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BriefingMedia

At the heart of general practice since 1960

DH agrees 20% rise in GP training places

Ministers order radical overhaul of medical workforce to aid shift of care from hospitals

EXCLUSIVE
By Gareth Iacobucci

Ministers plan to boost the number of GP trainees by 20% over the next three years as part of a radical reshaping of the medical workforce, Pulse can reveal.

Health secretary Andrew Lansley said he wanted to see a sharp increase in the proportion of specialty training places taken by GP registrars, from 41% currently to 50% by 2015.

The move aims to equip the medical profession for the shift of workload from hospitals into primary care and address the severe shortage of GPs, which has seen vacancy rates at practices double in a little over a year.

The Department of Health told Pulse the number of GP training places was scheduled to soar from 2,700 now to 3,250 in three years' time, assuming the overall number of medical specialty places remains at the present level of 6,600.

A separate Government review is examining how many medical school places should be made available.

GPs welcomed the move – but warned there were still major barriers to overcome to increase the number of doctors undergoing training for general practice, given the sharp fall in applications over the last three years.

Health secretary Andrew Lansley told a Reform conference in London last week: 'We know we will need a further expansion of the GP workforce – 50% of the newly trained medical workforce in the future will go into general practice.'

Mr Lansley added that he was also backing plans to extend GP training to four years, claiming the move – which is subject to Treasury approval – would help us to get general practice to the place we want'.

The DH said the Government had accepted recommendations from the Centre for Workforce Intelligence for a substantial increase in the number of entry-level GP training posts.

Ministers also met the RCGP earlier this month to discuss plans to address the severe shortage of GPs on the ground, with a particular emphasis on getting more GPs working across London.

A DH spokesperson said: 'The Centre for Workforce Intelligence recommended there should be 3,250 GP placements by 2015. We're currently working with SHAs and deaneries to implement those workforce plans.'

Last year, deaneries were forced to cut the number of GP training places by 7% because a fall of more than 40% in applications for general practice over three years had left them short of quality candidates.

Health minister Earl Howe said: 'We have many more GPs than we had 10 years ago. Unfortunately, we need more. There is a target every year for recruiting GPs, but we have not quite reached that target in the past three years. We need to do something about that.'

Dr Ben Molyneux, a GP trainee in London and deputy chair of the BMA's junior doctors committee, said: 'It's welcome news. We need to increase GP numbers to cope with the drive for increasing community care. The difficulty will be implementation. For there to be an expansion in GP trainees there has to be a reduction in the number of hospital trainees. But services are configured in such a way we rely on junior doctors in hospitals.'

Dr Beth McCarron-Nash, GPC negotiator and a GP in St Columb Major, Cornwall, said the Government needed to move beyond 'headline figures' and invest more in practices: 'There is no real mechanism for growing our practices. There is no point turning out more GPs if we can't offer them substantive posts.'

@garethiacobucci

EDITORIAL ▶
Trainee rise must not be false dawn 14

Dr Ben Molyneux: DH will face difficulties in implementing the increase in GP trainees

Boost in GP trainee numbers

Source: DH; each character represents 100 trainees

MORE ONLINE
Watch Andrew Lansley at the Reform conference
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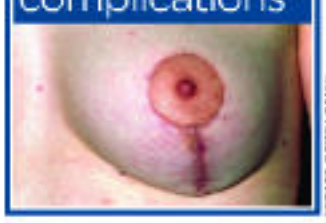

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Earn CPD for our Key questions and Post-op problems features, and articles on practice risks and cutting prescribing errors

GPs must offer email access by 2015

By Madlen Davies

GPs will have to arrange online appointment booking and a secure email system for patients to contact their practice by 2015, in a move to make the NHS more 'customer friendly'.

Health secretary Andrew Lansley announced the plans as part of a pledge to end the '8am rush' of people phoning GP surgeries to try to get an appointment. He promised that repeat prescriptions and test results would also be accessible online. Practices will have to appoint a lead GP to organise better electronic access, arrange secure lines of communication for patients and direct access to records for 'anyone registered with the practice that requests these services'.

Mr Lansley also reiterated a Government promise for all patients to be able to access their full medical records within three years, although he stopped short of NHS Future Forum proposals for patients to be able to add to and correct their notes.

The Government's 10-year NHS Information Strategy said: 'By 2015, all general practices will be expected to make available electronic booking and cancelling of appointments, ordering of repeat prescriptions, communication with the practice and access to records for anyone registered with the practice that requests these services.'

It will also allow other healthcare professionals to access GP records – with the patient's permission – and allow researchers to access anonymised data taken from them.

A new NHS website will be launched by 2013 to act as a 'one-stop shop' where patients can access information about the quality and performance of their local health services, and would give feedback on them.

'It's time to take the hassle out of using the health service' **Andrew Lansley**

Mr Lansley said the change would reduce 'the hassle of calling switchboards and trying to find the right person to speak to' and increase patient power: 'The internet has revolutionised how people shop, bank and travel, and for too long health and care services have not been part of that revolution. Our proposals will ensure these services become easier to understand, easier to access and will drive up standards of care. It's time to make patient power a reality and take the hassle out of using the health service.'

Dr Chris Hall, a GP in Hillsborough, Northern Ireland, said he had concerns over the additional workload and legal implications of providing email access to GPs: 'If a patient emails a doctor out of hours and they don't respond, the patient will hold the doctor accountable. Security would be another concern – I'm not sure the systems are properly encrypted.'

Dr John Cormack, a GP in South Woodham Ferrers, Essex, said he welcomed widening online access to patients, but warned the workload would be 'crazy': 'It's going to involve so much checking and changing.'

@madlendavies

ROADSHOWS

GP pay may be docked over pension action

BMA chair warns GPs taking industrial action could have payments withheld – or contracts terminated

EXCLUSIVE

By Jaimie Kaffash

Say No to 30% GPs who take industrial action over pensions should be prepared to have their pay docked by primary care organisations, and could risk contractual action or even contract termination, BMA chair Dr Hamish Meldrum has warned.

In a frank assessment of the dangers posed to practices, Dr Meldrum also warned GPs could face retribution in future pay awards for what would be the first industrial action by doctors since 1975.

The BMA is currently balloting members on whether to take industrial action over the Government's pension reforms, with a decision expected on 30 May, a day after the ballot closes.

Doctors at the BMA's roadshow last week in Stansted, Essex, expressed concern that they would lose pay if they went ahead with industrial action, which would see GPs suspend all routine work for 24 hours.

Dr Meldrum said: 'For GP practices, some payments from the PCT could be withheld – the equivalent of a day's pay.'

A BMA spokesperson later added: 'We haven't gone into more detail about the kinds of payments that might be withheld, mainly because the law is untested, but obviously some elements of GP pay would be very hard for PCOs to withdraw – such as payments through the QOF, which depend on annual measures of quality.'

Dr Meldrum also warned there was a 'possibility' of PCTs using the day of action as a chance to 'deal' with problematic practices by citing a breach of contract, and urged GPs to liaise with PCTs before taking action, which would be likely to take place in the week of 25 June.

He admitted 'the Government could make life harder in areas like pay awards' if doctors took action.

A BMA spokesperson said the chance of contract termination was 'very low', but warned: 'Commercially, the risk cannot be ruled out. For GMS contracts there would usually be a period of "grace" before proceeding to termination.

'In the very unlikely event a PCO issued a breach or remedial notice to a GMS contractor for intending to participate in indus-

WILL YOU VOTE FOR INDUSTRIAL ACTION?

FOR 'Unless they treat us better, GPs will quit.' Dr Richard Fieldhouse, chair of National Association of Sessional GPs and a GP in Chichester

AGAINST 'There are other ways of sorting this out.' Professor Mayur Lakhani, former RCGP chair and a GP in Loughborough

FOR 'Ministers cannot go back on an agreement.' Dr Fay Wilson, former LMC conference chair and a GP in Birmingham

The week in general practice

INSIDE

NHS managers are adopting a 'lower threshold' for referral of GPs to the GMC, sending cases soaring by 15% in a year
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Using midwives and a lead staff member for the flu campaign can increase vaccine uptake, a new study reveals
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Dr Helena McKeown

The DH is considering adding the rotavirus vaccination to the infant immunisation schedule
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NICE is to lose its rationing role, with the DH to instead set a price for new drugs
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MORE ONLINE

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GPs should be aware of the potential for QT interval prolongation and heart arrhythmias when prescribing azithromycin, the US drug regulator has warned
▶ pulsetoday.co.uk/clinicalnews

Download of the week
See what money you are owed – or may be asked to pay back – after a QOF coding error
▶ pulsetoday.co.uk/downloads

Video of the week
Watch Dr Charles Alessi, chair of the NAPC, speaking on leadership at the Reform High Quality Healthcare conference.
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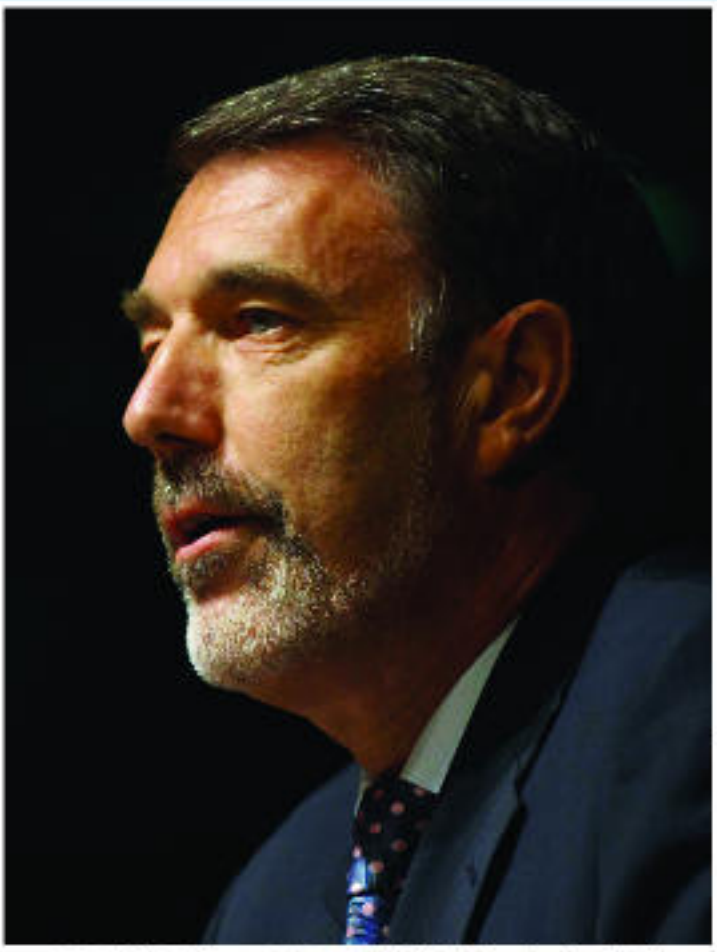


Dr Hamish Meldrum: PCTs could withhold pay for day of action

BALLOT

Support growing for industrial action, survey shows

GPs appear to be hardening in their support for industrial action, although not all of those who vote for it will join the proposed day of action themselves, a Pulse survey reveals.

Some 63% of GPs said they would vote Yes to industrial action short of a full strike, compared with 56% who were in favour when it was first announced in April. But only 58% of nearly 250 respondents said they would personally join the BMA's proposed day of action, reflecting concerns among many GP partners in particular over workload and contractual issues.

The survey also found most GPs back full strike action, which the BMA has ruled out, but wants support for to strengthen its mandate for other industrial action. Some 56% of GPs supported strike action, but 36% said they would vote against.

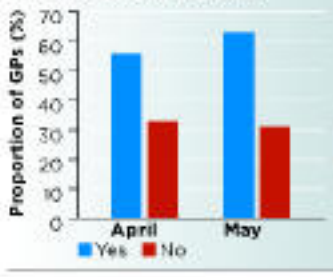
Almost half of the GPs surveyed said they felt the BMA had not gone far enough in its opposition to the reforms. Just over a third – 35% – said the BMA's stance was right, while 16% said it had gone too far. This mirrors the findings from the April survey. A small minority of GPs – 12% – said the ballot was causing tensions with colleagues at their practice, with 29% unsure.

Dr Peter Swinyard, chair of the Family Doctor Association, said he supported industrial action: 'You cannot just leave the issue. It may mean doctors are forced to work beyond the age it is safe to do so.'

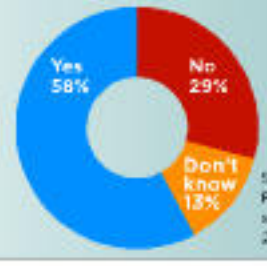
But Dr Paul Zollinger-Read, a GP in Braintree, Essex, said: 'All of Europe is bankrupt. Our country is bankrupt. There needs to be some degree of pensions reform.'

Pulse's pre-ballot poll

Will you vote for industrial action short of a strike?



Will you personally take action if doctors vote Yes?



Source: Pulse survey of 236 GPs

PLEDGE YOUR SUPPORT
Join our campaign
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UNSURE
'My gut feeling is I probably won't support the action.'
Dr Manpreet Pujara, GP clinical lead at Connecting for Health and a GP in Rochester, Kent

UNSURE
'I would not work on a day of industrial action.'
Dr Una Coales, RCGP Council member and a GP in Stockwell, south London

GPs kept in dark over Ca blunder

NHS managers kept GPs and patients in the dark for at least a month after concerns were raised that hundreds of people referred to hospital with suspected cancer might have missed investigation or treatment.

Pulse revealed last week that patients referred to Imperial College Healthcare NHS Trust urgently under the two-week rule might have slipped through the net because of 'data collection' issues. The trust said it had written to GPs to ask for their help in tracking and contacting the patients, after concerns that up to 900 records were incomplete.

But managers admitted this week they only began contacting GP practices on 3 May, and would only have completed the exercise by 21 May, despite NHS North West London flagging up problems in board minutes dated 10 April.

The paper made reference to an 'urgent meeting' scheduled with managers from Imperial, CCG chairs and the cluster, but made no mention of LMCs, and added: 'A clinical review had also started to determine if any risks to patients had arisen due to the delays.'

Dr Michelle Drage, chief executive of Londonwide LMCs, said she had written to the chief executive of NHS North West London to demand an explanation: 'It seems to have been going on a lot longer than at first appeared, but we and GPs on the ground weren't aware. It's ludicrous.'

A spokesperson for Imperial College Healthcare NHS Trust said: 'The trust started contacting GP practices, not patients, on 2 May to validate its records. By close of play today [21 May] all GP practices will have been contacted.'

An NHS North West London spokesperson said: 'The cluster's first priority was ensuring the trust informed GP practices directly involved, supported by a dedicated GP helpline.'

trial action, the practice is likely to be given an opportunity to consider whether or not to continue with the action.'

Dr Andrew Mimnagh, chair of Sefton LMC, said: 'I'm sure some PCTs will use this as a breach of contract. If the vote is positive, there will be definitive legal guidance from the PCTs.

'But, as with any other guidance, saying "PCTs should not be able to" is not the same as saying "PCTs will not try it on".'

Dr Paul Roblin, secretary of Berkshire, Buckinghamshire and Oxfordshire LMCs, said ministers were hoping to sow doubt among GPs: 'I think it is an option for the Government to advise PCTs via NHS Employers to maximise use of their powers and create uncertainty.'

@nigelpraities

Referrals to GMC jump by 15%

GPC warns PCTs are employing 'lower thresholds' for referral because they lack resources to resolve cases

EXCLUSIVE
By Nigel Praities

The number of cases sent to the GMC rose sharply last year, with the GPC warning NHS managers were adopting a 'lower threshold' for referral because they lacked the resources to deal with problems locally.

There was a 15% increase in the number of GPs referred to the GMC over the course of 2011 and a cumulative 62% increase over the last two years.

The number of serious cases, which require an immediate investigation by the GMC, has also risen, although more slowly - with 'stream one' cases involving GPs jumping by 7% last year. The GMC said it was unsure why the rise had occurred, but that it was planning an independent audit.

It said it had been allocated £500,000 in extra funding to conduct investigations because of the increase in serious cases.

Overall, cases involving GPs jumped from 3,577 in 2010 to 4,127 in 2011, and serious cases from 785 to 839.

Enquiries to the GMC from public organisations rose by 28% in the first two months of this year, although the GMC said it was too early to say if this was a significant rise.

Dr Richard Vautrey, GPC deputy chair, said he was concerned managers had become so overstretched by the NHS reforms they were 'effectively defaulting concerns to the GMC': 'PCTs have a lower threshold for referrals. They have lost experienced people who might have previously settled disputes.

'It's not good enough just to refer GPs on to the GMC. There's also a rising tendency among patients to complain.'

Dr Peter Swinyard, chair of the Family Doctor Association, said the increase could be the 'last desperate shot' of PCTs to get rid of people they didn't like: 'I don't believe a vast number of GPs have suddenly become negligent. PCTs play around with dashboards and other toys, and are less forgiving of mistakes.'

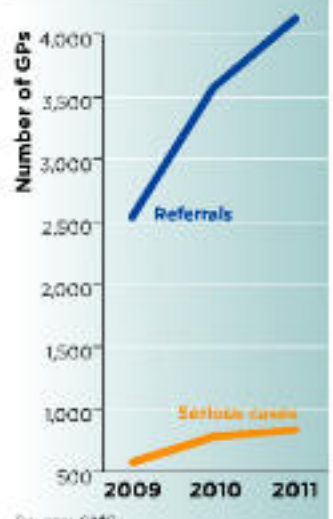
Dr Helena McKeown, a GP in Salisbury, Wiltshire, and a BMA Council member, called it a 'worrying trend': 'GPs are trying not to refer as much. That could be something to do with it.'

A GMC spokesperson said: 'We do not know why there has been such an increase. It may reflect a greater willingness to complain or improved knowledge of regulators - or a combination of the two.'

@nigelpraities

Dr Helena McKeown: rise in GP referrals a 'worrying trend'

GP referrals to the GMC



Source: GMC

Grant attacked over 'golf' remark

The chair of the NHS Commissioning Board has sparked a storm of criticism after attacking GPs for being 'out playing golf' rather than treating patients.

Speaking at the NICE conference in Birmingham last week, Professor Malcolm Grant called for a 'profound cultural change' across the NHS, and told the story of a woman whose cost to the NHS had been cut from £9,000 to £6,000 because of better organisation.

He claimed her GP 'was out playing golf', but was now making regular visits, reducing the cost of care.

But GPs responded furiously to the jibe, with dozens leaving comments on pulsetoday.co.uk and senior figures leading the criticism.

Dr Clare Gerada, RCGP chair, said Professor Grant had 'insulted an entire profession', while Sir John Oldham, the GP heading up the Department of Health's QIPP programme, said: 'He should get out of [his] London hospital more.'

Professor Grant later said the remark had been meant as a joke: 'It's unfortunate that what was intended as a light-hearted and humorous comment has been taken quite so seriously.'

'More side-effects' with dabigatran than warfarin

New anticoagulant dabigatran has a significantly higher rate of complications than warfarin when used in a real-world setting, a new analysis concludes.

Adverse events particularly affected older and female patients, and included one death from gastrointestinal bleeding. The findings come amid controversy over whether CCGs should allow GPs access to the drug and fears it will bring 'huge cost pressures'. Its manufacturer, Boehringer Ingelheim, responded to scepticism among CCG leaders by reducing its price by 13% last month.

US researchers carried out a prospective, observational cohort study at an anticoagulation clinic, following 2,200 patients, including some who switched from warfarin to dabigatran.

Preliminary findings in 113 patients presented to the Thrombosis and Hemostasis Summit of North America found one death, four other bleeds, one deep vein thrombosis, one atrial thrombus, one transient ischaemic attack, one skin rash and four gastrointestinal reactions with dabigatran. Outcome frequency was 11.5%, compared with 0.88% with warfarin.

Boehringer Ingelheim said: 'The US dosing referred to here is different from the reduced dose of 110mg recommended [in the UK] in the elderly and those with an increased bleeding risk. We do not believe this analysis will be relevant to the UK.'

NovoMix® 30 Biphasic insulin aspart.
NovoMix® 30 Penfill®
NovoMix® 30 FlexPen®
All presentations contain soluble insulin aspart/protamine-crystallised insulin aspart 100 U/ml in the ratio 30/70.
Indication: Treatment of diabetes mellitus in adults, adolescents and children aged 10 to 17 years. **Posology and administration:** Potency of insulin analogues is expressed in units (U). In patients with type 2 diabetes, NovoMix® 30 can be given in monotherapy or in combination with oral antidiabetic drugs (OADs) when blood glucose is inadequately controlled with OADs alone. The recommended starting dose is 6 U at breakfast and 6 U at the evening meal. Titration is according to pre-meal blood glucose levels (pre-breakfast glucose for adjustment of evening dose and pre-evening meal glucose for adjustment of breakfast dose). NovoMix® 30 can also be initiated once daily with 12 U at the evening meal and it is generally recommended to move to twice daily when the daily dose reaches 30 U; this can be done by splitting the dose into equal breakfast and dinner doses. 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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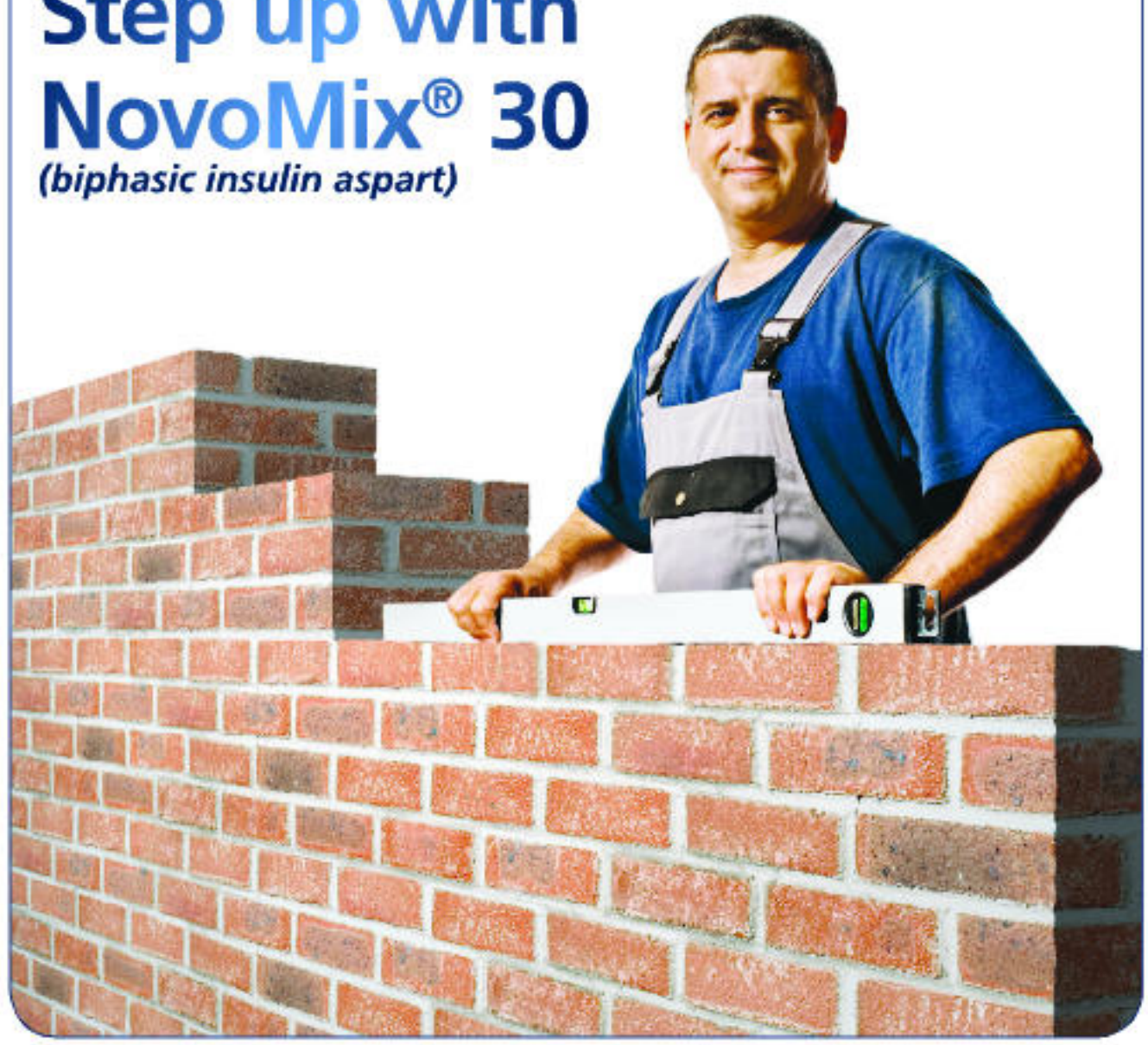


Observational study results show[1]:

(p<0.0001)

-1.8%
mean reduction in HbA1c (baseline 9.3%)
at 6 months after switching from basal analogue to NovoMix® 30[1]

55%
of patients were either **very or extremely satisfied** with NovoMix® 30 after switching from basal analogue insulin, vs 14% before the switch[1]

NovoMix® 30 FlexPen®
(biphasic insulin aspart)
Effective control, made simple [2,3]

Midwives aid flu vaccine uptake

Using midwives to give vaccines to pregnant women among seven strategies found to be evidence-based

By Madlen Davies

Using a lead staff member to co-ordinate the flu campaign, sending personal invitations to eligible patients and having midwives give vaccines to pregnant women can increase a practice's flu vaccination rates, research reveals.

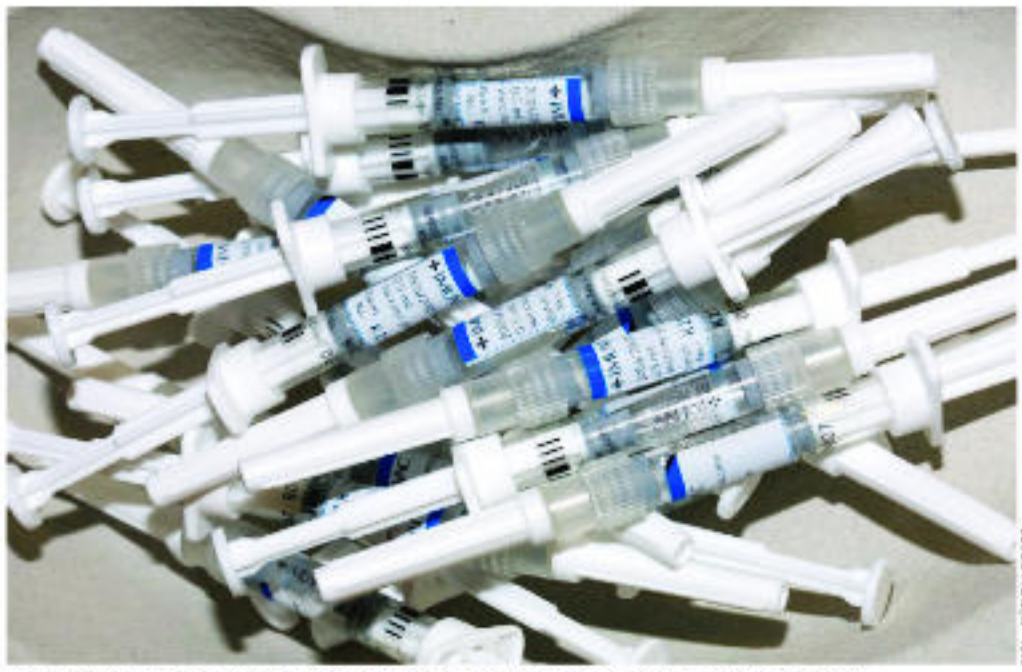
A wide-ranging study of 795 GP practices identified seven strategies that increased the number of high-risk patients who were vaccinated, as well as some that did not work.

Researchers said their study - funded by the Department of Health - was the first to provide firm evidence for how GPs can boost flu vaccine uptake, increasing their earnings from the flu campaign.

Having a lead staff member to plan the flu campaign raised uptake among at-risk patients under the age of 65 from 46% to 54% - an increase of almost a fifth.

Providing a written report of practice performance also increased uptake rates in under-65s, by the same amount.

Sending a personal invitation to all eligible patients and only stopping vaccinations when QOF targets were reached were each found to raise uptake by seven percentage points, from 71% to 78%, for patients over 65.



The study identifies seven strategies to help GPs boost income from flu vaccinations

Lead members of staff sorting through practice IT systems to identify eligible patients raised vaccination rates from 74% to 78% in the over-65s.

And among practices where community midwives gave flu vaccinations, uptake in pregnant women was 45%, compared with 41% where midwives did not.

But a couple of interventions did not make a statistical difference - offering vaccination at weekends or before 8am or after 6pm on weekdays, and staff having a positive attitude towards being vaccinated themselves.

Study leader Dr Laura Dexter, a virologist at University of Sheffield medical school, said the study was 'the first to provide statistical evidence to support the validity of approaches', many of which she said were 'common sense'.

Dr John Etherton, a GP in Rottingdean near Brighton, said midwives administering vaccines was a 'fantastic' idea: 'People are petrified of doing anything during pregnancy, but these women need these vaccines.

'Midwives are in the perfect position to educate mums-to-be because they are trusted.'

Dr Una Coales, a GP in Stockwell, south London, agreed the study's findings were 'useful': 'Any strategy that can increase uptake rates will prevent deaths - and should be implemented.'

She added that the public should be given a choice of buying flu vaccines: 'People pay for travel vaccines and go to their GP to get them, so why not flu vaccines?'

@madliendavies

What worked - and what didn't

Increased rates

- Lead staff member planning the flu campaign
- Lead staff member producing a written report of practice performance
- Member of staff identifying eligible patients using the practice IT system
- Midwives administering vaccinations to pregnant women

No association with increased rates

- Offering vaccinations at weekends, before 8am or after 6pm

Did not reach statistical significance

- Staff having a positive attitude towards being vaccinated themselves

MORE ONLINE
See the full list of what worked and what didn't
pulsetoday.co.uk/news-analysis

Practices face clawbacks of up to £800 after QOF error

Thousands of GP practices across the country face clawbacks of up to £800 on payments made last year because of a QOF calculation error dating back to 2010, as managers try to recoup overpayments.

The £1.1m cash grab by PCTs comes after an error in the QMAS system dating back seven years led to £28m in overdue QOF payments being distributed among GPs last February.

Now final calculations of the adjustment needed to correct the error are available, the Department of Health has written to PCTs to advise them to 'make good' any underpayments and reclaim any overpayments.

Full calculations for all practices have been published, with 512 practices underpaid and 7,677 overpaid. The average clawback per practice is £140, and the average underpayment is around £95, although one practice will have to pay back £825 to managers and another will receive a payment of over £1,100.

Richard Armstrong, head of the primary medical care commissioning development directorate, said: 'The final adjustments for 2010/11 have now been calculated and PCTs are required to take action to make the adjustments which are set out in the spreadsheet accompanying this letter. The legal advice we have received is clear that PCTs must make good any underpayments to practices.

'Where a GP contractor has been overpaid, PCTs have the discretion over whether they reclaim these payments. The total effect of reclaiming all underpayments would generate around £1.1m, which would be a net benefit to PCTs' baselines.'

MORE ONLINE
See your practice's figures
pulsetoday.co.uk/news-analysis

Managers plan for revalidation exodus

NHS managers are drawing up contingency plans for a mass exodus of single-handed GPs because of the introduction of revalidation.

Managers have predicted some single-handed GPs will quit practice rather than face 'the more stringent requirements of revalidation' and others will be forced into remediation.

An NHS Bedfordshire board meeting last month discussed plans for covering gaps in service in areas such as Luton, where of 31 practices, six are single-handed.

A board paper said: 'It is conceivable some GPs, faced with the more stringent requirements of revalidation, may decide to retire. Although not appropriate to speculate, the potential risk to business continuity must be considered, particularly since there is a relatively high proportion of single-handed practices in the cluster.

'The cluster will need contingency arrangements if faced with more than the expected rate of resignations within the first few years of revalidation. Should more than a very small number of doctors have to undergo remediation, this would also affect business continuity.'

Dr Peter Swinyard, chair of the Family Doctor Association and a GP in Swindon, said: 'Some PCTs don't like single-handed GPs and never have. They think single-handers must be delivering a poor-quality service and are hoping they'll jump before they're pushed.

'If they're really worried about GP performance problems, they should be doing something about it - not waiting for revalidation to sort it out. This is a real cop-out.'

Dr Fiona Sim, medical director of NHS Bedfordshire and Luton Cluster, said: 'We're working with our LMC and CCGs to develop a strategy to support general practice to address barriers to recruitment and retention.'

Fostair's extra-fine particles mean it's the only combination inhaler shown to reach both the large and small airways.[1,2]

FOSTAIR®
Beclometasone + formoterol

Extra-fine adult asthma control

Fostair® (beclometasone dipropionate and formoterol fumarate dihydrate pressurised inhalation solution). Please refer to Summary of Product Characteristics (SmPC) before prescribing. **Prescribing Information Presentations:** Pressurised inhalation solution containing 100 micrograms of beclometasone dipropionate and 6 micrograms of formoterol fumarate dihydrate per actuation. **Indications:** Regular treatment of asthma where use of a combination product (inhaled corticosteroid and long-acting beta$_2$-agonist) is appropriate: patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short-acting beta$_2$-agonist; or patients already adequately controlled on both inhaled corticosteroids and long-acting beta$_2$-agonists. Not appropriate for treatment of acute asthma attacks. **Dosage and Administration:** For inhalation use only. Fostair is not intended for the initial management of asthma. If an individual patient should require a combination of doses other than those available in the combination inhaler, appropriate doses of beta$_2$-agonists and/or corticosteroids by individual inhalers should be prescribed. Beclometasone dipropionate in Fostair is characterised by an extrafine particle size distribution which results in a more potent effect than formulations of beclometasone dipropionate with a non-extrafine particle size distribution (100 micrograms of beclometasone dipropionate extrafine in Fostair are equivalent to 250 micrograms of beclometasone dipropionate in a non-extrafine formulation). Therefore the total daily dose of beclometasone dipropionate administered in Fostair should be lower than the total daily dose of beclometasone dipropionate administered in a non-extrafine beclometasone dipropionate formulation. Adults 18 years and above: one or two inhalations twice daily, maximum four inhalations daily. Children and adolescents under 18 years: the safety and efficacy of Fostair has not yet been established. No data are available with Fostair in children under 12 years of age. Only limited data are available in adolescents between 12 and 17 years of age. Therefore Fostair is not recommended for children and adolescents under 18 years until further data become available. The dose should be titrated to the lowest dose at which effective control of symptoms is maintained. Fostair may be used with the AeroChamber Plus® spacer device. Patients should be advised in the proper use and care of their inhaler and spacer. **Contraindications:** Hypersensitivity to any of the components. **Warnings and Precautions:** Cardiovascular disorders including cardiac arrhythmias and QTc prolongation, thyrotoxicosis, diabetes mellitus, pheochromocytoma, untreated hypokalaemia, active or quiescent pulmonary tuberculosis, fungal and viral infections. Fostair should not be used as the first treatment for asthma, should not be initiated during an exacerbation, 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). Titrate to the lowest dose at which effective control of asthma is maintained to minimise systemic effects. Special care is needed in transferring patients from oral steroids. Fostair contains a small amount of ethanol (up pharmacopoeial 7 mg per actuation); at normal doses the amount of ethanol is negligible and does not pose a risk to patients. Patients should rinse mouth after inhalation to minimise risk of oropharyngeal candida infection. **Interactions:** Beclometasone dipropionate undergoes a very rapid metabolism via esterase enzymes without involvement of the cytochrome p450 system. Avoid beta-blockers (including eye drops). Caution is required when theophylline or other beta-adrenergic drugs are prescribed concomitantly with formoterol. Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines, MAOIs and TCAs can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with NASIDs, including agents with similar properties such as fluoxetamine and procainamide, may precipitate hypertensive reactions. Risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Theoretical potential for interaction in sensitive patients taking diuretics or methotrexate. **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, rhinorrhoea, influenza, oral fungal infection, oropharyngeal and oesophageal candidiasis, vulvovaginal candidiasis, gastroenteritis, sinusitis, rhinitis, granulocytopaenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, clinically significant cardiac arrhythmias, hyperaemia, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dyspepsia, dysphagia, burning sensation of the lips, nausea, dyspepsia, 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, asthenia, 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 (PL08626/0155) £39.52. 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): 137-148. **Date of preparation:** March 2012. CHI0512012072b.

Chiesi

1 in 4

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

ZOSTAVAX®▼

Shingles (herpes zoster) vaccine (live)

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

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX®▼ powder and solvent for suspension for injection (shingles (herpes zoster) vaccine (live)) *Refer to Summary of Product Characteristics for full product information.* **Presentation:** Vial containing a lyophilised preparation of live attenuated varicella-zoster virus (Oka/Merck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque forming units) varicella-zoster virus (Oka/Merck strain). **Indications:** Active immunisation for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN) in individuals 50 years of age and older. **Dosage and administration:** A single dose should be administered by subcutaneous injection, preferably in the deltoid region. **Contraindications:** Hypersensitivity to the vaccine or any of its components (including neomycin). Individuals receiving immunosuppressive therapy (including high-dose corticosteroids) or who have a primary or acquired immunodeficiency. Individuals with active untreated tuberculosis. Pregnancy. **Warnings and precautions:** Appropriate facilities and medication should be available in the rare event of anaphylaxis. Deferral of vaccination should be considered in the presence of fever. In clinical trials with Zostavax, transmission of the vaccine virus has not been reported. However, post-marketing experience with varicella vaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varicella-zoster virus (VZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zostavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zostavax may not result in protection in all vaccine recipients. **Pregnancy and lactation:** Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Caution should be exercised if Zostavax is administered to a breast-feeding woman. **Undesirable effects:** Very common side effects include: pain/tenderness, erythema and swelling at the injection site. Common side effects include pruritus, warmth and haematoma at the injection site and headache. Post-marketing use has shown hypersensitivity reactions including anaphylactic reactions, joint and muscle pain, fever, swollen glands, rash, also hives and rash at the injection site. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Vial and pre-filled syringe with two separate needles. This vaccine is currently not available through the NHS. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 Rue Jonas Salk, F-69007 Lyon, France **Marketing authorisation number:** EU/1/06/341/001 **Legal category:** POM ® Registered trademark **Date of last review:** August 2011

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

References: 1. Miller E, Marshall R, 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.

* The need for a second dose is currently unknown

Zostavax® cannot currently be prescribed on an NHS prescription (FP10) but can still be made available to your patients using a private prescription.

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

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vaccines for life

Read the first in our new series on post-operative complications
▶ page 24

Infants may get rotavirus vaccine

DH invites bids to provide vaccine and will add rotavirus to immunisation schedule if cost-effective

By Nigel Praities

Ministers are looking at the cost-effectiveness of including routine rotavirus vaccination in the infant immunisation schedule to reduce the incidence of serious cases of gastroenteritis, Pulse has learned.

The move has been welcomed by the RCGP and comes after several recent studies showed that introducing rotavirus vaccination into the infant schedule could eradicate serious disease.

There are an estimated 130,000 episodes of rotavirus-induced diarrhoea and vomiting annually in the under-fives, with thousands of children hospitalised, but UK vaccination advisers have until now ruled out introducing a rotavirus vaccination programme on the grounds of cost.

An evaluation by the Joint Committee on Vaccination and Immunisation in 2009 found that vaccines provided 'good protection' against infection, but prices did not meet 'current economic criteria' for the NHS.

But the Department of Health has now invited bids from vaccine companies to assess if a campaign as part of the child immunisation programme would be cost-effective.

The bids will cover vaccinating an estimated 800,000 infants over a three-year period, with the option to extend for another year.

Currently there are two available vaccines, Rotarix and RotaTeq, both orally administered. Rotarix is given in two doses and RotaTeq in three doses, at two-monthly intervals.

A DH spokesperson said: 'The DH is looking at whether a vaccination programme for young children against diarrhoea and vomiting caused by rotavirus is viable. This follows advice from the Government's independent vaccine advisory panel.'

A modelling study published last year showed that a routine rotavirus immunisation programme could eradicate severe infections in young children within two years in England and Wales.

Dr George Kassianos, RCGP immunisation lead and a GP in Bracknell, Berkshire, said the move was 'excellent news': 'We can easily add one of these two vaccines to our immunisation schedule at two, three and four months. I do hope there will be no further delay in implementing a rotavirus immunisation programme in the UK.'

@nigelpraities

The infant schedule could soon include rotavirus vaccination

Rotavirus vaccines head to head

	Rotarix	RotaTeq
Type	Human, live attenuated vaccine	Human and bovine, live attenuated vaccine
Administration	Oral, two doses at two and four months	Orally, three doses at two, four and six months
Manufacturer	GlaxoSmithKline	Merck
List price*	£35 per dose	£25 per dose

*Assumed price from JCVI, 2009

Call for statins for all over-50s

Public health experts have called for GPs to offer statins to all patients over the age of 50, after an analysis of 22 trials in the *Lancet* showed statins significantly reduced the risk of major cardiovascular events and death even in groups with an estimated five-year risk of less than 5%.

The UK and Australian researchers suggested their findings showed the current threshold for prescribing statins for primary prevention of CVD should be lowered. NICE said it would be looking at the research in its ongoing review of its guidance, which currently recommends a threshold of 20% or greater CVD risk over 10 years.

Any lowering of the threshold could have huge implications for GP workload, as most people aged over 50 years have greater than a 10% risk of cardiovascular disease. The analysis found statin use was associated with a 38% reduction in risk of major vascular events in patients with a five-year risk of less than 5% and a 31% reduction in those with a risk of 5-10%, compared with controls. This translated to an absolute reduction in risk of major vascular events of about 11 per 1,000 patients over five years in those with a CVD risk of less than 10%.

In a related editorial, Professor Shah Ebrahim, professor of public health at the London School of Hygiene and Tropical Medicine, and Dr Juan Casas, senior research associate in epidemiology at University College London, said: 'Because most people older than 50 years are likely to be at greater than a 10% 10-year risk of CVD, it would be more pragmatic to use age as the only indicator for statin prescription.'

IN BRIEF

Comorbidities advice

NICE is considering inserting advice on common comorbidities into guidelines.

Full story ▶ pulsetoday.co.uk/clinicalnews

Remedy UK closes

Pressure group Remedy UK has announced it is to close with immediate effect.

Full story ▶ pulsetoday.co.uk/practicenews

CQC bribes case

A CQC inspector is being investigated by police on suspicion of allegedly taking bribes.

Full story ▶ pulsetoday.co.uk/practicenews

Tackling the top five practice risks
▶ page 27

Patients' right to NHS treatments to depend on direct negotiation between DH and drug companies

DRUG PRICING

NICE to lose rationing role

By Nigel Praities

NICE will no longer make 'yes' or 'no' decisions on access to drugs from 2014, with the Department of Health instead setting a maximum price the NHS will pay.

Health secretary Andrew Lansley said patients' right to approved drugs would remain, but would no longer be determined by NICE appraisals – instead, the DH and manufacturers would agree a price that should be paid for them.

He told the NICE annual conference in Birmingham last week the change would allow more innovative medicines to be available, but critics branded the move a 'political fix' that would make it harder to balance budgets.

Mr Lansley said the Pharmaceutical Price Regulation Scheme, which expires in January 2014, had failed to ensure NHS patients had access to new treatments. He said the Government would open talks with drug companies later this year on introduction of value-based pricing.

Under the scheme, NICE will still make technology appraisals of new drugs, but as advisory reports to ministers, who will dictate the terms under which they are funded through negotiations with manufacturers.

The DH will determine how QALYs are weighed, potentially paying more for treatments showing additional benefits, more innovation or other 'societal benefits', Mr Lansley said.

Andrew Lansley: DH will agree drug prices with manufacturers

CCGs would have a legal responsibility to provide access to therapies at the price set by the DH, just as PCTs currently have under the 'funding direction' for NICE-approved therapies.

Mr Lansley said: 'As enshrined within the NHS Constitution, the NHS in England will continue to fund existing drugs recommended by NICE.

'That right will continue and will apply to new medicines for which value-based pricing applies.'

Dr David Jenner, GMS/PMS contract lead at the NHS Alliance and a GP in Cullompton, Devon, said: 'Judgments could be made on political, rather than evidential grounds. The crunch for CCGs will be if more drugs are let through – that could increase cost pressures.'

Professor James Raftery, professor of health technology assessment at the University of Southampton, said it was a 'political fix for difficult diseases': 'It is taking money on the basis of no evidence, for diseases that are difficult to say no to.'

Professor Alan Maynard, professor of health economics at the University of York, said the move was 'outrageous' and would 'abandon science'.

@nigelpraities

Value-based pricing

- Ministers set maximum QALY payment thresholds
- Companies submit evidence on cost and effectiveness
- NICE advises on health gain and calculates QALY
- QALY is weighted for any additional 'societal' benefits
- Government negotiates if the price is too high, asking for more evidence if available
- Drug is approved for use on NHS, or company has to state publicly why it was unable to agree a price

Source: Department of Health

OVERPAYMENT

GPs challenge coding

GPs have successfully challenged the coding by hospital managers of almost a third of outpatient attendances over a month, revealing the scale of money being drained from primary to secondary care under payment by results.

LMC leaders said an audit of successful challenges by GPs in Greenwich, south-east London, showed claims by hospitals 'may be highly inaccurate', and that successful challenges were crucial in making 'potentially substantial savings on the secondary care budget'.

It comes just a week after Pulse revealed how GPs in Bristol prompted an investigation into 'creative coding' by hospitals after providing evidence of what they claim to be routine misuse of payment by results.

GPs at a Greenwich practice successfully challenged claims by Queen Elizabeth Hospital for 25% of admissions for long-term conditions and 13% of outpatient attendances in the third quarter of last year. In November, 29% of outpatient attendances were successfully challenged.

But a spokesperson for South London Healthcare NHS Trust said its error rate was better than many hospitals: 'The trust's clinical coding process has recently been audited by the Audit Commission, where our error rate was 4.5 against a national average of 9.1.'

PATIENT CHOICE

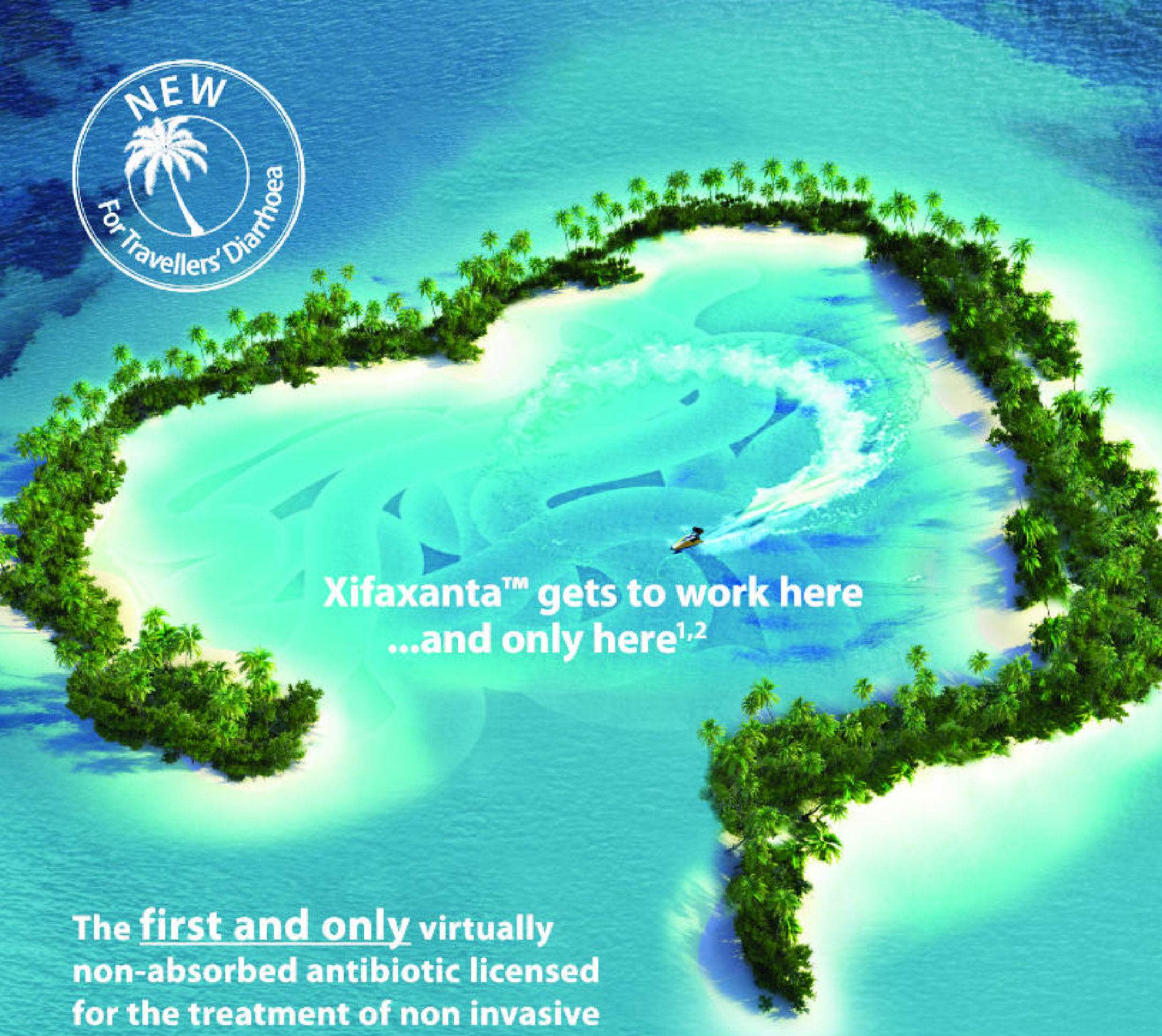
Managers attack choice

Health service managers have warned the Government's choice agenda is creating a 'mismatch of expectation' among patients, and called for the NHS to be 'more honest' about its affordability and suitability.

Speaking at the Reform High Quality Healthcare conference in London last week, NHS Confederation chief executive Mike Farrar questioned the wisdom of the choice agenda given its requirement for additional capacity, and said the NHS should be more discerning about where choice was applied.

He added that he believed publishing data on performance was a better driver of quality than patient choice: 'I am worried. I think choice has become highly politicised, but largely in a rhetorical space.'

Mr Farrar said it was important to understand the 'consequence of choice', and called for the NHS to be 'more forensic' about where it was feasible.



The first and only virtually non-absorbed antibiotic licensed for the treatment of non invasive Travellers' Diarrhoea[3]

Xifaxanta™
Rifaximin-α

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 J-J *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.

GPs urged to use COCs ahead of patches and vaginal rings after study finds VTE link

CONTRACEPTION

Patches double thrombosis risk

By David Swan

GPs have been advised to switch patients from contraceptive patches and vaginal rings, after a study found they doubled the risk of venous thrombosis compared with oral contraception.

Researchers showed transdermal patches raised the risk of venous thromboembolism (VTE) eightfold compared with women not taking contraception at all, in the first study to look specifically at the risk with patches.

They also found women who used vaginal rings had 6.5 times the VTE risk of those who did not take contraception.

GPs warned the study results could undo years of work reducing teenage pregnancies, while the authors urged GPs to use oral levonorgestrel- or norgestimate-based contraceptives to reduce the risk of VTEs.

Contraceptive patches have been found to raise the risk of VTE

The Danish researchers looked at a cohort of 1,626,000 women aged 15 to 49 years who were free from thrombotic risk at baseline from national registries.

After nine years, transdermal patches were associated with an adjusted relative risk increase of 130% and the vaginal ring was associated with a risk increase of 90%, compared with users of oral contraceptives containing levonorgestrel.

The incidence of confirmed VTEs was 4.52, 6.22, 7.75 and 9.71 events per 10,000 exposure-years, for oral contraception containing norgestimate, oral contraception containing levonorgestrel and oestrogen, rings and patches respectively.

When length of use was analysed more closely, the relative risk of venous thrombosis in women using combined oral contraceptives was reduced with increasing length of use by almost 50%, while no changes in relative risk over time were observed for patches or vaginal rings.

Study leader Dr Ojvind Lidegaard, professor of obstetrics and gynaecology at the University of Copenhagen, said the study had 'outstanding external validity' and should encourage GPs to use COCs more widely.

He added: 'A risk of 10 per 10,000 person-years implies a risk of venous thrombosis of more than 1% over a 10-year user period. Therefore, women should generally be advised to use COCs with levonorgestrel or norgestimate.'

Online CPD
PulsePlus: contraception
pulse-learning.co.uk

Dr Fiona Cornish, a GP in Cambridge and president elect of the Medical Women's Federation, said the study confirmed her own practice: 'We hardly use patches and rings as they are much more expensive than COCs. What is important is that GPs and nurses continue to advise the use of COCs in preference where possible.'

Dr Richard Ma, a GP in Halloway, north London, and London sexual health champion, said the raised risk of VTE was already listed in product information for patches and vaginal rings: 'Newer progestogens in combined methods such as vaginal rings and contraceptive patches are associated with higher risk of VTE compared with non-users.'

But Dr Anne Connolly, a GPSI in gynaecology in Bradford and chair of the Primary Care Women's Health Forum, said she was 'extremely concerned' that the study could undermine efforts to tackle teenage pregnancies.

She said: 'If commissioners and prescribing advisers make knee-jerk decisions based on poor studies such as this one, we will be reduced to providing a range of cheaper, older, less well tolerated options to women and we are likely to see unplanned pregnancy rates increasing again.'

BMJ 2012, online 10 May
david.swan@pulsetoday.co.uk

VTE relative risk compared with non-users

COC with levonorgestrel and oestrogen	6.22
COC with norgestimate	4.52
Patch	9.71
Vaginal ring	7.75
Levonorgestrel IUS	1.38

Source: *BMJ* 2012, online 10 May

CPD TIP OF THE WEEK

AF type not important for GP management

Atrial fibrillation can be defined in as many as five different ways, but by and large the definitions are more academic, and it is important to note that GP management is not significantly altered with the different types, according to a new case-based learning module. A patient with paroxysmal AF is at as high risk as a patient with permanent AF and should receive anticoagulation in the same way. The only exception is where rhythm control is being pursued. Each stage means the episode is likely to persist for longer while continuing an inexorable rise towards permanency.

ONLINE CPD
See the Hot topics in atrial fibrillation module at pulse-learning.co.uk

Key questions: dementia
▶ page 20

ATRIAL FIBRILLATION

Palpitations 'predict atrial fibrillation'

Palpitations and hypertension are the strongest predictors of future atrial fibrillation, say researchers.

Their study was part of an ongoing follow-up of inhabitants of Tromso in Norway. Patients aged 25 or over were eligible for inclusion, and a total of 22,815 gave consent.

After 11 years, researchers found men were 91% more likely to develop AF than those without the symptom.

In women, the risk was increased by 62%.

Hypertension was also a strong predictor – raising risk by 40% in men and 98% in women – and an increase in BMI was associated with a 47% increase in men and a 16% increase in women.

An association with HDL-cholesterol was also found, which was significant in both sexes. Men saw their risk increase by 16% for each incremental rise in HDL-cholesterol, while women saw it rise by 13%.

Study leader Dr Audhild Nyrnes, professor of community medicine at the University of Tromso, said: 'The clinical implication is to emphasise the importance of adequate treatment of high blood pressure.

'Subjects with palpitations could have paroxysms of AF and should be investigated further.'

***Eur J Prev Cardiol* 2012, online 15 May**

HIV

HIV testing in glandular fever finds new cases

All patients presenting with glandular fever-like symptoms should be tested for HIV, say UK researchers.

The researchers looked at samples from 1,046 patients submitted to Guy's and St Thomas' NHS Foundation Trust from primary care, with or without a concomitant HIV request.

They found an overall prevalence of HIV of 1.3%, which accounted for 11 patients that were newly diagnosed with HIV.

Five came from patients who were submitted with a concomitant HIV request, and six from those without one.

Of the 11 patients, only three were spotted in primary care as being HIV positive, meaning eight cases were missed at the initial GP consultation.

Study leader Dr Murad Ruf, assistant director of health protection for NHS Lambeth, said: 'Diagnosis of primary HIV infection represents a compelling economic argument for universal HIV testing in people presenting with glandular fever-like illness.'

***HIV Medicine* 2012, online 10 May**

ROSACEA

Alcohol 'marginally' increases risk of rosacea

Increased alcohol consumption does not play a major role in the development of rosacea, concludes a large study into the characteristics of patients with the disease.

The analysis of UK data from the General Practice Research Database looked at 80,000 patients with a first-time READ code for rosacea and an equivalent number of matched controls. The researchers found the overall incidence rate for diagnosed rosacea in the UK was 1.65 per 1,000 person-years.

Rosacea was diagnosed in 80% of cases after the age of 30 years and 21% of patients had ocular symptoms. Alcohol was linked to a 51% increased risk of rosacea in those consuming over 25 units per week, but the researchers said this represented only a 'marginal increase'.

Study leader Dr Christoph Meier, head of the pharmacoepidemiology unit at the University Hospital in Basel, said: 'These findings do not suggest that alcohol consumption plays a major role in the pathophysiology of rosacea.'

***Br J Dermatol* 2012, online 5 May**

STROKE

Older women with AF have higher stroke risk

Older women with atrial fibrillation are more likely to suffer a stroke than men of the same age, even if they are receiving anticoagulation therapy, a new study concludes.

Canadian researchers studied 84,000 patients aged 65 or older admitted to hospital with recently diagnosed AF between 1998 and 2007. At 30 days post discharge, 58% of men and 61% of women had filled a warfarin prescription and adherence was good in both sexes.

The incidence rate for stroke per 100 person-years was significantly higher in women than men – at 2.02 and 1.61 respectively.

Women also had a 14% greater risk of suffering a stroke than men after adjustment for CHADS2 scores, comorbid conditions and warfarin treatment.

Incidence increased with age for both sexes, but women had a significantly higher incidence in age bracket 75-79 (1.90 versus 1.63 for men) and age bracket 80-84 (2.26 versus 1.99).

Study leader Dr Meytal Avgil Tsadok, clinical epidemiologist at McGill University Health Centre in Montreal, said: 'Clinicians should be aware of the elevated stroke risk in older women with AF and new strategies should be applied to effectively prevent stroke equally in men and women.'

***JAMA* 2012;307:1952-8**

CONFERENCE ROUND-UP

Polymyalgia rheumatica and fatigue

Patients with polymyalgia rheumatica are more likely than those who do not have the condition to consult with their GP with fatigue before they are diagnosed, research from Keele University has discovered.

The study looked at consultation data from nine general practices in North Staffordshire over a nine-year period, and found a significant difference in the number of cases consulting with fatigue before diagnosis compared with controls, but no difference after diagnosis.

British Society of Rheumatology conference, abstract number 166

Musculoskeletal phone consultation

A physiotherapy telephone assessment service is clinically effective for patients with musculoskeletal problems, a trial has found.

Patients using the telephone service experienced an earlier improvement in health, and had shorter time to first assessment than patients receiving usual care.

British Society of Rheumatology conference, abstract number 32

Screen patients with RA for CVD

GPs should routinely screen patients with rheumatoid arthritis for cardiovascular disease, according to the Arthritis Research UK Primary Care Centre.

Their data showed patients with RA were no more likely than matched controls to be screened for blood pressure, body weight, cholesterol or glucose levels.

But there was an increased screening rate for smoking status in patients with RA compared with controls, and an increased screening for all risk factors in patients over 65.

British Society of Rheumatology conference, abstract number 35

Trainee rise must not be false dawn

Richard Hoey
Editor

After a dark period for general practice, the horizon is getting just a little bit brighter. The RCGP's recent approval in principle of four-year training was a fillip, even if legitimate questions remain over how a 'cost-neutral' programme will be delivered.

And now, as practices struggle to recruit from a job market acutely short of GPs, the Government has finally responded to demands from the profession's leaders to restock the supply. Health secretary Andrew Lansley's decision, revealed in Pulse this week, to increase the number of GP training places by about 20% is an overdue piece of good news.

Mr Lansley wants the proportion of specialty training places taken by GP registrars in England to rise from around 40% to 50% by 2015 – a significant shift in the way the country deploys its medical resources.

The absolute number of GP trainees would rise from 2,700 to 3,250 a year if the overall number of doctors trained stayed the same, although with ministers conducting a major review of medical school places, the actual number could be even higher or a little lower than that.

How will the profession woo medical students from other specialties?

GPs of course are currently under unprecedented pressure, with commissioning, the CQC and revalidation all coming in quick succession like the devil's own bus service, and within the context of pay freezes and budget squeezes.

Ministers have talked repeatedly of how they not only want GPs to take responsibility for key decisions in the NHS, but for practices to expand provision by taking on a rush of hospital work.

In that context, a 20% rise in new GPs is welcome but may hardly put a dent in the bulging demands on primary care.

Not only that, but the Department of Health's decision raises two pressing questions. The first is *how* it got the order of its decision making so wrong. Ministers knew from the early days of the coalition Government that GPs were to be central to their plans for the NHS.

It is exasperating that for so long they remained deaf to those who demanded some proper workforce planning, and who insisted the reforms could only ever work with an expansion of general practice.

And there is a second question, which needs to be answered if Mr Lansley's announcement is to prove anything more than hot air. How does the DH propose to ensure young doctors actually take up these new GP training places? The number of doctors applying to train as GPs has crashed by more than 40% in the last three years, and last year deaneries were unable to fill even the current number of allocated places, because they simply didn't have enough good candidates.

GPs have suffered nearly a decade of denigration and downward pressure on their pay – yet the profession is being expected to compete for candidates with a myriad of hospital specialties, all in a much better position than general practice to sell themselves to junior doctors.

Mr Lansley needs to make general practice attractive again to young doctors. Until he does so, it will be too early to hail this shaft of light as a new dawn.

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

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Should CCGs performance manage GP practices?

YES

It's important for CCGs to have oversight over local practices, argues Dr Charles Alessi

In times of austerity, it's better for GPs to be transparent about the tough decisions they must make, and how they plan to improve standards of care.

In less than a year, the majority of CCGs will become autonomous. They will be held accountable via their health and wellbeing boards and the NHS Commissioning Board for their performance, judged more by the outcomes they achieve than the processes by which they achieve them.

It is unlikely the climate of austerity will change over the next few years. The decisions CCGs will face may be difficult – we are in a new world of zero-sum gain where we won't be able to invest in anything unless we disinvest in something else. Prioritising care in a more integrated and transparent way is the only way to manage.

We also need to think through what the behaviours are that will make CCGs more likely to achieve their aims. NHS managers have tried to impose repressive and authoritarian regimes in the past and, as we know, they all fade and fragment in the attendant micromanagement they create. The critical flaw has all too often been the lack of ownership over these schemes.

The unit of currency that makes up a CCG is the individual GP practice. The CCG is thus a reflection of its constituent practices.

The relationship between the CCG and its practices is going to be the key determining factor in its success. If the CCG agenda is not owned by the practices, how can clinical behaviours change at practice level? We know that for system change to be successful, the people who implement it must engage with it.

We are seeing a whole spectrum of relationships in aspiring CCGs. In some, the more extreme aspects of the old regime seem to persist – where management still tells people what to do and relies on fear and punishment to deliver.

This tactic is unlikely to be sustainable or successful. It has become clear that the NHS Commissioning Board won't have as many outposts as originally trialled. This is a positive development, because it shows that the board is starting to take the autonomy of CCGs seriously. (Its duty to do so was highlighted prominently in a recent letter from the health secretary to the chair of the NHS Commissioning Board).

CCGs have realised they must work on relationships within

In other CCGs however, it is clear that a new way of working is being developed, born out of the appetite to manage unwarranted variations that persist in the NHS. If GPs wish to introduce systems of management via CCGs that go beyond what we have been used to in the past, and practices introduce these voluntarily, this is to be welcomed.

With the approval of the NHS Commissioning Board, CCGs can get much more involved in the management of primary care than the PCTs and SHAs that went before. Some CCGs have realised that they must work on relationships within, and that engaging with their constituent practices gives them a greater chance of successfully prioritising resources given their tight budgets. The key to success is consensus. If some CCGs are taking on responsibilities of management of primary care, it is important they do so with the support and buy-in from their constituent practices. The behaviours the new CCG leaders need to exhibit are very different to the linear style of old. New GP leaders need to start to develop their own autonomous behaviours, and make their presence felt as the NHS changes.

All transitions can be messy, and the next six months are probably where it is likely we will have a few problems, especially where some of the existing PCT clusters and new CCG structures continue to exhibit the old behaviours. We need to remain focused on engagement – a difficult task when the emphasis is so firmly now on authorisation.

But if we remain focused, there is a far greater chance of delivering better health and social care within the resources we have available.

Dr Charles Alessi is chair of the National Association of Primary Care and a GP in Kingston upon Thames

NO

Having CCGs performance manage practices will only alienate GPs, says Dr Michelle Drage

Most GPs do their best, and punishing them for missing 'targets' will only alienate them. Every cat owner knows that if you want to keep your cats away from the cream, you should give them a mouse to play with.

Every student of NHS behaviour knows that if they want to keep GPs away from the real money and influence, give them performance management of their GP colleagues to play with.

And so the prospect of CCGs 'doing performance management' of their members, as well as 'doing commissioning', risks turning the culture of CCGs into that of PCTs – the very bodies the health act was designed to abolish. For on the back of a single clause in the largest-ever act, just one single reference to improving the quality of primary care (note it doesn't say general practice) may be about to become CCGs' first and overriding duty.

But what actually is performance management? Is it a positive and supportive system underpinned by a strong culture of education, training and development, properly resourced and incentivised? Or is it a negative and punitive regime, based on the threat of sanctions and contractual action?

Evidence for the supportive approach extends as far back as the 1980s and 1990s, when family practitioner committees were enabled to pursue such cultures. This delivered a GP and practice nurse workforce motivated to radically improve what practices offered in clinical care – from asthma, diabetes and high-quality general practice to improved premises and primary care team growth. Such motivational cultures add huge value to service delivery by playing to the strengths of individuals' professionalism.

By contrast, negative, punitive performance management stresses, demotivates and burns out many GPs, undermines professionalism and often misses targets. It subjects those who would otherwise have improved under a supportive approach to a career of endurance rather than pride in what they could achieve.

Nobody could be more supportive of CCGs seeking to promote a system of positive performance support than myself, but promoting support does not appear to be the latest Department of Health direction of travel.

Must we accept there has to be a punitive regime?

Statements like 'the functions of a PCT have to go somewhere, and CCGs are the only place left' are heard frequently. They fill me with trepidation. Surely many of the functions of PCTs could be binned to reduce bureaucracy?

Another frequent comment is: 'Someone has to performance manage GPs...' Well, do they? Where is the evidence this works? What are the skills required, where is the training and to whom will the CCG performance managing GPs be accountable when it messes up the wrong colleague's livelihood? Then there's the latest excuse for promoting a negative approach: 'You can't commission good secondary care services if you don't put your own house in order.' Oh please.

Sometimes the messages get muddled. 'Peer pressure will lead to change', for example. In my book, it's supportive peer review that leads to positive change. Peer pressure often doesn't. The way to motivate peers is to provide intelligent information about outcomes and support them to navigate through the plethora of evidence to make sound clinical decisions. Success does not come by threatening professionals, funding-removal arm-twists or contractual compliance regimes.

Some say CCG performance management is okay because the contract is held by the NHS Commissioning Board, which will ensure there will be no conflict of interest. How so? From where and whom will the board get its referrals and intelligence? Others, including CCG lead colleagues, ask: 'Who are we to stand in judgment of our colleagues' clinical practice?' As if we haven't got enough to do.

Must we accept that there has to be a punitive regime for the majority to prevent patients from suffering at the hands of the few? GPs do not go into practice to do harm – the majority try to do good against the odds. In London, our survey of practices just this week shows that nearly 80% of respondents are worried about being performance managed by their CCGs. That speaks volumes – I hope our CCG colleagues hear it.

Dr Michelle Drage is chief executive of Londonwide LMCs

Damn right, I'm going to tell you off

ILLUSTRATION: JAMES MCLAUGHLIN

Copperfield is drooling with Pavlovian irritation and seriously considering violence, after a patient uses the most infuriating opening gambit of them all

Nails down blackboard. Drill against molar. Polystyrene edges scraped together. Excellent, I've got you in the mood.

So, in the 'teeth on edge' stakes, here's what does it for me: the patient walks in, she gives a rueful smile and she says: 'You're going to tell me off.'

...

...

...

That pause is because I just had to go and hit a pillow.

The GMC doesn't have a problem with that, but it does with me smashing the patient in the face with a plank, which is the alternative.

I know – get over it, Copperfield.

I'm now at a stage in my career when those stock opening gambits – 'I've got a list', 'I don't know where to start', 'I want a brain scan' etcetera – should be less red rag to a bull and more gauntlet thrown down in battle. With only one possible winner: me.

And, to be honest, I enjoy these fights – at my age, you have to take your pleasure where and when you can.

But, 'You're going to tell me off.'

Yep, that still does my head in.

Why the wind-up? Perhaps because, compared with the other hackneyed clichés, it's rare, so I've yet to build up an immunity.

Or maybe because it never features in the regular GP-only forum threads discussing 'opening gambits which make me head-butt a wall', leaving me wondering whether it's just me being idiosyncratic or even a bit mad. Or maybe it's because the phrase is simply overloaded with meaning.

Because it is. Let's analyse it. 'You're going to tell me off,' says something about the patient and the patient's perception of the doctor.

a) The patient: she's painting herself out as a self-sufficient, uncomplaining stoic who has soldiered on with what she's trying to convince me could be serious pathology that she's 'delayed' presenting.

'You're going to tell me off, doctor,' she'll say, with a long-suffering sigh.

'I've had this back ache for a whole week. But you know me, I don't bother you for nothing.'

Yes, I know you, and I know that what you're doing is using amateur reverse psychology to over-compensate for having the patience and pain tolerance of a two-year-old.

b) The patient's perception of the doctor: she thinks I care. Enough, that is, to reprimand her for a delayed presentation.

I don't: it would have to be rather more than backache and rather more than a week to have me expressing shock at a delayed presentation.

She's painting herself as a self-sufficient, uncomplaining stoic

And even with, say, a neglected tumour, I might raise an eyebrow, but I wouldn't tell someone off – people have the right to ignore illness without me rubbing salt in the fungating wound by making them feel stupid or guilty.

So: self-justification, self-aggrandisement, feigned self-sacrifice, false assumptions and manipulation. That's pretty impressive for six words.

Harsh, perhaps, but remember – this is Pavlovian. I'm positively drooling with irritation. Besides, some good may come of the catharsis.

Because any patients reading might realise that it's best to leave the melodrama at the door.

'You're going to tell me off'? Possibly, but not in the way you think.

Where's that plank?

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

More online

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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

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Cipralex® escitalopram

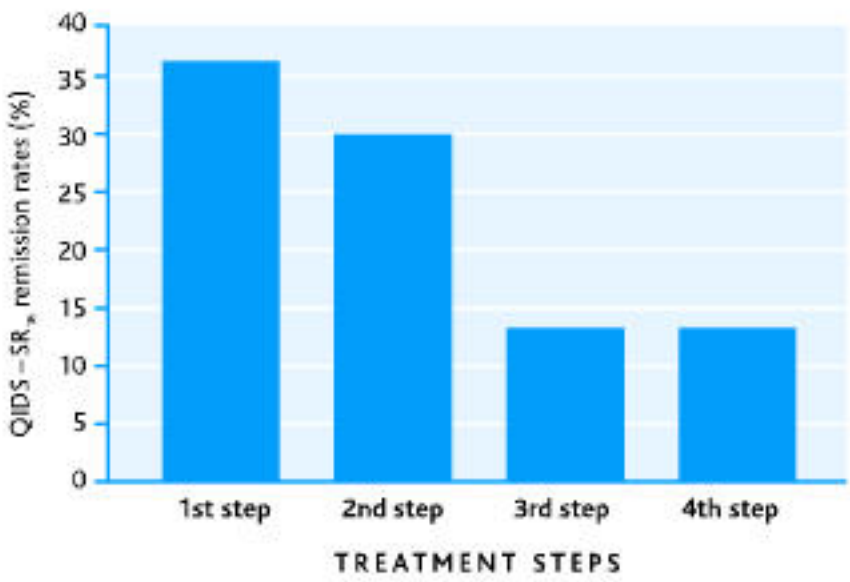

Figure 1. Acute remission rates by treatment step. Adapted from STAR*D, Rush et al.[3]

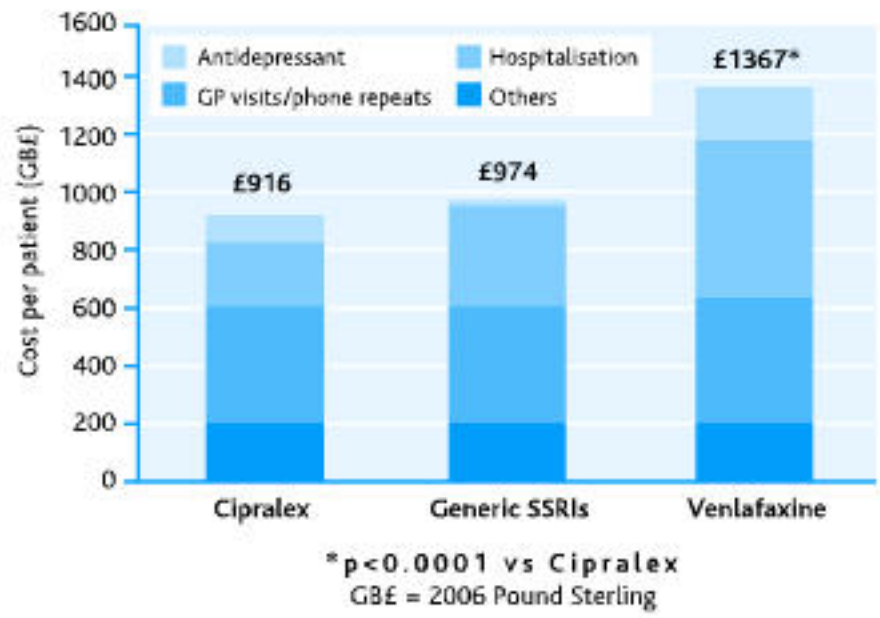

Figure 2. Total cost distribution per treatment group in severe depression for 12-month period following index date of study inclusion. Adapted from Wade et al, 2010[7]

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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 (eg 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 (eg phenothiazine derivatives, pimozide, haloperidol), tricyclic antidepressants, certain antimicrobial agents (eg 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. 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GPs powerless to correct NHS Choices claims

LETTER OF THE WEEK

From Dr Stephen Bowers
Bury

My colleagues have expressed concern about the way that a proportion of unsubstantiated negative comments are starting to appear on the NHS Choices site, using a process perhaps more suited to the budget hotel sector than our precious NHS.

We can relate one, for example, to a person who was not actually registered and behaved unreasonably towards our reception staff.

After a long process and wait we were unable to influence NHS Choices to change, remove or limit two of the original unfair, negative comments.

We have since been told by NHS Choices that all the comments made about practices are not moderated and can be withdrawn on appeal, but only if they are considered racist or contain major swear words.

Therefore the validity of any of the comments cannot be challenged, as NHS Choices considers these to be 'opinions', even if they are not true.

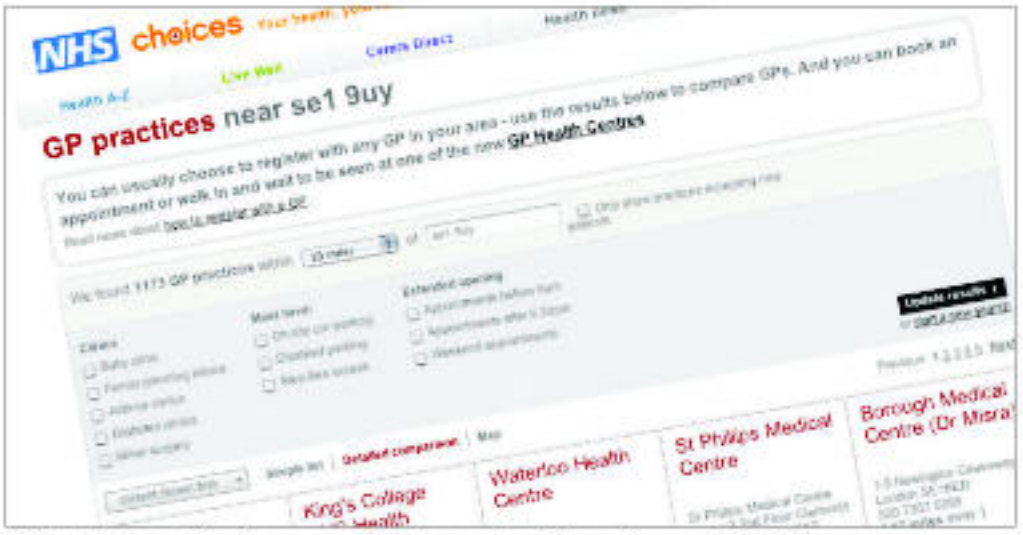
Because of this, we have published a general statement on the site, which says in part: 'The NHS Choices website is operated by the NHS on our behalf and as such we have little control over it.

'The patient comments made on this site are anonymous and are not necessarily made by actual patients registered at our practice. Although we can challenge these, the process is slow and there is no redress unless they are considered extreme. We would urge you to talk to local people for their opinions when choosing a practice.

'If you have a question about a specific comment made on this site we would be happy to answer it either in writing, or by telephone call to a senior member of the administrative team or the practice manager.'

It seems that there is little else that we can do.

MORE ONLINE
Read the practice's full NHS Choices response
pulsetoday.co.uk/letters



Patients have rated and commented on thousands of GP practices on NHS Choices

Don't let study limit choice of contraception

From Dr Anne Connolly
Bradford
Chair of the Primary Care Women's Health Forum

The latest study to be published claiming 'higher' venous thromboembolism risk in women using the medium-acting reversible contraceptives (patch and vaginal ring), and possibly also the long-acting reversible subdermal contraceptive implant, is extremely concerning.

These results will be picked up by commissioners and prescribing advisers who will then make decisions about restricting the use of these highly effective, popular contraceptives based on a poor evidence base.

This study, like previous ones based on the Danish registry, fails to compare like with like and does not include any data about the known risk factors for venous thromboembolism – smoking, family history and BMI greater than 30.

The data about the subdermal implant is very dubious, with small numbers and a relative risk of 1.4 with wide confidence intervals (0.6-3.4).

We have done well nationally with reductions in teen pregnancy and abortions over the past few years.

Good open access to a range of options has allowed women to make an informed choice of contraceptive method.

By having a choice they are more likely to comply with the requirements of their chosen method, which maximises efficacy and reduces the numbers of unplanned and unwanted pregnancies.

If commissioners and prescribing advisers make knee-jerk decisions based on poor studies such as this one we will be reduced to providing a range of cheaper, older, less well-tolerated options to women – and we are likely to see unplanned pregnancy rates increase again.

Double-check your two-week referrals

From Dr Rachel Bray
Godalming, Surrey
via pulsetoday.co.uk

In our practice we have a process in place to check that the two-week rule referral has been received and an appointment allocated by secondary care ('GPs asked to contact hundreds of patients who may have missed treatment after hospitals' cancer referral blunder', pulsetoday.co.uk/news).

We also advise our patients, at the point of referral, that they will be seen within two weeks and that if they do not receive an appointment to inform the practice.

In this way we have a double-check protocol. Why do other practices not do the same?

It is not difficult to put in place.

Breastlight? Gym kit's a better bet

From Dr Sally Dowler
Dulwich, south London
via pulsetoday.co.uk

Women would be better off spending the £90 on a pair of trainers and tracksuit bottoms and going for a good walk than buying a Breastlight ('Shining a light on self-test kits', pulsetoday.co.uk/margaret-mccartney).

We are creating a paranoid society that has lost all common sense.

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 3DB. Let us know where your practice is situated. Feedback may be edited

Beware divide and rule on pensions

From Dr James Bissett
Newtownards, Co Down
via pulsetoday.co.uk

And so the divide and conquer tactics over pensions have begun ('LMCs lukewarm on industrial action as pension ballot splits younger and old', pulsetoday.co.uk/news).

I am within the 10-year gap and I am not happy with the proposed package. These changes affect us all sooner or later. Industrial action is not the answer – but action is. We should disengage from health reforms, local commissioning groups and federations – and then wait for a rapid return to the negotiating table.

Why I am standing for RCGP Council

From Dr Bashir Qureshi
Hounslow, west London
RCGP Council candidate

Why should I like to serve on the RCGP Council? What would I do differently from all others?

GPs are the backbone of the NHS. The RCGP leads the medical profession today, nationally and internationally, because it has the largest membership among all the royal colleges. I am passionate about retaining and increasing college membership.

With my wide experience, having served on the RCGP communication executive, publication and international committees, and also having been the provost of the North and West London Faculty as well as editor of *Faculty News*, I shall actively support council to encourage:

- retired members to retain membership
- all members to get college support in their revalidation, recertification and continued professional development
- gender equality and ethnic diversity among membership and its council
- locum and salaried GPs to join membership and fellowship
- young GPs with recent MRCGP, who are reluctant to join the college, to join and be proud of it.

I believe that united we stand and divided we fall. Our college should lead in the quality of care for patients, who are the most important people in medicine. The BMA should be supported to act as a trade union of all doctors and the Government to govern after democratic consultation. In Britain, unity is our strength.

Of course we need smaller caseloads

From Dr Jonathan Harte
Nottingham
via pulsetoday.co.uk

Pulse reports a study finding that practices in deprived areas should be given smaller list sizes ('GPs in deprived areas "need smaller caseloads"', pulsetoday.co.uk/news). Well, no shit, Sherlock. I'm glad research has borne this out. Carr-Hill was meant to sort this back in the day, but it wasn't funded properly so didn't work and many (or most) deprived area practices had to rely on MPIG or go PMS.

It's not impossible to sort – but it needs financial tweaking, and reasonable actions on behalf of the Government.

Dogs unfairly targeted by police

From Dr Rosemary Alexander
Brent, north-west London

I cannot be the only viewer who felt very depressed after watching *Death row dogs* on the BBC recently. This exemplified all too clearly the legal loophole in the Dangerous Dogs Act that allows a friendly, pit-bull-type dog – who didn't stop wagging its tail even when put into a van by a stranger – to be killed because he came from a home that was less than immaculate. Another dog was condemned to a similar fate when it wasn't keen for a stranger to put a rope around its neck.

As a GP who has worked in large council estates, I have seen a lot of well-loved dogs from similar homes and feel it is very wrong for the police and lawyers to make a judgment of destruction without exploring all other options.

Boundary pilot thin end of the wedge

From Dr Amit Tiwari
Colchester
via pulsetoday.co.uk

We now need as GPs to boycott all these new measures – including the practice boundary pilots ('PCTs fail to agree terms for GP home visits in practice boundary pilots', pulsetoday.co.uk/news).

Let's start by refusing to engage with commissioning and nonsense ideas like abolishing practice boundaries, and offering a cup of tea or coffee to all punters who come through the door. It's just getting slightly too stupid for my liking.

Lab test economy is a basic GP skill

From Dr Louise Irvine
Lewisham, south London
via pulsetoday.co.uk

Experienced GPs are quite parsimonious with lab tests ('GPs to be ranked on lab test use', pulsetoday.co.uk/news).

Part of our role as trainers is to help registrars think about the utility of tests they are ordering – to ask themselves, 'what question am I trying to answer with this test?'

Doing appropriate tests is a basic competency, and a professional and educational issue. Feedback on significant variation could be educationally helpful to stimulate discussion and learning. It is not something we should be performance managed on and I doubt money will be saved.

Our guide to ethical prescribing

From Dr Edoardo Cervoni
Southport, Merseyside
via pulsetoday.co.uk

Being a physician is not easy, and our profession comes with unique moral and professional responsibilities and duties.

Prescribing is one challenge we face on a daily basis ('The GMC must defend off-label scripts', pulsetoday.co.uk/opinion). I find the Hippocratic Oath to still be a helpful guide: 'I will prescribe regimens for the good of my patients according to my ability and judgment and never do harm to anyone.'

I make sure I read, observe, listen, discuss and inform as much as I can. Once I am sure I have done all that, no prescribing action I should take in accordance with the above-quoted part of the Hippocratic Oath may be considered wrong or not legitimate. We would be fooling ourselves if we thought that our prescribing today will still be considered adequate in 50 years' time.

Glad to shelve quality accounts

From Dr Helena McKeown
Salisbury, Wiltshire
BMA and GPC Council member
via pulsetoday.co.uk

There were many problems with quality accounts ('GPs spared quality accounts as ministers shelve rollout to avoid CQC clash', pulsetoday.co.uk/news). One was the opportunity for partakers to choose what to showcase. This was fine for some if it's optional; but not if it's another expensive hoop to jump through.

For the record

In a recent opinion piece on off-label prescribing, Dr Bill Beeby referred to Novartis's legal action relating to bevacizumab (Avastin) and ranibizumab (Lucentis) ('GMC must defend off-label scripts', pulsetoday.co.uk/opinion). We would like to clarify that Novartis is the manufacturer of ranibizumab, but not bevacizumab. Pulse's priority is accuracy. However, in the busy process of preparing a weekly publication, mistakes can occur. To draw our attention to an error, email letters@pulsetoday.co.uk

Pulse Clinical

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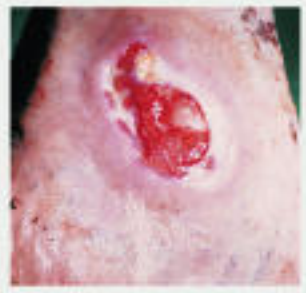

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More online

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Video module: hair and scalp disorders 1 CPD hour
Has been rated four out of five stars by GPs

Dermatology photofile: cryosurgery
1.5 CPD hours
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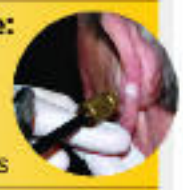

Hot topics in osteoporosis
2 CPD hours
Using typical GP case studies to update you on management

PulseToday
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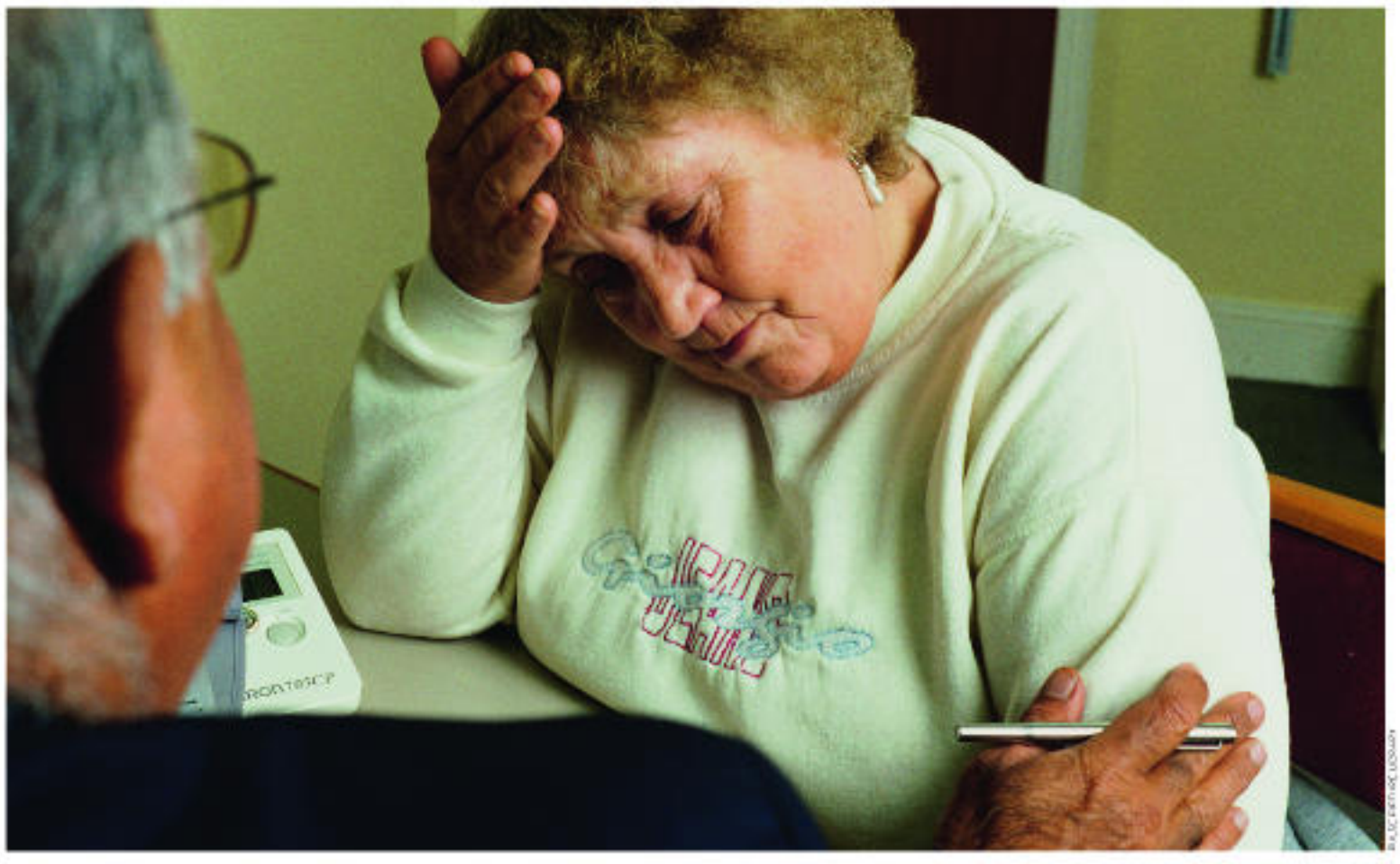
Resource of the week
Useful patient information from the Epilepsy Society for women with epilepsy

Professor Sube Banerjee, psychiatrist and professor of mental health and ageing, answers GP Dr Julian Spinks's questions on screening, diagnosis, antipsychotics and when to refer



KEY QUESTIONS

Dementia

1 Does having a parent with Alzheimer's disease increase the risk of developing it? If so, is there anything you would recommend to lower this risk?

Having a parent with Alzheimer's doesn't really increase risk. Over 99.5% of cases of dementia are of late onset and the genetic component is no more than a third – and that is in terms of complex susceptibility rather than simple heritability. Dementia is common and most families will have one or more elderly relatives affected. We do not yet understand the genetics of dementia in a way that is helpful to patients or families, so it is best not to worry about it. The exception is in patients whose parents developed dementia very early – in their 40s, for example. There are rare simply hereditable variants of dementia, so if you have any concern about this seek advice from specialist old-age psychiatric services and, if necessary, specialist regional genetic counselling services.

2 On initial presentation, what would be the key questions you'd ask a patient with memory problems, and how can this help with the diagnosis?

The key things to ask are:

- What are the main problems? Is the problem memory for recent events? Are there repetitive questioning or disorientation, or word-finding problems?
- Over what time have the problems developed? A rapid onset will alert you to the possibility of an acute physical reason for the memory problems – there may be delirium or a reversible physical cause. A long, slow decline would suggest dementia.

It is important to ask the patient themselves what they have noticed. But it is vital to spend five minutes talking to their spouse or a family member who is able to act as an informant, to get a collateral history – this may well be the most valuable evidence you obtain. Even in the early stages of dementia, patients may be unaware of the extent of their problems. So an informant history can make all the difference in getting a clear idea of what has been happening.

3 Is the Mini Mental State Examination (MMSE) still the best screening tool for patients in primary care suspected to have dementia, or are newer tests – such as Test Your Memory – better?

As a screening tool, the MMSE is not a very good test. The problem with the MMSE at an individual level is that you can score very highly and still have dementia, or score very low and not have dementia. But it is really no worse and no better than anything else available at the moment – including the Test Your Memory test – which is why population screening for dementia is not advocated.

The MMSE can be useful – you just need to be clear what you are using it for. GPs have to be alert to the symptoms of dementia and make sure that appropriate action, including referral for formal diagnosis, takes place if you are concerned that a patient might have dementia. The MMSE is best seen as a structured guide to clinical enquiry – a brief examination of cognition which covers some of the most important areas of cognitive function – rather than a screening or diagnostic tool.

You can download a factsheet on the MMSE from pulsetoday.co.uk/tools-and-resources.

4 I am aware that current guidance recommends referral of patients with suspected dementia to a memory clinic for diagnosis. But what examination and investigations are useful to carry out prior to referral?

Most memory services would like you to provide a brief description of the concerns you have and to have completed routine physical examination, to exclude delirium, and blood tests – for example FBC, U&E, LFT, TFT, B12 and folate – to identify possible treatable causes. The memory service can then make an accurate diagnosis,

communicate this to the patient and their family, and institute any treatment needed. Tell them what you know and what you want to know, and they should deliver.

5 A few years ago, the use of acetylcholinesterase inhibitors was restricted to a small subgroup of Alzheimer's patients – now they seem to be used more widely. What is the current thinking about these drugs?

It is now well established that cholinesterase inhibitors, as a class of drug, are of modest clinical benefit in some patients with dementia of all severities. These drugs make the most of depleted neurotransmitters and cause modest clinical improvement in cognition and activity limitation.

NICE had previously suggested that cholinesterase inhibitors should not be given to people with mild dementia because they were not cost-effective – even though they were clinically effective. This guidance was updated in 2011,[1] and NICE now recommends them for mild and moderate dementia. There is also accumulating evidence for their value in severe dementia.[2] And given that these drugs are all about to come off patent, the cost point is moot. Cholinesterase inhibitors are set to be part of the routine management for most people diagnosed with Alzheimer's disease and also those with mixed dementias. Given the seriousness of the condition, the lack of pharmacological alternatives and the benign side-effect profile of cholinesterase inhibitors, it is definitely worth at least trialling this medication in your patients with dementia.

6 How would you decide if a patient with dementia has sufficient capacity to write a will?

The key thing to remember here is that just because a patient has dementia, they do not necessarily lack the capacity to make a will. Early diagnosis can enable people with dementia to ensure they have a will, while they are still likely to have capacity. The assessment of capacity is specific to the task – a patient may have capacity to do one thing, but not another. It is important to get correct, clear instruction from the solicitor.

The main things to consider when assessing capacity to make a will are that the person making the will does not have a mental illness that influences him or her to make bequests (dispositions) in the will that he or she would not otherwise have included. The person making the will must also be capable of understanding:

- the nature and effect of making a will
- the extent of his or her estate
- the claims of those who might expect to benefit from the testator's will (both those being included in, and being excluded from, the will).

There is an excellent *BMJ* article on this which would be worth consulting if you are in this situation.[3]

7 What is mild cognitive impairment? Does it inevitably lead to full dementia?

Mild cognitive impairment is a label that is probably of most interest to specialists. It is essentially a confected term rather than a diagnosis, and indicates an increased risk of future dementia – but not one that is quantifiable – rather than a clinical state.

Mild cognitive impairment is defined by the individual having subjective memory impairment, but this is objectively small and there is no impact on functioning. Some patients with mild cognitive impairment will in fact have very early dementia and will go on to get the illness, but most will not. This conversion rate depends on the definition of mild cognitive impairment used and the population studied, and it varies from 10-70%.

It would be fantastic if we could identify patients who are going to get dementia before they are diagnosed clinically and prevent, delay or modify the disease process. But unfortunately this is not currently possible, so best management is to inform the patient of this uncertainty in a sensitive manner and to review them after a year or so to see if there has been resolution or progression of the cognitive impairment. This review will usually be a role for the memory service rather than primary care, but you may need to re-refer the patient.

8 How would you manage a patient where there is doubt about whether they have dementia, depression or a combination of both?

I would refer them to my local memory service or old-age psychiatric service. It can be really difficult to work out what is happening and whether the depression is a function of the cognitive impairment or vice versa. And antidepressants may not work as well in people with depression in dementia as they do in those with depression alone.[4] It is legitimate to ask for specialist help in these cases and for patients to expect to receive it.

If you do not make referrals of such cases because the local old-age psychiatric service or memory service is too busy, this should be a sign that more services should be commissioned to help you deal with the diagnosis of dementia and the management of complexity in dementia.

9 Aggressive behaviour can be distressing for families and create difficulties in residential settings. Now that it is considered bad practice for GPs to prescribe antipsychotics, what management strategy would you recommend for these patients?

This is a really challenging issue. Around 800,000 people in the UK have dementia and around 80% will exhibit non-cognitive symptoms and behaviour such as agitation, aggression, psychosis, wandering and sleep disturbance. These symptoms are sometimes referred to as the behavioural and psychological symptoms of dementia. For the patient, this may be a way of communicating distress. Underlying causes include psychotic experiences, discomfort or pain, basic needs not being met – for example being hungry, thirsty or left in wet clothing – or simply missing human contact. But for carers these behavioural and psychological symptoms may be a cause of distress and precipitate the transfer of the patient to institutional care.

It is estimated that up to a quarter of people with dementia in the UK are prescribed an antipsychotic in any year, of whom only 20% derive benefit – but there are 1,800 extra deaths per year directly due to the adverse effects of the medication. However, it can be critical to control behaviour and it would do more harm overall than good to ban the use of antipsychotics in dementia.[5]

In managing these patients we should first try to work out and treat the cause of the behaviour, and then try non-drug treatments including watchful waiting and carer support.

There is a really good guide on this published by the Alzheimer's Society, which you can download from pulsetoday.co.uk/tools-and-resources. It includes useful schema to help your decision making: antipsychotics can be used in emergency situations or if non-drug measures have failed.

Again, it is important to remember that you can seek help from specialist community old-age psychiatry services to generate a joint action plan.

PULSE Learning

1.5 CPD hours

Go online to complete this CPD module for a suggested 1.5 credits. This module will be available free to all members of Pulse Learning until 6 June 2012

▶ pulse-learning.co.uk

10 Recently, more patients with Parkinson's disease seem to be diagnosed with Lewy body dementia. What is the relationship between the two diseases? Do you have any tips for its management?

It is probably best to think of Lewy body dementia as an umbrella term for two related diagnoses – Parkinson's disease dementia and dementia with Lewy bodies.

The main difference between the two is that in Parkinson's disease dementia, the Parkinson's symptoms come first, and in dementia with Lewy bodies the dementia comes first. Over time, patients with both diagnoses will develop similar cognitive, physical, sleep and behavioural symptoms. The core symptom of both is a progressive dementia – deficits in attention and executive function are typical. Other common characteristics that indicate Lewy body dementia are: fluctuating cognition with variation in attention and alertness, recurrent complex visual hallucinations – which are often well formed and detailed – and features of Parkinsonism.

The differential diagnosis includes delirium and the effects of drugs.

In terms of management, it's important to be aware that up to 50% of people with Lewy body dementia may have severe sensitivity to antipsychotic medication, with a substantially increased mortality.

Professor Sube Banerjee is professor of mental health and ageing at the Institute of Psychiatry, King's College London, and an old age psychiatrist at South London and Maudsley NHS Foundation Trusts. He was the Department of Health for England's senior professional adviser on dementia

Dr Julian Spinks is a GP in Strood, Kent

References

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2 Howard R, Phillips P, Johnson T et al. Determining the minimum clinically important differences for outcomes in the DOMINO trial. *Int J Geriatr Psychiatry* 2011;26:812-7

3 Jacoby R and Steer P. How to assess capacity to make a will. *BMJ* 2007;335:155-7

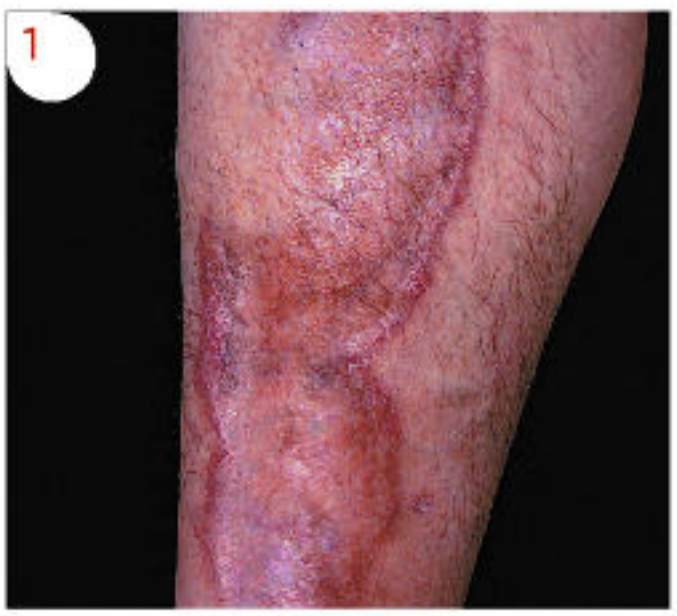
4 Banerjee S, Hellier J, Dewey M et al. Study of the use of anti-depressants for depression in dementia: the HTA-SADD Trial – a multicentre randomised double-blind, placebo-controlled trial of the clinical effectiveness of sertraline and mirtazapine. *Lancet* 2011;378:403-11

5 Banerjee S. Use of antipsychotics for people with dementia – time for action, 2009. London: DH. tinyurl.com/23mnyKO (accessed 8 May 2012)

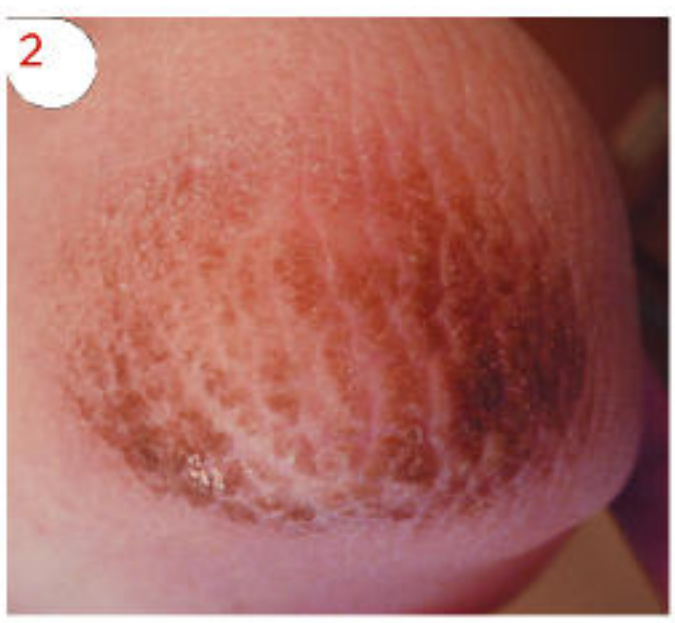
PICTURE QUIZ

Signs of internal disease

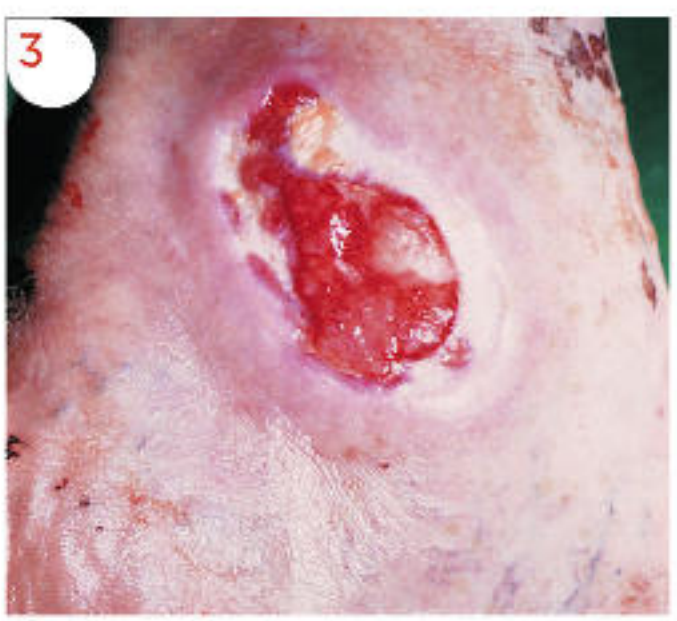
Can you identify the skin signs of internal disease in these five patients? Answers are at the bottom of the page



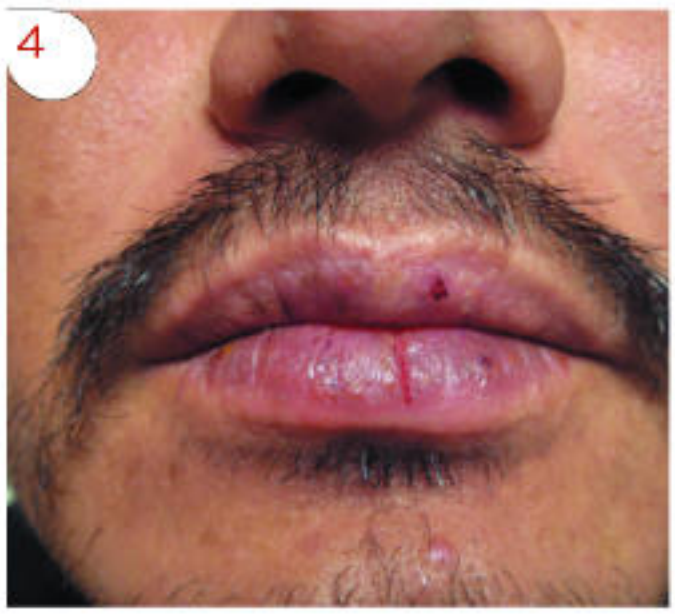
This 30-year-old man with diabetes had developed this extensive, brown, shiny lesion on his shin over the preceding six months or so. There was a similar, though smaller, patch on his other leg. Both lesions were painless.



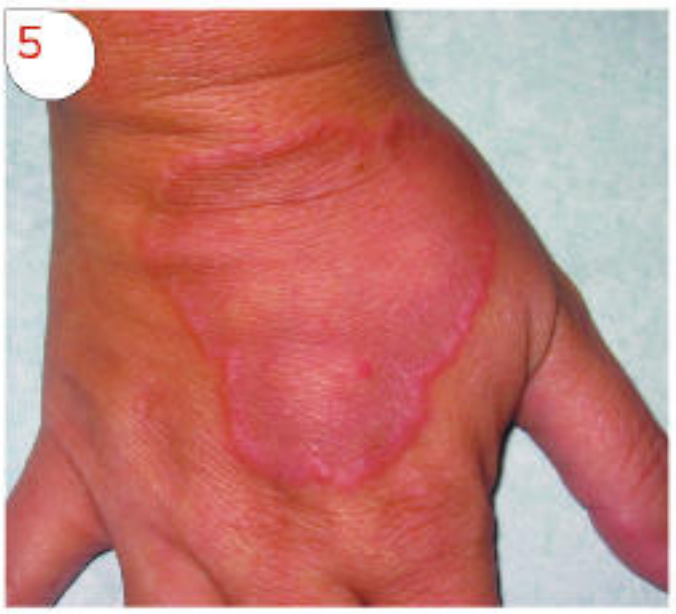
This woman was known to have a lymphoma and was very concerned when she developed these submammary patches – she feared it implied her malignancy had spread.



This lesion was becoming increasingly painful and was not responding to the usual leg ulcer management. The patient was a 65-year-old smoker with known peripheral vascular disease.



No amount of moisturiser would ease this man's cracked and sore lips. He was known to have coeliac disease, but he complied poorly with his gluten-free diet.



This lesion on the hand of a 55-year-old woman with diabetes was not responding to antifungals. It was not painful or itchy and had started as a collection of papules which subsequently coalesced.

ANSWERS

1 Necrobiosis lipoidica
Necrobiosis lipoidica is a granulomatous and necrobiotic disorder of collagen that affects the skin of the anterior pretibial surfaces. It is associated with diabetes. The disease results in a thinned and atrophic epidermis with yellowish, discoloured plaques and dilated underlying vessels. Although sometimes painful, often the patient's chief complaint is the unsightly appearance of the lesions. Necrobiosis lipoidica occurs in about 0.3% of patients with diabetes. It is three times more common in females than males. The average age of onset is 50 years, but it can occur at any age. Necrobiosis lipoidica can be difficult to treat – potent topical steroids under occlusion or intralesional steroids are often first-line treatment. Systemic steroids may be helpful, but are often difficult to use in elderly patients or those with diabetes.

2 Acanthosis nigricans
Acanthosis nigricans is a cutaneous manifestation of internal disease that occurs in two principle situations:
- classic – a benign variant associated with obesity and insulin resistance
- paraneoplastic – a malignant variant in association with cancer.

Classic acanthosis nigricans presents as hyperpigmented, slightly velvety, thickened skin on the nape of the neck, axillae, groin and other flexural surfaces. The malignant form of acanthosis nigricans is often more explosive and may involve the mucosal surfaces as well. To exclude malignant acanthosis nigricans, the first step is a careful history and age-appropriate cancer screening. Treatment of the skin lesions is generally not necessary and can be very difficult. Advise the patient on maintaining a healthy weight, exercise and routine blood glucose monitoring.

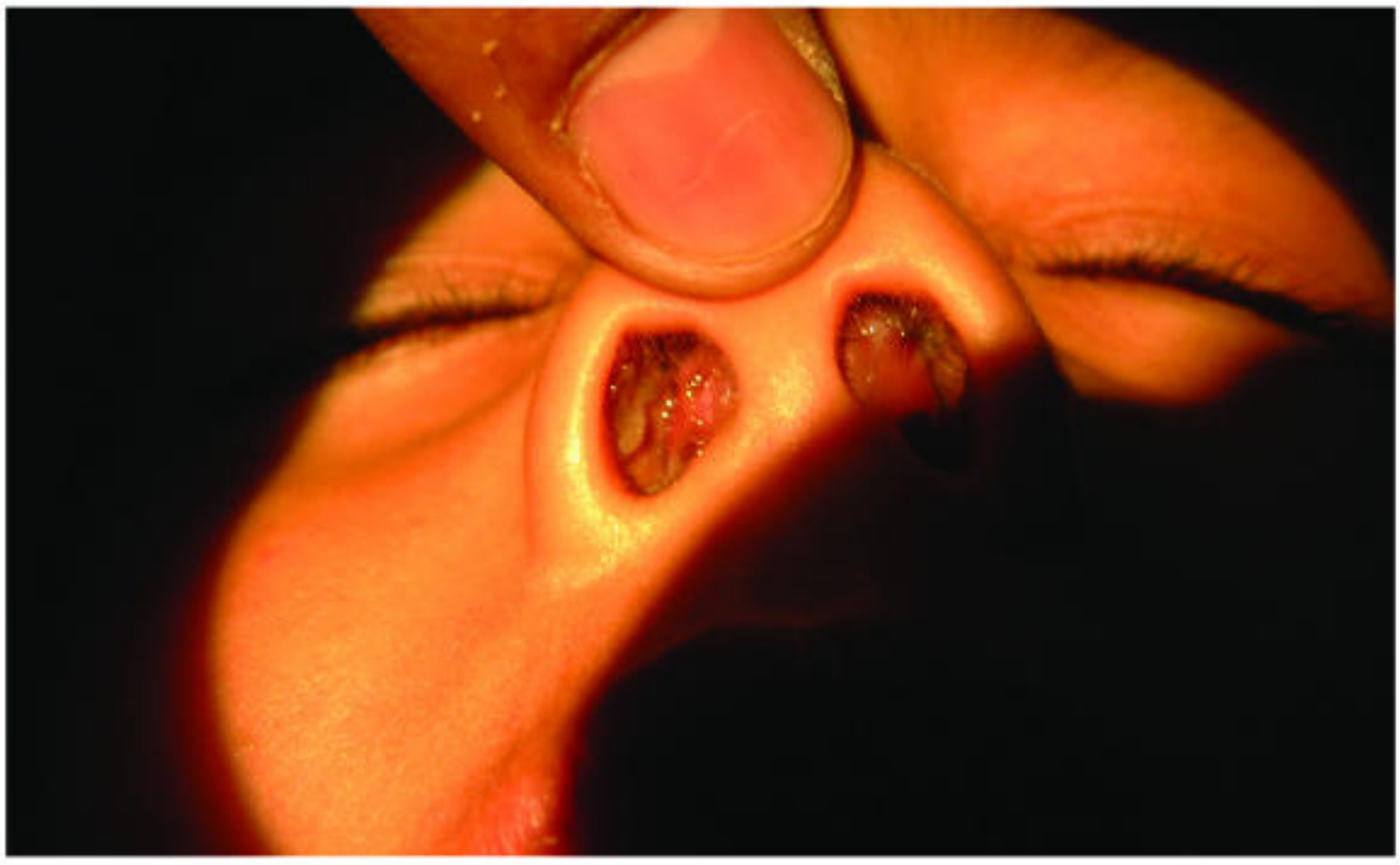
3 Arterial ulcer
A thorough examination and history are critical in elderly patients with leg ulcers, as there are many causes. In this case, the cause is vascular – ulceration from insufficient circulatory function is common in the elderly. Arterial ulcers tend to be on the dorsum of the foot or ankle and are usually quite painful. Venous ulcers are usually shallower and less painful than arterial ulcers. Wounds that do not heal despite treatment may need cultures to exclude primary or secondary infection, and biopsy to exclude skin cancers. Patients with arterial ulcers will require the management of the usual atherosclerosis risk factors – and may need referral to a vascular surgeon.

4 Cheilitis
Cheilitis is inflammation of the lip and has many potential causes. Clinically cheilitis is present when the common signs of inflammation are present on the lips and nearby skin – including erythema, pain or tenderness, and cracking or scaling. Potential causes include chronic sun exposure, candida overgrowth, and iron and vitamin B12 deficiency – as in this case. Patients with underlying medical problems such as swallowing difficulties, dental problems, neglect, dementia or alcoholism may not eat a varied diet and may become malnourished, with the resulting deficiencies leading to cheilitis. If you suspect this, blood testing of the relevant vitamin levels and supplementation should be undertaken. It is also important to treat the cause, when possible, to prevent recurrence. Emollient lip balm or a mild steroid ointment may be helpful.

5 Granuloma annulare
Granuloma annulare is an inflammatory disorder that typically presents as dermal papules and annular plaques. Most cases are idiopathic and limited, presenting usually on the distal extremities. The generalised form of granuloma annulare presents with papules measuring 2–5mm that range in colour from erythematous to flesh coloured. These lesions may coalesce into annular plaques of several centimetres' diameter. As it is a dermal process, there is no overlying scale or other epidermal changes. Generalised granuloma annulare comprises less than 10% of all cases of the disease. It occurs most often in patients aged 30 to 60 years of age. Localised cases are usually treated with topical or intralesional steroids. For more widespread cases, phototherapy is often helpful.

These cases are taken from *Skin diseases in the elderly – a colour handbook* by Colby Craig Evans and Whitney High. ISBN 9781840761542 (Manson Publishing); available from: mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95

ENT GPSI Dr Raj Singh describes a condition rare in adults but much more common in children after trauma to the nose



ENT CLINIC

Septal haematoma

THE CASE

A 10-year-old child presented with his mother as an emergency appointment with nasal and maxillary oedema and fever. Four days previously he had hit the kerb while riding his bike and fallen onto his face.

Although his nose had bled and was slightly swollen, the pain had subsided after a few hours and his mother was confident it wasn't broken.

On examination, the GP found oedema of both nasal fossae with the left nostril completely blocked, fluctuation and a grossly enlarged nasal septum with purulent discharge.

The child was sent immediately to A&E where he was admitted for emergency surgical drainage under general anaesthesia.

A vertical hemitransfixation incision was made and 2.5ml of purulent material drained. He was prescribed ceftriaxone for seven days.

There were no post-operative complications and two months after surgery the cosmetic and functional outcomes were good.

The problem

- A nasal septal haematoma is a collection of blood between the nasal septal cartilage and the overlying perichondrium and mucosa.
- The nose is the most frequently injured facial structure, and in around 1% of cases shearing forces pull the perichondrium from the cartilage - causing the submucosal blood vessels to tear and a haematoma to form.
- Bacterial infection may then develop within a few days of the trauma.[1]
- Although rare in adults, it is much more common in children and one study suggested as many as 15% of children who facture their nose will develop a septal haematoma.[1]
- Early diagnosis and treatment is important to prevent abscess formation, septal perforation, saddle-nose deformity and potentially permanent complications.[2]

Features

- Symptoms usually appear within the first 24 to 72 hours after trauma.
- Nasal septal haematoma in adults typically occurs with significant facial trauma and nasal fracture.
- In children, it can develop after relatively minor nasal trauma such as simple falls, collisions with stationary objects, or fights or rough play with other children. But keep aware of its potential as a sign of abuse.
- The most common symptoms in children are nasal obstruction (95%), pain (50%), rhinorrhoea (25%) and fever (25%).[2]

Diagnosis

- It is important to carefully examine anyone who sustains nasal trauma.
- The nasal septum is normally 2-4mm thick, but if the cartilage is fractured blood can diffuse through the fracture line and form bilateral haematomas - so both sides should be examined.
- Signs of external trauma - such as nasal deformity, epistaxis or significant pain - are associated with a septal haematoma, but it can present without any signs of external trauma.
- A septal haematoma can usually be diagnosed by inspecting the septum with a nasal speculum or an otoscope.
- Asymmetry of the septum with a bluish or reddish fluctuance can suggest a haematoma, but direct palpation may also be necessary because newly formed haematomas may not be the characteristic colour.
- Palpate by inserting a gloved small finger into the nose and palpate along the entire septum, feeling for swelling, fluctuance or widening of the septum.
- A suspected septal haematoma requires urgent referral to otolaryngology for drainage.

Management

- Early surgical drainage of the haematoma reduces the risk of cartilage necrosis and is always indicated.
- An incision is made at the lower border of the nasal septal cartilage (as the perichondrium is already separated from the cartilage) and blood and pus are aspirated.
- The nose is firmly packed on both sides to ensure adherence of the perichondrium to the cartilage.
- Antibiotics are usually given to prevent septal abscess.

Dr Raj Singh is an ENT GPSI in Manchester

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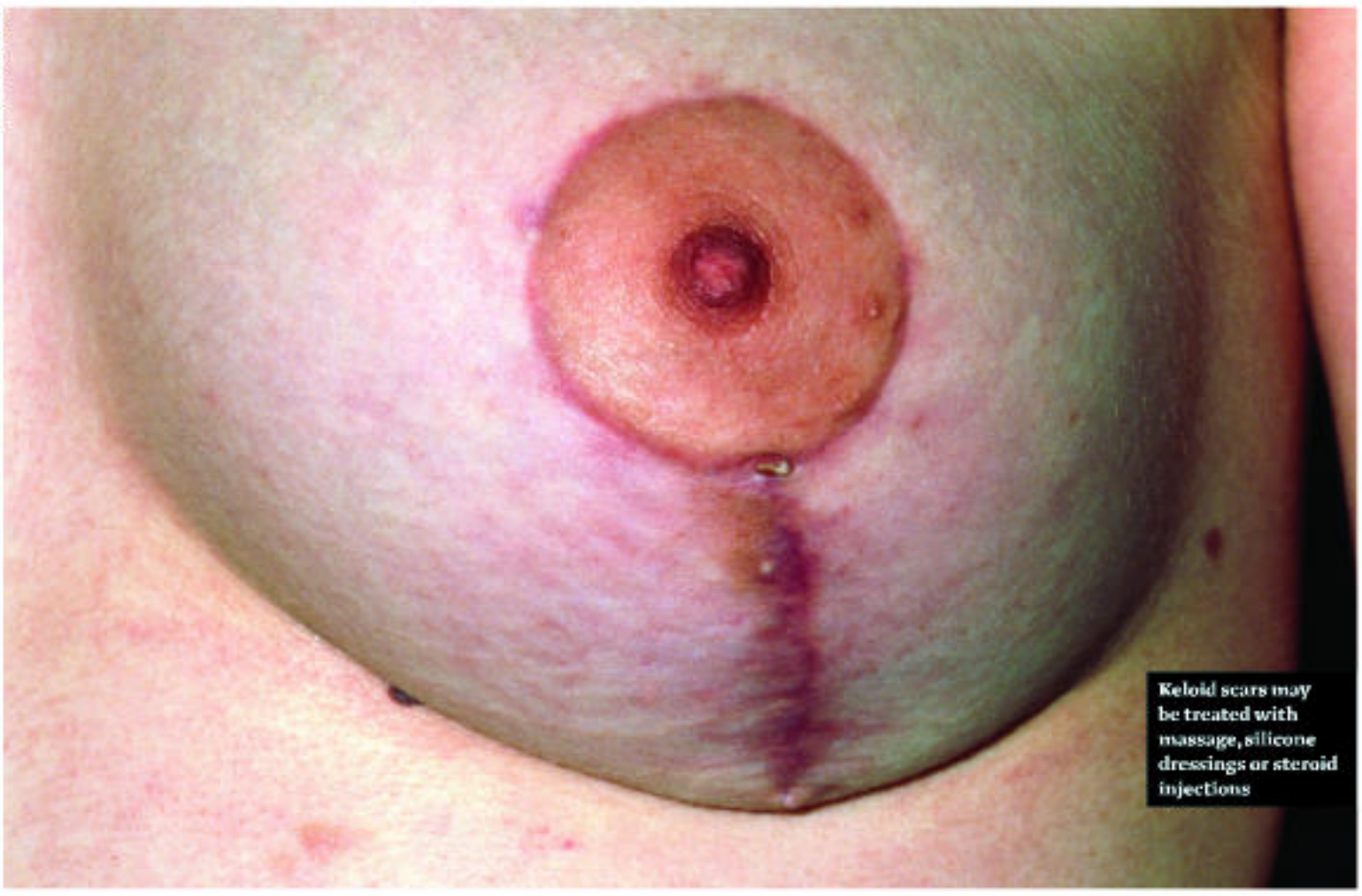

Keloid scars may be treated with massage, silicone dressings or steroid injections

NEW SERIES: POST-OP PROBLEMS

Breast surgery complications

Consultant breast surgeon Mr Dick Rainsbury and SpR in breast surgery Miss Sue Down kick off our new series on post-operative problems with a look at complications after breast surgery

Each year in the UK, around 50,000 women are diagnosed with breast cancer and most undergo tissue biopsy followed by definitive surgery. Many other surgical procedures are undertaken for benign breast conditions including duct surgery and symmetrisation operations. Each procedure carries a risk of complications, classified as immediate (within six hours of surgery), early (six to 72 hours after surgery) or late (after 72 hours post surgery).

An increasing number of breast operations are performed as day cases, facilitating early discharge – including patients who have drains in situ, as these can be managed in the community by a district nurse. So early post-operative complications are often seen in primary care. If complications are undiagnosed or untreated, there can be a delay in adjuvant treatments such as radiotherapy or chemotherapy, which may affect the patient's prognosis.

When a patient presents after breast surgery, it is important to ascertain exactly what procedure she has undergone. For example, there is a wide range of oncoplastic surgical procedures and, in particular, the presence of prosthetic material such as breast implants or acellular dermal matrices will influence the treatment of complications.

The majority of patients have a good understanding of their operation, as it will have been discussed with them in some detail. Patients should have a named breast care specialist nurse, who is the first point of contact in case of any complications.

The specialist nurse will have access to urgent clinic appointments and can liaise directly with the appropriate clinicians. Other patients should be discussed with the breast surgery team. Out-of-hours referrals should be made to the general surgical registrar on call for urgent assessments.

General complications

Some complications are common to all types of breast surgery:

Immediate and early

- *Haemorrhage or haematoma* are apparent as swelling deep in the wound, often with overlying bruising of the skin, which may track extensively. If minor, it can be managed conservatively with a supportive non-wired bra worn continuously for several days. If severe, there will be obvious deformity of the breast or axilla with possible systemic symptoms such as pallor or dizziness – this requires readmission and drainage under general anaesthetic with possible blood transfusion.
- *Seroma* is extremely common following breast or axillary surgery. This is apparent as swelling without overlying skin discolouration. In severe cases, the volume of seroma following mastectomy may create a pseudo breast mound. You can advise patients to limit arm abduction to 90 degrees to reduce seroma formation. Compression dressings are not effective. Refer to the breast outpatient clinic for sterile aspiration if it is uncomfortable – but beware of the risk of introducing infection, which will delay recovery. Rarely, there will be the need for formal excision of the seroma cavity.
- *Wound infection* occurs in 5-10% of patients following breast surgery. It presents as a tender, erythematous wound which may have a purulent discharge. The patient is at increased risk if she is immunocompromised, obese, diabetic or a smoker. Ideally, you should obtain wound cultures before starting a broad-spectrum antibiotic – usually co-amoxiclav 625mg tds. Refer all patients to the breast outpatient clinic for wound and antibiotic review. Wound infection may progress to abscess formation if it is untreated, and may delay adjuvant treatment following surgery.
- *A detached drain* is not an emergency. You should cover the entry site with a pressure dressing and inform the breast outpatient clinic. But be aware that the patient is at increased risk of seroma formation.

Late

- *Paraesthesia* is common following breast operations and usually improves slowly over time. Patients undergoing peri-areolar incisions are counselled pre-operatively about the risk of altered nipple sensation.
- *Fat necrosis* may present as a hard irregular mass, mimicking breast cancer. You should refer for imaging and biopsy.
- *Chronic pain* may be neuropathic. If pain is persistent despite simple analgesia, try serotonin norepinephrine reuptake inhibitors such as venlafaxine or tricyclics such as amitriptyline.
- *Thrombosis* is a risk. Most patients do not receive thromboprophylaxis following discharge, since breast operations are usually of short duration with early mobilisation. But malignancy causes a hypercoagulable state and there is a small risk (0.16%) of thrombosis post-operatively.
- *Hypertrophic or keloid scarring* is usually most marked near the midline and in patients of Afro-Caribbean descent. Hypertrophic scars settle spontaneously within 12 to 24 months, and keloid scar formation may be treated by massage, silicone dressings or steroid injection.

Procedure-specific complications

In addition to general complications, certain breast procedures carry specific risks. Flap-based breast reconstructions are not included here as these are not usually performed as day-case procedures.

Core biopsy

Early

- *Pneumothorax* is a breach of pleura, especially with freehand core biopsies. If the patient is symptomatic, refer to A&E for a chest X-ray. The patient will need insertion of a chest drain if there is a significant-volume pneumothorax.

Late

- *Implant rupture* is most common with freehand core biopsies performed without image guidance. Patients may present with breast pain, altered breast contour or a palpable lump (siliconoma or reactive lymph node). Refer patients to the breast clinic for an MRI to confirm diagnosis. The patient will need implant replacement.

Wide local excision

Early

- *Nipple ischaemia* is an issue, especially if the patient has had peri-areolar incision. Part or whole of the nipple feels cool and may be discoloured. Refer for urgent, same-day assessment. The condition may respond to topical glyceryl trinitrate ointment.

Late

- *Fibrosis* may occur following radiotherapy and can cause contour defects requiring revisional surgery.
- *Tumour recurrence* may be mistaken for

scar tissue. The peak incidence is in the first two years following surgery, but it can present many years later, especially in cases of lobular breast cancer. Refer for imaging and biopsy.

- *Late infection* can follow radiotherapy or chemotherapy. The patient will need imaging, biopsy and possible admission for a course of intravenous antibiotics or drainage.
- *Angiosarcoma* usually occurs four to 10 years after the operation, in the radiotherapy field. It may present as hard, red skin nodules or a non-blanching rash. Refer urgently for imaging and biopsy. Angiosarcoma will be treated by wide excision, sometimes requiring tissue coverage. It has a poor prognosis.

Mastectomy

Early

- *Flap necrosis* results in skin flaps that are discoloured and cool with no blanching on pressure. Check that the patient is not hypotensive and cover the wound with a warm compress. The patient needs urgent surgical assessment.

Late

- *Lumpy scars or 'dog-ears'* may need formal surgical revision.
- *Tumour recurrence* often presents as hard, red skin nodules, new lumps or a localised often marginated patch of erythema. Refer for urgent clinical assessment.

Sentinel lymph-node biopsy

Immediate

- *Blue dye allergy (2%) or urticaria* usually present at the time of surgery. Minor urticarial reaction requires an antihistamine. Major anaphylactic reaction requires anaesthetic supportive care. All patients should be made aware that their urine and faeces may be discoloured for several days.

Late

- *Cording* or *axillary web syndrome* presents as self-limiting fibrosis of lymphovascular channels in axilla or inner arm. This may benefit from physiotherapy and massage.
- *Lymphoedema* has a low incidence (7%) following uncomplicated sentinel lymph-node biopsy. It is managed in specialised lymphoedema clinics with compression bandaging and deep lymphatic massage.

Axillary lymph-node clearance

Early

- *Winged scapula* is caused by damage to the long thoracic nerve which innervates the serratus anterior. Patients may recover function if the nerve has not been transected.
- *Paraesthesia of the inner arm* occurs when intercostobrachial nerves are divided to gain access to axillary contents. It will reduce over time to leave a small residual area.

Late

- *Lymphoedema* occurs in 13-27% of level-three clearances. The incidence increases with obesity and axillary radiotherapy. Advise patients to avoid infection or trauma to the arm. Refer to a lymphoedema specialist.
- *Shoulder stiffness* or *weakness* may be due to damage to the thoracodorsal bundle which innervates the latissimus dorsi muscle, or to brachial neuropathy from intra-operative arm positioning. Refer the patient for physiotherapy.
- *Axillary web* occurs in fewer than 10% of patients. It is self-limiting with physiotherapy and massage.

Implant-based breast reconstruction

Early

- *Infection* may be catastrophic if not recognised and treated promptly – look for the same signs as for wound infection. Patients should be referred for urgent review in the breast clinic. If the implant is covered by a flap of tissue or acellular dermal matrix, infection may respond to oral antibiotics. But there is a low threshold for removing implants in the presence of infection.

Late

- *Capsule formation* can cause pain or obvious deformity, and may require capsulectomy (removal) or capsulotomy (scoring to increase pocket size).
- *Implant failure* presents as a change of breast contour, new pain or new lumps due to silicone reaction – which may suggest implant rupture. Refer for an MRI scan and consideration of implant replacement.

Mr Dick Rainsbury is a consultant oncoplastic breast surgeon at Royal Hampshire County Hospital, Winchester
Miss Sue Down is an SpR in breast surgery at Addenbrooke's Hospital, Cambridge

Further reading

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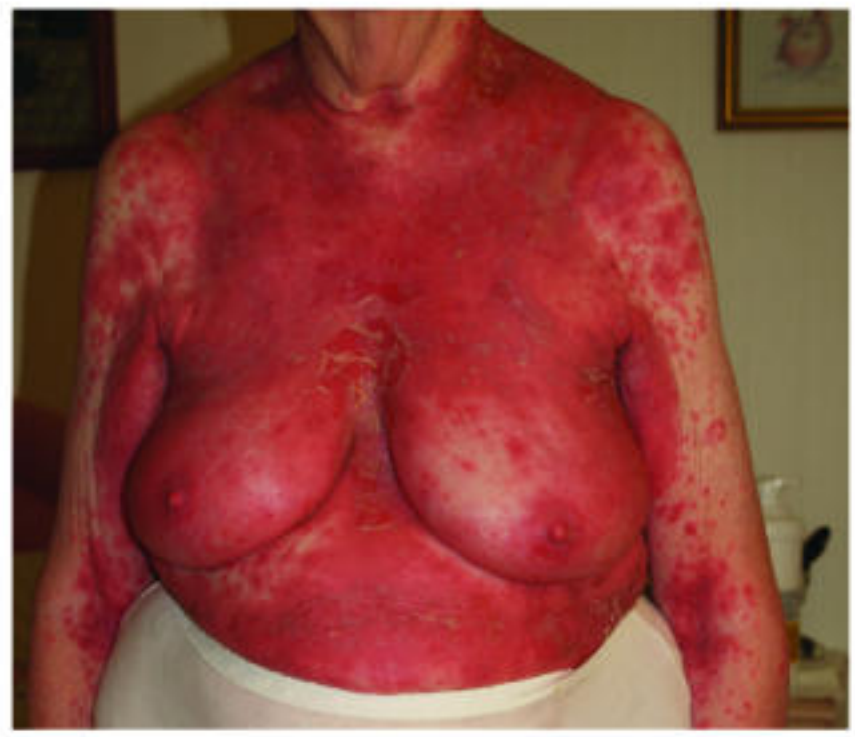
Coming up in this series

Surgical complications in ENT, gastroenterology, urology, cardiology, orthopaedics, gynaecology and ophthalmology

SNAPSHOT DIAGNOSIS

Peeling red skin



Dr Oliver Starr explains how he worked out what was causing the shocking red rash in this elderly woman

THE PATIENT

This 82-year-old woman was in reasonable health.

She had hypertension and was taking amlodipine. But her blood pressure was still a little high and we had added indapamide about five weeks earlier – an ACE inhibitor or ARB was avoided because these drugs had caused her intolerable giddiness in the past.

A few days before presentation, tiny spots had developed on her chest and spread rapidly – she had thought that it was measles. But before she knew it, the skin on her chest had turned red, was peeling and felt warm.

Thankfully she felt fairly well. Her temperature was 36.8°C and her heart rate was normal.

First instinct

Whatever this was, it was a severe systemic reaction to something, and my first thought was to stop her indapamide.

Though not a typical drug rash, the timing made a reaction to the treatment very likely. Besides, the diuretic might make any potential electrolyte disturbance worse.

Differential diagnoses

- Erythrodermic psoriasis
- Stevens-Johnson syndrome
- Exfoliative dermatitis.

Erythrodermic psoriasis is a complication of existing psoriasis, often caused by a withdrawal of topical or oral steroids. But the lack of a history of psoriasis made this unlikely, and it is accompanied by systemic malaise – which was not present here.

Stevens-Johnson syndrome is a life-threatening mucocutaneous condition with de-epithelialisation and blisters. It is a response to drugs – typically NSAIDs, penicillins and tetracyclines – or infections such as mycoplasma. Fortunately, this patient had no mucous membrane involvement and seemed too well to be suffering this syndrome.

Exfoliative dermatitis is really a descriptive term rather than a diagnosis – in keeping with peeling skin in the absence of systemic upset. This was my main differential as she was so well, and the most likely culprit was a drug. Treatment involves identifying and stopping any underlying cause, emollients and managing any superadded infection.

I did question her about whether she was using any new over-the-counter products, as patients don't always volunteer this in the history, but she denied this.

Getting on the right track

The look of her skin was so shocking that ;I arranged an urgent dermatology appointment for her. In the meantime, I just prescribed her some Dermol cream for its moisturising and anti-staphylococcus properties, and stopped the indapamide.

By the time she was seen by a dermatologist things were already improving, and within two weeks she was entirely well. The exfoliative dermatitis had healed by itself. The culprit was almost certainly the new drug, indapamide, although we could never prove it. This case just shows how our stringent blood pressure targets and the resulting polypharmacy can sometimes have serious consequences.

Dr Oliver Starr is a GP in Stevenage

Pulse Business & Commissioning

Practice Business In this issue

Mitigating practice risks How to meet CQC standards in the five top risk areas for GPs ▶ page 27

Practice dilemma What should you do if two employees start a relationship at work? ▶ page 30

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Managing social media
A guide to protecting your practice from confidentiality and communication issues online
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How we reduced prescribing errors by 42% Dr Tony Avery describes how his pharmacy intervention could be used by CCGs ▶ page 31

More online

Tips for avoiding script mistakes
Dr Avery and his team advise on quick wins to minimise slip-ups
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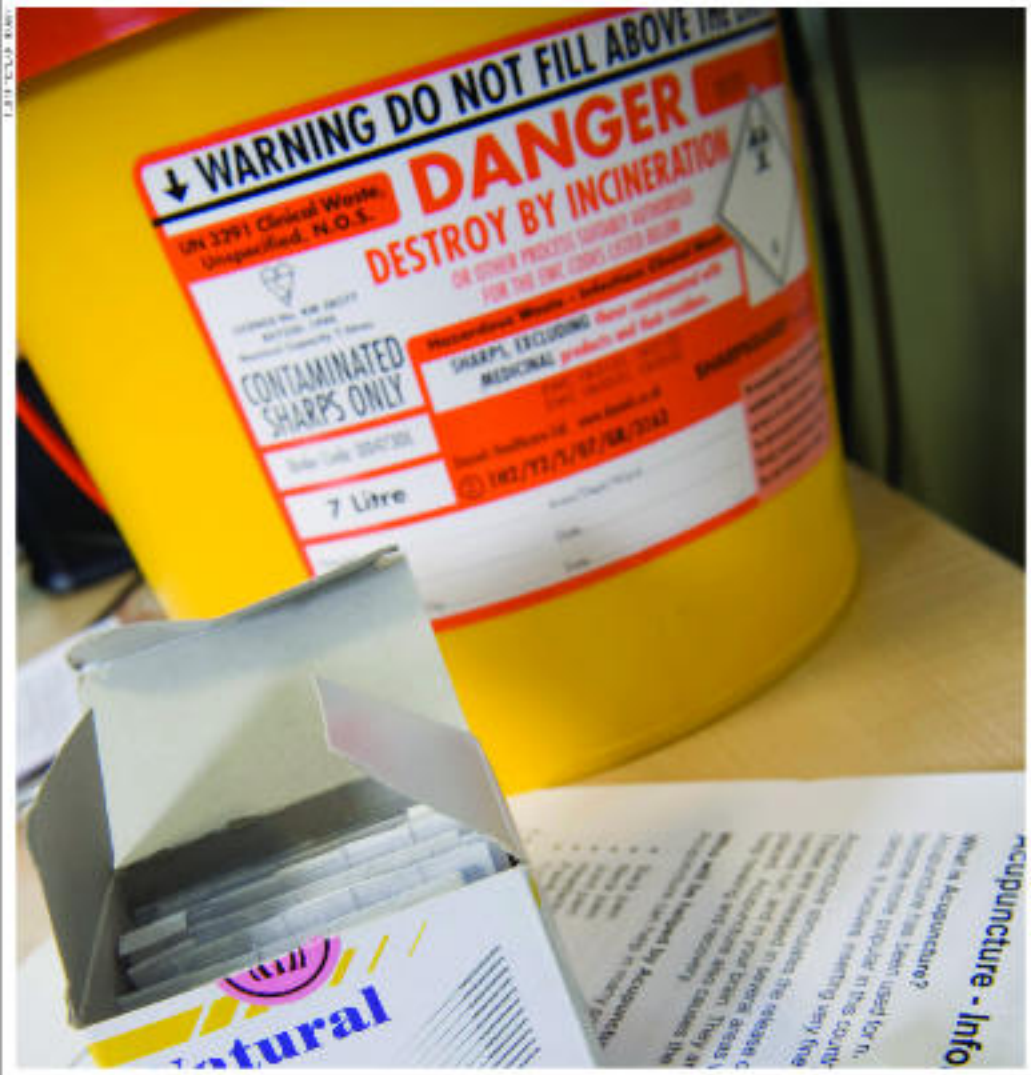

Tackling the five top practice risks

Dr Zaid Al-Najjar and **Julie Wilson** pinpoint the areas where practices are at greatest risk – and advise on becoming CQC compliant

There are many hurdles for general practices in 2012 – advances in technology, more competition within general practice, and the transition from PCTs to CCGs – but this year is also about getting your practice ready for Care Quality Commission registration by April 2013.

The Medical Protection Society conducts clinical risk self-assessments to identify and address potential risks in practices that may have an impact on patient and staff safety. This article will focus on the top five risks that were identified in assessments across more than 150 practices in 2011, and will demonstrate how to address each risk area and how to meet the relevant CQC standard.

1 Poor communication

Fundamental to patient care is communication – between all members of the practice team, the healthcare team and the patient. Better communication between staff and patients is a priority for improving patient safety. The risks identified during clinical risk self-assessments relating to communication are split into two categories, both of which correspond to regulations laid out by the CQC: internal communication (outcome 6, regulation 24) and communication with patients (outcome 1, regulation 17).[1]

Internal communication

- Ensure that the minutes of key practice meetings are kept, signed by the chair, dated and reviewed for both accuracy and 'matters arising' at the next meeting.
- Use an internal messaging protocol such as an electronic message system.
- Discourage the use of Post-It® notes and pieces of paper, which can easily get lost.
- Ensure there are effective systems in place for communicating with district nurses, health visitors and other members of the multidisciplinary clinical team.
- Ensure that all contacts from the out-of-hours service are reviewed by a clinical staff member and action taken as applicable.

Communication with patients

- Ensure information included in leaflets and websites is up to date – for example, the details of the practice services, opening times and so on.
- Consider whether there is a need to publish practice leaflets in other languages.
- Ensure the needs of visually and hearing-impaired patients are being adequately met – for example, with audio loops.
- Only send text messages to those patients where consent has been recorded for you to undertake this form of communication.
- Texts can also form part of the medical records and should be treated as such. Ensure a record of any text message is made in the patient's record.
- Consider how to encourage patients to be involved in how services are run, such as through a patient participation group.[2] The GPC flagged up this month that practices must set up patient participation groups in order to comply with registration.

2 Confidentiality breaches

Ensuring that a service user's privacy and dignity are upheld are important elements of CQC outcome 1, regulation 17 (respecting and involving people who use the services).[1]

The GMC states in its *Confidentiality guidance*, paragraph 13: 'You should not share identifiable information about patients where you can be overheard – for example, in a public place or an internet chat forum. You should not share passwords or leave patients' records, either on paper or screen, unattended or where they can be seen by other patients.

29

NEW

Trajenta®

(linagliptin) 5mg film-coated tablets

ONE DOSE ONCE DAILY 5mg

Control and care matter

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

Efficacy

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

Generally well tolerated

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

Different

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

Prescribing Information (UK) ▼ **TRAJENTA® 5 mg film-coated tablets**

Film-coated tablets containing 5 mg linagliptin. **Indication:** 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 analysis of placebo-controlled studies). The adverse reactions are listed by absolute frequency. Frequencies are defined as very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), or very rare (<1/10,000), not known (cannot be estimated from the available data).

Very common: hypoglycaemia (combination with/add on to metformin and sulphonylurea); Uncommon: nasopharyngitis (monotherapy; combination with/add on to metformin); hypersensitivity (combination with/add on to metformin; cough (monotherapy; combination with/ add on to metformin). Not known: nasopharyngitis (combination with/add on to metformin and sulphonylurea); hypersensitivity (monotherapy; combination with/add on to metformin and sulphonylurea); cough (combination with/add on to metformin and sulphonylurea); pancreatitis (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylurea). Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** 28 tablets £33.26. **Legal category:** POM. **MA number:** EU/1/11/707/003. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared in** September 2011.

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

References: 1. Trajenta® Summary of Product Characteristics, August 2011. **2.** Barnett AH *et al.* Poster No. 1021-P. The European Association for the Study of Diabetes 46th Annual Meeting, 20–24 September 2010, Stockholm, Sweden. **3.** Taskinen M-R *et al. Diabetes Obes Metab* 2011; 13:65–74. **4.** Owens DR *et al. Diabet Med* 2011;28:1352–61. **5.** Boehringer Ingelheim, data on file LIN1-06a. **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/23734/SPC/Galvus+50+mg+Tablets/ (accessed May 2012). **9.** Onglyza (saxagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22315/SPC/Onglyza+2.5mg+%26+5mg+film-coated+tablets/ (accessed May 2012). **10.** Deacon CF. *Diabetes Obes Metab* 2011;13:7–18. **11.** Bloch S *et al. Drug Metab Dispos* 2010;38:667–678.

UK/TRJ/0003a Date of preparation: May 2012

Boehringer Ingelheim

Lilly

unauthorised healthcare staff or the public.[3]

- In 77% of practices we surveyed, there was a possibility that patients may be able to overhear conversations at the reception desk. Consider reviewing the layout of the reception, reposition the computer screen or move the telephones away from the front desk to help to reduce the risk of breaching confidentiality. Perhaps have a queuing system, as in a bank, or confidential electronic booking-in systems.
- In the consulting rooms, patient-identifiable information is sometimes left on the consulting room desks (53% of practices) – easily read if a patient is left alone in the consulting room. It is good for a patient to see the computer screen when it is a matter concerning them, but be careful when a patient comes in with a relative; the patient may not wish them to see other medical history detailed on the screen.
- In the majority of practices visited, staff had signed a confidentiality statement – but these statements did not always contain a clause relating to after employment. It is also not appropriate for staff to discuss the practice or staff members on social networking sites such as Facebook. A clause could be included in an employee's contract to reflect these expectations.
- Many staff live in the area where they work, so it is very important to reinforce the need to keep this information confidential. Information about patients that is learned during the course of professional duties should be treated as confidential. The GMC is clear in its *Confidentiality guidance* that 'information must not be given to others unless the patient consents or you can justify the disclosure'.
- It is important that all members of staff are trained in confidentiality issues, and that the message to respect and maintain patient confidentiality is regularly repeated.

TOP FIVE RISKS IDENTIFIED IN GENERAL PRACTICE DURING 2011

	Percentage of practices with risks	%
1	Communication	99
2	Confidentiality	99
3	Health and safety	97
4	Prescribing	88
5	Record keeping	87

Source: MPS survey of 150 practices, 2011

3 Health and safety problems

All practices must ensure that they provide a safe environment for both patients and staff in order to comply with the Health and Safety at Work Act 1974.[4]

The CQC will be looking to see whether the provider has suitable arrangements in place to ensure that people receive care and work in, or visit, safe surroundings that promote their wellbeing (outcome 10, regulation 15).[1]

- Practices need to nominate a designated, trained health and safety lead for the practice and have a documented health and safety risk assessment.
- Ensure safe keeping and disposal of sharps and waste.
- Ensure security of all staff through the use of things like panic alarms, and by arranging training in dealing with violence and aggression.

4 Prescribing errors

Medication errors contribute to about 20% of all errors occurring in general practice, and many of these are preventable. Common examples include wrong dose, inappropriate medication and failure to monitor for toxicity and side-effects. The CQC will be looking to see whether a practice has suitable arrangements to ensure that patients have their medicines when they need them and in a safe way (outcome 9, regulation 13).[1]

- Discuss and draw up a comprehensive repeat-prescribing protocol that formalises prescribing systems.
- Ensure staff are trained in procedures and have access to the protocol, which should be dated and regularly reviewed.
- Best practice indicates that medication added to the prescription list should be done by the GP. If medication is added to the computer or changed by administration staff, it must be closely checked by the doctor afterwards.
- Considerable care needs to be taken to ensure that all the details are correct and have been added to the correct patient record. The GMC states in paragraph 31 of *Good practice in prescribing medicines – guidance for doctors*: 'It is important that any system for issuing repeat prescriptions takes full account of the obligations to prescribe responsibly and safely and that the doctor who signs the prescription takes responsibility for it.'[5]
- If generating a prescription for new patients, ensure the patient sees the doctor for a review of their medication.

For more information on safe prescribing, go to pulsetoday.co.uk/prescribing to download a free guide from the GMC.

5 Incomplete or inaccurate records

In outcome 21, regulation 20, the CQC will be looking to see that service users are protected against the risks of unsafe and inappropriate care, and treatment arising from a lack of relevant information.[1]

Complete and contemporaneous records are essential for good-quality patient care and are needed if a complaint or claim is made. In the case of a claim, some courts take the quality of the record as an example of the care provided to the patient.

- Ensure letters scanned onto a computer are saved in the correct record.
- Always make a record of telephone advice and home visits.
- Ensure both clinicians and summarisers are adding allergies in the correct way to the medical record.
- Ensure summarising is done by someone with a clinical background and who is suitably trained.
- Draw up a protocol for summarising.

Dr Zaid Al-Najjar is a GP in west London and medicolegal adviser at the MPS
Julie Wilson is clinical risk programme manager at the MPS

The Society has published *Signposting the CQC: understanding your new registration*, which is now available from tinyurl.com/dj3d8ag and will soon be launched as an app.

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PRACTICE DILEMMA

Romantic relationships between employees

How should you react when practice employees start a relationship? Solicitor **Matthew Smith** offers some advice

It has been brought to your attention that two staff members at your practice are involved in a romantic relationship outside work. What should you do? Should you have a practice policy that includes this scenario?

Some 25% of long-term relationships start at work, according to the Trades Union Congress, and relationships between colleagues may have a beneficial effect on the workplace.

The employees in question may be more motivated and there could be long-term benefits such as opening up lines of communication in the workplace.

However, there are many potential pitfalls. Problems with workplace relationships might include inappropriate behaviour in front of patients, conflicts of interest – for example, if a manager were to have a relationship with a subordinate – improper e-mail use, time wasting or the fall-out from a relationship breakdown.

Trying to stop the relationship straight away can be counterproductive. The employees will be demotivated and may even decide to leave.

In some circumstances, particularly where there is no immediate detriment to the employer, the employee may also have grounds to bring a claim for constructive dismissal. For public-sector employers, such an intervention would also arguably amount to breach of the right to respect for their private life under Article 8 of the *European Convention on Human Rights*.

Where the employees do not work directly together and are continuing to act professionally, then for the time being there is likely to be little that you can do. Where there appears to be a conflict of interest or the relationship is having an impact on work performance, then you would be justified in raising the issue with the employees informally to determine whether there is a problem.

Practice policy

A light touch will help foster an environment where employees are open about their workplace relationships rather than keeping them a secret for fear of disciplinary action.

If you decide to implement a practice policy, it therefore needs to be carefully worded with the aim of encouraging people to report relationships. Anything else is likely to be perceived as heavy handed, particularly in a small workplace.

Further, a strict policy which focuses on punishing employees who have relationships at work or who do not report them is likely to be unenforceable.

Most GPs would not want to put an end to a relationship before it begins, and it is only when there is a problem that they will want to do something.

In most cases, well-drafted disciplinary and performance-management policies, perhaps supplemented by a short policy on the reporting of relationships and what problems can arise if they are not reported, should allow you take appropriate action.

Matthew Smith is a solicitor in the employment team at national law firm Weightmans LLP

How we reduced prescribing errors by 42% with pharmacists' support

Professor Tony Avery and **Dr Sarah Rodgers** report on their trial into pharmacist interventions in GP prescribing

Dr Tony Avery: found GPs made fewer errors when they had support from pharmacy colleagues

The problem

Medication errors, particularly those relating to prescribing or insufficient medication monitoring, are often associated with considerable risk of patient harm, including hospital admissions.[1]

The highest rates tend to be found in patients taking multiple medications and also in relation to certain drugs that are frequently associated with preventable morbidity – such as anticoagulants, NSAIDs and diuretics.

Pharmacists working in general practices are well placed to identify and address these types of medication errors – however, few studies have identified effective pharmacist-led interventions to improve patient safety,[2] and some have shown no overall benefit.[3,4]

The PINCER trial was developed as a robust cluster randomised controlled trial to test whether a large, complex pharmacist-led, IT-based intervention – compared with simple feedback – could reduce medication error rates within a primary care setting. The results showed that the PINCER intervention is an effective method for reducing a range of medication errors in primary care.[5]

This article highlights the lessons learned and implications for the rollout of pharmacy support across UK practices.

What we did

The study involved at-risk patients in 72 practices who were being prescribed drugs commonly and consistently associated with medication errors, including NSAIDs and ß-blockers, and the monitoring of ACE inhibitors or loop diuretics, methotrexate, lithium, warfarin and amiodarone. These outcomes were chosen on the basis of medicines management difficulties that are important in the overall burden and severity of iatrogenic harm in primary care.[1,6]

Patients at risk from medication errors were identified by running searches for each of the 10 outcomes on the GP clinical system. Those allocated to receive simple information were provided with computerised feedback on patients identified to be at risk, along with information on the importance of each type of error. Practices were asked to institute changes they considered necessary within 12 weeks.

Practices allocated to the PINCER intervention were provided with computerised feedback on patients at risk from medication errors, and met with a pharmacist to agree on an action plan. All GPs were encouraged to attend this meeting with at least one member of the nursing staff, the practice manager and at least one member of the reception staff.

The pharmacist then spent up to three days per week for the next 12 weeks working in the practice to resolve any problems identified and improve medicine management systems to avoid future errors.

Pharmacists used the principles of educational outreach and root-cause analysis to help bring about change.

The types of activities undertaken by the pharmacists included reviewing patient records, discussions with GPs, inviting patients into the surgery for a prescription review or blood test to correct errors, and working with members of the practice team to improve local safety systems.

Lessons learned

Key findings included the perceived importance of focusing on prescribing errors, and the credibility and appropriateness of the pharmacist-led intervention – thought to be down to face-to-face contact and relationship building between pharmacists and practice staff.

However, concerns were raised about the need to make this new model of delivering care sustainable by ensuring appropriate support for pharmacists, and career development pathways.

Outcomes

At six months' follow-up, we found that the practices receiving computerised feedback and pharmacist support had significantly fewer prescribing errors than the practices that received computerised feedback alone.

Patients in the PINCER group were 42% less likely to have been prescribed a non-selective NSAID without gastroprotection if they had a history of peptic ulcer, 27% less likely to be given a ß-blocker if they had asthma, and almost 50% less likely to be prescribed an ACE inhibitor or loop diuretic without appropriate monitoring.

Participants were also significantly less likely to have been prescribed warfarin without monitoring in the previous three months or prescribed amiodarone without a TFT in the previous six months.

At 12-months' follow-up, participants in the PINCER group were still significantly less likely to have been prescribed a ß-blocker if they had a history of asthma, or prescribed an ACE inhibitor or diuretic without assessment of urea and electrolytes in the past 15 months.

The future

During the trial we used 10 prescribing safety indicators, but we have now developed additional indicators such as giving aspirin to children under 17 and warfarin with an oral NSAID.[7]

These may also reduce the costs associated with dealing with prescribing errors, which sometimes require hospital admission.

Although some practices already have in-house pharmacists, much of their time is spent on controlling prescribing costs. But with the transition of primary care pharmacists from PCTs to CCGs, there might be time to re-evaluate the role of the primary care pharmacist and increase their focus on quality and safety.

If the scheme gets rolled out then the design of the computer queries will be done centrally, and practices will be able to run the searches without charge.

If the intervention is not rolled out nationally then there may be some costs to commissioners, in terms of collating the data arising from computer searches and comparing practices, but I don't think these costs would be excessive.

If the intervention were not to be rolled out centrally then CCGs would need to take the following five steps, which I suspect would take six months:

1 Access the computer searches needed for running the prescribing safety indicators that we used in the PINCER trial. We are hoping to update these so they are freely available, but if CCGs had to do this themselves they would have to invest time and expertise in developing the computer searches, which would probably cost several thousand pounds each.

2 Run the computer searches in the practices. It is likely practices will be able to download searches in order to automate this process. If this were not possible, however, CCGs would need to pay for someone to go around practices running the searches – this would probably include travel time and approximately half a day of work per practice.

3 Train pharmacists to undertake the PINCER intervention. We had five or six days' training for our study, but it might be possible to do it in less – particularly if pharmacists are familiar with local computer systems.

4 Allocate the pharmacists to general practices if they were not allocated already.

5 Conduct the pharmacist-led intervention in practices, including meeting with the practice team, liaising with the practice manager and everything else the pharmacist would need to do to tackle the problems identified by the searches.

The main costs to commissioners would be employing the pharmacists. The cheapest way of doing this would be to use pharmacists who are currently employed by PCTs or CCGs and redirect some of their activities towards running a PINCER-type intervention, creating no additional salary costs.

In our study, the pharmacists spent approximately two days a week for 12 weeks on the intervention in each practice. However, if pharmacists were taken away from effective cost-control measures, some costs might arise.

Professor Tony Avery is a GP in Nottingham and professor of primary healthcare at the University of Nottingham

Dr Sarah Rodgers is a senior research fellow in the division of primary care at the University of Nottingham

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MORE ONLINE

Go to pulsetoday.co.uk/prescribing to see a description of trial outcomes, and download a guide for GPs on defences against prescribing errors

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Please apply in writing to
Angela Bonney, Practice Manager,
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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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or email mandy.neville@nhs.net

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For an application pack please contact:

Dorothy Pluck on 01442 892465 or Jenny Stevens on 01442 892466
Email: dorothypluck@nhs.net or jennystevens@nhs.net

Closing date 22nd June 2012

Salaried GP's
St Andrews Health Centre
London E3 3NS

We are looking for enthusiastic GP's who are interested in being part of our rapidly growing team at St Andrews GP Surgery and Walk In Centre. Our aim is to deliver high quality primary care which integrates with the local community while providing a supportive and enjoyable place to work.

St Andrews Health Centre will be moving into a brand new building at the end of June and we are looking to recruit two new full time GP's to join us.

We offer a salary of £75,000 p.a. and opportunities in leadership and professional development.

Application forms can be downloaded at eastendgp.co.uk. Please return completed application forms to carole.mccluskie@nhs.net by May 17th 2012.
Interviews will be held on May 24th.

If you require further information please contact Ian Jackson our Practice Director on ianjackson1@nhs.net

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(probable future partnership)

Large forward-thinking practice seeks full time GP due to retirement.

Our ambition is to achieve, by an effective team approach, the highest quality of progressive family health care, in a happy and compassionate environment.

We care for 16,100 patients in the pleasant Weald of Kent area. We operate four buildings, two of which are purpose-built Medical Centres. We are part dispensing and currently have 3 GP Trainers. We have an excellent nursing, ancillary and PHC team.

Please write with full CV to Peter Nicholas, Managing Partner, Hildenborough & Tonbridge Medical Group, Westwood, Tonbridge Road, Hildenborough, Kent, TN11 9HL.

Closing date 31st May 2012.

Shortlisted candidates will be welcome to arrange an informal visit to the practice.

DeMontfort Medical Centre Evesham
has a 6000 list size with 3 WTE doctors.

We require an additional GP to cover 6 sessions per week, salary & benefits negotiable.

One day per week as duty doctor 8 am – 6-30 pm, the other 2 days would be 8:30 – 5 : 30 with share of special clinics/agreed visits/ admin work, etc,.

The Practice is close to the A46 Evesham bypass which has good links to the M5 and surrounding areas.

Please Email CV, details and any enquiries to anthea.stewart@nhs.net

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GP Partnership opportunity from August 2012
(experienced or newly qualified)

North Swindon Practice (Wiltshire) is a 4 partner training practice that maximises the use of IT whilst retaining traditional values in patient care.

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Informal visits welcome.
Applications with CV by email to:
Chris Gebel, Practice Manager, North Swindon Practice

Chris.Gebel@nhs.net
Tel: 01793 707896

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TRAINING PRACTICE, KENT

Winterton Surgery, Westerham

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Please send CV with covering letter to Mrs M. Hirkaret-Staples, Winterton Surgery, Market Square, Westerham, Kent TN16 1RB or email to margaret.hirkaret-staples@nhs.net

Closing date 18th May

Salaried GP with a view to Partnership

Number of sessions negotiable - minimum of four.

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List Size: 7,500
High QOF Achiever
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Personal Development and Special Interests encouraged

For more information, arrange an informal visit or for applications please forward your C.V. to: Grainne Rodriguez, Practice Manager, Silver Springs Medical Practice, Beaufort Road, St Leonards on Sea, TN37 6PP.
Email grainne.rodrigue2@nhs.net

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Interview date week commencing 11th of June 2012
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Closing date: 31st May 2012
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Apply in writing with covering letter, CV and two referees to Dr Doran, 20 Kingsway, Waterloo, Merseyside, L22 4RQ
Tel 0151 920 9006

Closing date for applications 16th June 2012.

DALEFIELD SURGERY

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- *Excellent Management, Nursing and Support staff*
- *Maximum achieving QOF*
- *Vision INPS system*

Please send CV to Mrs Marie Bryan, Practice Manager, Dalefield Surgery, Avondale Health Centre, Avondale Street, Bolton, BL1 4JP.
Or e-mail: marie.bryan@nhs.net

Closing date for applications 31st May 2012
Interviews to be held Monday 11th June 2012

Bolton
Full Time Partnership

We are looking for a new full time partner to start by October 2012 due to partner retiring.

Very friendly 3 partner practice, 6000 patients, family practice with very low turnover of staff and patients.

Own premises, purpose built Health Centre.

We are looking for someone able to commit to an equal share in the responsibilities, workloads and rewards.

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EDITOR'S CHOICE

My vote for RCGP president

Our blogger Jobbing Doctor mulls the candidates for RCGP president

Normally the election of the RCGP president is ignored by jobbing doctors. (I have never voted.) But this time is different. In a period of mayhem, when we are facing untold issues, threats and opportunities, this appointment will be important for our college.

I know two of the candidates from when I was on RCGP Council. Both are clever and forthright, and college insiders of many years' standing.

Professor Mike Pringle is a previous chair and has been involved with a number of initiatives, including revalidation.

Professor Jacky Hayden has been a regional chief for many years.

Dr John Chisholm was key in setting up the new contract, with the pluses and minuses of that, then took advantage of the process that New Labour set up.

Sir John Oldham I have never met. I have an inherent suspicion of anyone given a knighthood by the Government, and he has been a power player in central circles for some time.

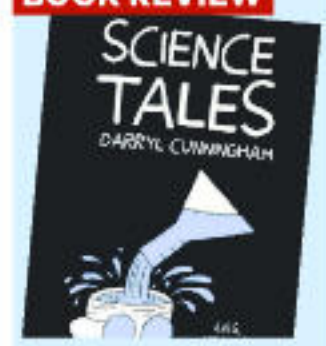
That leaves two jobbing doctors on the list. Dr Una Coales works in London, has run courses, written books and is closely connected with the Conservative party.

Dr Terry Kemple has spent his career in Bristol, without seeking the metropolitan route.

Six GPs are standing for RCGP president

FIND OUT...
...who Jobbing Doctor will vote for at pulsetoday.co.uk/blogs and view the candidates' manifestos at pulsetoday.co.uk/news-analysis

BOOK REVIEW



In *Science Tales*, Darryl Cunningham has given us a truly lovely book! A series of clever cartoons direct us to the heart of the matter, stimulate critical thinking and debunk myths...
▶ Read the GP review at pulsetoday.co.uk/book-reviews

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"This guy should get a job on Top Gear."
... on Professor Malcolm Grant's GP golf jibe

"Great: more herceptins!"
... on the DH taking over NICE's rationing role

"In about three years' time, the merry-go-round will change its tune and the whole danse macabre will start all over again."
... on marketisation of the NHS

"Can we go back to doctor knows best? Patients should do as they're told."
... on study doubting self-care

OPINION

A career only for the strong

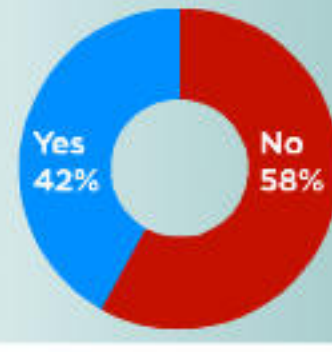
Strength of character is deemed essential. Survival of the fittest really does seem to apply during medical school and GP training years. Even once these are completed the world of medicine is increasingly more challenging, even for the strongest. And with this comes a more insidious downside, which has always been somewhat taboo...

OPINION
More from Dr Jenny Wenman on why GPs need to admit they're vulnerable too
pulsetoday.co.uk/opinion

THIS WEEK'S POLL

Will online booking ease the 8am rush?
Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Is self-care the answer to the NHS efficiency drive?



Turn inside for this week's Copperfield column
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