non-significant 6% rise in cancer diagnoses in campaign areas, compared with a 0.6% rise in control areas.**

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UK/GEN/12/0015 June 2012

Yorkshire GPs told to expect £19m debt despite ministers' assurances

DEBTS

PCT warns CCGs they will inherit deficits

By Gareth Iacobucci

NHS managers have admitted GP commissioners will inherit multimillion-pound PCT deficits from next April – despite repeated assurances from ministers that 'no legacy debts' will be passed on to CCGs.

NHS North Yorkshire and York said it had notified the Department of Health of its intention to pass on £19m debt to CCGs from next April because of the 'significant financial challenges' facing the PCT.

The disclosure comes despite ministers continuing to insist that debts will not be passed on to CCGs – a key demand of Pulse's *A Clean Slate* campaign last year.

Health secretary Andrew Lansley told CCG leaders at the Commissioning Show in London last week: 'As we have said before, we are still intending for CCGs to start in April 2013 with no legacy debts. It won't be true in the provider sector – it will be true for you as commissioners.'

NHS North Yorkshire and York, which will be superseded by four CCGs from next April, warned in its latest financial board report that it risked 'running out of money' this year.

The report said: 'We have formally notified the DH of our projected deficit (overspend) of £19m for 2012/13.

'This means that on our current projections, we do not believe we will be able to meet our statutory duty to break even in financial terms.'

The report added: 'Without significant changes to patterns of expenditure, NHS commissioners in North Yorkshire and York risk running out of money this year.

Dr Vicky Pleydell: this year there will be no bail-out

'This means they will be unable to pay providers for services to patients, which in turn means providers will be forced to take drastic actions in order to cut their costs. This kind of unplanned cost-cutting must be avoided.'

Dr Vicky Pleydell, a GP in Catterick, North Yorkshire, and shadow accountable officer for Hambleton, Richmondshire and Whitby CCG, said there was 'no easy solution' to the historical financial problem.

Writing on her personal blog, Dr Pleydell said: '[The financial problem] has been there for years and years, but in the past it has been temporarily sorted with loans from the SHA and made up of money from other PCTs who have underspent. This year there is no bail out and so we will probably finish the year in deficit too.'

Dr Pleydell said the CCG would need to 're-engineer our system' to tackle the deficit, by shifting more care into the community.

'That means fewer beds in hospital and the money that used to pay for those beds can be used to employ community staff,' she said.

A DH spokesperson confirmed CCGs would inherit any debts incurred during 2011/12 and 2012/13, adding: 'The NHS is delivering excellent results for patients, but we know that a small number of organisations have financial problems.'

@garethiacobucci

NAPC 2012
Hear how to develop a good working relationship with your CCG
napcannual.co.uk

RECONFIGURATION

CCG leaders back major hospital re-jig

CCG leaders have lent their backing to one of the largest reconfigurations of hospital services to date, in a move that will radically reshape NHS services for two million patients.

NHS North West London this week revealed details of its *Shaping a healthier future* consultation, which proposes closing three A&E units in a bid to tackle both financial and clinical challenges.

The plans have received backing from acute providers and all eight CCGs in north-west London, who said the changes were necessary.

NHS chief executive Sir David Nicholson last month cited the plans as a blueprint for CCGs looking to reconfigure services, in his keynote speech at the NHS Confederation conference.

The preferred option outlined in the consultation, which will run for 14 weeks, would close A&E departments at Ealing, Charing Cross and Central Middlesex hospitals, and consolidate services into five major hospitals.

Dr Ruth O'Hare, chair of Central London CCG, said it supported the consultation: 'The CCG will take forward the resulting plans given adequate resources.'

DOWNLOAD
Read the full consultation
pulsetoday.co.uk/downloads

AQP

LES competition welcomed

Private companies have welcomed the drive to open up local enhanced service funding under any qualified provider.

Last week the NHS Commissioning Board urged CCGs to remove some LESs from practices and commission 'wraparound' community services.

Leading private providers told Pulse they were keen to take advantage of the more competitive market. Dr Jeremy Rose, clinical director of the Practice Plc, said it was preparing to take on more primary care services: 'CCGs should be commissioning on behalf of patients, not member GPs.' Care UK said it was 'working to understand the needs and priorities of local commissioners', while Virgin Care said: 'Where we think services can make a difference to health outcomes and improve patient experience, we'll take a look.'

But Dr Simon Poole, deputy chair of the GPC's commissioning and service development subcommittee, warned CCGs to ensure services were not fragmented.

REFERRALS

Consultants 'educate' GPs on referrals

GP commissioners are planning to bring in hospital consultants to 'educate' practices and troubleshoot spiralling outpatient referral rates.

CCGs in Buckinghamshire decided to take action in May following data suggesting that GP outpatient referrals were 7% above the planned level and 6% above the same period last year.

They are now collaborating with local consultants to identify specialties where unnecessary hospital follow-up appointments are taking place and to provide feedback to GPs on referrals. The work will focus on areas with high levels of follow-up appointments, such as haematology and trauma.

Board papers from NHS Buckinghamshire and Oxfordshire Cluster said the move came after Aylesbury Vale CCG and Chiltern CCG took responsibility for £20.6m of QIPP efficiency savings.

Dr Prit Buttar, chair of Oxfordshire LMC, said: 'Anything that improves the efficiency of the system and improves care for patients is beneficial.'

'Anything that improves the efficiency of the system is beneficial'
Dr Prit Buttar

Post-op problems: gastrointestinal complications ▶ page 26

Child maltreatment 'not coded'

Study recommends GPs use 'non-stigmatising' codes to record niggling concerns over child maltreatment

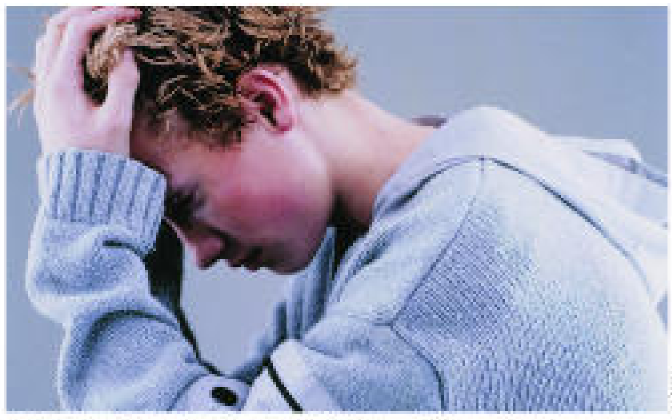
By Emma Wilkinson

Children suffering maltreatment may be missed due to concerns over recording information that relates to other family members in GP notes, an RCGP-funded study has warned.

The analysis found low levels of recording child maltreatment among GPs and recommended non-stigmatising codes indicating a 'cause for concern' should be used more widely.

The study comes just two weeks before the launch of new GMC guidance on child protection, which is expected to say that every doctor has a responsibility to protect children, including if they are treating parents for a condition that could affect their ability to care for a child, and should record even minor concerns.

Analysis of the THIN database of 876,000 children showed eight in every 1,000 children were assigned a maltreatment-related code each year – much lower than the expected rate of 47 per 1,000 suggested by epidemiological studies. In a further detailed analysis of data from 11 practices – published in the July issue of the *British Journal of General Practice* – 25 children had known maltreatment, but six had no maltreatment-related codes recorded in their notes. GPs instead often wrote worries in free text or attached other documents.



A study has found low levels of GPs recording maltreatment

In a series of interviews with a GP from each practice, researchers found GPs were wary of coding concerns because of worries about potential harm to the child or parents from seeing documented concerns, fears over recording third-party information in a child's notes and uncertainty over which codes to use.

The researchers concluded that although primary care would not know of every case, GPs should record any niggling concerns using 'non-stigmatising' codes (see box, above).

Dr Janice Allister, a GP in Peterborough and co-author of the study, said recording third-party information was allowed in Caldicott information governance guidelines, but GPs tended to feel 'very under-confident' about it: 'The main thing is to flag up "child is a cause for concern", but you need to have that discussion with the parent or carer.'

Dr Brian Balmer, chief executive of Essex LMCs and a GP in Chelmsford, welcomed the recommendations and said: 'We take this very seriously and would certainly welcome any guidance from the GMC or the college.'

feedback@pulsetoday.co.uk

What codes should GPs use?

131f Child is cause for concern
8CM5 Child in need
131F.11 Vulnerable child
63CA:hv Mother not managing well
ZV61300 Other parent-child problems

Source: *Br J Gen Pract* 2012, online 25 June

ANALYSIS

GPs must record concerns

This is not about criticising GPs. Quietly, behind the scenes, we do an enormous amount of work to support families. But what we have to do now is say we are doing it.

GPs often see multiple family members and can detect stressors – such as violence, parental depression and drug or alcohol abuse – that put children at risk of maltreatment. We hold the continuous health record and are a key resource for sharing information about maltreatment-related concerns.

Yet, from our research, we found GPs have worries about writing something in the notes that could cause argument or offence later on. GPs do sometimes feel under-confident about the legal aspects of recording information about third parties in records, but this is covered by the Caldicott guidelines on information governance. New GMC guidance will be published next month and will address the ethical questions over this. The key thing is to develop a relationship with the patient to keep them engaged with services and get them the help they need.

It is about a balance of benefit and harm, and feeling confident in saying to a parent or carer: 'We will do all we can to support you and your family – what arrangements shall we make to check how you (and the child or young person) are getting on?'

Dr Janice Allister is the RCGP clinical champion for child health and a GP in Peterborough

IN BRIEF

NHS change urged

Sir David Nicholson has warned the NHS is 'not delivering' on service change.

Full story ▶ pulsetoday.co.uk/commissioning-news

CCGs not GPs' 'creatures'

The NHS reforms are being driven from the top, the GPC has claimed.

Full story ▶ pulsetoday.co.uk/commissioning-news

Anti-NHS reforms party

A new political party will field 50 candidates to campaign against the NHS reforms.

Full story ▶ pulsetoday.co.uk/politicalnews

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References:
1. Donohue JF. *et al. Am J Respir Crit Care Med* 2010;**182**:155-162. **2.** Buhl R. *et al. Eur Respir J* 2011;**38**:797-803.
3. Yorgancioglu A. *et al.* Poster presentation at European Respiratory Society Annual Congress, Vienna, September 2009.
4. Onbrez Breezhaler, Summary of Product Characteristics, July 2011.

Date of preparation: March 2012 IND12-C052

Prescribing information can be found overleaf

NOVARTIS

Concerns over older risk score suggest GPs should switch to QRISK2

CVD

Framingham has 'no clinical utility'

By David Swan

GPs should no longer use the Framingham risk score to assess patients for statin treatment, as the algorithm has 'no clinical utility' compared with the latest version of QRISK, according to researchers.

The damning conclusions of the study provide solid evidence for GPs to switch to use of the QRISK2 equation, as it identified up to five more cases per 1,000 patients than Framingham.

Current NICE guidance leaves it open to GPs to decide which cardiovascular risk score they wish to use - either a modified version of Framingham or QRISK2.

UK researchers looked at over two million patients, aged between 30 and 74 years and with no previous diagnosis of cardiovascular disease, recorded on The Health Improvement Network (THIN) database. Each patient's first diagnosis of cardiovascular disease was recorded in the five-year follow-up.

The independent analysis found the 2011 version of QRISK2 identified five more cases of patients at high risk of cardiovascular disease per 1,000 in males, compared with the NICE version of the Framingham equation. For women, QRISK2 identified two more cases of patients at high risk per 1,000.

This suggested an increased accuracy in estimating cardiovascular risk in UK patients, and did not come with any significant increase in the number of patients treated unnecessarily.

When predicted risk was compared with observed risk, QRISK2 showed good agreement across all age groups.

But Framingham showed a near-constant over-prediction of around 5% across all age groups in men. Figures were not calculated for women.

The authors, from the University of Oxford, concluded: 'If the Framingham equation is to continue to be used and doctors advised to treat patients if their predicted risk is 20% or higher, it is necessary for it to be recalibrated and updated.'

Dr John Ashcroft, a GP in Derbyshire and member of the Derbyshire CHD committee, said a switch to QRISK2 would be a wise choice: 'It includes risk factors that are important and often overlooked or difficult to factor in, including family history and atrial fibrillation.'

But he added it may have implications for the NICE threshold for primary prevention, currently set at a 20% 10-year risk of CVD, which may be set too high.

***BMJ* 2012, online 21 June**

david.swan@pulsetoday.co.uk

Framingham should be updated for UK patients

SEMINAR
Diabetes and CVD Update 2012
pulse-seminars.com

CANCER

GPs told not to rely on 'red flags' in child cancer

GPs should not rely on 'red flag' symptoms for cancer in children as only one in five cases will present with then, according to Danish researchers.

The retrospective analysis used data from GP questionnaires looking at the symptoms in children who had subsequently been diagnosed with cancer. Of the 315 children whose symptoms were included in the study, only 20% had symptoms that were interpreted by GPs as red flags, such as weight loss, or a lump or swelling.

The proportion of red flags was highest in those with leukaemia, at 44%, and lowest in those with bone tumours, at 6%. There was also evidence that red-flag symptoms increased in frequency as children got older.

The authors, from Aarhus University, Denmark, said: 'This shows the need to take a detailed medical history in children presenting with vague symptoms.'

***Br J Gen Pract* 2012, online 25 June**

HEART FAILURE

BNP and clinical features best for predicting HF

GPs should use BNP testing and a list of clinical features rather than ECGs to determine whether a patient with suspected heart failure needs to be referred for an echocardiogram, concludes a UK analysis.

The authors looked at five primary care studies that evaluated clinical features and investigations predictive of heart failure, and then formed different models of predicting heart failure.

They found that using clinical features of a myocardial infarction – crepitations and ankle oedema – plus a measure of BNP or NT-pro BNP was most sensitive (between 90-96%).

The study authors, from the University of Birmingham, concluded: 'Natriuretic peptide testing should be recommended over ECG. Some patients could be referred for early echocardiography without undergoing preliminary investigation.'

***Eur J Heart Fail* 2012, online 19 June**

DEPRESSION

Mental health 'worse with depressed parent'

Almost a quarter of children with a parent suffering from depression meet the criteria for a diagnosis of a psychiatric disorder themselves, according to UK research.

The study looked at 333 children aged between nine and 17 years who had a parent with a history of recurrent depression. Parents with bipolar depression or a psychosis were excluded. Data were gathered using structured interviews, with trained interviewers used to assess the child's mental health over the preceding three months. Any child meeting criteria for a diagnosis was then reviewed by two senior psychiatrists. They found 24% of the children identified had a psychiatric disorder.

The authors, from Cardiff University, concluded: 'This highlights the need for GPs who are seeing parents with depression to be aware of the risk of problems in their children.'

***Br J Gen Pract* 2012, online 25 June**

CPD TIP OF THE WEEK

Consider psychogenic cough in children

If a child presents with a chronic cough that does not wake them at night, you should consider psychogenic cough as a potential cause, say the authors of a new case-based learning module. A psychogenic cough is usually a dry, repetitive cough that persists after an upper respiratory infection has cleared. It is less prominent at night and when the child is distracted. Hot topics in childhood cough – available to premium members of Pulse Learning and worth a suggested 2 CPD hours – covers both acute and chronic cough, community-acquired pneumonia, pertussis and when to refer children for chest X-ray.

ONLINE CPD
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NEW

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Generally well tolerated

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

Different

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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. 923-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 UM11-066a. **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/22815/SPC/Onglyza+2.5mg+%26+5mg+film-coated+tablets/ (accessed May 2012). **10.** Drazon CF. *Diabetes Obes Metab* 2011;13:7–18. **11.** Blech S *et al. Drug Metab Dispos* 2010;38:667–678.

UK/TRJ/0004a Date of preparation: May 2012

Boehringer Ingelheim

Lilly

BMA chair must listen, then lead

As Dr Mark Porter woke up last Friday morning, to begin his first day as the newly elected chair of the BMA, he could have been forgiven for pausing a second, looking in the mirror and wondering what exactly he had got himself into.

Representing the association's 150,000 members is no easy job at the best of times, but these are not the best of times.

The NHS is gearing up for the biggest reorganisation in its history, eye-watering efficiency targets are increasingly forcing doctors into an unpalatable rationing role – and then, of course, there's pensions.

The man Dr Porter is replacing, Dr Hamish Meldrum, drew a standing ovation from delegates at his farewell speech,

Steve Nowottny
Acting editor

and rightly so. He has been a distinguished servant of the BMA, and represented doctors with dignity, gravitas and authority over the past five years.

And yet there remain real questions over some of the BMA's recent decisions – questions which will inevitably shape Dr Porter's thoughts as he looks to put his own stamp on the association's strategy.

On the NHS reforms, the policy of 'critical engagement' initially appeared statesmanlike, but then increasingly exposed as doctors' views on the health bill hardened. Ultimately the policy became more 'critical' than 'engagement', but many rank-and-file GPs felt it was too little, too late.

The vote at last week's Annual Representative Meeting instructing the BMA to campaign for the health act to be repealed, against Dr Meldrum's bidding, suggested lingering discontent.

On pensions, the BMA has been much more robust. But with the benefit of hindsight, its refusal to join other health unions in NHS-wide industrial action last November left it exposed when going it alone this year, and its handling of the day of action itself was politically tone-deaf.

The decision to target patient care rather than paperwork was curious, and the BMA invested so much energy in averting a possible legal challenge and running a media campaign to reassure the public

that somewhere along the way it forgot to sell the whole idea to its own members.

The result was a lacklustre turnout, which fatally undermined the first industrial action by doctors in a generation – and a nagging fear that on pensions the BMA may have shot its bolt, with nowhere left to go.

All of which adds up to a daunting to-do list for the new BMA chair – and a profession which, in the coming months, will need strong, sure-footed direction.

To have any hope of influencing the NHS reforms, winning concessions on pensions, getting members on side and restoring the BMA's credibility with the Government and the national media, Dr Porter will need to listen carefully, and then lead decisively.

A little luck wouldn't go amiss either.

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

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Free at the point of abuse

Phil only really got one thing out of the day of action – an object lesson in just how ridiculous it is to allow patients to decide what is 'urgent'

SIMON KANE / SCIENCE PHOTO LIBRARY

Well, thank heavens that's all over. It wasn't too bad, was it?

Thanks to our prompt, decisive and above all unanimous and co-ordinated industrial action, the Government has rolled over like the pussies we always knew they were and restored our promised pension agreements, just like we knew they would.

The worst thing we could have done would have been to present a disunited front, put up a few token Uncle Toms for the popular press – who would parrot the idea that we do this job out of liberal guilt and not for any sort of living wage – and then, despite displaying a shamefully small percentage of participating doctors, back out of this even further on the day and offer to the public, as some sort of desperate half-assed child's attempt at a strike, two doctors in Penge who flatly refuse to remove ingrowing toenails until tomorrow.

Lucky that we didn't do that, eh?

Or maybe you don't care that our employment contract was theoretically in some way binding on *both* parties. It appears now that it wasn't, certainly.

If our Government can unilaterally piss my pension and retirement age away into the ether, then presumably I can also tear up the same contract and, say, refuse to treat any ailment from mid-thigh downwards. Nobody would die as a result. Let's see just how far I get with that idea, shall we?

However, this was never going to be an easy gig, frankly, and I can hardly hold my own practice up as a beacon of excellence when it comes to Citizen Smith-style, bandana-wearing, fist-waving popular protest.

I'm the only one who insisted on taking any industrial action at all.

I refused to see anything but emergencies on the day, but as my partners insisted on working as normal, and as it is our patients who define the word 'emergency', then all that happened is that I saw all the 'urgent extras' that would have otherwise been (and are, on any other day) distributed among the lot of us.

And what an utterly depressing day of unrelenting crap it was.

Nobody likes to contemplate their own insignificance, or indeed have the bald fact of it thrust in their faces, but for heaven's sake, are we not here to deal with more important stuff than this?

This is urgent? For this, we cost the nation £25 per appointment? (And I'm well aware that this is a bargain compared with anyone else.)

I had intended to use this article to demonstrate the pathetic nature of most urgent requests to see a GP, and I kept a list of the utter rubbish that I saw on the day of action – the lost sick notes, the prescription queries, the requests for advice about

This is urgent? For this we cost £25 per appointment?

a parent who isn't actually a patient of yours, it goes on and on.

But what's the point? You've heard it all before. You all get it, every single day.

This profession deeply depresses me at times, and it always comes back to the fact that our services are free at the point of use (or abuse, if you will).

Some 90% of my time, or rather 100% on the day of supposed industrial action, is taken up by about 5% of our patients, and there is no evidence to suggest that they are the 5% that need it most.

Sometimes I can barely tolerate what I do for a living, and I'm in one of those periods now. During these times there seems only one realistic solution: charge them.

The type of patient who makes another appointment on the way out of the last one, on the grounds that they are bound to think of something else to moan about before then has to be... well, I was going to say discouraged, but I am actually tempted to say they should be socked on the back of the head with a baseball bat.

The patients we are actually here for cannot get easily accessible appointments because of the tedious minority who spend far too much of our time indulging their hobby of free, self-indulgent self-aggrandisement.

I honestly believe that the time for free access to medical care is over; ruined by the selfish few.

Dr Phil Peverley is a GP in Sunderland

Don't settle science in court

Doctors must be able to have a full and open debate about the evidence behind the science without being afraid they will be sued for libel, says Margaret

ILLUSTRATION: JAN WILLEY

If one thing is clear, it is that robust discussion is essential when it comes to disputes about evidence. This is what makes us grown-up – this is what protects our patients.

I feel proud when I hear the rough and tumble of Prime Minister's Question Time in parliamentary session on Wednesdays – our democracy can take the free-for-all.

I feel glad that we have *Private Eye*, rude and cynical and so often completely correct. We need to be able to poke fun, vigorously question, slate, annoy, demand and push for debate and talk and chide. Personal attack is not so good, but free speech is sacrosanct.

This is what makes our country great – this is the kind of Britain I want to live in. It is good for medicine and good for patients. We should not be hemmed in by fear about libelling someone and prevented from debating the data.

This is why doctors should be supporting Sense about Science's attempts to make good the poor libel laws in the UK.

Most doctors are likely to have heard of Simon Singh's travails after the British Chiropractic Association attempted to sue him for libel, or when cardiologist Dr Peter Wilmshurst was threatened with libel after speaking out about trial data of a heart device.

Then there is plastic surgeon Mrs Dalia Nield, who contested claims about 'Boob Job' cream, and the Burzynski Clinic, which threatened bloggers who wanted to dispute their claims about antineoplastin treatments for cancer.

And now a new possible libel action is looming after a long-running dispute between a private GP and a scientist, over their differing views on the evidence base for the therapies the GP was offering to patients with chronic fatigue syndrome.

GPs are often the first contact for people who have read about miracle cures.

It's part of our job to help people reach good decisions about their health – and as the internet becomes our debating ground, it's essential that doctors can freely talk about the shortcomings and problems with evidence.

It would be even better if patients – or potential patients – could read these debates for themselves, and that's only possible if we are unafraid of being sued just because we disagree.

We should not be hemmed in by fears about libel

The Defamation Bill is currently going through the House of Commons. While it has cross-parliamentary support, there is substantive concern that as it stands, it will be ineffective where it counts.

I support Sense about Science's efforts to make the bill effective, and would urge GPs to consider supporting them. We need freedom to call out for evidence, and we need to be assured that debate will not end with a demand for libel damages.

It's clear that in the UK, defamation proceedings cost more than in other European countries.

As it stands, patients lose out where their doctors cannot challenge and debate openly matters of evidence.

The court is not the place to settle science. Everywhere else is.

Dr Margaret McCartney is a GP in Glasgow

More online

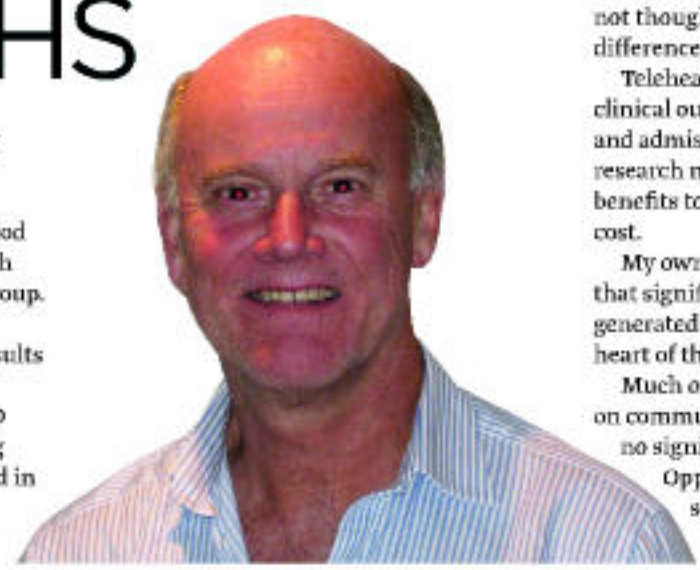
Copperfield returns next week, but if you can't wait until then to get your regular blast of the world according to Copperfield, you can read his blog at pulsetoday.co.uk/copperfield, or following him on Twitter @doccopperfield.

Telehealth shows enormous potential for the NHS

Trial data proves telehealth can improve care, but done right it can also cut costs, writes **Dr Julian Neal**

The first of five detailed papers from the Whole Systems Demonstrator (WSD) trial, published last month in the *BMJ*, found that, over the course of a year, patients provided with telehealth had 19% fewer emergency admissions than the control group, who were cared for 'in the usual way'. More significantly, over the same 12-month period only 4.6% of those provided with telehealth died, compared with 8.3% of the control group.

Both these findings are statistically significant and are consistent with the results from a study my practice undertook two winters ago, when 100 patients with COPD were provided with telehealth monitoring and 11 hospital admissions were prevented in just three months.



The study in the *BMJ*, which covered 3,154 patients, also concluded that for those patients with telehealth the overall costs of hospital care were £188 per patient less than those for control patients (though this was not thought to be a statistically significant difference).

Telehealth is clearly good for patients: clinical outcomes are improved, lives saved and admissions prevented. But more detailed research needs to be done to prove the benefits to patients can be achieved at a lower cost.

My own experience of telehealth suggests that significant cost savings can only be generated by having nurse-led triage at the heart of the service.

Much of the WSD trial imposed technology on community and primary care staff with no significant service redesign.

Opportunities for economies of scale were lost – for example, one specialist nurse could cost-effectively monitor several hundred patients.

Too often telehealth became an additional cumbersome layer rather than a focused cost-effective improvement.

A wealth of overseas data exists that confirms the clinical and financial benefits of telehealth.

Reproducing these gains in the NHS will require more than just technology – sensitive patient selection and large-scale integrated implementations are essential prerequisites.

The Department of Health also needs to do its bit by providing incentives. A new 'telehealth tariff' should encourage rollout of services to practices and CCGs, which in turn should drive down costs and encourage provision under any qualified provider.

It should also encourage the adoption of cheaper and smarter technological solutions, including mobile phone apps.

My own practice is currently four months into a two-year observational study of the effects of telehealth on hundreds of patients with COPD, chronic heart failure and diabetes.

As well as recording clinical outcomes and a large range of socioeconomic factors, we will analyse total NHS use for two years before and after deployment of telehealth.

The potential to reduce demand on both GPs and the out-of-hours services is enormous.

Dr Julian Neal is a GP in Portsmouth and clinical adviser to Telehealth Solutions

MORE ONLINE
Dr Mark McCartney argues that the WSD trial leaves a number of questions unanswered. Read his side of the debate and have your say at pulsetoday.co.uk/opinion

PULSE VIEWS LETTERS

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Pathology variation down to poor practice

From Dr John Orchard
Alfreton, Derbyshire

Dr Robert Morley is severely misinformed when he seeks to justify wide variation in pathology tests ('Yet another stick to beat us with', pulsetoday.co.uk/opinion). The truth is that variation is down to poor practice.

When one individual in a multi-partner practice has investigation rates four times those of his peers, he has a problem.

When the phlebotomist expresses surprise the locum is requesting so many tests, the locum has a problem. When the number of tests requested by general practice has increased enormously, the profession has a problem.

My observation is that defensive medical practice is driving the desire to exclude everything at the expense of rational practice.

The time-honoured practice of history taking leading to a differential diagnosis, investigated by appropriate examination and then clarified by targeted testing and imaging, has been replaced by minimal history taking, differential diagnoses from an undergraduate textbook, blanket laboratory screening and unnecessary referral.

The fault lies in the failure to deal with uncertainty, which results from insufficient clinical exposure in training caused by restricted working hours, part-time training and a reluctance to accept responsibility for dealing with patients' anxieties.

The result of the QOF and internet misinformation is a belief in the infallibility of tests and the dumbing down of clinical acumen.

What is needed are competent doctors with the courage to practise the skills they have learned who do not bow to the demand for every test because it can be done.

LETTER OF THE WEEK

Is wide variation in use of lab tests linked GPs 'dumbing down'?

Just what do we mean by 'telehealth'?

From Dr Stuart Berry
Nelson, Lancashire
via pulsetoday.co.uk

Telehealth, like other health interventions, is most useful if the patient develops greater understanding about their own self-care by the end of episode ('Telehealth cuts admissions, but not costs', pulsetoday.co.uk/news).

But the term is too inclusive and has the potential mess up some innovative ideas. After all, the telephone is probably the simplest 'telehealth' device used in healthcare today.

Show us the evidence, not the spin

From Dr George Farrelly
Bow, east London
via pulsetoday.co.uk

Policy development on telehealth must be guided by robust evidence and seeing how things actually work ('Data does not support the DH's extraordinary claims for telehealth', pulsetoday.co.uk/margaret-mccartney).

Dr McCartney is very right to push the Department of Health to produce evidence, and not spin. It seems to me that there are parts of the DH which are driven by spin, in a sort of evidence denial.

This is no way to develop and implement policies – indeed, it is actually damaging.

Drop the CQC? I'm with Copperfield

From Dr Kevin D'Mello
Hucknall, Nottinghamshire

Copperfield was on the ball with his article on CQC registration ('Standardised into submission', pulsetoday.co.uk/copperfield). How has the BMA colluded on such rubbish?

It will not make any real difference, as the CQC regulating body has proved its incompetence time and again. They regularly bury their heads in the piles of information collected so that, when alerted to misdemeanours and poor practice, they are unable – or unwilling – to respond. Surely if the majority of us refuse to engage in this task, we will not have to pay for the privilege.

● **From Dr Robert Cullen**
Romney, Kent
via pulsetoday.co.uk

Dr Copperfield is right, CQC registration will be a complete waste of time. I have tried to encourage my local practices to boycott the process. If we all did, then there is no way we could all be closed down.

● **From Dr John Derounian**
Glenlivet, Banffshire
via pulsetoday.co.uk

Nobody else has realised yet, but I think you'll find that CQC actually stands for Can't Quite Comply. That will probably apply to me anyway. Anybody else?

Will the BMA commit to more action?

From Dr Peter Budden
Manchester
via pulsetoday.co.uk

As numerous commentators and jobbing GPs keep telling our 'representatives', we have three powerful options available right now to effect change ('Change tack on industrial action, says GP candidate for BMA chair', pulsetoday.co.uk/news).

These are no co-operation with the CQC, no co-operation with revalidation and ultimately refusal to apply for CCG authorisation.

None of these affect patients. Will the BMA now kindly step up to the mark?

Hell, I may even re-join if they did.

Targeting the CQC won't hurt patients

From Dr Ian King
Redhill, Surrey
via pulsetoday.co.uk

The BMA has made a poor choice for action and it hurt patients.

Let's refuse to co-operate with the CQC until the Government backs off. No patients get hurt that way. We don't have to worry about lots of box-ticking.

The Government will, however, have to justify that it is still safe for patients to go to primary care, even if nobody is CQC-accredited. What can go wrong if we all stand united?

● **From Dr Steve Hirst**
Preston
via pulsetoday.co.uk

I agree with Dr Gary Taylor ('Above all, we must protect our patients', pulsetoday.co.uk/letters).

Will someone at the GPC please listen to us for once?

We should start a campaign now of non-cooperation, targeting the Government (and not patients) and starting with CQC registration – before it is too late.

For once, I agree with the Government

From Dr C John McHenry
York

As a semi-retired GP who worked nights and weekends, I am sickened by the action of GPs ('Third of GPs taking industrial action', pulsetoday.co.uk/news).

I thought we were members of what used to be a profession. For a change, I endorse the Government's response.

We need psychiatry support

From Dr Thomas Caldwell
Worcester
via pulsetoday.co.uk

While I welcome the calls for training in psychiatry, it is the access to psychiatrists and therapies that I see as the major problem ('GPs must make sure that mental health doesn't lose out', pulsetoday.co.uk/opinion).

I did psychiatry as part of my rotation, and would start medications and try to start therapies.

However, access to acute psychiatry is appalling and moves at a glacial pace – access to counselling or talking therapies is almost impossible.

No amount of training compensates for the fact than when you see a clinical need you can access so little, and what you can access seems hopelessly slow.

Choose and Book's locality divide

From Dr Peter McEvedy
Blyth, Northumberland
via pulsetoday.co.uk

The figures for Choose and Book use make interesting reading ('Choose and Book usage dips below 50%', pulsetoday.co.uk/news).

Coming from the North East, we have a high usage figure, but Choose and Book is an illusion here as there is very little choice. At best, it's a choice between two trusts.

Booking is a boon though – that is, when the system actually works.

I imagine the choice element is far greater in the south and east of England where there is the lowest adherence – the plethora of choices makes the system far more unwieldy.

All doctors should have CSA training

From Dr Rob Fletcher
Croydon, south London
via pulsetoday.co.uk

I was a hospital doctor for 11 years before taking the MRCGP last year, largely working in orthopaedics and A&E, and I came to the same conclusion as Dr Avradeep Chakrabarti when I was doing my VTS ('GPs love all that tree-hugging stuff, don't they?', pulsetoday.co.uk/gpstobe).

It is laughable that the consultation models, training and assessment are considered specific to general practice as a specialty – these should be mandatory for all trainees, students and junior docs alike. I suspect there is an inversely proportional relationship between years spent as a hospital doctor and CSA pass rates.

The problem is that in hospital, the doctor doesn't want the patient to elaborate and expand – they just want to deal with the most pressing issue.

Performing an ideas, concerns and expectations consultation on a patient in A&E can be the kiss of death for timekeeping.

Remember that almost all junior hospital doctors work on the principle that they will never see the patient again, so his leaving satisfied is far less important to them than the GP who must establish a totally different relationship with the patient, who's going to keep coming back until they get satisfaction.

Useful joint injection guidance

From Dr Samia Bushra
Dagenham
via pulsetoday.co.uk

I don't administer joint injections myself, though Dr Ted Willis's article on NICE's current approach to osteoarthritis was interesting ('Why NICE is wrong on OA', pulsetoday.co.uk/clinicalwriting).

However, my colleague does, and as usual, it is the steroid injection rather than the hyaluronan injections Dr Willis discusses.

I have known about the hyaluronan injections for some time, and would imagine that, as he says, physiologically it would be the better injection.

Maynard is wrong on the QOF

From Dr Mary Church
Glasgow
via pulsetoday.co.uk

I wanted to respond to Professor Maynard's remarks about incentivising GPs ('NHS should use 'reputational threats' to keep GPs in line, says expert', pulsetoday.co.uk/news).

Because of incentives like the QOF, GPs took on work that should have been done in hospital, did it better and should be paid for it. Plenty of evidence supports the improvement in care of those with long-term illnesses that resulted from our work. Business markers also improved overall practice performance.

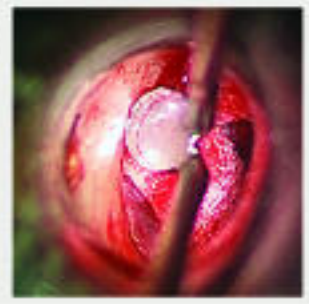
I believe Professor Maynard is talking out of a lack of understanding of what GPs do.

For the record

Pulse's priority is accuracy. However, in the busy process of preparing a weekly publication, mistakes can occur. To draw our attention to an error, email letters@pulsetoday.co.uk

Pulse Clinical

In this issue



Stapedectomy restores hearing in 95% of cases

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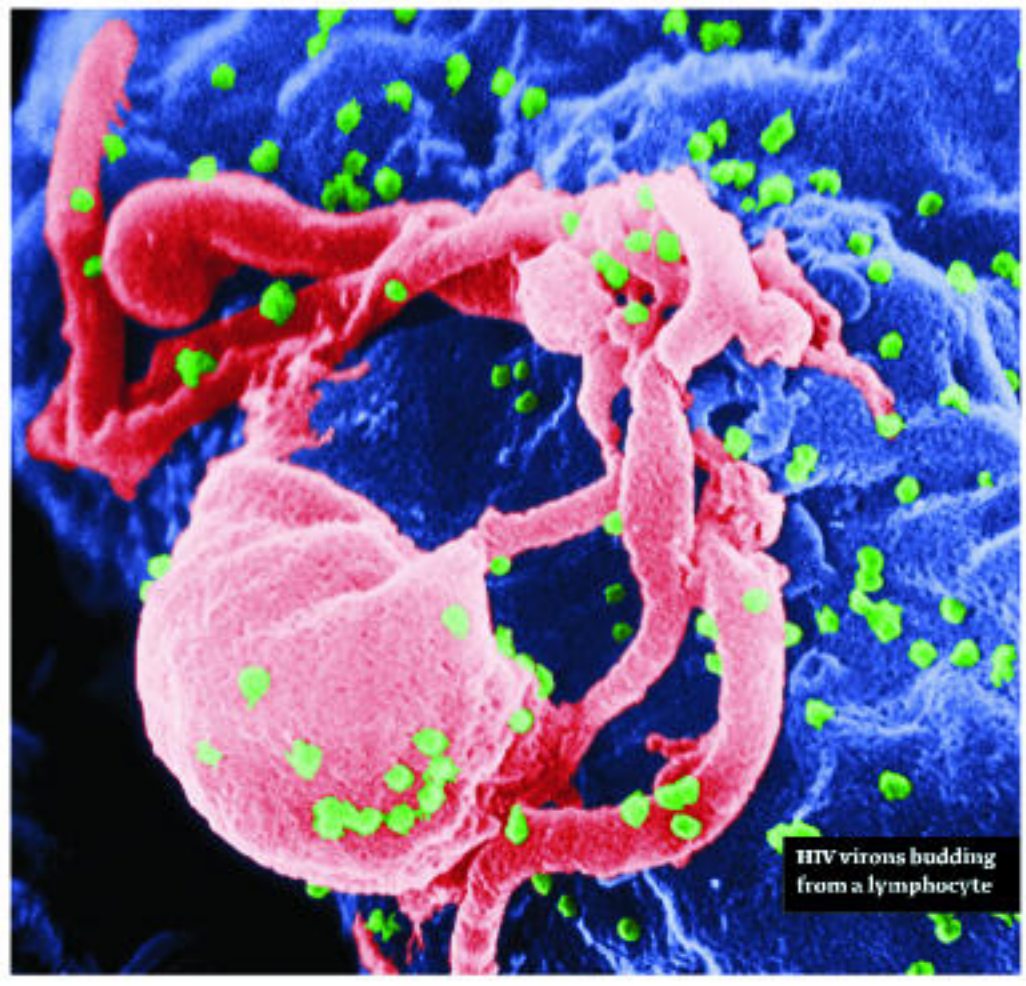
Resource of the week NICE has launched a new BNF app, which can be downloaded for free

KEY QUESTIONS

HIV

Dr Michael Brady, consultant in sexual health and HIV, tackles questions from GP Dr Pam Brown on HIV testing, pre-test counselling and antiretrovirals



HIV virons budding from a lymphocyte

1 What presentations should prompt us to suggest HIV testing?

HIV seroconversion illness is the first prompt to test for HIV. The symptoms are non-specific and typically mimic a flu-like illness such as glandular fever.

Common symptoms include fever, sore throat, rash and lymphadenopathy – severity of symptoms varies, but most patients will experience them.

A recent study in south London showed that 1.3% of glandular fever screening samples were positive for HIV.[1]

This highlights the need to include HIV testing in investigations of flu-like illnesses, especially in high-risk groups (gay men and black African people).

Following seroconversion, patients enter a period of asymptomatic infection that can last for many years.

During this time there will be nothing clinical to indicate they have HIV. Routine testing of high-risk groups is the only way to detect undiagnosed infection at this stage. In 2011, NICE produced guidance to support this.[2,3]

As HIV disease progresses and immune function worsens, patients may present with a wide range of signs and symptoms. Suspect HIV in any patient with unusual presentations or conditions that are more severe, or harder to treat, than you would expect.

Clinical indicator diseases for adult HIV infection

System	AIDS-defining conditions	Other conditions where HIV testing should be offered
Respiratory	Pneumocystis	Bacterial pneumonia Tuberculosis
Dermatology	Kaposi's sarcoma	Severe or recalcitrant seborrhoeic dermatitis or psoriasis Multi-dermatomal or recurrent herpes zoster
Neurology	Cerebral toxoplasmosis Primary cerebral lymphoma	Cerebral abscess Peripheral neuropathy Dementia
Gastroenterology	Persistent cryptosporidiosis	Oral candidiasis Oral hairy leukoplakia Chronic diarrhoea Weight loss Hepatitis B or C
Haematology		Unexplained blood dyscrasia (anaemia, neutropaenia, lymphopaenia, thrombocytopaenia)
Other		Glandular fever-like illness Lymphadenopathy (unknown cause) Any sexually transmitted infection

2 What are the common presentations of long-standing HIV infection which we should be aware of in primary care?

The UK National Guidelines for HIV testing[4] includes a useful table describing the clinical indicator diseases for adult HIV infection. It lists both AIDS-defining illnesses and conditions that are more common in people with HIV. The table (below left), which doesn't include every condition, is taken from those guidelines.

3 When is it appropriate for HIV testing to be undertaken in a general practice setting, and do we need to document consent?

It is always appropriate for HIV testing to be undertaken in general practice. There are two approaches – routine opt-out screening (which is recommended in high-prevalence areas) or targeted testing of patients at highest risk and those presenting with symptoms suggestive of HIV.

Opt-out testing of all new GP registrants is recommended in areas where diagnosed HIV prevalence is greater than 0.2%. You can find details of your local HIV prevalence and information supporting opt-out testing on the Health Protection Agency website.[5] In areas of low prevalence, opt-out screening is unlikely to be cost effective – so here, targeted testing of patients at highest risk should be undertaken. There is no need for written consent for an HIV test – verbal consent is sufficient. Ensure that the patient is aware they are having an HIV test and what the benefits and implications are and note that you have done so.

4 What is the specificity and sensitivity of point-of-care tests? If it's negative, should we recommend laboratory testing?

The sensitivity and specificity of point-of-care tests is very good. The tests available in the UK have reported sensitivities of 99–100% and specificities of 96–99.6%.

The key thing to know with any HIV test is the window period – the time it takes from acquiring infection to it being detectable by the test. Third-generation HIV tests only detect HIV antibodies and have a window period of three months. Fourth-generation HIV tests detect both HIV antibodies and HIV p24 antigen, and have a window period of just one month. Most UK labs use fourth-

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generation tests. Most point-of-care tests are third-generation tests.

If you are concerned that a patient may have been infected within the last three months, it is best to do a fourth-generation laboratory test. All positive results on point-of-care tests need to be confirmed with a serological test because false positives do occur, particularly in low-prevalence populations. But if a point-of-care test is negative and the patient is beyond the window period for that test, there is no need to recommend laboratory testing as well.

5 What pre-test counselling should we give?

A pre-test discussion with the patient is recommended, to give them information about the test. This can be given in written form if that helps to save time. Pre-test discussion should focus on the benefits of a diagnosis - explain that HIV is now an easily treatable long-term condition. Access to treatment means patients stay well and should live long and healthy lives. Treatment also dramatically reduces the risk of transmission to others and enables women to have normal pregnancies, labour and uninfected children.

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The pre-test discussion should also include information about the window period and advice about the timing of a re-test if needed, and clear information about how and when they will get the test result. More detailed pre-test discussion or counselling may be necessary for patients whose first language isn't English, patients at higher risk or patients who are particularly anxious about the result.

6 What are the important interactions with antiretroviral medication? How can we find out that our patient is taking these drugs, as they are prescribed by specialist clinics?

Most antiretroviral drugs are metabolised via cytochrome p450 in the liver and so can cause, or be affected by, alterations in the activity of this enzyme system. It's impossible to list all potential interactions here, but the University of Liverpool has an excellent website where you can look up potential antiretroviral drug interactions – go to pulsetoday.co.uk/tools-and-resources for a link to the site.

Some of the drugs that can interact with antiretroviral medications include:

- tuberculosis medications
- some antidepressants
- PPIs and H2-antagonists
- statins
- oral contraceptive pill
- warfarin
- antiepileptics
- methadone
- herbal medicines such as St John's wort and milk thistle.

Specialists generally encourage patients to disclose their HIV status to their GP so details of their medications and recent blood test results can be provided. If you know one

of your patients is HIV positive and have not heard from their specialist centre, I would advise contacting them for details of any medication the patient is taking.

7 Very rarely, GPs might find themselves having to explain the implications of a positive HIV result. What areas should the GP cover in this initial post-test consultation?

Everyone reacts differently, so be flexible – some patients will want a lot of information and some will want none. The focus should be on supporting the patient to deal with the diagnosis. How are they feeling? Was it a surprise? Who will they tell?

The key thing is to explain that HIV is a treatable condition and life expectancy for patients living with HIV and accessing treatment is expected to be much the same as the non-HIV positive population. This doesn't diminish the impact an HIV diagnosis can have on an individual, and it is important to be able to help patients cope with, and come to terms with, an HIV diagnosis. Organisations such as the Terrence Higgins Trust are useful sources of support in these early days and I always give patients their contact details (tht.org.uk and THT Direct: 0808 802 1221).

Rapid referral to your local HIV service is essential, so ensure you have an agreed referral pathway in place.

Supporting you with CPD

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Go online to read an extended version of this article, with Dr Brady answering questions on completing insurance forms, managing intercurrent illness, prophylaxis and palliative care for patients with AIDS.

Dr Michael Brady is a consultant in sexual health and HIV at King's College Hospital and medical director of the Terrence Higgins Trust

Dr Pam Brown is a GP in Swansea

The Terrence Higgins Trust is the UK's leading HIV and sexual health charity. Wednesday 4 July marks 30 years since the death of Terry Higgins, the first person publicly identified as dying with AIDS in the UK. To view the charity's 30th anniversary campaign 'Thanks Terry', visit tht.org.uk.

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5 HPA. Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas. April 2012. hpa.org.uk (accessed 14 June 2012)

Stapedectomy restores hearing in 95% of cases

ENT CLINIC

Otosclerosis

ENT GPSI Dr Raj Singh on a common cause of progressive hearing loss in young adults

CASE

A 19-year-old student presented to his GP shortly after starting his first term at the local university.

He described a five-year history of gradually progressive hearing loss, originally in his right ear but bilateral for around two years. He had never presented with the problem before as he found he could compensate at school – for example, by sitting near the front in class.

But he was finding it more difficult to cope at university – with loud social situations particularly stressful – and he felt the problem had recently got much worse. He also described the recent development of mild, intermittent tinnitus. There was no family history of hearing problems and he was otherwise healthy.

Auroscopy was normal, but Weber and Rinne testing revealed conductive hearing loss in his right ear and was inconclusive in his left. He was referred to ENT, where pure-tone audiometry confirmed purely conductive, predominantly low-tone hearing loss in both ears and he was diagnosed with otosclerosis.

Three months later he had a stapedectomy in his right ear, which almost totally restored his hearing in that ear. He is currently being monitored for possible surgery on his left ear.

The problem

- Otosclerosis is a failure in sound conduction caused by a pathological increase in bone turnover, leading to sclerosis and ankylosis of the stapes footplate in the fenestra ovalis.
- The process sometimes extends to the cochlea itself.
- There is an autosomal dominant inheritance pattern, but variable penetrance – so often there is no family history – and environmental factors have also been implicated, including oestrogens and measles infection.[1]
- European prevalence estimates range from around 1.4% to 2.1% – seen in one UK study[2] – but there are suggestions the incidence has declined with fewer measles infections.[3]
- It typically presents between the ages of 15 and 35, is more common in women than men and most common in Asian and Caucasian populations.
- If untreated, otosclerosis leads to significant hearing loss of about 50-60dB – though total deafness is uncommon.

Features

- The main symptoms are progressive hearing loss – bilateral in around 70% of cases – and tinnitus.
- The hearing loss is usually in the lower range and particular difficulty hearing deep, male voices is a characteristic sign.
- There are usually no vestibular symptoms, but some patients might also experience mild dizziness and in rare cases there is severe rotatory nystagmus as in Ménière's disease.

Diagnosis

- Auroscopy is usually normal, although increased vascularity of the promontory will cause a reddish-blue discolouration behind the tympanic membrane in about 10% of cases – Schwartz's sign.
- Weber and Rinne testing usually shows a conductive pattern deafness.
- If the cochlea has become involved, there may be a mixed conductive/sensory pattern of hearing loss.
- Paget's disease – which shares some pathophysiological similarities – can present with exactly the same pattern of hearing loss, but usually also with other features of the disease such as bone pain. This usually affects older age groups.
- Audiometry is the primary investigation of choice and will usually reveal a purely conductive, mostly low-tone loss.
- Characteristic audiogram patterns can seal the diagnosis if there is the mixed conductive/sensorineural loss seen with cochlea involvement.
- In a few cases, CT scanning will be used to look for abnormal bone deposition in the temporal bone.

Management

- Hearing aids can be very effective, but advances in surgical treatment over the past 20 years make this the most popular management option.
- There are two surgical options, both with the aim of enhancing the vibration of fluid within the cochlear canal. Stapedectomy involves the extraction of the stapes footplate, while stapedotomy involves small holes being made in the footplate. Both are done as day cases.[3]
- Restoration of normal hearing loss is seen in up to 95% of cases for both procedures, but total hearing loss occurs after about 1% of procedures for unknown reasons and does not seem to be linked to surgical skill.

Dr Raj Singh is an ENT GPSI in Manchester

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TEN TOP TIPS

Bronchiectasis

Respiratory GPSI Dr Tarek Bakht outlines 10 key points in managing bronchiectasis

In bronchiectasis the bronchi are thickened and dilated

1 **Consider bronchiectasis in persistent productive cough.**
Think of bronchiectasis in patients who have a persistent productive cough for many years with increased sputum production or recurrent chest infections, especially younger patients with no smoking history. Other symptoms include dyspnoea, wheezing, haemoptysis and chest pain.

2 **Do baseline investigations before referral.**
In most regions you need to refer for confirmation of diagnosis and further assessment. It is useful for GPs to request a baseline chest X-ray, spirometry and sputum culture and sensitivity. Chest X-ray is often normal in bronchiectasis but advanced cases may show thickened dilated bronchi with 'tram lines', cystic spaces and ring opacities. Tests for cystic fibrosis should be done if indicated – especially in patients younger than 40.

3 **Vaccinate against influenza and pneumococcal pneumonia.**
Make sure patients with bronchiectasis have their annual flu vaccine and also have had the pneumococcal vaccine.

4 **Refer for chest physiotherapy.**
All patients with bronchiectasis should see a chest physiotherapist.
This can help improve sputum clearance from the lungs, which reduces symptoms and exacerbations and improves quality of life.

5 **Be aware of chronic colonisation.**
Two-thirds of bronchiectasis patients chronically colonise bacteria in their lungs – commonly *Pseudomonas aeruginosa*, *Haemophilus influenzae*, *Staphylococcus aureus*, *Moraxella catarrhalis* and occasionally opportunistic mycobacterium.
Sputum culture and sensitivity will help guide antibiotic treatments and identify patients with pseudomonas colonisation, who often have poor disease progression, increased hospital admissions and poor quality of life.

6 **Assess for airway obstruction.**
Some bronchiectasis patients have airway obstruction related to the disease, asthma or COPD. Do spirometry on all bronchiectasis patients to detect related airway obstruction and assess for reversibility.
Patients with co-existing asthma or COPD should be managed according to the relevant guidelines.
There is insufficient evidence to determine whether mucolytics are useful in bronchiectasis.

7 **Don't delay antibiotics in exacerbations.**
Exacerbations are characterised by worsening cough, purulent sputum production, increasing wheeze, breathlessness and haemoptysis or systemic upset.
Don't wait for the results of a sputum sample – start empirical treatment with amoxicillin 500mg TDS or clarithromycin 500mg BD (in penicillin-allergic patients) for 14 days.
Where previous sputum bacteriology is known, antibiotic treatment can be guided by this. Ciprofloxacin should be used in patients known to have pseudomonas colonisation.

8 **Consider long-term antibiotics for frequent exacerbations.**
Long-term oral antibiotics can be considered in patients with three or more exacerbations a year, or fewer exacerbations if there is significant morbidity.
Long-term nebulised antibiotics can also be considered in similar patients if they chronically colonise *Pseudomonas aeruginosa*.
Refer to a specialist if you are considering long-term antibiotics.

9 **Do annual spirometry.**
It is useful to do annual spirometry in patients with bronchiectosis to detect and monitor obstructive airway disease.

10 **Refer patients with deterioration, chronic colonisation or comorbidities.**
Consider specialist referral in patients who have three or more exacerbations a year, deteriorating bronchiectasis with declining lung function, chronic pseudomonas, opportunistic mycobacteria or MRSA colonisation, or who are on long-term antibiotics.
Also consider referring patients who have comorbidities, advanced disease and those considering transplantation or surgery.

Dr Tarek Bakht is a GPSI in respiratory medicine in Bolton, Greater Manchester, and executive board member of the Primary Care Respiratory Society UK

The Primary Care Respiratory Society UK (PCRS-UK) is the UK-wide professional society committed to improving respiratory care in primary care. PCRS-UK is a registered charity, led by its members through a range of committees and faculties dedicated to meeting the vision of 'optimal respiratory care for all', providing education, policy support and research. As a member you'll have unlimited access to a wealth of specialist respiratory care information, expertise and resources, plus practical everyday tools to help you make a difference in respiratory care. For more information about PCRS-UK and how to join, go to pcrs-uk.org/join.

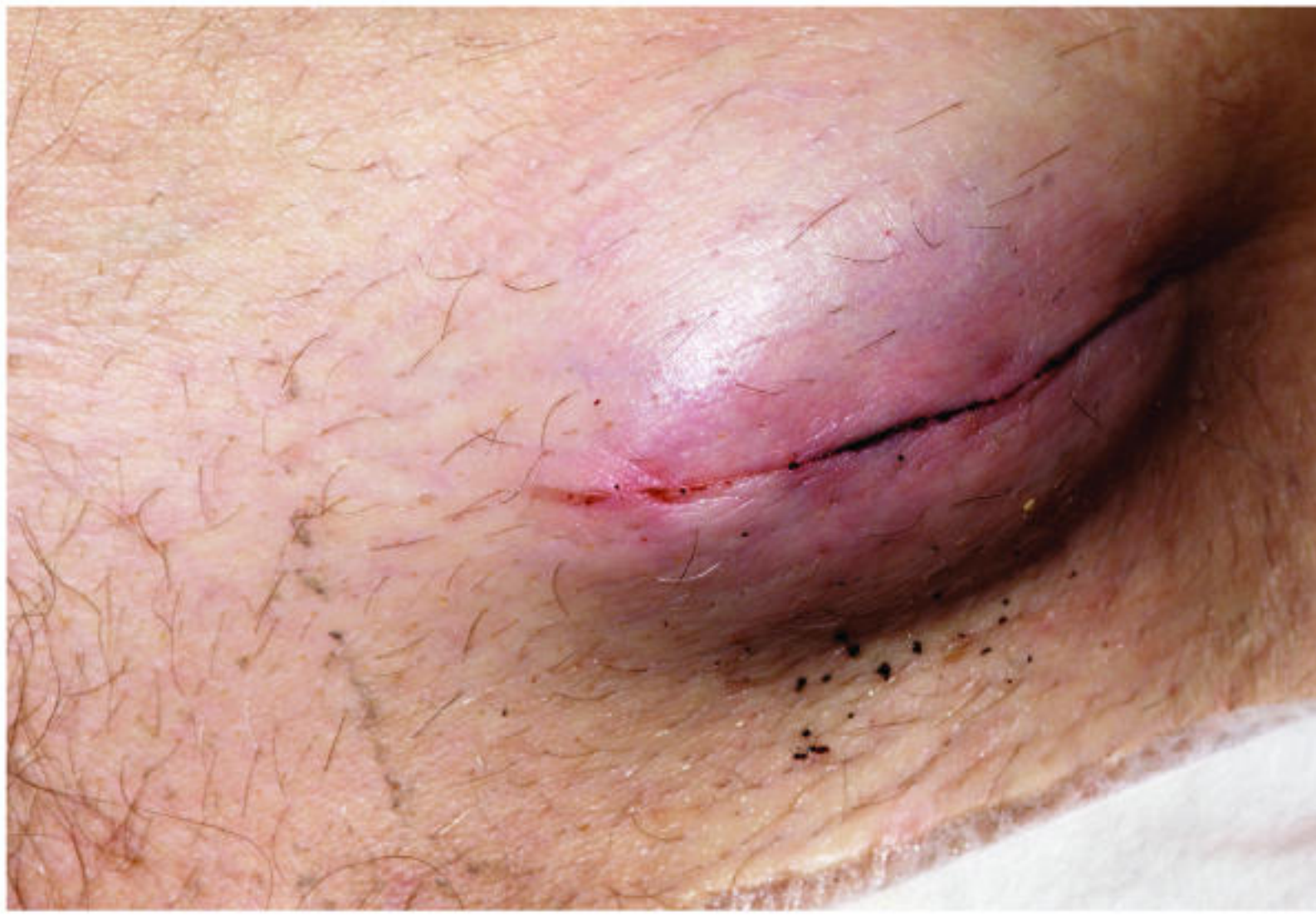
Further reading

1 Mandal P and Hill A. *Bronchiectasis Opinion Short*. Primary Care Respiratory Society UK, 2011.
2 Pasteur MC, Bilton D and Hill AT. British Thoracic Society guideline for non-CF bronchiectasis. *Thorax* 2010;65:i1–i58
3 Hill A, Pasteur M, Cornford C et al. Primary care summary of the British Thoracic Society Guideline on the management of non-cystic fibrosis bronchiectasis. *Prim Care Respir J* 2011; 20:135–40

POST-OP PROBLEMS

Gastrointestinal surgery

Consultant surgeon Mr Mike Parker continues our series with a discussion of complications after GI surgery



In this article I will cover the post-operative complications of some common gastrointestinal (GI) operations which are usually done as day cases – hopefully helping GPs to deal with these complications in the community where possible, and to know when referral should be considered.

Classification

In GI surgery, complications can be classified as immediate (within 24 hours), early (24 hours to one week) or late (after one week).[1]

Oesophago-gastro-duodenoscopy

Oesophago-gastro-duodenoscopy (OGD) is one of the most common investigations performed for GI problems.

Most patients will go home the same day perfectly well. Intravenous sedatives wear off after about 45 minutes, but may stay in the system for up to 24 hours, and patients are usually advised not to drive, operate heavy machinery or sign legal documents during this time.

Immediate and early

- *Bleeding* occurs rarely post-OGD, and this nearly always stops spontaneously – unless the reason for the endoscopy was upper GI bleeding.
- *Perforation of the upper GI tract* occurs very rarely – the incidence is about one in 25,000 cases. This is an absolute emergency. The patient will be unwell, possibly with crepitus in the neck and sometimes with early signs of mediastinitis – for example, pyrexia, tachycardia, dyspnoea, nausea and vomiting. If any patient presents within 24 hours (or even longer) with such symptoms, they must be taken to hospital immediately. If possible inform the clinician concerned at the hospital, as emergency surgery may be required.
- *Aspiration* may occur at the time of OGD, and this will usually be treated by keeping the patient in hospital. But occasionally it may not be recognised and the patient may present over the next few days with a cough, temperature, tachycardia and signs of a chest infection. The diagnosis is actually a chemical pneumonitis (inflammatory) and any infection is secondary, but patients do need to be treated aggressively with antibiotics, physiotherapy and possibly steroids. If the patient does not respond rapidly to treatment, consider semi-emergency referral to the endoscopy team or to a respiratory physician.

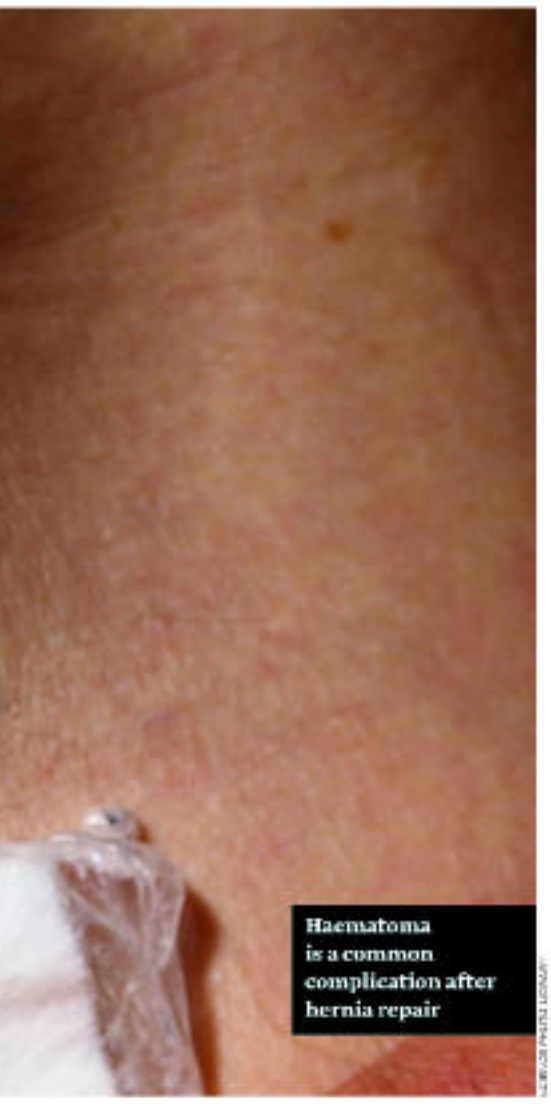
Colonoscopy

Colonoscopy is also usually performed under intravenous sedation, and so the same advice about driving and operating machinery is given as for OGD.

Immediate and early

- *Perforation* is more common in colonoscopy than OGD, with about a one in 2,000 incidence in the UK. Any patient with signs suggesting perforation – such as abdominal pain or tenderness, tachycardia and a temperature – should be referred back to the endoscopy unit immediately. Onset of severe pain after discharge means something untoward might have occurred, because no patient should be discharged from hospital after a colonoscopy if they are still in pain.
- *Bleeding* sometimes occurs because of the colonoscope chafing the wall of the bowel, but in my experience this always stops spontaneously and does not need referral unless catastrophic in volume, which I have never seen.

complications



Haematoma is a common complication after hernia repair

Liver biopsy

Liver biopsy is a common diagnostic investigation for liver disease.

Immediate

- *Bleeding or biliary leakage* into the peritoneal cavity will usually settle if treated conservatively, but any patient with spreading peritoneal signs in the hours after a liver biopsy should be referred back to the unit where it took place for observation and ultrasound to assess the volume of leakage or bleeding. Occasionally surgical intervention will be required.

Early

- *Pneumothorax* occurs rarely, if the biopsy needle accidentally enters the pleural cavity. The patient may present with dyspnoea, tachycardia and classical physical signs of diminished breath sounds and hyper-resonance to percussion. Referral back to the hospital is necessary on the day of diagnosis for further assessment, observation and occasionally chest drainage. Pneumothorax may also present as an immediate complication, but would probably have been treated in hospital.
- *Tension pneumothorax with mediastinal shift* may occur very rarely. The patient will be extremely unwell, verging on unconscious, and cyanosed with the trachea deviated to the contra-lateral side. Immediate aspiration of the right chest is necessary to keep the patient alive. If you are familiar with this technique, it may have to be performed at the scene – a cannula placed in the mid axillary line in the fourth intercostal interspace or the mid clavicular line is the safest approach and will likely be rewarded with a hiss of air released, which will be sufficient to keep the patient alive until they reach A&E. Failing this, blue light transfer to A&E is necessary.

Late

- *A sub-phrenic or liver abscess* usually occurs about a week after surgery. Patients will present with a swinging temperature, tachycardia and rising white cell count and elevated LFTs, but often there will be remarkably few clinical symptoms and signs except that the patient feels generally unwell and may be mildly jaundiced. These patients need to be referred back to hospital fairly quickly for a surgical opinion.

Cholecystectomy

Cholecystectomy is carried out laparoscopically in the UK in 95% of cases, so most patients go home within 24–48 hours.

Immediate

- *Respiratory problems*, such as atelectasis, lobar collapse, mucus plug or pneumothorax, would usually be noted before the patient leaves hospital. But if the patient has any symptoms and signs worse than a simple cough – and certainly if they are dyspnoeic at rest – consider referral back to hospital.
- *Secondary haemorrhage* is unusual but not impossible, and will present with increasing abdominal pain and swelling with a tachycardia and eventually hypotension if untreated. Immediate referral back to the hospital is required.
- *Biliary leak* is also unusual and tends to present subtly, with abdominal swelling initially, and eventually pain that becomes progressively more severe over the next couple of days. A high index of suspicion is often necessary to diagnose this complication and an abdominal ultrasound, if available, will show a lot of fluid in the peritoneal cavity. Immediate referral back to the hospital is necessary.

Early

- *Obstructive jaundice* is usually because of a surgical error, but could be because of a retained bile duct stone. Either way, the patient needs immediate referral back to the surgical unit for investigation and treatment.
- *A sub-hepatic or sub-phrenic abcess* should be managed as described above, after liver biopsy.
- *Respiratory infection* can often be treated at home with physiotherapy and, if necessary, antibiotics. Failure to improve might require a non-emergency referral.
- *Urinary tract infection* can almost always be investigated and treated in the community.
- *Wound infections* are quite rare in laparoscopic surgery, and most can be dealt with at home with release of pus from the wound. Antibiotics are only necessary if there are signs of cellulitis or systemic illness.
- *Port site hernia* is a rare complication of laparoscopic surgery in which a loop of small bowel may become incarcerated in a port site. It is rare, with an incidence of less than 1%. Patients will present with symptoms and signs of small bowel obstruction, usually with a painful tender lump at one of the port sites, pyrexia, tachycardia and rarely hypotension. They need emergency referral for re-laparoscopy to release the hernia and repair the defect.
- *Deep vein thrombosis* or *pulmonary embolus* is rare after laparoscopic surgery, with an incidence of less than 1%. If you suspect this, urgent referral is necessary.

Late

- *Keloid scarring* of the port site wounds can be referred non-urgently to the surgeon concerned if necessary.
- *Chronic intermittent small bowel adhesion obstruction* occurs in fewer than 5% of cases and needs non-urgent referral to the surgeon, unless it occurs suddenly and with severe abdominal pain, distension, vomiting and tachycardia with or without hypotension – in which case, emergency referral may be needed.
- *Diarrhoea*, caused by bile salt depletion, can be treated with either cholestyramine or constipating agents, but if this fails refer the patient non-urgently.
- *Post-cholecystectomy syndrome* presents with virtually the same symptoms as the patient had prior to surgery – likely to be irritable bowel syndrome or right sub-costal nerve entrapment. Re-referral to the specialist is necessary.

Hernia repair

Hernia repair is still carried out by open surgery in most hospitals, but is increasingly being done laparoscopically – which results in fewer complications and more rapid recovery.

Immediate

- *Primary haemorrhage* presents with tachycardia and hypotension, sometimes with obvious signs of bleeding in the wound – but in laparoscopic surgery this may be more difficult to determine. A high index of suspicion is required. If you suspect bleeding, contact the surgeon and immediately refer back to the hospital.
- *Urinary retention* may require urgent catheterisation followed by referral back to the hospital at a later stage.
- *Respiratory problems* range from atelectasis, to pneumothorax, lung collapse or mucus plug obstruction. If the clinical signs are worrying – for example, cyanosis, tachycardia and hyperventilation – immediate referral back to the hospital is recommended.

Early

- *Seroma/haematoma* is the most common complication of hernia repair, and seroma is seen in about 10% of laparoscopic repairs. It is simply serum collecting in the remnant sac and does not require referral or any intervention. Reassurance that this is likely to resolve spontaneously is all that is required. Sometimes patients and clinicians think this represents an early local recurrence, but it is easy to differentiate as there is never a cough impulse and it is always cystic with signs of fluctuance.
- *Wound infection* is more common in open surgery than laparoscopic, but still only occurs in about 5% of cases after open surgery. Antibiotics will sometimes settle the problem – although if there is spreading cellulitis and signs of a localised abscess, the wound may need to be opened to release pus.
- *Wound dehiscence* only occurs after open surgery and is very rare. Patients should be referred back to the surgeon.
- *Secondary haemorrhage* is also rare – but if it happens, it requires referral back to the surgeon.
- *Port site hernia* presents, and should be managed, as above.
- *Chest infection* can usually be treated in primary care with antibiotics and physiotherapy. Very rarely pulmonary embolus may occur, requiring immediate referral.
- *Deep vein thrombosis* is a rare complication, as these operations rarely take more than an hour to complete – but occasionally it may be seen, and will require referral.
- *Urinary tract infection* can be treated with antibiotics.

Late

- *Recurrence* can be differentiated from a seroma or haematoma as described above, and needs re-referral.
- *Keloid scarring* should be managed as above.
- *Mesh infection* requires all, or part of, the mesh to be removed.
- *Chronic groin pain* requires non-urgent referral if the patient requires advice and treatment.
- *Adhesional small bowel obstruction* is very rare and should be managed as described above.

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This series was produced in collaboration with The Royal College of Surgeons – a professional body that sets the highest possible standards for surgical practice and training, leading to the delivery of safe and high quality patient care. The Royal College of Surgeons has expertise, authority and independence, allowing it to act in the best interests of patients and in support of those providing their care. Go to rcseng.ac.uk for more information.

References

1 Ellis H, Calne R and Watson C. *Lecture notes on general surgery* (10th edition). Blackwell Publishing, 2003

Coming up in this series

Surgical complications of cardiology, orthopaedics, gynaecology and ophthalmology

PULSESERVICES
TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Updated: May 2012

Destination	Typhoid	Hepatitis A	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
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			S	No			Le
Algeria	R	R				S	S	S	C				Yes, area around Illizi	W		Sh Le
Angola	R	R	S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Antigua & Barbuda		S					S		C				No			
Argentina	S	R					S	S	S				Yes, rural areas near NE border with Bolivia and NW border with Brazil and Paraguay	C	P	
													Other areas very low	W		
Armenia	S	R			S	S	S	S				S	Variable risk Ararat Valley Jun-Oct	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	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	ME or DO or MON	PC	Le
													Elsewhere, low risk	W		
Barbados		S			S		S		C				No			
Belarus		R			S	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		R	S	S	S	C		S		Yes, southern districts	ME or DO or MON	DMF	Le
Bolivia	R	R			R	S	S	S	R				Yes, high risk in Amazon basin	ME or DO or MON	PC	
													Variable risk on Paraguayan and Argentine borders	PC	DMF	
Borneo	R	R	S		S	S	S	S	C		S		Low risk, coastal areas of Malaysian	W		
													Sarawak and Saba	ME or DO or MON	PC	
	R	R	S		R	S	S	S	C		S		Indonesian Kalimantan, high risk all areas	PC	PC	
Bosnia		R			S	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 Ta
Brazil	S	R			S	S	S	S	R				High risk in NW half in Amazon states	ME or DO or MON	PC	Sh Le Tc
													Elsewhere, very low	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 Ta
Cambodia	R	R	S		R	S	S	S	C		S		Yes	DO or MON	PC	
													Yes, significant risk elsewhere	ME or DO or MON	PC	
													Minimal risk Phnom Penh, Angkor Wat, Siem Reap	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 Aug-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 Ta
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	S					No			Tc
China (Mainland)	S	R	S	R		S	S	S	C		S	S	Yes, in Yunnan and inland Hainan	ME or DO or MON	PC	Sh
													Elsewhere, very low/no risk	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 Tc
													Variable risk elsewhere <1,600m	PC	DMF	
													Very low around Medellin, Bogota & 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 Ta
Congo-Dem. Rep.	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Cook Islands		R					S						No			
Costa Rica		R			S		S	S	C				Small variable risk areas on East coast.	C	P	Le Tc
													Rest of country, low risk	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	C		S		Yes, high risk	ME or DO or MON	PC	Le
Ecuador	R	R				S	S	S	R				Yes, high risk Esmeraldas and substantial risk bordering Colombia	ME or DO or MON	PC	Tc
													and Peru. Elsewhere low risk	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 (No 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 risk	ME or DO or MON	PC	Sh Tc
French Polynesia		R					S		C				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	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 July-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	DRF	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	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	DRF	
Indonesia	R	R	S		R	S	S	S	C		S		Yes, high in Lombok	ME or DO or MON	PC	Sh
													Very low in Bali and cities	W		
													Yes, variable elsewhere	PC	DRF	
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 in 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	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			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 & 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			
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

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 **C** is required for travellers from yellow fever zones who wish to enter countries bordering the margins of a yellow fever endemic area, or from more distant countries where a mosquito vector provides the potential for transmission. A certificate may also be required for travellers who have been in transit through yellow fever endemic zones.

● An International Certificate of Vaccination may be required (**M**=Mandatory) for all entering travellers over the age of 12 months. For further details see International Travel and Health Requirements and Health Advice, WHO, Geneva 2008. www.who.int.ith

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

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)

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

Legionnaires' disease
A cluster of Legionnaires' disease has been reported from the tourist resort of Alanya, Turkey, affecting four Danish tourists with the last case notified on 6 April. Although no UK tourists have been affected so far, Alanya is popular with British travellers. Legionnaires' disease should be suspected in any patients with pneumonia returning from Alanya and, if confirmed, notified to the appropriate national centre as soon as possible.

Polio in Nigeria
The goal of global eradication of polio remains elusive and six new cases were reported recently in Nigeria – five WPV1 and one WPV3. All six presented with paralysis this year, bringing the total number of cases in 2012 to 23. All travellers to Nigeria should have their protection checked and receive a booster where necessary. Other countries with a polio risk are listed in the vaccination chart.

Dengue fever in South America
The absence of a vaccine for this serious viral illness means that avoiding dengue tends not to be emphasised in travel medicine consultations. There is a large current epidemic in South America this year affecting Argentina (1,100 cases), Brazil (about 15,000 cases), Ecuador (over 4,000 cases) and Peru (about 7,000 cases). Avoiding mosquito bites is the only protection available to travellers, who should consider wearing long-sleeved clothing, and use repellents and bed nets.

Measles
Also often forgotten is the risk of measles. Uganda has just reported over 3,000 cases and the Democratic Republic of Congo over 10,000, but outbreaks have also been recently reported in the US, Canada, Japan, Israel and several European countries. Those born before 1970 are likely to have had measles as a childhood illness. Those born since 1970 may have deficits in immunity or vaccination, which can be corrected with the MMR vaccine.

Source
travax.nhs.uk

PULSE

XIFAXANTA™ Prescribing Information
REFER TO FULL SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) BEFORE PRESCRIBING.
Presentation: Film-coated tablet containing rifaximin 200 mg. **Uses:** Xifaxanta is indicated for the treatment of travellers' diarrhoea that is not associated with fever, bloody diarrhoea, eight or more unformed stools in the previous 24 h, occult blood or leucocytes in the stool. **Dosage and administration:** Adults over 18 years of age: 200 mg every 8 hours for three days (total 9 doses). Rifaximin must not be used for more than 3 days even if symptoms continue and a second course of treatment must not be taken. Not recommended in children under 18 years of age. **Contraindications:** Hypersensitivity to the active substance, to any rifamycin (e.g. rifampicin or rifabutin) or to any of the excipients. **Warnings and precautions for use:** Not recommended for the treatment of travellers' diarrhoea caused by invasive enteric pathogens. If symptoms worsen, treatment with rifaximin should be interrupted. If symptoms have not resolved after 3 days of treatment, or recur shortly afterwards, a second course is not recommended. The potential association of rifaximin treatment with *Clostridium difficile* associated diarrhoea and pseudomembranous colitis cannot be ruled out. **Interactions:** Due to the negligible gastrointestinal absorption of orally administered rifaximin (less than 1%), the systemic drug interaction potential is low. Rifaximin should not be administered concomitantly with other rifamycins and the tablets should not be administered for at least two hours after the administration of charcoal. **Pregnancy and lactation:** Rifaximin is not recommended during pregnancy and in women of childbearing potential not using contraception. The benefits of rifaximin treatment should be assessed against the need to continue breastfeeding. **Undesirable effects:** Common effects reported in clinical trials are dizziness, headache, abdominal pain, constipation, defecation urgency, diarrhoea, flatulence, bloating, distension, nausea, vomiting, rectal tenesmus and pyrexia. Other effects that have been reported are candidiasis, herpes simplex infections, clostridial infections, palpitations, increased blood pressure, liver function test abnormalities, blood disorders (e.g. thrombocytopenia) and anaphylactic reactions, (e.g. angioedemas,hypersensitivity and skin reactions). **Licensing and legal category:** Legal category: POM. **Cost:** Basic NHS price £15.15 (9 tablets). **MA number:** PL 20011/0021. **For further information contact:** Norgine Pharmaceuticals Limited, Norgine House, Moorhall Road, Harefield, Middlesex, UB9 6NS. 01895 826606. E-mail: medinfo@norgine.com. **Date of preparation/revision:** XIF/2553/AUG/11.

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 Medical Information at Norgine Pharmaceuticals Ltd on 01895 826606.

References
1. Jiang ZD *et al.* Antimicrob Agents Chemother 2000;**44** (8):2205-2206.
2. Descombe JJ *et al.* Int J Clin Pharmacol Res 1994;**14** (2):51-56.
3. Xifaxanta™ Summary of Product Characteristics.

XIF/2620/SEP/11. Date of preparation: September 2011.

PULSESERVICES
TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Updated: May 2012

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Mening/ACWY	Japanese enceph	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
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	ME or DO or MON	PC	
													Yes, low risk deep forests of Malaysia	PC		
													Very low risk elsewhere	W		
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						No			Sh
Mauritania	R	R	S	R	R	S	S	S	M	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					Yes, high risk	ME or DO or MON	PC	Le
Mexico	R	R					S	S					Yes, southern rural areas only	C	P	Tc
													Elsewhere and tourist areas	W		
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, east part of Shan State	DO or MON	PC	
													Yes, elsewhere	ME or DO or MON	PC	
Namibia	R	R	S		S	S	S	S	C				Yes, north east 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											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	ME or DO or MON	PC	
													Variable risk east to west of Canal	C	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, in three rural areas, Oct–May	C	P	Le Tc
Peru	R	R				S	S	S	R				Yes, high risk in Loreto Dept (Amazon basin)	ME or DO or MON	PC	Le Tc
													Variable risk SE area bordering Brazil and Bolivia	C	P	
Philippines	R	R	S		S	S	S	S	C		S		Yes, many rural areas below 600m	PC	DRF	Sh
													[illegible], Cebu, Bohol, Catanduanes	W		
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	ME or DO or MON	PC	
													Low risk coastal areas and Kota Kinabalu	W		
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, local areas of W region	ME or DO or MON	PC	Sh Le
													Elsewhere (no risk Mecca, Medina)	W		
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 (in bordering Zimbabwe, Mozambique & Eastern Swaziland, including Kruger, Kosi Bay & Josini	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			Le
Sri Lanka	R	R				S	S	S	C		S		Yes, E, north and NE, north of Anuradhapura & Polonnaruwa	PC	ME, DO DRF	
													Elsewhere	W		
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		C		S		No			
Tajikistan	R	R	S	R		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 fringes of international borders	DO or MON		
													Elsewhere	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	C	P	Le
													Elsewhere	W		
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 in 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	ME or DO or MON	PC	Le Tc
													Variable/low risk north of Orinoco	C	P	
													No risk Caracas or Margarita	W		
Vietnam	R	R	S		S	S	S	S	C		S		Low risk in cities, coast between Ho Chi Minh and Hanoi, Mekong Delta	W		
													Elsewhere	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	ME or DO or MON	PC	Sh Ta
													Yes, elsewhere below 1,200m Nov–Jun	ME or DO or MON	PC	
													Negligible risk Harare and Bulawayo	W		

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 2½ 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

Imported malaria in the UK

An important survey recently published in the *BMJ* should be read by all travel medicine advisers.[1] Between 1987 and 2006, 191 malaria-associated deaths were recorded in the UK out of 39,320 cases. Seven deaths occurred in non-falciparum species with a case fatality rate of 0.05%, while in 25,054 falciparum cases there were 181 deaths – giving a case fatality rate of 0.73%.

Case fatality rates were higher, at 2.56%, in tourists than in those visiting friends and relatives (VFRs) at 0.32%. VFRs born in Africa had lower case fatality (0.4%) than those born outside of Africa (2.4%). Case fatality was particularly high in those visiting the Gambia, at 3.9%, and this difference increased to 6% for tourists. Although most malaria deaths in endemic areas occur in children, no deaths were reported in the zero-to-five years age group, but mortality increases with age and was 10 times more likely in those over 65 years of age than those aged 18-35 years. December is the most risky month to present with malaria, with an overall risk of dying of 2.55% compared with 0.58% for all other months.

Also recently released is the HPA report on malaria in the UK in 2011, showing a 5% decrease in malaria infections compared with 2010 but a 22% increase in cases from the Indian subcontinent, mostly due to a doubling of cases of *Plasmodium vivax* acquired in Pakistan.[2]

References

1 Checkley AM, Smith A, Smith V et al. Risk factors for mortality from imported falciparum malaria in the UK over 20 years: an observational study. *BMJ* 2012; 344:e2116
2 HPA. hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317133806548

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Your countdown to CQC registration

Richard Banyard walks practices month-by-month through the steps they should take to prepare

By April 2013, all English GP practices will need to have registered with the CQC.

While some of the final details have yet to be decided, the key steps along the registration journey are already clear. The key messages in preparing for the CQC are:

- Start early.
- Recognise that this is a progressive process – and it is about much more than just filling in the registration form in the autumn and then forgetting about it.
- Focus on the six key risk areas of non-compliance. Know what they are – for GPs, these are medicines management, staffing, records management, safeguarding, confidentiality and information control – and have clear action plans in place as necessary to deal with them.
- If in doubt, don't be afraid to ask the CQC for advice.

Below is a month-by-month timeline to help your practice prepare.

Before July 2012

By now, you should have made sure that the practice is properly legally constituted. Partnerships, for example, will need to make sure that the partnership agreement is up to date, as the CQC can only register a practice if it legally exists.

Lead management responsibilities also need to be sorted out. A crucial step will be to decide who the registered manager or managers will be, as this is the person who will be accountable in law for the services being operated. At least one GP partner will need to take the lead for CQC issues; it cannot all be left to the practice manager to sort out.

Key players in the practice will also need to have begun to learn more about the CQC itself and its powers. By now, practices should have started the process of assessing their compliance against the 250+ CQC standards. Don't underestimate how long this process might take. Some of the standards only apply to certain providers, so as an initial step practices will need to determine which 'service types' are offered before starting to assess compliance. The key to CQC compliance is working out where any key risks lie for patients and staff.

If you have a spare moment, make sure that your key policies – such as complaints,

safeguarding procedures and patient information leaflets – are up to date in order to save time later in the year.

July 2012

Formal processes begin. The CQC will contact all practices to sort out the 28-day window during the autumn for each practice's registration application.

Look out for the CQC application form. This will be available online, so can be completed incrementally. Practices need to identify the questions that might cause the most difficulties, and then focus on these during the lead-up period to completing the application itself. Make sure that CQC issues appear regularly on practice meeting agendas throughout the application period.

Another important issue to decide early on is which 'locations' your practice is operating. For most practices, this will be straightforward – but if a practice is operating from more than one surgery or has a branch, you will have to decide whether separate applications are also needed.

By July, you will also need to decide which are the 'regulated activities' for which you will be seeking CQC registration. These are likely to be 'treatment of disease, disorder and injury' and 'diagnostic and screening procedures'. However, there are another 13 possible activities that are all to be registered with the CQC, so you will need to work through them just to check whether you also need to apply for these. For a full list, go to pulsetoday.co.uk/gp-regulation-cqc.

Finally, be absolutely clear about who will need to have a Criminal Records Bureau (CRB) check. GPs with current GMC registration

Make sure CQC issues appear regularly on practice meeting agendas

should be exempt from this, but others – for example, non-clinicians in the partnership and non-medical registered managers – are almost certain to need enhanced checks.

This process needs to be started as early as possible. Most other staff in the practice may also need to have been CRB checked, especially those who work single-handed with patients and children.

September 2012

From September, practices will begin submitting applications. Allow time for the application to be fully signed by all the partners, and also fully checked through before submission. If it is incomplete, it will just arrive back from the CQC in your in-tray.

It is important that you prepare an action plan for any areas you have assessed as being non-compliant or only partly compliant with the CQC standards. It is far better to have a remedial action plan in place than to feign compliance and be caught out later.

December 2012

This is the latest deadline for CQC applications to be submitted. If there are subsequent queries from the CQC, make sure that these are answered promptly and accurately in order to ensure your application is not delayed.

In addition, as soon as your application has gone in, there will be other CQC-related tasks to consider such as training and budgeting for the costs of compliance and registration. It will also be prudent to start working up the internal practice procedures that you will need to follow once registration commences. For example, any deaths or untoward incidents in the practice will need to be notified to the CQC from April.

A key member of the practice team and a deputy will need to be identified to co-ordinate such ongoing notifications to the CQC, which are a legal requirement.

March 2013

Make sure you have notified the CQC of any substantive changes since your application was submitted. If your CQC registration letter has not arrived by now check where it has got to, and once it is available check that it is accurate – for example, does it include all the services that you offer?

April 2013 onwards

Celebrate your CQC registration – but don't relax too much. Check the ongoing requirements that practices will need to follow once registered on the CQC website, and be aware that a CQC inspector can arrive at any time – announced or unannounced.

Richard Banyard is director of CQC registration consultants CQCassist

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Working with a charity

Dr Steve Kirk explains how working with the third sector helped his CCG improve primary prevention for stroke

In Gateshead, we have a 10% higher than average mortality rate for stroke and about 10% more admissions for stroke than the England average. The prevalence of strokes in Gateshead is 2.2%, compared with 1.7% in England as a whole.

We knew that one of the ways to tackle stroke death and emergencies was to focus on primary prevention. That meant better diagnosis of atrial fibrillation (AF) – notably we didn't use any risk scoring for stroke at that time – and addressing the fact that local GPs seemed reluctant to prescribe anticoagulants; it was often felt that warfarin prescribing was a specialist decision for secondary care to make.

For both of those problems we needed to improve education and confidence among primary care practitioners.

Gateshead CCG decided to focus on reducing stroke risk in patients with AF, with case finding and anticoagulant prescribing for patients at high risk.

What we did

The CCG's initial contact with the Stroke Association arose from discussions on moving secondary prevention clinics from secondary to primary care, which laid the foundations for our future joint working. We were keen to collaborate with the charity to maximise the impact of their campaigns and to use their experience in working with the public to enhance our work on stroke prevention.

Our first step was to organise training on stroke awareness, and on how our local stroke services worked. We asked our local stroke team and the Stroke Association to lead an update session at one of our area's regular education half-days.

Education sessions happen around six times a year – every local practice shuts for an afternoon and the PCT pays for staff cover while we run a training session on a particular clinical area for GPs, nurses and practice staff.

We followed this initial session with regular updates on using CHADS2 risk scores, safe prescribing of warfarin, ECG interpretation and risk stratification.

Throughout the year we encouraged practices to promote the Stroke Association campaigns including the Act Fast campaign, which educates the public on recognising and reacting to stroke symptoms. The charity provided campaign materials – namely posters – which were well designed and saved us time and money.

We also worked with the Stroke Association to ensure practices used its Ask First publicity materials, which highlighted the importance of identifying anyone with undiagnosed AF.

The charity helped us provide an education session at my practice's patient forum, which included a presentation on stroke prevention and services available to those affected by strokes.

Alongside our work with the Stroke Association, we developed a local enhanced service for practices to screen patients over the age of 65 for pulse irregularities when they attended for their flu jab – 30 out of 34 practices took part, and practices were paid £2 per patient screened.

We ran a local incentive scheme, which paid all 34 practices up to £2.05 per patient for taking part in risk stratification. This involved practice clinicians and staff attending our regular training half-days, taking part in audits and surveys and undertaking a wide variety of clinical improvement projects.

All 34 practices in our locality decided to use the Grasp AF toolkit to find patients at high risk of stroke.

It works by searching for any Read codes that might indicate AF, such as 'pulse irregular', and produces a list of patients whose notes need to be reviewed.

The CCG provided IT support to enable each practice to download the toolkit and run the searches. We also gave our practice managers training on using it.

Working together with a charity helped both sides achieve their aims

The second stage of Grasp AF allocated a CHADS2 stroke risk score to each patient. We reviewed the records of every patient who was at high risk of stroke to ensure they were receiving appropriate anticoagulation therapy.

Patients were then invited to attend an appointment with a GP to discuss their risk of stroke and the benefits of anticoagulant therapy.

Lessons learned

Working with a charity in this way was a new experience for us as a CCG. We got fantastic support from the Stroke Association for our projects and access to high-quality educational and promotional materials.

The joint education programme with the Stroke Association for patients and clinicians helped raise the profile of our prevention work, and we hope that the links made between individual practices and the Stroke Association will lead to more joint working in the future.

Working together with a charity helped both sides achieve their aims.

We have also worked with the British Heart Foundation, a much larger charity, which paid the salary of one of our heart failure nurses. It's a little different working with a charity who has given you funding, as it wants to be clear its funding is meeting its needs as well as yours.

We had to be adaptable to changing circumstances – midway through the project, we were asked to select contracts to be commissioned through any qualified provider. We chose anticoagulation services in order to increase capacity, to accommodate the expected increase in referrals.

Some of the work on stroke was more thanks to the NHS than the third sector. The local Cardiac Network, the North of England branch, was helpful on Grasp AF – providing experts to give education sessions and educational materials to support clinicians in prescribing warfarin. There are 28 Cardiac Networks across Britain, all run by NHS Improvement.

Outcomes

At the end of nine months, the total number of patients with recorded AF had risen by 96 patients – from 3,235 to 3,331.

We think the true number of new patients identified was much higher, as many practices removed or put into past problems the AF diagnosis from patients where AF had resolved or had been an incorrect diagnosis.

The number of patients at high risk of stroke (CHADS2 score >1) prescribed warfarin rose from 1,175 to 1,269, a rise of 8%, and referrals to the anticoagulation clinic rose by 11%. Many patients had previously not been prescribed warfarin or had any documented contraindication or record of declining warfarin, and this number reduced from 533 to 215 – a fall of 60%.

The Grasp AF toolkit does not remove patients who have AF that has resolved, meaning it is not possible to have for all patients at high risk to be prescribed warfarin or have a record of contraindication or declining warfarin.

Before our project 16 practices did their own ECGs, only six of which could send electronic copies for cardiologist interpretation. We now have 24 practices providing in-house ECGs with access to cardiologist interpretation of ECGs through 'advice and guidance' on Choose and Book.

The pulse irregularities LES was a success, with 15,504 patients having their pulse checked and 765 new irregular pulses identified.

Unfortunately, we were not able to say how many of these 765 patients went on to be diagnosed with AF – the LES did not ask practices to collect this data.

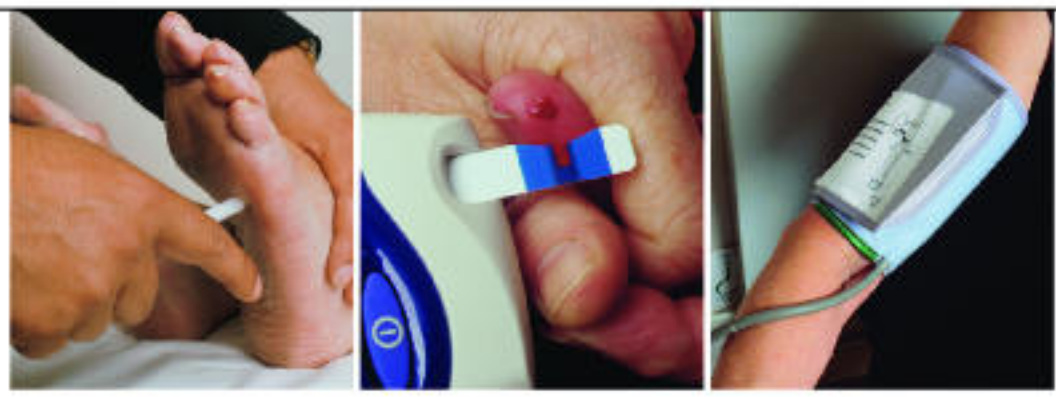
Lastly, in June, I accepted on behalf of the CCG the 2012 Life After Stroke award from the Stroke Association for our work.

Hopefully this award will help both patients and clinicians locally build on the good work we've started in this area.

The future

While we know that working with bigger charities with more funding might entail more compromise or negotiation, we will look to increase the number of charities we work with as our experience with the Stroke Association has been very rewarding.

Dr Steve Kirk is a GP in Gateshead and vice chair of Gateshead CCG



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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

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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

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Please apply with covering letter and CV to: Suzanne Gibbs, Practice Manager, 73 Upper Wickham Lane, Welling, Kent DA16 3AF or e-mail suzanne.gibbs@nhs.net

Closing date 27th July 2012

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For further information please contact:
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Maternity Locum Required

with Possible View to Partnership

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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

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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
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Job Type:	Salaried GP

Salaried GP

Upton Road Surgery-Watford, Herts

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- To start as soon as possible
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Contact: Denise Cooper, Practice Manager,
Upton Road Surgery, 30 Upton Road, Watford WD18 0JS
Tel: 01923 226266

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Applications in writing with an accompanying CV and references by post or e-mail to; Ellaine Jackson, Aston Healthcare Ltd, Manor Farm Medical Centre, Manor Farm Road, Huyton, L36 0UB. Ellaine.Jackson@knowsley.nhs.uk

Informal enquiry:
Dr Aftab Hossain,
Lead GP and Managing Director of Aston Healthcare Ltd,
Tele: 0151 480 1244, E-mail: Aftab.hossain@knowsley.nhs.uk

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Saxon Spires Practice,
West Haddon Road, Guilsborough,
Northamptonshire NN6 8QE
Tel: 01604 740210 Email: Kathryn.Baines@gp-K83064.nhs.uk

Informal visits welcome.
Closing date 13th July 2012

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www.prospect-house.co.uk

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

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For an informal visit or to apply please contact Carole Edwards, Business Manager 01394 615500 or email carol.edwards@gp-d83057nhs.uk

Closing date for applications July 31st 2012

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Nicholas Emery, Practice Manager, East Cowes Health Centre, York Avenue, East Cowes, Isle of Wight PO32 6RR.

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Closing date for applications 13th July 2012

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Seeks Salaried GP with view to Partnership

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enquiries to:
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Telephone 01239 - 820194 / 820397
Email Julie.Evans@GP-W92064.Wales.nhs.uk

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e mail: anitajones2@nhs.net

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Applications in writing, with CV, to Susan Harris, Practice Manager, Summervale Medical Centre, Wharf Lane, Ilminster, Somerset, TA19 0DT
or susan.harris@summervaleilm.nhs.uk
If you would like to arrange an informal visit or require further information please e mail or ring 01460 52354

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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

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Tel: 01248 600212
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Closing date end of July 2012

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EDITOR'S CHOICE

Snapshots of a life in practice

Dr Kate Adams explains how her practice helped inspire an eye-opening photography exhibition

MICHAEL VON GRAFFENRIED

The 'Shoreditch Stories' photographic exhibition focused on patients at home

After most surgeries, the GPs in my practice partner up and discuss the patients we have seen. It was during one of these feedback sessions, after discussing a patient who used to be a bare-knuckle fighter, that the idea of a photography exhibition was floated.

Our practice is in Hackney, east London. We have 7,000 patients and are situated in one of the most ethnically and culturally diverse and deprived parts of the UK.

In recent years, the way GPs are performance managed has changed the way we work – and sometimes the way we think.

Medical records are beginning to appear as a list of templates. This biomedical approach risks dehumanising both patients and practitioners and I fear the art of narrative-based medicine is at risk of being overlooked, and with it the needs of the individual patient. After all, there is so much work GPs do that is simply not measurable.

In creating the exhibition, we worked with Michael von Graffenried, an award-winning photographer whose trademark is his panoramic camera.

The 'Shoreditch Stories' project – a series of photos of patients at home – involved either me or another doctor from the practice accompanying Michael and visiting patients and their families. I found that when I visited patients without the time pressure of an appointment, it was lovely to just sit, observe and listen with no agenda.

Like GPs everywhere, each day we bear witness to amazing and touching stories about people's lives. We are generalists – that is what marks us out from the other specialties and what motivated me to become a GP in the first place.

Dr Kate Adams is a GP in Hackney, east London. 'Shoreditch Stories' will be open to the public at Shoreditch Park Surgery until the end of August, when it moves to the new RCGP headquarters in September.

VIDEO

What would you do if a patient had a heart attack in your waiting room? Would your receptionist know what to do, or your practice manager? Watch our video on new emergency training for GP practices to see how talking mannequins could help make your surgery better prepared...

▶ pulsetoday.co.uk/videos

WHAT YOU'VE BEEN SAYING

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Talk about poachers turned gamekeepers.

... on CCGs performance-managing GPs

A bit wet for my liking.

... on outgoing BMA chair Dr Hamish Meldrum's warning against 'rushing to repeat' pensions action

I'm sure I can find 52 patients who find sticking a banana on their head effective treatment.

... on the use of personal budgets to buy theatre tickets

BLOGS

Meet our new blogger

Dr Nicholas Ramscar, a GP registrar in Basingstoke, won our clinical writing competition with his tale of the 'Perils of private medicine', then summed up the best of general practice with a piece about a cat called Arthur. Now he's a member of the Pulse blogger team.

PULSE BLOGS Read Dr Ramscar's new blog at pulsetoday.co.uk/ramscar

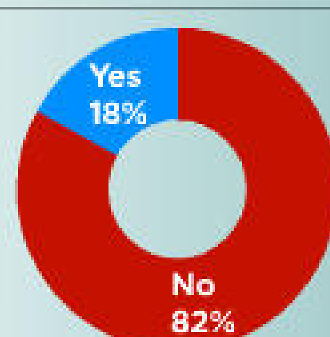
THIS WEEK'S POLL

Will a composite QOF indicator improve diabetes care?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

Are personal budgets a worthwhile use of NHS resources?



Turn inside for this week's Phil Peverley and Margaret McCartney columns ▶ pages 16, 17