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PULSE

09.05.12
Issue 17 | Volume 72

BriefingMedia

At the heart of general practice since 1960

BMA pension ballot splits GPs by age

LMCs report workload fears and generational divide over prospect of industrial action

EXCLUSIVE
By Jaimie Kaffasæh

Say No to 30% Large numbers of GPs are telling LMCs they are not willing to join BMA industrial action over pensions, with a stark divide opening up between older GPs and their younger colleagues.

Half of some 30 LMCs surveyed by Pulse said there was little support for industrial action in their areas, with older GPs in particular concerned over the workload and contractual implications of offering only urgent care, and the likely reaction of the national media.

EDITORIAL ▶

GPs must stand united over pensions 13

Dr Sandeep Geeranavar: the Government's pension changes are an issue for the younger generation of GPs in particular

In 11 LMCs, GPs warned a clear generational divide existed, with younger GPs much more militant than their older colleagues. Younger GPs are hit hardest by the changes, while those within 10 years of retirement largely escape their effects.

The BMA last week launched a 'get out the vote' campaign and released detailed guidance setting out exactly what GPs will be asked to do ahead of the first ballot of doctors on industrial action for almost 40 years, beginning next week. GPs will be asked to cancel routine appointments for a day, although they will still be required to provide urgent and emergency care and deal with urgent administrative tasks such as reviewing test results.

Just five out of 30 LMCs contacted said members had showed overall support for action, compared with 15 who said there was little support and 10 unable to say. Eleven LMCs identified a split between younger and older GPs, while 12 reported little difference of opinion. And 10 LMCs warned the backlog of work generated by suspending routine appointments for a day was likely to dissuade GPs from taking part. A BMA spokesperson this week acknowledged 'practices would need to catch up over subsequent days'.

Pulse's *Say No to 30%* campaign has backed a Yes vote to support GP negotiators - but is pushing for a boycott of non-clinical work rather than routine care.

Berkshire, Buckinghamshire and Oxfordshire LMCs' newsletter said: 'GPs could decide to take industrial action for media purposes, but in reality take none at all. Stopping routine care for a day would only produce a stressful workload bulge.'

Dr Paul Roblin, the LMCs' chief executive, told Pulse GPs were the 'only people who would be hurt' by cancelling routine appointments: 'Many LMC reps don't feel it is the right thing to do, but are concerned to support their younger colleagues.'

Dr Philip Fielding, chair of Gloucestershire LMC, said there was 'not a militant mood', while Dr Ravi Mene, secretary of Salford and Trafford LMC, said GPs feared action could be 'counter-productive'.

Dr Manoj Pal, former chair and current member of Coventry LMC, said: 'Strikes by medics usually result in a loss of public support. There is a split between younger and older GPs.'

Dr Andrew Mimnagh, chair of Sefton LMC, said: 'Younger GPs who may be salaried may be very keen, whereas older GPs are saying: "Are we certain this activity will not allow removal of the contract?"'

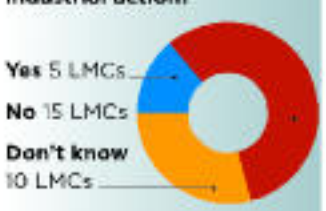
Dr Laurence Buckman, GPC chair, acknowledged it was 'probably the case' that younger GPs were keener to take action, but said: 'We will see what people will vote, and if they vote with their conscience. I am keen for people to vote.'

Dr Sandeep Geeranavar, a GP in Birmingham, said the pension reforms were particularly 'an issue for younger GPs' like himself, and added industrial action would 'send a clear message that GPs feel strongly about the way they have been treated'.

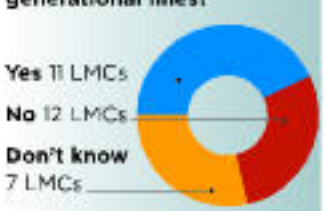
feedback@pulsetoday.co.uk

LMCs gauge pensions mood

Is there an appetite for industrial action?



Is support split along generational lines?



Source: Pulse survey of 30 LMCs

SAY NO TO 30%
Join the campaign
pulsetoday.co.uk/saynoto30

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CPD in this issue: 4 hours
Earn CPD for our Key questions and Clinical casebook articles, as well as our feature on the new A&E indicators

Atorvastatin price crashes by 93%

A leading adviser to NICE has called for restrictions on the use of atorvastatin to be thrown aside after its price tumbled by 93% this week, following the expiry of its patent.

The massive drop in cost will save millions for the NHS and is set to herald a sea change in GP management of hypercholesterolaemia, with all new patients needing statin treatment placed on the drug in preference to simvastatin. A legal block on producing generic versions was removed this week with the ending of Pfizer's patent.

Pulse revealed in February that GPs were set to be enrolled in schemes to switch patients en masse to atorvastatin after an NHS-commissioned analysis found its price could plummet by as much as 95% when it came off patent.

The highest price for a 28-pill pack of the first UK generic version of 80mg atorvastatin has been set at £2.26, compared with £28.21 for Lipitor, the branded version. The price of other doses of the generic drug - manufactured by Teva UK - are set at 91p for a 10mg pack and £1.72 for both 20mg and 40mg packs.

GPs set for mass drug switch to atorvastatin

In February, Pulse reported on forecasts of a price drop

NICE adviser Dr Rubin Minhas, clinical director of the BMJ Clinical Evidence Centre and a GP in Hoo, Kent, said: 'Atorvastatin is now the cholesterol-lowering treatment of choice.

'GPs should begin switching their patients across from simvastatin.'

Kim Innes, commercial director at Teva, said: 'Millions of prescriptions are written each year in the UK for atorvastatin, and the availability of the generic will save the NHS millions of pounds each year.'

One in eight book for over 10 minutes

One practice in eight routinely books consultations for longer than 10 minutes - and some are even booking patients for over 15 minutes - according to a new study.

A survey of hundreds of practices found a significant minority were adapting their appointments to accommodate patients with more complex health needs - although most still only provide 10 minute slots.

The survey in the *British Journal of General Practice* involved 1,492 trainees providing evidence on the current consultation lengths offered by their GP trainers. Some 83% of practices provided 10-minute appointments, 11.4% provided appointments of 10-15 minutes and 1.5% provided appointments of more than 15 minutes, while 2.7% booked consultations shorter than 10 minutes.

Asked what length of appointment they would prefer, 56% of trainees said they would like 15-minute appointments, 27% appointments of 11-14 minutes and just 13% with 10-minute slots.

Study leader Dr Greg Irving, former chair of the RCGP AiT Committee and a GP in Merseyside, said: 'This will need reorganisation within practices, but we've been able to offer 15-minute appointments as standard for eight years in our practice with huge benefits.'

GPs to be ranked on lab test use

DH to provide CCGs with benchmarking data after audits reveal 100-fold variation in use of tests

EXCLUSIVE
By Nigel Praities

GPs will be benchmarked on the laboratory tests they order under Government plans to cut the cost of pathology services by 20% over three years, Pulse can reveal.

Ministers aim to arm CCGs with information on variation in requests from GPs and their adherence to NICE guidelines, after audits showed request rates differed by up to 100-fold between practices. But GP leaders warned the move could add to the 'big black cloud' of performance management from CCGs, as they scrabble to find savings under QIPP.

Dr Ian Barnes, national clinical director of pathology, told a meeting of pathologists earlier this year a 'major culture shift' was required in use of lab services, and that the Department of Health was determined to implement cost-cutting recommendations from the 2006 Carter review.

Variation in practice lab testing

Source: Dr Ian Barnes, DH national clinical director, pathology

He highlighted data from Connecting for Health pilots showing request rates from GP practices varied by over 100-fold for rheumatoid factor, and nearly 30-fold for parathyroid hormone: 'A minimum of 20% efficiency savings are required. We need to change working practices.'

The DH said it had asked the NHS Information Centre to collate data on GP requests extracted from the pathology messaging system: 'Such an approach, if supported by commissioning groups, will enable analysis of variance linked to population and disease prevalence. It will also allow the NHS to monitor adoption of standards suggested by NICE.'

The DH said it was looking at whether there was any correlation with testing rates and further diagnostic steps, potentially showing whether the testing thresholds of GPs were too high.

A review of pathology services by Lord Carter in 2006 found they should be 'streamlined' and set up as independent networks from hospitals.

Pulse has learned NHS managers across the country are beginning to reconfigure pa-

The week in general practice

INSIDE

Not a single GP practice has agreed to register commuters by the DH's deadline for its practice boundary pilots
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A NICE-backed self-care programme shows little benefit
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GPs are poised for a national shingles vaccine programme as the DH solves supply problems
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GPs can write mandatory retirement ages into partnership contracts
page 11

Dr Peter Swinyard

MORE ONLINE
▶ pulsetoday.co.uk/news

GPs could be faced with 'mopping up' if a meningitis C booster vaccination programme is rolled out in schools, say DH immunisation experts
▶ pulsetoday.co.uk/clinicalnews

A GP has narrowly beaten Richard Barnes, the deputy mayor of London, to win a seat on the London Assembly
▶ pulsetoday.co.uk/politicalnews

Video of the week
Professor Tony Avery, PRACTICE study leader and a GP, explains the significance of his research into GP prescribing errors
▶ pulsetoday.co.uk/videos

BIG Question Are GPs ordering too many lab tests? ▶ pulsetoday.co.uk

DH wants a 'major culture shift' in the use of lab tests

thology services. Trusts are developing 'demand management' strategies and electronic systems to reduce duplication of tests by GPs.

NHS Midlands and East launched a consultation last month on a scheme to save £30m, and plans to reduce 'duplicate testing' by developing 'better communication and IT solutions'.

NHS London is to reconfigure pathology services, including plans for GPs to send all results with their referral to prevent duplication.

Dr Robert Morley, executive secretary of Birmingham LMC, said there were 'enormous' differences in testing rates, but variation should not be used to performance manage GPs.

'I fear this exercise will be done neither properly nor for the right reasons,' he said.

'We all know the big black cloud of performance management is looming large over us with the advent of the NHS Commissioning Board, who will use CCGs to do their dirty work.'

Dr Richard Dales, secretary of Herefordshire LMC, said: 'I suspect a rigid approach via NICE guidelines may increase testing rather than decrease it.'

@nigelpraities

Nurses ease white-coat BP

By Madlen Davies

Swapping a GP for a nurse is an effective way of eradicating white-coat hypertension, because it relaxes patients and lowers their blood-pressure readings, new research reveals.

A UK meta-analysis of 14 studies found that mean blood pressures measured by nurses were 8.5/4.2mmHg lower than readings from doctors.

It concluded that blood pressure measurements from GPs might be 'unreliable for clinical decisions', and that all measurements should be delegated to nurses - in a recommendation with wide-ranging implications for how practices organise services.

When studies with a high risk of bias were removed from the analysis, the gap was reduced but remained, with a mean difference of 4.8mmHg in systolic blood pressure and 1.5mmHg for diastolic.

The difference in diastolic readings was not found to be statistically significant.

Researchers told the European Society of Hypertension Congress in London last month, that the findings meant practices should move to nurse-only or home blood pressure monitoring.

Study leader Dr Chris Clark, clinical academic fellow at the Peninsula Medical School and a GP in Witheridge, Devon, said: 'The difference could affect treatment decisions, especially when the measurement is marginal, between one course of treatment and another.

'The study might lead to a move to nurses taking blood pressure or increased use of home blood pressure readings.'

'I always ask the nurse to take the reading before the patient leaves' **Professor Mike Kirby**

Professor Mike Kirby, professor of health and human sciences at the University of Hertfordshire and GP in Letchworth, said the study was 'useful'.

He added: 'I always ask the nurse to take the reading before the patient leaves.

'It's a very good idea to get patients to buy their own home blood pressure machines. They're only £10-15.'

@madlendavies

SEMINAR
Diabetes Update 2012 - 19 September, London
pulse-seminars.com

Ex GPC chair on RCGP ballot

The list of candidates standing to be next RCGP president includes a former GPC chair, a Department of Health QIPP lead and one of the architects of revalidation, Pulse can reveal.

The race for election as constitutional head of the college - a role currently held by Dr Iona Heath - also features several prominent GP educators and current RCGP Council members. Ballot papers will be sent to RCGP members from 14 May, with the closing date 1 June.

Prominent candidates include Professor Mike Pringle, RCGP lead for revalidation and head of the University of Nottingham school of community health sciences, who has charted a perilous course in designing the system to revalidate GPs.

Sir John Oldham masterminded the Government's QIPP programme as national clinical lead for quality and productivity, but will not be continuing his QIPP role on the NHS Commissioning Board.

Dr John Chisholm was an influential GPC chair, negotiating the 2004 deal that created the QOF and secured the out-of-hours opt-out, and has since run private firm Concordia Health.

Dr Una Coales is a nationally elected council member and outspoken supporter of the NHS health reforms as secretary of Conservative Health. Dr Coales came second in the presidential election three years ago.

Professor Jacky Hayden is postgraduate dean for North Western Deanery, a GMC associate, board member of Medical Education England and chair of the English Deans Committee.

Completing the line-up, Dr Terry Kemple is a GP in Bristol and clinical champion for the South West at the Primary Care Research Network.

The RCGP said it would be 'making a formal announcement of the candidates at the beginning of the election process'.

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Generally well tolerated – Trajenta®, studied in over 4,000 patients in clinical trials, 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]

Prescribe – Trajenta® 5 mg once daily[1]

NEW
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Film-coated tablets containing 5 mg linagliptin. Indications: Trajenta is indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as monotherapy – in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to intolerance, or contraindicated due to renal impairment; as combination therapy – in combination with metformin when diet and exercise plus metformin alone do not provide adequate glycaemic control; – in combination with a sulphonylurea and metformin when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control. Dose and Administration: 5 mg once daily. If added to metformin, the dose of metformin should be maintained and linagliptin administered concomitantly. When used in combination with a sulphonylurea, a lower dose of the sulphonylurea may be considered to reduce the risk of hypoglycaemia. Patients with renal impairment: no dose adjustment required. Pharmacokinetic studies suggest that no dose adjustment is required for patients with hepatic impairment, but clinical experience in such patients is lacking. Elderly: no dose adjustment is necessary based on age; however, clinical experience in patients > 75 years of age is limited. The safety and efficacy of linagliptin in children and adolescents has not yet been established. No data are available. Trajenta can be taken with or without a meal at any time of the day. If a dose is missed, it should be taken as soon as possible but a double dose should not be taken on the same day. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and Precautions: Trajenta should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Caution is advised when linagliptin is used in combination with a sulphonylurea: a dose reduction of the sulphonylurea may be considered. Interactions: Linagliptin is a weak competitive and a weak to moderate mechanism-based inhibitor of CYP isoenzyme CYP3A4, but does not inhibit other CYP isoenzymes. It is not an inducer of CYP isoenzymes. 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 or 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 therapy in 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 sulfonylurea), nasopharyngitis (combination with metformin and sulphonylurea). Uncommon: nasopharyngitis (monotherapy), constipation (combination with metformin), hypertension (combination with sulfonylurea), pruritus (combination with metformin), rash (monotherapy), urticaria (combination with metformin), hypertension (combination with metformin and sulphonylurea), rash (combination with metformin and sulphonylurea), hypertension (combination with metformin and sulfonylurea), pruritus (combination with metformin and sulfonylurea). Prescribers should consult the Summary of Product Characteristics for further information on side effects. Pack sizes and NHS price: 28 tablets £33.28. Legal category: POM. MA number: EU/1/11/700/003. 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 www.yellowcard.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 66. 372-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;28:1092–41. 5. Boehringer Ingelheim, data on file D8011-C00-4. 6. Bristol JS et al. Drug Metab Dispos 2007;35:502–510. 7. Jauricic (linagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/18808/SPC/JAURICA+10mg+film-coated+tablets/ (accessed January 2012). 8. Dafiro (linagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22724/SPC/Dafiro+5E+mg+tablets/ (accessed January 2012). 9. Ondero (linagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22715/SPC/Ondero+2.5mg+%26+5mg+film-coated+tablets/ (accessed January 2012). 10. Deacon CF. Diabetes Obes Metab 2011;13:7–18. 11. Bach S et al. Drug Metab Dispos 2010;38:667–678.
UK/TRJ/0195b Date of preparation: January 2012

Boehringer Ingelheim

Lilly

Copperfield's world is beginning to unravel... ▶ page 14

PCTs miss boundary deadline

Not a single GP practice has agreed to register commuters in time for practice boundary pilot's April start

By Gareth Iacobucci

Not a single GP practice has begun offering commuters the chance to register near their work under the Government's much-trumpeted pilots of the removal of practice boundaries.

The Government had said the Choice of GP Practice pilots would begin 'during April 2012', but all six pilots have missed that deadline, with some saying they would not be ready until later in the year.

The pilots to allow patients to either register or attend as an out-of-area patient near their work have been thrown into disarray by a practice boycott and continuing uncertainty about local arrangements. All six pilot areas told Pulse that no practice had yet formally agreed to participate in the scheme, although some had expressed interest.

Dr Deborah Colvin: PCT has failed to respond to GPs' boycott calls

A spokesperson for NHS East London and the City cluster said no practices had signed up to date to take part in the pilot, following a call from LMC leaders for local practices to boycott the scheme.

A spokesperson said: 'We don't have any because of the LMCs. We are working to identify the best way to cater for the potentially large population of commuters who may be interested. We are hopeful of having a solution in place later in the pilot year.'

Dr Deborah Colvin, chair of City and Hackney LMC, had written to GPs and the PCT warning the pilots would 'inevitably result in cuts in services for existing patients'. She told Pulse she had still had no response from the PCT to her letter.

Both NHS Manchester and NHS Salford said they were awaiting further guidance from the Department of Health on the contract variations needed for practices wishing to participate.

A spokesman for NHS Salford said: 'We are taking formal plans out to practices at the moment. We hope we'll have everything running for the pilots at the start of June – 13 practices have expressed an interest.'

NHS Westminster said the process of signing up practices was 'still being worked through' and a spokesperson for the Nottinghamshire cluster, where the Nottingham City pilot is due to take place, said no practices had signed up.

He added: 'We are meeting with GP practices who have expressed an interest later in May.'

Chris Locke, secretary of Nottinghamshire LMC, said practices were concerned over hospital care for commuter patients: 'They are not happy with the money situation. Even if the money that they are paid is okay, there is no allowance made for use of hospital resources by patients that register with them.'

@garethiacobucci

Commuters going nowhere

Salford – hope to be ready 'at the start of June'
Manchester – service level agreement 'still to be finalised'
Nottingham – meeting with practices 'later in May'
City and Hackney/Tower Hamlets – hopeful of a solution 'later in the pilot year'
Westminster – process 'still being worked through'

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GP face-to-face time with patients 'unsustainable'

General practice is 'no longer sustainable' in its current form, with a squeezed workforce, increasingly complex demands and a shifting financial landscape requiring GPs to radically alter way they work, a new report has claimed.

An analysis by the Deloitte Centre for Health Solutions, *Primary care: today and tomorrow*, warned thousands of GPs would retire in the next five years, citing figures from the NHS Information Centre showing that 22% of GPs are aged over 55, compared with 17% in 2000, as evidence of 'a significant primary care supply challenge'.

If the pattern of GP consultations remains unchanged, the report forecast there could be 433 million practice consultations annually by 2035, including 180 million for people aged 65 and over – nearly double the current figure.

Karen Taylor, research director of Deloitte UK Centre for Health Solutions, said: 'The traditional ways of working, which rely on face-to-face consultations between the patient and the GP, and increasingly the practice nurse, are no longer sustainable. GPs will still need to act as gatekeepers, but also increasingly as care navigators.'

IN BRIEF

AF case-finding call

QOF indicators for anticoagulation therapy will overlook a 'significant proportion' of older people with atrial fibrillation, say experts.

Full story ▶ pulsetoday.co.uk/clinicalnews

NHS Direct action

NHS Direct staff have taken part in a 'work-in' to protest at plans to replace the service with the new NHS 111 helpline.

Full story ▶ pulsetoday.co.uk/practicenews

Nurse safety warning

The GPC has warned practices to ensure their practice nurses are registered.

Full story ▶ pulsetoday.co.uk/practicenews

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All presentations contain soluble insulin aspart/protamine-crystallised insulin aspart 100 U/ml in the ratio 30/70.
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If twice daily dosing results in recurrent daytime hypoglycaemic reactions the morning dose can be split into morning and lunchtime doses and thrice daily dosing instituted. Only consider combination of NovoMix® 30 with pioglitazone following clinical evaluation of the patient's risk of developing signs and symptoms of fluid related adverse reactions. Initiate NovoMix® 30 cautiously, titrating to the lowest dose required to obtain glycaemic control. In patients with type 1 diabetes the individual insulin requirement is usually between 0.5 and 1.0 U/kg/day and may be fully or partially supplied with NovoMix® 30. Dose adjustment may be necessary with increased physical activity, changes in diet or during concomitant illness. NovoMix® 30 can be used in the elderly; limited experience of NovoMix® 30 in combination with OADs in patients older than 75 yrs. Renal or hepatic impairment may reduce insulin requirements. In this population or the elderly glucose monitoring should be intensified and dose adjusted accordingly. NovoMix® 30 can be used in children and adolescents aged 10 yrs and above, limited clinical data for children aged 6-9 yrs. No studies in children under the age of 6 yrs; only use in this age group under careful medical supervision. When transferring a patient from biphasic human insulin to NovoMix® 30, start with the same dose and regimen, then titrate according to individual needs. For subcutaneous administration only; not to be used in infusion pumps. NovoMix® 30 has a faster onset of action than biphasic human insulin and should generally be given immediately before a meal. When necessary it can be given soon after a meal. Penfill® designed to be used with Novo Nordisk insulin delivery systems. Penfill® and FlexPen® are designed to be used with NovoFine® and NovoTwist® needles. **Contraindications:** Hypersensitivity to active substance/ excipients. **Special warnings and precautions for use:** Use of inadequate doses or discontinuation of treatment may lead to hyperglycaemia and ketoacidosis which are potentially lethal. Travelling between time zones may require change in the insulin regimen. Too much insulin, omission of a meal or strenuous exercise may lead to hypoglycaemia. Compared with biphasic human insulin NovoMix® 30 may have a more pronounced glucose-lowering effect up to 6 hours after injection. This may need to be compensated for through adjustment of dose and/or food intake. Reduction of early warning symptoms of hypoglycaemia may be seen upon tightening control and symptoms may disappear with longstanding diabetes. Tighter control of glucose levels can increase the potential for hypoglycaemic episodes and therefore require special attention during dose intensification. The fast onset of action should be considered in patients where a delayed absorption of food might be expected. Concomitant disease in kidney, liver, adrenal, pituitary or thyroid gland may require change in dose. Transferring to a new type or brand of insulin should be done under strict medical supervision; may require changes in dose/number of injections. Injection site reactions, usually transitory, may occur; rotation of injection sites may help reduce or prevent these reactions, rarely they may require discontinuation of NovoMix® 30. Cases of cardiac failure were reported when pioglitazone was used in combination with insulin, especially in patients with risk factors for development of cardiac heart failure; if the combination is used, patients should be observed for signs and symptoms of heart failure, weight gain and oedema. Pioglitazone should be discontinued if any deterioration in cardiac symptoms occurs. Hypoglycaemia may constitute a risk when driving or operating machinery. **Fertility, pregnancy and lactation:** Limited clinical experience in pregnancy. No restrictions on use during breast-feeding. No differences in animal studies between insulin aspart and human insulin regarding fertility. **Undesirable effects:** Very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000), not known (cannot be estimated from the available data). Very common: hypoglycaemia; Uncommon: urticaria, rash, eruptions; refraction anomalies, oedema and local hypersensitivity reactions on instituting therapy and are usually of transitory nature; diabetic retinopathy with intensification may result in temporary worsening; lipodystrophy; Rare: peripheral neuropathy – acute painful neuropathy, usually reversible, may occur with rapid improvement in glycaemic control; Very rare: anaphylactic reactions - generalised hypersensitivity reactions are potentially life-threatening. The Summary of Product Characteristics should be consulted for a full list of side effects. **MA numbers:** NovoMix® 30 Penfill® EU/1/00/142/004 NovoMix® 30 FlexPen® EU/1/00/142/009 **Legal Category:** POM **Basic NHS Price:** 5 x 3 ml Penfill® £28.84 5 x 3 ml FlexPen® £29.99 **Further prescribing information can be obtained from:** Novo Nordisk Limited, Broadfield Park, Brighton Road, Crawley, West Sussex, RH11 9RT.
Date created/last revised: March 2012
NovoMix®, FlexPen®, Penfill®, NovoFine® and NovoTwist® are trademarks owned by Novo Nordisk A/S.

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

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 Novo Nordisk Limited. (Telephone Novo Nordisk Customer Care Centre 0845 6005055). Calls may be monitored for training purposes.

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

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

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NICE-backed programme little better than usual GP care

DIABETES

Diabetes self-care advice fails long term

By David Swan

A NICE-backed programme to educate patients to self-manage their diabetes has little effect on their lifestyle choices or health outcomes in the long term, concludes a major UK study.

The analysis found no difference in HbA$_1$c levels, physical activity or smoking, three years after a group of patients was given a full day of advice on self-care of diabetes soon after diagnosis, compared with the control group given usual GP care.

The findings, published online by the *BMJ*, cast doubt over the validity of NICE guidelines that recommend all patients diagnosed with diabetes are given 'structured education' around the time of diagnosis and annually thereafter. They prompted one expert to call for a return to traditional GP care.

The DESMOND programme – which had a mean cost of £82 per person – was the first national education scheme for diabetes, and NICE's advice was partly based on the cost-effectiveness of the DESMOND study at one year. But that finding is now under scrutiny given new evidence of a diminishing effect of the programme over time.

The UK analysis included 824 patients from over 200 general practices that were randomised either to a one-day group education programme looking at lifestyle change and their 'personal risk factors', or usual GP care.

Three years later, HbA$_1$c decreased in both groups, but a change of -1.32 in the intervention group was not significantly different from the -0.81 change in the controls.

There were some measurable improvements in patient knowledge about diabetes, but no significant differences between groups in coronary risk scores, smoking or physical activity.

Study leader Professor Khamlesh Khunti, professor of primary care diabetes and vascular medicine at the University of Leicester and a GP in the city, said the study showed the importance of regular advice rather than a one-off intervention: 'These patients need annual advice – rather than a one-off programme when they are diagnosed – in order to see continued benefits in biomedical outcomes.'

Dr Alan Begg, a GP in Montrose, Scotland, and co-editor of *Practical Diabetes*, queried whether the programme was cost-effective: 'Previous research assumed that lifestyle change, such as smoking cessation, could only be maintained if the intervention continued. Will educational programmes be commissioned if there are only "soft" educational outcomes rather than measurable improvements in morbidity and mortality?'

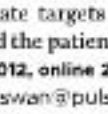
In an editorial on the study, Professor Frank Snoek – professor of medical psychology at the VU University Medical Centre in the Netherlands – said the study showed why GP care was so important: 'Perhaps we should focus again on the setting of appropriate targets by professionals and the patients themselves.'

***BMJ* 2012, online 26 April**

david.swan@pulsetoday.co.uk

Online CPD

Management of hyperglycaemia



pulse-learning.co.uk

A one-off session on self-care has little benefit in diabetes

Change in outcomes

	Intervention group	Control group
HbA$_1$c (%)	-1.32	-0.81*
Body weight (kg)	-1.75	-1.44*
LDL-cholesterol (mmol/l)	-0.92	-0.84*

*non-significant difference. Source: *BMJ* 2012, online 26 April

PRESCRIBING

Text messages encourage adherence

Weekly text messages are an easy and effective way of encouraging patients to take their medication, according to Dutch researchers.

They systematically reviewed 13 studies that looked at various types of electronic medication reminders for patients with long-term conditions, such as text messages and pagers.

They found that three of the four studies that looked at text message reminders showed significant positive effects on adherence. One of them found the percentage of participants achieving 90% adherence increased by 13-16% with weekly reminders. Of the seven studies that looked at audio and visual electronic reminder devices, or a combination of both, four significantly improved patient adherence.

Study leader Dr Marcia Vervloet, researcher at the Netherlands Institute for Health Services Research, said: 'After providing patients with electronic reminders, no additional effort is needed, making this an intervention easy to implement in daily practice.'

***J Am Med Inform Assoc* 2012, online 25 April**

CHAMPIX has more than 18 million treatment courses initiated worldwide[6]

CHAMPIX® Film-Coated Tablets (varenicline tartrate) **APPROVED PRESCRIBING INFORMATION – UK (See CHAMPIX Summary of Product characteristics for full Prescribing Information)** Please refer to the SmPC before prescribing CHAMPIX 0.5 mg and 1 mg. **Presentation:** White, capsule-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsule-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** CHAMPIX is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily; Days 4-7: 0.5 mg twice daily and Day 8 – end of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should usually start 1-2 weeks before this date. Patients who are not willing or able to set the target quit date within 1-2 weeks, could be offered to start treatment and then choose their own quit date within 5 weeks. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with CHAMPIX for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** Mild to moderate renal impairment: No dosage adjustment is necessary. Patients with moderate renal impairment who experience intolerable adverse events: Dosing may be reduced to 1 mg once daily. Severe renal impairment: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. Patients with end stage renal disease: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Changes in behaviour or thinking, anxiety, psychosis, mood swings, aggressive behaviour, depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with CHAMPIX in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. CHAMPIX should be discontinued immediately if agitation, depressed mood or changes in behaviour or thinking that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. In many post-marketing cases, resolution of symptoms after discontinuation of varenicline was reported, although in some cases the symptoms persisted; therefore, ongoing follow up should be provided until symptoms resolve. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). In a trial of patients with stable cardiovascular disease (CVD) certain cardiovascular events were reported more frequently in patients treated with CHAMPIX. Patients taking CHAMPIX should be instructed to notify their doctor of new or worsening cardiovascular symptoms and to seek immediate medical attention if they experience signs and symptoms of myocardial infarction. The safety and efficacy of CHAMPIX in patients with serious psychiatric illness has not been established. There is no clinical experience with CHAMPIX in patients with epilepsy. At the end of treatment, discontinuation of CHAMPIX was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. There have been post-marketing reports of hypersensitivity reactions including angioedema and reports of rare but severe cutaneous reactions, including Stevens-Johnson Syndrome and Erythema Multiforme in patients using varenicline. Patients experiencing these symptoms should discontinue treatment with varenicline and contact a health care provider immediately. **Fertility, pregnancy and lactation:** CHAMPIX should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. CHAMPIX should only be prescribed to breast feeding mothers when the benefit outweighs the risk. There are no clinical data on the effects of varenicline on fertility. Non-clinical data revealed no hazard for humans based on standard tests and the male fertility studies in rats. **Driving and operating machinery:** CHAMPIX may have minor or moderate influence on the ability to drive and use machines. CHAMPIX may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side-effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialysed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 28 1 x 0.5 mg and 14 x 1 mg tablets Card (BLISTER) £28.00; Pack of 28 1mg tablets Card (BLISTER) £27.50; Pack of 28 1mg tablets HDPE Bottle £27.50; Pack of 56 0.5 mg tablets HDPE Bottle (BLISTER) £54.60; Pack of 56 1mg tablets HDPE Bottle (BLISTER) £54.60; Pack of 56 1mg tablets Card (BLISTER) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. **Last revised:** 11/2011. **Ref:** CN_J

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Pfizer Medical Information on 01304616161

References: 1. Hughes JR. New treatments for smoking cessation. CA Cancer J Clin 2000; 50:149-151. 2. Nides M et al. Varenicline versus buproprion SR or placebo for smoking cessation: a pooled analysis. Am J Health Behav 2008; 32:664-675. 3. Brookes H et al. Effectiveness of varenicline as an aid to smoking cessation: results of an inter-European observational study. Curr Med Res Opin 2011; 27:769-775. 4. Blak BT et al. Evaluation of varenicline on an aid to smoking cessation in UK general practice – a THIN database study. Curr Med Res Opin 2010; 26:661-670. 5. CHAMPIX® Summary of Product Characteristics. Last updated November 2011. 6. Data on file – IMS Midas Data, Nov 2011 – June 2012.

Pfizer

Date of preparation: January 2012 CHA/0432

This week's Clinical casebook looks at infertility
▶ page 24

CPD TIP OF THE WEEK

Give bone-protective therapy with steroids in osteoporosis

Patients with osteoporosis that need a course of oral steroid therapy for three months or longer should be given bone-protective therapy plus calcium and vitamin D as close as possible to the start date of the steroid therapy. These measures should continue for the duration of treatment, a new case-based learning module recommends. Patients who are intolerant of bone-protective therapy with oral bisphosphonates should be referred for consideration of IV zoledronic acid.
With inhaled steroids, the BTS/SIGN guidelines on asthma reference a systematic review that reports no effect on bone density with doses of up to 1,000µg BDP per day in adults.

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

CONTRACEPTION

Mood disorders 'less likely' with COC

Women are much less likely to develop a mood disorder if they are taking a combined pill than those taking other oral contraceptives, conclude researchers.

The study examined data from nearly 500 women aged 20 to 50 years, with 375 of the group taking COCs on enrolment. Of these, 40 women (8%) had a current mood disorder.

Women taking a progestin-only contraceptive were three times more likely to have a current mood disorder than those taking other contraceptives. In contrast, women taking a COC were 70% less likely to have a mood disorder than those taking other oral contraceptives.

Study leader Dr Gjertrud Svendal, lecturer at the University of Bergen in Norway, said: 'Because of the potential adverse effect progestin-only agents have on current mood, caution should be taken when prescribing these to women. If clinically indicated, the combined contraceptive agents appear preferable in terms of mood endpoints.'

***J Affect Disord* 2012, online 24 April**

ASTHMA

Mindfulness training helps quality of life in asthma

Mindfulness training produces clinically significant improvements in quality of life and stress that are equivalent to those seen with inhalers in patients with asthma, a US trial has found.

Researchers studied 83 patients who had a physician-documented case of asthma and randomised participants to receive either mindfulness-based stress reduction, or the control of a healthy living course.

Mindfulness-based stress reduction featured eight weekly sessions lasting two and a half hours each, with one six-hour session in the sixth week.

At 12 months, those in the intervention group had a clinically significant improvement in quality of life compared with the controls – as measured by the Asthma Quality of Life questionnaire – with an increase in scores of 0.72 and 0.06 respectively.

Perceived stress scores had also decreased by 4.3 in the intervention group, compared with an increase of 0.2 in the controls. There were no significant differences between groups in the percentage of patients with well-controlled asthma.

Study leader Dr Lori Pbert, professor of medicine at the University of Massachusetts medical school, said: 'From a clinical perspective, these findings are comparable to quality-of-life improvements in trials of widely prescribed asthma medications, including inhaled steroids and an anti-IgE antibody.'

***Thorax* 2012, online 27 April**

Years of smoking...
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Time to try CHAMPIX?[1–4]

- Many of your patients may have tried and failed to quit with willpower or over-the-counter NRT[1]
- CHAMPIX has a mode of action with dual effects that reduce the satisfaction of smoking as well as the craving and withdrawal symptoms[5]
- Prescribe CHAMPIX to help make the difference to your patients' success[5]

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DIABETES

Incretin injections better than gliptins for HbA_1c

Long-acting GLP-1 receptor agonist injections are more effective at reducing HbA_1c levels in patients with diabetes than gliptins when added to metformin, say European researchers.

Their meta-analysis looked at 21 studies into incretin-based therapy as an add-on to metformin for 16-30 weeks, compared with short-acting GLP-1 receptor agonists and DPP-4 inhibitors.

Long-acting GLP-1 receptor agonists produced an overall mean reduction of 6.9mmol/l (1.3%) in HbA_1c compared with 5.7mmol/l (0.7%) for DPP-4 inhibitors, and 5.5mmol/l (0.6%) for short-acting GLP-1 receptor agonists.

Body weight was reduced by a similar extent in the two groups with GLP-1 receptor agonists, but was not significantly altered in the groups taking DPP-4 inhibitors.

Study leader Dr Carolyn Deacon, senior lecturer at the department of biomedical sciences at the University of Copenhagen, said: 'There is a more pronounced reduction in HbA_1c with long-acting GLP-1 receptor agonists than with exenetide BID and DPP-4 inhibitors. The injectable GLP-1 receptor agonists reduce body weight – whereas the DPP-4 inhibitors are weight neutral – but are also associated with a greater incidence of gastrointestinal side-effects and a tendency to increase heart rate.'

***Diabetes Obes Metab* 2012, online 24 April**

SEMINAR
Diabetes Update 2012
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GUIDANCE ROUND-UP

Headache advice

NICE has urged GPs to consider medication overuse in patients who present with chronic headache in a draft guideline.
It recommends regular use of the following drugs for three months or more should be considered for medication overuse headache: triptans, opioids, ergots or combination analgesic medications.

NICE draft guidance, April 2012

Aliskiren warning

The US Food and Drug Administration is warning that blood pressure medications containing aliskiren should not be used in combination with ACE inhibitors or angiotensin-receptor blockers in patients with diabetes or renal failure.
The warning comes after the ALTITUDE trial discovered patients taking this combination of medications had an increased risk of hypotension, kidney impairment and hyperkalaemia compared with those taking ACE inhibitors and ARBs with a placebo.

FDA safety communication, April 2012

PPIs and vitamin D

The MHRA has warned GPs to be aware of PPIs used over the counter in any patients at risk of osteoporosis.
The advice comes after evidence showing an increased risk of bone fracture with PPIs used for one year or more. Patients at risk of osteoporosis should ensure regular intake of calcium and vitamin D.

MHRA drug safety update, April 2012

The latest in our series on PUNs and DENs: tennis elbow
▶ page 21

The DH hopes to vaccinate all aged 70 to 79 against shingles

Shingles vaccine for elderly moves closer

GPs poised for national immunisation programme for all adults aged over 70 as DH solves supply problems

By Nigel Praities

The Department of Health has successfully resolved supply problems with the shingles vaccine, paving the way for a national immunisation programme in the elderly.

A DH spokesperson told Pulse an 'adequate supply of vaccine' was now available, and that it was looking at whether the programme would be cost-effective.

It comes as the largest study of the herpes zoster vaccine to date showed it was associated with a low risk of serious adverse events.

In 2010, the Joint Committee on Vaccination and Immunisation recommended the DH consider a programme for all adults aged between 70 and 79, because of the higher risk of serious infection and hospitalisation from shingles in this group.

The DH accepted the recommendation and announced plans to vaccinate 4.7 million patients, but in February this year said it had been forced to delay the plans because there was 'not enough vaccine available'.

But this week a DH spokesperson told Pulse this problem has been resolved: 'The DH is looking at whether vaccinating people aged between 70 and 79 years against shingles is cost-effective, now that adequate supply of vaccine is available.

'This follows advice from the Government's independent vaccine advisory panel.'

GPs welcomed the move, as a US study showed a low rate of serious complications when herpes zoster vaccination was widely used in the community.

The study in nearly 200,000 patients aged 50 or over showed vaccination was associated with a doubling of the risk of an allergic reaction such as swelling or itching in the first seven days after administration.

Shingles vaccine cleared as safe

Relative risk of adverse events 42 days after herpes zoster vaccine compared with before vaccination

1.0
Stroke

1.07
Acute MI

0.94
Cardiomyopathy

0.91
Heart failure

Source: *J Intern Med* 2012;271: 510-20

But there was no evidence of any increased risk of serious adverse reactions such as stroke or CVD.

Study leader Dr Hung Fu Tseng, a research scientist with Kaiser Permanente in California, said: 'The results of this study support the findings from the pre-licensure clinical trials, providing reassurance that the herpes zoster vaccine is generally safe and well tolerated with a low increased risk of inflammatory or allergic reactions.'

Dr Douglas Fleming, a retired GP and a member of the JCVI, said: 'Shingles is a painful and unpleasant illness, particularly in people over 65 years of age. A vaccine to prevent it is needed.

'This study has shown that excepting some relatively minor adverse effects, the vaccine was not associated with an increased risk of serious adverse events and that is welcome.'

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Conference to consider reprimanding BMA leadership for failing to 'wake up' to Health Act dangers

LMC CONFERENCE

Meldrum faces LMC reforms heat

By Gareth Iacobucci

LMCs are to heap pressure on senior BMA leaders at their annual conference later this month by debating a motion that 'reprimands the BMA leadership for taking so long to wake up to the malignant effects' of the Government's NHS reforms.

An angry backlash to the Health Act seems certain to dominate the summit in Liverpool on 22 and 23 May, with GPs also due to vote on calls for the resignation of both the Prime Minister and the health secretary over their handling of the controversial legislation.

And LMCs will consider a motion calling for 'disengagement in commissioning to be included in industrial action' over pensions – despite BMA chair Dr Hamish Meldrum recently ruling out such a move as 'counter-productive'.

The motion from Kent LMC reprimanding the BMA leadership is paired with one from Cornwall and Isles of Scilly LMC that reads: 'Conference believes the phrase "critical engagement" when used by our representative bodies, [is] merely synonymous with "procrastination".' Kent LMC declined to comment on the motion ahead of the debate.

BMA chair Dr Hamish Meldrum will face criticism at the LMC conference

But Dr Kailash Chand, recently re-elected to BMA Council, said there was anger and disappointment among some grassroots GPs: 'The BMA is in a very difficult position – that being said, I understand why GPs feel this way and why the LMCs have been critical. The BMA leaders could have been more proactive at an earlier stage and acted more maturely and efficiently. BMA leaders should have been quicker in understanding that commissioning is a smokescreen for privatisation.'

But Dr David Brownridge, former secretary of the BMA's Worcestershire Division, said: 'The problem lies with the LMCs in the first place, having failed to dissuade their constituents from engaging with commissioning and thus removing any political clout we might have had.

'The blame for where we are at the moment is seated not in the top of the tree, but in its roots.'

A BMA spokesperson declined to respond to the motions, and BMA chair Dr Hamish Meldrum was not available for comment.

GPs could also turn both barrels on the Government if they back a call from Sefton LMC that 'deplores the political arrogance towards the medical profession' and 'calls for the resignation of the Prime Minister [and] the secretary of state for health'.

Other key motions on commissioning will tackle the bureaucracy faced by clinical commissioners, potential conflicts of interest within CCGs and the quality premium.

@garethiacobucci

Key motions

- **Kent LMC** That conference reprimands the BMA for taking so long to realise the malignant effects of the Health Act
- **Cornwall and Isles of Scilly LMC** That conference believes the proposed changes are merely a smoke screen for parcelling up the NHS in preparation for privatisation
- **Hampshire and Isle of Wight LMC** That conference insists all CCGs must consult with LMCs on decisions affecting GP providers and that this should be written into legislation

LMCs 2012 ONLINE
Read the full list of LMC motions
pulsetoday.co.uk/lmcs2012

NAPC 2012
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CCGs

First 35 CCGs seek authorisation

The NHS Commissioning Board has revealed the names of 35 shadow CCGs who have chosen to be assessed in the first wave of authorisation.

The CCGs, from across England, will if successful become the first GP-led statutory bodies from next year.

The list includes six CCGs within NHS South Central, six from the North West, five from Yorkshire and the Humber, five from the West Midlands, four from the East Midlands, three from the East of England, three from London and three from the South West.

Applications for authorisation will take place in four waves from July to January 2013.

Dame Barbara Hakin, national director of commissioning development at the NHS Commissioning Board Authority, said: 'All the emerging clinical commissioning groups have made fantastic progress to prepare themselves for authorisation.

'We expect confirmation of which CCGs will be assessed in waves two, three and four shortly.'

Dr Caron Morton, designate accountable officer for Shropshire County CCG, said: 'Together with our managerial colleagues, we have embarked on a programme of strategic transformational change across the local health economy to support the delivery of high-quality sustainable healthcare locally.

'We look forward to progressing these areas of work and realising the improvements for our patients.'

Last month health secretary Andrew Lansley revealed he expected all CCGs to be authorised by next April.

More online

View our map of the CCGs applying in the first wave

pulsetoday.co.uk/commissioning

NHS COMMISSIONING BOARD

QIPP lead quits with warning to board

Sir John Oldham, head of the Department of Health's QIPP programme, has decided not to take up a position at the NHS Commissioning Board and warned of the need for the board to sign up leading GPs to balance its current secondary care 'emphasis'.

Sir John, who this week emerged as a candidate for RCGP president, will step down 'towards the end of the year' from his role as national clinical lead for quality and productivity.

He said he believed his efforts would be better focused on helping GP practices adapt to their role in the new world as providers than in taking up a commissioning position with the board.

He said it would be 'inappropriate' to comment on the likely performance of the NHS Commissioning Board, but urged it to sign up some 'prominent GPs' to balance the large number of hospital specialisms gaining an input.

'Board needs strong, established voices in primary care.' Sir John Oldham

He said: 'It will be important for the NHS Commissioning Board to get input from strong, established voices in primary care to balance the strong emphasis that comes from having such a variety of specialist input, with a background in secondary care.

'I think it's important that the board widens its input from a variety of backgrounds, rather than the triangular hierarchy that has gone on in the past. I'm sure it will do that.'

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.[1] However successive trials of therapy can result in lower remission rates and higher relapse rates (Fig 1).[1]

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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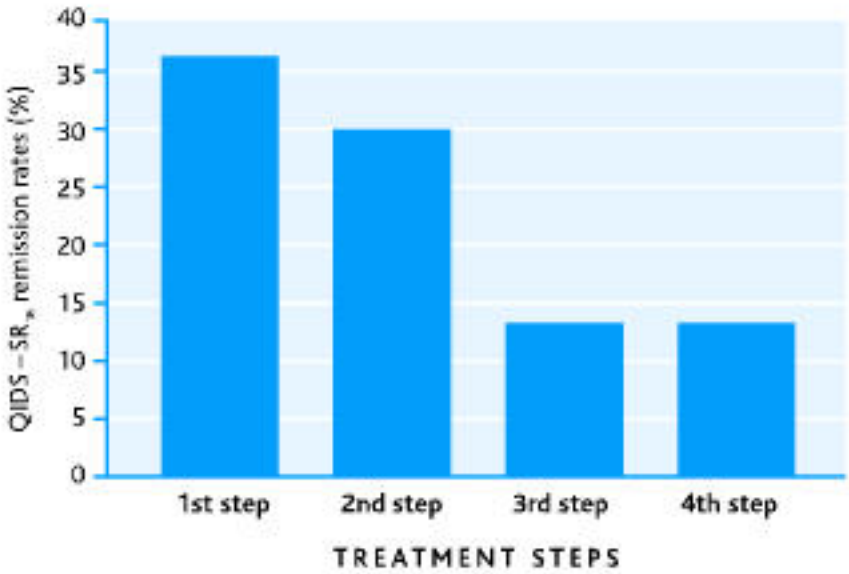

Figure 1. Acute remission rates by treatment step. Adapted from STAR*D, Rush et al.[3]

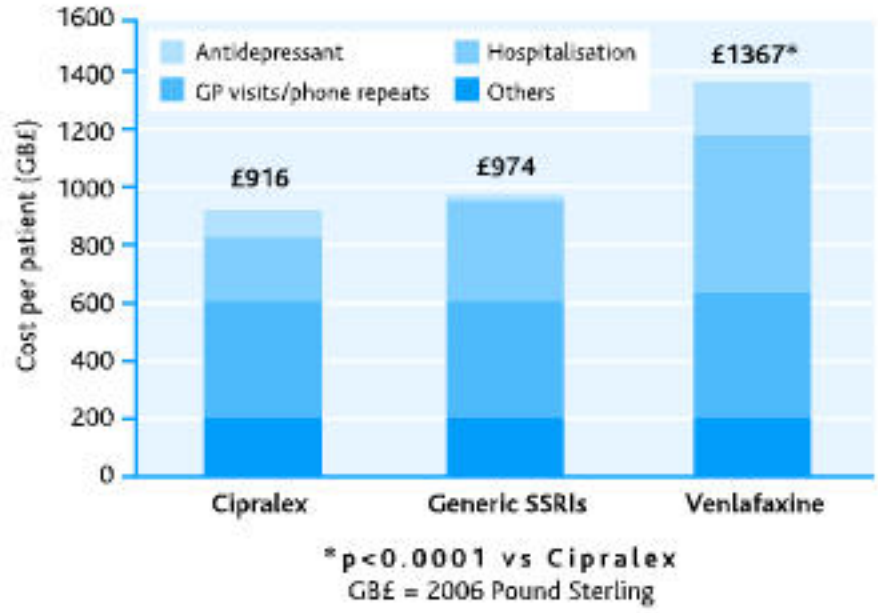

Figure 2. Total cost distribution per treatment group in severe depression for 12-month period following index date of study inclusion. Adapted from Wade et al, 2010[7]

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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-A (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 drugs 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 disorder or taking medicines that will affect clotting of blood or platelet function. Escitalopram has been found to cause dose-dependent prolongation of the QT interval. Caution is advised in patients with coronary heart disease, significant bradycardia, recent myocardial infarction or uncompensated heart failure. Correct electrolyte disturbances such as hypokalaemia or hypomagnesaemia before treatment. Consider ECG review in patients with stable cardiac disease before treatment. Withdraw treatment and perform an ECG if signs of cardiac arrhythmia occur. Do not stop treatment abruptly. Closely supervise patients, especially those at high risk, for suicide-related behaviours during first few weeks of treatment, until improvement occurs. **Drug interactions:** MAOIs, MAO-A and MAO-B inhibitors. Potential interaction with serotonergic medicines (e.g. triptans), lithium, tryptophan, St John's wort, products which may lower the seizure threshold, omeprazole, esomeprazole, lansoprazole, flavoxamine, bupropione and cimetidine. Caution in poor metabolisers of CYP2C19. Use caution with drugs metabolised by the enzymes CYP2D6 or CYP2C19. Co-administration with medicinal products that prolong the QT interval, such as Class IA and III antiarrhythmics, antipsychotics (e.g. phenothiazine derivatives, pimozide, haloperidol), tricyclic antidepressants, certain antimicrobial agents (e.g. sparfloxacin, moxifloxacin, erythromycin IV, pentamidine, anti-malarial treatment particularly halofantrine), certain antihistamines (astemizole, mizolastine) etc. is contraindicated. **Adverse events:** Adverse reactions are most frequent during the first or second week of treatment and include nausea, decreased or increased appetite, increased weight, anxiety, restlessness, abnormal dreams, decreased libido, anorgasmia in females, insomnia, somnolence, dizziness, paraesthesia, tremor, sinusitis, yawning, diarrhoea, constipation, vomiting, dry mouth, increased sweating, arthralgia, myalgia, ejaculation disorder, impotence, fatigue and pyrexia. Thrombocytopenia, anaphylactic reaction, hyponatraemia, anorexia, serotonin syndrome, convulsions, psychomotor restlessness/akathisia, mania, suicidal ideation, suicidal behaviour, QT prolongation, ventricular arrhythmia including torsade de pointes, gastrointestinal haemorrhages, hepatitis and angioedema have also been reported. Abrupt cessation may produce discontinuation symptoms. Studies in patients ≥50 years of age, show an increased risk of bone fractures in patients receiving SSRIs and TCAs. ECG monitoring is advisable in overdose. Prescribers should consult the full Summary of Product Characteristics in relation to other side effects. **Legal category:** POM. Cipralex Tablets 5 mg (PL 13761/0006) 28 tablets £8.97; 10 mg (PL 13761/0009) 28 tablets £14.91; 20 mg (PL 13761/0011) 28 tablets £25.20. Cipralex 20 mg/ml oral drops (PL 13761/0028) 1 bottle x 15ml £20.16. **Further information available from:** Lundbeck Limited, Lundbeck House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LG. ® Cipralex is a Registered Trade Mark. © 2012 Lundbeck Limited. **Date of last revision of PI:** February 2012.

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Medical Information, on: 01908 638872.

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

Practices can set GP retirement age

Court rules retirement age can be written into partnership contracts

By Alisdair Stirling

GP practices will be able to enforce a mandatory retirement age for partners following a landmark legal ruling on age discrimination - but lawyers are warning they will need strong justification for nominating a specific age.

The Supreme Court has ruled that a mandatory retirement age in partnership agreements is 'capable of justification' because it is founded on principles of 'dignity' and the need to avoid 'performance managing a partner out'.

The decision was reached at the end of last month in *Seldon vs Clarkson Wright and Jakes*, a case in which Leslie Seldon, a solicitor, was forced against his will to retire at the age of 65 as provided for in his partnership agreement.

The case is now returning to an employment tribunal to consider whether the firm's selection of the age of 65 was justifiable.

The ruling could potentially affect a large number of practices where GPs continue to work after 65. Figures from the NHS Information Centre show there are currently 955 GPs aged between 65 and 69 and 406 GPs over 70.

David Walker, employment law partner in law firm Dundas & Wilson, said: 'Any medical practice should be dusting down its partnership agreement to see if this and other related issues need to be reviewed. This is a growing issue.'

Michael Rourke, an associate at Lockharts solicitors, told Pulse it was 'only a matter of time' before the stipulation of a specific age for mandatory retirement from a GP partnership was tested in law.

'Many GP practices would want to do this but it's not yet tested in law,' he said. 'If they want to do it they'll have to have expert advice and think very carefully about specifying an age.'

Dr Peter Holden, GPC negotiator, said many practices had introduced stipulated retirement ages into their partnership agreements in the 1980s and 1990s: 'The real problem now is going to be what happens in practices that have a mandatory age of 65, to GPs who have to wait until 68 to draw their pensions. What happens to those guys?

'The next ruling on the specific age is going to be crucial.'

Dr Peter Swinyard, chair of the Family Doctor Association, said: 'Some GPs over 65 are a pain in the arse and it might be quite good for their practice to have a nice way of getting rid of them. But sometimes the eldest doctor is much valued for their knowledge of patients and their organisational memory is something to be cherished.'

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Dr Peter Swinyard: sometimes elderly GPs are much valued for their organisational memory

Can partners be forced to retire?

A partnership with a mandatory retirement age would, if a forced retirement was challenged, have to justify:

- **that the imposition of a mandatory retirement age was to avoid the need to 'performance manage' a partner out of the partnership, [and defend] any challenge on the basis that less discriminatory measures would have achieved this aim**
- **that the age chosen is both appropriate and (reasonably) necessary to achieving those aims.**

Source: Lockharts solicitors

Actimel is a probiotic drinking yogurt containing the probiotic strain *Lactobacillus casei* DN-114 001. Actimel has been researched for more than 15 years with **28 publications of clinical studies.** It has been shown to reduce the incidence[1,2] and duration or severity[3-5] of acute and infectious diarrhoea and to significantly reduce the incidence of AAD and CDAD in a clinical study in older hospitalised patients (over 50 years old) during a course of antibiotics and for one week after.[6] **WGO practice guidelines** report, "One study indicated that ***L. casei* DN-114 001** is effective in hospitalized adult patients for preventing antibiotic-associated diarrhea and C. difficile diarrhea"[13] and in the "prevention of acute diarrhea" there is "suggestive evidence that... ***L. casei* DN-114 001**... [is] effective in some specific settings".[13] A number of UK hospitals have integrated Actimel into their C. difficile management plans.

Activia is a probiotic yogurt containing the probiotic strain *Bifidobacterium lactis* DN-173 010. Activia has been researched for more than 15 years with **17 publications of clinical studies.** Studies have shown Activia can help reduce IBS-related bloating† and distension.[8] **NICE guidelines** state, "There is fair evidence to show that some probiotics [single or combination] give a significantly greater improvement in global symptoms of IBS than placebo"[14] and **Map of Medicine** states, "Some specific strains, such as ***Bifidobacterium lactis* DN-173 010** ... have clinical trial evidence of efficacy for bloating [and] distension".[15]

* Based on studies using two bottles/pots consumed daily

† Abdominal bloating and distension are part of digestive discomfort.

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GPs must stand united over pensions

Say No to 30%

General practice has always been at its most vulnerable when it has lacked unity.

The GPC's response to the NHS reforms was compromised by division, PCTs have played on tensions within the profession to launch a wave of PMS reviews, and there is still no resolution to the MPIG fiasco because of different views among practices in deprived and more affluent areas. So it is worrying to learn that the profession's response to the Government's pension changes is beginning to splinter – and particularly that it is doing so along age lines.

There have been tensions between older GPs and their younger colleagues ever since the 2004 contract handed practices an active financial incentive to recruit salaried GPs rather than take on partners.

Ministers are very clever when it comes to divide and and rule

A number of leading GPs, including GPC chair Dr Laurence Buckman, have warned those divisions threatened to weaken the profession. There are now signs the prophecies of doom are becoming reality, as the generations begin to drift apart in their views on the BMA's planned ballot on pensions action.

The arguments on both sides are wholly reasonable. Younger GPs are furious they face having to pay as much as £200,000 extra over their lifetime in pension contributions – and given many are in salaried positions rather than partners, they see little drawback in taking a militant stand against the Government.

Richard Hoey
Editor

Older partners are no less outraged at the Government's pension plans, but they are more cautious, bruised from previous occasions where the profession incurred the wrath of the national media, and nervous that boycotting routine care will do nothing except load practices with a nightmarish backlog of workload.

And while many older GPs are speaking out on behalf of their younger colleagues, those within 10 years of retirement are spared the worst of the changes, so don't have quite the same personal motivation to take action. The Government is very clever when it comes to the game of divide and rule.

So what should be the way forward, as LMCs report increasing nervousness at the prospect of a vote for industrial action?

Pulse's *Say No to 30%* campaign has called for GPs to vote Yes in the ballot – to provide the BMA with ammunition for its negotiations with ministers – but we also warned the planned protest would leave GPs 'exposed to the full fury of the press', and that future action should focus on non-clinical work. The BMA must reassure GPs who fear a day's boycott of routine appointments will bring unpopularity but no benefits that it will be backed by future action targeted at the bureaucracy of healthcare. LMCs, too, have a responsibility, to support practices in addressing the workload issues and avoiding any possible contractual disputes. They can play a key role in rallying the profession behind a strong vote in support of industrial action – even if some of those GPs who vote Yes choose not to take action themselves.

Only by presenting a united front can the profession win this fight.

Pledge your support

For more information and to sign up, go to pulsetoday.co.uk/saynoto30

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When everything starts to unravel

ILLUSTRATION: DAVID WILLIAMS

Copperfield is dealing with NHS incompetence while locked in an old people's home

As we're all likely to do at some point, I have just mentally unravelled. I don't know how many neuronal threads there are in the GP brain, but the story of how it happened to me has two.

Thread one: the local nursing home calls me to see an old geezer with a cough.

Thread two: for weeks, I've been trying to jump through the right hoops to access help for a 13-year-old school refuser and his increasingly frazzled family. It's unclear whether he's phobic, depressed, suffering family dysfunction or just being a screwed-up adolescent. It's complicated, escalating and the education authorities are putting the frighteners on his parents.

Gawd knows I've tried to sort it, but we really need the child and family to consult with the experts.

Let's see. Child, family, consultation... that would be the Child and Family Consultation Service, right? Yet despite various letters, CAF forms and phone calls, nothing's happening, not even the statutory triage before the pre-assessment before the assessment before the treatment. In evolutionary terms, this kid's management is still in the primordial soup. The parents aren't happy, and nor am I. So I phone the 'service' and leave a curt message asking the Man With No Discernible Child Psychology Plan to phone me back.

So here I am at the nursing home, seeing the old geezer with cough, only to discover that he was sorted out by the community matron yesterday, which they forgot to tell me. Before I can find the right expletive to sum up the situation, my mobile rings.

Before I can find the right expletive, my mobile rings

It's the child psychology gateway person. The conversation is difficult because a) a demented lady in the next room is screaming 'For f**'s sake let me out of here!' every 30 seconds and b) I'm expected to endure from him 20 minutes of obfuscation, evasion, excuses and wiggling.

Thanks to screaming bonkers lady, I'm having trouble hearing what I don't really want to hear anyway. As far as I can tell, the referral stumbling block is that I'm supposed to come up with a diagnosis and specify the treatment needed. In other words, CFCS will only help if I can solve it myself, and if I can't, they won't. Nice.

Weeks of suppressed rage erupt. I hear myself shouting down the phone that he's not devising a treatment 'pathway' but an obstacle course, that his team needs to get off its big fat stupid multidisciplinary arse and do something and that, if I don't see some action, I'll personally send my dog round to gnaw off one of his testicles. Ridiculous. I don't even have a dog.

I look up slightly shell-shocked and realise that the carer who guided me to coughing old geezer's room has long gone.

The doors partitioning the corridor are locked and I don't know the combination. I'm trapped, incarcerated in an old people's home.

I swear and then I hammer on the door, shouting: 'For f**'s sake let me out of here!'

Bonkers woman peers at me. And I realise, with a chill, that some years ago she could well have been a GP asked to visit an old geezer with a cough.

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OPINION
BILL BEEBY

GMC must defend off-label scripts

GP prescribing should be determined by evidence, not commercial interests, writes **Dr Bill Beeby**

In 2010, the GMC started a process to review its guidance document *Good practice in prescribing and managing medicines and devices*.

There was a recognition that GP behaviour and prescribing practice on unlicensed or off-label drugs was putting them in conflict with GMC guidance.

A consultation draft therefore included advice that 'unlicensed or off-label medicines could be prescribed where, on the basis of authoritative clinical guidelines, a doctor judged that the medicine was as safe and as effective as an appropriately licensed medicine'.

Prescribers are faced with over 200 off-label recommendations in the BNF – and even clear and explicit guidance from NICE suggesting we use products outside of their licensed indications.

The proposed changes to the GMC *Good practice* document were well received by 70% of respondents, reflecting that in many cases we were using older medicines in off-label situations to avoid prescribing a high-cost, licensed product.

Established clinical practice left us comfortable with using amitriptyline as our first line as an adjunct to managing chronic pain before turning to the newer and far more expensive drugs with the right approvals.

So it is with disappointment that many of us will read the GMC's new conclusions, reported in Pulse last month.

Its attention has been drawn to the EC directives on medicinal products for human use, and the advice it has received is that unlicensed medicines could only be prescribed where there is a 'special need'.

Such a special need does not include people with a rare disease if there is a licensed alternative.

Nor does the decision of a commissioning body that the licensed medicine cannot be funded constitute a special need.

Cost and affordability of near-identical products is not to be considered, just the licence.

Off-label prescribing is not covered specifically by the EC directive, but the implication and concern is that the same situation will exist here and may prevent off-label use when there is a licensed alternative.

The revised GMC guidance will therefore be published with many welcome revisions, such as prohibiting botox prescribing without a face-to-face consultation, but will retain the old wording on off-label and unlicensed prescribing – while advice is taken to ensure that the GMC document is legal.

Meanwhile, we are left in a no man's land when following the guidance from NICE or the BNF that puts us in conflict with our registering body.

Not all risks are the same

Many will wonder why I am so unhappy with this. After all, I have consistently warned GPs that prescribing medicines in these off-label and unlicensed situations might expose them to risk as they will not have the fallback of diverting liability to a manufacturer if things go wrong.

But we must consider that not all risks are the same, and many of these situations are supported by a considerable body of opinion that such use is safe and effective, as well as financially astute.

Recent news reports show that this has already started to move from the theoretical to the courts. Novartis has started legal action to prevent advice being issued that authorises the use of one product over another in exactly the situations described above.

Strangely, the company markets both of the drugs involved – bevacizumab (Avastin) and ranibizumab (Lucentis) – each derived from a common origin and developed to block vascular endothelial growth factor.

They differ in cost, and that one has been marketed with a licence for cancer and the other for the condition in question, age-related macular degeneration.

The outcome of this legal action, and of the GMC's legal opinions, will have effects far beyond the narrow circumstances of this specific case.

Decisions taken by pharmaceutical companies will determine the use of medicines by all prescribers, whether in primary or secondary care. Research and learned experience in the way medicines are used to the benefit of patients under our care will count for nothing.

Peer-reviewed papers supporting innovative uses for existing medicines could be worthless unless a manufacturer chooses to apply for their inclusion in a product licence, which they may not care to do if there is a competing licensed product already available. That would be a commercial decision – not a scientific one.

It will be a sad day for medicine if commerce – not science – ultimately determines our use of medicines, and if the GMC says that allowing men of science to apply their knowledge to the benefit of patients contravenes good practice.

Dr Bill Beeby is chair of the GPC's clinical and prescribing subcommittee and a GP in Middlesbrough

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Women in puerperium can experience prolonged and heavy bleeding, therefore caution is required, and women should be advised accordingly. If the puerperal woman will breast-feed, the initial injection should be no sooner than 6 weeks post partum. *Further doses:* These should be given at 12 week intervals, however as long as the injection is given no later than 5 days after the 12 week interval, no additional contraception measures are required. For partners of men undergoing vasectomy, a second injection 12 weeks after the first may be necessary in a small proportion of patients where the partner's sperm count has not fallen to zero. If the dose repeat interval is greater than 89 days (12 weeks and 5 days) for any reason, then pregnancy should be excluded before the next injection is given and the patient should use additional contraceptive measures (e.g. barrier) for fourteen days after this subsequent injection. Elderly: Not appropriate. Children: Depo-Provera is not indicated before menarche. Data in adolescent females (12-18 years) is available. *Refer to the Summary of Product Characteristics* for further information. Other than concerns about loss of BMD, the safety and effectiveness of Depo-Provera is expected to be the same for adolescents after menarche and adult females. Depo-Provera may be poorly metabolised in patients with severe liver insufficiency. No dosage adjustment is required for renal insufficiency. **Administration:** By deep intramuscular injection. The sterile aqueous suspension should be vigorously shaken just before use to ensure the dose being given represents a uniform suspension. **Contraindications:** Known sensitivity to medroxyprogesterone acetate or any of its ingredients. Pregnancy. Known or suspected hormone-dependent malignancy of breast or genital organs. Patients with presence or a history of severe hepatic liver disease where liver function has not returned to normal. 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1. Trussell J. Common table of contraceptive efficacy. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Stewart FH, Kowal D (eds). Contraceptive Technology (19th edition). New York: NY Ardent Media, 2007.

UK/DPR/11/0001a. Date of preparation: January 2012

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As GP trainers, we can't make up for undergraduate failings

LETTER OF THE WEEK

From Dr Sheelin Newton and local GP trainers
Ellesmere, Shropshire

As a trainers group that meets regularly to discuss issues with GP training in Shropshire, we have spent much time recently discussing the suitability of trainees entering vocational training.

First, we have had some concerns over the standard of undergraduate teaching from certain universities – sometimes even in the EU – where basic examination techniques and medical knowledge have not been thoroughly taught.

Can we as GP trainers really be expected to cover the whole MRCGP curriculum, language and communication issues as well as teaching all basic examination skills and medical knowledge in the two to three hours' teaching time we have each week?

These problems might be avoided by a more detailed look at the candidate's undergraduate experience before allowing them to start vocational training. Perhaps for those deemed to have potential, a preparatory clinical period could be arranged before joining the usual three-year scheme.

Second, we have found some trainees do not possess the necessary communication and interpersonal skills to pass the clinical skills assessment part of the nMRCGP. Statistically, it has been shown that certain groups of doctors are more likely than others to repeatedly fail the CSA – as we have witnessed locally.

A trainee who has grown up in the UK must be at an advantage in understanding and using not only the words of the English language, but also the colloquialisms and nuances of speech, as well as appreciating broader cultural aspects.

We understand that the UK does rely heavily on filling posts with doctors from overseas. But if the UK continues to award training places to doctors who may later struggle – despite their best efforts – we feel it would only be fair to offer increased support with language and communication skills when they are accepted by the NHS, or at the latest when they start their specialist training.

However, some of us doubt if this can easily be taught. We wonder if the situation is similar throughout the rest of the country.

The selection process already seems to have altered locally, as the West Midlands Deanery did not fill all its vacancies on the GP training scheme in 2011 in order to avoid taking doctors who were unlikely to succeed.

We would invite further discussion regarding these issues, as we feel at present some trainees may have been treated unfairly.

The consequences for them as individuals will be life-long, as they will be unable to work in general practice or retrain for any other specialty.

Would improved undergraduate teaching help ease GP trainers' workload?

Extended hours cuts pointless

From Dr Malcolm Freeth
Eastbourne, East Sussex

The suggestion that LES payments should be cut if attendance at GP extended hours surgeries fails to reach a certain threshold is as useless as it is stupid ('GPs face pay cut as patients shun extended hours', pulsetoday.co.uk/news).

It will only antagonise GPs more. The initial suggestion for out-of-hours surgeries was at the behest of a government that felt there was a political point to be made to win votes.

Those practices that tried and managed to open extra surgeries – even after identifying minimal demand – are now to be chastised by financial loss.

Enough is enough – there has to be a reason to go to the barricades and perhaps the GPC will take notice of this.

● From Dr Alison Davies
St Albans
via pulsetoday.co.uk

The money assigned to extended hours was taken from other parts of the contract in the first place, to be earned back by working early, late and at weekends.

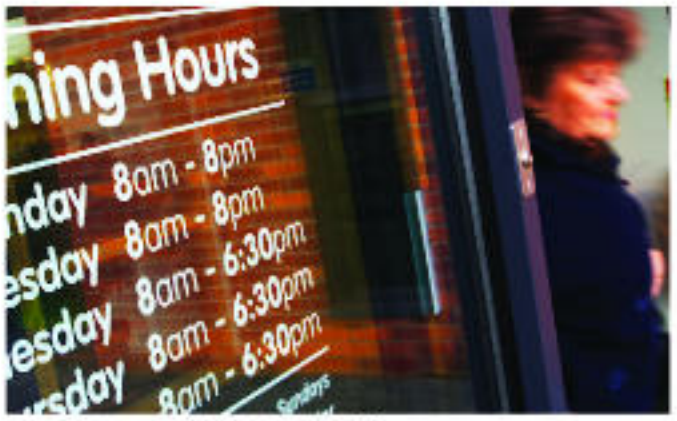
If the extended-hours surgeries are not being filled through patient choice, this money should go back where it belongs – in the global sum.

● From Dr Simon Ruffle
Twyford, Berkshire
via pulsetoday.co.uk

I'm afraid this is the bean counters doing their job, and very well too.

Until there is truly a combination of medics and finance specialists working together and with the same responsibilities for the budget, it will always be them and us.

Make partners of the financiers and let them be exposed to the reductions that I am facing.



Some PCTs are rewriting extended-hours LES contracts

Is prescribing now lost in translation?

From Dr David Church
Machynlleth, Wales

I think there is some confusion regarding 'off-label' prescribing and 'off-licence' dispensing ('GPs face clampdown on off-label prescribing after pharma company challenge', pulsetoday.co.uk/news).

Doctors can prescribe whatever they feel is necessary for the patient, especially if they do so generically, because that does not necessarily identify an actual product with or without a licence. For free supply in the NHS, we are more restricted, since we can essentially only pick what will be available for supply from the pharmacist – which the pharmacist decides, but they only get reimbursed what the NHS will allow.

Quite often a proprietary product used to exist, but the manufacturer who held the licence stopped producing it for financial reasons. This does not stop us 'prescribing' it if an alternative 'unlicensed' product is available – possibly as a licensed dietary supplement or over-the-counter treatment – but it may prevent us giving NHS prescriptions for it.

We need to clarify the difference between a doctor's prescription and an FP10 NHS medicines reimbursement claim form, which is a financial authorisation for reimbursement of the supplying dispenser, not an actual prescription. Look at 'pre-scription' – it must be written before the drug is administered or supplied. Does that always happen in respect of an FP10?

Someone needs to look at the translation of European directives and how other countries apply and interpret them, and whether this misinterpretation is causing threats to national sovereignty and patient autonomy – which are enshrined in European directives on human rights that the EU cannot countermand through a drug supply review.

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GPs must give CCGs a chance

From Dr Richard Deacon
Haslingden, East Lancashire

CCGs are getting a bad press without anyone giving them a chance ('CCGs lobby for tougher performance management of GPs', pulsetoday.co.uk/news).

Perhaps this is what's wrong with the NHS system.

All those who believe the system we work in is perfect, say so now! I'm hearing complete silence.

Shame on those who are so destructive so early on in the process - and shame on those who remain clinician-centric.

● From Dr Peter Patel
Chief executive, South Birmingham Independent Commissioners
Executive member of the NAPC
via pulsetoday.co.uk

Responsibility for GPs' performance management is with the PCT clusters, and will eventually be transferred to the NHS Commissioning Board who will be responsible for these contracts.

CCGs are responsible for the clinical commissioning performance of their groups and the membership.

There is a grey area for GPs who purchase commissioned services from various providers through referrals or prescribing, or who reduce A&E attendances and non-elective admissions by improving access to practices.

Since CCGs do not directly control GP contracts, the key challenge will be how they will be able to address inappropriate clinical behaviour or even prove inappropriate clinical behaviour.

It will be even more difficult for CCGs to take GPs to task on clinical behaviour in relation to their GMS/PMS contracts for delivering contracted primary care services. Litigation, disputes resolution, conflict of interest, data control and patient confidentiality will be some of the issues which will need to be addressed.

● From Dr Kosta Mahis
Bexley, Kent
via pulsetoday.co.uk

Quis custodiet ipsos custodes? As Juvenal put it so nicely. Who will guard the guards? In the Animal Farm of clinical commissioning, we are all equal - though 10% of us are more equal than the other 90%...

Telehealth's worth the cost of the kit

From Dave Tyas
Telehealth and service improvement manager, Peninsula Community Health, Bodmin, Cornwall

There has been a lot of speculation and comment about the QALY calculations presented as part of the King's Fund International Telehealth and Telecare Congress earlier this month, all of which is really missing the point ('"Telehealth unlikely to be cost effective," admit researchers leading DH pilot,' pulsetoday.co.uk/news).

The figures quoted show that the high cost of the equipment used in the Whole Systems Demonstrator project affects the QALY results - so by the same token, if the price point for the equipment is reduced, then the cost per QALY will be significantly lower.

We must remember that this was a trial with cost-based data that is now three years out of date. Industry has moved on and so has the technology.

In my experience, just bringing the cost down is not enough - we need to look at different ways of doing business with our colleagues in industry.

You would question buying a smartphone for a few hundred pounds when you could get one on contract with regular upgrades for a monthly fee. The same could be said for telehealth.

The real point we should take from the WSD programme is the potential that telehealth gives us for reduced hospital admissions and reductions in mortality.

Translate that into reality with a significant reduction in the cost of the technology, changes to the means of payment and overall integration of the technology into services, and we address concerns over cost-effectiveness.

EMIS practices should give access a go

From Dr Brian Fisher
Lewisham, south London
via pulsetoday.co.uk

It's clear why, among other good reasons, patients should have access to their records ('Patients should be able to add to and correct their own records, Field says', pulsetoday.co.uk/news).

They should be able to add comments or change demographic details, 30% of which are incorrect in GP records.

It should also be possible for patients to complete a template or questionnaire before attending, for instance, an asthma or an epilepsy review. There should be an option for a truly co-written care plan.

However, people should not be able to cut out any data. There remains a debate about whether a patient should be able to show different parts of their record to different people.

Record access is available to all EMIS practices. Try it. It is safe and makes a reality of self-care and shared decision making.

Did script errors harm patients?

From Dr Richard Mitchell
Brighton
via pulsetoday.co.uk

Following figures in your recent story on prescribing errors, according to my fag-packet calculations just 0.19% of all prescribing was judged to result in a 'severe' error ('GMC study finds errors in one in 20 GP prescriptions', pulsetoday.co.uk/news).

The relevant question is what percentage of these 0.19% actually resulted in patient harm? Otherwise, this is a spelling-contest assessment published in order to lower the public trust in doctors as a justification for further monitoring, testing and education.

Prescribing errors can be cut using IT

From Dr Shaun O'Hanlon
Clinical and development director, EMIS

The GMC study on prescribing errors reveals just how complex prescribing decisions are. As a former GP, I know all too well that there are times when we need to balance one risk against another - this is often not evident when reviewing the prescription in isolation.

It is worth noting, however, that the smart software called for by the GMC is already being implemented - and an increasing number of GPs and pharmacists have sophisticated tools to make prescribing safer.

Integrated record systems include advanced decision support for prescribing, which flags up key drug safety alerts that make GPs stop and think and even justify their decision, circumventing 'alert fatigue'.

These systems also allow GPs to monitor and manage patients on drugs with a low therapeutic index, such as warfarin, more safely.

GPs and community pharmacies are already collaborating when making complex prescribing decisions and are realising the benefits in terms of patient safety, compliance and improved care.

Can technology help cut prescribing errors?

Changes to NCAS will not be for worst

From Lynn Hugo
Interim Director, National Clinical Assessment Service (NCAS)

Thank you for your article about NCAS's move from being centrally funded to becoming self-funded ('NCAS self-funding plans could compromise mediation standards, LMCs warn', pulsetoday.co.uk/news).

Our move to self-funding was determined by *Liberating the NHS: report of the arms-length bodies review*, published in July 2010.

It was made clear to us when the report was published and subsequently by the Department of Health and our stakeholders - including LMC colleagues - that NCAS's core services must remain accessible.

In developing our future funding model, we will ensure that the model does not in any way inhibit referrals.

At present, members of the medical profession do not pay for NCAS - in cases of remediation, they may contribute to the costs of it along with their contracting or employing trusts.

There are no plans in place to change this position in the move to self-funding.

NCAS will be hosted by NICE for a year and will remain a 'freestanding' body, as described in your article.

Our future model work is being taken forward with the Department of Health and is unrelated to the hosting arrangement with NICE. We will continue to provide our core services during this year.

As part of our ongoing work to improve our services, we will be embarking on a programme of stakeholder engagement and will continue to ensure the involvement of LMC colleagues.

For the record

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Date of preparation: April 12

Pulse Clinical

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Pectus excavatum
This photo was a gold winner in the 2012 Institute of Medical Illustrators awards

Resource of the week A factsheet on the Mini Mental State Exam from the Alzheimer's Society

Respiratory GPSI Dr John Stevenson answers Dr Mandy Fry's questions on montelukast, mould, allergy testing and non-drug options

In severe allergic rhinitis without asthma, montelukast off-label may be useful

KEY QUESTIONS

Allergic rhinitis

1 Some patients believe their nasal symptoms get much worse in the winter due to damp and mould in their house – usually a council house. Is this likely to be the case? What treatments are likely to be most effective – apart from sorting out the mould?

Yes, it's possible that damp could exacerbate symptoms, but it's important to tease out the various effects when answering this question.

First, there is some limited evidence that living in a damp environment itself increases your risk of developing allergic rhinitis, but the association is weak.[1]

Second, several fungal species – most of them moulds – can cause allergic disease. Some, such as cladosporium and alternaria, are common in outdoor environments and tend not to vary widely from season to season – in fact, they are slightly less of a problem in the winter. But other fungi readily invade indoor environments, thrive in damp conditions and can cause allergic disease. Penicillium and aspergillus species are commonly found in enclosed spaces, followed by rhizopus and mucor species.

The *Pollution and the young* study included more than 58,000 six- to 12-year-olds in Russia, North America and Western Europe. A positive association between exposure to mould and children's respiratory and allergy symptoms – including rhinitis – has been consistently noted across studies.[2]

Dirty upholstery and kitchen bins are all good sites for indoor fungal growth, as are cellars, window casings, shower curtains and plumbing fixtures. And the damp, warm, enclosed conditions of poor housing in the winter promote growth. So it's perfectly possible rhinitis symptoms may become worse and there is evidence mould allergy may be most prevalent in winter because of the airtight insulation used in homes built recently. A history of prolonged cold symptoms that last for more than two weeks in winter may indicate mould allergy.

There doesn't appear to be any evidence to back treating rhinitis caused by mould allergy differently to any other type of allergic rhinitis. Allergen avoidance should help – although little high-quality research has been done on this area.[3] It might be helpful to send the patient for allergy testing as proof they are allergic to mould, as this would strengthen the case for the landlord or local council to sort the problem out.

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2 What role do leukotriene receptor antagonists have in the treatment of allergic rhinitis?

Two leukotriene receptor antagonists are licensed for the treatment of asthma in the UK – zafirlukast and montelukast – but only the latter also has a licence for the treatment of seasonal allergic rhinitis and then only in patients who also have asthma.

European and UK allergic rhinitis guidelines – both from 2008 – summarise the benefit as follows: leukotriene receptor antagonists are more effective than placebo for treating allergic rhinitis, equivalent to oral antihistamines and inferior to intranasal steroids.[3,4] And as the UK guidance points out, the response to them seems to vary widely from patient to patient.

Since then, the evidence hasn't moved on much – although there is some welcome new data on how these treatments work in combination. A 2010 study in patients with allergic rhinitis suggested montelukast plus fexofenadine was more effective than the antihistamine alone.[5]

But montelukast is an expensive option compared with intranasal steroids and antihistamines and should be reserved for those whose symptoms are not controlled with a combination of the latter, and only then – as per the licence – in patients who also have asthma. If a patient is very severely affected with allergic rhinitis in the absence of asthma, it's arguably worth a trial of montelukast off-label.

3 Is there any role for nasal decongestants?

Yes, but a fairly limited one – and it's important to bear in mind their

20

19 potential for abuse. Decongestants are α-1 adrenergic receptor agonists that shrink the oedematous airways' mucosa and so should improve ventilation.[6]

For treatment of nasal obstruction in both allergic and non-allergic rhinitis, intranasal decongestants are effective in the short term – but do not improve nasal itching, sneezing or rhinorrhea.[3] UK guidance from 2008 recommends decongestants only be used, briefly, if patients are still suffering congestion despite using an intranasal steroid and an antihistamine. They should probably not be used for longer than three days and certainly no longer than 10 because of the risk of rebound congestion.

More recently, a 2010 update to the European allergic rhinitis guidance was even more restrictive and recommended decongestants only be used as a rescue mediation and for no longer than five days.[7]

4 How do you prevent patients continually using decongestants over the counter, risking rebound symptoms? How should we manage them if they have rebound symptoms?

Rhinitis medicamentosa – also termed rebound rhinitis or chemical rhinitis – is a condition characterised by nasal congestion without rhinorrhea or sneezing, triggered by the overuse of topical vasoconstrictors sometimes for as little as a week. Patients need to be educated about the risk and offered other methods to control the congestion that originally triggered the decongestant use.

'Cold turkey' is probably the best approach to the problem, but there are a few methods that can ease the withdrawal process if patients are unable or unwilling to stop immediately. Nasal decongestants can be stopped gradually, allowing patients to use sprays at night in one nostril only and alternating the left and right nostril until congestion is decreased – usually within a week or two. Patients can also be offered nasal steroids while being weaned off decongestants, and saline irrigation can help.

5 I have one patient with allergic rhinitis who swears by the effect of Turkish baths on her symptoms. Should we be advocating other patients try a trial of steam inhalation?

Like you, I have patients with allergic rhinitis who swear by steam inhalation and if patients are willing to try it then I don't see why they shouldn't – but stress the effects only last an hour or so. There is only very limited evidence to back its use, but anecdotes suggest it might help. I have a patient who finds it particularly useful when she gets home from work, allowing her to enjoy the rest of the evening.

For patients wanting non-pharmacological options, there is more evidence to back the use of nasal irrigation with saline. A number of small trials suggest it is effective for the treatment of congestion associated with rhinosinusitis and it appears to be safe. It is recommended in US guidelines as an adjunct therapy to flush out mucus and irritants, and improve the flow of air through the nose in patients with allergic rhinitis. It appears to be more effective than steam inhalation.[8]

6 Is it worth trying to establish exactly which allergens are causing a patient's symptoms, or is this of limited clinical value? How would you go about finding out?

Allergy testing can be useful to identify or exclude an allergic trigger, which can help management, and clinical history should identify those who would benefit.[9]

Although antihistamines and nasal steroids will control symptoms in most patients, those with poorly controlled or persistent symptoms may benefit from testing to identify a specific trigger which they might then be able to avoid. Conversely, finding out an allergen trigger is not the cause of a patient's symptoms might prevent unnecessary lifestyle changes.

There is only limited evidence for a benefit in avoiding airborne allergens, but the following aspects of management may be improved by identifying an allergen:

- Avoiding exposure or taking treatment prior to exposure is an option in pet allergy.
- Starting treatment for grass or tree pollen allergy pre-seasonally can result in better symptom control.
- Patients with perennial rhinitis who are sensitised to dust mites might find the use of acaricides useful – perhaps as part of allergen avoidance measures like HEPA filters and allergy control bedding.[10]

In testing, remember that the clinical history is the most important factor and that any test results have to be interpreted in this light. Skin-prick testing is simple and systemic reactions are rare. It has a high negative predictive value – so patients with negative skin-prick tests are highly unlikely to be sensitised to that allergen.

Remember that results can be suppressed by antihistamines, tricyclic antidepressants and topical steroids used at the site of testing (but not oral). Total IgE is not diagnostic, but specific IgE levels can be requested if skin-prick testing is unavailable and correlate fairly well with skin-prick tests.

7 What would be your first-line intranasal steroid choice?

A 2008 review of intranasal steroids found that in adults with seasonal allergic rhinitis, beclomethasone improves symptoms similarly to budesonide, flunisolide, fluticasone, mometasone, and triamcinolone. Prophylaxis with mometasone is superior to beclomethasone in reducing symptoms before and during peak season, but mometasone is associated with higher rates of headaches.[11]

In adults, there appear to be few differences between beclomethasone, budesonide, fluticasone, and mometasone for improving symptoms. In children, beclomethasone, fluticasone, and mometasone similarly improve symptoms of allergic rhinitis. As they appear equally effective, the least expensive product that suits the patient should be prescribed.

Dr John Stevenson is a respiratory GPSI in Manchester and runs a community allergy service

Competing interests None declared

Dr Mandy Fry is a GP in Cirencester and senior lecturer in primary care at Oxford Brookes University

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Go online to read an extended version of this article, with Dr Stevenson answering questions on vasomotor rhinitis and oral steroids

SNAPSHOT DIAGNOSIS

Lesion on the leg

Dr Keith Hopcroft explains how a simple test led him to the correct diagnosis in this patient

The patient

This 35-year-old woman presented in a very anxious state. She had been aware of a small lesion on her leg for a few months. But it hadn't really bothered her, until a work colleague had recently been diagnosed with a melanoma.

The nodule was on her right shin and wasn't painful or itchy. It had appeared spontaneously and there weren't any similar lesions elsewhere. She had an unremarkable past medical history and, in particular, she had not suffered any previous dermatological problems. Her colleague's experience had clearly scared her though – and she was requesting referral for a private dermatological opinion before I'd had a chance to take a proper look at the lesion.

First instinct

Examination revealed a 0.5cm firm, non-tender brownish-red nodule on her shin. The surrounding skin was normal and there was no regional lymphadenopathy.

It was a fairly nondescript lesion and didn't have any alarming features. The temptation in this situation is to simply reassure the patient that this is 'nothing to worry about', even if we can't provide a specific label.

In this case, though, it was clear that the patient was after a dose of certainty. And my best guess was that this was a histiocytoma.

Differential diagnosis

- Histiocytoma
- Malignancy such as melanoma or basal cell carcinoma
- Sebaceous cyst
- Keloid scar.

A patient's anxiety can be infectious and so I illuminated and magnified the lesion and took a long, hard look at it. A sun-exposed site always raises the possibility of malignancy, but there were none of the characteristic features of a melanoma, nor even of the rather less alarming basal cell carcinoma.

The nodular feel in a hairy area raised the possibility of a sebaceous cyst – but it was an atypical position and an odd colour for this diagnosis.

A small keloid scar was another differential, but she couldn't recall any episode of trauma in that area.

So I thought that my gut instinct was likely to be correct – it was the right morphology in the right position to be a harmless histiocytoma.

The hidden clue

I was obviously less convincing than I thought – despite me giving her a specific diagnosis, with an impressive sounding name, she remained anxious and sceptical. It was then that I recalled a trick I'd learned a year or so previously on a dermatology study day.

Histiocytomas are tethered to the underlying fibrous tissue – so squeezing the skin to the sides of the lesions produces a characteristic dimple. I demonstrated this, to my immense satisfaction.

Getting on the right track

I may have felt satisfied by this point, but my patient remained keen on using her private health insurance to have the nodule removed. So I referred her, and was gratified to receive the histology a week or two after an excision biopsy – it was a histiocytoma.

Dr Keith Hopcroft is a GP in Laindon, Essex

Consultant orthopaedic surgeon Mr Mike Hayton continues our series of evidence-based lowdowns on common presentations using PUNs and DENs

Adverse reactions to steroid injections include fat necrosis and changes in skin pigmentation

THE INFORMATION

Tennis elbow

THE PATIENT'S UNMET NEEDS (PUNS)

A 35-year-old plumber attends with a two-month history of elbow pain, which is now starting to affect his work. He hasn't injured it and he's tried NSAIDs without any benefit.

Examination reveals tenderness over the lateral epicondyle and pain on resisted extension of the wrist. You diagnose tennis elbow and start to explain the condition to him, but he interrupts by saying that he just wants some treatment to get him back to work as soon as possible.

THE DOCTOR'S EDUCATIONAL NEEDS (DENS)

What is the natural history of tennis elbow? Does a period of rest speed up recovery?

Tennis elbow is very common, with a general population prevalence of about 2%. The usual age range in presentation is between 35 and 55 years, and it affects men and women equally. The cause of the pain is uncertain and likely to be multifactorial. Despite the term epicondylitis, there is no histological evidence of inflammation at biopsy.

Most cases of tennis elbow resolve with time, and in approximately 80% of cases symptoms will have significantly improved after one year. But patients do often want a quick fix rather than waiting for the natural history to provide relief. Avoiding the provoking activity does help recovery – but, of course, may not be possible.

Do occupational factors often play a part? Is there any simple advice we can give which might enable someone to continue at work in this situation?

Activities that cause excessive overload of the common wrist and finger extensors may cause tennis elbow, particularly if these activities are repetitive – manual workers are often affected. Patients can be advised that simple analgesia may help, and to avoid the provoking activity where possible. The use of forearm clasps and braces may give temporary benefit by off-loading the lateral epicondyle, and this can enable the patient to return to work.

What are the relative merits of strapping or braces, physiotherapy and anti-inflammatory drugs?

Forearm braces that act as counter-force devices aim to reduce the extensor muscle pull on the lateral epicondyle. But studies have failed to show any benefit for these over physiotherapy or a brace combined with physiotherapy.[1] Physiotherapy has been shown to give benefit over no treatment in the first six weeks, and over steroid injection after six weeks.[2] NSAIDs are useful as analgesia, but because tennis elbow doesn't involve inflammation their anti-inflammatory properties aren't useful.

A Cochrane database systematic review in 2005 gave platinum evidence showing no benefit from the use of shock-wave therapy in tennis elbow.

One of my own publications considered the use of botulinum toxin, the theory being to relax the common extensor muscles while the natural healing process takes place. But we found no benefit in the use of botulinum toxin injection over a placebo injection – patients reported no improvement in elbow pain.[3]

Recently there has been some excitement about platelet-rich plasma injections. The patient's own blood is placed in a centrifuge and spun down, separating the platelet-rich plasma – which is then injected into the tennis elbow area. The growth factors present in platelets are thought to enhance healing.

Recent prospective randomised trials have supported the use of platelet-rich plasma injections.[4] The endpoint for success in this paper was defined as a 25% reduction in visual analogue score for pain or a similar reduction in the Disabilities of the Arm, Shoulder and Hand (DASH) score, but many of my patients just want to be pain free, and this would equate to a visual analogue score closer to zero out of 10.

My opinion is that the beneficial effect of injections may be the actual needle trauma rather than the injected substance.

Tennis elbow is a chronic condition with no active healing. It may be that the body heals this noxious stimulus and secondarily resolves the chronic tennis elbow.

There seems to have been a move away from cortisone injections for this condition in recent years. Why is this? Do they still have a role in some cases?

The use of steroid injections does seem to give temporary benefit. But there has been a slow move away from them because when studied beyond 12 months, patients who received the steroid injection appear to be worse off than patients who received nothing.[2]

Steroid injections still remain the first-line treatment for many clinicians in primary and secondary care. I always warn patients about adverse reactions and – in particular – lipodystrophy, which may manifest as fat necrosis with changes in skin pigmentation.

To minimise this risk you should inject deep to the extensor forearm fascia and use a concentration of no more than 10mg of triamcinolone (or equivalent).

Who should be referred for specialist assessment? What secondary care interventions are effective?

Patients who have failed conservative treatment and want the pain to be eradicated may be considered for surgery after three to six months.

There are many different operations – the most common is release of the common extensor origin from the lateral epicondyle and decortication of the underlying bone. The mechanism by which this works is not known.

The technique I use for classic extra articular tennis elbow is performed under local anaesthetic which is very well tolerated, and without a tourniquet. Around 10% of patients with tennis elbow have coexisting intra-articular pathology, and this explains the occasional tennis elbow release performed arthroscopically.

A Cochrane review in 2002[5] found no definitive conclusion as to the outcome of one surgical technique over another due to a lack of randomised controlled trials comparing techniques.

Key points

Causes

Caused by repetitive excessive load on the wrist and hand extensor muscles

Epidemiology

- Tennis elbow has a prevalence of 2%
- Men and women are equally affected
- Age range between 35 and 55 years

Clinical features

- Very localised pain over the lateral epicodyle of the elbow
- Pain is made worse with resisted wrist extension (Mill's test)

Differential diagnoses

- There are very few differential diagnoses
- Some 10% of cases are associated with intra-articular pathology – such as locking – and radial tunnel syndrome

Treatment

Unfortunately there is no evidence-based guidance on the appropriate treatments. But this may be a useful pathway:

- Rest and analgesia
- Physiotherapy
- Steroid injection (low dose to avoid skin bleaching and fat necrosis)
- Consider platelet-rich plasma injections
- Surgery as a last resort

Complications

- Lipodystrophy and skin pigmentation changes with steroid injections
- Steroids may make the situation worse at 12 months

Prognosis

The prognosis for tennis elbow is good – most cases settle within 12 months and the rest usually respond well to treatment

Mr Mike Hayton is a consultant orthopaedic surgeon at Wrightington, Wigan and Leigh NHS Foundation Trust

Go to mikehayton.com for further information on a wide range of hand conditions and videos of several hand operations.

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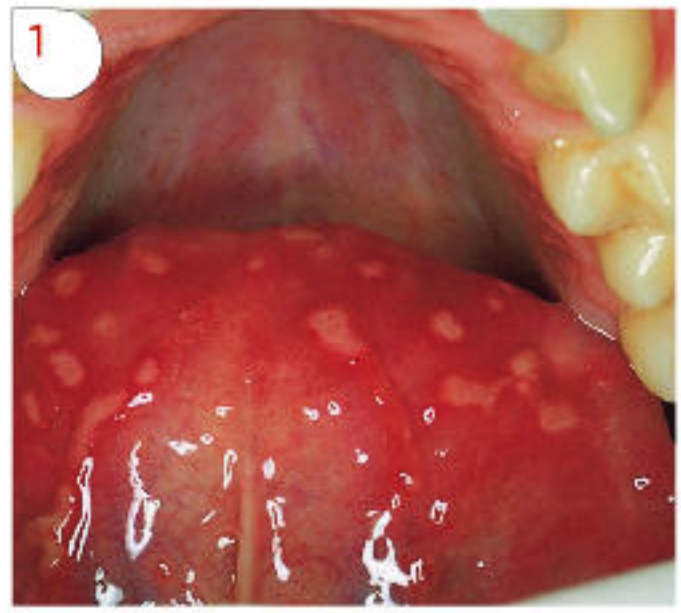
PICTURE QUIZ

Oral blisters

These five patients presented with oral lesions – can you work out the diagnosis in each case? Answers are at the bottom of the page



This three-year-old child has been refusing to eat or drink for the last couple of days and is miserable. On examination, he has cervical lymphadenopathy and a high fever.

This 75-year-old woman is complaining of severe pain on one side of her hard palate which has been present for about a week. There are also some vesicles on her ipsilateral ear.

The main symptom in this six-year-old child is painful spots on his palms. He has also had a low-grade fever for a few days. Examination reveals these blisters on the inner aspect of his lower lip.

A week prior to presentation, this man suffered a cold sore in the angle of his mouth. As this was healing, he developed the abrupt onset of a florid rash affecting his hands and arms, and his lips started to blister and crust.

This four-year-old child has been complaining of earache for a few days and has been having trouble swallowing. Examination shows blisters on the posterior pharynx and palate, although his ear looks normal.

ANSWERS

1 Primary herpetic gingivostomatitis

Primary herpetic gingivostomatitis is the most frequent viral infection of the mouth and spreads easily through saliva. The herpes simplex virus (HSV) initially infects the non-keratinised epithelial cells of the oral mucosa to produce intra-oral blisters. Primary infection often goes unnoticed or is dismissed as an episode of teething during childhood.

The condition is associated with pyrexia, headache and cervical lymphadenopathy. Patients, and in the case of children usually their parents, should be reassured about the basis of the condition and advised of the infectious nature of the lesions. Symptomatic therapy should include a chlorhexidine mouthwash, analgesic therapy, soft diet and adequate fluid intake.

2 Shingles of the hard palate

The reactivation of varicella zoster virus in herpes zoster produces severe pain that is followed within 24 hours by the appearance of vesiculobullous lesions.

The trigeminal nerve is affected in about 15% of cases of zoster. The vesicular eruption is characteristically unilateral and limited to the mucosa and skin of one division of the trigeminal nerve. The clinical presentation is usually sufficiently characteristic to enable diagnosis.

Although shingles is self-limiting, antiviral therapy should be considered in cases that present within the first 48 hours of onset of symptoms. Treatment with acyclovir 800mg five times daily for seven to 10 days is the treatment of choice.

3 Hand, foot and mouth disease

The characteristic distribution of lesions involves macular and vesicular eruptions on the hands, feet and mucosa of the pharynx, soft palate, buccal sulcus and tongue. Signs and symptoms usually resolve within seven to 10 days.

It is important to differentiate this condition from primary herpes gingivostomatitis or varicella zoster infection – the relatively mild symptoms, cutaneous distribution and epidemic spread help separate this condition.

The self-limiting nature of the disease and the lack of virus-specific therapy limits treatment to symptomatic measures. A bland mouthwash, such as sodium bicarbonate in warm water or chlorhexidine, alleviates oral discomfort. Analgesics may also be necessary for pain relief.

4 Erythema multiforme

The cause of erythema multiforme is uncertain, but has been associated with certain predisposing factors – including previous infection with HSV or Mycoplasma pneumoniae, certain systemic drugs, pregnancy, inflammatory bowel disease and exposure to sunlight.

The oral-facial lesions of erythema multiforme consist of blood-crusted lips and widespread painful oral ulceration. Skin involvement classically presents as concentric rings of erythema, the so-called 'target lesions'.

The symptoms of erythema multiforme usually resolve spontaneously within 10 to 14 days. There is no specific treatment, but antiseptic mouthwash and – in severe cases – a short course of systemic steroid therapy has been found to be helpful.

5 Herpangina

Herpangina is caused by infection with Coxsackie virus. The condition is usually spread by contaminated saliva. Infection is usually endemic, with outbreaks occurring in summer or early autumn.

Patients complain of malaise, fever, dysphagia and sore throat. A vesicular eruption appears on the soft palate, fauces and tonsils. A diffuse erythematous pharyngitis is also a frequent feature.

The clinical outcome is variable, but resolution can be expected within seven to 10 days, even in the absence of treatment. Treatment involves bed rest and the use of an antiseptic mouthwash. Patients should be encouraged to maintain adequate fluid intake.

These cases are taken from *Oral medicine – a colour handbook* by Michael Lewis and Richard Jordan. ISBN 9781840760330 (Manson Publishing); available from: mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95

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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.

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Selection of sperm before a course of IVF

CLINICAL CASEBOOK

Infertility

Consultant clinical andrologist Dr Iwan Lewis-Jones offers his advice on four primary care case histories

CASE ONE

An overweight 28-year-old woman who has polycystic ovary syndrome (PCOS) attends asking for help with fertility – she has been trying, unsuccessfully, for a pregnancy for 18 months. Her cycle is long and her periods are scanty, which concerns her. She is also worried because she has a past history of genital chlamydia infection.

How likely is it that weight loss alone – if achievable – will significantly improve fertility in a case like this?
It is well recognised that women with PCOS have considerable problems losing weight – the exact reason for this is uncertain, although it may be linked to problems with insulin metabolism. If the patient can achieve weight loss this can significantly improve her chances of conception naturally, although in many cases medical intervention may be necessary to help her to achieve her goal.

What specific treatment might be offered? In particular, what are the relative merits of metformin or clomiphene in PCOS?
Patients with PCOS are usually treated initially with clomiphene if they are not ovulating, which is one of the main problems with PCOS. But if this does not work then the recommended treatment is metformin to increase ovulation.

Neither of these treatments should be initiated in general practice. Clomiphene can cause multiple pregnancies and so follicular scanning to assess the number of oocytes available for treatment is needed. Metformin is also best used in a dedicated fertility unit where side-effects and effectiveness of treatment can be accurately assessed.

If these treatments fail, referral will be made to the assisted conception unit. Here treatment will be modified in relation to the PCOS itself, where ovarian stimulation can prove excessive with the usual stimulation regimes.

How significant is a past history of chlamydia? Should she be retested for this infection?
A past history of chlamydia is very relevant as this can seriously damage the fallopian tubes. Current research demonstrates that sperm populate the isthmus of the fallopian tube, binding to receptor sites on the tubal epithelium. Ovulation causes the sperm to detach from the tubal epithelium, undergo capacitation and enter hyperactivation prior to sperm-oocyte interaction. This is why assessment of tubal patency and anatomy is an important investigation.

In patients with a history of chlamydia, GPs should test for infection. A positive chlamydia culture would require treatment, and evidence of chlamydia antibodies would alert the specialist to possible tubal damage from past infection.

CASE TWO

A 23-year-old man with no relevant past medical history attends for the results of his male fertility test. Neither he nor his partner – who is registered with another practice and is undergoing assessment there – has had any children, and they've been trying for 18 months. His male fertility test reveals 4% normal morphology, poor motility and a sperm density of 18 million per ml.

In a suboptimal sperm test, how likely is it that a repeat test will show an improvement, and how soon after the original test should the repeat be taken?
It would be useful to do a second sperm sample around four days after the first, although this is a personal recommendation and the World Health Organisation guidelines on male fertility investigations recommend that a further sample is examined 12 weeks after the original – which is a full spermatogenic cycle. This would give a clear indication as to whether the semen is normal or not.[1]

How important are all of the various parameters measured in these tests? How useful are the results in predicting fertility?
All parameters examined in a semen analysis are important – but unfortunately they don't give a clear indication of whether the man has a fertility problem, as a normal semen analysis does not necessarily mean he is fertile. However, abnormal parameters in the semen analysis are an indication to refer the patient to a specialist in male fertility problems.[2]

What general advice and specific treatments are available to men in these situations? Are they best referred to a urologist, or – together with their partner – to the local infertility service?
Research has demonstrated that lifestyle and environmental factors may cause problems with male fertility, and initial treatment with antioxidants can prove effective. The most potent antioxidants which are also cost-effective are vitamin C 1,000mg with zinc and vitamin E.

The best approach in a patient with an abnormal semen analysis is to refer them to a specialist in male infertility – either a clinical andrologist or a urologist who may specialise in it. The specialist will be able to assess whether the patient has a problem that is treatable or whether they would be better referred to an assisted conception unit.[4]

CASE THREE

A couple in their early 20s attend seeking help for their primary infertility of two years' duration. The male partner has already had a male fertility test which was satisfactory. His wife asks about the value of over-the-counter home ovulation test kits and wants to know what further tests should be considered.

What is the value of ovulation prediction kits? Should they be encouraged?
One of the most important factors in achieving a natural pregnancy is to have intercourse at the correct time of the month – when ovulation is occurring.

The timing of ovulation has been extensively researched and the only method of accurately pinpointing it is with the luteinising hormone (LH) surge, which is the basis of ovulation prediction kits. There are many types of ovulation predictor kits manufactured by different companies, and if patients want further specific information they can speak to their specialist.[5]

Other methods of ovulation prediction – such as temperature changes, ovulation pains and cervical mucus quality – are not advised as they may well indicate that ovulation has occurred but don't give advance notice to allow couples to time intercourse.

What tests should the GP perform as a baseline? Many referral protocols now insist that blood should be taken for follicle-stimulating hormone (FSH), LH, TFTs and prolactin prior to referral – is this logical or necessary if the woman has a regular menstrual cycle?
A GP can really help the investigation of the infertile couple by performing baseline investigations on the woman as well as the man. The woman should have baseline hormones – FSH, LH, estradiol and prolactin – tested on day two, three or four of her menstrual cycle, with day one being the first day of proper menstrual flow.

She should also have a rubella test and then a day 21 progesterone level. Normal hormone levels will indicate to the specialist whether the patient has a problem with ovarian reserve irrespective of a regular menstrual cycle.

If the baseline tests are normal and the couple is referred to hospital, what further tests might they anticipate in what order?
At the specialist unit the woman will have an anti-Müllarian hormone test to assess in more detail her ovarian reserve and the quality of her oocytes. She will usually then have a pelvic ultrasound to confirm normal pelvic anatomy before having a test of fallopian tube patency – a hysterosalpingogram or a laparoscopy and dye test.

The man will probably have further semen analyses in the specialist's andrology laboratory, where sperm function will be assessed in detail to determine whether the patient has an andrological problem that can be treated, or whether the couple are better referred to the assisted conception unit. The results of these latter investigations will

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determine which form of assisted conception would be best offered to the patients to give them the best chance of success.

Hormonal investigations will be done, including assessment of FSH, LH, estradiol, prolactin and testosterone. Again, this will indicate whether the man has a hormonal problem that may be treatable – for example, hypogonadotrophic hypogonadism.

If possible, the man will also undergo a scrotal ultrasound to assess scrotal anatomy and determine testicular volume, epididymal anatomy and identify any anatomical abnormalities such as varicocele and hydrocele.

CASE FOUR

A childless couple in their mid-20s have a two-year history of failure to conceive, with entirely normal baseline tests. They are keen to discuss their options and want lifestyle information as a first step – the female partner has concerns about the possible adverse effects of assisted conception.

What lifestyle advice can make a significant difference to fertility?

Couples should be encouraged to pursue a healthy lifestyle – maintain a good diet, reduce alcohol intake, stop smoking and avoid recreational drugs. Men can be advised to avoid hot baths, wear loose underwear and try to avoid any toxic chemicals or materials – although this may not be possible.

As mentioned earlier, the man should take antioxidant therapy to see if this improves sperm quality before any specific treatment is given. Discuss timing of intercourse and suggest using an ovulation prediction kit.

If this couple are referred for assisted conception, what factors are likely to influence decisions about choice of technique? To what extent does a lack of success within the first few attempts suggest an overall poor prognosis?

If the couple are referred for assisted conception, the type of treatment will depend on the results of the investigations performed.

In women, if the problem is ovulatory, ovulation induction treatment will be used. If the problem is tubal then in vitro fertilisation will be suggested.

In men, the detailed semen analysis will indicate whether there is a sperm problem, and which assisted conception technology would be most appropriate – for example, traditional IVF or intra-cytoplasmic sperm injection. Certain centres will also be able to consider the use of newer technologies such as the study of embryo cell division rates and greatly enhanced sperm morphological assessment. If initial attempts at treatment are unsuccessful, the prognosis is not necessarily poor, but different treatments may need to be considered in future.

What are the risks of infertility treatments? Is there any connection between ovarian stimulation and subsequent ovarian cancer?

With infertility treatment there is always the risk of failure. There is also the risk of multiple pregnancies, and a raised incidence of premature labour, foetal anomalies, cerebral palsy and delivery problems. This is why the Human Fertilisation and Embryology Authority – the regulatory body for assisted conception centres – is advocating the current move to single-embryo transfer, which will significantly reduce the chance of multiple pregnancy.

Multiple pregnancy is also a problem with the more simple ovulation-induction treatments, such as clomiphene therapy, which is not recommended in primary care because ultrasound should be used in conjunction to assess the number of ovarian follicles and their maturity.

Assisted conception can cause ovarian hyperstimulation syndrome. This condition can cause catastrophic physiological problems in the female and can be fatal. The protocols in assisted conception units are designed to try to identify those at risk of this condition and to deal with the condition if it occurs. The patient will be admitted to hospital and embryo transfer will be avoided, as an ensuing pregnancy will make the condition even worse. In this situation patients would undergo frozen embryo transfers in an attempt to achieve a pregnancy so that the treatment cycle is not wasted. The medical procedures involved in assisted conception involve surgical intervention, and so there is, of course, a risk of damage to pelvic organs or other structures within the pelvis.

There is no concrete agreement about whether ovarian stimulation can cause subsequent ovarian cancer – this matter is controversial and studies have provided conflicting results.[4,5]

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Dr Iwan Lewis-Jones is a consultant clinical andrologist at Liverpool Women's Hospital

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Infertility Network UK (IN UK) is the leading national infertility charity, working to ensure anyone trying to conceive who needs support, information or advice for their fertility or infertility can find it easily and in one place. IN UK also leads the campaign for fair and equitable access to NHS-funded treatment. Contact IN UK any time on 0800 008 7464 or visit infertilitynetwork.uk.com

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Pulse Business & Commissioning

Practice Business In this issue

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Electronic prescribing Dr Anthony Kaye advises on the second release of the electronic prescribing service
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NICE compliance scorecard Dr Charles Alessi explains how CCGs will be held to account on drug access
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Dr Amir Hannan demonstrates the practice website with a patient

How we saved £20 a patient by offering records access

Dr Amir Hannan explains how his practice has saved money and resources by providing access to records and self-care advice on its website

The problem

There has been a steady rise in general practice consultation rates, which research indicates soared from 3.9 to 5.5 consultations per patient per year between 1995 and 2009[1] – a trend that shows no sign of abating. Maintaining control of consultation rates within primary care is therefore a real challenge. Our early findings and research elsewhere suggest that practice resources – particularly for routine follow-up appointments – can be most efficiently deployed in those patients we would describe as 'online' and enabled.

We wanted to give patients greater ownership of their own health, and help them understand what was happening and why we were doing what we were doing.

The vast majority of our patients were – and still are – unaware that they have the right to access their medical records. They have not been aware of what the benefits might be should they access their records and some feared the notes would be difficult to understand even if they could access them.

But the feedback from our practice's patient participation group was that patients felt they should be encouraged to do more for themselves wherever possible through self-care. We wanted to respond to this by improving access to records.

There were concerns among practice staff about litigation, that patient access would add to workload – especially if patients did not understand information – or that there might be harmful data in the records that would upset patients. Some felt that it was not the role of our staff to promote access to records and that it was unfair for those patients who did not have access to the internet and who could be disadvantaged by this process.

How we did it

In 2000, we installed EMIS LV and since then we have gradually moved away from writing in Lloyd George paper notes to exclusively writing in an electronic health record that includes all consultations, blood test results and other investigations, and letters. All clinicians and non-clinicians have been encouraged to use electronic records.

Entries also contain salient points of the history, examination, possible diagnoses and a plan of action. We find this type of record useful for immediate problems such as chest infections, and for ongoing long-term conditions such as diabetes or depression or unexplained problems such as abdominal pain or sleep disorder.

Our practice started to offer a range of online facilities to patients, including providing access to health records in 2006. After early success and involvement with our patient group, we embarked on a determined effort to actively engage with our patients online via a purpose-built patient website – htmc.co.uk. It was created in conjunction with experienced electronic publishing and patient e-health specialist Glen Griffiths, who implemented a content management system (CMS) that made it easy to create and update multimedia content.

We developed a three-stage process for patients to sign up for the service. First, patients collect their PIN from our receptionists, which activates their account and allows them to register online.

Second, we invite patients to fill in an online questionnaire that determines whether they have understood what records access means and how they can safely deal with some of the challenges – such as seeing abnormal test results. This is embedded on the practice website along with YouTube video tutorials, information developed by patients on the advantages and potential pitfalls, and the passwords

for a test patient record so that patients can try the system out before committing themselves. This is all part of a self-contained explicit consent process that allows patients to learn online when it is convenient for them.

If there are no potential problems, the records are activated and an email is sent to the patient to confirm their request has been accepted and encourage them to look at the practice web portal for further information to help them understand their records. If there are any concerns around the record or because of answers in the online questionnaire, they are passed to the doctors for review. The staff deal with any queries patients may have, so the clinicians simply ask patients to sign up for the service.

Third, all practice staff and clinicians are given support material – including leaflets and consent forms – so that whenever patients contact the practice, they can be encouraged to sign up for access to their records.

The website also provides a section on 'self-care for family and friends'. Being able to easily add content and pages without needing any special technical knowledge has meant free text can be embedded alongside photos and videos we have made or that have been supplied by patients.

This functionality to build our own content linked to national online resources makes it very powerful – we can respond to the practice's or patients' needs as soon as they arise without having to wait or being charged for the privilege. We can inform our patients about new developments or initiatives and help people to learn for themselves instead of relying on coming to see us at the practice.

We've created specific web pages for patients with diabetes, heart disease and asthma, for example, which helps them to understand how access to medical records could help them. Our site is a web portal with testimonials from patients, specific information encouraging personalised care and links to national resources. We also use the website to promote health events put on by our patient participation group, and host videos of these.

We have developed a robust process with responsibilities for different staff members to process requests for records access. This is mainly an administrative process, with our reception staff looking after a table in the waiting room area where there are posters, consent forms and leaflets. Our reception staff hand out PINs and reset passwords, certain back-office staff members download the online questionnaires and process the answers.

Staff check whether there might be any problems with the patient accessing information in their record that might be regarded as harmful – for instance, mental health or psychiatric notes that they might be unaware of – or third party information such as health concerns voiced by a spouse or carer. We follow the guidance laid out by the RCGP on these cases.[3] We also try to pre-empt problems by raising the possibility of that the patient might see 'unseen information', using the questionnaire stage of signing up to records access.

Results

We now have over 1,850 patients accessing their records. Some 16% of patients have currently signed up, with on average 10-30 patients signing up every week. Patients from the ages of zero to over 90 have joined the scheme, with the largest group being women between the ages of 20 and 65. Nearly 30% of our patients with type 1 diabetes, 34% of our obese patients, 46% of patients on methotrexate and 9% of our Bengali patients now have access to their records.

Overall 16% of our practice's patients have signed up. Over the last three months there were over 40,000 page views on our website, averaging over 13,000 page views per month, and over 3,400 recorded logins for a range of online services and access to electronic records.

There were an average of five online visits per patient – well over 650 individual patients out of the total of 1,850 patients registered went online over this time. An average of 50 appointments and 20 appointment cancellations were made online each month, helping improve access and reduce DNA rates.

We have recently completed a joint study with Manor House surgery in Glossop to show that, as a result of providing patients access to their records, we could make savings of almost £20 per patient per year in saved appointments.

Our study showed that on average, we have saved more than one appointment per patient per year and that we saved more than three telephone consultations per patient. The full results of this study will be published soon.

The future

We are now developing a programme with the local strategic health authority to support CCGs that may wish to encourage local GP practices to follow in our steps – our evidence indicates that basing rollout on a comprehensive practice website is required to achieve scale. Other vendors, including TPP, are beginning trials to enable their patients to access records too. We would be keen to reach out to other practices that are offering access to records, or would like to do so, to learn and share experiences.

Dr Amir Hannan is a GP in Hyde, Greater Manchester, and primary care IT lead at NHS North West. He can be contacted at amir.hannan@nhs.net

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A guide to the new A&E indicators

Dr Chaand Nagpaul, GPC lead negotiator on commissioning, addresses some frequently asked questions on the new QP indicators added to the QOF

The most significant change to the QOF for 2012/13 was the withdrawal of the quality and productivity (QP) prescribing indicators, and the introduction of new QP indicators on A&E admissions. This article provides advice on some of the main questions GPs are asking about the new indicators.

1 What is the definition of an A&E attendance?

Attendances at A&E are defined as patients seen in a 'type-one A&E department', described as a 'consultant-led, 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients'.[1] Where the majority of patients do not use a type-one A&E department, practices and primary care organisations can agree which most frequently used local urgent care service will be included.

2 How do practices receive data on A&E attendances?

These QP indicators require the PCO to provide the practice with data on A&E attendances on a monthly basis. This should include patient details, reasons for attendance and diagnosis, and the time and date of attendance. Practices should not be incurring further workload to identify this cohort of patients – such as from discharge letters or conducting searches – and should contact their PCO for this information.

3 Are there any specific categories of patients that should be reviewed?

The indicators ask practices to focus on the following three risk groups:

- older patients with comorbidities at high risk of admission (patients aged 65 years and over)
- children with minor illness or injury (patients aged 15 years and under)
- patients who frequently re-attend A&E who could be dealt with in primary care.

If the data provided to the practice does not allow focusing on these groups, that should be noted in its report.

4 What do the individual indicators ask practices to do?

There are three indicators:

QP12 – seven points

This indicator requires the practice to meet once to review data on A&E attendances and to produce a report for the PCO by 31 July. This should be a priority for practices, and can form part of the same practice meeting that reviews the outpatient and emergency care QP indicators.

At the meeting, the reasons for patients' attendances at A&E should be explored, with reference to any available care pathways, as well as factors outside the practice's control that influence patients accessing A&E.

Practices should consider whether same-day access to clinicians in the practice is appropriate and whether there is any correlation between this and the level of A&E attendances.

This indicator gives practices the opportunity to identify the varying factors that result in patients attending A&E, as well as identifying patients who have needlessly self-presented to A&E – for a viral URTI, for example – and who would have been effectively managed had they attended the GP surgery.

QP13 – nine points

For this indicator, the practice must carry out an external peer review of its data on A&E attendances in the form of a single meeting with a peer group of local practices in the PCO, which could be the same as that used for the other QP indicators.

This external review would compare the practice's data with comparable data from other peer-group practices or from practices in the PCO area. The aim is to identify variance and find an explanation, if any, to account for this. The peer group should reflect on reasons and patterns of A&E attendances and whether any improvements could be made to the quality of care for patients at the primary care/A&E interface.

Practices should then develop an improvement plan, which should include any peer group recommendations to the PCO for service redesign or commissioning changes that could reduce avoidable A&E attendances.

A report should then be sent to the PCO by 30 September, detailing that an external peer review group meeting had taken place, with the practice report produced under QP12 being accepted or amended as a result, and should include a summary of discussions and the practice improvement plan to review A&E attendances.

QP14 – 15 points

This indicator requires the practice to implement the improvement plan as defined under QP13, and produce a report to be sent to the PCO no later than 31 March 2013. Practices should review their monthly data on A&E use in the priority groups listed above. If the data provided to the practice does not allow this to be done for all patients, this should be noted in the report.

5 Is the achievement payment dependent on practices reducing their patients' A&E attendance?

These indicators do not set any 'targets' based on crude reductions in A&E attendances, which should allow for a more mature and reflective approach. Given the multifactorial reasons why patients attend A&E, it would be inappropriate to link attendance rates specifically to practice behaviour. However, as stated above, the practice and peer review reports may identify wider commissioning changes that could reduce avoidable A&E attendances.

6 What if the practice review does not establish any practice factors that could result in avoidable A&E attendances?

If the practice is demonstrating appropriate systems of access in general practice that result in low levels of avoidable A&E attendances, then the improvement plan can state this and the practice can continue to maintain its quality of care.

7 What about factors outside GPs' control that influence patient attendance at A&E?

We know there are many reasons for patients attending A&E, such as proximity to an A&E unit, the illness behaviour of certain types of patient, the influence of unscheduled care triage or advice – for instance NHS Direct, NHS Choices or 111 – and the availability of out-of-hours services.

QP13 specifically enables the peer group to make recommendations to the PCO for improvements in commissioning or service redesign to reduce avoidable A&E attendances.

This could include, for instance, enhanced provision of community nursing or rapid response services, development of community pathways for clinical areas such as COPD, commissioning an appropriate local enhanced service for urgent care, or improvements to out-of-hours provision or to unscheduled care triage – all likely to have a greater impact on A&E attendances than practice changes.

8 What workload will practices incur in implementing these indicators?

The workload for these QP indicators is well defined. It is the PCO's responsibility to provide practices with data on A&E attendances, and practices should not incur additional work in performing any searches or collating data. Practices need to have a single reflective internal meeting of all referring clinicians, with a report to the PCO by 31 July. This should be followed by a single peer review meeting, with a report by 30September 2012.

Both the practice and peer review meetings can be combined with the meetings for the existing QP indicators for outpatient and emergency care. Practices will then be required to implement their improvement plan, with monthly monitoring of A&E attendances in the priority groups defined above and a final report sent to the PCO by 31 March 2013.

It is important for practices restrict their workload to the remit of these indicators, and PCOs should not widen their scope.

9 Are these QP indicators financially worthwhile for practices?

These indicators are favourable compared with the prescribing QP indicators they replace, since they can be aligned to the work of the existing QP indicators and without the need for local negotiation to agree priorities. And as these indicators are not based on any target or specific outcomes, they provide practices with a realistic possibility of achieving maximum QOF points in this area.

Dr Chaand Nagpaul is a GP in Stanmore, Middlesex, and a GPC negotiator with a lead role in commissioning

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

Key

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

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

Vaccinations information

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

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

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

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

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

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

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

Specialist advice

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

Parasitic infections

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

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

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

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

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

Travel medicine update

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

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

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

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

Source
travax.nhs.uk

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

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

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

NORGINE

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

PULSESERVICES
TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Updated: May 2012

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

Key to malaria prophylaxis regimens

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

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

Regimen ME
Mefloquine, 1x250mg tablet weekly. ACMP suggest it is safe in continuous use for periods of at least 3 years. Begin at least 2½ weeks before travel (at least 3 doses before arriving in malarious area). Avoid in first trimester of pregnancy and do not start pregnancy until 3 months after stopping mefloquine. Inadvertent use in first trimester is not an indication for termination. If pregnant women must travel to chloroquine-resistant falciparum area, seek expert advice and conduct careful risk-benefit analysis. Use in any trimester may be justified.

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

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

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

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

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

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

Children's doses of antimalarial prophylactics

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

Doxycycline only above 12 years and the adult dose is given

Children's doses

Paediatric malarone for prophylaxis

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

Specialist advice

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

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TIP OF THE MONTH

Imported malaria in the UK

An important survey recently published in the *BMJ* should be read by all travel medicine advisers.[1] Between 1987 and 2006, 161 malaria-associated deaths were recorded in the UK out of 39,320 cases. Seven deaths occurred in non-falciparum species with a case fatality rate of 0.05%, while in 25,054 falciparum cases there were 181 deaths – giving a case fatality rate of 0.73%.

Case fatality rates were higher, at 2.96%, in tourists than in those visiting friends and relatives (VFRs) at 0.32%. VFRs born in Africa had lower case fatality (0.4%) than those born outside of Africa (2.4%). Case fatality was particularly high in those visiting the Gambia, at 3.9%, and this difference increased to 6% for tourists. Although most malaria deaths in endemic areas occur in children, no deaths were reported in the zero-to-five years age group, but mortality increases with age and was 10 times more likely in those over 65 years of age than those aged 18-35 years. December is the most risky month to present with malaria, with an overall risk of dying of 2.55% compared with 0.58% for all other months.

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

References

1 Checkley AM, Smith A, Smith V et al. Risk factors for mortality from imported falciparum malaria in the UK over 20 years: an observational study. *BMJ* 2012; 344:e2116
2 HPA. hpa.org.uk/webw/HPAwebEnHPAwebStandard/HPAweb_C/1317138806548

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NHS
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NIHR Clinician Scientist Award Scheme for Applied Research

The National Institute for Health Research is pleased to invite applications to the twelfth round of the NIHR Clinician Scientist (NIHR CS) Award Scheme.

The Scheme, which is part of the NIHR Trainees Co-ordinating Centre (NIHR TCC) Integrated Academic Training Programme, is intended to nurture a cadre of clinical academics capable of leading research in their discipline and will provide up to five years post-doctoral funding with access to academic mentorship; flexible academic career development; and clinical specialist training where appropriate.

Medical and dental graduates who have been awarded a research doctorate in a basic science/ clinical or health related subject or who have submitted their doctoral thesis at the time of application to the NIHR CS scheme are eligible to apply. The NIHR CS Award scheme is aimed at researchers wishing to pursue clinical and applied health research topics and is not suitable for applicants wishing to undertake basic research.

Awards provide for salary costs of the award holder and support post, research costs appropriate for completing a training fellowship and a sum to support training, travel and/or conference attendance during the Award. Successful applicants may spend up to 4 sessions a week on NHS clinical sessions within the time funded by an Award.

Application packs and further information are available from www.nihrtcc.org.uk. Should you require any further assistance, please contact the NIHR TCC (0113 346 6270) or email NIHR.ClinicianScientists@nihrtcc.org.uk

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4 sessions per week
Potential for partnership

Dalefield Surgery is an expanding practice that requires a motivated salaried GP with view to partnership

- *Progressive GMS practice – list size 5,700*
- *2 partners , 1 salaried GP, 1 Nurse Prachtioner*
- *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

Amman Valley Practice, Ammanford SA18 1EG

Salaried GP required

Gateway to the Black Mountain
Varied and diverse workload
Opportunity to develop clinical interests in a supportive and innovative team
4 or 8 sessions, commencement summer 2012

Closing date: May 28th 2012

Informal enquiries welcome
All enquiries and CVs to the Practice Manager
Helen.Fender@gp-w92610.wales.nhs.uk

Newark Nottinghamshire

Full Time/Part Time Partner

We are looking for a full time partner to join our supportive and friendly practice.

- New purpose-built premises opened in October 2011 as part of town centre development
- Well organised and forward thinking practice
- Training practice
- Achieved RCGP Quality Practice Award 2011
- Multi Professional Learning Organisation
- List size: 17,400
- 11 Partners: 8+ WTE
- No compulsory OOH
- Consistently high QOF achievements
- Nurse led triage and minor illness clinics
- Mixed skills nursing team
- Excellent management and support structure
- Medieval market town with easy access to Nottingham/Lincolnshire/Peak District
- London 1 hour 15 min by main line train

This is an exciting opportunity for an enthusiastic and motivated team player. To find out more, ask for our practice profile.

Contact James Cusack (Partner) or Diana Kirk (Practice Director)
E-mail: James.Cusack@gp-c84029.nhs.uk
Diana.Kirk@gp-c84029.nhs.uk
Lombard Medical Centre, 2 Portland Street,
Newark, Notts NG24 4XG
Tel: 01636 702363
www.lombardmedicalcentre.co.uk

Closing Date for applications: 30/05/12
Interview Date: 20/06/12

HIMG

Full Time GP

(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.

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7 David Place Medical Practice, St. Helier, Jersey, JE2 4TD
Email: dr.sarah_kennea@me.com
Tel: 07797810570

FULL OR PART-TIME SALARIED GPs

Tudor Surgery is a close-knit practice situated in the market town of Nantwich, South Cheshire.

We are seeking two or more Salaried GPs to cover a total of 14 sessions from July 2012. We are happy to consider job shares or other innovative proposals to support a satisfying work-life balance.

With a list of 4,600 patients, we share purpose-built premises with on-site community staff. The Practice has excellent nurse-led triage and chronic disease management. We are fully EMIS computerised, achieve high QOF points, teach students and hold regular meetings to support Clinical Governance.

The successful applicants will be computer literate with good written and oral communication skills. They will practice evidence-based medicine, prescribe cost-effectively and be keen to be involved in reflective practice. Time will also be allowed to lead on specific areas of the QOF.

Annual Salary: £6,000 – £8,500 per session
(depending upon experience) plus MDDUS cover.

If you wish to join our enthusiastic team please apply with CV and covering letter by email or to:
Dr Keith Malone, Tudor Surgery, Church View PCC, Beam Street, Nantwich CW5 5NG.
Tel 01270 610686.
Email: keith.malone@gp-n81090.nhs.uk

Closing date 31-5-2012

Salaried GP with a view to Partnership

Number of sessions negotiable - minimum of four.

Due to retirement, we are looking for an innovative, enthusiastic individual to share our commitment in providing high quality healthcare in a friendly long established GMS Practice.

List Size: 7,500
High QOF Achiever
Paperlight; Vision; Docman
Excellent nursing and administrative support teams
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.rodriguez@nhs.net

Closing Date 31st May 2012

SALARIED GP

SENIOR PARTNER DUE TO RETIRE IN 2-3 YEARS
SOUTH WARWICKSHIRE/NORTH OXFORDSHIRE

8 sessions per week from 1st August 2012
Currently 2 partners and 2 salaried doctors
Competitive salary
Almost 100% dispensing, rural practice, excellent schools
100% QOF to date. 2 sites. List size 5600

Interest in minor surgery, business and finance an advantage

Please apply with CV and covering letter or for more details to Julie Robson.
The Surgery, High St. Fenny Compton, Southam, Warwickshire CV47 2YG
Email Julie.Robson@gp-M84009.nhs.uk

Closing date for applications 1st June 2012

DOCTORS/GPS REQUIRED

Sawston Medical Practice

2 Salaried GP posts

Total session 12 (either 2 x 6 sessions or 1x 8 and 1x 4)

We are looking to recruit enthusiastic, motivated GP's to enhance our team. A semi rural practice, on the outskirts of Cambridge, with an interesting and diverse patient population. We are a friendly, democratic practice and would be delighted to encourage candidates with special interests who are keen to further develop their skills, particularly ENT, Ophthalmology and Rheumatology. We strive to provide excellent patient care whilst maintaining a healthy work/life balance.

- *GMS Dispensing Practice with 10 GP's*
- *List size 13,800 steadily expanding*
- *Excellent modern, purpose built premises inc minor Ops suite*
- *Monday evening and Friday morning extended hours*
- *3 Nurse Practitioners and excellent nursing support*
- *Wide range of enhanced services*
- *Good QOF achievement*
- *Teaching Practice*
- *SystmOne and paperlight*
- *On-site pharmacy*
- *7 miles from Addenbrookes Hospital*

Please contact Gerard Newnham, Business Practice Manager for application pack or informal discussion.
01223 727555 gerard.newnham@nhs.net

We would welcome applicants to visit the practice.

Closing date 27th May 2012

Full - Time Salaried GP London NW10

We are looking for a Full-Time Salaried GP
Willesden, London NW10

Start date 1.7.2012.

Computerised with Emis.
Friendly 6 Partner Practice, List size approx 10,000.
8 Sessions per week including on call + late evenings on alternative weeks. No weekends (OOH).
With at least 2 years Clinical Experience.
Preferable qualified for contraception services
MRCGP, 6 weeks annual leave,
(includes 1 week study leave).
We encourage Team work and good Communication.
Visit to the Practice, Welcome.

For more information please contact:
Dr D Durica or Practice Manager - Patsy Campbell.
Patsy.campbell@nhs.net
Tel 0208 459 5550
Fax 0208 451 7268
Or apply with CV with handwritten letter
Dr S Ramdahen & Partners, The Medical Centre,
144 - 150 High Road, Willesden London NW10 2PT
Closing date for applications – 31.5.2012

Salaried GP

The New Mill Street Surgery
London Bridge SE1

Enthusiastic and Highly Motivated with high level of patient care?
Want to join our caring and committed team?
Full time (or substantive full time) from June 2012

- PMS
- List Size 5,500
- High QOF Achievement
- Emis Computer System
- Training Practice

Apply with Full CV to:
The New Mill Street Surgery, 1 Wolseley Street, London SE1 2BP
Email to: Malcolm.cramb@nhs.net

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

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

Strand Medical Group

in Goring by Sea is a friendly, supportive training 7-doctor PMS practice by the sea in West Sussex with the following exciting job opportunities:

Salaried doctor and 6 month locum

We are an innovative forward thinking practice, with a consistently high QoF achievement and paperlight accreditation and continually strive to provide high quality care to our 14,200 patients.

Sessions negotiable for both positions, preferably full time, job share considered.
Competitive remuneration package.

For job description and application details, please contact:
Jane Rimber, Business Manager, Strand Medical Group,
2 - 6 The Strand, Goring by Sea, West Sussex BN12 6DN
or email janerimber@nhs.net

Closing date: 23rd May 2012

London NW2 Practice

Requires Two Salaried GPs' ASAP

One Full time – 8 sessions,
One Part time– 5 (AM) sessions
(Job share considered)

Following the retirement of our practice establishing partner. We are looking for hard working, enthusiastic and committed GP's for our friendly practice.

We are: 4300 patient GMS 2 partner practice, Emis LV
High QOF achievers
Ethnically diverse community
No OOH work

Salary depending on experience
Closing date 25th May.
Please apply with covering letter and CV to:
Dr Rajan Dalsania, Crest Medical Centre,
157 Crest Road, London NW2 7NA
Tel: 0208 452 5155, Email: rajan.dalsania@nhs.net

SALARIED GP

Six sessions per week - £48,000
plus MDU contribution & pension

6 weeks holidays plus one week's study leave
East Barnet/Southgate borders

Enthusiastic, committed GP required for small supportive practice

To start as soon as possible

Fully staffed, EMIS LV Paperlight, High QOF Achiever, GMS Practice, No OOH, 3100 patients

Send CV to: Jacqui Perfect (Practice Manager) Jacqui.perfect@nhs.net

www.osidgemedicalpractice.co.uk

Closing date for applications: Friday 25th May 2012

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.

We are looking for an enthusiastic GP to join our friendly and supportive team of partners and salaried doctors providing care for around 11,000 patients from our purpose built surgery.

Visit our website www.homegroundsurgery.nhs.uk to see what our patients say about us.

A sense of humour and a "can do" attitude are essential!

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

Chris.Gebel@nhs.net
Tel: 01793 707896

Closing date: Friday 15th June 2012

TOWER HOUSE SURGERY, HIGH WYCOMBE

SALARIED GP REQUIRED: 4 SESSIONS

www.towerhousesurgery.com

Join our friendly, supportive, teaching and training practice in the Chilterns!
We believe in providing high quality care to our diverse patient population of 8,600.
A Specialist interest would be an advantage.
BMA Contract and Salary Scale.

Contact Dr Christopher Binns or Dr Sarah Annetts on 01494 551832
Or email cwampbell@nhs.net for further information

Informal visits welcome

Closing date for applications 31st May, with Interviews 30th June 2012

PULBOROUGH MEDICAL GROUP

SALARIED GP POSITION

Established and friendly 9 doctor training practice with 12,400 patients, fully computerised using the SystmOne clinical system.
We are looking for a salaried GP to work 6 sessions per week. Specialist skills welcomed particularly in Minor Surgery. However enthusiasm and motivation equally important.

Start date: beginning of August 2012
Interview date: Wednesday 23rd May

Enquiries and applications with CV and covering letter by Friday 18th May to Alan Bolt, Managing Partner, Pulborough Medical Group, Spiro Close, Pulborough, West Sussex RH20 1FG.

PMG is committed to excellence in patient care and investment in their people.

Does your Practice currently include a Pharmacy?

Do you receive an annual rent from the Pharmacy?

If the answer to both these questions is 'Yes' then you might be able to sell the space that the pharmacy occupies for at least 10 times the current annual rental and in some cases even more than that. This means that the current Practice Partners can share in the value of the pharmacy premises now and unlock a sizeable amount of value.

For an informal discussion on your best options please email Conor Daly of Rushport Advisory LLP at conor.daly@rushport.co.uk

Rushport Advisory

DOCTORS/GPS REQUIRED

Hertfordshire, Whitwell Surgery

Full Time Partner / Salaried GP

part time / job share considered

GP required to join well organised and established small friendly practice.

- Salary negotiable
- 2500 patients
- Consistently high QOF achievement
- Purpose built premises
- EMIS LV
- Excellent admin & clinical support

Informal visits welcome.

To apply please send CV & covering letter to: Beverley Sheaver, Practice Manager, Whitwell Surgery, 60 High Street, Whitwell, Hitchin, Herts SG4 8AG. 01438 871398 beverley.sheaver@nhs.net

GROSVENOR MEDICAL CENTRE

Grosvenor Street, Crewe Cheshire CW1 3HB Tel: 01270 256940

Full time Salaried GP

We are a long established, committed PMS Training Practice, covering Crewe and surrounding rural villages, Practice populationis approximately 14,500.

- Induction programme as required
- Opportunity and support to develop:
  Minor Operations Skills
  Management Skills
- EMIS and Docman system in use
- Experienced Primary Care team
- Supportive and engaged practice population
- Recently expanded Branch Surgery
- Good local schools and transport

Please submit your CV and covering letter to Dr. A.L. Spooner
Please feel free to browse our website: www.grosvenormedicalcentre.org.uk
Closing date: 28th May 2012

Surrey/Sussex Border
Salaried GP (Full time)

We are a friendly and progressive PMS Training Practice with a list of 15,000 patients on 2 town sites near Gatwick.

We are looking for a candidate who is motivated, committed to clinical excellence, teamwork, and is willing to work with immigration detainees.

Salary range £71,158 - £81,158 (FTE) based on experience

For further information or to arrange an informal visit please contact Christine Stuckle on 01293 658814 or via email christine.stuckle@nhs.net

www.saxonbrook.co.uk

WORSLEY MANCHESTER

We are a friendly, high achieving 3 doctor practice looking for an enthusiastic salaried GP to join us, with a view to partnership.

+ 6/8 sessions negotiable. + 7 weeks annual leave. + EMIS PCS paperlite. + GMS List size 5800. + Excellent QOF.
+ Medical students. + Excellent nursing and support staff.

For further information, please contact practice manager, Sangeeta Ganvir on 0161 790 8621 or sangeeta.ganvir@nhs.net

Kingsfold Medical Centre, Preston

SALARIED GP REQUIRED

WITH A VIEW TO PARTNERSHIP
9 sessions per week

- GMS practice
- Approximately 4000 patients
- EMIS LV
- High QOF achievement
- Nurse led Chronic Disease Clinics

Please apply with covering letter and CV to: Sangeeta Chikhalikar
Kingsfold Medical Centre, Woodcroft Close, Penwortham, Preston PR1 9BX
Telephone - 01772 909128
Email: Sangeeta.chikhalikar@gp-p81081.nhs.uk
www.kingsfoldmedicalcentre.co.uk

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

Part-time Salaried GP (6 sessions)
Shepperton Medical Practice, Middlesex

Required to join our long-established friendly and forward-thinking 6 Partner busy GMS Practice.

Applications: CV with covering letter to
Mrs Isata Green, Practice Manager
Shepperton Medical Practice,
Shepperton Court Drive, Laleham Road, TW17 8EJ

Informal Enquiries: Tel. 01932 211 900
or email isata.green@nhs.net

Closing date: **9th May 2012**
Interview date: **Friday 18th May 2012**
Start date: **August 2012**

Rochdale Road Medical Centre
48a Rochdale Road, Middleton, Manchester M24 2PT
Telephone 0161 643 9131

We are seeking to find a motivated and enthusiastic
SALARIED GP
to join our friendly practice.

Five to Eight sessions per week £80K pro rata (including pension).

- *Fully computerised using EMIS LV*
- *PMS Contract and excellent QoF results*
- *Training Practice*
- *Close to M62 junction 12 and M60 junction 19*
- *Position commencing ASAP.*

Applications in writing, enclosing your C.V. to Mr Stefan Bingley, Practice Manager or email to stefanbingley@nhs.net

Closing date 12th May 2012.

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4 GP teaching practice requires a caring enthusiastic GP interested in quality medicine.

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Plse reply Dr J.Allan
Email: jacqueline@tiakinatrova.co.nz or Ph. 0064-9-2980778 [wk]

Spilsby Surgery - Salaried GP

Spilsby Surgery is looking for a whole-time or substantive part-time salaried doctor to join their friendly innovative team from August 2012. We are committed to delivering patient centric care within the beautiful setting of the Lincolnshire Wolds, an Area of Outstanding Natural Beauty that offers affordable property and good schools.

We are a high performing surgery that has been at the centre of innovative practice over the last 20 years. We have led within our locality on the care of patients with LTC and been at the forefront of developing new clinical roles within primary care. We offer a mixed skills nursing team with an excellent management and support structure. We are fully engaged and participate in the local Clinical Commissioning Group and have striven to see the opportunity this may afford us in providing more local services to our patients. The practice is committed to undergraduate and postgraduate education.

We are looking for a doctor who is committed to primary care in the 21st century and offer an attractive financial package to the successful candidate.

We welcome meeting all prospective applicants at the surgery so that we can convey our passion and vision for the practice moving into the future.

For further information or an informal discussion, please contact:

Mrs Jeannie Bee, Executive Partner
Tel: 0844 477 3309 Email: jeannie.bee@lpct.nhs.uk
Spilsby Surgery, Bull Yard, Simpson Street, Spilsby, PE23 5LG

Closing date for applications is Thursday 31st May

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2011 Gynae delegate

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Friday 15 June 2012

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Faculty to include; Dr Edwina Attie, Director of West Midlands Commissioning Support Unit; Dr Neil Deuchar, Medical Director, NHS West Midlands

Course fee: £150

To register for either course or for more information please contact **Tamara Ball**
Tel: 0121 414 3281
Email: t.c.ball@bham.ac.uk
Website: www.anticoagulation.org.uk

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EDITOR'S CHOICE

Helping parents to say goodbye

GPs often have patients struggling to come to terms with a miscarriage, says Dr Ursula Oeitker. A new service can help...

Dr Ursula Oeitker

Approximately one in four pregnancies ends in miscarriage. Parents' reactions vary – most feel a real sadness, some are distraught, and for some the loss remains a deep grief for years.

A baby that is born with any sign of life is regarded as a neonatal death, whatever its gestation, and has to be registered at a registry office by a parent. If there is no sign of life at birth beyond 24 weeks gestation, this is termed a stillbirth, and is registered as such. Again a certificate is issued. Before 24 weeks gestation, if there are no signs of life, then this is called a miscarriage. While all products of conception, whether ectopic or intrauterine, are disposed of in a respectful way, separate from other surgical specimens, there is no requirement to register this life or loss of it and there is no certificate issued.

Crucially there is no rite of passage to mark this loss for parents. This leaves many couples struggling to come to terms with their loss, to grieve and to say farewell. They may be well supported by family, friends, their GPs, counsellors, charitable organisations and hospital units – but they don't get to say goodbye.

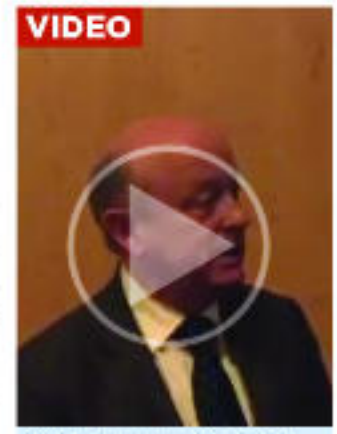
In my local hospital, there is a bereavement team attached to the obstetric and gynaecology department who offer support and counselling to patients, but this isn't widespread. Clark-Coates Event Management is arranging services at cathedrals, minsters and churches across the UK this year, in partnership with the Miscarriage Association – the leading charity working in this field. The company directors have lost five babies themselves, so know firsthand the trauma of miscarriage. The 'Saying Goodbye' services will commemorate the children parents have lost to miscarriage, and help parents say farewell.

GPs may be surprised at how many parents express a need for such a rite of passage.

Dr Ursula Oeitker is a GP in Birmingham

MORE ONLINE
To read the full article and gain details of services planned at various venues in 2012, visit **pulsetoday.co.uk/opinion**. And GPs can refer patients to the Saying Goodbye website at **sayinggoodbye.org**

VIDEO



Clinical news editor Nigel Praities speaks to GMC chair Professor Peter Rubin about the regulator's study which found errors in one in 20 GP prescriptions.

▶ pulsetoday.co.uk/videos

WHAT YOU'VE BEEN SAYING

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"I can think of no other country where this would be allowed to happen."

... on UK hospitals being owed up to £40m for the treatment of foreign nationals

"If you want to do charity, go to Africa."

... on GPs and surgeons volunteering for the Olympics undergoing paracetamol training

"I thought by now we would be swamped by a mass of unemployed, young doctors."

... on plans to review medical school places

EDITOR'S BLOG

Britain needs more GPs

Everyone knows we need more GPs. To GPs, themselves, it is self-evident. GP educators know it too.

So when the Government last week announced it was reviewing the number of medical students it planned to train up over coming years, it had to be good news for general practice.

But will an increase in medical students translate into an increase in GPs...

MORE ONLINE
Read the full post online at pulsetoday.co.uk/editorblog

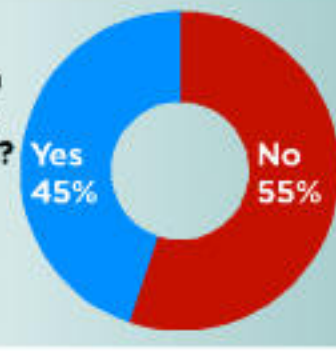
THIS WEEK'S POLL

Are GPs ordering too many lab tests?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

Should CCGs have a role in performance managing practices?



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