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BriefingMedia

At the heart of general practice since 1960

Practices waver over BMA's day of action

Pulse poll suggests some GPs having second thoughts amid fears over impact on patients

EXCLUSIVE
By Jaimie Kaffash

The BMA's decision to call a day of industrial action over ministers' pensions raid has split the profession, with a third of practices indicating they will not cancel routine appointments and even BMA Council members yet to confirm if their practice will take part.

Partners across the country have been holding meetings to decide if their practice will provide only urgent and emergency care on 21 June, with the extent of grassroots support for the BMA's action increasingly uncertain.

Pulse's snapshot poll of 161 GPs this week reveals just 29% so far expect their practice to take part fully in the day of action, with a further 15% reporting that some parts of the practice will participate.

Some 37% said their practice had already ruled out taking action, while almost one in five had yet to decide.

At the end of last month, BMA Council announced that the first industrial action by doctors for almost 40 years will see practices stop all routine care for 24 hours.

The decision came after 84% of doctors voted for industrial action short of a strike in the BMA ballot – including 79% of GPs.

Most practices have yet to formally tell local NHS managers whether they plan to take part, but the Pulse poll's findings were also matched by a survey undertaken by NHS Gloucestershire.

Just 26% of the 51 practices and 261 GPs who responded to the PCT said they were planning to take action.

Even many BMA Council members, who took just two hours after the ballot results were announced to unanimously approve industrial action, were unable to confirm they would participate.

As Pulse went to press, just one out of 10 GPs on BMA Council contacted – GPC chair Dr Laurence Buckman – would say that his practice would definitely be closed for routine appointments on 21 June, with many yet to discuss it with their partners and several refusing even to discuss their own practice's decision.

A series of high-profile GPs have been fiercely critical of the BMA's decision to take action. NAPC president Dr James Kingsland warned it could harm patient safety, while the *Times* newspaper columnist Dr Mark Porter, who is a GP in Wotton-under-Edge, Gloucestershire, claimed it was the 'wrong battle at the wrong time'.

Dr Sarah Wollaston, a Conservative MP on the House of Commons health committee and a former GP, told Pulse: 'I get a lot of correspondence from doctors who are horrified at what the BMA is doing.

'People have been in touch to say "I voted Yes/Yes in the poll, but now regret it and won't be taking action". The risks of undermining the goodwill and trust [of patients] are just not worth it.'

But others were more enthusiastic. Dr Gaurav Gupta, a GP in Faversham, Kent, said his whole practice would be taking part: 'Our pension was renegotiated in 2008, but the Government has decided to renege on this agreement.

'We are being singled out, and it is time for the profession to take a stand.'

The Pulse poll does suggest there is some appetite for ongoing action over pensions, with 46% of respondents prepared to consider further days of action if the BMA decides they are required.

Dr Richard Vautrey, GPC deputy chair and a GP in Leeds, downplayed fears that a large number of practices would ignore the first day of action.

'We need to go on the actual ballot, which had a very clear message and the numbers who responded were overwhelming,' he said. 'We are not under any illusions that the action we take is going to win huge levels of support from the public or patients.'

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Dr Gaurav Gupta: 'It is time for the profession to take a stand'

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The BMA must hold its nerve 14

MORE ONLINE
See the full survey results
pulsetoday.co.uk/news-analysis

Inside: Pulse pensions special

Health minister Simon Burns on why strikes won't win concessions
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GPC chair Dr Laurence Buckman on how to prepare for 21 June
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Frequently asked questions: practical advice on taking action
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CPD in this issue: 4.5 hours
Earn CPD for our Key questions, cardiology and post-op problems articles and feature on prescribing

The week in general practice

INSIDE

MORE ONLINE

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The BMA has announced the names of the doctors standing to succeed Dr Hamish Meldrum as chair, including GPC member Dr George Rae

▶ pulsetoday.co.uk/politicalnews

Video of the week

Watch GMC chair Professor Peter Rubin respond to GPs' concerns over revalidation, in our exclusive interview

▶ pulsetoday.co.uk/videos

Download of the week

Download the BMA's template letter for practices taking industrial action to send to their PCO

▶ pulsetoday.co.uk/news-analysis

PULSENEWSEXTRA
PENSIONS INDUSTRIAL ACTION

CONTRACT

GPs in limbo over contract sanctions

Many PCOs yet to rule on docking pay

EXCLUSIVE
By Jamie Kaffash

GPs in some areas are likely to face financial or contractual sanctions if they take industrial action over pensions, while others are unlikely to suffer any ill effects, amid confusion over whether the BMA's day of action constitutes 'breach of contract'.

Guidance from NHS Employers – issued to HR directors last week – stipulates NHS management boards are allowed to withhold pay from doctors who take industrial action, but was unable to give specific guidance on GP contracts. Of the 26 PCT clusters and 20 LMCs approached by Pulse, five PCT clusters – NHS Buckinghamshire and Oxfordshire, NHS Berkshire, NHS Derbyshire County, Cheshire, Warrington and Wirral PCT cluster and NHS Bristol – said they would not be docking pay or imposing further sanctions on GP contract holders if urgent services were still provided.

The remainder said they had no final policy or were considering sanctions if there was a breach of contract.

Pulse's survey of 161 GPs found 8% believed their PCO would take contractual or financial action, a further 21% said they were not sure what action would be taken and three in four said they did not think any action would be taken.

In advice sent to HR directors, NHS Employers director Dean Royles stated: 'An employer is legally entitled to withhold pay for days when staff take part in industrial action.'

A spokesperson for NHS Birmingham and Solihull said: 'GPs who hold contracts will be expected to fulfil their requirements. Failure to do so could result in imposition of contract sanctions.'

NHS South Essex Cluster said practices that took part in the action 'may be in breach of their contract' and it was still determining any possible action.

Dr Andrew Mimnagh, chair of Sefton LMC, said there was con-

Pensions survey results

Will your practice be taking industrial action on 21 June?

Yes, the whole practice 28%
Some of the practice 15%
We haven't decided yet 20%
No 37%

Is your PCT planning on taking any action against you if you take industrial action?

Yes 7%
Yes, but not sure what 20%
No 73%

Source: survey of 161 GPs

How action became inevitable

MAR 2011	JUL 2011	NOV 2011	DEC 2011
Lord Hutton recommends linking retirement age to state pension age	Government consults on proposed increases to pension contributions	Trades Union Congress leads day of action over public-sector pensions	Government makes 'final offer' on the NHS pension scheme

ANALYSIS

Profession needs to find a common voice

Gareth Iacobucci
Chief reporter

The BMA's decision to proceed with industrial action in protest at the Government's pensions reforms was inevitably going to split opinion.

A YouGov survey last week found 62% of the public opposed the action, and health minister Simon Burns was quick to seize on the results, claiming patients had 'every right to be angry'.

The problem, one GP negotiator told me last week, is that 'most patients don't

Do you support the day of action?

FOR 'We need to send the strongest message possible to the Government'

Dr Beth McCarron-Nash, GPC negotiator

AGAINST 'There could be as much damage as good coming out of it'

Dr James Kingsland, DH clinical commissioning network lead

siderable uncertainty around whether the industrial action constituted a breach of contract: 'We are supportive, but the debate is over what constitutes sufficient industrial action without jeopardising the contract.'

Dr Katherine Murrison, a GP in East Ayrshire, said locally there had been rumours about financial sanctions: 'If legally they are allowed to take money off GPs, of course they will do it.'

A spokesperson from NHS Ayrshire and Arran said it 'was in the process of identifying the implications of this industrial action'.

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▶ Pensions industrial action special starts page 24

FEB 2012 — **BMA announces it will hold ballot on industrial action**

MAY 2012 — **84% of doctors vote in favour of action in the BMA ballot**

JUN 2012 — **Participating doctors will carry out only emergency care on 21 June**

JUN 2012 — **BMA Council to decide if further action is needed on 28 June**

understand the dispute, because it's extremely complicated'.

The trouble is, the BMA is not only struggling to communicate the crux of its grievance – that the pension cuts are unfairly skewed against doctors – to the general public.

It is also having to contend with a fierce split in the profession itself.

For proof, look no further than the reaction to two Pulse stories last week. When we revealed some prominent GPs would not be taking part as they believed it risked patient safety, GPs were urged to 'start standing up for ourselves'.

Conversely, our story in which the GPC hailed the ballot result as 'a huge mandate' drew comments – also from GPs – that described the action as 'uncaring, selfish and greedy'.

With ministers stepping up the PR assault, general practice urgently needs to find a common voice if it is to stand any chance of being heard.

COMMISSIONING

Senior GP commissioner resigns

A senior GP commissioner has resigned from his CCG in protest at the Government's pensions reforms.

It comes as the BMA announced plans to debate withdrawing en masse from commissioning over pensions, with a motion tabled for debate at the association's Annual Representative Meeting in Bournemouth later this month.

Dr Prit Buttar, a GP in Abingdon, Oxfordshire, and former GPC member, has resigned from his role as deputy locality lead for Oxfordshire CCG, claiming he had become 'utterly disengaged' because of his dissatisfaction with the enforced changes to GPs' pensions.

Dr Buttar, who will be taking part in the day of action on 21 June, said he 'bitterly resented' having to take the decision and warned the Government it should expect more commissioning enthusiasts to lose heart because of the pension changes.

He said: 'I have resigned from that post because, given how disaffected I am feeling, I did not think I could go round asking other people to engage when I'm feeling utterly disengaged. I bitterly resent being put in this position.

'At a time when the Government needs engagement of GPs like no other time before, it strikes me as curious to pick a fight with the entire profession.'

The resignation comes after LMC leaders backed a call last month to include disengagement from commissioning in any industrial action over the Government's pension reforms.

Dr Chaand Nagpaul, BMA Council member and a GP in Stanmore, north-west London, said: 'We would consider any vote. The Government should be warned if it damages the goodwill of English GPs, one of the casualties is likely to be disengagement in commissioning as a consequence.

'It's a very real risk. The implementation of what are clearly blatantly unfair pension reforms is likely to damage that goodwill.'

The move comes as the chair of the Conservative Health Society admitted even Tory-supporting medics were turning against the Government over pensions.

Dr Paul Charlson, a GP in East Yorkshire, said there was 'resentment' among active Conservative supporters about the reforms: 'There is a general feeling that this was all sorted not so long ago and that the current pension is fair compared with other civil servants.'

Weight patient survey, DH told

Major study recommends adjustment for case mix after some practices found to be unfairly represented

By Jaimie Kaffash

The Department of Health is considering adjusting the satisfaction scores practices receive under the patient survey, after a study found those in more deprived areas were being unfairly represented.

The move comes as the Government announced practices' individual pages on the NHS Choices website will display more information from the survey, with a new measure of 'patient experience' included on the site from this month.

The study – led by one of the architects of the patient survey – recommends patient satisfaction scores should be up-rated for practices with younger, more deprived or more ethnic-minority patients to give them a 'level playing field'.

The analysis, published in *BMJ Quality and Safety* last month, showed the current survey encouraged GPs to 'cream-skim' and exclude hard-to-treat patients.

Researchers analysed data from more than two million patients registered with 8,267 practices in England and looked at their scores in the 2009 patient survey. They found case mix was a powerful factor in influencing results, resulting in increases in scores for certain questions of more than 20% for some practices when adjusted for age, deprivation and ethnic mix.

The 10% of practices that benefited most from case-mix adjustment had a case mix with 35% of patients below the age of 35, 45% Caucasian and 83% living in deprived areas. This compared with the case mix at the 10% of practices who gained the least by the adjustment, who on average had 9% of patients below the age of 35, 97% Caucasian and 11% living in deprived areas.

Which practices win and lose from case-mix adjustment?

Patient type	10% of practices that benefit most	10% of practices that benefit least
Below the age of 35	35%	9%
Caucasian	45%	97%
Deprived	82%	11%

Source: *BMJ Quality and Safety* 2012, online 23 May

The authors concluded: 'Such adjustment should be applied because it meaningfully improves performance measurement for practices with less typical and often under-privileged patient populations. This would discourage practices from "cream-skimming" by avoiding enrolling patients who could be seen as "hard to treat".'

Study leader Professor Martin Roland, professor of health services research at the University of Cambridge, said practices in certain areas 'may feel there isn't a level playing field': 'Even though they are providing the same standard of care, it may not appear to be as good.'

A DH spokesperson said it was considering the study's conclusions, although no case-mix adjustment would be included in this year's survey.

The analysis comes as the DH announced responses from the GP patient survey would be included on NHS Choices. It will give practices in England a single score out of 10 for performance against measures such as GP listening skills, how convenient it is to get an appointment and the length of time patients wait in reception. Ministers said the new ratings would give patients an idea of 'exactly what the experience of being a patient at each GP surgery is really like' and would drive up 'standards in the profession'. But GP leaders strongly criticised the plans as 'demoralising'.

Dr Richard Vautrey, GPC deputy chair, said: 'It is simplistic nonsense to try and reduce the rich quality of general practice to a single number. It will mislead – not help – patients.'

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RCGP elects Pringle

The RCGP has announced that revalidation lead Professor Mike Pringle has been elected as the next president of the college.

Professor Pringle will take over the presidency from Dr Iona Heath from 16 November. He was voted in as the constitutional head of the college ahead of Dr John Chisholm and Dr Una Coales, who came second and third respectively.

Professor Pringle said: 'I am delighted and honoured to have been elected as the 23rd president of the RCGP. Dr Iona Heath will be a very hard act to follow, but I will do my very best to represent the college and support its members.'

The RCGP also announced six new council members, with Dr Coales, Dr Maureen Baker, Dr Tim Ballard, Dr Terry John, Dr Kirsty Balwin and Dr Valerie Wass taking up a three-year term of office from 17 November.

MORE ONLINE
Full election results
pulsetoday.co.uk/news-analysis

'Agreeable' GPs a problem

Managers have been advised to crack down on GPs who are too 'agreeable' and have 'a desire to do well', in new NHS advice on how to performance manage practices.

The National Clinical Assessment Service says managers should intervene early to tackle 'behavioural difficulties' in all healthcare practitioners, including those who follow guidelines too rigidly or try to please patients. NCAS assesses complaints from managers about GPs, and has issued the new guidance this month to help assist PCTs to deal with problems with healthcare practitioners.

The good practice guide on behaviour and conduct says agreeability in healthcare practitioners was as serious a problem as rude or aggressive behaviour, even though it admits this may be 'counterintuitive'.

The guidance says: 'Practitioners who are agreeable may present behavioural difficulties. A practitioner's desire to do a job well may, at times, border on an overly fixed or rigid approach that means their behaviour can cause conflict.'

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If twice daily dosing results in recurrent daytime hypoglycaemic reactions the morning dose can be split into morning and lunchtime doses and thrice daily dosing instituted. Only consider combination of NovoMix® 30 with pioglitazone following clinical evaluation of the patient's risk of developing signs and symptoms of fluid related adverse reactions. Initiate NovoMix® 30 cautiously, titrating to the lowest dose required to obtain glycaemic control. In patients with type 1 diabetes the individual insulin requirement is usually between 0.5 and 1.0 U/kg/day and may be fully or partially supplied with NovoMix® 30. Dose adjustment may be necessary with increased physical activity, changes in diet or during concomitant illness. NovoMix® 30 can be used in the elderly; limited experience of NovoMix® 30 in combination with OADs in patients older than 75 yrs. Renal or hepatic impairment may reduce insulin requirements. In this population or the elderly glucose monitoring should be intensified and dose adjusted accordingly. NovoMix® 30 can be used in children and adolescents aged 10 yrs and above, limited clinical data for children aged 6-9 yrs. No studies in children under the age of 6 yrs; only use in this age group under careful medical supervision. When transferring a patient from biphasic human insulin to NovoMix® 30, start with the same dose and regimen, then titrate according to individual needs. For subcutaneous administration only; not to be used in infusion pumps. NovoMix® 30 has a faster onset of action than biphasic human insulin and should generally be given immediately before a meal. When necessary it can be given soon after a meal. Penfill® designed to be used with Novo Nordisk insulin delivery systems. Penfill® and FlexPen® are designed to be used with NovoFine® and NovoTwist® needles. **Contraindications:** Hypersensitivity to active substance/ excipients. **Special warnings and precautions for use:** Use of inadequate doses or discontinuation of treatment may lead to hyperglycaemia and ketoacidosis which are potentially lethal. Travelling between time zones may require change in the insulin regimen. Too much insulin, omission of a meal or strenuous exercise may lead to hypoglycaemia. Compared with biphasic human insulin NovoMix® 30 may have a more pronounced glucose-lowering effect up to 6 hours after injection. This may need to be compensated for through adjustment of dose and/or food intake. Reduction of early warning symptoms of hypoglycaemia may be seen upon tightening control and symptoms may disappear with longstanding diabetes. Tighter control of glucose levels can increase the potential for hypoglycaemic episodes and therefore require special attention during dose intensification. The fast onset of action should be considered in patients where a delayed absorption of food might be expected. Concomitant disease in kidney, liver, adrenal, pituitary or thyroid gland may require change in dose. Transferring to a new type or brand of insulin should be done under strict medical supervision; may require changes in dose/number of injections. Injection site reactions, usually transitory, may occur; rotation of injection sites may help reduce or prevent these reactions, rarely they may require discontinuation of NovoMix® 30. Cases of cardiac failure were reported when pioglitazone was used in combination with insulin, especially in patients with risk factors for development of cardiac heart failure; if the combination is used, patients should be observed for signs and symptoms of heart failure, weight gain and oedema. Pioglitazone should be discontinued if any deterioration in cardiac symptoms occurs. Hypoglycaemia may constitute a risk when driving or operating machinery. **Fertility, pregnancy and lactation:** Limited clinical experience in pregnancy. No restrictions on use during breast-feeding. No differences in animal studies between insulin aspart and human insulin regarding fertility. **Undesirable effects:** 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); very rare (<1/10,000), not known (cannot be estimated from the available data). Very common: hypoglycaemia; Uncommon: urticaria, rash, eruptions; refraction anomalies, oedema and local hypersensitivity reactions on instituting therapy and are usually of transitory nature; diabetic retinopathy with intensification may result in temporary worsening; lipodystrophy; Rare: peripheral neuropathy – acute painful neuropathy, usually reversible, may occur with rapid improvement in glycaemic control; Very rare: anaphylactic reactions - generalised hypersensitivity reactions are potentially life-threatening. The Summary of Product Characteristics should be consulted for a full list of side effects. **MA numbers:** NovoMix® 30 Penfill® EU/1/00/142/004 NovoMix® 30 FlexPen® EU/1/00/142/009 **Legal Category:** POM **Basic NHS Price:** 5 x 3 ml Penfill® £28.84 5 x 3 ml FlexPen® £29.99 **Further prescribing information can be obtained from:** Novo Nordisk Limited, Broadfield Park, Brighton Road, Crawley, West Sussex, RH11 9RT.
Date created/last revised: March 2012
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References: 1. Gumprecht J *et al.* Intensification to biphasic insulin aspart 30/70 (BIAsp 30, NovoMix® 30) can improve glycaemic control in patients treated with basal insulins: A subgroup analysis of the IMPROVE™ observational study. *Int J Clin Pract* 2009; **63**(6): 966–972. **2.** Qayyum R *et al.* Systematic Review: Comparative Effectiveness and Safety of Premixed Insulin Analogues in Type 2 Diabetes. *Ann Intern Med* 2008; **149**: 1–12. **3.** Unnikrishnan A *et al.* Practical guidance on intensification on insulin therapy with BIAsp 30: a consensus statement. *Int J Clin Pract* 2009; **63**(11): 1571–1577.

UK/NM30/0312/0008e Date of preparation: April 2012

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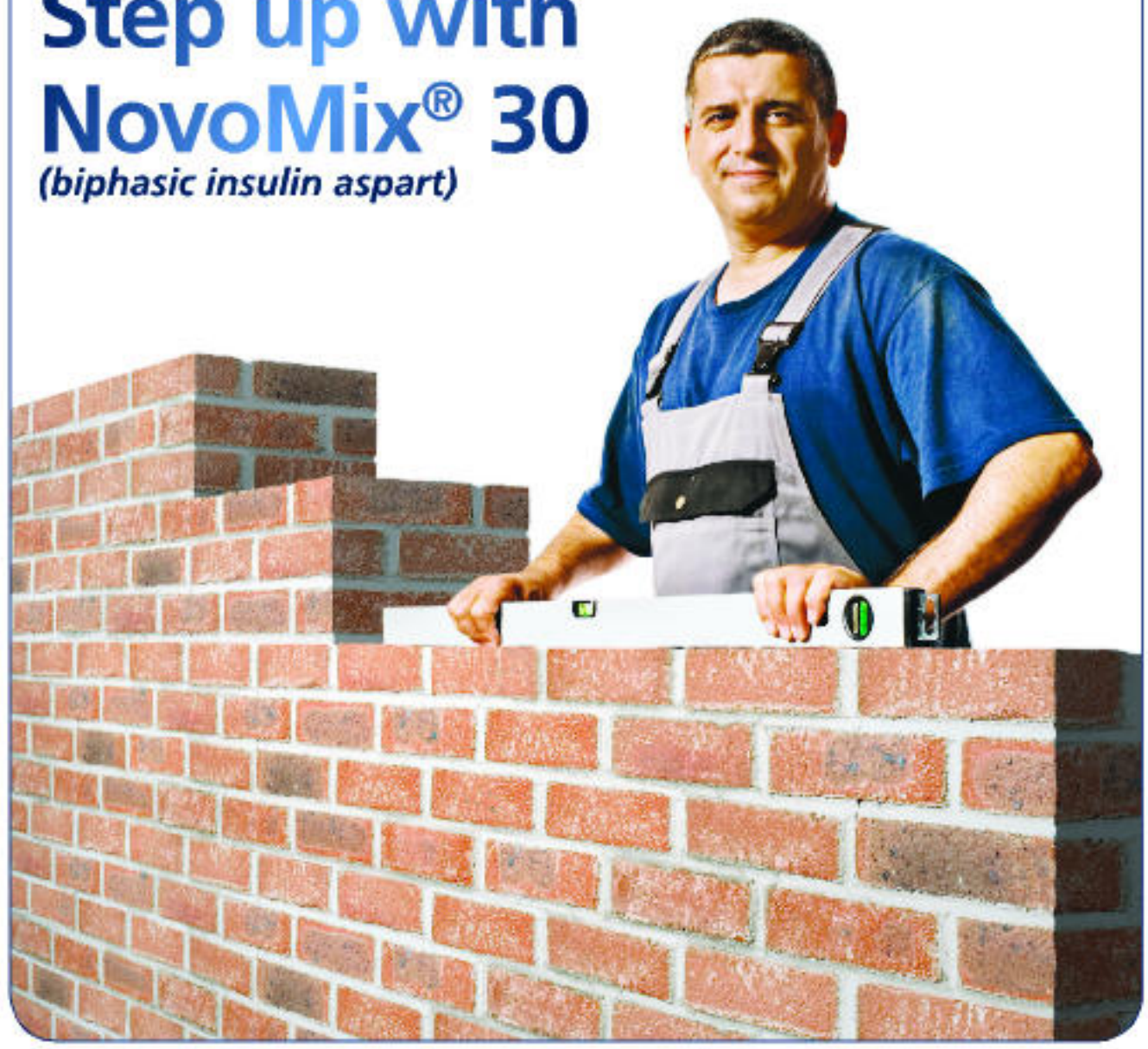

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Study backs risk-based approach to vaccination for patients over 65

IMMUNISATION

Pneumococcal risks 'lessen with age'

By Alisdair Stirling

Department of Health advisers are considering a new study that raises questions over the use of pneumococcal vaccination in all patients aged over 65.

Researchers at the Health Protection Agency said evidence suggested patients aged over 65 had a lower risk of hospitalisation and death from invasive pneumococcal infection than younger age groups.

Current NHS guidance is that all patients aged 65 years or over should have the vaccination, regardless of risk. But a Joint Committee on Vaccination and Immunisation review last year concluded the vaccination programme in older patients had 'no discernible impact' on rates of pneumococcal disease.

This recommendation was later withdrawn by the JCVI, but Pulse understands the committee will reconsider this position in light of the publication of the HPA paper at a meeting this week.

The HPA looked at the records of more than 22,000 patients with invasive pneumococcal disease and compared them to the general population.

They found an increased rate of invasive pneumococcal disease in older patients, with an overall incidence per 100,000 in 2009/10 of 4.8 in two- to 15-year-olds, 8.3 in 16- to 64-year-olds and 56.7 in those aged 65 or older.

But the risk of hospitalisation and death due to pneumococcal disease reduced with age.

Those aged two to 15 years had nearly a 12-fold risk of hospitalisation and a risk of death of 2.4, compared with the general populations.

Those aged 16 to 24 had odds of 7.6 and 3.9, respectively, and this fell to 2.4 and 1.2 for those aged 65 years or older.

The most important risk factors that predicted invasive pneumococcal disease were chronic liver disease, immunosuppression, and chronic respiratory diseases.

Study leader Dr Albert Jan van Hoek, an infectious disease

Vaccination campaign had 'no discernible impact' on disease

Reduced risk with age

Age group	Risk from invasive pneumococcal disease*	
	Of hospitalisation	Of death
Two to 15 years	11.7	2.4
16 to 64	7.6	3.9
65+	2.4	1.2

*Relative risk compared with general population
Source: *Journal of Infection* 2012; 65: 17-24

CONTRACEPTION

LARCs more effective than pills for teenagers

GPs should recommend long-acting contraception to sexually active teenagers, as they will be 20 times less likely to have an unintended pregnancy due to contraceptive failure, compared to those using pills, patches or rings, say researchers.

Investigators looked at pregnancy rates for 7,486 women aged between 14-45 years who were given a contraceptive method of their choosing. All participants were sexually active, or planning to become so during the following six-month period.

The failure rate in the group using pills, patches or rings was 9.4% at three years. This compared with failure rates of 0.9% in those who had Depo-Provera injections and 0.7% for those using IUDs or implants.

Overall, pills, patches or rings conferred a 20-fold risk of unintended pregnancies compared with using LARCs. Women using Depo-Provera were 30% less likely to have one compared with those using IUDs or implants.

***NEJM* 2012; 366: 1998-2007**

CANCER

Jaundice 'best predictor' of pancreatic tumours

UK researchers say GPs should investigate all unexplained cases of jaundice as it is the best predictor for the development of a pancreatic tumour.

Their study looked at 3,635 cases of pancreatic tumours in the UK from 2000 to 2009 in patients aged 40 years or over.

They identified the common features of pancreatic cancer and found jaundice was present in 30% of patients with tumours, and had the highest positive predictive value, at 12.8%. The next highest was weight loss, at 0.44%.

Patients with jaundice had an odds ratio of 1,000 of developing pancreatic cancer, compared with a ratio of 12 for weight loss.

NICE guidance recommends urgent referral only for obstructive jaundice. But study leader Professor Willie Hamilton, professor of primary care diagnostics at the University of Exeter, said the results 'would suggest investigation for jaundice per se is warranted, unless there is a clear alternative cause'.

***Br J Cancer* 2012, online 22 May**

CHD

Scoring system for chest pain 'can rule out CHD'

European researchers say they have developed a score to help GPs accurately rule out coronary heart disease in patients with chest pain.

Researchers looked at the Marburg Heart Score in 844 patients aged over 35 years presenting with chest pains as the primary or secondary complaint.

The components of the score were age, sex, known clinical vascular disease, a patient who assumes a cardiac origin of pain, pain that worsens with exercise and pain that is not reproducible by palpation. Each score component is worth one point – three points or more rules out CHD.

It was found 270 patients with a score of three or more were also classified as CHD negative by an expert panel, with only 10 patients falsely classified as CHD negative by the score.

Study leader Dr Jörg Haasenritter, a researcher in family medicine at Germany's University of Marburg, said: 'Consider further clinical assessment in patients with positive results.'

***Br J Gen Pract* 2012, online 1 June**

SINUSITIS

Intranasal steroids reduce symptoms of sinusitis

Intranasal steroids reduce symptoms of acute sinusitis in the short term, say the authors of a UK analysis.

Researchers looked at six randomised controlled trials of 2,495 patients from outpatient settings in the UK, Turkey and the US, and compared data for intranasal steroid use with placebo in children or adults.

Those on intranasal steroids were 8% more likely to experience improvement or resolution of symptoms after 14 to 21 days of therapy than those on placebo. Symptoms had an 11% likelihood at 21 days of being resolved, compared with 5% at 14 to 15 days.

They also found symptom resolution was affected by the dose, with a dose-response relationship with mometasone furoate spray.

Study leader Dr Gail Hayward, professor at the department of primary care health sciences at the University of Oxford, said: 'We recommend 800µg of mometasone furoate daily.'

***Ann Fam Med* 2012; 10: 241-24935**

modeller at the HPA, said its data proved vaccination in at-risk groups was crucial.

He said: 'It provides an evidence base for the targeted vaccination approach adopted by many countries, or if an age-based vaccination approach is adopted, that evaluating the coverage among risk groups is key.'

But Dr George Kassianos, RCGP immunisation lead and a GP in Bracknell, Berkshire, said an age-based strategy was still valid: 'There is no question about the benefit of pneumococcal immunisation in those with underlying clinical conditions of any age, but this does not mean it is not worth immunising the over-65s.'

He added: 'The case fatality rate from pneumococcal bacteraemia is 20% in the general population, but among the elderly it is 60%.

'We should immunise against pneumococcal infection patients with underlying medical conditions of any age, but we must also immunise the over-65s as they are more vulnerable.'

Journal of Infection 2012;65:17-24

feedback@pulsetoday.co.uk

CONFERENCE ROUND-UP

COPD patients still suffer dyspnoea

High numbers of patients with COPD still suffer from clinically significant dyspnoea despite treatment. A search of the UK General Practice Research Database identified that 40% of a cohort of 42,175 patients had clinically significant dyspnoea.

American Thoracic Society conference, abstract number J80

Cycle superhighway black carbon risk

Cyclists in London using cycle 'superhighways' are exposed to greater concentrations of black carbon particles when compared to alternative routes, says new research. Mean minute exposure to particles on the superhighway was significantly higher at 18080ng/m³ than on other routes (11340ng/m³).

American Thoracic Society conference, abstract number A12

Step-down dosing change for asthma

A change in dosing frequency at the time of a step-down in patients with asthma may improve outcomes, says UK research. Stepping down to once-daily therapy was associated with improved adherence and reduced exacerbations, compared with twice-daily therapy.

American Thoracic Society conference, abstract number 501

Fast physiotherapy cuts back pain costs

By David Swan

GPs referring patients with low back pain for urgent physiotherapy halve the chances of that patient having to undergo surgery or steroid injections, say US researchers.

Their study showed referral to a physiotherapist within two weeks can 'profoundly' cut care costs and the chances of a patient having to see their GP again.

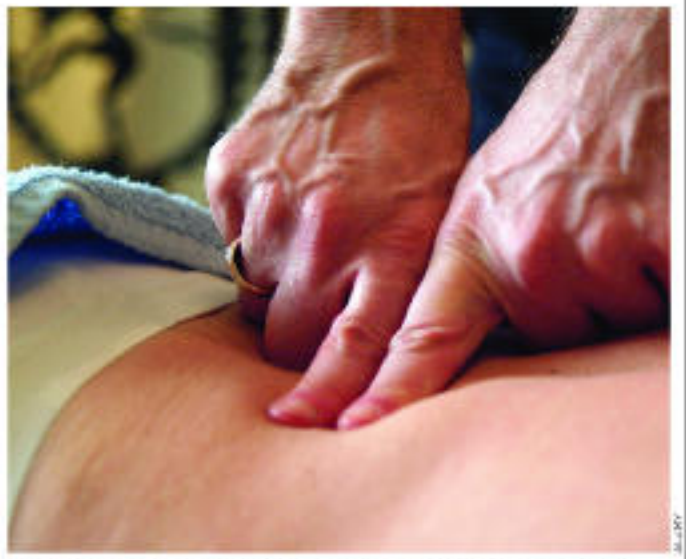
NICE guidance currently advocates the use of painkillers and referral for manual therapy, structured exercise or acupuncture for low back pain, but does not suggest a period within which a patient must see a physiotherapist.

The US study, published in the journal *Spine* last month, found referring patients with low back pain for physiotherapy within 14 days reduced the chances of more costly interventions later on.

The US researchers looked at 2,234 patients aged between 18 to 60 years of age who had a new consultation with a primary care physician with a diagnosis of low back pain and went on to have physiotherapy.

They measured the length of time it took before the patient was seen by a physiotherapist and correlated this with the interventions experienced by the patient.

Patients seeing a physiotherapist within 14 days of visiting their GP were 74% less likely to visit a doctor again, 55% less likely to require major surgery and 58% less likely to require lumbar injections, when compared to patients receiving physiotherapy after 14 days.



Patients seeing a physio within 14 days had better outcomes

This resulted in reduced care costs in this group, with total low back pain costs for patients receiving early physiotherapy $2,736 (£1,767) lower than those receiving physiotherapy later.

Patients receiving physiotherapy earlier also had a 50% decrease in costs for surgical procedures and a 41% decrease in imaging costs, compared with patients receiving physiotherapy later.

Study leader Dr Julie Fritz, associate professor of physiotherapy at the University of Utah, said the findings could have a huge effect on the way GPs manage back pain.

She said: 'It is increasingly evident that initial management decisions following a new low back pain consultation can have profound implications for outcomes and downstream costs.'

Dr Michael Burke, a GPSI in musculoskeletal medicine in the Wirral, said the study showed the benefits of early referral to a physiotherapist, but it would be difficult to achieve a two-week wait in the NHS.

He said: 'Currently it is very difficult for patients to access physiotherapy within 14 days, unless they are using the private sector. The best practice for care of patients with low back pain would be a stratified approach, using prognostic screening with matched pathways, resulting in modest cost savings at one year, compared with the existing best practice.'

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Aspirin 'will cut cancers'

A public health programme to encourage the routine use of low-dose aspirin in patients aged over 50 could prevent more than 2,000 cancers a year in Wales, but only after a decade, a new analysis has found.

The researchers from Cardiff, Wales, estimated the impact of a widespread primary prevention programme for cancer with aspirin, and found a substantial reduction in the risk of cancer after 10 to 20 years.

Pulse revealed last month that the Department of Health was looking at 'next steps' for aspirin in the light of a run of positive data for the drug in preventing malignancy.

This latest analysis from the Cochrane Institute of Primary Care and Public Health in Cardiff estimated the number needed to treat to avoid one extra vascular event with aspirin was approximately one in 2,000 annually, and one in 30 to prevent one case of cancer after 20 years.

They calculated around 500 cases of cancer in Wales were currently being prevented in those taking aspirin to prevent cardiovascular events, but this could be quadrupled if all patients over 50 took the drug for a decade.

The research – published in *Public Health* last month – called for a revisit of a health impact assessment into increased use of aspirin in Wales published in 2005.

Study leader Gareth Morgan, secretary of the Welsh Aspirin Group at the department of primary care and public health school of medicine at Cardiff University, said the study showed a rationale for using aspirin to prevent cancer: 'The main benefit of aspirin for primary prevention is on non-vascular disease, namely malignancy.

'The long-term benefit may discourage policy makers from developing aspirin primary prevention initiatives given that the initial visibility may be on the undesirable effects.'

IN BRIEF

Pathology hub concern

GPs have raised concerns over moves to create a pathology services 'hub' across central England, saying it will harm communication with colleagues over abnormal test results.

Full story ▶ pulsetoday.co.uk/commissioningnews

Lung cancer campaign

GP cancer leads have criticised the Government's lung cancer awareness campaign, warning it will undo years of work persuading patients with minor ailments to stay at home.

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1. Schulman C. Br J Urol Int 2007; **100**(Suppl 3): 6–11.

Date of preparation: January 2012. DEC08622

Patients told to spend more time in sun to mitigate 'strong impact' of supplements on prescribing costs

CCGs act to cut vitamin D costs

By Madlen Davies

CCGs are advising patients to spend more time in the sun and buy supplements over the counter, in order to mitigate the 'strong impact' Government advice on prescribing vitamin D is having on prescribing budgets.

The move comes as GP commissioners in one area estimated the cost of supplying vitamin D supplements could escalate to £20m over the next few years.

The chief medical officer wrote to all GPs earlier this year to urge them to prescribe vitamin D supplements in all patients at risk of being deficient in the mineral.

But GP commissioners said they were concerned about the impact the advice will have on resources, and in one area have already embarked on a major public awareness campaign to mitigate this.

After estimating vitamin D supplements could cost them up to £20m over the next few years, a CCG in Tower Hamlets, east London, has launched a campaign to encourage all groups at risk of vitamin D deficiency to spend more time in the sun and eat vitamin D-rich foods.

They have produced a leaflet and will talk with schools to ensure children are encouraged to spend more time in the sun and eat a balanced diet.

Dr Sam Everington, chair of Tower Hamlets CCG, said the CCG hoped the campaign would allow it to strip £2m from vitamin D budgets this year: 'The risk in prescribing vitamin D is that you don't solve the underlying problem.

'The issue is changing lifestyles. We would much rather invest the same money in public health responses, which are a more cost-effective solution.'

Dr Sam Everington: the real issue is changing lifestyles

Elsewhere, Leicester City CCG said it was concerned vitamin D prescribing costs 'will have a strong impact on budgets' and suggested GPs should prescribe a cheaper vitamin D supplement instead.

And NHS Oxfordshire is sticking to a policy set out in 2009 that says there is 'insufficient evidence' to support the routine commissioning of high-dose vitamin D supplements, and that they should be a 'low priority'.

Dr Sally Hope, a GP in Woodstock, Oxfordshire, said she was being encouraged to tell patients to buy supplements rather than prescribe them: 'People at the highest risk of hip fracture, which is a huge expense to the NHS, are housebound – either at home or in residential care – and they don't get out, ever. Housebound patients need to be prescribed vitamin D.'

A Department of Health spokesperson said: 'We strongly urge all health professionals to play their part in preventing vitamin D deficiency.'

@madlendavies

Patient leaflet

- **Sunlight is the main source of vitamin D; more than 90% of what we need is supplied this way.**
- **Enjoying the sun safely, while taking care not to burn, can help to provide the benefits of vitamin D without overly raising the risk of skin cancer.**
- **People who are physically active and spend time outdoors are less likely to have low vitamin D levels.**

Source: NHS North East London and the City

NHS 111

Provider urges 111 delay

A leading private firm has urged the Government to delay the rollout of NHS 111 to mitigate 'significant risks' with the current tender process, after withdrawing its bid to run the service.

Capita told Pulse it had pulled out of the bidding process, and said delaying the rollout of the service 'would allow many of these risks to be mitigated'.

It comes as two other private companies confirmed they would not be bidding to run the Government's new urgent care line. Serco said it would no longer be bidding to run the service 'for internal reasons', while Care UK also revealed it was not bidding for any contracts.

Capita told Pulse it was concerned that the current specification for the service, due to replace NHS Direct from April 2013, had 'significant risks' and did not allow for online interaction: 'We have communicated these [risks] to the Department of Health directly. A delay in rollout would allow many of these risks to be mitigated.'

A spokesperson for Care UK said: 'We look forward to seeing more detail of any proposed changes.'

A DH spokesperson said there had been 'no decision' on whether to delay the rollout.

HOSPITAL DISCHARGE

Trust fined for late letters

GP commissioners have fined their foundation trust over its poor performance in sending out discharge letters.

The fine, currently under negotiation, was levied because electronic discharge letters were arriving late, with incorrect or inadequate information, or never arriving, Dudley CCG said in a letter to GPs.

The CCG used contractual levers to serve a performance notice on Dudley Group NHS Foundation Trust, following an audit by three GP practices in 2011.

This was followed by a remedial action plan, but performance did not improve.

'We had no choice but to impose a financial penalty, as set out within the contract,' the CCG's letter said. 'With this money the CCG has reinvested in software, which will allow better communication electronically between [the trust] and our constituent practices.'

Dr Tim Horsburgh, clinical lead for children at Dudley CCG and secretary of Dudley LMC, said: 'There was no uniformity about how the letters were arriving.'

Paula Clark, chief executive of Dudley Group NHS Foundation Trust, said: 'We are in the process of validating the audit findings to review the circumstances agreed in the action plan.'

Diabetes risk 'cut by 70%'

Landmark study supports DH plans to radically expand GP treatment of pre-diabetes

By Pat Anderson

Reducing blood glucose levels in patients with impaired glucose tolerance cuts their chances of developing diabetes by up to 70%, according to a landmark study.

The US researchers said their results showed 'early and aggressive' treatment of pre-diabetes is warranted. The results are likely to boost Department of Health plans for GPs to target those at risk of diabetes.

The follow-up to the largest diabetes prevention study yet undertaken – published in *The Lancet* last week – found the risk reduction for diabetes over almost six years was 'strongly associated' with the number of times normal glucose regulation was achieved during the study.

Pulse revealed in March the DH planned to expand the treatment of those at risk of diabetes, by asking GPs to provide annual blood tests and lifestyle interventions in all high-risk patients, regardless of HbA,c levels.

These plans are being considered by NICE for its guideline on preventing diabetes.

Diabetes progression was cut by both metformin and lifestyle

Reduction in diabetes risk

Reduced risk of progression according to periods of normal glucose levels:	
At least once	47%
At least twice	61%
At least three times	67%

Source: Lancet 2012, online 9 June

The study followed 1,990 patients with impaired glucose tolerance plus a fasting plasma glucose of 5.3-6.9mmol/l, who had been randomly assigned to a lifestyle intervention, metformin or placebo during the Diabetes Prevention Program in 1999-2001.

They looked at whether these patients developed diabetes over the six years after the trial ended, and correlated this with whether any periods of normal blood glucose – defined as fasting glucose of less than 5.6mmol/l – were achieved in the original study period in the previous trial.

Those with at least one period of normal glucose levels had a 47% reduced risk compared with those who did not, and this increased to a reduction in risk of 61% if it was achieved twice, and 67% if reached three times in the previous trial.

The authors concluded their findings supported a shift towards 'early and aggressive measures' to prevent diabetes in people at high risk.

These risk reductions were irrespective of whether metformin or lifestyle interventions led to the blood glucose reduction.

Study leader Dr Leigh Perreault, associate professor of medicine at the University of Colorado, said: 'The strategy is unimportant as long as the intervention is early and can restore normal glucose regulation, even if transiently.'

Dr Roger Gadsby, a GP in Nuneaton and associate clinical professor at Warwick Medical School, told Pulse the study provided a strong rationale to encourage GPs to intervene earlier.

He said: 'We should encourage everyone at risk of developing diabetes to do their very best at lifestyle change, because if they can get their blood glucose levels to normal they will reduce their risk of getting type 2 diabetes.'

But Dr Colin Kenny, a GP in Dromore, Northern Ireland, and committee member of the Primary Care Diabetes Society, said aggressive treatment was not suitable for all patients: 'A minority of approximately 40% don't go on to develop diabetes.'

Dr Harry Yoxall, medical secretary of Somerset LMC, said there was no funding for a full-scale prevention programme: 'We would have to look at a completely new way of doing it because we don't have the resources.'

feedback@pulsetoday.co.uk

Patients deregistered for 'financial reasons'

A PMS practice formerly run by NAPC chair Dr Charles Alessi has been criticised by NHS managers after an investigation into its decision to deregister 48 elderly patients from a care home last July.

An investigation by NHS South West London into the Churchill Medical Centre in Kingston, where Dr Alessi was a partner for 26 years until this February, said the practice was in breach of its contract.

The review, released under the Freedom of Information Act to the *Surrey Comet*, was carried out after LMC leaders reported concerns from other local GPs about the decision.

In a letter to the practice informing it of the decision, the PCT said: 'It is evident, therefore, that your practice has removed the Kingston Care Home patients from its list for financial reasons. This is not reasonable grounds.'

In a statement released in response to the review, the Churchill Medical Centre said it was 'disappointed', but added: 'We are confident lessons have been learned by all parties.'

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References: 1. Miller E, Marshall R, Vurdien J. Epidemiology, outcome and control of varicella-zoster infection. *Rev Med Microbiol* 1993; 4: 222-30. **2.** Bowsher D. The lifetime occurrence of Herpes zoster and prevalence of post-herpetic neuralgia: A retrospective survey in an elderly population. *Eur J Pain* 1999; 3: 335-42. **3.** ZOSTAVAX® SmPC, 2011.

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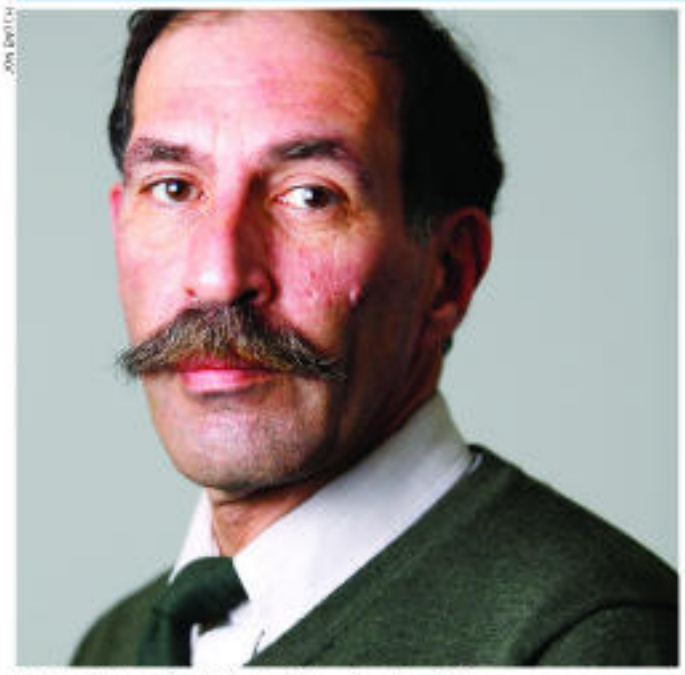

Dr Tony Grewal: patients will understand delays

Cut services during Olympics, GPs told

London practices warned to prepare as they would for 'severe weather'

By Madlen Davies

London GPs are being advised to treat the Olympics like a bout of 'severe weather' and consider reducing appointments, closing branch surgeries or transferring patients to A&E to ride out the storm.

In a newsletter sent to reassure GPs, LMC leaders in the Olympic borough of Greenwich have advised practices they will have to draw up detailed plans in order to be 'Games ready' for the summer.

The plans include reducing routine appointments, offering more telephone advice, being flexible about prescriptions and ensuring the practice is fully stocked up with medicines before the start of the Games.

Practices are also advised to consider closing smaller branch surgeries, avoiding home visits and 'lowering the threshold' for calling an ambulance in urgent situations.

The LMC newsletter said: 'Our advice to you is to not think of the Olympics as an extended Christmas – which you can largely plan for – but as extended severe weather, which cannot be entirely predicted.

'You are advised not to completely stop any service for which you are contracted, but you might reasonably reduce that service without breaching your contract.'

The LMC said PCTs would be unlikely to penalise practices for not providing a full service as 'the adverse publicity would be too damaging to them'.

The advice comes after City and East London LMC warned practices near the Olympic park in Stratford in January that 'capacity, contingency and travel issues' could hinder their ability to offer healthcare during the Olympics.

Dr Dermot Kenny, a member of Greenwich LMC, said practices close to the Olympic park were likely to be 'paralysed' and completely unable to run services as normal.

How GPs can cut services

- Reduce routine appointments
- Use skeleton staff
- Offer telephone advice
- Be flexible about prescriptions
- Make sure medicines are fully stocked up in advance
- Lower the threshold for requesting an ambulance where there is urgent clinical need
- Consider closing branch services

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He said: 'You can plan as much as you like but that doesn't mean you'll be all right. You have to adapt to situations as they come.'

Dr Tony Grewal, medical director for Londonwide LMCs, said: 'Nobody wants to do this – if you cut routine appointments, you just increase your workload for the next fortnight. Patients will understand this. It's like a bout of bad weather – if there's five feet of snow on the ground, they will understand if they have to wait two weeks to get in the usual 10 minutes.'

A spokesperson for NHS Greenwich admitted services were expected to 'come under a degree of pressure', but said it was working with GPs to plan ahead.

'Greenwich regularly hosts major events such as the London Marathon with minimal disruption,' she said. 'It is not expected large numbers of visitors will directly access GP surgeries but if this is the case, retrospective payments will be considered in exceptional circumstances.'

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References:

1. Data on file.
2. IMS Health, MPA™ Monthly, TRxs, October 2006 - November 2011
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The BMA must hold its nerve

The backlash, when it came, was as fierce as it was predictable. The morning after the BMA announced the first industrial action by doctors since 1975, the national media let rip, and GPs in particular were the focus of their ire. 'Doctor, doctor, why is my GP going on strike?' asked the front page of the *Independent*. 'Because a £53,000-a-year pension deal isn't enough…'

The BMA has always been aware of the PR difficulties in taking a stand over pensions. But for rank-and-file GPs, the sheer vitriol of the criticism has come as a shock – particularly for those who have been directly challenged by patients.

Steve Nowottny
Acting editor

Intellectually supporting doctors' right to defend their pensions from an unjustified hike in contributions is one thing. Explaining to an angry patient paid a quarter of what you are why he won't be able to make an appointment is quite another.

It's unsurprising, then, that many GPs are wavering. It remains to be seen how many surgeries do close their doors to routine appointments on 21 June, and some have yet to decide. But our snapshot poll this week suggests a fair proportion of the 79% of GPs who voted for action won't actually carry it out.

What can the BMA do to shore up support? For a start, it must lead from the front, and from the very top. That almost two weeks after BMA Council unanimously approved industrial action just one out of 10 GPs on BMA Council was able to confirm his practice would definitely be participating is surprising. And while the need to consult with partners is understandable, the refusal by some to even discuss their own practice's participation is less so. Grassroots GPs have legitimate concerns about patient safety, public perception and contractual repercussions, and certainly deserve to know whether their leaders who have drawn the battle lines will be leading them over the top.

Secondly, in order to achieve meaningful movement on pensions, the BMA will have to dig in for a sustained campaign – and show it is willing to do so. That means talking now about the possibility of further days of action. But it also means seriously considering action targeted less at patients and more at the bureaucracy of healthcare – including, perhaps, a boycott of commissioning.

Significantly, the LMC conference voted for just that last month, and the BMA's Annual Representative Meeting will consider a similar motion shortly. And even without official sanction there are signs that some GPs may quit commissioning groups of their own accord. The BMA so far has been determined to avoid conflating the NHS reforms with pensions. But targeting commissioning would give ministers pause for thought, and garner wider GP support.

Finally, media backlash notwithstanding, the BMA must hold its nerve. It is committed now, and must stay the course.

The protest on 21 June is more of a test for the BMA than the Government, to see if it has the grassroots muscle and political stomach for a fight. But if the day of action heralds a summer of doctors' discontent – and GPs' disengagement with commissioning leaves a vacuum just as PCTs start to wind down – it may yet be ministers who feel the heat.

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

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*Providing the first injection is given during the first five days of a normal menstrual cycle and subsequent injections are given no later than twelve weeks and five days after the previous injection.

In adolescents, Depo-Provera may be used, but only after other methods of contraception have been discussed with the patient and considered unsuitable or unacceptable.

As with all LARC prescriptions a barrier method should always be advised to provide protection against sexually transmitted diseases.

Depo-Provera® 150 mg/ml powder and solvent for suspension for injection
ABBREVIATED PRESCRIBING INFORMATION (UK)

Please refer to the SmPC before prescribing Depo-Provera 150 mg/ml. **Presentation:** 1 ml Disposable syringe, containing 150 mg medroxyprogesterone acetate in a Sterile suspension for injection. **Indication:** Long-term contraceptive agent, in women who have been counselled concerning the likelihood of menstrual disturbance, potential delay in return to full fertility and risks of bone mineral density losses. Short-term contraception for the following (i) for partners of men undergoing vasectomy, until the vasectomy becomes effective, (ii) in women who are being immunised against rubella (iii) in women awaiting sterilisation. May only be used in adolescents after other methods of contraception were considered to be unsuitable. **Dosage:** *First Injection:* 150mg intramuscular injection during the first 5 days of a normal menstrual cycle. *Post Partum:* Within 5 days post partum (if not breast-feeding). Women in puerperium can experience prolonged and heavy bleeding, therefore caution is required, and women should be advised accordingly. If the puerperal woman will breast-feed, the initial injection should be no sooner than 6 weeks post partum. *Further doses:* These should be given at 12 week intervals, however as long as the injection is given no later than 5 days after the 12 week interval, no additional contraception measures are required. For partners of men undergoing vasectomy, a second injection 12 weeks after the first may be necessary in a small proportion of patients where the partner's sperm count has not fallen to zero. If the dose repeat interval is greater than (>) 13 weeks (12 weeks and 5 days) for any reason, then pregnancy should be excluded before the next injection is given and the patient should use additional contraceptive measures (e.g. barrier) for fourteen days after this subsequent injection. Elderly: Not applicable. Children: Depo-Provera is not indicated before menarche. Data in adolescent females (12-16 years) is available, *Refer to the Summary of Product Characteristics* for further information. Other than concerns about loss of BMD, the safety and effectiveness of Depo-Provera is expected to be the same for adolescents after menarche and adult females. Depo-Provera may be poorly metabolised in patients with severe liver insufficiency. No dosage adjustment is required for renal insufficiency. **Administration:** Deep intramuscular injection. The sterile aqueous suspension should be vigorously shaken just before use to ensure the dose being given represents a uniform suspension. **Contraindications:** Known sensitivity to medroxyprogesterone acetate or any of its ingredients. Pregnancy. Known or suspected hormone-dependent malignancy of breast or genital organs. Patients with presence or a history of severe hepatic liver disease where liver function has not returned to normal. Patients with abnormal uterine bleeding, whether administered alone or in combination with oestrogen until a definite diagnosis has been established and the possibility of genital tract malignancy eliminated. **Special Warnings and Precautions:** Use of Depo-Provera reduces serum oestrogen levels and is associated with significant loss of BMD due to the known effect of oestrogen deficiency on the bone remodelling system. Bone loss is greater with increasing duration of use, however BMD appears to increase after Depo-Provera is discontinued and ovarian oestrogen production increases. In adolescents and women with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered before using Depo-Provera. Results from a study support the conclusion that the higher observed incidence of fractures among DMPA users was principally a result of factors other than exposure to DMPA. DMPA injection can be used for 2 years as both contraceptive method or endometrial treatment if other birth control methods or endometrial treatments are inadequate. BMD should be evaluated when a female needs to continue use of DMPA injection long-term, in adolescent females, interpretation of BMD results should take into account patient age and variability in density. The administration of Depo-Provera usually causes disruption of the normal menstrual cycle. Bleeding patterns can include amenorrhoea. Women should be counselled that there is a potential for delay in return to full fertility following use of the method, regardless of the duration of use. Long-term case-controlled surveillance of Depo-Provera users found no overall increased risk of ovarian, liver, or cervical cancer and a prolonged, protective effect of reducing the risk of endometrial cancer in the population of users. *Refer to the Summary of Product Characteristics* for further information. There is a tendency for women to gain weight while on Depo-Provera therapy. Reports of anaphylactic responses (including facial reactions, anaphylactic shock, anaphylactoid reactions) have been received. Should the patient experience pulmonary embolism, cerebrovascular disease or retinal thrombosis while receiving Depo-Provera, the drug should not be re-administered. Patients with a history of endogenous depression should be carefully monitored. Some patients may complain of premenstrual type depression while on Depo-Provera therapy. As with any intramuscular injection, especially if not administered correctly, there is a risk of abscess formation at the site of injection, which may require medical and/or surgical intervention. Patients with a history of the following conditions should be carefully monitored: endogenous depression (including premenstrual-type depression), migraine or unusually severe headaches, acute visual disturbances of any kind, pathological changes in liver function or hormone levels. Diabetic patients should be carefully monitored while receiving DMPA; increases and decreases in total cholesterol, triglycerides and low density lipoprotein (LDL) cholesterol have been observed. DMPA does been associated with a 15-20% reduction in serum high density lipoprotein (HDL) cholesterol levels. Potential for an increased risk of coronary disease should be considered prior to use. Doctors should carefully consider the use of DMPA in patients with recent thromboembolic disease before levels of human chorionic gonadotrophin have returned to normal. Pathologists should be informed of the patient's use of Depo-Provera if endometrial or endocervical tissue is submitted for examination. Results of certain laboratory tests may be affected. *Refer to the Summary of Product Characteristics* for further information. **Drug Interactions:** Aminoglutethimide, administered concurrently may significantly depress hormone levels. The possibility of interaction (including oral anticoagulants) should be borne in mind in patients receiving concomitant treatment with other drugs. **Pregnancy and Lactation:** Check for pregnancy before initial injection, and also if administration of subsequent injection is delayed beyond 88 days (12 weeks and 5 days). **Side-effects:** The following adverse events were commonly reported (by more than 5% of subjects): menstrual irregularities (bleeding and/or amenorrhoea), weight changes, headache, nervousness, abdominal pain or discomfort, dizziness, asthenia (weakness or fatigue). Further adverse events reported (by 1% to 5% of subjects) include: decreased libido or energy, backache, leg cramps, depression, nausea, insomnia, leucorrhoea, acne, vaginitis, pelvic pain, breast pain, no hair growth or alopecia, bloating, rash, oedema, hot flushes. *Refer to the Summary of Product Characteristics* for more detailed information on side-effects. **Package Quantities and Basic NHS Cost:** Single 1ml syringe pack: £21.01. **Legal Category:** POM. **Marketing Authorisation Number and Holder:** PL 00057/0065, Pfizer Limited, Ramsgate Road, Sandwich, CT13 9NJ, UK. **Last Updated:** January 2012. Further information is available on request from: Medical Information at Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS, UK. Tel: +44 (0) 1304 616161 **Ref: DP d_0**

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk.
Adverse events should also be reported to Pfizer Medical Information on 01304 616161

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UK/DPR/11/0002 Date of preparation: January 2012

Advertisement Feature

Next steps in antidepressant selection

What to consider when first line pharmacological treatment for depression does not succeed

Drug treatment of depression frequently involves switching to find a drug that works well for the individual patient, either because of adverse events or poor response to the first line agent.[1]

Regular review of patients receiving antidepressants can help to ensure that patients who are not responding are considered for further treatment, referral or alternative medication.[2]

The first treatment selected may not achieve remission of symptoms, and a number of treatment steps may be needed.[3] However successive trials of therapy can result in lower remission rates and higher relapse rates (Fig 1).[3]

NICE guidelines (CG90) for drug treatment recommend initial use of a generic Selective Serotonin Re-uptake Inhibitor (SSRI), but if response is limited or absent, or side effects occur, consider switching to an alternative antidepressant.[4] When switching antidepressants, NICE recommends considering, initially, a different SSRI or a better tolerated newer –generation antidepressant.[4] Use of the SSRI Cipralex (escitalopram) in the care pathway, in such circumstances, is consistent with national guidelines (NICE CG90).[4]

Use of Cipralex in patients who have not responded to initial therapy makes clinical and financial sense.

An independent meta-analysis conducted in nearly 26,000 patients with major depression showed that Cipralex was one of two antidepressants judged to have achieved the best possible balance between efficacy and acceptability.[5] Cipralex was also superior to citalopram ($p \leq 0.02$) in achieving acute response and remission in major depression (after 6-12 weeks) in an independent Cochrane review.[6]

In their health economic analysis, NICE found Cipralex to be one of the most cost-effective SSRIs (after sertraline) in both moderate and severe depression.[4] In a UK primary care record database study, usage of Cipralex in patients with severe depression was associated with fewer hospitalisations (all causes) compared with generic SSRIs and venlafaxine.[7] The overall cost of treatment was no higher with Cipralex than with generic SSRIs and was significantly lower ($p<0.0001$) than with venlafaxine in patients with severe depression (Fig 2).[7]

Use of Cipralex can represent a good use of NHS resources.

More information on depression and Cipralex can be found at: www.challengingdepression.co.uk

Lundbeck

Cipralex® escitalopram

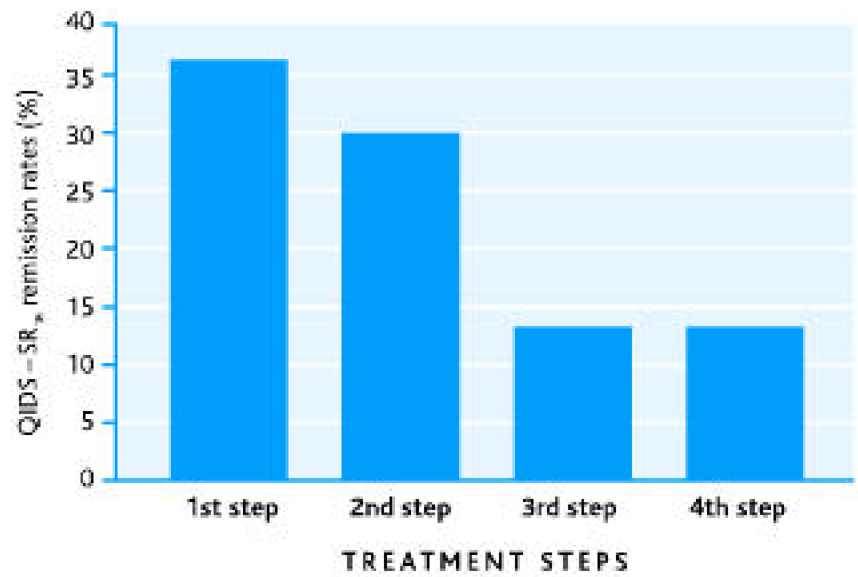

Figure 1. Acute remission rates by treatment step. Adapted from STAR*D, Rush et al.[3]

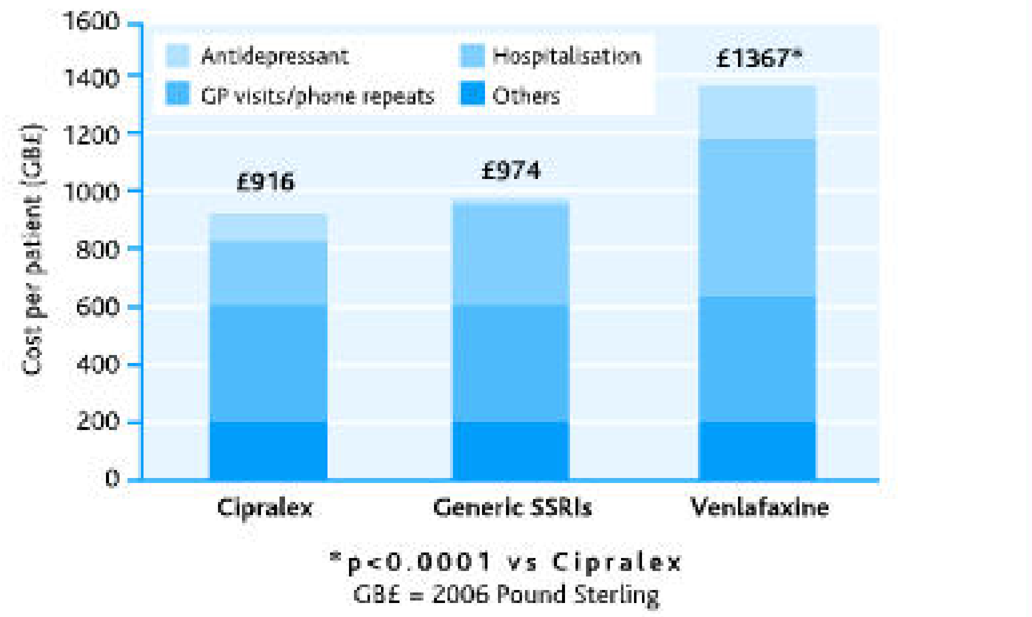

Figure 2. Total cost distribution per treatment group in severe depression for 12-month period following index date of study inclusion. Adapted from Wade et al, 2010[7]

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Abbreviated Prescribing Information.

Cipralex® (escitalopram) Tablets and Oral Drops, Solution
Prescribing information: Please refer to the full Summary of Product Characteristics before prescribing, particularly in relation to side effects, precautions and contra-indications. **Presentation:** Tablets containing 5, 10 or 20 mg of escitalopram (as the oxalate). Cipralex oral drops, solution containing 20 mg/ml escitalopram (as the oxalate); each drop contains 1 mg escitalopram. **Indications:** Treatment of major depressive episodes, panic disorder with or without agoraphobia, social anxiety disorder (social phobia), generalised anxiety disorder and obsessive-compulsive disorder. **Dosage:** Depression: 10 mg once daily. Dose may be increased to a maximum of 20 mg daily. Treatment for at least 6 months is required. Panic disorder: 5 mg for the first week increasing to 10 mg daily and, if needed, 20 mg daily. Maximum effectiveness is reached after about 3 months. Social anxiety disorder: Usual dose 10 mg once daily until symptom relief obtained (usually 2-4 weeks). Dose may be decreased to 5 mg or increased to a maximum of 20 mg daily. Treatment for 12 weeks is recommended. Treatment should be re-evaluated regularly. Generalised anxiety disorder: Initial dose 10 mg once daily. May be increased to a maximum of 20 mg daily. Obsessive-compulsive disorder: Initial dose 10 mg daily, increased to a maximum of 20 mg if required. Elderly (>65 years): Initial dosage is 5 mg once daily. Depending on individual patient response the dose may be increased up to 10 mg daily. Children and adolescents (<18 years): Not recommended. **Reduced hepatic function:** 5 mg daily for the first 2 weeks in mild-moderate impairment, increasing to 10 mg, if required. Use with caution and careful dose titration in severely impaired hepatic function. **Reduced renal function:** Use with caution in severely reduced renal function (CLCR 30ml/min). **Contra-indications:** Hypersensitivity to escitalopram or excipients. Use in combination with non-selective, irreversible monoamine oxidase inhibitors (MAOIs). Use in combination with reversible MAO-As (moclobemide) or linezolid. Use in patients with known QT interval prolongation or congenital long QT syndrome. Use together with medicinal products that are known to prolong the QT interval. **Fertility, pregnancy and lactation:** Do not use in pregnancy unless clearly necessary. Breastfeeding is not recommended. SSRI use in pregnancy, particularly in late pregnancy, may increase the risk of persistent pulmonary hypertension in the newborn (PPHN). **Precautions:** Possible risk in ability to drive a car or operate machinery. Alcoholic drinks not advised. Co-administration with serotonergic compounds not recommended. Insulin and/or oral hypoglycaemic dosage may require adjustment. Use with caution in patients at risk of hyponatraemia, with a history of mania/hypomania, undergoing ECT, with epilepsy (discontinue if seizures begin for the first time or increase in frequency), with bleeding disorders or taking medicines that will affect clotting of blood or platelet function. Escitalopram has been found to cause dose-dependent prolongation of the QT interval. Caution is advised in patients with coronary heart disease, significant bradycardia, recent myocardial infarction or uncompensated heart failure. Correct electrolyte disturbances such as hypokalaemia or hypomagnesaemia before treatment. Consider ECG review in patients with stable cardiac disease before treatment. Withdraw treatment and perform an ECG if signs of cardiac arrhythmia occur. Do not stop treatment abruptly. Closely supervise patients, especially those at high risk, for suicide-related behaviours during first few weeks of treatment, until improvement occurs. **Drug interactions:** MAOIs, MAO-A and MAO-B inhibitors. Potential interaction with serotonergic medicines (e.g. triptans), lithium, tryptophan, St John's wort, products which may lower the seizure threshold, omeprazole, esomeprazole, lansoprazole, fluvoxamine, ticlopidine and cimetidine. Caution in poor metabolisers of CYP2C19. Use caution with drugs metabolised by the enzymes CYP2D6 or CYP2C19. Co-administration with medicinal products that prolong the QT interval, such as Class IA and III antiarrhythmics, antipsychotics (e.g. phenothiazine derivatives, pimozide, haloperidol), tricyclic antidepressants, certain antimicrobial agents (e.g. sparfloxacin, moxifloxacin, erythromycin IV, pentamidine, anti-malarial treatment particularly halofantrine), certain antihistamines (astemizole, mizolastine) etc., is contraindicated. **Adverse events:** Adverse reactions are most frequent during the first or second week of treatment and include nausea, decreased or increased appetite, increased weight, anxiety, restlessness, abnormal dreams, decreased libido, anorgasmia in females, insomnia, somnolence, dizziness, paraesthesia, tremor, sinusitis, yawning, diarrhoea, constipation, vomiting, dry mouth, increased sweating, arthralgia, myalgia, ejaculation disorder, impotence, fatigue and pyrexia. Thrombocytopenia, anaphylactic reaction, hyponatraemia, anorexia, serotonin syndrome, convulsions, psychomotor restlessness/akathisia, mania, suicidal ideation, suicidal behaviour, QT prolongation, ventricular arrhythmia including torsade de pointes, gastrointestinal haemorrhages, hepatitis and angioedemas have also been reported. Abrupt cessation may produce discontinuation symptoms. Studies in patients ≥50 years of age, show an increased risk of bone fractures in patients receiving SSRIs and TCAs. ECG monitoring is advisable in overdose. Prescribers should consult the full Summary of Product Characteristics in relation to other side effects. **Legal category:** POM. Cipralex Tablets 5 mg (PL 13761/0008) 28 tablets £8.97; 10 mg (PL 13761/0009) 28 tablets £14.91; 20 mg (PL 13761/0011) 28 tablets £25.20. Cipralex 20 mg/ml oral drops (PL 13761/0028) 1 bottle x 15ml £20.16. **Further information available from:** Lundbeck Limited, Lundbeck House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LG. ® Cipralex is a Registered Trade Mark © 2012 Lundbeck Limited. **Date of last revision of PI** February 2012.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to Lundbeck Limited,
Medical Information, on: 01908 638972.

Job Code: UK/ESC/1202/0350 **Date of preparation:** March 2012

Standardised into submission

CQC registration is the ultimate example of bonkers bureaucracy, says **Copperfield** – and we're expected to pay for the privilege

Once upon a time, though not actually all that long ago, someone who really, really hated general practice decided to devise something really, really stupid that would really, really wind us up.

And that, for those of you perplexed, frustrated and dismayed from reading the BMA's guidance on the process – and for those who haven't yet had the pleasure – is how CQC registration was born.

I've come across plenty of bonkers bureaucracy in my time, but this takes the whole pack of Hobnobs.

It is the epitome of some officious twat with a clipboard, and no knowledge of general practice, ticking boxes and causing trouble.

Yes, I know it doesn't only apply to GPs – dentists enjoyed the process so much they started drilling holes in their own skulls. It just feels like it does.

Here's the guidance in numbers.

Forty-six pages. Sixteen 'essential standards of quality and safety'. Fifteen 'regulated activities that can trigger the need to register with the CQC'.

Thirty-two mentions of the word 'compliant'. Twenty-seven 'procedures' or 'protocols'. Eighteen 'enforcements'. Eleven 'prosecutions'. Three 'suspensions'.

And 40,000 GPs vomiting

Boycotting the CQC would have galvanised the entire profession

noisily in a corner.

Basically, we're going to spend an awfully long time demonstrating we're excellent at documenting lots of policies and procedures, or we'll get punched in the face, repeatedly.

And for kowtowing to this process – remember, possibly the most annoying thing that's happened to us, ever – we'll have to pay.

Yes. We. Will. Have. To. Pay. An as-yet undisclosed amount. Every year.

Not only have we been

ILLUSTRATION: JOHN LEECH

irritated by a bloke with a clipboard – and for some reason, in my mind's eye, he's almost certainly wearing a moustache, even if he's a woman – we've been mugged by him, too.

And, of course, CQC registration is just the tip of the iceberg.

I was discussing with my partners recently why, these days, we so rarely innovate within our practice. The answer, as they pointed out, is obvious.

We're paralysed by everything that is handed down from on high: thanks to NICE guidance, appraisal, revalidation and now the CQC, we no longer have time to think, the latitude to experiment, the energy to drive forward.

To remedy the perceived shortcomings of a tiny minority, we're all stifled and standardised into submission.

And while we're distracted into proving what a good job we're doing, we are, of course, unable to do a good job – an irony lost only on those who devise these insane initiatives.

Well, BMA. Have you missed an open goal here? Thanks for the 46 pages of guidance. But maybe this was a time when we should probably have said 'enough' rather than 'here's how you do it'. Particularly given that we've been looking for 'action' to highlight our pension rage.

Boycotting the CQC process would have galvanised virtually the entire profession. We all know that, sooner or later, like all lunatic bureaucracy, it'll be scrapped by some politician banging a 'let's slash red tape' drum.

Why didn't we pitch for the happy ending by forcing the issue now – to save time, and our souls from being destroyed?

Dr Tony Copperfield is a GP in Essex. You can follow him on Twitter @DocCopperfield

'A day that will go down in infamy – except it won't'

I mean, what is the point? Just what is the sodding point of a strike that doesn't inconvenience anybody? We're planning to withdraw our labour on Thursday 21 June 2012, a day that will go down in infamy. Except that it won't, because we aren't. We'll all turn up at the office as usual like good little soldiers and spend the entire day scratching our arses. We'll be so bored that Mrs Incopad's repeat prescription update for tolterodine might find itself redefined as an 'urgent' problem, rather than 'a matter of urgency', just so we can do something, anything, to pass the time.

Considering that it's taken 40 years to organise a strike, we could at least have done it properly. Taken a week off, barricaded the hospital doorways, let the homeopaths, witch-doctors, nutritionists and crystal healers have the healthcare arena to themselves for a few days to see how patients got on without us.

But if it is only going to be a day, at least bugger off out of there. Hit the golf courses en masse, even if you don't play golf. Better still, particularly if you don't play golf, in the name of comedic irony...

Read the full blog at pulsetoday.co.uk/copperfield

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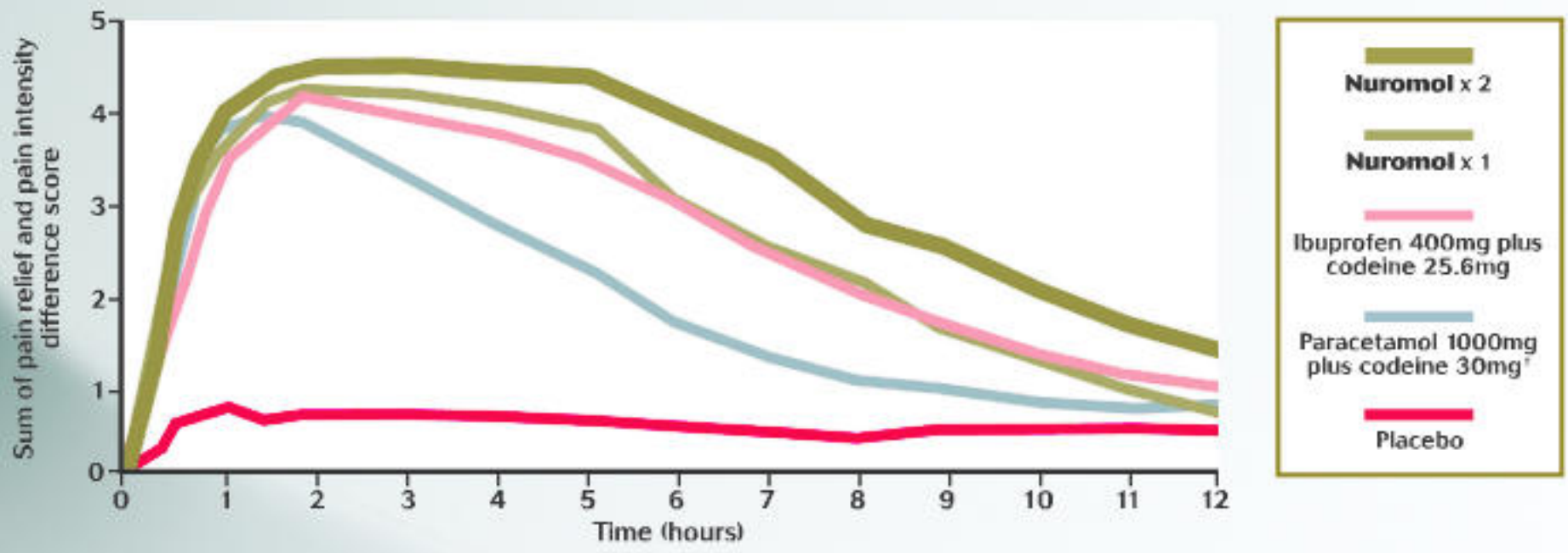

The outcomes of a dental pain study comparing the efficacy and tolerability of a novel single tablet combination of ibuprofen and paracetamol with that of an ibuprofen/codeine combination and a paracetamol/codeine combination using the dental impaction pain model.[1] This comparison relates to cumulative pain relief over 12 hours following a single dose.

† The maximum allowed OTC dose in the UK is 1000mg paracetamol plus 25.6mg codeine.

NUROMOL does not contain actives known to cause addiction

Nuromol 200mg/500mg Tablets (film-coated) Essential information **Refer to the SmPC for full details.**

Active ingredients: Each tablet contains ibuprofen (200mg) and paracetamol (500mg). **Indications:** For the temporary relief of mild to moderate pain associated with migraine, headache, backache, period pain, dental pain, rheumatic and muscular pain, pain of non-serious arthritis, cold and flu symptoms, sore throat and fever. This product is especially suitable for pain which requires stronger analgesia than ibuprofen or paracetamol alone. **Dosage instructions:** Adults over 18 yrs: One tablet to be taken up to three times per day with water. If needed, dose may be increased to two tablets three times a day. Leave at least six hours between doses. Maximum of 6 tablets per 24 hours. To minimise side effects it is recommended that patients take Nuromol with food. If symptoms persist, worsen or if the product is required for more than 3 days, the patient should consult a doctor. Elderly: The lowest effective dose should be used for the lowest possible duration. The patient should be monitored regularly for gastrointestinal bleeding when using a NSAID. **Contra-indications:** Known hypersensitivity to ibuprofen, paracetamol or any other excipients. History of hypersensitivity reactions associated with acetylsalicylic acid/NSAIDs. History of, or an existing gastrointestinal ulceration/perforation or bleeding, defects in coagulation, severe hepatic failure, severe renal failure or severe heart failure. Do not give : in concomitant use with other paracetamol-containing products, in concomitant use with other NSAID containing products, including cyclo-oxygenase-2 (COX-2) specific inhibitors and doses of acetylsalicylic acid above 75 mg daily, during the last trimester of pregnancy. **Side effects, precautions:** The risk of paracetamol overdose is greater in patients with non-cirrhotic alcoholic liver disease. Immediate medical advice should be sought in the event of an overdose, even if the patient feels well, because of the risk of delayed, serious liver damage. Caution is required in elderly patients and in patients with certain conditions: respiratory disorders, cardiovascular, cerebrovascular, renal and hepatic impairment, gastrointestinal bleeding, ulceration and perforation, SLE and mixed connective tissue disease. Serious skin conditions and impaired female fertility may occur. **Warnings for use:** do not give to patients who have taken ibuprofen or paracetamol in the last 6 hours; do not give in combination with paracetamol or NSAID containing medicine.Common side effects: abdominal pain, diarrhoea, dyspepsia, nausea, stomach discomfort and vomiting. Increase in amino-transferase, gammaglutamyltransferase, blood creatine, blood urea, liver disfunction. **Recommended retail price:** (ex. VAT): 6s £2.08, 12s: £3.33 and 24s: £5.83. **Supply classification:** P. **Marketing authorisation holder:** Reckitt Benckiser Healthcare (UK) Ltd, Slough, SL1 3UH Tel: 0500 455 456. **MA number:** PL 00063/0579. **Date last revised:** September 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Reckitt Benckiser Healthcare (UK) ltd on: 0500 455 456

Further information: For replacement leaflets or enquiries concerning this product, please contact our Medical Information Unit via email: **info.miu@reckittbenckiser.com**

References

1. RB Data on file: Study No. NL0811.2010. * Two Nuromol tablets compared with two tablets of Ibuprofen 200mg and Codeine 12.8mg.

Strike action will come to nothing

GPs who take part in the pension protest should be under no illusions that the Government will cave in, warns health minister **Simon Burns**

On 21 June, members of the BMA plan a day of strike action in protest against the proposed changes to their pensions.

This is incredibly disappointing news, most of all because of the disruption and distress it will inevitably cause to patients.

The action could see up to 30,000 operations cancelled, as many as 58,000 diagnostic tests postponed and more than 200,000 outpatient appointments rescheduled. The effects of this will echo through the NHS long after the strike is over.

The BMA has stated that patient safety will be its overriding priority during the industrial action. The public expects nothing less.

To this end, I call on the BMA to co-operate fully with all NHS organisations in planning for the proposed strike and its aftermath.

Of course, the NHS Constitution ensures the right of all NHS staff to representation through a trade union. Yet it also gives patients the right to wait no longer than 18 weeks from referral to treatment.

Just as those intending to strike are exercising their rights under the NHS Constitution, they also have a responsibility not to contravene the rights of their patients. I hope the BMA will publicly accept this obligation.

The offer we negotiated is the best available

The decision to strike is also disappointing because it is hard to justify on the facts.

During the negotiations on pension reform, our overarching aim has been to secure a deal that is both fair and sustainable for everyone who works in the NHS.

NHS staff deserve the best pension we can provide and I believe we have done exactly that. A doctor joining the NHS in three years' time, when the changes take effect, and who retires at the age of 68 can expect to receive a pension of £68,000 a year in today's money. That equates on average to around £4 for every £1 they pay in. The 24-year-old female junior doctor today can expect to live on average to the age of 94. That will mean 26 years of drawing a pension more than two-and-a-half times the UK average income, or more than £1.75m. It is hard to see how this can be described as anything other than fair.

It is particularly disappointing that industrial action is being taken – action from which other trade unions have refrained – so that doctors can pay less in their pension contributions than nurses and other less well-paid NHS workers. It is hard to see how this can be described as anything other than grossly unfair.

I know some claim that the current system is sustainable and hold up the fact that the scheme is currently running a surplus to support this argument.

But running a surplus is not the same as being sustainable.

The NHS Pension Scheme is currently collecting more in contributions than it pays out. This is because there are thousands more people working in the NHS than ever before, all contributing to the pension scheme.

In time, these staff will retire and start to draw a pension. Things could then look very different indeed.

Your pension is guaranteed by the Government on behalf of taxpayers. This guarantee will remain even if future contributions fall below the cost of the pension. There have also been claims that doctors will be forced to work until they are 68. This is not true. Doctors can choose to retire earlier, but obviously with a reduced pension. During these negotiations, officials met with the BMA 23 times and the secretary of state for health, Andrew Lansley, has met with BMA chair Dr Hamish Meldrum on five separate occasions.

The offer we negotiated with the BMA and with the other health trades unions is the best offer available.

I want to make it absolutely clear that the proposed industrial action has no chance of reopening these negotiations. All those intent on striking should understand that.

Public sector pensions need to be reformed. The secretary of state and I have worked hard throughout this process to ensure that everyone who works in the NHS secures the best possible pension.

I do not want doctors to take industrial action. I do not think patients would wish them to either.

Simon Burns MP is a health minister and the Conservative MP for Chelmsford

How could 50% of doctors not bother to vote?

LETTER OF THE WEEK

From Dr Colin Lees,
Airdrie, North Lanarkshire
via pulsetoday.co.uk

While being more than pleasantly surprised that a majority of doctors who voted in the pensions ballot agreed to take action, I am a little disheartened that apparently only 50% of doctors actually voted ('Doctors back industrial action over pensions in BMA ballot', pulsetoday.co.uk/news).

Does that mean they didn't get their voting papers? Or are they so apathetic that they didn't bother to vote? Or are they so overjoyed at the prospect of paying more, working until the age of 68 and getting less of a pension, that they had no reason to vote – not even to vote 'No, No'? Perhaps it was the thought that doing a day's emergency cover would produce a flood of 'catch-up' work the following day?

Why not refuse to co-operate with things we don't like but which have no effect on patient care – like refusing to be appraised or revalidated (both a waste of time). Any takers?

Give us parity with civil servants

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

A politician uses statistics like a drunk uses a lamp post – for support rather than illumination. But both sides of this argument are guilty of doing this – while the pension pot is in surplus at present, if you extrapolate it forward it will not be so plentiful.

The important part of the argument is the parity with other public servants. Why should there not be a single tiered contribution rate? Senior civil servants should not contribute half what we do and also retire at 55.

The BMA has failed us

From Dr Encarna Fernandez
Brent, north-west London
via pulsetoday.co.uk

I think that we should all leave the BMA. It has been unable to protect us from any Government changes, and it is still unable to get the right message across to the public and our patients who are thinking of us as greedy doctors.

One of my patients told me yesterday how he could understand why we wanted to go on strike – how could a doctor possibly live with a £58,000-a-year pension? I'm not sure what he has heard on TV, but I could understand his point when he is an unemployed builder and his daughter is the first generation in his family to go to university.

I will be taking action

From Dr Nicola Williams
Castleford, West Yorkshire
via pulsetoday.co.uk

This is not just about GP pay and pensions, it is an issue for all NHS staff. We have to start standing up for ourselves instead of moaning and letting the Government walk all over us as they usually do. The current pension increase is unjustified for all staff and we have to make our point. Our protests so far have failed, so what other options do we have? I will be striking.

We want to hear your views

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

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

Industrial action was backed by 84% of doctors who voted

Boycott commissioning instead

From Dr David Brownridge
Kidderminster, Worcestershire
via pulsetoday.co.uk

I applaud the LMC delegates for their common sense and realpolitik when they voted to disengage from commissioning ('LMCs demand pensions action includes commissioning boycott', pulsetoday.co.uk/news).

Dr David Bailey told the conference that a handful of GPs think clinical commissioning is a way of controlling colleagues. Let these doctors be universally reviled if they go against this democratic process.

From Dr Roderick Shaw
Edinburgh
via pulsetoday.co.uk

Commissioning and the QOF were the obvious targets for industrial action. The public wouldn't have cared, the *Daily Mail* would have struggled for a headline and the Government would have got the message. I fear now the BMA has been hoist by its own petard.

Let's highlight the true cost of pensions

From Dr David Iles
Southampton

In its *Say No to 30%* campaign, Pulse promised to highlight the truth and challenge the media inaccuracies regarding pensions. The media is still lumping consultants and GPs together - and nobody has ever mentioned the reality of up to 30% contributions.

While I don't want to split the profession, it's time to get the figures right - it's a simple matter of fairness. Too much rubbish is written in the press and this is crunch time, not only for doctors but for Pulse too.

Will your magazine honour its pledge to highlight the truth about contributions? I urge you to reactivate the *Say No to 30%* campaign.

Editor's note

Pulse has already begun publicising the sharp rise in pension contributions faced by GPs, with some success - for instance, our survey last month that found GPs were poised to take industrial action was covered in the *Daily Telegraph*. We're keen to do more, and will do our best to champion GPs' cause in the national press as the pensions dispute unfolds. Any thoughts on how we can best make the case would be very welcome.

Choose and Book shouldn't require training

From Dr Lisa Silver
Nettlebed, Oxfordshire

I was surprised to read your story on the Government's latest drive to get GPs to use Choose and Book, ('GPs to be forced to use Choose and

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Book', pulsetoday.co.uk/news).

The general public with no training whatsoever manages quite successfully to use eBay and Amazon. Yet Choose and Book, which arguably offers a service simpler than eBay, is so anachronistic, clunky, slow and unintuitive that GPs and practice staff have to be trained and have ongoing training on how to use it.

● From Dr Neil Bhatia
Yateley, Hampshire
via pulsetoday.co.uk

Those few patients who exert their 'choice' invariably come already armed with the name of the specialist they wish to be referred to.

They don't usually ask where else they could be seen other than the GP's first choice. They already know. If they haven't already printed off the internet details for you, it takes just a few moments in a Google search to find the address, fax number or, increasingly, email address of the chosen specialist.

And then of course comes the desperately labour-intensive 'sending hard-copy referral letters', faxing it (very time-consuming) or even emailing it if an @nhs.net address exists (crippling in its complexity). Get real, Department of Health.

And no, I won't be ringing to check appointment availability. I will send my referral letter to the patient's chosen specialist as requested and the patient can ring up and organise their own appointment.

Choose and Book has divided the profession

● From Dr David Shore
Brinklow, Warwickshire
via pulsetoday.co.uk

I have never used Choose and Book. It is cumbersome, labour-intensive and confusing to patients. I have no intention of starting to use it now. I offer my patients a choice and they all elect to go to the local hospital, so what's the point of it?

● From Dr Geoff Schrecker
Sheffield
via pulsetoday.co.uk

I am a regular user of electronic booking, but here in Sheffield the choice agenda is a non-starter. The question, 'would you like to be seen in Sheffield, Chesterfield or Rotherham?' is met with a wry smile. I always offer a choice, though the outcome is the same 99% of the time.

Choice is a London agenda with little relevance to the rest of us. Forcing the use of Choose and Book risks antagonising GPs further and will disadvantage those of us attempting to show the benefits of electronic booking.

Give Choose and Book a chance

From Dr Nigel Speak
Birmingham
via pulsetoday.co.uk

Choose and Book can work brilliantly when referrers and providers work together to make it happen and it has genuinely great potential value to us for the future.

In north Birmingham we've noted the many myths that discredit the service, and our major provider trust has sorted out many of the issues that need to be addressed by the provider – for example, with appointment slots and the directory of services.

We understand and support those colleagues who delegate Choose and Book issues to secretaries, and our IT support organisation has started a major project to support referrers and providers including infrastructure upgrades and training.

Nobody underestimates the challenges, but I urge the sceptics to keep an eye on the solutions which can make it work as a useful tool that will benefit everyone, and in particular our patients.

We need to rethink charging

From Dr Martin Harris
Barnet, north London
Founder of shinglesvaccine.co.uk

via pulsetoday.co.uk

Following the motion about non-NHS services at the LMC conference, I read the report and the comments on Pulse's story ('GP leaders demand right to charge for non-NHS services', pulsetoday.co.uk/news).

I was present at conference and followed this debate, which was not a repetition of the regular debate to find a method of charging our NHS-registered patients – which is illegal.

I would like to give one personal example.

The shingles vaccine is now available in the UK and licensed for the over-50s, but not allowed by the NHS.

So currently I can provide this vaccine privately to anyone except my own registered NHS patients.

A 79-year-old lady with multiple system disease recently wrote to me after receiving the vaccine to say she was very happy to find a doctor who could offer it.

Draw a line in the sand on boundaries

From Dr Atul Kothare
Coventry
via pulsetoday.co.uk

Practices are struggling to meet their existing needs while facing extra financial pressure from the boundaries pilot ('Boundary pilot practices could be swamped by 120,000 commuter patients, NHS research warns', pulsetoday.co.uk/news).

I recommend practices put up notices telling these commuters that they can't look after extra patients as there are no resources to do so, and that they only register new patients with a local address.

Let them complain to the PCT and then let it try to take action.

If the PCT tries to fiddle with your contract, then sue it or make it take legal action.

To ask a practice to take on such a huge number of patients with no funding is crazy and will not stand up in court. Time to draw a line in the sand.

Have you seen DVLA's HGV changes?

From Dr Hercules Robinson
Castletown, Caithness

Like most practices, we do a number of HGV examinations for the DVLA.

I checked the *At a Glance Guide to Current Medical Standards of Fitness to Drive* and was surprised to see that for Group 2, the visual acuity standards have changed.

The required acuity for the better eye is 6/7.5 rather than 6/9.

As far as I am aware, GPs have not been notified of the change and indeed we do not have a suitable Snellen chart with a 6/7.5 line. In addition, there seems to be an extra requirement for Group 1 visual acuity.

I was quite shocked that fundamental changes such as these were not notified to GPs in advance.

Don't dismiss drug firms joint working

From Stephen Whitehead
ABPI chief executive

I was disappointed to read your recent article on joint working schemes between the pharmaceutical industry and the NHS ('Drug companies to work with CCGs on care pathways and case finding under DH-backed scheme', pulsetoday.co.uk/news).

Joint working was painted in overly simplistic terms with little acknowledgement of the benefits these projects can bring, or the money and time they can save.

It is not, as your article implies, about industry trying to unduly influence clinical decision making – there are rules in place that strictly regulate joint-working projects.

There is also no basis for the claim that pharmaceutical companies are somehow buying influence through these projects.

Both the NHS and the company involved must make significant contributions to a project – in the case study in your article, the NHS funding considerably outweighed that provided by industry.

Joint working was not an idea conceived and driven by industry. Rather, it has had equal backing from the Department of Health since its inception.

Where innovative joint working projects benefit patients, we shouldn't dismiss the good work done on their behalf based on old prejudices and outdated stereotypes.

I can't wait to work with drug firms

From Dr Saj Azfar
Rochdale
via pulsetoday.co.uk

It's interesting how a bit of a financial squeeze alters the Government's focus.

There was plenty of money slushing around a couple of years ago and 'pharma' was a dirty word. Now look. Give over with all your doom and gloom.

Let's get down and dirty with them just like the DH wants – at expensive venues with pads, pens, cordon bleu dinners and fine wines.

Bring it on.

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 Pensions special

In this issue

Preparing for a day of action

Dr Laurence Buckman, GPC chair, advises practices on the practical steps they should take to get ready for 21 June

For most of us who voted in favour of industrial action over pensions it was a decision taken with regret; none of us will really have wanted to get to this stage. But the results of the ballot – which we only held after repeatedly trying to get the Government to the table for genuine negotiations – show how let down we feel. The fact that a majority of the 17,500 GPs who took part (representing a turnout of well over 50%) voted in favour of both industrial action short of a strike, and strike action, demonstrates how let-down we feel by the attack on the NHS pension scheme. It also represents a clear mandate.

Views within the profession on whether this is the right way forward are still mixed. But whatever your opinion, with the 21 June date now set, what's most important is that we respect each other's rights. That means no coercion or pressure on colleagues in either direction, and us all getting on with preparing for the day.

Patient safety has to be our number one priority. To help with this we would suggest that if you haven't done so already, you meet as a team to discuss the action and what the implications are for you as a practice. We would also recommend that you appoint a practice lead as co-ordinator. If all doctors in the practice want to take part in industrial action, the way ahead will be relatively straightforward.

If not, you need to reach agreement on operational issues. If as a partner you are not taking part in industrial action, but you employ salaried GPs who wish to take part, then be aware that arrangements for cover for staff participating in industrial action have to be made within the complement of practice staff. It is an offence to engage an agency to provide locum cover for doctors participating in industrial action.

Practices will also be under no obligation to pay salaried GPs taking part in industrial action, but we hope you will be supportive and, in particular, not make any deductions in pay. In a situation where partners wanted to take action but a salaried GP did not, it would be reasonable for partners to ask salaried GPs not to undertake routine appointments for the day.

When it comes to other staff working in the practice, as employers you will be expected to act reasonably in what you can ask staff to do on the day, so you shouldn't ask them to carry out additional duties not specified in their contract. However it would, for example, be reasonable to ask reception staff to operate a different system for booking appointments during the day. The GPC will shortly be issuing a core script to help reception staff dealing with patients' queries about the industrial action and the impact on their care.

Approaching your PCO

Once you have come to an agreement within your practice you will need to have a discussion with your PCO. Ideally, you want to be able to agree the extent of the service provided on the day of action itself. We have issued a template letter to send to your PCO giving them notice of your proposed arrangements. It would help us to monitor participation if you could also email a copy of the letter to your LMC, and to inbox.gppractice@bma.org.uk.

When it comes to non-clinical activities, these do not usually constitute urgent or emergency care. Some duties may, however, be necessary for the safe delivery of clinical services on the day of action. If so, you should engage and co-operate as necessary. There will also be activities taking place on the day that may have a serious impact on doctors or students if unfulfilled – for example participating in exams, interviews for training and so on. Where possible, these ought to be postponed but this may not always be possible.

Steps to action

1. Hold a practice meeting
2. Appoint a co-ordinator
3. Prepare your non-clinical staff
4. Agree services for 21 June with your PCO
5. Explain the action you are taking and the issues to patients

You may have time during the day that is not being spent on urgent or emergency care and you will need to take a decision on how best to spend it. We suggest you support colleagues who are carrying out urgent or emergency work, or take part in activities to raise awareness of the unfairness of the major changes to our pensions. It is up to you to take decisions about what other work could be done, which would still be compatible with the overall aim of having an impact.

Getting the message across

The other crucial priority is communication. The huge media coverage the ballot result has attracted means you have probably already had questions from patients about the action. Those whose appointments on 21 June need to be postponed should be given as much notice as possible and there should be clear information on your website and in your waiting room about your plans for service provision.

However, the communication challenge facing us is obviously not just explaining the mechanics of 21 June – it's about explaining why it's happening. In the face of a generally hostile media, and in the current economic climate, we might not get the public to support our action, but we can hope that they will understand why we are taking it. Adverts, in the form of a letter from BMA chair Dr Hamish Meldrum, appeared in three national newspapers the day after we announced the ballot results. The BMA will also shortly be distributing posters making the same points to help get the message across to your patients.

We have more detailed guidance on industrial action for GPs and a set of FAQs at bma.org.uk/nhspensionreform. As you will be aware by now, the form of action we are taking does not involve the full withdrawal of doctors' labour, and is not strike action as the term is normally understood by the public. Patient safety is our over-riding priority. Any patient who is, or believes themselves to be, in need of urgent and emergency care on 21 June should be seen. You should look to operate your usual systems for patients needing urgent attention that day, including telephone triage. You should also deal with urgent administration, for example reviewing test results and acting on abnormal results, in the normal way. Urgent prescription requests should be processed but routine repeat prescription requests should not. You should also continue to make proper clinical records on the patients you are managing, but you shouldn't do other administrative work if it is not urgent.

This is new territory for all of us. If you have any questions or need any advice please contact the BMA: ia@bma.org.uk.

Dr Laurence Buckman is GPC chair and a GP in Finchley, north London.

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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

The last time I took action, I slept on the streets in December

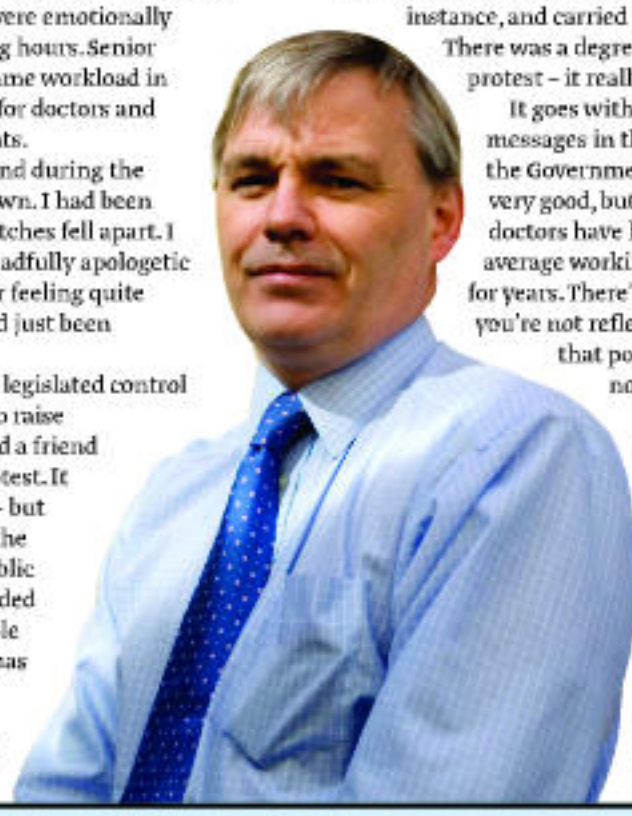
After campaigning for junior doctors' rights in 1989, Dr Sam Everington knows public support will be crucial in the pensions dispute

In 1989 I was a GP trainee, doing my hospital scheme and working at the Royal London. At the time we were working extremely long hours, which often led to chronic tiredness. We worked an average of 84 hours a week, and there were cases in which doctors worked as many as 120 hours. Research published at the time showed 28% of junior doctors had evidence of depression and 50% were emotionally disturbed – both linked to the long hours. Senior doctors argued they'd done the same workload in their day – but I felt this was bad for doctors and moreover a safety issue for patients.

In fact it had led to mistakes, and during the campaign I admitted one of my own. I had been sewing an episiotomy and the stitches fell apart. I felt terrible about it and I was dreadfully apologetic to the patient but I remember her feeling quite sorry for me, despite the fact she'd just been through labour.

So the junior doctors called for legislated control of the profession's working day. To raise awareness for the campaign, I and a friend slept outside the hospital as a protest. It was Christmas, and bitterly cold – but we got great coverage from both the BBC and ITV. We had amazing public support, too, as passing cars sounded their horns for us, and some people even brought us pies and Christmas dinner.

Afterwards the BMA got involved and began negotiations with the then health minister Virginia Bottomley. In the end, we managed to secure a new agreement.



To me, the main issue for any campaign is public support for what you're trying to achieve. Recently some NHS Direct staff did a 'work-in' – meaning they didn't get any headlines about going on strike and risking patient health. What would it be like if a whole raft of doctors refused to go home, for instance, and carried on working until they dropped? There was a degree of theatricality in the sleep-out protest – it really got our message across.

It goes without saying there's a raft of hidden messages in the pension debate. For instance, the Government might argue our pensions are very good, but they never mention the hours doctors have had to work to earn them. My average working week is 60 hours and has been for years. There's not a waking moment when you're not reflecting on patient care and I feel that point gets lost in the 'strike versus no strike' sort of headlines.

Our issue in 1989 was simple, but pensions will be a more difficult campaign because it's a more complex issue – although again it disproportionately affects younger doctors.

Dr Sam Everington is a GP in Tower Hamlets, east London, and was formerly deputy chair of the BMA

BMA ballot: the breakdown

How did GPs vote?

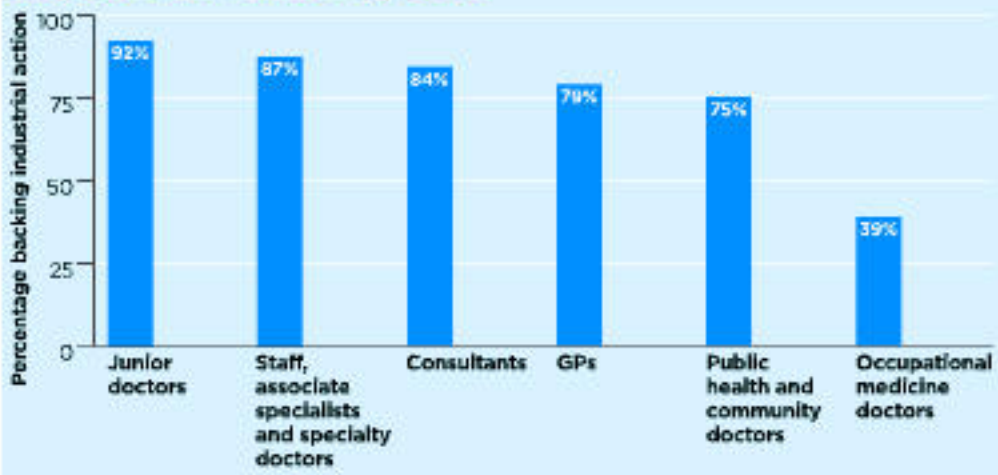
Are you prepared to take part in industrial action short of a strike?

Yes 79%
No 21%

Are you prepared to take part in a strike?

Yes 63%
No 37%

Support for action by craft



The votes

Source: BMA

Q who?

Qdem pharmaceuticals

Qdem is a UK pharmaceutical company that aims to provide a reliable supply of medicines to the NHS offering excellent value without compromising on quality.

enquiries@qdem.co.uk *+44 (0)1223 426929*

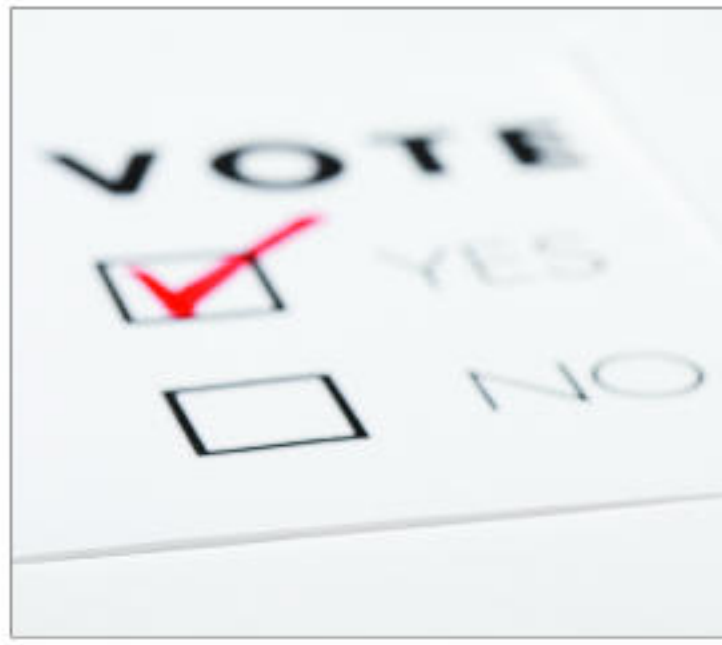
www.qdem.co.uk

Code: UK/QDEM-12003a

Date of preparation: April 12

Key questions for

Pulse answers some of the most pressing questions faced by GPs as they prepare for the BMA's 'day of action'



What action have GPs been asked to take?

Doctors taking part in the day of action will not do routine work, but GPs will still attend surgery for the whole day and see patients in urgent need of care.

The BMA says providing urgent and emergency care will consist of any treatment you believe cannot be safely postponed to another day.

Examples it gives include:

- in primary care, patients who consider themselves in need of urgent attention that day
- any patient who doctors feel uncomfortable postponing for clinical reasons
- emergency and urgent procedures, investigations and discharges for inpatients
- outpatients under close review for an unstable condition (for instance deteriorating Crohn's)
- documentation necessary for safe discharge and any urgent community care or follow-up
- attendances at A&E, labour ward or patients in early pregnancy.

When will doctors be taking action?

The first planned day of action is Thursday 21 June. The BMA has yet to decide whether it will hold further days of action.

Is it a strike?

No. On the ballot paper, the BMA asked whether doctors would be prepared to take strike action, but this was to provide the union with the necessary legal protection and to provide flexibility.

What happens if not all GPs in a practice wish to participate in industrial action?

Each practice will need to decide for itself how to operate. If not all partners wish to participate, an agreement should be reached on operational issues.

The BMA says it would be reasonable for a practice to ask a salaried GP or locum not to undertake routine appointments for the day and it would encourage all practices to support salaried and other colleagues who choose to participate in industrial action, regardless of the practice's stance. Employees are protected from unfair dismissal.

Do I have to take industrial action?

The BMA says it would strongly encourage you to support your colleagues by taking action or demonstrating your support (whatever you voted in the ballot). However, you are under no obligation to take part in the day of action.

Isn't the dispute really with the Government, and not my employer?

Although the dispute over pensions is with the Government,

Avoiding the legal pitfalls

Solicitors Rebecca Pallot and Philippa Doyle look at where GPs who are taking part in the industrial action stand legally

Any employed GP who is a member of a union that has properly authorised action (following a successful ballot of its members), or who is not a member of any union, can lawfully participate in industrial action.

A GP who is a member of a union that has not authorised action but takes it anyway will be acting unlawfully.

If the action is sanctioned by a union (official action), salaried GPs are entitled to certain employment protections. They cannot be dismissed for taking action and any such dismissal would be automatically unfair.

However, even action authorised by the unions is likely to amount to a breach of the contract of employment so legally GP practices do not, therefore, have to pay any member of staff for any day during which they are absent from work - even if they are only absent for part of a day.

Rules for partners

The position is different for self-employed GP partners who cannot rely upon the protection of employment legislation and who therefore have no pre-ordained right to strike.

If a GP partner decides to take action as a matter of principle, there are two key issues to consider within the partnership.

First, the partnership should consider whether it is viable for all the partners to take action, which could leave the business without access to an accountable person. Partners might not all be physically present on site each day and so long as they are not taking action they remain legally accountable.

But if the partners are officially taking action their status changes in this respect in that they are declaring they are not available either to perform their role or to undertake the responsibilities allotted to them.

Second, partners should consider how to resolve the costs of providing cover in circumstances where some partners elect to strike while others continue to work.

Delivering essential services

Inevitably, the absence of several GPs from a practice will cause disruption. The provisions of GMS, PMS and APMS contracts relate to the provision of essential, additional and enhanced services as part of core hours.

That does not mean all GPs need to be present on the premises at all times during core hours, but GPs need to work

21 June

and not an employer directly, lawful industrial action can still be taken. Trade union law recognises that a dispute about pensions is, in reality, a dispute between 'workers and their employer' as pension benefits form part of the employment contract.

Should locum GPs be taking industrial action too?

If a locum is contracted by the PCO, they can take part in action. However, if they are self-employed or employed by an agency, they will not have been balloted and therefore will not be allowed to take action.

More online

For more answers to frequently asked questions, and to post your own queries, go to pulsetoday.co.uk/pensions-ballot.

Protecting patient safety

Dr Michael Devlin, head of advisory services at the Medical Defence Union, explains how GPs can minimise clinical risk during industrial action

How do I honour my duty of care to patients?

All doctors have a contractual and ethical obligation to provide appropriate clinical services to their registered patients.

Ultimately it will be your decision as to whether or not a patient requires an urgent appointment on the day of 21 June.

You may be required to justify any decisions not to see patients, for example if a problem is not detected or if the patient's condition worsens.

It is important to always keep clear and comprehensive notes of any discussions that take place about a patient's health, including those where a patient's request for an appointment during industrial action is refused.

What about requests for prescriptions?

If a patient was to request an urgent prescription and also had non-urgent prescriptions to collect, for example, it's not obvious what you should do. It would be difficult to justify declining to issue an urgent prescription.

And while it might be possible to justify declining to provide an additional non-urgent prescription, the patient's individual circumstances would be relevant.

Some patients might be merely inconvenienced, others might be put in significant difficulties – for example if they rely on carers to collect medications for them.

What about urgent referrals?

If a patient called up with an urgent concern, for example if she had noticed a lump in her breast, although it could wait until the next day, most GPs would normally offer to see such a patient straight away if they could.

Even if you feel that clinically (from the perspective of managing the lump) the patient could wait to be seen, they are likely to be very worried. That anxiety could potentially be heightened if they have to wait before being seen, examined and given reassurance or urgent referral if necessary.

Rebecca Pallot

Philippa Doyle

carefully to ensure that their contractual obligations to the PCT are not compromised if they plan to take action.

Essential services must be provided throughout core hours. In practice, this is arranged through booked surgery sessions, with a GP and/or nurse being on site to deal with emergencies.

In the event that services cannot be delivered, then subcontracting of the services should be organised. This can be as simple as an arrangement with the out-of-hours service of a local practice, provided this is clearly notified to patients. This must as a minimum include information on the telephone answering system and notices within the practice and on the practice door on the day.

As much notice as possible should be given to patients, with no booked appointments being made for that day – in this case, 21 June.

However, whatever arrangements a practice puts in place for GP cover elsewhere, the PCT will be critical of a practice that is completely closed. So, where possible, nurse appointments should still be in place and reception should remain open as normal.

Ideally the practice should look to put a locum in place as a bare minimum. Legislation prevents practices hiring a temporary worker through an agency to perform the duties normally performed by a GP, but that does not stop the practice from bringing an existing employee from another part of the business to carry out the work, or from approaching and employing a temporary worker direct without the use of an agency.

Practices should be aware that the PCT may serve them with a breach notice for failure to deliver the full range of services if GPs are absent and the service suffers as a result (likely to be a notice requiring that the breach is not repeated).

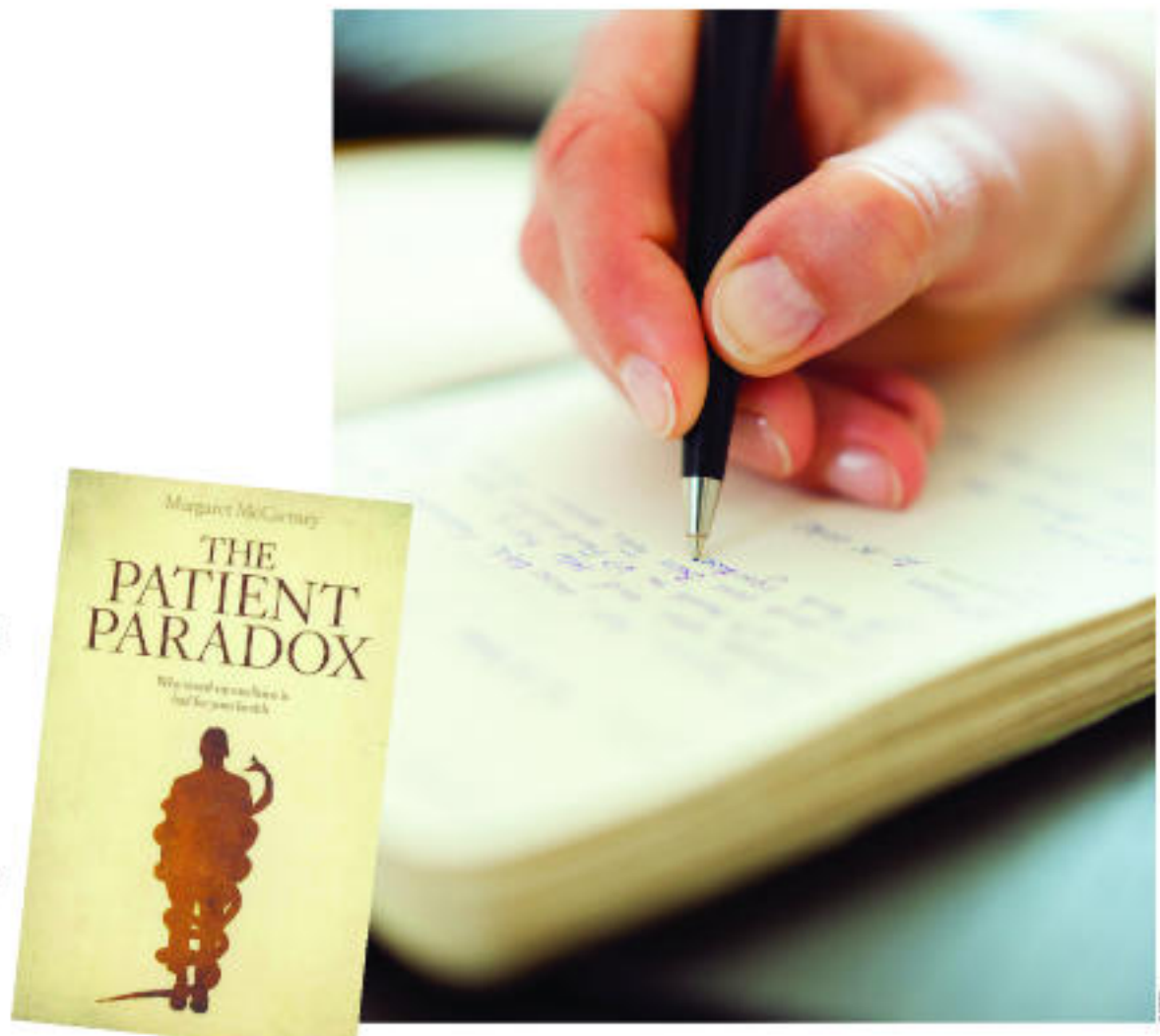
The PCT may also look to withhold monies from the practice in respect of that one day. Each PCT is likely to take a different approach, and its attitude may depend upon whether there are other points of issue between the PCT and practice.

Practices also ought to bear in mind that industrial action, if not handled well, can have an adverse impact on those employees who are not taking part. It would be advisable for practices to hold meetings with all their staff, in advance of action, to consider what temporary measures might be implemented to alleviate problems.

Rebecca Pallot and Philippa Doyle are associates at Hempsons Solicitors

GP clinical writing at its best

Pulse's clinical writing competition attracted a brilliant set of entries from GPs, covering a wide variety of styles – from pieces based on personal experiences of medicine, to tips and clinical opinion. Many were strongly argued or carefully reasoned – others took a rather lighter approach to the challenges faced by GPs. The best pieces – published here – win copies of Dr Margaret McCartney's new book, *The Patient Paradox*. But it would be a shame to waste such good entries, so we've also included some highly commended pieces



Perils of private medicine

WINNER

Dr Nicholas Ramscar is a GP registrar in Basingstoke

Politicians believe private medicine has the potential to save the NHS. I wonder if it can perform an even greater miracle – generating sympathy for a banker on the receiving end of expensive misinformation. Let's see.

At a wedding recently, on a Greek island, I was sat opposite a wealthy expat in his early 30s. Originally British, he was working in Dubai for a US company. Between drags on his cigarette, he was telling the group how he liked to look after his health, by splashing cash on an annual two-day check-up at a North American hospital. At his last visit he had been offered the opportunity to tailor his physical examination, and as he was a heavy smoker – 30 to 40 a day – he had asked them to concentrate on his lungs.

Any GP in this country could have told him that his chest X-ray and examination would be normal, at least for the time being. At 30 he might be merrily sowing, but he wouldn't be quite ready for the scythe yet. In private medicine though, minimal activity means minimal fees.

After a few words about the general dangers of smoking, the doctor auscultated and percussed, measured chest expansion and irradiated his customer. He pronounced himself satisfied that everything was normal, but was frank enough to say that his investigations so far didn't give a full picture. For a little extra, his client could have one more test done, just to make sure that he really was uniquely impervious to the effects of tobacco.

The group at our table was made up of educated people – financiers and oil company executives. They were broadly approving of his responsible attitude to his health, and most had had similar check-ups.

They were interested to know the result of his test, and he was happy to give a good description of his spirometry. He'd been delighted with the discussion that followed and recounted his words, and the doctor's, verbatim.

'So I asked him what the print-out said. The doctor looked pleased and told me: "The lung function tests have all come back normal."

"'Normal?" I asked. And he said: "One-hundred per cent." I was so relieved. And of course, I've carried on smoking.'

If an accurate representation of what he was told, this conversation represents the most high-ticket piece of bad advice I have ever heard. And here lies the rub of private medicine, competition and payment by activity.

This man was wealthy and educated – but not medically trained. He was no more qualified to see the absurdity of the service he bought than I would be able to run the finances of his company. He trusted the hospital to give him good advice and thorough investigation, although in fairness the clinic's concern sounds exemplary – before he left, it had arranged next year's appointment. With repeat spirometry added to the bill, to make sure nothing had changed.

Increasing private enterprise in healthcare will not improve its quality. The practice of medicine teaches tough lessons about the reliability of tests, the need to interpret them in context and the importance of applying experience.

People buying their care based on advertising brochures do not have the full facts or the hinterland of experience needed to interpret them. They are vulnerable to care that may be useless or downright dangerous.

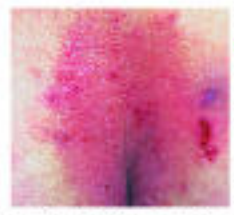
Currently in the NHS, GPs have a vital role in regulating access to healthcare. Economics and ethics demand we do our best to limit unnecessary medicine, because even the most non-invasive test can cause indirect harm. Increasing competition and private enterprise will make this harder.

TEN TOP TIPS

Skin problems in the traveller

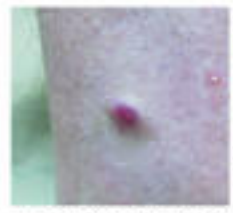
RUNNER-UP

Dr Sara Ritchie is a GP in Stoke Newington, north London, and clinical assistant in dermatology at University College London Hospital



1 Eczema is extremely common after travel

Eczema is often precipitated by or exacerbated by a change in climate. Heat and sweating can make eczema worse, and a cold, dry environment can also cause an exacerbation. Unless you suspect unusual infection, you will rarely go amiss with an initial two-week trial of a strong topical steroid – or topical steroid with antibiotic – to reduce any superimposed inflammation, helping guide any further investigation and management.



2 Insect bites can lead to nodular prurigo

Insect bites on exposed areas are common after travel to hot countries, but patients rarely remember being bitten unless they have had multiple bites. The pruritus caused by insect bites will frequently lead to scratching, which can result in the development of nodular prurigo. Treatment of nodular prurigo requires use of both emollients and potent topical steroids,

32

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Fostair should not be used as the first treatment for asthma, should not be initiated during an exacerbations, or during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. If patients find the treatment ineffective medical attention must be sought. Paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing, treat immediately. Patients should take Fostair as prescribed even when asymptomatic. Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for long periods. These effects are much less likely to occur with inhaled than with oral corticosteroids. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, growth retardation in children and adolescents, cataract, glaucoma and more rarely a range of psychological or behavioural effects (particularly in children). 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L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with NNRTIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertensive reactions. Risk of arrhythmias in persons receiving anaesthesia with halogenated hydrocarbons. Theoretical potential for interaction in sensitive patients taking disulfiram or metronidazole. **Pregnancy and Lactation:** No relevant clinical data. Should only be used during pregnancy or lactation if the expected benefits outweigh the potential risks. **Undesirable effects:** Common: pharyngitis, headache, dysphonia, viral upper respiratory tract infection, oral candidiasis, rhinitis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, atrioventricular arrhythmias, hyperaemia, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dyspepsia, dysphagia, burning sensation of the lips, nausea, dysgeusia, pruritus, rash, hyperhidrosis, muscle spasms, myalgia, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased. Rare: ventricular extrasystoles, angina pectoris, bronchospasm paradoxical, urticaria, angioedema, nephritis, blood pressure increased, blood pressure decreased. Very rare: thrombocytopenia, hypersensitivity reactions, adrenal suppression, glaucoma, cataract, atrial fibrillation, dyspnoea, exacerbation of asthma, growth retardation in children and adolescents, oedema peripheral, bone density decreased. Unknown: psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children). **Legal Category:** POM **Packs and Prices:** Fostair 100/6 (PL/0828/0155) £29.52. Each inhaler contains 120 actuations. ™ denotes Trademark. AeroChamber Plus® is a trademark of Trudell Medical International. Full prescribing information is available from the **Marketing Authorisation Holder:** Chiesi Limited, Cheadle Royal Business Park, Highfield, Cheadle, SK8 3GY. **Date of preparation:** February 2012.

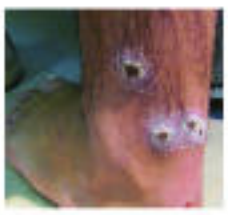
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Chiesi Limited. (address as above) Tel: 0161 488 5555.

1. FOSTAIR. Summary of Product Characteristics. Chiesi Ltd. October 2011. 2. De Backer W, Devolder A, Poli G, et al. Lung deposition of BDP/formoterol HFA pMDI in healthy volunteers, asthmatics, and COPD patients. J Aerosol Med Pulm Drug Deliv. 2010; 23(3): 137-143. **Date of preparation:** March 2012. CHI052012001(1).

Chiesi

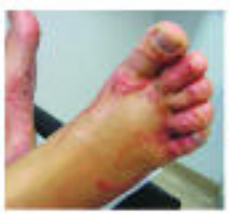
32 PULSE WRITING COMPETITION RESULTS

30 sometimes under occlusion. Histology may be necessary for a single nodule, or for treatment-resistant cases.



3 Ecthyma can be travel-related

If a patient presents with nodules on the limbs after travel, it is important to include travel-related ecthyma in the differential diagnosis. Ecthyma may be due to infection with staphylococcus or streptococcus, or after travel may be due to more unusual bacteria. Travel-related ecthyma can occur after direct trauma or from contact with wild animals. If suppurating or ulcerative lesions do not respond to a two-week course of a penicillin or second-generation macrolide, consider referral.



4 Cutaneous larva migrans is a common global infestation

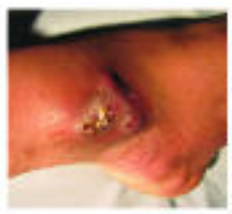
Cutaneous larva migrans is caused by canine hookworm larvae, for whom humans are accidental hosts.

This parasitic infection is widespread in the tropics and sub-tropics, and there is usually a history of walking barefoot on sand or soil.

The larvae cannot complete their life cycle or penetrate beyond the epidermis, and migrate slowly at a rate of 1-2cm per day.

This leaves an itchy, irregular red track with a typical clinical appearance.

Treatment is with albendazole 400-800mg (according to body weight) daily for three days, or ivermectin 200µg/kg stat dose. Avoid these drugs in pregnancy.

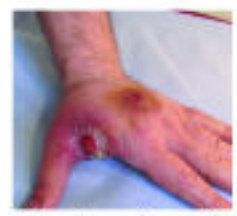


5 Always consider fungal infection

If the eruption has a well-demarcated border or pustular appearance, but is not responding to anti-inflammatory or anti-staphylococcal treatment, consider dermatophyte infection.

Consider deep fungal infection with unusual species in the traveller returning with slow-growing, progressive nodular lesions, particularly on the extremities.

Remember to take a good travel history, including exposure to bat or bird droppings, or exposure to spores in soil from tree planting.



6 Think of cutaneous leishmaniasis with slowly progressive lesions

Leishmaniasis is a parasitic infection transmitted via the bite of certain species of sand fly, which is now endemic in all countries bordering the Mediterranean.

It should be considered in any traveller returning from a country of endemicity who has unresolving skin lesions that slowly progress despite initial antimicrobial therapy.

The incubation period is typically a few weeks after the bite, with characteristic appearance initially as a papule, which slowly progresses to either dry or wet plaques with a raised, undermined edge.

Referral should be considered to the Hospital for Tropical Diseases in London.

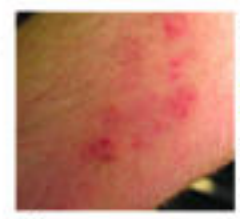
7 Coral and marine life can cause a dermatitis, or atypical mycobacterial infection

Skin contact with coral or other sea life from swimming, snorkelling or diving can lead to a persistent dermatitis.

Seabather's eruption is a relatively common dermatitis, occurring within hours of the toxin's release from particular sea anemone larvae which can become trapped under bathing suits or wetsuits.

Jellyfish stings can cause a persistent contact dermatitis with recurrent eruptions for some months after exposure.

Skin abrasions from coral can cause a contact dermatitis, or a nodular eruption. Atypical mycobacterial infection must then be considered.



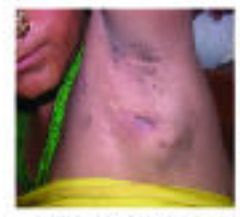
8 Consider empirical treatment if symptoms occur after a tick bite

Ticks can carry a variety of pathogens and can cause Lyme disease at temperate latitudes, or typhus or spotted fever at tropical latitudes.

The erythema migrans rash of Lyme disease is an expanding red annular plaque that can appear up to a month after an infectious bite.

Typhus or spotted fever can occur, typically from a tick bite on safari after visiting a game park. These cause a petechial rash, and if the patient is systemically unwell they may require admission.

Empirical treatment for all of these infections should begin as soon as the diagnosis is suspected, prior to serological confirmation. The drug of choice is doxycycline 100mg bd for two weeks.

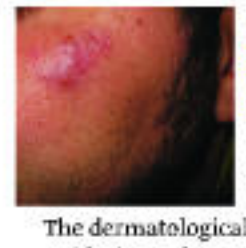


9 Include in the history country of origin and immunosuppression

The history is vitally important in getting on the right diagnostic track. Cutaneous tuberculosis can have a number of presentations and may need to be suspected in travellers who arrive from high-prevalence areas – such as the Indian subcontinent.

HIV often presents with skin manifestations and needs to be considered with travel from sub-Saharan Africa.

A history of current immunosuppressive medication is also crucial in helping with the differential diagnosis, as this may increase the risk of both unusual infections and malignant skin lesions.



10 Inflammatory disorders can arise coincidentally after travel

Inflammatory disorders can also present after travel.

The dermatological presentation of sarcoidosis can be protean.

Systemic lupus erythematosus and subacute lupus can present with a photosensitive rash.

If the patient has not responded to initial treatment measures, and you don't want to miss an inflammatory aetiology, request blood tests for FBC, erythrocyte sedimentation rate, TFTs, antinuclear antibodies, antineutrophil cytoplasmic antibody and angiotensin-converting enzyme, and consider a chest X-ray.

References

1 British Infection Association. The epidemiology, prevention, investigation and treatment of lyme borreliosis in UK patients: a position statement by the British Infection Association. *J Infect* 2011;62, 325-38

2 Reedy P. Leishmaniasis emergence in Europe. *Euro Surveill* 2010;15:pii-19605

3 Burnett J, Hepper K, Aurelian L et al. Recurrent eruptions following unusual solitary coelenterate envenomations. *J Am Acad Dermatol* 1987;17:86-92

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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.

Reference:
1. Attar A et al. Gut 1999; **44**: 226–230.

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When enough is enough

RUNNER-UP

Dr Clare Dyer is a GP in Watford

I have finally given in. I can no longer be that sounding board – the compassionate GP who will sit for 20 minutes (yes, a double appointment) and listen to the sob story of her life and how none of it is really her fault. Today, for the first time in 10 years of general practice, I have requested a patient is removed from my list.

What, you may ask, has driven me to this decision? For it is not something that is done very often in leafy Hertfordshire, and is a decision that I have agonised over for the last week.

A crime, for that is what she committed, will go unpunished bar me refusing to have any more to do with her. The patient has driven me to such anger with her and the system that I have declared a complete breakdown in the doctor-patient relationship. Last week my patient, who I have been nurturing through prescription medicine addiction, broke the final taboo and forged my signature.

I have been looking after her for the last nine months, the longest she has ever been a patient with a GP, starting with weekly appointments and gradually decreasing the frequency to monthly.

All prescriptions, however, have always been for a week at a time, with the rest post-dated for the following weeks. As with all addicts, I never really believed exactly what she told me, but I felt that we had developed a hint of honesty.

I made promises to her about not cutting her meds without her agreement and she was to be honest with me about all the medication that she took – both prescribed and over the counter, via the internet and the street.

It amazed me that the local drug and alcohol team believed everything she told them, including that she was taking at least 50% more than what I was prescribing. They made a plan with her on that basis.

Having said that I would never increase her prescription, I was then left with a dilemma – since the drug and alcohol team had put in writing how much they wanted her to have.

The final straw

Then – the week after they had discharged her back to my care and prior to me increasing her meds – she decided she couldn't hold out for two days until her next prescription. Firstly she tried to get her post-dated script dispensed early – something I now believe she has succeeded in doing at least once before – but after failing with this, rather than coming to see me she decided to alter the date on the scripts and forge my signature.

Luckily for her she bottled it, and came to the surgery, admitted her crime and handed

us the prescriptions rather than handing them into a pharmacist who I believe would have called the police. It is what happened next, though, that really angered me.

The NHS Counter Fraud Service is not interested because the health service has not lost any money. And my medical defence body says it is not a significant enough crime to warrant me breaking patient confidentiality by going to the police.

So the only punishment she will get is to have to go through finding another GP. To top it all she has put in a complaint to the PCT about her removal, arguing that it was unfair, and her mother has called me unprofessional down the phone.

So enough really is enough. When the system lets you as a GP down and you feel you have no support from the authorities to deal with criminal activity, all that is left is the rather pathetic response of telling a patient you won't see them any more.

Why NICE is wrong on OA

RUNNER-UP

Dr Ted Willis is a GP in Brigg, Lincolnshire

Viscosupplementation, or use of hyaluronan injections, is a very useful, simple and cost-effective treatment for osteoarthritis of the knee. NICE is wrong to 'not recommend' it. GP practices who do not give this treatment to their patients are letting them down.

For many years, I have used intra-articular steroid injections to treat degenerative arthritis of the knee. Patients are usually very pleased with the effect after a few days, but they often come back after a month asking for another one – as the effect has worn off.

Three or four steroid injections per year is regarded as the maximum safe frequency, which is quite the workload. So when I heard about hyaluronan injections, a treatment that worked for several months, I was interested.

Hyaluronans are a type of large molecule called glycosamino-glycans produced by synovial joint-lining cells. They increase joint fluid viscosity, and help maintain tissue hydration and lubricate the joint. They are extracted from chicken rooster combs and have been used in eye surgery since the 1960s. In recent years, chemical cross-linking of some of the molecules – such as Hylan GF-20 – has increased the molecular weight, which is

TEN TOP TIPS

Keeping the upper hand

RUNNER-UP

Dr Julian Le Saux is a GP in Cranbrook, Kent

The essential thing to understand about consultations is that they're a struggle for the upper hand. Forget all that stuff about listening to the patient, holistic care or sharing the decision-making process. Concentrate on keeping your patient off-balance and ill at ease, and you won't go far wrong.

The fact is, the patient wants one thing from a consultation and you want another. They want antibiotics, you want them to clear off because it's just a virus. They want a referral to a heart specialist in London, you want them to see a GPSI in cardiology who works down the road. They want something expensive and complicated, and you want them to have something cheap and quick. They want to tell you their life stories, and you fancy a biscuit. You get the idea. Here are my 10 top tips for ensuring the kind of consultation you want to have.

1 Never see your first patient on time
Always start surgery at least 15 minutes late. Come rushing in with your mobile phone pressed to your ear, and vanish into your consulting room with a slammed door. This gives the patients the impression that you're terribly busy, which means you must also be rather important, and you'll certainly be in too much of a hurry to listen to all the pointless details they'd like to burden you with.

2 Never remember your patient's name
If you start by saying 'Good morning, Mr Roundbottom', or worse still 'Morning, George', he'll think he's your chum. Much better to make him remind you of who he is. 'I'm so sorry, what was your name again? Something to do with buttocks? Was it Widearse?'

3 Never share your space with the patient
It's best to have the desk between the two of you – it's more intimidating, you don't get so many germs and it also means that you can busy yourself with your computer screen for long periods of time without the patient having any idea of what you're doing. While he's fidgeting in his chair and feeling awkward, you can be ordering yourself some DVDs from Amazon. Excellent.

4 Tell the patient off
'I see you missed an appointment with the rheumatologist last May, Mr Chestikov.' This will provoke a spate of apologies and excuses, to which you should reply with a bored-sounding and noncommittal: 'I see.'

5 Interrupt the patient's presentation to check irrelevant details
Let's say an old lady has just been pouring out her heart to you about how depressed she's been since the death of her cat Felix. You should butt in mid-sentence, to enquire whether she'd describe her recent bowel-movements as smooth or lumpy.

6 Emphasise financial considerations
'Well, Mr Tumble, of course it would be nice if I could refer you for an exercise ECG and a CT scan. On the other hand, it would also be nice if I could afford a new desk. The NHS doesn't really do "nice" any more, does it?'

7 If you've been in practice a long time, always mention your years of experience
'Well, I've been a GP for more than 20 years, Miss Bucket, and I can't recall ever having clapped eyes on a baby as ugly as yours.'

claimed to prolong the intra-articular life and hence the effectiveness of the product.

I started doing the injections for patients without gross inflammation and have been very pleased with the results. The result is that I now refer fewer patients for knee replacements, which do serious harm to a small but significant proportion of patients. The injections are simple and only take five minutes once a week for three weeks, so the workload is not bad, and there are very few problems.

So I am amazed that few GPs use this treatment, and few patients are aware of it. Most orthopods are positive about viscosupplementation – but they aren't funded to do it by PCTs. But I thought this would change in 2006, when a Cochrane review came out strongly in favour.

'Overall, the analyses support the use of the hyaluronan class of products in the treatment of knee osteoarthritis,' the review said.

The authors found very good evidence of effectiveness – P values for pain at rest, pain on walking, pain at night and functional scores compared with placebo injections were typically less than 0.0001. The maximum effectiveness was between five and 13 weeks, and there was a significant improvement in function at the last review at nine months.

But there was little publicity – no big pharma company was involved and nothing much happened. The review also confirmed that the benefit of steroid injections was limited to about a month. And it included results of several trials directly comparing hyaluronan products with steroid injections, which overwhelmingly favoured the hyaluronan injections.

When NICE started working on its osteoarthritis guideline, I was confident change was finally coming. I knew that guideline CG59 had come out when my PCT – which had been paying me a small fee per injection – notified me that this would stop. It quoted the new NICE guidance: 'Intra-articular hyaluronan injections are not recommended for treatment of osteoarthritis.' I was surprised I was still offered money to give steroid injections, 0in view of the poor duration of effect.

Of course, nobody at the PCT had bothered to actually read the full NICE guidance – which is laughable. NICE admits that hyaluronan injections are clearly effective, but says it needs evidence of cost-effectiveness – even though there is no analysis of cost-effectiveness for steroid injections. It looks at economic evaluations on hyaluronan from four countries. The

following are quotes from the document:

- **France** 'Synvisc would appear to be cost-effective... The reimbursement regime in France means that this study cannot be used to make evidence statements.'
- **Canada** The cost per quality-adjusted life year was under $10,000 – well within NICE's limit – but: 'The fact that the study was not blind may weaken any evidence statements made, and so again, given these problems, no evidence statements are made.' How does one do a blind cost-effectiveness study?
- **Taiwan** 'Being set in Taiwan makes the study of limited use.'
- **US** 'The study is not a formal cost-effectiveness or cost-utility analysis, as it does not include a measure of health gain attributable to the treatment.'

So NICE approves the less effective treatment for which there is no cost-effectiveness analysis. NICE does not recommend a more effective treatment for which there is an economic analysis showing cost-effectiveness because the studies are not British or not blind. In my view, it is the British who are blind.

8 Think out loud
'Of course, Mr Bushnell, I shall be only too glad to refer you to the neurologist.' Then, sotto voce: 'Yet another sodding referral letter I've got to write. Eighteen so far today.'

9 Gaze out of the window and quote poetry
Say it's evening surgery. The sun's going down. You stand up, look out of the window with your hands behind your back, and slowly murmur: 'Light thickens, and the crow makes wing to the rooky wood. Good things of day begin to droop and drowse...' When you turn back, the expression on your face is grim and distant. You extract a handkerchief from your pocket and rub your hands repeatedly, as if you're unable to remove an invisible stain.

10 Have a buzzer on your desk, which sounds outside in reception
Press it if all else fails. In response, your reception staff should be trained to knock on your door immediately and tell you there's an urgent phone call. You can then excuse yourself, and leave the patient to stew in his or her own juice for 10 or 15 minutes while you go upstairs for a reviving glass of brandy and a smoke.

Of course, there are many other excellent techniques for keeping your patients off-balance.

These include feigning a nervous twitch, talking in such a dense foreign accent that nobody can understand you, having something unspeakable in a jar of cloudy liquid on your desk and tapping it absentmindedly with your pen – or the old favourite, meeting your patient at the consulting room door with your flies undone and a bit of shirt poking out. If you're female, the equivalent is to have your skirt tucked into your knickers at the back.

By using these simple techniques or others like them, not only will you always have your patients at a disadvantage – you'll also enliven many a dull consultation.

Prescribe by brand
to reduce possible errors[1,2]

OxyContin®

Prolonged release oxycodone hydrochloride tablets

A leading London teaching hospital demonstrated an error rate in the prescribing of opioids of 27%.

4% of the errors being potentially fatal.[3]

For prolonged release oxycodone write ***OxyContin***.

OxyContin® tablets contain an opioid analgesic

***OxyContin*® (oxycodone hydrochloride) 5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 120 mg prolonged release tablets**

Prescribing Information, United Kingdom.

Please read the Summary of Product Characteristics (SmPC) before prescribing.

Indications Moderate to severe pain in patients with cancer or post–operative pain. Severe pain requiring the use of a strong opioid.

Dosage and administration Tablets must be swallowed whole, and not broken, chewed or crushed. *Elderly and adults over 18 years:* Take tablets at 12–hourly intervals. Dosage is dependent on the severity of pain and the patient's previous history of analgesic requirements. Not intended for use as a prn analgesic. Usual starting dose for opioid naïve patients, or patients presenting with severe pain uncontrolled by weaker opioids: 10 mg, 12–hourly. Some patients may benefit from a starting dose of 5 mg to minimise the incidence of side–effects. Opioid naïve patients with mild to moderate renal and/or mild hepatic impairment may be started on 5 mg, 12–hourly and titrated to pain relief. Any dose increases should be made, where possible, in 25% – 50% increments. When transferring from morphine, the following ratio should be used as guidance: 10 mg oral oxycodone is equivalent to 20 mg oral morphine. Opioids are not firstline therapy in non malignant pain, nor are they recommended as the only treatment. The need for continued treatment in non–malignant pain should be assessed at regular intervals. *Children under 18 years:* Not recommended.

Contra-indications Respiratory depression, head injury, paralytic ileus, acute abdomen, delayed gastric emptying, chronic obstructive airways disease, cor pulmonale, severe bronchial asthma, hypercarbia, known sensitivity to oxycodone or any of the constituents, moderate to severe hepatic impairment, severe renal impairment, chronic constipation, concurrent administration of monoamine oxidase inhibitors or within two weeks of discontinuation of their use, galactose intolerance, lactase deficiency, glucose–galactose malabsorption, any situation where opioids are contraindicated, pre–operative use or use during the first 24 hours post operatively, pregnancy.

Precautions and warnings Hypothyroidism, opioid dependent patients, raised intracranial pressure, hypotension, hypovolaemia, toxic psychosis, diseases of the biliary tract, pancreatitis, inflammatory bowel disorders, prostatic hypertrophy, adrenocortical insufficiency, alcoholism, delirium tremens, chronic renal and hepatic disease, severe pulmonary disease, debilitated patients, elderly and infirm patients, history of alcohol and/or drug abuse. Do not use where there is a possibility of paralytic ileus occurring and if this is suspected or occurs during use discontinue immediately. Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive ***OxyContin*** tablets for 12 hours prior to the intervention. ***OxyContin*** 60 mg, 80 mg and 120 mg tablets should not be used in opioid naïve patients. ***OxyContin*** tablets should be used with caution following abdominal surgery, and not used until normal bowel function returns. ***OxyContin*** tablets have a similar abuse profile to other strong opioids. ***OxyContin*** tablets must be swallowed whole and not broken, chewed or crushed which leads to a rapid release and absorption of a potentially fatal dose of oxycodone. Concomitant use of alcohol and ***OxyContin*** tablets may increase the undesirable effects of ***OxyContin*** tablets; concomitant use should be avoided.

Interactions ***OxyContin*** tablets, like other opioids, potentiate the effects of transquilisers, anaesthetics, hypnotics, antidepressants, sedatives, phenothiazines, neuroleptic drugs, other opioids, muscle relaxants and antihypertensives. Monoamine oxidase inhibitors are known to interact with narcotic analgesics, producing CNS excitation or depression with hypertensive or hypotensive crisis. Inhibitors of CYP3A4 or CYP2D6 may inhibit the metabolism of oxycodone. Alcohol may enhance the pharmacodynamic effects of ***OxyContin*** tablets; concomitant use should be avoided.

Pregnancy and lactation Not recommended.

Side effects Common (≥ 1%): constipation, nausea, vomiting, dry mouth, anorexia, dyspepsia, abdominal pain, diarrhoea, headache, confusional state, asthenic conditions, dizziness, sedation, anxiety, abnormal dreams, nervousness, insomnia, thinking abnormal, somnolence, bronchospasm, dyspnoea, cough decreased, rash, pruritus, hyperhidrosis, chills.
Uncommon (≤ 1%): but potentially serious: anaphylactic reaction, anaphylactoid reaction, hypersensitivity, biliary colic, cholestasis, ileus, gastritis, dysphagia, dental caries, hallucinations, depression, dysphoria, affect lability, mood altered, restlessness, agitation, euphoria, disorientation, amnesia, vision abnormal, vertigo, drug tolerance, drug dependence, drug withdrawal syndrome, paraesthesia, speech disorder, convulsions, urinary retention, ureteral spasm, libido decreased, supraventricular tachycardia, hypotension, orthostatic hypotension, respiratory depression, syncope, oedema, oedema peripheral, increased hepatic enzymes, exfoliative dermatitis, urticaria, amenorrhoea, erectile dysfunction. Overdose may produce respiratory depression, pin–point pupils, hypotension and hallucinations. Circulatory failure and somnolence progressing to stupor or deepening coma, skeletal muscle flaccidity, bradycardia and death may occur in more severe cases. The effects of overdosage will be potentiated by the simultaneous ingestion of alcohol or other psychotropic drugs. Please refer to the SmPC for a full list of side effects. Tolerance and dependence may occur. It may be advisable to taper the dose when stopping treatment to prevent withdrawal symptoms.

Legal category CD (Sch2) POM.

Package quantities and price 5 mg – £12.50 (28 tablets). 10 mg – £24.99 (56 tablets). 15 mg – £37.41 (56 tablets). 20 mg – £49.98 (56 tablets). 30 mg – £74.81 (56 tablets). 40 mg – £99.98 (56 tablets). 60 mg – £149.66 (56 tablets). 80 mg – £199.97 (56 tablets). 120 mg – £299.31 (56 tablets).

Marketing Authorisation number
PL 16950/0097–0100, 0123, 0139–0141, 0150

Marketing Authorisation holder Napp Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0GW, UK. Tel: 01223 424444.
Member of the Napp Pharmaceutical Group. For medical information enquiries, please contact medicalinformationuk@napp.co.uk

Date effective January 2012 (UK/OXYC-11026).

European Patent (UK) 0 253 104. European Patent (UK) 0 576 643.
European Patent Application No. 96102992.3

Adverse events should be reported. Reporting forms and information can be found at use www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Napp Pharmaceuticals Limited on 01223 424444.

1. Department of Health. Building a safer NHS for patients: Improving medication safety. 2004.
2. Dickman A. Branded prescribing of strong opioids should be adopted as good practice. The Pharmaceutical Journal 2005; 275: 546.
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NAPP **OxyContin®**
Prolonged release oxycodone hydrochloride tablets

Code: UK/OXYC-12001e. Date of preparation: April 2012.

The doctor, the patient and the prescribing adviser

HIGHLY COMMENDED

Dr Pat Aitchesen is a GP in Northampton

Like many experienced GPs, I trained under the apprenticeship model – or 'see one, do one, teach one' – which seems quaint today in the age of competencies and evidence. The aim of my teachers was to get me practising safely, competently and above all independently.

These days, it seems that independent practice is under attack from all directions. We are urged to sit together as a clinical team to discuss problems, significant events, prescribing, referrals and admissions week after week, mainly with the aim of reducing some aspects of our work in order to cut expenditure. Prescribing is a particular focus, since this is one area a GP can control. The question is: who is really in charge?

I have been trained to sit with a patient and work out together what we will do next with their problem. The patient has come to tell me of his annoyance about a letter telling him he must switch medication. Clinically, there is little to choose between the two medications apart from cost, which shifts from year to year. But other considerations now influence my decision on drug therapy.

The prescribing adviser wants me to prescribe statin A this year. This patient is happy on statin B, which we switched him to some years ago as it was more cost-effective then. The prescribing lead partner wants me to persuade him to switch, which will allow us to stay green on the prescribing incentive scheme and protect our income.

The commissioning group and locality want to control drug budgets. A growing group of others have found their way into the room. More needless activity is added to the increasing workload.

It seems that independent practice is under attack

We no longer expect complete clinical freedom, but we must keep the core values of general practice while we adapt and move forward. I work in a partnership of doctors with differing skills and attributes. We stay up to date and are fully aware of the financial implications of our decisions. We all value the opportunity to have discussions about clinical problems when we need them, and none of us is afraid to admit ignorance or that we are unsure how to proceed.

Despite all this, it now seems that a GP cannot make the decision to prescribe, treat or refer without clearing it with colleagues in the practice, the locality or the PCT.

This second-guessing of my actions amounts to an attack on my professional judgment. The act of prescribing is being reduced from a clinical decision formed after considering the complexities of an individual case to a purely cost-driven exercise that takes little account of the bigger picture.

Prescribing incentive schemes, started with the laudable intention of getting maximum value for limited resources, are being used to direct and limit clinical behaviour on flimsy evidence enforced by financial penalties.

Our new local scheme has metrics so wide and vague in some areas that it is possible to achieve near maximum points on QOF clinical indicators but still not achieve a green status on arbitrary financial targets.

My job is to deal with a person who comes to consult with me as a professional. A consultation does not occur in isolation from the wider environment, but always contains four key elements. The essence of general practice is these four Ps; a patient, a physician, a problem and a plan. If we allow others to impose their own agendas on this and move to treatment by committee, neither patients nor doctors will ultimately benefit.

When treating the whole patient bears fruit

HIGHLY COMMENDED

Dr Samia Bushra is a GP in Dagenham, east London

Pain is a very subjective symptom. So when my patient first presented with a request for more painkillers, I complied.

He was around 50 years old, Caucasian, six-feet tall and a bit overweight. It was a Friday evening and he had been given a prescription of gabapentin for 'facial pain' by his neurologist, but had failed to pick it up at the hospital. In addition, he wanted his usual painkiller – codeine plus paracetamol. He was almost in tears. I issued a script and asked that he book an appointment for follow-up.

Over the next few months I got to know him better as a patient. He had had this pain for the past two years and it was gradually increasing, causing him to finally seek medical help a year before. His previous GP had referred him to hospital when nothing worked. Other causes of facial pain, including dental and maxillary surgical causes, had been investigated and ruled out. I decided to review and repeat his blood tests.

They were all reported as 'normal', but I noted that his TFT was somewhat borderline. I did not have previous bloods to compare, but his TSH was at the upper limit of normal.

At the time, I also tried to address lifestyle changes. One problem was an ongoing knee pain that he claimed stopped him from losing weight. His knee examination was normal.

After excluding other causes for ongoing pain – and checking on time off work, home stresses and psychiatric illness – I repeated his TFTs and requested a thyroid antibody test. Repeated TSH was always above 5.6 and his thyroid antibodies were high. This was a man who still worked regularly and was only attending the surgery for his pain relief.

Wide-ranging effects

The thyroid gland affects the metabolism of muscles and nerves. It is widely known for 'weight gain' and 'feeling tired', but is also a cause of both polyneuropathy and mononeuropathy, and in long-standing hypothyroidism has been shown to cause patchy demyelination of nerves. It also causes myopathy, which in long-standing hypothyroidism manifests as weakness, decreased muscle reflexes and pain.

The advantage of being a GP is that one is able to see the patient as a whole, and so determine whether only reassurance is needed or the patient should have further investigation and treatment.

I decided he needed further assessment. I discussed the blood results with him and the fact that so far nothing had been found to explain his symptoms of pain. The blood results were within the normal range, but 'normal' differs for each individual. So theoretically if his 'normal' TSH used to be 1 or 2, he could have been gradually becoming hypothyroid and exhibiting symptoms.

He agreed to start on a low dose of thyroxine. I explained the symptoms of over-treatment and in the following few months monitored his response and blood levels of TSH and T4. It took up to a dose of 100µg of levothyroxine for his TSH to come down to around or below 2. He himself said he was 'feeling so much better'.

His knee pain, although still an occasional problem, had not stopped him from being active and taking up a sport. His 'thick ankles' were actually partly a result of hypothyroid swelling of the lower limbs.

My focus on getting his levels of TSH adequate and his enthusiasm for lifestyle change meant we forgot about his original complaint – facial pain. He had gradually stopped all his painkillers and gabapentin and was actually pain free.

Low-carb diet is the way forward in diabetes

HIGHLY COMMENDED

Dr Katharine Morrison is a GP in Mauchline, Ayrshire

In the UK, babies born to women with diabetes have four times the background abnormality rate of those born to women without diabetes.

In Professor Lois Jovanovich's clinic in Santa Barbara in the US, the rate for babies of mothers with diabetes is the same as in the general population. She encourages patients to eat a restricted carbohydrate diet of 90-135g a day. She uses this and other techniques to maintain blood sugars as normal as possible in pre-pregnancy and pregnancy. You would think that pregnancy centres in the UK would be keen to try this out – but they aren't.

The complications of diabetes exact a terrible toll on patients with type 1 and type 2 diabetes. The landmark Diabetes Control and Complications Trial (DCCT)[1] showed the higher the blood sugars, the faster complications develop.

High post-prandial blood sugars not only cause glycaemic-related damage,

40

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

Efficacy

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

Generally well tolerated

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

Different

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

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

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

References: 1. Trajenta® Summary of Product Characteristics, August 2011. **2.** Barnett AH *et al.* Poster No. 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 UM11-086a. **6.** Vincent SH *et al. Drug Metab Dispos* 2007;35:533–538. **7.** Januvia (sitagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/19609/SPC/JANUVIA+100mg+film-coated+tablets/ (accessed May 2012). **8.** Galvus (vildagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22734/SPC/Galvus+50+mg+Tablets/ (accessed May 2012). **9.** Onglyza (saxagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/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/08/0004a Date of preparation: May 2012

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38 but set off an inflammatory cascade that causes endothelial damage and cancer. Post-meal blood sugars can be reduced if a restricted carbohydrate diet is adopted. Long-term adherence and prevention of complications can be achieved. Some complications can even be reversed. So why don't diabetes clinics throughout the UK promote the restricted-carb diet for their patients?

The DCCT trial showed adolescent patients with type 1 diabetes had three times as many hypos as adult patients, despite having an average HbA_1c of 8% compared with the adult group average of 7%. Some US endocrinologists encourage their adolescent patients to follow a restricted-carb diet so that they can safely reduce their blood sugar. So why aren't adolescent diabetes clinics in the UK exploring this option with their patients?

The current high carb/low fat diet started off in the 1970s in the US, when Senator George McGovern brought in dietary guidelines to limit fat in the diet for the first time. He was strongly influenced by people who genuinely believed that fat, particularly saturated fat, was a major cause of arteriosclerosis. Scientists of the time pleaded for time, aware there was no evidence to support the claims. Senator McGovern famously said: 'We don't have time to wait for evidence. We have to do something now.'

We are still waiting for evidence that saturated fat causes heart disease. But as the fat content of our diets has decreased over the last 20 years, the carbohydrate intake has zoomed, and we have seen a massive rise in obesity and its related illnesses.

Every day we hear how the NHS is in financial crisis. A patient with diabetes who has complications costs the NHS nine times more than a well-controlled patient without complications. All the features of metabolic syndrome can be reversed by a low carb/high fat/moderate protein diet. This saves money on drugs and other treatments too. What are the economic and personal costs of failing to give women with diabetes the dietary information to reduce their risk of having a deformed or dead baby?

If any one macronutrient deserves the blame for the obesity crisis and poor diabetic control, it is surely carbohydrates rather than fats. Sugars and starch all end up raising the blood sugar pretty quickly after a meal. Although patients with diabetes are advised to reduce sugars to some extent, the same advice is not given to restrict starch. Diabetes UK tells patients to base every meal around starch. In the patient's interest? I don't think so.

Reference

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It pays to listen and understand

HIGHLY COMMENDED

Dr John Allingham is medical secretary of Kent LMC and a GP in Dover

'It's me town halls doc, I think I might be a jaffa.' As consultation opening gambits go, this is my all-time favourite.

The patient was

a heavily muscled guy in workman's clothes. I had only met him once before. He walked into my office, sat down and without any exchange of pleasantries offered that rather startling sentence, then waited for my reply. I hesitated, open mouthed, while it sank in.

Fortunately, I knew town halls could be used as rhyming slang for balls and a jaffa is a seedless orange. So I figured that the patient was concerned his testicular problem might have rendered him infertile.

The consultation that followed lasted less than the 10-minute standard and was a quick and simple determination of his epididymitis, with reassurance about his fertility and formulation of a treatment plan.

Today's medical students have regular sessions in communication skills, so teaching registrars that if you listen to the patient they will tell you the diagnosis is preaching to the converted. But it still surprises many how little time a patient will speak without seeking input from the doctor. I have recorded patients' opening uninterrupted speech on numerous occasions and asked trainees to estimate their length. The error rate is close to 100%. Most patients struggle to exceed 30 seconds, but to the doctor that feels like at least a minute.

Becoming a listening doctor

If you are a GP who has forgotten, or was never taught, to let the patient speak without interruption – try it.

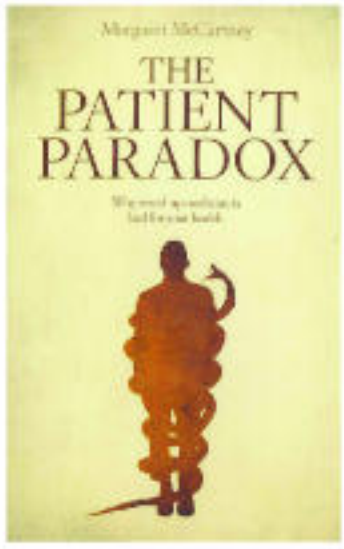
After the exchange of pleasantries say something like 'How can I help you?' or 'What brings you here today?' and sit back and wait. It doesn't make for over-running surgeries, helps gain a reputation as a listening doctor and even when of no clinical value provides entertainment.

And it is important, too, to try to understand the language patients use and to speak to them in a way they understand. I don't mean that we should be fluent in everything from Pashtun to Gaelic, but that we should recognise how they use words.

'I feel dizzy' might actually mean 'I am about to fall over', 'I am about to faint' or 'I am stupid'. It is easy to make a mistake, but just as easy to learn how patients speak and to remember it.

Teenagers who say it 'was like a sore throat' actually mean it was a sore throat. The lady who wanted fibreglass for her constipation didn't want to chew the insulation, just a script for Fybogel. Her colleague who came to discuss her 'polly-go-lightly' was reviewing her steroid dose for her polymyalgia.

We have all been told it before, but in the mess of bureaucracy, data collection and point collecting that is each consultation we can forget that listening to the patient and understanding what they are saying is time well spent.



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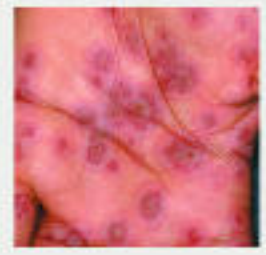

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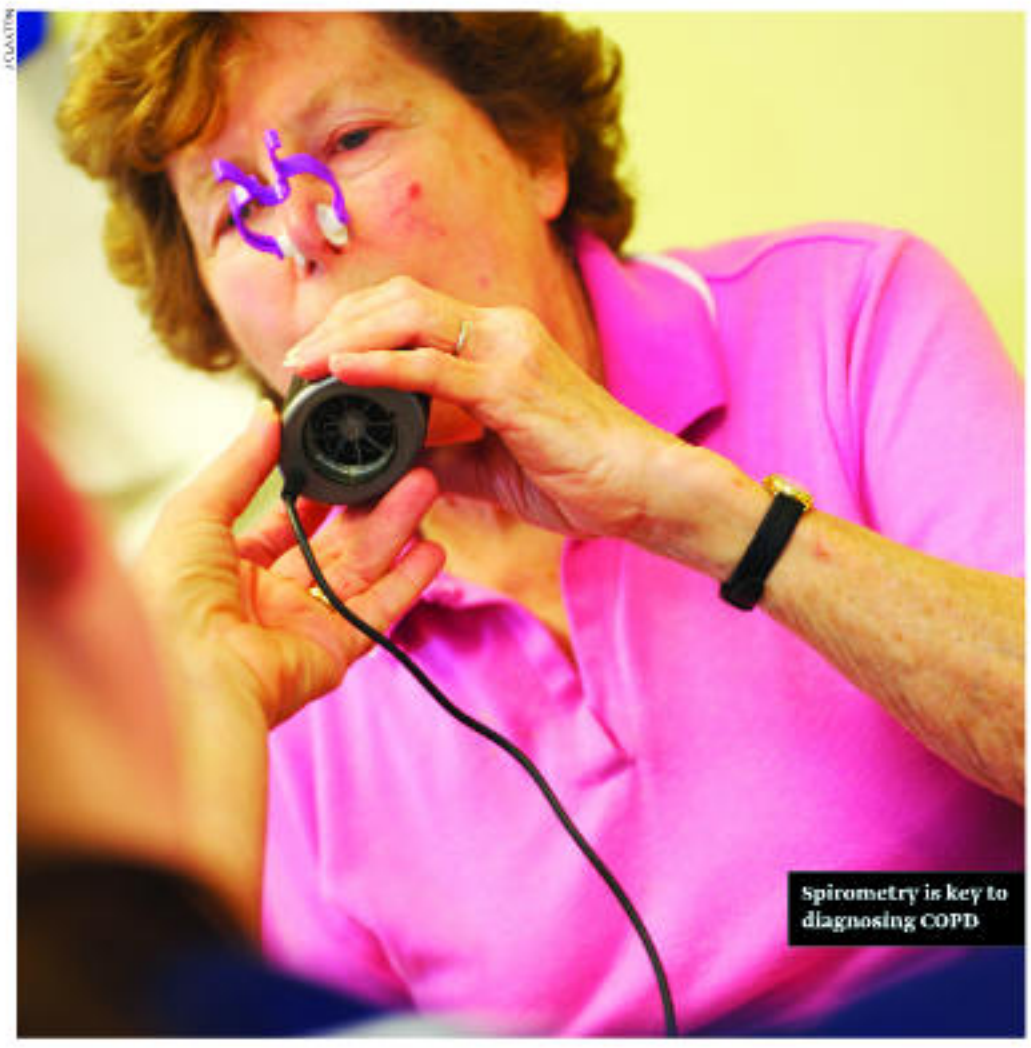
Resource of the week Diabetes UK has launched an iPhone app to help patients manage this condition



Spirometry is key to diagnosing COPD

KEY QUESTIONS

COPD

GP and respiratory clinical lead Dr Iain Small answers GP Dr Julian Spinks's questions on this common condition

1 It's often difficult to distinguish between asthma and COPD. What clues would you look for in the history and examination that may suggest further investigation for COPD would be indicated?

The likelihood that respiratory symptoms are a result of asthma is increased in younger people, particularly if they have a history of other atopic conditions such as eczema and rhinitis. Having a close relative with asthma is also significant. Symptoms often have diurnal variation, being worse at night, and with exercise and trigger exposure.[1]

With COPD, 20 years of smoking, productive cough and less variable dyspnoea are more common than in asthma.[1]

Don't forget to check for an occupational association in both diseases. Occupational asthma is common in bakers, and people working with isocyanate paints, latex, animals and shellfish. COPD is most common in those who work in heavy industry – particularly mining, textiles and steel.

2 How useful are investigations such as spirometry and chest X-ray in confirming the diagnosis of COPD and classifying its severity?

Spirometry is key to diagnosing COPD. In patients with symptoms suggestive of the disease, airway obstruction must always be confirmed by spirometry before a diagnosis of COPD can be made.[1] Obstruction is demonstrated by a reduced FEV1/FVC ratio – less than 0.7.

Note that relaxed vital capacity should be used if it is greater than FVC.

Disease severity can be classified in a number of ways – by functional disability, exercise capacity, hypoxia and so on – all of which are important.

In routine practice, a reduction of FEV1 against that of a standardised normal, adjusted for height, age, sex and ethnicity (expressed as a percentage of predicted) classifies patients as having:

- mild COPD (>80%)
- moderate COPD (50-79%)
- severe COPD (30-49%)
- very severe COPD (<30%).

While we can't diagnose COPD by chest X-ray, it's an important investigation to perform at diagnostic assessment, as lung cancer is a common comorbidity in patients with COPD.

3 What would be your first-line management for patients with stable mild to moderate COPD, for example, with an FEV1 over 50% predicted?

First-line management depends on *how* symptomatic the patient is. In patients with intermittent symptoms, I would start with a short-acting bronchodilator, either a ß-agonist such as salbutamol, or less commonly a short-acting antimuscarinic like ipratropium bromide.

But if the patient is regularly symptomatic, a long-acting ß-agonist (LABA) or long-acting antimuscarinic may be the pharmacological first choice. Or a long-acting antimuscarinic could be added to salbutamol. Remember short- and long-acting antimuscarinics should never be prescribed concomitantly.

4 At what point would you consider adding in inhaled steroids, and would you carry out a reversibility test after initial treatment?

The key benefits of inhaled steroids in COPD are a reduction in exacerbations, improved quality of life and slower decline in lung function – although data on a reduction in mortality is tantalisingly inconclusive.

The strongest evidence is in patients with severe and very severe disease – an FEV1 below 50% predicted – and if such patients suffer exacerbations, I would add an inhaled steroid to a LABA, usually in fixed-dose combination, or add the combination to a long-acting antimuscarinic.[2] We now know that a relatively small group of patients with mild disease but frequent exacerbations suffer a rapid rate of lung function decline – so it's also valid to consider an inhaled steroid and LABA combination here.

If you are confident after taking the history that COPD is the most likely diagnosis, reversibility testing is no longer mandatory – either under NICE guidance or the QOF. But spirometry should be carried out after using a bronchodilator – usually 400µg of salbutamol via a pressurised metered-dose inhaler and spacer. If we suspect asthma, we can still perform pre- and post-bronchodilator tests, looking for a 400ml FEV1 difference – or a 20% change where the initial value is less than 2l.

We can, of course, review the patient and repeat spirometry at an interval of, say, three months after treatment if we are concerned we might have missed asthma.

5 I understand there have been safety concerns raised about one type of tiotropium inhaler. Could you clarify the potential risks with tiotropium?

I'm not sure that I can with absolute certainty. There have been two systematic reviews that raise concerns about cardiac rhythm disorders with antimuscarinic agents. The first of these looked at both short- and long-acting agents and was widely criticised on methodological grounds.[3]

The second looked specifically at the five published placebo-controlled trials in which tiotropium was delivered by pressurised mist. It showed a statistically significant relative

risk for those tiotropium inhalers of 1.52.[6]

But this needs to be offset against the safety data from the UPLIFT study, which showed no increase in cardiac or all-cause mortality, and indeed a trend towards reduction in risk of cardiac death at 0.73.[7] There was also a risk reduction of similar magnitude in all-cause mortality, although again this was not statistically significant. It's worth noting that this study used a dry powder device, not the pressurised mist.

My own clinical approach is to be cautious when giving tiotropium by pressurised mist in patients with known cardiac problems, particularly rhythm disorders.

6 What is the role of other drugs – such as theophyllines, mucolytics and antitussives – in the management of COPD? Is there any data on vitamins?

Theophyllines still have a role, but usually after all inhaled options have been tried or if there are clinical reasons for not using them.

They are more likely to cause toxicity in the elderly, where particular care should be taken during exacerbations – especially when a macrolide antibiotic is being considered.

Mucolytics have a role in patients with a more bronchitic pattern, involving regular sputum production, but there is no added benefit gained in risk reduction for exacerbations over that of inhaled therapy.

Vitamin D supplementation has been reported to enhance the benefits of pulmonary rehabilitation.[8] A beneficial role for antioxidants – specifically vitamins A, C and E – in COPD exacerbations has been postulated, although more research is probably needed and as yet their use is not recommended in guidance.

7 How would you manage an acute exacerbation of COPD?

If a patient suffers an exacerbation, they should be assessed for hypoxaemia, confusion, comorbidity that might increase risk and also for their level of social support.

Early intervention with antibiotics and systemic steroids is likely to reduce the chances of hospital admission, and written self-management and anticipatory care plans can make sure this happens as quickly as possible. Simple antibiotics such as amoxicillin – or erythromycin in patients allergic to penicillin – are effective.

Prednisolone should be given orally, usually at a dose of no higher than 30mg (unlike asthma), but for longer courses. There is usually no need to step down treatment at the end of a seven- to 10-day course, unless the long-term exposure to steroids has been significant. There may be a role for nebulised bronchodilators in exacerbations, and there is increasing evidence that good nutritional support and early pulmonary rehabilitation is beneficial. Despite all this, many patients will still to be need admitted. The 2010 NICE COPD guidance has a useful table of clinical parameters that would suggest admission.[2]

8 If a patient appears to be developing cor pulmonale secondary to COPD, what steps would you take to confirm the diagnosis and treat the patient?

First, a suspicion of cor pulmonale is based on clinical signs: raised jugular venous pressure, peripheral oedema and so on. But confirming the diagnosis of right heart failure isn't easy.

Echocardiography may help, and more specialist investigation including pulmonary arterial pressure assessment may confirm pulmonary hypertension associated with COPD – or indeed, any other chronic fibrosing lung disease. Cor pulmonale is a key prognostic indicator in COPD.

9 Patients with COPD who have received rescue oxygen therapy during an admission are then often keen to have cylinders at home. Is this a reasonable approach or is long-term oxygen therapy a more appropriate management plan?

The consensus opinion is that oxygen therapy at home is not a good strategy. In the acute setting, oxygen is a treatment for breathlessness caused by hypoxaemia – and as such should only be used where there is proof that hypoxaemia is present.

A significant number of patients with COPD will have developed type 2 respiratory failure and regulate their breathing on their hypoxic – rather than hypercapnoeic – drive. Injudicious use of oxygen in such patients can result in CO_2 retention and fatal acidosis.

The evidence for long-term oxygen therapy is well established and requires appropriate assessment to confirm the indication (hypoxaemia when stable) and safety (lack of CO_2 retention when given oxygen).[9,10] Although this assessment can be done in the community, it does require arterial blood gas assessment to be carried out.

10 What would you do if a patient who would benefit from oxygen therapy refuses to stop smoking?

Every year in the UK, between 10 and 20 patients die as a consequence of fire associated with domiciliary oxygen. This may be due to an explosion (in the case of cylinders) or incineration (with both cylinders or concentrators). Also, no trials have ever assessed the clinical efficacy of long-term oxygen therapy in smokers. So the guideline groups and respiratory societies take the view it should not be given.

11 Which patients with COPD would benefit from referral for pulmonary rehabilitation?

Probably any patient with COPD would benefit from pulmonary rehabilitation.[11] But the evidence is strongest for patients with functional disability – defined as an MRC dyspnoea score of 3,4 or 5 – and significant obstruction of FEV1 50% of predicted or less.

Patients with less severe disability will still gain benefit from regular exercise and patient education, but programmes like these are less convincingly cost-effective. There is emerging evidence that in-hospital rehabilitation, continued on discharge, is of benefit to patients suffering exacerbations.

Dr Iain Small is a GP in Peterhead, Aberdeenshire, clinical lead for Grampian Managed Clinical Network for COPD and chair of the Primary Care Respiratory Society UK Executive

Dr Julian Spinks is a GP in Strood, Kent

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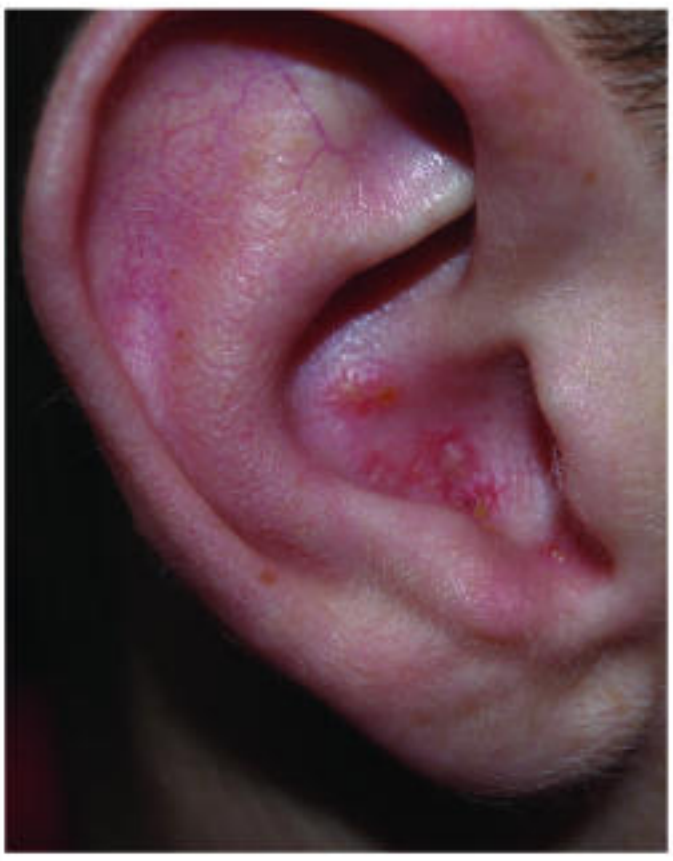
Go online to read an extended version of this article, with Dr Small discussing how to deal with distressing symptoms in end-stage COPD



SNAPSHOT DIAGNOSIS

Spots in the ear

GP Dr Oliver Starr explains how he reached the right diagnosis when this young man arrived in his surgery with painful ear lesions

THE PATIENT

This young man was normally healthy, but these tiny spots had appeared in his right conchal bowl over a few days.

They were painful, and he admitted to picking away at his ear a little recently, from habit.

He asked what they were, and what I could do about them.

Differential diagnoses

- Carbuncles
- Herpes simplex
- Herpes zoster.

Carbuncles are an infection of the hair follicle, usually by *Staphylococcus aureus* or other Gram-positive bacteria.

Carbuncles in the conchal bowl or ear canal are fairly common – they even have their own Read code – and were a possibility.

Herpes is usually found around the mouth (herpes simplex virus type I) or the genital area (type II).

I thought it was less likely to find it in the ear, although not entirely impossible.

Herpes zoster (shingles) is caused by the virus varicella zoster.

After the initial infection the virus lies dormant in the dorsal root ganglion, recurring typically at times of immunocompromise or stress.

Some 50% of people will have had shingles by the age of 85.

Getting on the right track

Things became clearer three days later.

He came back concerned about why one side of his face looked odd.

I could see what he meant – he couldn't raise his right eyebrow or the right side of his mouth.

In other words, he had a right-sided lower motor neurone lesion of the facial nerve.

This was Ramsay Hunt syndrome – essentially, shingles of the facial nerve.

I was seeing him in the very early stages, so prescribed aciclovir and prednisolone.

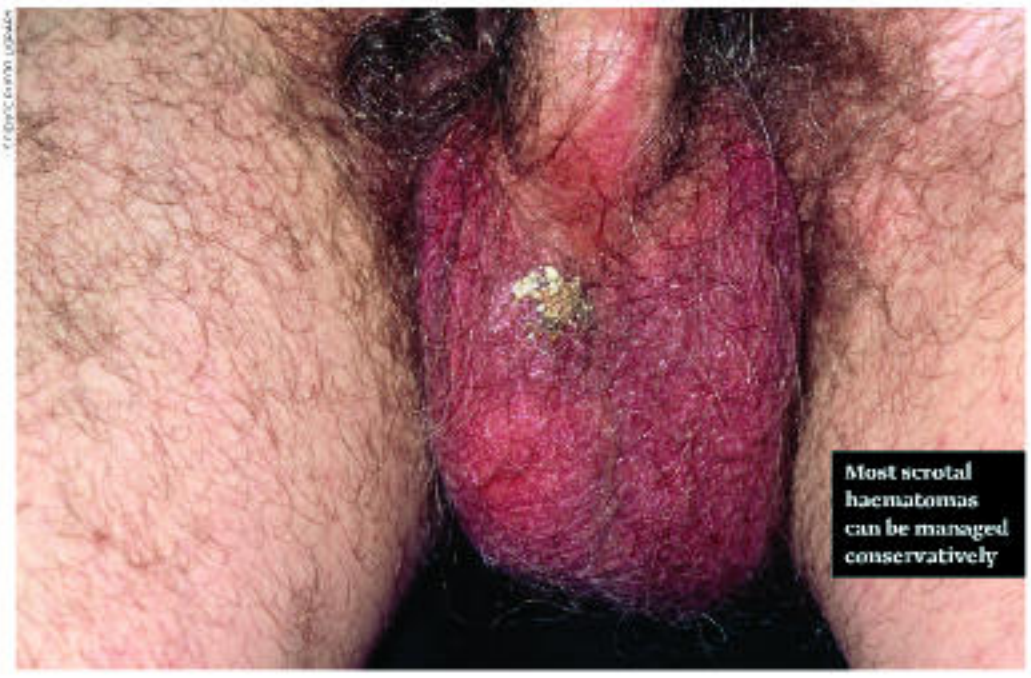
Within two weeks his eye closure had improved and within a month his mouth and forehead had gone back to normal.

Dr Oliver Starr is a GP in Stevenage, Hertfordshire

POST-OP PROBLEMS

Urological surgery complications

Consultant urologist Mr Ian Eardley and SpR in urology Miss Lehana Yeo continue our series on post-operative problems with a look at complications after urological surgery



Most scrotal haematomas can be managed conservatively

Between 10% and 12% of patients who are referred to urology by their GP require operations, and most can be carried out as a day case. The British Association of Urological Surgeons[1] produces useful information leaflets for patients who are due to undergo surgery – these can be downloaded from pulsetoday.co.uk/tools-and-resources.

GPs should be aware of the complications that may arise from common urological procedures and how to manage them. Most of these complications can be managed in the community, and many patients will only need reassurance. In some cases, assessment by the on-call urology team is necessary.

These complications can be classified as immediate (within six hours), early (six to 72 hours) or late (after 72 hours).

General complications

Endourological surgery

Cystoscopy is the most common urological procedure. Other procedures can be performed at the same time as cystoscopy, including biopsy, diathermy and stent insertion. Some complications are common to all of these procedures.

Immediate and early

- *Haematuria* is usually mild and self-limiting. Post-operative bleeding requiring return to theatre occurs in less than 0.5% of cases. On discharge from hospital, patients should increase their fluid intake until the urine becomes clear – this will usually take one to two days. In rare cases, bleeding can be significant and if the patient develops painful clot retention then readmission for urethral catheterisation and irrigation is necessary.
- *Dysuria* is usually mild and self-limiting, lasting for one to two days. Patients should be reassured. If it persists, urinalysis should be performed to identify UTI.
- *Irritative bladder storage symptoms* such as frequency, urgency and urge incontinence are usually self-limiting – but again, urinalysis should be performed to identify UTI.
- *Urinary retention* may be a complication of anaesthesia or may be caused by the procedure itself. A urethral catheter might be necessary for a short period of time in those who develop painful retention, usually with a bladder volume of more than 500ml.
- *Perforation of the bladder* is extremely rare and typically presents 12 to 48 hours after cystoscopy. The patient passes little or no urine and develops abdominal pain and sepsis. Referral to hospital is indicated, where the diagnosis will be confirmed by cystogram and treated with catheterisation, or occasionally surgical repair.

Late

- *Infection* typically occurs two to four days after cystoscopy, and can occur even if antimicrobial prophylaxis was given at the time of surgery. Confirmation is by urinalysis, and a midstream urine sample should be sent for microscopy and culture prior to starting any antimicrobial therapy.
- *Urethral stricture* results from scar tissue formation after injury to the urethra. It is usually seen in men, and presents with symptoms of hesitancy and poor urinary stream. Treatment by urethral dilatation or optical urethrotomy may be needed.

Scrotal and penile surgery

Scrotal and penile operations – including vasectomy, circumcision and hydrocele repair – also share some common complications.

Immediate and early

- *Bleeding* occurs because there is no natural cutaneous tamponade in the scrotum, because of scrotal laxity. Moderate bruising is common and does not need treatment, but occasionally haematomas can occur. Most scrotal haematomas can be managed conservatively, but there is a risk of secondary infection and antibiotics can be given to prevent this. Large, tense, expanding or infected haematomas require drainage.

Late

- *Wound infection* is usually superficial, and treatment is with antibiotics, guided by local policies. If you suspect an infected collection, stitch removal may be necessary. Significant intra-scrotal abscesses require surgical drainage.
- *Persistence of absorbable sutures* beyond three or four weeks may require removal if they trouble the patient.

Procedure-specific complications

Ureteric calculi surgery

Including ureteric stent insertion.

Early

- *Loin pain* is normal for 24 to 48 hours following surgical treatment of ureteric calculi. But if it persists beyond this time, there may be retained stone fragments.
- *Pyuria* is common in patients with a stent, but only a small proportion develop significant sepsis. Urinalysis is the first step in determining whether antibiotics are required.
- *Stent symptoms* such as haematuria or *irritative storage symptoms* including frequency, urgency and nocturia are common. This reflects irritation of the bladder by the lower end of the stent. Patients just need reassurance – symptoms will resolve after stent removal.

A guide for patients can be downloaded from pulsetoday.co.uk/tools-and-resources.

Late

- *Loin pain* is typically caused by acute reflux of urine into the kidney during micturition in patients with a ureteric stent. It often improves with time and completely resolves after stent removal.
- *Displaced stent* is less common and often asymptomatic. Very rarely, the stent can be displaced downwards into the bladder and is actually voided by the patient. This complication is confined to women due to their shorter urethra.
- *Stent blockage* occurs when the stent becomes coated with a biofilm and later becomes encrusted, resulting in stone formation. Stents typically should not remain in situ for longer than six months. New-onset loin pain in a patient with a previously asymptomatic stent is strongly suggestive of stent blockage and requires urological intervention. If the loin pain is associated with fever, urgent urological assessment is necessary because of the possibility of obstructive pyonephrosis.

Transurethral resection of the prostate (TURP)

Immediate and early

- *TUR syndrome* is a very rare condition which presents with hyponatraemia – confusion, nausea and vomiting, visual disturbances and seizures. This usually occurs during the inpatient stay and so is typically resolved by the time patients are discharged, but requires urgent referral if seen in primary care.

Late

- *Failure to void* can be caused by initial oedema from residual prostatic tissue and urethral pain, but most patients will void after a second trial without catheter. Only 1% of patients will need a long-term catheter post-operatively, and this usually reflects detrusor failure.
- *Haematuria* two to three weeks post-operatively is common and can be due to separation of sloughed tissue from the operative bed – patients just need reassurance. Occasionally the bleeding can be persistent, and then increased oral fluids and a short course of antibiotics is appropriate. Rarely, this 'secondary haemorrhage' results in clot retention, requiring admission to hospital and catheterisation.
- *Urinary incontinence* occurs in around 10% of men at discharge from hospital, although the prevalence diminishes with time. If the incontinence persists beyond six to eight weeks and the symptoms are predominantly irritative (frequency, urgency and urge incontinence), then antimuscarinic agents may be helpful. Damage to the external urethral sphincter during surgery will cause stress urinary incontinence that persists and requires surgical intervention.
- *Sexual dysfunction* can include retrograde ejaculation and erectile dysfunction. Patients are counselled pre-operatively about the risks. Retrograde ejaculation occurs in 75% of men after TURP, and there is no useful treatment for this. Erectile dysfunction occurs in 5-10% of men and this is typically responsive to a PDE5 inhibitor. About 50% of patients experience absent or altered sensation of orgasm.
- *Recurrent lower urinary tract symptoms*, especially in a patient who had a good initial response to surgery, usually indicate some sort of obstruction. If symptoms recur within

two to six months, the cause is typically a urethral stricture requiring re-referral. If symptoms occur later, there may be regrowth of the prostate. Around 10% of men who undergo TURP may subsequently require re-operation over a five-year period, because of regrowth of prostatic tissue.

- *Prostate cancer* is found in 10% of patients at histology. This does not always require treatment, but a post-op PSA is useful in these patients.

Transurethral resection of a bladder tumour (TURBT)

Immediate and early

- *Loin pain* because of damage to the ureteric orifice at the time of surgery can consequently affect drainage of that kidney. Surgical decompression with a nephrostomy and ureteric stent may be required – although in many cases, the obstruction is due to oedema and resolves without intervention. Loin pain and a fever is an emergency, as it strongly suggests infection – an urgent ultrasound is required to identify obstruction.

Late

- *Haematuria* at two to three weeks post-operatively is common. Management is the same as discussed above, following TURP.

Vasectomy

Late

- *Persistent sperm in the ejaculate* can be due to spontaneous recanalisation of the vas deferens or failure to perform a bilateral vas deferentectomy. Alternative forms of contraception are vital until the semen analyses are negative – if sperm persist in the ejaculate beyond nine to 12 months, re-exploration and a repeat operation is necessary. Recanalisation may occur after a prior negative semen analysis, and pregnancy may result. But the risk of this is around one in 2,000-3,000.
- *Sperm granuloma* is due to sperm leak from the testicular end of the vas deferens. The patient will notice a small lump in the scrotum which is usually non-tender and located on the epididymis. The diagnosis is confirmed by ultrasound and no treatment is needed.
- *Chronic testicular pain* can occur in 5% of patients, and although a sperm granuloma can be the site of pain, the cause is not usually apparent. The pain should be treated conservatively with scrotal support and regular analgesia. If it persists, urological referral is indicated, although resolution may be difficult to achieve.

Circumcision

Immediate and early

- *Persistent bleeding* from the skin edges is rare. If pressure does not resolve the problem, an extra suture or two will be required.
- *Penile bruising and swelling* can last several days and usually does not need treatment.
- *Permanent altered sensation* can occur because removal of the non-retractile foreskin initially leaves the glans penis hypersensitive. No treatment is necessary. In the longer term, there are reports of both hyper- and hypoaesthesia. The latter is thought to be due to cornification of the epithelium of the glans – there is no available treatment.

Late

- *Separation of the skin on the shaft of the penis from the coronal sulcus mucosa* can occur. This will usually heal spontaneously if limited to a small area, otherwise re-suturing will be needed.
- *Skin bridges* are rare, but if they develop they can be divided surgically.
- *Urethrocutaneous fistula* can occur when haemostatic sutures, used at the frenular artery, pass through the urethra and the wound later breaks down. Patients will notice urine leaking from the wound on voiding. This is extremely rare and requires surgical repair.
- *Meatal stenosis* usually occurs because of the coexistence of balanitis xerotica obliterans. The urethral meatus will be narrowed and patients will complain of a weak stream. Topical steroid cream may be helpful.

Scrotal surgery

Including hydrocele repair, excision of epididymal cyst or spermatocele, and orchidopexy.

Late

- *Recurrence of the hydrocele* occurs in around 5-10% of cases, when redundant tunica vaginalis forms an enclosed space for re-accumulation of fluid. Re-operation is required if it is troublesome to the patient.
- *Recurrence of an epididymal cyst* can occur in around 10% of cases. If troublesome, further surgery – usually an epididymectomy – is required.
- *Subfertility* can be caused by scar damage to the epididymis. There is no treatment for this, but surgical sperm retrieval may be indicated after a full assessment of the couple.
- *Testicular atrophy* is a rare complication resulting from damage to testicular vessels. It can occur after difficult surgery to a large cyst – often with a significant haematoma post-operatively. There is no treatment for testicular atrophy, so referral is not indicated. If there is chronic pain, then orchidectomy is required.

Mr Ian Eardley is a consultant urologist and Miss Lehana Yeo is an SpR in urology at St James's Hospital, Leeds

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Further reading

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Cardiology GPSI Dr Matt Hughes outlines five key recent developments and their impact on GP practice

WHAT'S NEW IN Cardiology

1 Latest NICE guidance on hypertension

This update of the 2006 NICE guidance focuses largely on diagnosis, rather than management, and the biggest change is the recommendation that all new diagnoses should be confirmed by ambulatory blood pressure monitoring (ABPM).[1]

If the clinic blood pressure is 140/90mmHg or higher, the diagnosis should be confirmed by ABPM. At least two measurements an hour should be taken and at least 14 in total during waking hours. This has huge implications and some have argued it has not been properly thought through.

We know ABPM is better than clinic readings in identifying patients who are likely to have a cardiovascular event, but know less about how it compares to home blood pressure monitoring. A practice that does not carry out its own ABPM and still has to refer to an outpatient service would probably find it easier to buy a set of home monitors than bring ABPM in house.

This is especially important in light of a study published in November 2011 which suggested that if patients were left alone, using an automated device could virtually eliminate white-coat hypertension.[2]

Other changes to the NICE guidance include diuretics being removed as a first-line option for black people and patients aged over 55. If one needs to be used, a thiazide-like diuretic is specifically recommended rather than a traditional diuretic.

1 NICE. *Hypertension: clinical management of primary hypertension in adults*. August 2011;CG127
2 Myers M, Godwin M, Dawes M et al. Conventional versus automated measurement of blood pressure in the office (CAMBO) trial. *Family Practice* 2011, online 24 November

2 Doubts over the value of exercise referral

Many of us use exercise referral programmes where a sports centre or health club can provide a tailored and monitored 10- to 12-week exercise programme.

But in November 2011, a *BMJ* Health Technology Assessment cast doubt about the effectiveness of these schemes for increasing physical activity, fitness or health outcomes. Exercise referral schemes did increase the chance of patients doing the recommended weekly exercise by 16% and reduced risk of depression by 18%, but there was no difference in other clinical outcomes between the exercise referral and control groups.

There was only weak evidence that exercise referral is any better than giving basic advice and the researchers found no difference between taking part in an exercise referral scheme or other interventions such as a walking programme. One key drawback identified in the study was a failure to properly address long-term behaviour change.

This analysis does not mean we should give up on these schemes. It did not answer some important questions, specifically whether the schemes have any particular benefit in patients with a pre-existing diagnosis. But it should be a spur to fully evaluate such schemes.

Pavey T, Taylor A, Fox K et al. Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: systematic review and meta-analysis. *BMJ* 2011;343:d6462

3 Dabigatran as an alternative to warfarin

There is overwhelming evidence to back the use of warfarin in patients with atrial fibrillation, but no clinician needs reminding that it is a very troublesome drug to use.

In March 2012, a NICE technology appraisal of dabigatran – a direct thrombin inhibitor – recommended it as an alternative to warfarin.[1] The real-world benefit of dabigatran is that it is a fixed-dose, oral tablet with no need for regular monitoring apart from intermittent renal function checks. The key trial demonstrated dabigatran 110mg bd to be as effective as warfarin with less bleeding, and 150mg bd more effective but with a slightly increased bleeding rate.

But, of course, there are downsides. Although the half-life is relatively short (around 12 hours), there is no antidote in the event of a serious bleed. At around £66 per month it is an eye-watering 80 times more expensive than warfarin – so most of our patients with atrial fibrillation will be stuck with warfarin for a good few years.

Finally, last month a US meeting heard preliminary data from a study looking at patients on dabigatran attending a 'real world' anticoagulation clinic. Early data in 113 patients suggested there were complications in 11.5% of patients treated with dabigatran compared with 0.88% with warfarin.

But this finding needs to be put in context. There will be 2,200 patients in the final analysis and these problems tended to be seen in older patients on a higher dose than the 110mg recommended in the UK.

There is little doubt that dabigatran and the other upcoming alternatives to warfarin will make a big difference to patients with atrial fibrillation. But a cautious approach is justified.

1 NICE. Dabigatran etexilate for the prevention of stroke and systemic embolism in atrial fibrillation. Technology appraisal guidance 249, March 2012

4 Atorvastatin becomes generic

The patent for atorvastatin has now expired and generics are being released at around 10% of the cost of Lipitor. There is no doubt this will have a profound impact on our prescribing, with many patients currently on simvastatin being switched to the more powerful lipid lowerer.

Personally, I will start using atorvastatin as my first-choice statin, getting more patients to target more quickly. In my clinical experience it is a very well-tolerated statin and I would have been using it far more if it were not for the cost. But it's important to be aware that – at the time of writing – the cost reductions are not yet reflected in the *Drug tariff* price of atorvastatin and prescriptions will continue to be charged at the high rate until this changes.

5 The four big unanswered questions on hypertension

There is a lot we don't know about hypertension, and this was the subject of a session at the European Society of Hypertension annual meeting this year.[1]

Here, the chair of the NICE hypertension guideline development group Professor Bryan Williams admitted that we have no idea what an ideal blood pressure-lowering target is – while highlighting this wouldn't be helpful in helping our patients tackle hypertension. The society has now identified four key questions which need to be answered by pragmatic, clinical trials:

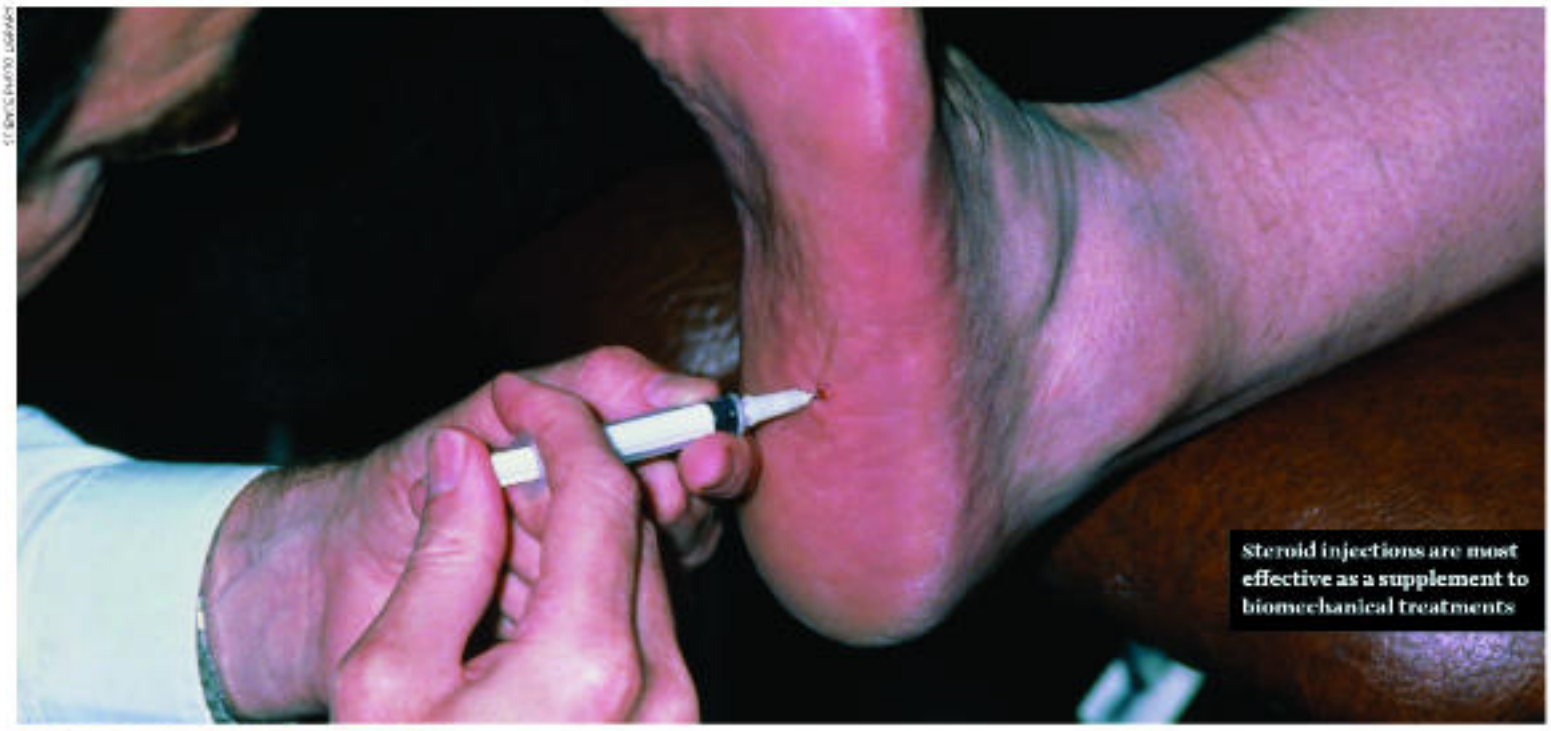
- Should everyone younger than 65 with grade 1 hypertension be treated with antihypertensives, even when total cardiovascular risk is relatively low? And what about older patients?
- Should everyone with diabetes – or pre-diabetes – or patients with cardiovascular or kidney disease be treated, even when their blood pressure is in the so-called high-normal level – 120-139mmHg?
- Are the benefits progressively greater the lower the blood pressure? What's the clinical significance of the J curve?
- Similarly, what are the lowest safe blood pressure goals in different patient groups?

These won't be answered in four single trials – they need to be explored in different clinical groups. And, for example, trials looking at the J curve will need three blood pressure target groups. At least one of these trials is under way – a joint European and Chinese trial is looking at the J curve and clinical outcomes in three systolic target groups: 145-135mmHg, 135-125mmHg and less than 125mmHg.

1 European Society of Hypertension. 22nd European Meeting on Hypertension and Cardiovascular Protection. London. Plenary session 4A, 28 April 2012. eshonline.org

Dr Matt Hughes is a cardiology GPSI in Birmingham

Competing interests None declared



Steroid injections are most effective as a supplement to biomechanical treatments

THE INFORMATION

Plantar fasciitis

Mr Rohit Madhav, consultant orthopaedic surgeon, continues our series of evidence-based lowdowns on common presentations using PUNs and DENs

THE PATIENT'S UNMET NEEDS (PUNS)

A 50-year-old man hobbles into the surgery. He has had a painful heel for over six months. Despite using NSAIDs and heel pads, the symptoms are no better, and he's reached the 'something must be done' stage. In particular, he's keen on an X-ray, as a friend with the same condition had one and this revealed a 'spur'. He would also like an injection, as his friend said that had proved effective.

THE DOCTOR'S EDUCATIONAL NEEDS (DENS)

What is the specific pathology in plantar fasciitis? Is the presence of a calcaneal spur of any relevance? Is an X-ray, or any other investigation, helpful?

Plantar fasciitis is localised inflammation of the fibrous band called the plantar aponeurosis. It affects the medial band at the heel insertion in 80% of cases, with middle to distal pathology in the remaining 20%.

The exact aetiology of plantar fasciitis is poorly understood, but it is usually thought to be due to overuse injury, secondary to prolonged weight bearing. It can occur in athletically active or in sedentary individuals.

It may be associated with autoimmune conditions as part of an enthesopathy, and these patients will often need assessment and treatment from a rheumatologist. It is more common and more resistant in patients with diabetes, but treatment is essentially the same.

There isn't a general consensus on the gold-standard investigation for plantar fasciitis and diagnosis is usually made on the basis of history and clinical findings. Patients typically present with start-up heel pain that eases briefly, and returns on further weight-bearing activities. The patient is usually tender around the medial calcaneal tuberosity or central heel pad.

The presence of a calcaneal spur is usually a coincidental finding – they are seen in 20% of asymptomatic people – and its presence or absence is not helpful in making the diagnosis. Ultrasound scanning is the most commonly used investigation to aid diagnosis and treatment, with MRI and other investigations such as scintigraphy being reserved for difficult cases.

We often tell patients that plantar fasciitis can take some time to improve, but what is the precise prognosis? How often is it linked to an inherent abnormality of the foot or associated arthropathies, and how do these affect the outlook?

Overall, the prognosis for mechanical plantar fasciitis is very favourable – with 95% improvement or resolution. Most people have complete recovery within one to one and a half years, but it can take anywhere from three months to three years, leaving 5% of patients who may require surgery.

The condition can occur in a variety of foot shapes such as planus or cavus. It is most common in planus feet and if there is a significant abnormality patients may require additional biomechanical correction with functional foot orthotics.

Plantar fasciitis is often more resistant when associated with inflammatory arthropathies, diabetes or as part of an enthesopathy syndrome.

How effective are NSAIDs, heel pads and stretching exercises? Does rest help?

First-line treatment consists of NSAIDs, cushioned footwear with heel lifts, stretching the achilles and plantar fascia[1] and using night splints. These strategies are very effective and are the main recommended treatment pathway. But if the injury is proving resistant or if it is severe, then second-line treatment with steroid injections followed by extracorporeal shockwave therapies can be recommended. These have a cumulative resolution rate of up to 95%.

Although prolonged immobilisation or resting is not proven to work, serial casting can be effective in resistant cases and can be used in combination with a steroid injection. And, in addition to the biomechanical treatment methods already mentioned, it is advantageous for patients to reduce the amount of time they spend on their feet – advise them to perch or sit at every opportunity, stop impact activities such as racquet sports and have shorter walks.

What is the evidence for steroid injections? If they are useful, what is the most effective approach?

Although the evidence for the use of steroid injections is very limited, they are widely accepted and used. A Cochrane database review[2] did show improvement in symptoms at one month, but this was not maintained at six months.

The method of delivery is equally effective whether it is undertaken by injecting the most tender spot or targeted using ultrasound guidance. Again, it is best used and most likely to be effective as a supplement to the above biomechanical treatments.

What other treatments are available and how effective are they?

Recent randomised controlled trials have shown that extracorporeal shockwave therapy in conjunction with physiotherapy treatments is more effective than either method alone. This is reserved for patients with symptoms lasting over six months, and where steroid injection has not worked.[3]

Platelet-rich plasma is currently under evaluation. Early results show it to be as effective as steroids. The systems available for obtaining platelet-rich plasma vary and this means the quantity of platelets in the mixtures are different, making comparison studies difficult. The procedure is undertaken within trials or under strict audit – the techniques are evolving and may prove to be a promising adjunct.

A course of electroacupuncture and transcutaneous electrical nerve stimulation can be used with chronic pain in resistant cases. They are equally effective, but the longevity of pain relief is not known.

Mr Rohit Madhav is a consultant in orthopaedic and trauma surgery at University College London Hospitals NHS Trust and the London Orthopaedic Clinic

For more information on the London Orthopaedic Clinic, go to londonorthopaedic.com

Key points

Causes
- The cause of plantar fasciitis is usually repetitive minor injuries to the fascia.
- Risk factors include ankle stiffness in dorsiflexion, obesity or activities involving prolonged weight bearing or standing.
- It can be precipitated by changes in footwear, daily routine or athletic training.
- The aetiology of plantar fasciitis remains unknown in approximately 85% of cases.

Epidemiology
- Around one in 10 people will get plantar fasciitis at some point in their life, most commonly between the ages of 40 and 60.
- It occurs in very athletic people and in people with more sedentary lifestyles.
- It is twice as common in women as in men.

Clinical features
- The classic symptoms are stiffness and pain following periods of rest – for example, first thing in the morning or after prolonged sitting – which eases off after a few minutes or steps, and then progressively returns with prolonged walking or standing.
- Palpation of the plantar fascia on full stretch usually reveals tenderness either along the medial or lateral band, and a maximal painful focus at the proximal insertion.
- Radiographs are usually inconclusive – calcific heel spurs are coincidental.
- MRI or ultrasound scans usually show plantar fascial thickening, tissue inflammation, or calcaneal bone oedema at insertion.

Main differential diagnoses
- Heel contusion
- Plantar fascial rupture
- Tibialis posterior tendonitis
- Calcaneal stress fracture
- Infection
- Inflammatory enthesitis
- Tarsal tunnel syndrome
- Subtalar arthrosis
- Tumours.

Treatment
- First-line treatment is with NSAIDs, cushioned footwear with heel lifts, stretching, and night splints.
- Occasionally, steroid injection and extracorporeal shockwave therapy can be used second line.

Complications
- Misdiagnosis
- Plantar fascial ruptures.

Prognosis
- Plantar fasciitis generally has a good prognosis and most patients recover within one to one and a half years.

References

1 Digiovanni B, Nawoczenski D, Malay D et al. Plantar fascial-specific stretching exercises improve outcomes in a patient with chronic plantar fasciitis. *JBJS* 2006;88:1775-81
2 Crawford F and Thomson C. Interventions for treating plantar heel pain. *Cochrane Database Syst Rev* 2003;3:CD000416
3 NICE. Extracorporeal shockwave therapy for fracture pains and fasciitis. *NICE interventional procedure guidelines* 2009;IPG331

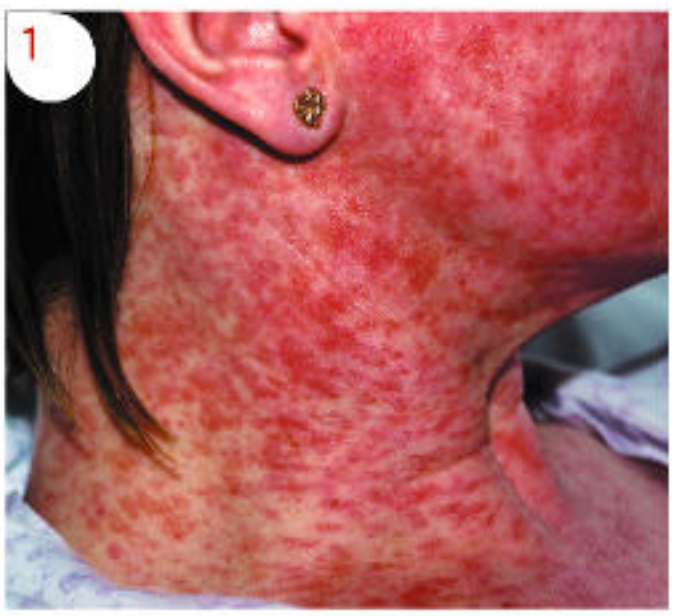
Further reading

Clinical Knowledge Summaries. *Plantar fasciitis*. cks.nhs.uk (accessed 11 May 2012)

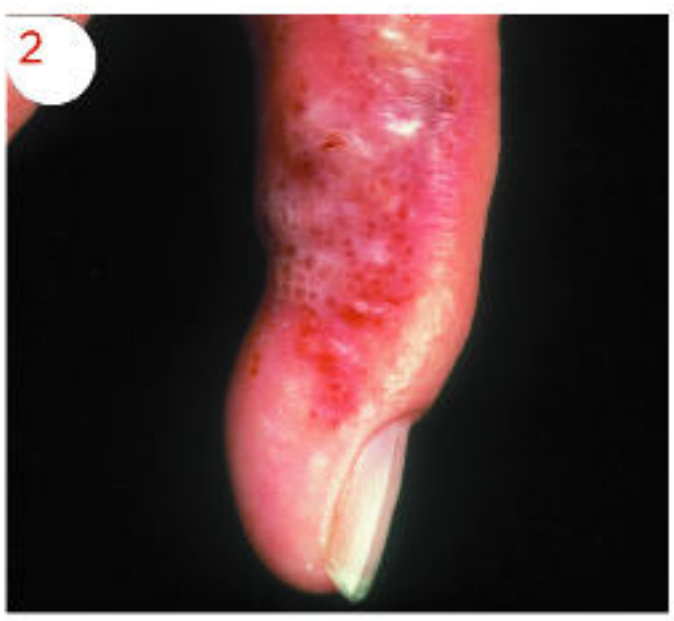
PICTURE QUIZ

Viral diseases

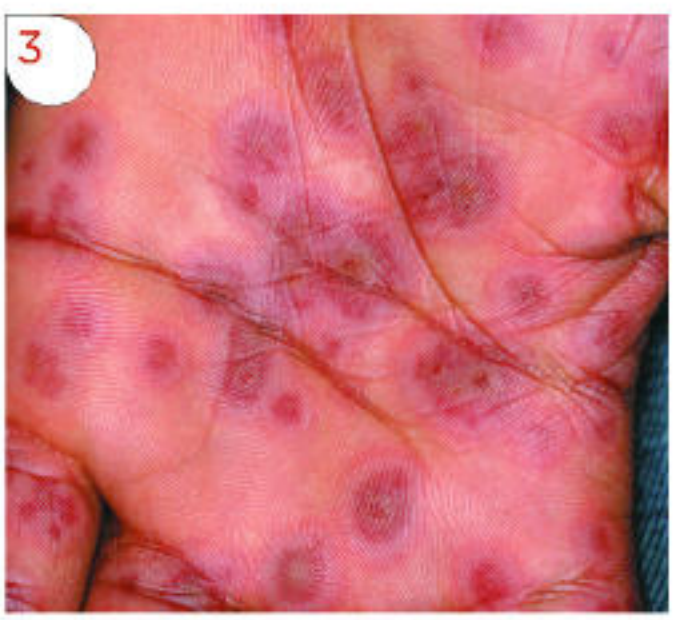
These five patients presented with skin complaints – can you work out what viral disease each patient has? Answers are at the bottom of the page



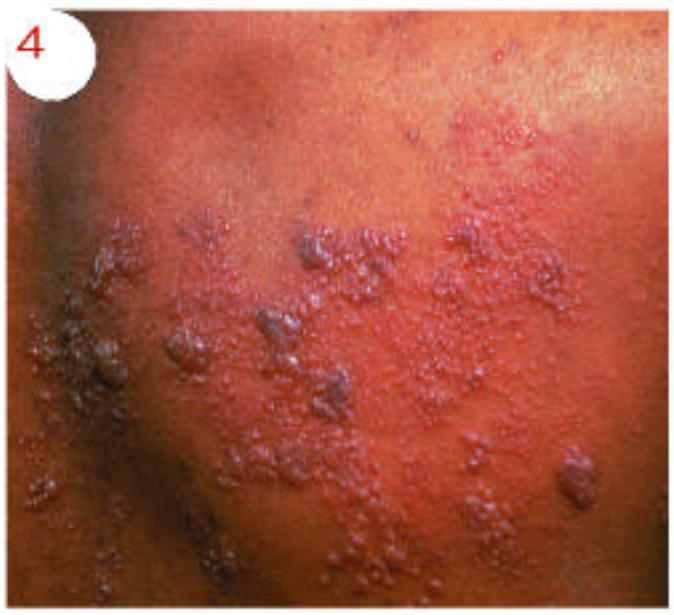
This 30-year-old woman had a cold and a fever for a few days before this florid rash appeared and she started to feel really unwell.



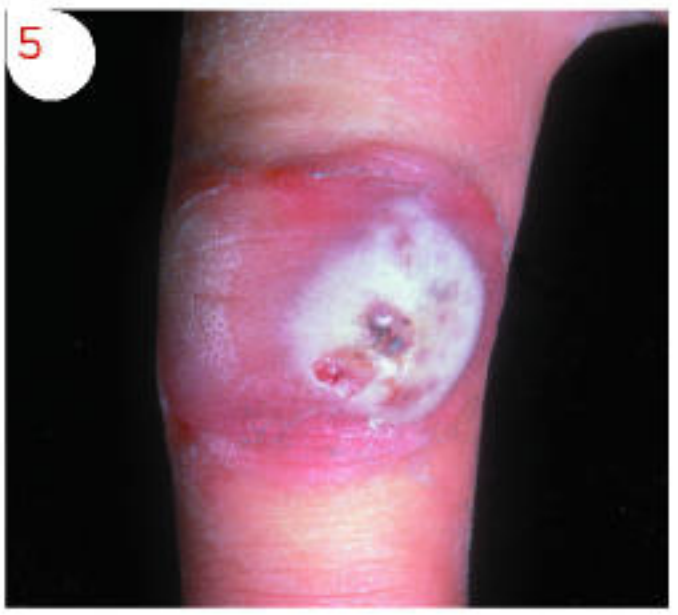
These blisters had been present on this woman's finger for about five days before she presented complaining that her finger was becoming increasingly painful. She was otherwise well.



A week prior to presentation, this 30-year-old man had suffered his first episode of genital herpes. Now he was developing this symmetrical rash on his palms, which was spreading up his arms.



This fit, 20-year-old man was worried about some thoracic pain that had been present for a few days. His attendance was finally prompted by the appearance of this rash on his upper back.



This butcher thought he had an infected cut on his finger and was keen on some antibiotics so he could resume work. The lesion had been present for a week and was painful.

ANSWERS

1 Measles
A systemic viral infection may be accompanied by a widespread eruption – an exanthem. In this patient with measles, there is a morbilliform exanthem of red macules which started on the face and neck. In measles there is a three-day prodrome of fever, cough, coryza and conjunctivitis. Koplik's spots develop on the buccal mucosae one to two days before the exanthem. The rash starts behind the ears and on the forehead, and then spreads over the entire body. It fades in a cephalocaudal manner over the next two days. Viral exanthems resolve spontaneously without long-term problems. If it is mildly itchy use general emollient therapy – if very itchy use steroid ointment, twice per day.

2 Herpetic whitlow
Herpes simplex is a common viral infection affecting the skin and mucous membranes. Two sub-types are recognised; HSV1 is the main cause of oral and facial lesions, while HSV2 is responsible for the majority of genital infections. Both viruses persist in the sensory nerve ganglia after primary infection and can travel peripherally to the skin or mucous membranes to cause recurrent disease. The acute eruption consists of grouped vesicles on an inflamed base, which become pustular and then crusted before healing within seven to 10 days – in this case, numerous vesicles have coalesced along the side of the finger producing a herpetic whitlow. Infection is usually self-limiting and often no treatment is necessary.

3 Erythema multiforme
Erythema multiforme is a distinctive eruption that occurs most commonly in response to an infection with herpes simplex virus. Lesions appear abruptly approximately seven days after either HSV1 or HSV2 infections. Palms, soles, backs of hands, tops of feet, elbows and knees are the most common sites. Classical lesions are target-like, comprising a series of alternating red and pale rings. The centre of each lesion is often dusky or blistered. Most cases are self-limiting, with the lesions regressing within two weeks. Repeated episodes are usually associated with HSV reactivation, and in these cases, prophylactic antiherpetic therapy is usually indicated – aciclovir 400mg twice per day or valaciclovir 500mg once daily for six months.

4 Herpes zoster
Herpes zoster or shingles is a localised, dermatomal eruption caused by reactivation of latent varicella zoster virus within the peripheral sensory nerves. There is a prodrome of regional pain that precedes the appearance of herpes zoster by one to three days. The eruption is characterised by one or more groups of red papules, which evolve into vesicles. With time, the vesicles become confluent and form a distinctive unilateral, linear distribution. Dissemination to the lesions regressing within two weeks. Repeated episodes are usually associated with HSV reactivation, and in these cases, prophylactic antiherpetic therapy is usually indicated – aciclovir 400mg five times per day or valaciclovir 1g three times per day for seven days.

5 Orf
Orf is caused by a parapox virus that infects young sheep and goats. In humans, orf occurs mainly as an occupational disease in individuals who handle these animals, such as farmers and butchers. Direct inoculation from an infected source into the skin usually produces the inflammatory lesion. The initial lesion is a small, firm, red or violaceous papule which gradually enlarges. In established orf, a larger appearance may occur with a central area of erythema surrounded by concentric white and red rings. With time, the typical nodule becomes necrotic and develops a crusted, umbilicated centre, growing to 1-2cm before gradually regressing. The lesions are often painful and itchy. Treatment is usually not necessary and orf will clear spontaneously within six weeks.

These cases are taken from *Acute adult dermatology – a colour handbook* by Daniel Creamer, Jonathan Barker and Francisco A Kerdel. ISBN 9781840761023 (Manson Publishing); available from mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95

 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 DD 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 DD 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, N and Chittagong Hill Tracts.	ME or DD 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 DD or MON	PC	Sh Le
Bermuda		S					S						No			
Bhutan	R	R	S		R	S	S	S	C		S		Yes, southern districts	ME or DD or MON	EBT	Le
Bolivia	R	R			R	S	S	S	R				Yes, high risk in Amazon basin.	ME or DD or MON	PC	
													Variable risk on Paraguayan and Argentine borders	PC	EBT	
Borneo	R	R	S		S	S	S	S	C		S		Low risk, coastal areas of Malaysian	W		
													Sarawak and Sabah	ME or DD 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 DD or MON	PC	Sh Ta
Brazil	S	R			S	S	S	S	R				High risk in NW half in Amazonia states	ME or DD 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 DD or MON	PC	Sh Le Ta
Burundi	R	R	S			S	S	S	M				Yes, high risk	ME or DD or MON	PC	Sh Ta
Cambodia	R	R	S		R	S	S	S	C		S		Yes	DD or MON	PC	
													Yes, significant risk elsewhere	ME or DD 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 DD 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 DD or MON	PC	Sh Ta
Chad	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DD 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 DD 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 DD or MON	PC	Le Ta
													Variable risk elsewhere <1,000m	PC	EBT	
													Very low around Medellin, Bogota & Cartagena	W		
Comoros	R	R	S		S	S	S	S					Yes, high risk	ME or DD or MON	PC	Le
Congo	R	R	S	R	R	S	S	S	M				Yes, high risk	ME or DD or MON	PC	Sh Ta
Congo-Dem. Rep.	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DD or MON	PC	Sh Ta
Cook Islands		R					S						No			
Costa Rica		R			S		S	S	C				Small variable risk area 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 DD 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 DD or MON	PC	Le
Ecuador	R	R				S	S	S	R				Yes, high risk Esmeraldas and its littoral rim bordering Colombia and Peru.	ME or DD or MON	PC	Tc
													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 DD or MON	PC	Sh Ta
Eritrea	R	R	S		R	S	S	S	C	S			Yes, high risk (no risk in Asmara)	ME or DD 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 DD 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 DD 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 DD or MON	PC	Sh
Gambia	R	R	S			S	S	S	R	S			Yes, high risk	ME or DD 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 DD or MON	PC	Sh Ta
Goa	R	R		R	R	S	S	S	C		S		Yes, variable risk	PC	EBT	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 DD or MON	PC	Sh Ta
Guinea Bissau	R	R	S		S	S	S	S	M	S			Yes, high risk	ME or DD or MON	PC	Sh Ta
Guyana	S	R				S	S	S	R				Yes, high risk all areas except coastal strip	ME or DD or MON	PC	Sh
Haiti	R	R	S		R	S	S	S	C				Yes, high risk throughout country	ME or DD 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 DD or MON	PC	Le
													Yes, low risk in southern states, Delhi, Jaipur, Agra, Mumbai.	W		
													Yes, elsewhere	PC	EBT	
Indonesia	R	R	S		R	S	S	S	C		S		Yes, high in Lombok	ME or DD or MON	PC	Sh
													Very low in Bali and cities	W		
													Yes, variable elsewhere	PC	EBT	
Iran	S	R	S		S		S	S	C				Yes, rural SE provinces Mar-Nov	ME or DD or MON	PC	Sh Le
Iraq	R	R	S		R	S	S	S	C				Yes, v. low risk rural north May-Nov	W	P	Sh Le
Israel		R					S	S					No			Le
Italy		S					S					S	No			Le
Ivory Coast	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DD 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 DD 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 DD 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 DD 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 reduviid 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

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.

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
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 forest in 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.	ME or DO or MON	PC	Sh
													Yes, all year – along Kavango and Cunene Rivers			
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 departments, 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
													No risk: 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, rural 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 rim bordering Zimbabwe, Mozambique & Eastern Swaziland, including Kruger, Kosi Bay & Jozini	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			Le
Sri Lanka	R	R				S	S	S	C		S		Yes, far north and NE, north of Anuradhapura & Polonnaruwa	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, 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 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 HoChiMinh 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 2.96%, 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

Pulse Business & Commissioning

Practice Business

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Managing difficult consultations
In the first of a series of three articles, psychologist Louise Robb advises how GPs can handle stressful appointments

Effective telephone conversations
Consultant Sally-Anne Pygall looks at how phone consultations can leave both GP and patient happy

Commissioning

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How we set up a 'Fairness Commission'
Dr Ian Wilkinson explains how Oldham CCG explored the ethics of commissioning

NAPC 10-step guide to authorisation
Legal firm Hempsons has partnered with the NAPC to offer detailed advice for CCGs

Seven ways to manage rapid practice list growth

Dr Stuart Bingham and **Ross Arnold** advise how to handle significant expansion

The benefits of increasing your list size are many: more income and more profit, economies of scale in administrative and managerial functions, greater opportunities for service development (for example in clinical specialisms that require a critical mass of patients to be viable), more opportunities for staff career progression, and greater standing as power and influence shifts from PCTs to clinical commissioning groups.

But expanding your list rapidly is hard work and not for the faint hearted. Regular recruitment decisions have to be made that represent serious financial investment in the business. It can sometimes feel like half the working week is spent sifting through job applications, the other half in constant change management and revision of your business strategy.

Our practice was originally located in a run-down area of London's Docklands. It was closed after its list shrank to 800 or so patients, but after a campaign by local residents in 2002 the PCT opened it again. The practice moved into purpose-built premises in December 2007 and is now located in the Barkantine Centre with a pharmacy, a café, a dentistry suite (special needs and teaching), the community mental health team, health visitors and a birth centre.

In September 2010 the Barkantine was commissioned as an APMS practice. Now located next door to Canary Wharf, an area of extensive urban regeneration and fast population growth, the practice anticipates a net immigration of 40,000 patients to its catchment area over the next decade. The Barkantine's patient list has been growing steadily at a rate of 2,000 to 2,500 annually since it moved into its new premises, and we currently have just under 18,000 patients on its books.


Dr Stuart Bingham: expanding your list is not for the faint-hearted

While list growth at this rate tends to happen only in urban areas, any practice can face a period of rapid expansion – in fact, many will seek to attract large numbers of patients quickly if they are running a specific campaign. Here are seven suggestions to help you maximise the financial benefits of a new patient population, and avoid costly mistakes regarding staff, premises and service quality.

1 Discuss with partners whether rapid list growth is right for your practice

Significant list growth will not be for everyone and the business case must look closely at whether the additional income will result in additional profit. Certainly for many inner-city practices, the capitated income under GMS may not be high enough to warrant expanding the list. Premises may simply not be big enough. And once a practice has embarked on a plan for rapid list expansion, it has to be ready to manage that growth proactively to ensure that neither its quality of care nor its organisational stability is compromised.

The key thing before embarking on a project like this is to make sure everyone has come on side and is engaged with the challenges ahead.

2 Increase your visibility

It is important to understand what factors will help or hinder list growth. Visibility and accessibility are obvious factors. A practice on a main road in a large purpose-built premises, served by several bus routes, has a clear advantage over a practice set back from a quiet side-street. A practice that encourages additional footfall by co-locating with a pharmacy or

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a dentist, or accommodating community-based activities like expert patient or parenting classes, yoga or weight management, can advertise itself in a subtle but effective way.

3 Treat patients with respect

Receptionists should be trained in customer service skills – eye contact and a smile being the basics. Use technology such as automatic telephone and online appointment booking systems to create better access and reduce the demand on staff, ultimately saving money. The staffing rota should be rearranged to cope with peak times for call volume. Keep the practice website up to date: these days it may be the first point of contact for a new resident wondering where to register. Develop and invest in your patient forum and e-forum, and listen to what patients are saying in the forum or on NHS Choices for signs that things are going wrong. Don't forget to market the changes that you make so patients know you're responsive.

4 Plan your recruitment strategy

Clinical staffing at the Barkantine is reviewed every quarter and recruitment options are considered. Standard benchmarks combined with local experience are used – for example, we have an access plan of 80 appointments per week per 1,000 patients to maintain 48-hour access, which drops to 65 over the summer. We aim for list growth to be a smooth process with additional clinicians joining the team just before they are needed. One of the challenges we face is attracting clinicians, particularly GPs, to our shift-based working pattern. We are open 8am to 8pm every day – not something that appeals to everyone. But we know that short-term staffing by locums is not a good solution and patients prefer the continuity offered by permanent staff.

Bigger lists will also require more capacity in some administrative functions, for example secretarial services and summarising notes. It is important to understand these functions and to know, for example, the average time taken to summarise a set of notes, or how many referral letters per 1,000 patients are written, and to review capacity.

Practice workforce planning is essential but consider also the effects on attached services such as health visitors or midwives, whose caseloads will grow. Keep them aware of the rate of growth and provide them with more information if you can. CCGs will, we hope, give us the influence to do more than just manage need – in Tower Hamlets, local practices have successfully supported the business case for the creation of five new health visitor posts.

5 Make your premises work for you

It is one thing to ensure you are recruiting the staff to see all your new patients, but have you got enough consulting rooms to accommodate them? Consider how to make the best use of clinical space. Combining extended hours with a four-hour shift system means a room can be used three times a day (8am till midday, midday till 4pm, 4pm till 8pm) compared with the typical twice-a-day usage, creating an instant 50% increase in room space.

Bigger lists have an impact on attached healthcare services

In the longer term, think strategically: new residential developments, changes at neighbouring practices and options for premises growth are the key areas to keep an eye on. We have recently taken on a second site with five consulting rooms. At the current rate of list growth of 15-17%, this will be fully utilised in less than three years.

6 Keep staff engaged

More patients mean more income and more profit for the partners, but what is in it for the staff, apart from more work? It is essential to continue consulting with staff through any period of change, which rapid list expansion most certainly is. Communicate your plans for recruiting more staff to cope with the increasing activity so that your existing staff are reassured about workload issues. As your workforce grows, consider how to integrate new workers with old hands. Opportunities for internal promotion are positive in terms of individuals' career progression. Make sure recruitment processes are open and transparent to avoid disappointing unsuccessful internal candidates.

A large practice that is growing rapidly risks becoming impersonal and losing the human touch. Involve staff in quality improvement or patient education programmes, and take fresh approaches to interaction with patients. Barkantine's Summer Baby competition, sponsored by a local telecommunications company and the on-site pharmacy, invited parents to send in photos of their babies. Staff organising the competition have enjoyed tackling new issues such as the ethics of commercial sponsorship and found it was an easy way for staff to show extra care for young patients, for example making sure immunisations are up to date.

7 Manage data closely

A rapidly growing list requires a close eye to be kept on prevalence recording, the QOF and assimilating medical records and other data gathered by other practices (and in the case of the Barkantine, overseas healthcare professionals). Reconciling childhood immunisations or cytology schedules from, say, Eastern Europe, with our own UK schedules is a challenge and time has to be invested to ensure targets are still met. Make sure you have the capacity to deal with bigger volumes of data by making accurate estimates of the administrative burden that, say, 1,000 new patients will create.

Ensure that commissioning and prescribing budgets attached to the practice are updated to reflect the bigger patient list as well, otherwise you risk missing out on the financial benefits of list growth. Commissioning budgets are mainly just indicative at the moment – but they will become more of an issue soon.

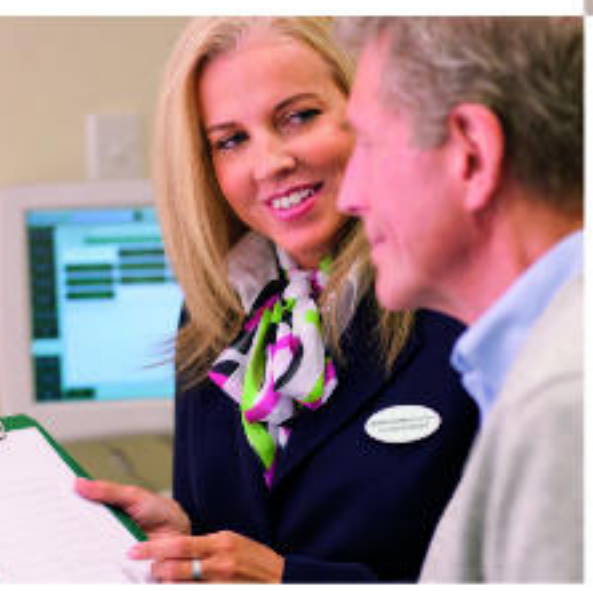
Dr Stuart Bingham is a GP and Ross Arnold practice manager at the Barkantine Practice on the Isle of Dogs, east London.

Darius Rejali FRCS, an ENT consultant with University Hospitals Coventry and Warwickshire NHS Trust, details how weekly community ENT clinics, supported by Specsavers, are making audiology assessments more convenient for patients in the West Midlands.

ACCESSIBLE AUDIOLOGY ASSESSMENTS

The Government has introduced elements of competition through any qualified provider (AQP) for a range of community and mental health services. Eight potential services were identified as being ready for initial implementation, and these included adult hearing services in the community.

AQP will extend choice of provider for patients to new services, and providers will compete for patients under terms fixed by commissioners. Under the AQP requirements for 2012, clinical commissioning groups and primary care organisations are increasingly introducing AQP for adult hearing services in England.



Community ENT clinics

Since 2009 Darius Rejali has divided his time working as an ENT consultant in a university teaching hospital and providing weekly community ENT clinics in the West Midlands.

These clinics are provided in partnership with a local GP practice and with hearing testing support from Specsavers. Under this arrangement, Specsavers provides the diagnostic audiological facility as well as audiological rehabilitation.

The clinic takes place once a week when a practice room is available. General non-emergency ENT assessment is provided, which includes flexible nasendoscopy and microscopy, using EarVac, a form of microsuction.

Choice of provider

These are very similar to the facilities available in an ENT outpatient clinic in secondary care. In addition, one of the practice nurses has trained to provide ear-cleaning services for wax problems.

If required, direct access to radiology or other investigations are available at the local hospital. Meanwhile, patients requiring surgery are offered with choice of provider and are often operated on at local hospitals.

Patients who require audiological assessments undergo pure tone audiometry in the clinic by a qualified audiologist working with Specsavers. Some patients seen will require hearing aids, and these can be arranged swiftly by the company. Specsavers is then well placed to provide the patient with all their ongoing hearing aid care.

Patient satisfaction

Mr Rejali said that this arrangement has worked well and there had been a high patient satisfaction rate. Other benefits of this service include the fact that patients can be seen locally. According to Mr Rejali, the community clinic remains popular among the patients and has the continuing support of the local commissioning group.

As in the case of this community clinic in the West Midlands, a close working relationship between complementary services (such as general practice, ENT and audiology via Specsavers) can enhance the quality of the patient experience on audit reviews.

Innovative working arrangements

In a further development, the local audiological rehabilitation arrangements have recently been opened to competition under the AQP scheme. This has given patients' representatives the choice of provider with respect to their audiological rehabilitation, and has resulted in cost savings for the local primary care trust/ commissioning group.

These innovative working arrangements have blurred the traditional boundaries between primary care and secondary care. This can result in improvements for the patients' journey and their care pathway while reducing overall costs.

Mr Darius Rejali FRCS, ENT consultant
Dr Upile MRCGP

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Generic alternatives to Lipitor are on their way

Ten new generics to look out for in 2012-13

Dr Bill Beeby, GPC prescribing lead, gives 10 examples of upcoming cost savings

We are just into the new accounting year, and most of us will have learned by now how well we managed to keep within our medicines management budgets during the last 12 months. Drug costs seem to always be on the rise – apart from periodic pauses when a new prescription pricing agreement comes into force – so we are all looking for ways to contain costs without compromising care.

As the UK is the most consistent user of generics in Europe, we always stand to benefit when drug patents expire and generic medications appear on the market, usually driving the price down. However, there are a lot of potential hurdles that may prevent us from seeing those savings, and not all of these are within our control. Of those factors that are unpredictable, the first has to be that we do not control the behaviour of generic manufacturers. We have no control over whether they will start to manufacture a particular molecule, or when, and though the basic patent may expire, patents over the manufacturing process may slow down the appearance of generic equivalents.

We must also consider product licences. When pioglitazone became available in a generic form the manufacturer pointed out that the licence for this version did not include its use in combination with metformin, resulting in a lot of prescriptions being referred back from pharmacies with the suggestion to change to the proprietary version. Depending on the outcome of the court case regarding Avastin and Lucentis for age-related macular degeneration, we may see more of this.

Finally, we must remember that to save money this way requires us to use older medications – no bad thing for those of us familiar with the benefits and problems that emerge in the post-marketing surveillance phase. Although fewer 'blockbuster' drugs have been introduced in the past 10 years or so, we still see new therapies launched with claims of being statistically better than their predecessors.

Many treatments are initiated in hospital and it will become increasingly important that we develop pathways that cross traditional boundaries. Health secretary Andrew Lansley, speaking at the recent NICE conference in Birmingham, made it clear that we no longer have the absolute right to treat the patient in front of us in complete isolation. His implication was clear: cost is a factor in deciding which treatments will deliver best value for the whole population. While this is nothing new for general practice, we may be expected to do more in future. Savings from patent expiry will be difficult to predict and impossible to rely on, so we will all still need to work at cost-effective prescribing from all angles. GPs will also have to work closely with colleagues to ensure pathways feature the most cost-effective drugs as a first line.

However, wider availability of generics within therapeutic categories may encourage us to be more comfortable switching treatments. Lower costs may lead to lower thresholds for prescribing, moderating savings and perhaps enhancing outcomes.

Looking through the lists of patents expiring in 2012 and 2013 reveals a series of drugs and clusters of similar medications that might allow our patients wider choice and remain cost effective.[1] I've picked what I think will be the 10 most significant for general practice.

Atorvastatin

Date of expiry: May 2012
BNF: 2.12

This is one of the easiest patent expiries to predict in terms of availability, because the worldwide market is going to be very attractive. A lot of practices may feel the work they have put in under the QIPP agenda will have been wasted, but though the first generics have come in at a low enough price to make it a first-line choice, the Drug Tariff has lagged behind so savings will only be realised when the reimbursible price falls. Watch out for the doses – the 80mg tablet may not have a generic replacement for a while and prescribing 2x40mg may be necessary.

Candesartan

Date of expiry: April 2012
BNF: 2.5.5.2

Until very recently this was the most cost-effective angiotensin receptor blocker and widely promoted as the one to switch to. When losartan came off patent last year some thought that we should switch everyone back, but I resisted and like many GPs I have a number of patients waiting for candesartan. Once again, all the strengths may not be available as generics immediately so care will be needed to maximise savings.

Irbesartan

Date of expiry: August 2012
BNF: 2.5.5.2

Irbesartan was heavily promoted during its introduction and once patients were settled, there was little reason to change. Other drugs have been more widely used but practices may still have significant numbers waiting for the generic to arrive.

Irbesartan and hydrochlorothiazide

Date of expiry: October 2013
BNF: 2.5.5.2

Combination drugs were always sold on patient convenience, but with multiple therapies that may not be such a factor. What will be more important is that combination drugs tend to be more slowly introduced as generics, if at all. Given that the patent for irbesartan on its own expires 14 months earlier, practices who have favoured combination products may re-evaluate.

Telmisartan

Date of expiry: December 2013
BNF: 2.5.5.2

This drug was late into the market so is likely to have several viable generic alternatives. It's at the end of the period covered here, and though its world market might support generic manufacture eventually, there may be a good argument for changing patients to another ARB.

Donepezil

Date of expiry: February 2012
BNF: 4.11

Unique at the time of its introduction, donepezil is still widely used and unlikely to be replaced as first-line therapy for dementia. The increasing emphasis on identifying and treating dementia means a generic version will be welcome. But potential savings may disappear through increased use.

Montelukast

Date of expiry: February 2013
BNF: 3.3.2

Leukotriene antagonists have a firm place in treatment schedules for asthma. Most practices will have a number of patients taking it for whom there is no alternative. A generic version will help contain costs but even if it becomes cheaper it is unlikely to move up in the treatment schedules.

Quetiapine (including XL formulations)

Date of expiry: March 2012
BNF: 4.2.1

The date for quetiapine's patent expiry has long been known, but the exclusion of sustained release preparations from further patent protection was a big surprise. The development of innovative release methods for drugs as the expiry date approaches is a tried and trusted method of extending the life of a product, but if your mental health trust has embraced the new version, this will be welcome news.

Rabeprazole

Date of expiry: November 2012
BNF: 1.3.5

PPIs have been a major cost for the NHS, and a consistent target for QIPP for several years. Each practice may only have a small percentage of patients left on rabeprazole but the costs are disproportionate and the savings will be real.

Zolmitriptan

Date of expiry: March 2012
BNF: 4.7.4

Migraine therapies have been a popular financial target for practices after the introduction of generic sumatriptan, driven by tenfold differences between generics and the proprietary product. But not every patient responds to sumatriptan, so many are on the higher-cost drugs. We can expect to see significant savings, and patients will benefit from a wider choice of economically viable therapies. Rizatriptan (expiring August 2013, BNF 4.7.4) will similarly expand choice.

Dr Bill Beeby is a GP in Middlesbrough and the GPC lead on prescribing

Reference

1 National Electronic Library for Medicines. Drug patents: which will expire in 2012 and 2013? 27 March 2012. tinyurl.com/cshnn43

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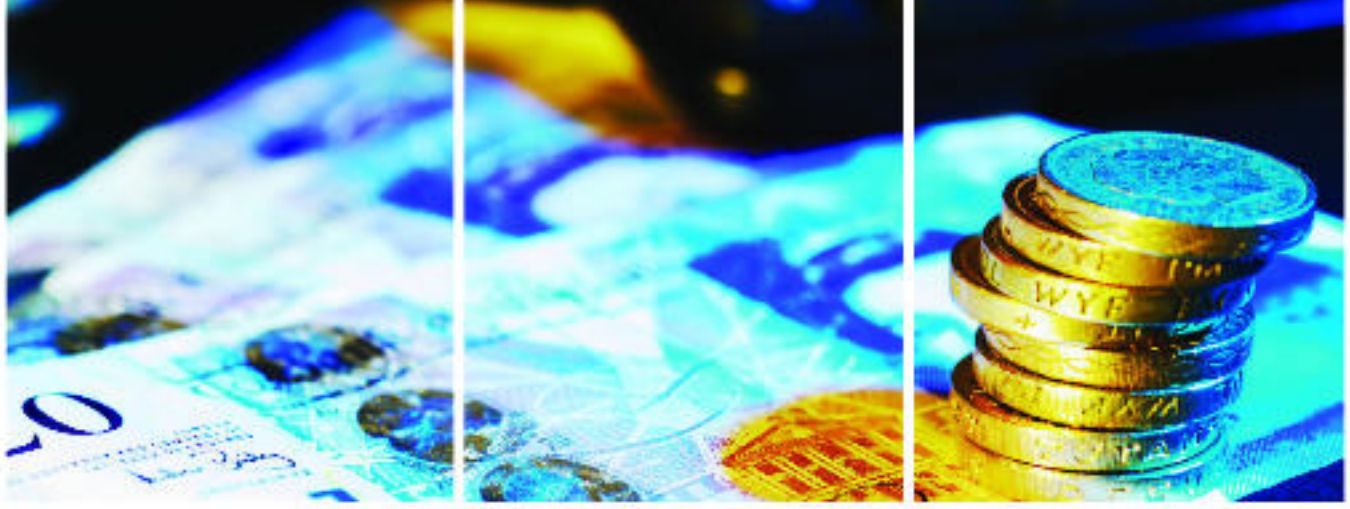

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If you are interested, please send a CV with a covering letter (by email only) to: **Sanjiv Gupta, Practice Manager,** email: **staunton.group@nhs.net**

For Informal enquiries: **020 8826 1981**

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The successful candidate would be committed to the provision of quality care and the onward development of the practice. Partnership would be considered after a successful mutual assessment period.

Closing date Friday 6th July 2012

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Please e-mail CV and letter of application Richard Lawson, Practice Manager richardlawson@nhs.net

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Full or Part-time Salaried GPs

To join Church Close Surgery, Madeley, Telford, which is a small friendly practice of approx 4700 patients. We are seeking 2 or more salaried GPs to cover between 12 – 14 sessions per week, some starting in Aug-Sept this year and more next April 2013. We are happy to consider job share or any other proposals. BMA Contract and salary scales.

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Successful applicants will practice evidence based medicine and prescribe cost-effectively, and be flexible in their role to meet the needs of the surgery. Minor op skills or willingness to train is desirable.

All informal enquiries to Julie Ellis (Nurse Partner/Managing Partner) 01952 586616 or apply in writing with CV to Julie Ellis, Church Close Surgery, Church Close, Madeley, Telford. TF7 5BP. julie.ellis1@nhs.net

Closing date End June 2012.

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Ambitious individuals with a particular interest in Sports Medicine are invited to apply for this unique and exciting opportunity.

Candidates must have a minimum of five years post-qualification experience, a history of treating sporting injuries and an ability to conduct departmental audits. Desirable attributes include specialist SEM registration and qualifications, Musculoskeletal Ultrasound and experience of delivering QOF.

Closing date for applications: 2nd July 2012

To apply or receive further information
recruit@sportinghealthgroup.com
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WITH A VIEW TO A PARTNERSHIP

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We are a friendly and efficient training Practice in a pleasant seaside location, with long serving and experienced clinical and admin teams.

We offer:

- **5 Partner GMS Practice of 8680 patients**
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Dr Hallier & Partners
Ansdell Medical Centre
Albany Road, Lytham St Annes
Lancashire FY8 4GW
Tel: 01253 657319

carole.bonney@gp-81037.nhs.uk
www.ansdellmedicalcentre.co.uk

Please email or telephone to arrange an informal visit.

Closing date 13th July 2012

Thorpewood Medical Group - East Norwich

Salaried GP

Forward looking PMS practice with circa 14,200 patients requires a salaried doctor for 4.5 sessions per week from 13/08/2012.

Friendly and supportive PHCT. Active members of Norwich Clinical Commissioning Group. Good QOF scores. SystmOne users. Excellent terms for the right candidate.

Informal enquiries to Stephen Edwards, Managing Partner on 07850-255-340 or Carol Postle, Patient Services Manager on 01603-706417.

Application by covering letter and CV to Mrs. C. Postle, Patient Services Manager, Thorpewood Medical Group, 140 Woodside Road, Norwich NR7 9QL.

– SALARIED GPs –

Morden Hall Medical Centre is a friendly GP Practice in SW London currently looking to recruit ***salaried GPs*** to fill up to ten sessions per week. CVs initially to Stephen Hartley, practice manager – Stephen.hartley1@nhs.net

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If you feel this is you please send your CV with covering letter to:
Mrs Rose Fells, Managing Partner, The Scott Practice, 1 Greenfield Lane, Balby, Doncaster DN4 0TG

Closing date for applications 25.6.12

Please note interviews will be held on Saturday 30th June only.

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Applicants should contact the Practice Manager, Anne Osbaldeston by email at anneosbaldeston@nhs.at or by calling 01375 898702.

Informal enquiries welcome

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Full/Part time GP Required

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Please apply in writing to Angela Bonney, Practice Manager, Dallam Lane Medical Centre, Warrington, Cheshire, WA2 7NG.
Tel: 01925 572 334 or email warr-pct.dllmc@nhs.net.
For further information please call Angela Bonney on 07811 768103.

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- GMS
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- 7 sessions per week

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Tel 0151 920 9060

Closing date for applications 16th June 2012.

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Please contact: Sam Paul, Practice Manager, Putnoe Medical & NHS Walk in Centre. Tel: 01234 319990. Email: sam.paul@nhs.net

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Dr Mughal and Dr Bhatti Partners are looking for a salaried GP for 6 sessions. Wages negotiable. High QOF achievement and friendly environment.

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EDITOR'S CHOICE

Revalidation: finally ready to roll?

By Gareth Iacobucci

'The two words you'll be hearing a lot from the GMC are pragmatic and incremental'. Professor Peter Rubin, GMC chair, is on a charm offensive, with his mission to convince GPs that introducing revalidation later this year is both workable and acceptable.

The policy, which will require doctors to undergo relicensing every five years, seems to have been in the pipeline for ever.

But finally, after more than a decade of false starts, it is set to be rolled out, with 20% of doctors due to be processed in 2013.

But all is not rosy with revalidation. GPs at last month's LMC conference poured scorn on the GMC for its 'shocking complacency', with demonstrable anger at the regulator for proceeding with the plans despite unanswered questions over who will fund remediation, how appraisals will work, how locums will be able to compile their portfolios of evidence, and how any doctor will have the time or wherewithal to gather multi-source feedback from 15 colleagues.

So how would Professor Rubin respond to LMCs' criticism that the GMC has shown a 'total lack of leadership'?

'There will be a lot of leadership being shown by the GMC, a lot of clarification coming,' he promises, his relaxed demeanour belying the scale of the task he faces.

'But we want to time it just right so that we are telling doctors things when they need to know them, not before.'

Watch the full video interview at pulsetoday.co.uk/videos

On the key issue of remediation funding, he is unable to provide answers, other than that the Government and the BMA are 'still discussing the issue'.

The issue came to a head at the LMC conference, when GMC Council member Professor Malcolm Lewis angered GPs by claiming that thrashing out an agreement on remediation funding should not delay revalidation, because most GPs would not need such support.

Professor Rubin acknowledges GPs' concerns, but insists there would be 'incredulity' among patients if the process was further delayed.

@garethiacobucci

MORE ONLINE
Read the full article
pulsetoday.co.uk/news-analysis

JOBBING DOCTOR

I have been on strike before. I am old enough to remember the junior doctors' strike in 1975. That was then. My first industrial action six months on from qualification, my second just six months away from retirement. A career bookended by industrial strife...

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WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

> **It is uncaring, selfish and greedy.**
>
> ... one GP criticises plans for industrial action

> **Short-sighted and short-termist are other words for government, I am sure.**
>
> ... another GP backs the BMA on pensions

> **Thank goodness! I can carry on being obnoxious.**
>
> ... on NCAS calling for 'agreeable' GPs to face disciplinary action

OPINION

Is revalidation susceptible to prejudice?

I am firm. You are obstinate. He is pig-headed. Is revalidation susceptible to prejudice? Of course it is. Every process is, unless you build in equality impact assessments to look for sources of bias and try to eliminate them.

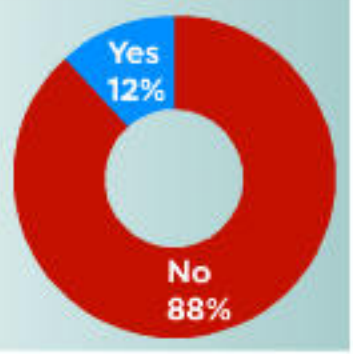
MORE ONLINE
Read Dr Catherine Harkin's full article
pulsetoday.co.uk/opinion

THIS WEEK'S POLL

Should the BMA boycott commissioning over pensions?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Should revalidation go ahead this year?



Turn inside for this week's column from Copperfield
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