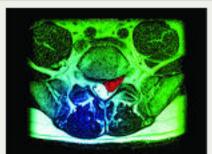
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19.09.12

Issue 30 | Volume 72



At the heart of general practice since 1960

# **GPs face the flak as NHS** rationing drive accelerates

Pulse survey finds three in four GPs believe rationing is adversely affecting the doctor-patient relationship

#### **EXCLUSIVE**

By Sofia Lind

oulsetoday.co.ul

GPs are bearing RATIONING the brunt of increasing pressure to ration NHS services, with three-quarters saying local rationing of treatments is now adversely affecting their relationship with patients, a Pulse survey reveals.

The survey of 237 GPs comes at the midpoint of the so-called 'Nicholson challenge' to identify £20bn of savings in the NHS, with nine in 10 GPs reporting the pressure on them to ration treatments or services has worsened over the past year.

Two-thirds said local rationing decisions were adversely affecting patient care, while 75% said the doctor-patient relationship was suffering - leading to renewed calls from GP leaders for a national list of low clinical priority treatments.

Over 40% of GPs said they had had to switch patients to a less effective therapy because of local rationing guidelines in the past year. Over a third said they had struggled to get patients to guideline-directed targets, citing restrictions on statins, newer diabetes therapies and referrals for orthopaedic surgery as



Dr Claire Lehman: Rationing makes GPs the 'big bad ogre' in the eyes of patients

#### Pulse survey

adversely affecting the doctor-



Yes 75% No 16% Don't know 91

particularly problematic.

Common examples of rationing were for GP referrals for bariatric, hip and knee and cataract surgery. Mental health services were also badly affected, with half of GPs experiencing rationing of cognitive behavioural therapy and 30% for child mental health services.

GPs also said patients were being hit by subtler forms of rationing, with 89% saying they had had a patient referred back to them because of missed hospital appointments, and 31% claiming hospitals were deliber-

ately overemphasising the risks of surgery to prevent patients choosing it.

Dr Terese Tubman, a GP in Portscatho, Cornwall, said patients were often angry as they were told the cuts were about reducing waste. She said: 'If the public were told to expect restrictions in clinical services, GPs would not continually have to explain the funding shortfall."

Dr Claire Lehman, a GP in Dorset, said rationing was placing a huge strain on her relationship with patients. She said: 'It is difficult to maintain an ef-

#### EDITORIAL

fective doctor-patient relation-

ship when you appear like the

big bad ogre forbidding certain

referrals. If there is to be ration-

ing, we need to do so on nation-

ally, so the playing field is level."

politicians, not GPs: 'GPs are

waking up to the problems of

the Health and Social Care Act,

which will, in the eyes of pa-

tients, make them seem respon-

RCGP chair Dr Clare Gerada said rationing should be led by

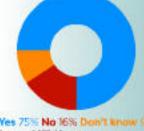
GPs set up to take the blame 19

sible for making these cuts in services.

The Department of Health said rationing on cost alone was wrong, and it would be writing to the NHS to remind it of this. @sofialind Pulse



is rationing of NHS treatments patient relationship?



Survey of 237 6Ps

Clinical

Key questions Ocular disorders

NEW Paediatric clinic Meckel's diverticulum

Guideline update Venous thromboembolism

#### **Business & Commissioning**

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Peverley Screw these toolkits and workshops

Leak reveals BMA

GPs support charging

reforms turmoil

for no-shows

#### Margaret McCartney Catching the running bug

Opinion Recruiting more GPs is key to future-proofing the NHS

Letters No wonder Peverley is going part time

#### CPD in this issue: 1.5 hours

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#### The week in general practice

#### INSIDE

GPs forced to pay for revalidation feedback after PCOs refuse to fund colleague questionnaires

page 4

Pilot to abolish practice boundaries trial to be extended page 6

Dr Deborah Colvin

Major European study backs benefits of breast cancer screening

#### page 10

Daily steroids are 'not needed' for mild asthma, say researchers

page 14

### MORE ONLINE > pulsetoday.co.uk/news

The RCGP has launched a consultation on its vision for the future of general practice as part of a new 10-year plan to improve patient care

pulsetoday.co.uk/practice-news

#### Download of the week

Read the RCGP's plans for the future of general practice

pulsetoday.co.uk/downloads

#### Video of the week

Watch our interview with new Scottish GPC chair Dr Alan McDevitt, as he discusses whether the break-up of the UK-wide GP contract is imminent

▶ pulsetoday.co.uk/videos

# Leak reveals **BMA** reforms turmoil

Emails show fierce debate among council members, with some calling for commissioning boycott

#### EXCLUSIVE

By Sofia Lind

GP leaders are facing mounting pressure to take a much tougher line on the NHS reforms

boycott of commissioning, after intense behind-the-scenes lobbying from some of the BMA's most senior figures.

A series of emails circulated on the BMA Council's internal email list, amonymously leaked to Pulse, lift the lid on the fierce ongoing debate among council members, with some calling for a mass withdrawal from commissioning or legal advice on possible industrial action.

Pulse understands that many of the concerns raised, under the subject line 'It's all

and consider a profession-wide

**PULSENEWS** 

#### RATIONING SPECIAL

APPEALS

#### Rise in exceptional funding appeals from patients

GPs are seeing increasing numbers of patients appeal against NHS rationing decisions, as more patients turn to exceptional cases panels to fight rejections for procedures such as breast reductions and bariatric

Pulse's survey found that 53% had experienced a rise in the number of patient appeals to an exceptional cases panel this year. Some 34% said they had not experienced more patient appeals, while the remainder were

Dr Mike Ellwood, a GP in Hull, said he had not seen any such appeals last year, but was now seeing one a month.

"We get a lot of upset and unhappy patients,' he said. 'We know that bariatric surgery reverses diabetic problems and the arthritis associated with be-

ing overweight. Patients are suffering from increased turmoil from not having access to these procedures, or having them delaved."

Dr Oliver Start, a GP in Stevenage, Hertfordshire, said even the rationing of procedures deemed 'cosmetic' could have a severe psychological impact on patients: 'I had one patient who needed an abdominoplasty severely. It was cosmetic, but still really awful. She was rejected for the treatment on the NHS. Plastic surgeons used to do these procedures based on their own judgments whereas now they need permission because of funding.

A spokesperson from NHS Hertfordshire said: 'We have seen an increase in individual funding requests over the past two years."

#### KNEE REPLACEMENTS

#### Obese patients 'penalised' by knee surgery rules

Obese patients are being un- underwent a knee replacement fairly 'penalised' when they are blocked from having a knee replacement as their improvement after surgery is equivalent to those with a 'normal' weight, researchers have concluded.

Using national patientreported outcome measures (PROMS) data, the researchers found although obese patients had lower scores overall, they showed an equivalent improvement in scores after surgery.

Pulse revealed last year that LMC and CCG leaders had backed moves by NHS Hertfordshire to block any patient with a BMI over 30 from being referred for joint replacement surgery unless they took part in a weight-loss schedule.

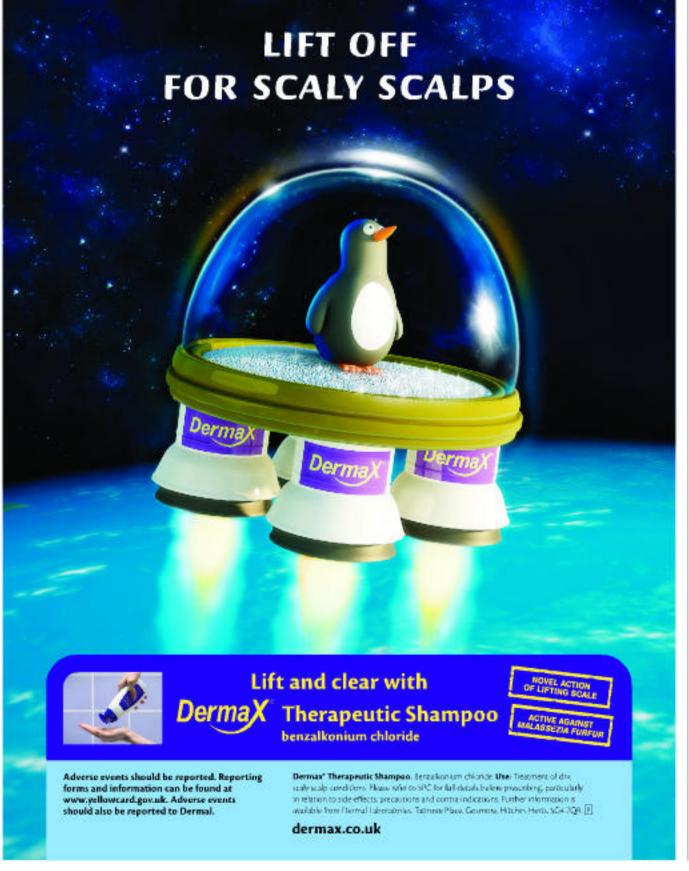
UK researchers looked at data from 13,600 patients who

between May 2008 and September 2010.

They found the change in preoperative and postoperative PROM scores was equivalent in both groups of patients, with a change in knee health score of 16 in the obese group and 15.7 in the normal weight group.

Writing in the Journal of Bone and Joint Surgery last month, the authors concluded: 'It is important that those in control of healthcare resources do not penalise obese patients on the basis of the limited functional outcome data available from previous studies."

Dr Sally Hope, a GP in Woodstock, Oxfordshire, and a member of NICE's hip fracture guideline committee, said: 'This paper will be helpful in appeals."





going horribly wrong', will be debated at the next BMA Council meeting on 27 September.

Dr Jacky Davis, a BMA Council member and consultant in north Lendon who has long opposed the NHS reforms, apparently began the thread, asking: 'Dear Laurence and other GPs time to discuss withdrawal from commissioning? It's still not too late but suspect it will be soon. Many feel BMA/GPC leadership urgently required.

Dr Bob Morley, Birmingham. LMC secretary and another BMA Council member, wrote: "The socalled clinical commissioning agenda and contractual obligation of practices to be the constituent members of the statutory rationing bodies puts tens of thousands of BMA members in a position of impossible conflict with their professional responsibilities to patients.

We need to take an unequivocal position, both to the public and the profession, against the CCG agenda,' he added. 'We need a definitive answer as to whether there would be legitimate grounds for industrial dispute by means of GP non-engagement with COGs."

Other members stapped short of demanding a boycott, but pressed for renewed debute.

Dr Kailash Chand, who led calls earlier this summer for the BMA to consider boycotting commissioning in response to the pension reforms, and has since been elected as the association's deputy chair, wrote: 'The entire concept of CCGs is fundamentally flawed.

The BMA/GPC needs to proactively formulate a policy to safeguard not only its members' interests, but [those] of patients

Dr Helena McKeown, a BMA and GPC council member who recently quit as an RCGP com-

missioning champion in protest against what she called 'covert rationing', backed 'an all-out publicity campaign with ... a public-facing ethical basis'.

GPC chair Dr Laurence Buckman responded by predicting 'CCGs will turn into worse monsters than PCTs', but played down the prospects of a boycott.

'Most GPs will ignore [clinical commissioning) and just dump

Dr Bob Morley

it in the "annoying box",' he said. They simply don't care as long as they can do their job and take home enough pay.

'I fear that the public will blame GPs for the mess that will result from a shrinking health economy but my campaign would major on that. Not doomsaying, not trying to get

most GPs to refuse to co-operate with the whole enterprise ... but facing the profession and the public and warning them what might happen and what the BMA can do to change it.'

I know we agreed about analysis but not tactics up to now. I believe the gloves are coming off but we need to convince 32,000 GPs that now is the time to act."

Pulse approached each of the contributors to the email discussion for comment. While each of the doctors that responded expressed surprise that we had been given copies of the emails, none denied their authenticity.

When Pulse asked Dr Chand about the leaked emails, he declined to speculate how a boycott of commissioning could be staged, but said: 'Something has to be done, because it is harming patient care. Everything is still on the table."

@Sofialind Pulse



CHARGES

# **GPs support charging for no-shows**

three-RATIONING SURVEY Nearly quarters of GPs support charging patients for missed appoint-

ments if they are serial nonattenders. Pulse's survey reveals. The survey of 237 GPs shows

that - in certain circumstances - GPs are supportive of removing the cherished NHS commitment to be free at the point of delivery'.

A further 30% said they would support a limit on the number of GP appointments per year that patients are allowed before they have to pay. Some 34% would support charging for all GP appointments, the survey reveals.

The survey is the first to test the temperature of general practice on charging as the QIPP efficiency drive begins to bite, and comes shortly before GPs take the helm in COGs.

Some 38% of GPs said they would support a limit on the number of A&E attendances



Dr Richard van Mellaerts: charging patients deserves debate

that patients could rack up before they were charged, and half said they backed a reduction in the number of people eligible for free prescriptions.

After the PIP breast implant debacle, 44% of GPs said patients should have to pay for followups after private treatment or screening.

Almost 45% of GPs backed controversial treatment restrictions recently introduced in some areas for patients whose lifestyle could affect the outcome of surgery, such as smoking and obesity.

But the proposal to add GP appointments to the list of other major paid-for health services such as prescriptions, opticians and dentistry - is likely to be more controversial.

Dr John Etherton, a GP in Rottingdean, Sussex, said: They should charge and potients could get a refund or partial refund. It would make people think twice about whether they need to see a doctor. It would filter out an unnecessary core."

Dr Richard van Mellaerts, a GP in Kingston-upon-Thames, south-west London, said charging for appointments should be looked at, as it had worked 'relatively successfully' in the Republic of Ireland and Aus-

He said: There needs to be a discussion about it with patient groups, politicians, and the BMIA and the medical colleges because the current system is running into more and more

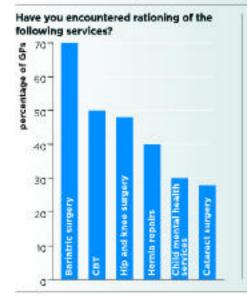
But Dr Mark Selman, a GP in Exeter, Devon, said he was against all charges. He said: 'It will affect those who need healthcare most. If you have an NHS, it must be free at the point of delivery."

A Department of Health spokesperson said: 'The NHS is free for everyone. The GP contract does not allow registered patients to be charged for any form of NHS care a practice delivers or arranges."

@pulsetoday







Over the past year, has the pressure on your daily practice:



Become much worse 43% Become somewhat worse 45% Reduced somewhat 1% Reduced a lot 0%

Does local rationing of NHS treatments



No 16% Don't know 16%

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#### **PULSENEWS**

# GPs face 360-degree feedback bill

Some PCOs refuse to pick up costs of revalidation feedback, leaving GPs to pay up to £200 each

#### **EXCLUSIVE**

By Jaimie Kaffash

GPs in some parts of the country may have to pay up to £200 per head for revalidation because their primary care organisation is refusing to pay for their colleague questionnaires to be assessed.

Revalidation, which is set to be rolled out nationally from December, will require GPs to collect 360-degree feedback on their competence from both col-

leagues and nationts

The GMC has said this will need to be carried out by an 'independent questionnaire company' in most cases.

But although some PCOs have agreed to purchase packages for GPs, others have said it is up to GPs to fund their own assessments, with one nine-partner practice claiming it could cost them up to £1,800.

A range of companies are understood to be quoting GPs a flat fee of between £100 and £200 to provide the service. An-



Dr Dominique Thompson: quoted up to £200 for feedback

other company, Clarity, said it had signed up 73 PCOs to use its package. It said a further 10,000 GPs, whose costs are not being paid by their PCOs, are now paying a £50 annual subscription, which includes one assessment as part of the five-year revalidation cycle.

The GMC said: 'Independent survey organisations will usually charge for the administration of questionnaires. The question of who pays is a matter that should be determined locally.'

PCT clusters paying for the packages include NHS Humber, NHS Arden and NHS Outer North East London. In contrast, NHS Buckinghamshire and Oxfordshire, NHS Bedfordshire and Luton and NHS North East London and the City are not providing funding at this point.

Dr Dominique Thompson, a GP in Bristol, said her practice was being asked to pay for the questionnaires: "The costs are about £100 to £200 per GP. We have nine GPs so we will have a choice of spending £900 or £1,800. That will mean the money is not spent on patients."

#### What GPs need for revalidation

360-degree feedback

One patient and one colleague questionnaire in the five years before revalidation

CPD At least 50 learning credits in the 12 months prior to the last appraisal before revalidation

Significant event audits

At least two for the 12 months prior to the last appraisal; any serious incident must be included

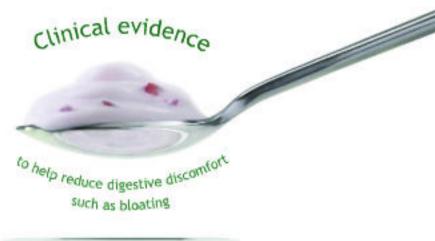
Clinical audits Evidence of regular participation in quality improvement activity

Source: PCGP Guide to Revalidation

Dr Richard Vautrey, GPC deputy chair and a GP in Leeds, said: 'No doctor should have to pay for colleague feedback or patient surveys.' He added that different arrangements for collating the information were of concern. 'We are taking that up with the national bodies,' he said.

@pulsetoday

# What's inside?





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The GMC's

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#### Private sector to cash in on reforms

The Government's health reforms offer a potential £20bn opportunity to the private sector, according to a new report aimed at encouraging profit-making companies to take a bigger share of the NHS.

The report from corporate finance adviser Catalyst says there is a huge opportunity for the private sector to expand on its 2.2% share of the primary care market.

Although the report admits that 'ownership structure and access to pension entitlements' pose 'significant challenges' to increased market penetration, it says measures such as removing practice boundaries offer 'considerable scope' for the private sector to provide more GP services.

It predicts there will be a wave of mergers and acquisitions in primary and secondary care in the medium to long term, driven by 'further promotion by the Government of the alternative models used by the private sector, combined with the removal of regulatory barriers to the sector's increasing participation'.

Dr Thomas Caldwell, a GP in Worcester, said: 'So in short, Lansley's changes mean that the NHS is ripe for privatisation. Goodbye NHS, hello widening health inequalities.'

#### Half of GMC complaints are against GPs

Nearly half of all patient complaints about doctors are made against GPs, even though they represent just a quarter of doctors, according to a new report from the GMC.

The number of complaints against doctors overall has hit a record high, with the total number of complaints to the GMC increasing by 23% from 7,153 in 2010 to 8,781 in 2011.

The GMC's second annual State of Medical Education and Practice in the UK report also found nearly three-quarters of all complaints in 2011 were about male doctors, though only 57% of all registered doctors were men. General practice, psychiatry and surgery were overrepresented as specialties. Some 47% of all complaints made were against GPs.

The GMC said greater expectations, an increased willingness to complain, less tolerance of poor practice within the profession as well as media attention for high profile cases could be behind the increase.

Niall Dickson, GMC chief executive, said: 'We do need to develop a better understanding [but] we do not believe it reflects falling standards.' FOR PATIENTS WITH TYPE 2 DIABETES

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- \*\* For patients with creatinine clearance ≥ 30 to <50ml/min

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· in patients inadequately controlled by diet and exercise alone and for whom melformin is inappropriate due to contraindications or intolerance.

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- · a FPMRy agenist (i.e. a thiazolidinedione) when use of a PRARy agenist is appropriate and when diet and exercise plus the PPARy agonist alone do not provide adequate glycaemic control

#### as triple and thurspy in combination with

- · a suiphonylurea and mettermin when diet and exercise plus dual therapy with these medicinal products do not provide adequate physaemic control.
- . a PPMRy agonist and metformin when use of a PPMRy agonist. is accomplate and when diet and evencian also due therapy with these medicinal products do not provide adequate

Januaria is also indicated as add-on to insulin (with or without metformin) when diet and exercise plus stable dosage of insufin do not provide adequate plycaemic control.

#### DOSAGE AND ADMINISTRATION

One 100 mg tablet once daily, with or without facel. When stagligtin is used in combination with metformin ancilor a PFARy agenist, maintain the sissage of methornin and/or PRARy agonist, and administer situality fin concomitantly. When used in combination with a sulphonylurea or with insulin, consider a lewer dose of sulphonylurea or insulin, to reduce risk of hypoglycaemia. If a dose of Januvia is missed, take as soon as the parient remembers. Do not take a double dose on the same day

Recal impairment when considering use in combination with other anti-diabetic products, check conditions for use in patients with renal impairment. No desage adjustment required for mild renal impairment (creatinine clearance [CrCl] ±50 ml/ mini. For patients with moderate renal impairment (CrCl >30) to <50 int/min; the dose of 'Januara' is 50 mg once daily. For patients with severe renal impairment (CrCl <30 mL/lnin) or with end-stage renal disease (ESRI); requiring haemodistysis or peritoneal dialysis, the dose of 'Januvia' is 25 mg once daily. 'Januaria' may be administrated without regard to the timing of dialysis, Because there is a dosage adjustment based upon renal function, assessment of renal function is recommended prior to initiation of Canonia' and periodically thereafter. Hepatic impainment: no desage adjustment necessary for patients with mild to moderate hepatic impairment. Januara has not been studied in patients with severe hepatic impairment. Elderly: no desage adjustment necessary. Exercise care in patients > 75 years of age as there are limited safety data in this group. Children: not recommended in children below 18 years of age.

#### CONTRA-INCICATIONS

Hypersensitivity to active substance or excipients.

General: do not use in patients with type 1 diabetes or for diabetic ketnucidosis.

Passing Past-marketing experience - sportaneously reported adverse reactions of acute pancrealitis, inform patients of the symptom of acute pancreatitis; persistent, severe abdominal pair. Resolution of pancreafffs has been observed after discontinuation of siting lightin, but very rare cases of recrottating or harmorrhagic pancrealitis and/or death have been reported. If pancrealitis is suspected, 'Januvia' and other potentially suspect medicinal products should be discontinued. Hypoglycaemia when used with other anti-hyperglycaemic agests. Rubts of hypoglycaenia reported with sitaplictin were generally similar to rates in patients taking placebo. When situalistin was added to a sulphonyluna or to insulin, the incidence of hypoglycaemia was increased over that of placebo: therefore consider a lower dose of sulphorytures or insulin to reduce the risk of hypophycaemis. Renal impairment: 'Januvia' is renally excreted. To achieve plasma concentrations: of 'Januaria' similar to those in patients with normal renal lower dreages are recommended in patients with moderate and severe renal impairment, as well as in ESRD patients requiring haemodialysis or peritorical dialysis (see section Tosage and administration' above and section 4.2 and 5.2 of the SmPC). Hypersensitivity reactions: Serious hypersensitivity reactions have been reported, including anaphylads, andredons, and estitlative skin conditions including Stevens-Johnson syndrame. Onest occurred within the first 3 months after initiation of breament with some reports occurring after the first does. If supported, discontinue

'Januvia', assess for other potential causes and institute alternative treatment for planetes.

#### Drug interactions

Law risk of clinically meanineful interactions with melformin and ciclosporin. Meaningful interactions would not be expected with other p-glycoprotein inhibitors. The primary enzyme responsible for the limited metabolism of sitagliptin is CYP3A4, with contribution from CVP2C8.

Digasiv: sitagliplin had a small effect on plasma digasin. concentrations, and may be a mild inhibitor of p-glyceproteinin vivo. No dosage adjustment of digosin is recommended, but monitor patients at risk of algorin toxicity if the two are used

Pregramcy and Installent Do not use during pregramcy or breast-feeding.

#### SIDE OFFECTS

#### Refer to SPC for complete information on side effects

Situation manotherapy. Common & 1/100 to <1/100 upper respiratory tract infection\*, masopharyogitis\*, astecarthritist, pain in extremity! hypoglycaemia!, headache; Bresownon: & 1/1,000 to <1/100): skinness, constitution. Combination with melformin: Common & 1/100 to <1/10): hypoglycaminal, rauses, flatulence, varieting; Uncoverse & 1/1,000 to <1/100: somnolence, constitution, upper abdominal pain, diarrhote, blood glucose decreased. Combination with a sulphonylarea: Constron & 1/100 to <1/10/: hypoglycaemia\*. Combination with metiornin and a sulphorylurea: Very common \$4770: hypoglycaemia"; Converse p. 1/100 to <1/10): constipation. Combination with a PPARy agonist is logitisatine's Common (a 1/100 to <1/10): hypophycaemia', flatulenes, peripheral cederns, blood plucess. decreased. Combination with a PPARy agonist and metformin: Common (≥ 1/100 to <1/100 upper respiratory tract infection). hearlache, diarrhoea, womiting, hypoglycaemial, peripheral. gedema, cough?; Uncommon /e. 1/1,000 fo <1/1000 fungal skininfections. Combination with insulin with/without metformin. Common ( 1/100 to <1/10): headache, hypoglyczemia', influenza; Uncommon je 1/1,000 to <1/100; dry mouth,

Adverse events with stagliptin alone in clinical studies, or storing post-approval use alone and/or with other diabetes medicines where frequency is not known impersonalityly reactions including analytelactic responses (see section 4.4/#1/... interstitial lung disease", vernifing", acute pancreatitis! fatal and non-total haemorrhapic and necrolizing concreatitis? angioederna!,1, raef!;1, urticaria!;1, cutaneous vasculitie!;1, enfoliative akin conditions?.1 including Stevens-Johnson syndrome<sup>\*,\*</sup>, arthralgia<sup>\*</sup>, myalgia<sup>\*</sup>, impaired renal function<sup>\*</sup>, abute renal failures.

- † Based on incidence regardless of causal relationship.
- # Adverse reactions were identified through poetmarketing
- § 54-week time point.
- If See procautions.

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#### Marketing Authorisation Holder

Merck Sharp & Bohme Limited

Hertford Road, Hoddesdon, Hertfordshire ENT1 98U, UK

#### PDM Date of review of prescribing information: March 2012

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Date of preparation: March 2012



#### **PULSENEWS**

# **Boundaries trial** to be extended

#### Practice boundaries pilot will last a further six months

#### By Madlen Davies

The Department of Health has announced a six-month extension of its trial of the abolition of practice boundaries, after the controversial pilots were beset by delays and a lack of enthusiasm from GPs.

The DH told Pulse that the pilots, which allow patients in six PCTs across three cities to register at participating practices near their work or attend as an out-of-area patient, will run for six months longer than planned and will now conclude at the end of September 2013.

A letter sent to PCTs in the pilot areas last week, exclusively revealed on PulseToday, confirmed the extension. However, the DH said no new areas would pilot the policy in the interim.

The news comes after the GPC raised concerns about whether the pilots would yield reliable data.

As of last month, only 42 practices in the pilot areas had agreed to take part, while LMC leaders in east London have led a boycott of the scheme in NHS Tower Hamlets and NHS City and Hackney.

A DH spokesperson said: 'The GP Choice pilots have been extended from April 2013 to the end of September 2013. This extension will provide stability for existing patients who have



Dr Deborah Colvin: LMC will continue to boycott pilots

#### Why DH has extended pilots

- To encourage more patients to register with participating practices, to 'further assist' evaluation of pilots
- To provide 'stability' for patients registering with participating practices

Source: Department of Health

chosen to register with a participating practice. We also believe this extension will encourage patients to continue to register with a participating practice over the coming months, which will further assist in the evaluation of the pilots."

Dr Nigel Watson, chair of the GPC's commissioning and service development subcommittee, said: 'The perception that lots of workers can't access their GP so need to see one near their place of work hasn't been borne out in the pilots. We didn't think this policy was a solution to the problem because we thought it was unworkable, and we've been proved right."

Dr Deborah Colvin, chair of City and Hackney LMC, said: 'There has been no commitment to looking at funding of secondary care for patients registered away from where they live. We will continue to boycott this project."

@pulsetoday

#### **ANALYSIS**

#### Low take-up made delay inevitable

It is not surprising the timeframe for the boundary pilots has been extended. As the start date in Nottingham was delayed from April to July this year, it was clear more time would be needed for a proper evaluation.

Nottingham seems a strange choice for such a pilot since it does not have a large number of commuters. Only 54 patients have registered, and 23 are temporary residents of a drug rehabilitation centre caught between practice boundaries.

Out of 14 practices that expressed an interest, six

have signed up.

Nottingham also has a successful walk-in centre, a reason why the number of 'day patients' may not be very large.

The concern about what registered patients will do if they fall ill at home has been answered. They will be directed to their home PCT's patient services department and, from next April, the 111 service, which will direct them to a locally commissioned home visiting service. Who pays for this has not been clarified, nor whose budget will cover

the cost of secondary care treatment or community care services the patients need - the pilot practice or the CCG in whose area they live? Whose budget will cover any secondary care treatment or community care services the patients need?

this threatens more complexity. is chief executive of Nottinghamshire

The NHS Commissioning Board is said to favour a more streamlined GP contract, but

#### College calls for better OOH access

The Royal College of Physicians has called for improved access to GPs out of hours to relieve the pressure on A&E departments.

In a new report Hospitals on the edge? The time for action, the college warned acute care could be on the brink of collapse, with the last decade seeing a 37% increase in emergency admissions despite general and acute beds having been reduced by a third compared to 25 years ago.

In the report, the college accused the NHS of being 'slow to develop comprehensive, effective alternatives' to hospital admission.

It suggested out-of-hours GP coverage has become more 'fragmented' since the introduction of the new GMS contract in 2004, and urged: 'We must ensure the availability of primary care serv-

ices whenever they are needed, including at the weekend and at night.

But Dr David Lloyd, co-founder of leading out-of-hours provider Harmoni, said the real issue was the provision of urgent care: 'It isn't out-of-hours care that is the problem. The vast majority of patients that clos up A&E are sent there during the

# NEW data demonstrates superiority of CHAMPIX over single and combination NRT for quit success at 1 year

The systematic review and multiple treatment comparison (MTC) meta-analysis reviewed 146 smoking cessation randomised controlled trials (RCTs), consisting of 53,412 patients, using direct and indirect comparisons of treatments.

#### CHAMPIX showed statistically significant improvements in smoking abstinence at 1 year vs.:

- Standard-dose NRT patch (≤22 mg)
- High-dose NRT patch (>22 mg)
- Combination NRT (NRT patch PLUS one additional NRT formulation\*)

#### Statistical significance in smoking abstinence over time



Adapted from Mills EJ et al. Ann Med 2012. OR = Odds Ratio (OR>1 favours CHAMPIX)

Crt = 95% Credible Interval (Credible Intervals are the Bayesian equivalent of classic Confidence Intervals)

The meta-analysis only included open-label and blinded RCTs with at least 3 months follow-up post-target quit date together with biochemical confirmation of smoking abstinence.

Limitations with the MTC approach are that assumptions are made that the trials measure a similar outcome, study populations are appropriate to combine, and direct and indirect evidence is consistent.

Safety was not investigated in this meta-analysis. There are special warnings and precautions in relation to CHAMPIX regarding neuropsychiatric and cardiovascular risks – for further information please see the SmPC.

The results from this meta-analysis provide additional evidence to support the use of CHAMPIX as a first-line treatment option for smokers.

"The additional NRT formulation included gum, lozenge, inhalator and nasal spray.



Date of Preparation: August 2012

CHA1360

CHAMPIX\* Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information). Please Product characteristics for full Prescribing Information). Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. Presentation: White, capsular-shaped, biconvex tablets debassed with "Pitzer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debassed with "Pitzer" on one side and "CHX 1.0" on the other side Indications: Champix is indicated for smaking cessation in adults. Dosage: The recommended dose is 1 mg varenicine twice daily following a I-week titration as follows: Days 1-3. 0.5 mg once daily, Days 4-7.0.5 mg twice daily and Day 8-6nd of treatment 1 mg twice daily. The patient should set a date to stop smaking. Dasing should usually start 1-2 weeks before this date. Patients who are not willing or able to set the target guit date within 1-2 weeks, could be offered to start treatment and then choose their own out date within 5 weeks. Patients who treatment and then choose their own guit date within 5 weeks. Patients who cannot tolerate adverse effects may have the dase lowered temporarily or permanently to 0.5 mg twicedaily. Patients should be treated with Champix for 12 weeks. For potents who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twicedaily may be considered. Following the end of treatment, dose topening may be considered in patients with a high risk of relapse. Patients with renal insufficiency; Ahid to moderate renal importment. No dasage objustment is necessary. Patients with moderate renal importment who experience intolerable adverse events. Dasing may be reduced to 1 mg ance daily. Severe renal impairment: I 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; No recommended in patients below the age of 18 years. Contraindications: Hypersensitivity to the orbits substance or to any of the exciptents. Warnings and precoutions; Effect of smaking cessotion. Stapping smaking may all the observations of the stage of the patients. the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary lexamples include theophylline, worfarin and insulini. Changes in behaviour or thinking, arrively, psychosis, mood swings, aggressive behaviour, depression, suitable ideation and behaviour and suitable attempts have been reported. in patients attempting to aut smoking with Champk in the post-marketing experience. Not all patients had stopped smoking at the time of anset of symptoms and not all patients had known pre-existing psychiatric finess. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour or thinking that are of concern for the dactor, the patient, lamity or caregivers are observed, or if the patient develops swicted ideation or swicted behaviour. In many post-marketing cases, resolution of symptoms after discontinuation of varenicline was reported, although in some cases the symptoms persisted, therefore, angoing follow up should be provided until symptoms resolve. Depressed mood, rarely including suicidal ideation and suicide aftempt, may be a symptom of nicoline withdrawal. In addition, smaking cessation, with or without pharmacetherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). In a Irial of patients with stable cardiovascular disease KCVD certain cardiovascular events were reported more frequently in patients heated with CHAMPIX. Patients taking CHAMPIX should be instructed to notify their doctor of new or worsening. cordiovascular symptoms and to seek immediate medical attention if they experience signs and symptoms of myocordial 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. been established. There is no dinical experience with Champix in portants with epilepsy. At the end of freatment, discontinuation of Champix was associated with an increase in irritability, urge to smake, depression, and/or insomina in up to 3% of patients, therefore dose topering may be considered. There have been post-marketing reports of hypersensitivity reactions including angiaedema and reports of rare but severe culoneaus reactions, including Stevens-Johnson Syndrome and Erythema Multiforma in patients using varenicline. Patients experiencing these symptoms should discontinue treatment with varenicline and contact a health care provider immediately. Fertility, pregnancy and lactations 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 leeding mathers when the benefit autweighs the risk. There are no clinical data on the effects of varenicline on fertility. Non-clinical data investigation in the rat. for humans based on standard male and female fertility studies in the rat **Driving and operating machinery:** Champix may have minor at maderate 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 loown whether this medicinal product affects their ability to perform these activities. Side effects: Adverse reactions during clinical trials were usually mild to maderate. Wast commanly reported side effects were abnormal dreams, insomnia, headache and nousea. Commanly reported side effects were increased appetite, somnolence, dizzness, dysgeusia, vorniting, constipation, diarrhaea, abdominal distension, slomach discamfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side effects. **Overdose:** Standard supportive measures to be adapted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no expenence in dialysis following overdose. **Legal category:** <u>POM</u> **Basic NHS cost:** Pack of 25 II x 0.5 mg and 4 x Img tablets Card (EU/I/06/360/003) £27:30. Pack of 26 Img tablets Card (EU/I/06/360/004) £27:30. Pack of 56 img tablets HDPE Battle (EU/I/06/360/001) £54:60. Pack of 56 img tablets HDPE Battle (EU/I/06/360/002) £54:60. Pack of 56 img tablet HDPE Battle (EU/I/06/360/003) £254:60. Natial pack sizes may be marketed of marketed at lounch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CTI2 9NJ, United dreams, insomnia, headache and nousea. Commonly reported side effects Authorisation Holder: Pfizer Limited, Sandwich, Kent, CTI3 9NJ, United Kingdom: Further Information on request: Pfizer Limited, Walton Caks, Darking Road, Tadworth, Surrey KT20 7NS Last revised: 03/2012. Ref. C 10\_0

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 Pfizer Medical Information on 01304 616161.

For further information, please contact Plizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

#### Reference

 Wills E. et al. Comparisons of high dose and combination nicotine replacement. Therapy, varieticine and buprapion for smoking cessation: a systematic review and multiple treatment mate-analysis. Ann. Med. August 2012.





With a long-term record of success in reducing symptoms, exacerbations and hospitalisations vs placebo, SPIRIVA® is a LAMA you can count on to help lead your COPD patients to everyday victories.<sup>1,2</sup>



Prescribing Information (UK) SPIRIVA® (tiotropium)

Inhalation powder, hard capsules containing 18 microgram tiotropium (as bromide monohydrate). Indication: Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). Dose and Administration: Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler\* device. Contraindications: Hypersensitivity to tietropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which centains milk protein. Warnings and Precautions: Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrowangle glaucema, prestatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalationinduced bronchospasm. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the drug powder into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discemfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and comeal nedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tietropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. Interactions: Although no formal drug interaction studies have been performed, tiotropium bremide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic branchedilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. Fertility, Pregnancy and Lactation: No documented clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Tietropium bromide should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of tiotropium bramide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tistropium bramide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotrenium bromide therapy to the woman. Clinical data on fertility are not available for tiotropium. Effects on ability to drive and use machines: No studies have been performed. The occurrence of dizziness, blurred vision, or headache may influence the ability to drive and use machinery. Undesirable effects: Common (> 1/100 to <1/10) Dry mouth, Uncommon (≥ 1/1000 to <1/100) Dizziness, headache, taste disorders, visien blurred, atrial fibrillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, orepharyngeal candidiasis, rash, dysuria, urinary retention. Serious undesirable effects consistent with anticholinergic effects include glaucoma, constipation and intestinal obstruction including ileus paralytic as well as urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on side effects. Pack sizes and NHS price: Combopack HandiHaler device and 30 capsules (3 blister strips) £34.87 Refill Pack 30 capsules (3 blister strips) £33.50. Legal category: POM. MA Number: PL 14598/0062. Marketing Authorisation Holden: Boelvinger Ingelheim International GmbH, D-55216 Ingellieim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in August 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 Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

Date of preparation: August 201

UK/SPI-121330





# Review backs breast screening

#### Benefits of screening for breast cancer outweigh the harms of over-diagnosis, says European review

#### By Gemma Collins

The benefits of breast cancer screening outweigh the harms of over-diagnosis, a major European review has concluded.

The review of established screening programmes across 18 European countries, including the UK, concluded that lives saved by mammographic screening outnumbered overdiagnosed cases by two to one.

The review, published in the Journal of Medical Screening this month, looked at the impact of screening over the past 20 years



Breast screening does more good than harm, the review found

#### The evidence

Orange.

powder for oral solution

potassium chloride

Macrogol 3350, sodium chloride

sodium hydrogen carbonate.

cases overdiagnosed

Source: J Med Screen 2012/19(suppl) 5-13

on breast cancer mortality, the over-diagnosis of cancer cases and false positive screening re-

It found that, on average, for every 1,000 women screened every two years aged between 50 and 69, an estimated seven to nine lives were saved and four cases were over-diag-

For every 1,000 women screened, there were 170 who had at least one recall followed by a non-invasive assessment with a negative result, and 30 women who had at least one re-

alceos

SUPPLEMENT

call followed by an invasive procedure that yielded a negative

Members of the EURO-SCREEN working group that carried out the study - including Professor Stephen Duffy, professor of cancer screening at Queen Mary, University of London - said the findings should be clearly communicated to patients through a benefit and harm balance sheet' when they are invited for screening.

The researchers calculated an over-diagnosis rate of 6.5%

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Lavido George, powder for oral equation: Please rater to the Summary of Product Characteristics (SPC) before prescribing Alteroristed Prescribing Information. Prescription: Style-dea suchet each containing a white powder compared at thereagh 3050 13 1050; lookum officiale 350 Tm, collum hydrogen corbonia This Smy, and phase which had 45 fmy Indicationer. The hand of direction constitution and facult impaction. **Designs Exercise** expedie attory. A copy selot treatment for directing construction with Lankit Corrue dess nut no moilly stored 2 vevils, although fills can be repected. If required, byterated use may be reported in the cars of patients with united city residual consultation, according to malityle actions or Parkinson's Biscase, or indicated by regelar constiputing munication in per facility opinity and and transactions. Adults, adulescents and the eliterty: 1-3 cacters duly in elected states, according to instribute important, for to tended size, the dead can be adjusted deem to 1 or 2. sticks 6 stay. Children before 12 years old: Not accommodule. Fagest Impaction: A cause of treatment for facult impactor with Larkit Comparises not comparty exceed 3 days. Adults, adolescents and the withorty. Social study of or his docks all the compared within 5 G year potest. Of this on below 10 years suit that have to invite 1.7 Morets **with impaired nandinvescular function.** For the discriminist facial impaction tile doce who all the studed on that not becoming a varieties we believe to see from a varieties of the facial to the form that the discrimination of the first that the discrimination of the first than the discrimination of the discri in 10.5 yil violite. For use in Decal Impaction, 2 sected a roy to should not in the affector. The reconstituted solution should be obtained sovered in a refragation of 10 for 2° D, for any to sell heuro. Controlledicationer Intestinal abstraction or perforation consect for functional or strectural fraction of the gull wall, less and in patients with aware informatory crediting of their distinuit back jug intension carbo. Durn is diseased to took inequation, Hypersent With to the suffice substances or up of the excitents continued in Louist Crange. Warnings and Presistines: Te begit importure alognoso al subt be confirmed for oppropriate physical or subological energializer of the inclusional subsidiario. If potents accepts any executors indicating all fig. of flake/electros/tex. Louisit Cleange should be steeped immediately. The attemption of other medichal postate cruft framerity be related that to an increase in gratherinative transit indicard by cardo therige, **interactions:** it is a these diad possibility that absorption of other weational products could be telluped transportly during paraplimitarit approvide Ligardic Crames. These kan been labated reports of decreased of flacqueth connect constitute wire interest medicinal products e.g., and epileptics. Therefore, other medicines of caldinative taken uptily for one had before and for one had after biding Lunids Orange. Programmy and locations Studies in animals have strose reproductive booking. Income of the viscource of these findings to homeous is calculous. These size in or feetbeddeship from the size of Lacido Charge in progressive ones. Lacido Dissign can be considerating transferring. Effects on ability to drive and use machines: Loriet ange has ne-littlemon on the ability to drive and use machines, electroble effects: Reachers related to the gastrointestral text are The free Learning and include aboth that pain, writing makes, dyspepsia, abdominal distension, borbongmi, flabulence with small discussion flabulence may also vocan mile actes of mileto usually expected to discuss relations. Allegat resolutions to taking a partitions, originations, alphomes and sich mactions can social Other effects can include sketh ight elitheriances, heatistle und perjohald ouderes. Overdoset fielde to Stv., Logal Category P. HAS Sheet Cartine if 20 suches 50.05 on suches 50.04. MA Mandes Fig. 2010 broth Fall prescribing information available from the MA Halder: Lohn ew traksat lat Edisda, Chalparens, BTS::: ELA . Detivat Kingdons, Date of Preparations June 2015.

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Calorest Chemoble Tablets Prescribing Information Firms ele in the Surmary of Product Dissolvinitis (SPG televi-plescribing Calcons\*, **Procedules:** Clearable biblio containing caldium carbonate 125 kg (i.e. 900 kg of elemental caldium) and calcolinhim). If intragatures (commonling to 400 L) of vitentin E) for and year **involuntiums**: Conection of vitentin E and calcium. of fairney in the other's William and calcium supplement as an adjust, to see the therapy for adequatests. Desage: Adults the table to be cheened and looke with a calcium of water, table per day. Official Mail securities still. Centra-hadications: Colos of the such a indicated in paller b. with Topocadown is. Typocadom codes r. Wisco-calulfooder, vitanin D eventure, rejet no and bore nectostaces, enal issufficients and hypostenolisity to any of the ingredients. This product contains partially hybrography) soythern call. Partie to should not take Tild medicinal product if they are alongs to permit or copy. Wantings and Propositions: Care should be been not use of other neclection on the high productions. Departments, above noticities and principles calculated in which should be married and expectably in the related, in prefer to soft in social. Nation or in colour of long-horn fruitment. This product contains contain (CEC) and accross. Patients with rise linealizary colories, of fruitment inchessors, a placeton-polations mobile open in a consumer tendence transference observed in the colories. The purpose on the product in the product of the reactions. eay be hereful to had if taken of or neatly arg. for the seads of more interactioned Codien should be excepted when combining Cultus of with digitals glycoides and bitande director. Calcium may inpair the absorption of telescycless, statement, from the and too and the slote ators of load 3 is not believe failured from their agents. Positive Merchin with our touch, etc. to SPC for note death, Pragnatory and lactation: Colone? you be provided during programy; and to suring regimes last should be given at least 3 house believe or after cufficiently to produce on adverse effect in the intart. Effects on ability to drive and use machines: Nove known. Side effects: Masters, fejtus calcitata, Trypophesipholoxenia, Trypotculculunia and reflet gests: introduced eleterhyeaus is inhibit constitution. Overdesse: Preseiefe to SPC. Radia IMS costs Pucks bestelling 4 lates of 15 tablet 53.05. Legal classification: It Warforing Authorization Holder Laboratoric Irvanterio International, 22 premie Ariefate Briand, 34110 Avouel, France, Warketing Authorisation Mumbers Pt. 10152/0001. Rull presprising information available frame Gold is that Subjectinish Eddle, Gragueon, Northern Install, \$150, 504. **State of** Propagation: December 2011

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Diabetes and CVD Update 2012: 26 September, London

pulse-seminars.com

among screened women, compared with a rate of 1% to 10% before screening - although they warned breast cancer incidence and mortality rates have changed over time.

Consequently, the estimates of lives saved and over-diagnosed cases were approxima-

But they added the figures 'clearly indicate that the relationship between benefit and harm of mammographic screening is much more favourable than some recent publications suggest'.

Dr Sarah Jarvis, a GP in Hammersmith, west London, said the study looked 'robust', but added: We are still going to keep an eye out for future research."

Dr Margaret McCartney, a GP in Glasgow, said a randomised controlled trial was needed to fully establish the benefits of breast screening. She added: 'It's randomised controlled trials assessed by independent observers that we should be referring

But in an accompanying editorial, Professor Allan Hackshaw, professor of epidemiology and medical statistics at the Cancer Research UK and University College London Cancer Trials Centre, said: 'This tells us that the time has come to move away from relying solely on the older randomised trials of mammographic screening for the evidence base, and to use data regularly collected and monitored from service screening programmes, with proper statistical analyses in addition to the results from randomised

feedback@pulsetoday.co.uk

#### MP calls for non-UK residents to pay for care

Non-UK residents should be charged to see their GP as part of a crackdown on foreign nationals using the NHS without paying, according to a Conservative MP on the House of Commons Health Committee.

Chris Skidmore, MP for Kingswood in Surrey, has written to new health secretary Jeremy Hunt offering recommendations on how to stop non-UK residents taking advantage of the free service, which he says has cost the NHS millions.

Currently, primary care is free for all non-UK residents. But Mr Skidmore is calling for non-UK residents to be charged a flat fee for consulting a GP and for

patients registering with a doctor to be obliged to demonstrate that they are ordinarily resident in the UK and thus eligible for free care', including proof of address and citizenship.

In European countries, British patients are charged for primary care - with the costs being paid for by the NHS, he said.

'It should be the same, therefore, that European users of the NHS should similarly pay for their care. This need not be a disproportionate fee, but it would underline the fact that healthcare has to be paid for by someone, and that the contributory principle of the British welfare state should apply to all'.

#### IN BRIEF

#### Intermediate care group

Demand for intermediate care services far outstrips capacity, the first ever national audit of intermediate care has suggested.





#### Rare condition guidance

The Department of Health has set out recommendations on how NHS services treating rare and uncommon conditions should be nationally commissioned from April 2013.

Full story ➤ pulsetoday.co.uk/clinicalnews

#### GPs to check pilot fitness

GPs in the UK will be able to assess the fitness of pilots applying for the new pan-European light aircraft pilot's licence.

Full story ▶ pulsetoday.co.uk/practicenews



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Figures from 360-degree stakeholder surveys reveal many practices do not feel engaged by their CCG

ENGAGEMENT

# **GPs frozen out of CCG planning**

#### By Helen Mooney

CCGs are struggling to involve GPs in their configuration and decision-making, with official surveys before authorisation showing that many GPs feel frozen out by the new organisa-

An analysis of the first wave of reports from the NHS Commissioning Board's CCG authorisation 360-degree stakeholder surveys show many practices reported a lack of involvement in and understanding of their COG's plans.

The NHS Commissioning Board said the results of the surveys would be used to help assess CCGs for authorisation but said it was not a prerequisite that all practices were 'actively involved'.

In NHS Islington CCG, north London, 56% of GPs responding to the questionnaires, carried out by IPSOS Mori, said they either 'did not feel very involved or [were] not at all involved' in decisions about the 'configuration, structure and governance arrangements' of their CCG.

Similarly, 50% of practices in NHS Oldham CCG, 43% in NHS Dudley CCG and 41% in East Leicestershire and Rutland COG said they did not feel involved in decisions being taken.

In both North East Lincolnshire CCG and Liverpool CCG, a third of GP practices said they did feel involved, while three in five practices in Liverpool also said they were not clear about the arrangements for the delegation of functions in their CCG.



Dr Rob Barnett: many GPs see CCGs as 'the new PCTs'

#### Are GPs engaged with CCGs?

% of members who feel not very/not at all involved NHS Islington CCG - 56% NHS Oldham CCG - 50% NHS Dudley CCG - 43% East Leicestershire and Rutland CCG - 41% Liverpool CCG - 33% North East Lincolnshire CCG Portsmouth CCG - 33% West Cheshire CCG - 21%

Only 35% of practices in Portsmouth CCG, and 52% in NHS Islington CCG, said they understood the financial implications of their CCG's plans.

Source: CCG 360-degree reports

Also in NHS Islington CCG,

only 40% said they understood what was required of their practice to implement plans.

However, the report by NHS Islington CCG insisted that 'overall stakeholders also feel

they have been engaged'.

West Cheshire CCG had more positive feedback, with 79% of practices saying they felt involved in discussions, which the report said was 'significantly higher than the average'.

Dr Russell Walshaw, chief executive of Humberside Group of LMCs, which includes North East Lincolnshire LMC, said communication issues and GP apathy were partly to blame: 'I know North East Lincolnshire CCG has had a review of the processes, and one recommendation was about how they are communicating with practices. In a lot of the meetings, people don't turn up which may reflect GP apathy because an awful lot of GPs just want to get on with seeing their patients.

#### CCGs must overcome culture of suspicion

#### Gareth lacobucci

#### Chief reporter

Figures showing CCGs are failing to engage member practices lay bare the full scale of the challenge to reverse the culture of apathy and suspicion that poisoned the relationship between PCTs and GPs.

These new beasts are meant to be led from the bottom up, driven by the will of member practices. The reality, of course, is that many GPs fear they will become carbon copies of their predecessors, strangled by bureaucracy and divorced from the reality on the ground.

Official reports from the NHS Commissioning Board's CCG authorisation 360° stakeholder surveys show many practices report a lack of involvement and understanding of their CCGs' plans.

Achieving 100% engagement

with GPs would, of course, be a struggle for anyone. But if half do not feel involved with the vision it raises huge questions over how clinically led the new system will really be.

With many conflicting pressures on GPs' time and workload, perhaps it was inevitable that CCGs would struggle to involve them - the message from many seems to be, let us get on with the day

But with GPs about to be handed the unenviable task of commissioning services with a substantial reduction in management costs, CCGs failing to engage their constituent practices will find life increasingly difficult.

Dr Rob Barnett, secretary of Liverpool LMC, told Pulse: 'People are quite rightly sceptical, [feeling] CCGs are just new PCTs. As GPs we all have a day job to do and that is more important than attending CCG meetings."

The board's formal assessment of CCGs will be based on evidence from a combination of the 360-degree surveys, desktop reviews, case studies and site vistice to be actively involved in the CCG. However, we do expect effective engagement mechanisms to allow participation and sign up to the constitution." A spokeswoman for the NHS

its. Its guidance says: 'We don't

expect every GP in every prac-

Commissioning Board said: "We are confident there has been a good level of engagement." @pulsetoday

AUTHORISATION

PRESCRIBING

#### CCGs told to consult pharma over drugs

#### By Madlen Davies

CCGs will be required to engage with pharmaceutical companies when making decisions about the inclusion of non-NICE approved drugs on local draft formularies, according to new guidance.

In February this year, NICE was charged with standardising the process for drawing up and updating drug formularies, after a Pulse investigation revealed a postcode lottery in the availability of NICE approved drugs.

New draft guidance from NICE makes a series of recommendations on who CCGs should involve in decisions re-

garding the inclusion of new drugs yet to be recommended by NICE in local drug formularies.

It says OCGs should engage with 'relevant manufacturers of medicines' as they can offer 'additional evidence and insight that can assist with decision

It adds that while clinicians should make the application for

Dr Shane Gordon



the inclusion of a new drug or treatment, manufacturers may 'support evidence gathering'.

The views of patients and patient representation groups should also be sought as part of the decision-making process.

The document stresses the importance of explicit consideration and inclusion of all stakeholders.

Dr Shane Gordon, CEO of North East Essex CCG, said engagement with patients was 'quite appropriate', but urged caution over assessing evidence from manufacturers that have vested interests.

He said: 'It's appropriate for the manufacturers to give evidence-based input. But it's not unknown for manufacturers to overstate their case."

He added: 'I would advise caution in allowing those groups with the most interest in a drug's inclusion to drown out the needs of the whole population. That's the challenge for COGs.

But Dr Stewart Findlay, a GP in Bishop Auckland and chair of Durham Dales CCG, said engaging with manufacturers was 'good practice'.

He said: 'Their representatives produce a considerable amount of valuable informa-

@madlendavies

#### CCG deadline extended

The NHS Commissioning Board has agreed to grant CCGs an extra two-week period of grace in their applications to become statutory bodies, to give new organisations a better chance of being authorised without condi-

CCGs that have conditions attached to their authorisation when they first submit their applications will now have an extra two weeks to comment and provide more evidence, before their final reports are passed onto the board for autherisation.

As a result, the final authorisation dates for each wave of CCGs will be pushed back by four to five weeks, the board said.

Dame Barbara Hakin, national director of commissioning development, said: "The additional two weeks, designed in consultation with CCGs ... does mean that the final authorisation date for CCGs will be later."

But she added: 'These changes will not have a material impact on the preparations or readiness of individual CCGs."

The move was discussed in this month's NHS Commissioning Board meeting, where the

panel said that the grace period would 'maintain dialogue with the CCG' and 'minimise the number of conditions' that pend to be set.

The combined effect of this and the other stages of dialogue with CCGs during the decisionmaking phase would be to extend the published timescales for decisions for each wave by four to five weeks with decisions

#### The changes will not have a mater impact on readiness of individual CCGs

Dame Barbara Hakin

being made five to seven weeks after final evidence reports are issued, it said.

The final authorisation dates for CCGs will now be November for wave one, December for wave two, January for wave three and February for wave four.

@pulsetoday



#### NHS COMMISSIONING BOARD

#### Alliance warning over commissioning structure

The Government must avoid disengaging CCG leaders with a top-heavy structure and let clinical commissioning 'unfold organically', the chair of the NHS Alliance has said.

Speaking at a Westminster Health Forum session on the Health and Social Care Act, Dr

Michael Dixon, who is also interim president of NHS Clinical Commissioners, called for GPs to get involved in clinical commissioning or they will be 'subservient' in the service going forward.

He warned the Government they must not disengage GPs from commissioning by making the structure unhelpful, because if frontline conditions return to how they were before we have lost the plot'.

He said: 'For me, the way the DH and the Commissioning Board are setting things up seems like saying to David Cameron and Clegg "yes you can

come to the Government, but Gordon Brown will come in and tell you the rules, and then he is going to continually assess you on what you're doing and come in and take over the Govern-

'Do you ever create a revolutionary change in that way?"



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



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

#### ABRIDGED PRESCRIBING INFORMATION

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the vaccine virus has not been reported. However, post-marketing experience with varicellavaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varice la-zaster virus (YZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zastavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zastavax may not result in protection in all vaccine recipients. Pregnancy and lociation: Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Coution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. conficusteroids) or who have a primary or acquired immunodoficiency. Individuals with active Undestrable effects: Very common side effects include: pain/tendemess, erythema, unitested tuberculesis. Pregnancy: Warnings and precoutions: Appropriate fucilities swelling and pruntus at the injection site. Common side effects include warmth, basmatoma and medication should be available in the rare event of anaphylaxis. Deferral of vaccination and industrian at the injection site, pain in extremity, and headache. Post marketing use

fever, swallen glands, rash, also hives and rash at the injection site. For a complete list of undestrable effects please refer to the Summary of Product Characteristics. Package quantities and basic cost: Vial and prefilled syringe with two separate needles. The cost of this vaccine is \$99.96. Marketing authorisation holder: Sanoti Pasteur MSD SNC, 8 Tue Jones Solk, F-69007 Lyon, France Marketing authorisation number: EU/1/06/341/011 Legal category: POM \* Registered trademark Date of last review: June 2012

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

References: 1. Willer E, Marshall R, Vudien J. Epidemiology, autoome and control of varicella-aaster infection. Rev Med Microbiol 1993; 4: 222-30. 2. Bowsher D. The lifetime. occurrence of Herpes zoster and prevalence of post-herpetic neuralgia: A retrospective survey in an elderly population. Eur / Pain 1999; 3: 335-42. 3. ZOSTAVAX® SmPC. The need for a second dose is currently unknown.





Daily inhaled steroids are no more effective than use when asthma symptoms worsen, say researchers

# Daily steroids dose 'not needed'

By Emma Wilkinson

Regular daily doses of an inhaled steroid may be no more effective in mild to moderate asthma than only using a preventer inhaler when symptoms worsen, a US study suggests.

Researchers found no difference on a Variety of measures between patients who only used an inhaled steroid when using rescue therapy and those who took regular daily doses.

The results question current British Thoracic Society and SIGN asthma guidelines that recommend daily inhaled steroids for patients with stage two asthma or above.

The researchers said their findings 'could eventually change the way doctors and patients manage asthma', but GPs warned further studies were needed.

BASALT study ran-The domised 342 patients with mild to moderate asthma who were controlled by low-dose inhaled steroid therapy into three treatment groups.

The groups took either daily



Researchers say their study could eventually 'change the way doctors manage asthma'

#### Online CPD

Case-based learning: asthma in adults

pulse-learning.co.uk

low-dose inhaled steroids as directed by their doctor, steroid dosing that was adjusted on the basis of exhaled nitric oxide testing or a symptom-based adjustment, where patients used a steroid inhaler whenever they needed a rescue inhaler.

The researchers reviewed patients every six weeks for nine months and found no sig-

nificant statistical difference in time to treatment failure - defined as unscheduled care for an exacerbation or a significant worsening of control - between the three groups.

Failure rates were 22% for the daily regime, 20% for the nitric oxide testing group and 15% for the symptom-based approach group. There were also no measreactivity, lung function, days missed from school or work and exacerbation of symptoms and attacks between the three

But cumulative doses of inhaled steroid were significantly lower in patients who took them when symptomatic, with a monthly beclomethasone use of 832µg in this group compared with 1,610µg in those taking daily doses.

Study leader Dr William Calhoun, vice chair for research in internal medicine at the University of Texas in the US, added that adjusting doses of inhaled steroids on the basis of symptoms could be a cheaper and easier option.

Dr Calhoun said: "The flexibility a symptom-based approach may offer will appeal to many patients."

Dr Kevin Gruffydd-Jones, a GP in Box, Wiltshire, who has been involved in the development of several asthma guidelines, said the study showed that intermittent use of inhaled steroids could be useful for some

#### Failure rates

With daily doses of inhaled

With intermittent dosing when taking rescue medication

JAMA 2012;308:987-97

patients, but that it was a fairly small trial.

He said: 'In a selected group of patients, this intermittent approach might help - but in the vast majority of adult patients, regular treatment with inhaled steroids is still more appropri-

He added that asthma was fluctuating condition and patients who appear mild at times may have periods when their condition is moderate to

JAMA 2012;308:987-97 feedback@pulsetoday.co.uk

**ASTHMA** 

#### **GP risk registers halve** admissions in asthma



At-risk registers of Thorax vulnerable patients with asthma in general practice reduce hospital admissions by half

compared with routine care, a UK study suggests.

A study of 29 GP practices - 15 of which implemented an electronic system to flag up at-risk patients - showed the strategy cut the risk of hospitalisation by half compared with routine asthma care over 12 months.

There was also a non-significant drop in patients using A&E and out-of-hours services compared with those receiving routine care. Those on the atrisk register - because they had

DEMENTIA

severe asthma plus psychosocial factors such as smoking, obesity, poor adherence or learning difficulties - were also significantly less likely to receive nebulised 8-agonists than patients receiving routine care.

Even with a cost of £52 per patient for setting the system up, intervention practices spent £138.21 less per patient over one year than those providing routine care, the analysis showed.

The researchers, from the University of East Anglia, concluded: 'The overall pattern of results suggests that use of asthma risk registers improved patient management and out-

Thorax 2012, online 31 August

benzodiazepines. This level of

risk remained when research-

ers adjusted to take account of

factors such as psychological

The researchers, from the University of Cardiff, conclud-

ed that a causal effect would

be 'alarming', although this

could not be proven by the

They added the results sug-

gested the effect may be limited

to a susceptible subgroup rather

J Epidemial Community Health

than being widespread.

2012;66:869-73

#### DIABETES

#### HbA₁c fluctuations raise microalbuminuria risk



Patients with fluctuating HbA,c levels have a 40% increased risk of developing microalbuminuria, con-

cludes a new study.

The Taiwanese researchers found patients with the most variation in HbA,c, measured by standard deviation from the mean of serial tests, were 37% more likely to develop microalbuminuria.

They followed more than 800 middle-aged people with type 2 diabetes over five to seven years, with all showing normal albuminuria readings at baseline. They found just three or four HbA,c measurements over the two-year period were enough to predict the complication.

The researchers said the results suggested poor glycaemie control, even for a short time, can be 'memorised' and cause detrimental effects later on: 'Patients with high HbA,c variability often live unhealthier lifestyles and this may intensify their vulnerability to the development of diabetic nephropathy.

"The predictability of the twoyear HbA,c standard deviation for development of microalbuminuria conveys a clinical message that sustaining glycaemic control at an early stage is cru-

Diabetologia 2012, online 26

#### CANCER

#### Repeated **UTIs linked** with cancer



GPs should investigate repeated urinary tract infections, even if they resolve, as they are predictors of blad-

der cancer, say UK researchers. Their analysis looked at primary care data from 29,000 patients, including almost 5,000 diagnosed with bladder cancer, and highlighted four symptoms

and three laboratory tests that

were independently associated with the condition. Haematuria was the most predictive symptom, and the other symptoms they found with a positive predictive value of more than 2% were dysuria, abdominal pain and constipation. Raised creatinine, inflammatory markers and white blood cell counts were all also independent predictors. The data also

tions were an important marker. But in the first study to look at symptoms other than haematuria in primary care, they suggested GPs use a risk chart to discuss with patients whether a referral in certain circumstances is warranted.

showed that urinary tract infec-

Study leader Professor Willie Hamilton, professor of primary care diagnostics at Peninsula College of Medicine and Dentistry, said: 'This can be a clinical trap, especially in the elderly. We should perhaps be quicker to think of cancer when a UTI isn't responding in the expected way." Br J Gen Pract 2012;62:466-7

#### CONFERENCE ROUND-UP

#### Take smoking history in COPD

Assessing the smoking history of patients with COPD can predict their prognosis, say researchers. Their study looked at 208 individuals with COPD and found that age and the packyears that each patient had smoked were statistically significant predictors of

ERS annual congress 2012

#### Sleep apnoea ups cancer risk

Sleep apnoea is associated with an increased risk of cancer mortality, according to new research. Researchers looked at more than 5,600 patients from sleep clinics in Spain and found those who spent more than 14% of their time with oxygen saturations below 90% had almost double the relative risk of death due to cancer compared with people without sleep apnoea. ERS annual congress 2012

#### Lung cancer in non-smokers rising

The number of non-smokers being diagnosed with non-small cell lung cancer is increasing, say French researchers. Their study looked at 6,000 new cases of non-small-cell lung cancer and found 11.9% of them were in non-smokers, compared to a figure of just 4% from a similar study conducted in 2000. Some 24.4% were female, an increase of 16% from 2000.

ERS annual congress 2012

# Use alcohol screening

Abbreviated alcohol scoring tools - like CAGE and AUDIT-C - are useful for screening newly registered patients and as part of chronic disease management, for example. But patients should not be asked about their

alcohol use before they are asked to fill in the answers, according to a recent case-based learning module.

sensitivity was greatly enhanced by an openended introduction but greatly reduced when patients were asked about the quantity and frequency of their drinking beforehand.

CASE-BASED LEARNING ulse-learning.co.uk

#### TIP OF tools before asking about drinking

Research into the CAGE questionnaire found its

Hot topics in alcohol misuse

Benzodiazepines use

linked with dementia

Patients taking ben-

zodiazepines have

more than a three-

fold increased risk

of developing de-

mentia, shows a

long-term UK epidemiological

Welsh researchers followed

more than 1,100 men over 22

years and found 9% of them took

benzodiazepines regularly at

Those patients had a 3.5-

fold increased risk of devel-

oping dementia compared

with those who did not take

some point during the study.

study.

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# Fighting to keep a UK contract

New Scottish GPC chair Dr Alan McDevitt backs 'tartanisation' of the GP contract over a clean break



By Sofia Lind

Dr Alan McDevitt is stepping into his new role as chair of the Scottish GPC at a crucial juncture, amid an overhaul of health services both north and south of the border, and as Scotland considers a fresh break for independence from the UK.

Arguments over Scotland's political sovereignty are mirrored by the ongoing discussions over the future of the UKwide GP contract, which appears increasingly under threat.



#### McDevitt on...

#### **GP** workload

'if you add anything else to GPs' tasks, then patient needs may not be met.'

'They have been left fallow for a while. We have been distracted from that at our peril.'

#### Sessional doctors

They are essential for the continuation of the delivery of service in general practice.

The private sector

'in Scotland we're talking about having a more collaborative, less market-led The debate on whether Scotland would be better off pursuing a separate contract is raging, agitated by a right-wing think tank pushing for a fully Scottish contract earlier this month, while the Scottish Government seeks a distinct 'tartanised' version of the existing UK deal.

The softly spoken Dr McDevitt replaced the more voluble Dr Dean Marshall as Scottish GPC chair in July, with Dr Marshall remaining on the GPC team after being elected as a UK negotiator.

One notable difference north of the border is the relationship between GPs and politicians, with GPs in Scotland enjoying a constructive relationship with former Scotlish health secretary Nicola Sturgeon.

The new man in the hot-seat says he will be shortly be sitting down with Ms Sturgeon's successor, Alex Neil, to discuss specifics, including the possibility of Scottish-only QOF indicators that are tailored to Scotland's particular public health challenges.

'They want to look at some of the public health areas of the OOF to see that they are meeting the requirements in Scotland as well as issues that might be relevant across the UK,' says Dr McDevitt.

"They also want to look at organisational points and other things like that. It's at a very early stage, but they haven't said they want to negotiate the whole contract - in fact they have quite explicitly said they don't want that."

But he admits it is almost inevitable that the contract will separate further because of the divergence in health policies in the two countries.

'The reality is that if England moves away from the current UK contract with the Health and Social Care Act, then the UK contract may be less applicable to Scotland,' he says.

It has become common in the past few years for GPs to paint Scotland as a utopian paradise compared to the market-driven NHS in England, but Dr McDevitt stresses similarities in patient needs, which he believes justifies the UK-wide contract.

'Scottish general practice requires the same kind of support as practices across the UK,' he affirms. 'You have to remember back to how long it took to renegotiate the last contract. It took three years of intense negotiations, so that's not an easy process to go through, and We don't want to be spending time on something that at the end will be much the same.'

But he may face some resistance from hardliners who believe the time has come to separate, such as Dr Sandy Sutherland, former chair of the Scottish LMCs conference, who in a letter to Pulse this week accuses Dr McDevitt of adopting an 'ostrich-like approach' to the need for a Scottish contract.

The Scottish Government is also consulting on plans to replace unpopular community health partnerships with new health and social care partnerships, with a wider remit to plan and budget across health and social care. Dr McDevitt is upbeat: 'There's often been a failure in clinical engagement [in the past]. I am optimistic we will develop something worthwhile.'

Dr McDevitt recently stepped down as chair of Glasgow LMC after a 17-year spell, and only stopped working full time at his five-partner surgery in Clydebank three weeks ago.

After 23 years, he admits it was 'a tough decision' to go part time, but he insists he was willing to do it to protect an NHS under threat: 'It's about being where the decisions are made to ensure the continuation of British general practice, which I am very passionate about.'

(a:pulsetoday





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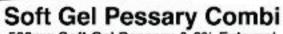
#### Canesten



Oral Capsule 150mg Fluconazole & 2% External Cream Clotrimazole

#### Canesten

Trush Crear



500mg Soft Gel Pessary & 2% External Cream Clotrimazole



saver careefen oo uk



Conscient Conthi Sitting Pescary & 2% Gream alchimasale Sit Implementary and alchimasale 2% whe tream), fedications: Treatment of contidal expirate and rebad expert infections where *Nichronnus* is present or sespected, and candidal relatification from the contract as sets treatment for pure Technologies except when systemic the rape is contracted by can be set used for freatment of the contract parties a point to present to infection. Legal category FOM.

can also be used for treatment of the sexual partner's penie to present reinfaction. Legal

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Adverse events should be reported. Reporting forms and information can be founded "www.mhra.gov.uk/yellowcard". Adverse events should also be reported to Bayer ptc, Consumer Care Division.

Further information is available from Bayer plc, Consumer Care District, Newburg, Berkshire R614 NA, UK. Consult the Summary of Product Characteristics before prescribing, porticularly in relation to side effects, precoudings and contrating cations.

New sode: CGV216 - Date of preparation: Wanch 2512

#### The Big Interviews







Watch the full-length interview with Dr Alan McDevitt and previous interviews with Dr Michelle Drage, Professor Greg Rubin and Professor Helen Lester



pulsetoday.co.uk/the-big-interview

### > Ready for revalidation

#### Dear Doctor

We're getting ready to start revalidating doctors from December onwards, subject to the Secretary of State's decision to go ahead with revalidation this year.

Organisations across the UK are getting ready to support doctors; the systems the GMC needs to start revalidation are in place; and patients say they've waited long enough for the assurance that revalidation will give them.

As licensed doctors, we can get ready in the following ways:

- Xnow the organisation that will give you a regular appraisal and support you with revalidation. The responsible officer of this organisation – your 'designated body' – will be the person who makes a revalidation recommendation about you.
- Make sure you have a regular appraisal based on Good Medical Practice.
  If you're a doctor in training, you should take part in the ARCP process as normal.
- Start collecting your supporting information. You will need six types for your appraisal, including evidence of CPD. Many doctors collect this information already for their practice.

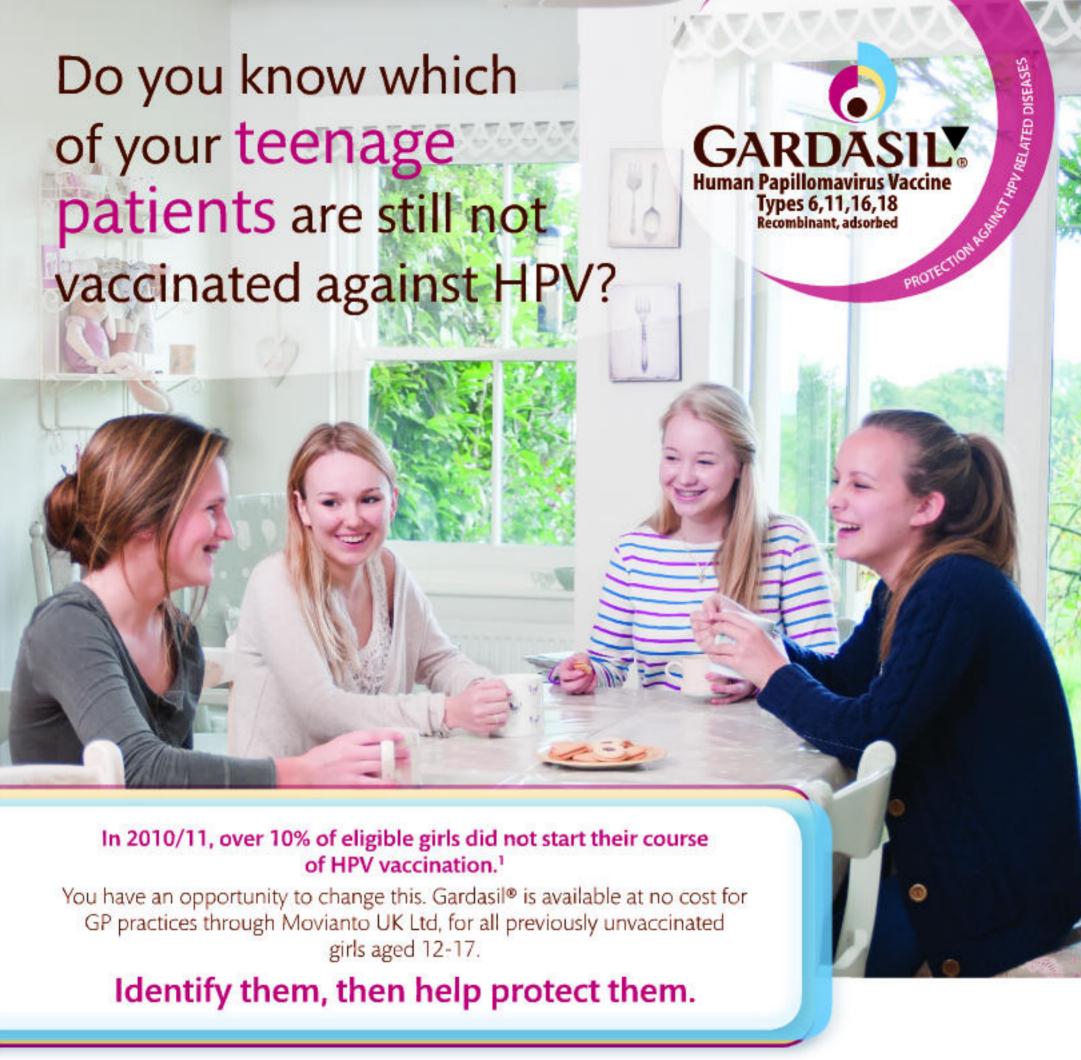
#### Your first revalidation

We will give you plenty of notice and plan to start telling you the date of your first revalidation in December. Most doctors will revalidate between April 2013 and March 2016.

Professor Sir Peter Rubin Chair of the GMC

Our website has guidance and more information to help you prepare for revalidation. Please visit www.gmc-uk.org/ready4reval

General Medical Council



#### For further information, contact your local Sanofi Pasteur MSD representative or visit www.gardasil.co.uk

#### ABRIDGED PRESCRIBING INFORMATION

GARDASIL® (Human Papillomavirus Vaccine [Types 6, 11, 16, 18] (Recombinant, advarted)).

Refer to Summary of Product Characteristics for full product information

**Presentation:** Gardesi is supplied as a single dose pre-filled syrings containing 0.5 millithe of suspension. Each dose of the guadrivalent vaccine contains highly purified viruslike particles (VLPs) of the major capsid LT protein of Human Papillomavines (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (20 µg). Indications: Gordasil is a voccine for use from the age of 9 years for the prevention of premalignant genital lesions (convical, valver and vaginal) and convical concer causally related to certain encegenic Human Papillemavirus (HPV) types and genital worts (condylama acuminata) countly related to specific HPV types. The indication is based on the demonstration of efficacy of Cardasil in females 16 to 45 years of age and in males 16 to 26 years of age. and on the demonstration of immunogenicity of Gordosk in 9- to 15-year old children and adolescents. Despace and administration: The primary receipation series consists of 3 separate 0.5 mill little doses administered according to the following schedule: 0, 2, 6 menths. If an alternate schedule is necessary the second close should be administered at least one month after the first and the third dose at least three months after the second. All three doses should be given within a 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection. Contraindications: Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gordas I. Acute severe febrile liness. Warnings and precontions: The decision to vaccinate on individual should take into account the risk

for previous HPV exposure and patential benefit from vaccination. As with all vaccines, appropriate medical treatment should always be available in case of rare anaphylactic reactions. The vaccine should be given with contain to individuals with thrombocytopaenia or any congulation disorder because bleeding may occur following an inframuscular administration in these individuals. Syncope, same times associated with falling, has accurred after vaccination with Baséasit, vaccinees should be carefully observed for approximately 15 minutes after vaccination. There is insufficient data to recommend use of Gardasil during pregrancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastlessing women, Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, or other causes, may not respond to the veccine. As with any vaccine, veccination with Gordes'll may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gordasil with other HPV vaccines. Undestrable effects: Yery common side effects include: headache and at the injection site, erythema, pain and swelling. Common side effects include brusing and pruntus at the injection site, pyrecia, noused, and pain in the extremity. Rarely orticate and very rarely branchaspesia. has been reported. Idiopathic thrembocytopenic purpura, Guillein-Berré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undestrable effects please refer to the Summary of Product Characteristics. Package quantities and basic NHS cost: Single pack containing one 0.5 mill the dose prefilled syrings with two separate needes. NHS cost: \$86.50 per dose. Marketing authorisation holder: Sandi Posteur MSD SNC, 8 me lones Salk, F-69007, Lyan, France Marketing authorisation number: Ell/1/06/357/007 (pre-filled syrings with two separate needles) Legal category: POM ® Registered holderrock Date of last review: Nov 2012

References: 1. Department of Health, Third Annual Report on HFV coverage. http:// immunisation.ch.gov.uk/annual-kovvacche-coverage-in-england-in-201011-report/ Bate recessed August 2012.

Adverse events should be reported.

Reporting forms and information can be found at www.mhra.gov.uk/yellow.card

Adverse events should also be reported to Sanafi Pasteur MSD, telephone number 01628 785291.





# GPs set up to take the blame

Ever since Sir David Nicholson put a timescale and a figure to the NHS's pressing need to make efficiency savings, funding constraints have been at the very top of the health service's agenda.

While ministers and civil servants may have been distracted by the politics of the health act and the bureaucratic minutiae of rebuilding the NHS from the ground up, PCTs, CCGs and practices have been desperately trying to work out what they can keep paying

The first part of Pulse's rationing survey, which we publish this week, sets out the alarming extent to which large parts of the NHS are now being forced to routinely ration care in a desperate bid to meet punishing cost-cutting targets.

Andrew Lansley may have flatly denied in July that rationing was on the rise, describing a Labour party dossier of treatment restrictions as 'meaningless' - but coalface GPs tell a different story.

Most reported they had seen an increase in the rationing of care in their area over the past year. Examples include not only the usual suspects - bariatric surgery, cataracts, hips and knees - but also gallstone surgery, cognitive behavioural therapy and child mental health services, as well as more subtle methods of managing patient demand. It is not very surprising that patients are now routinely sent back to their GP if they miss hospital appointments, but much more so that one in three GPs believe hospitals are deliberately overemphasising the risks of surgery to avoid operating.

Such findings are deeply worrying for patients, politicians and the profession alike but for the profession there is one particularly unwelcome twist. Increasingly, as the NHS does less, it is being left to GPs to explain



Steve Nowottny

why. A clear majority of GPs told us their relationship with patients has suffered as a direct result of rationing. In the absence of explanation from politicians or a central list of rationed treatments, GPs are being forced to play, as one put it, 'the big, bad ogre'.

GPs have long been aware of their crucial gatekeeper role, and being able to say no to a patient is part of being a good doctor. But there can be little doubt the NHS reforms have upped the ante - and when GPs take on full commissioning responsibility and start receiving the quality premium next year, the blame game is only going to get worse.

Significantly, the leaked emails from senior BMA figures highlighting concerns about the NHS reforms, which we cover this week,

centre largely on rationing. Even GPC chair Dr Laurence Buckman, the voice of moderation on talk of boycotting commissioning, warned 'the public will blame GPs for the mess that will result from a shrinking health economy'.

Responsibility for rationing is the sharp end of GP commissioning, the point at which abstract political arguments over the merits of the NHS reforms elbow their way into the GP consultation room. What we can pay for - and we can't - is going to remain at the very top of every GP's agenda for quite some

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

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# 20 PhilPeverley

#### **PPA COLUMNIST OF THE YEAR 2012**

# Screw these so-called 'toolkits'



An acting masterclass at a communication skills 'workshop' has **Phil** spitting nails

'If there's one word that sums up everything that has gone wrong since the war, it's "workshop".' So said Kingsley Amis in Jake's Thing, and as was so often the case, the old curmudgeon had put his gnarled finger on it.

A workshop, according to my trusty old Collins Concise, is 'a room or building in which manufacturing or other forms of manual work are carried on'. If you are reading this column, it's a fairly safe bet that you are not involved in light engineering, and the interior of a proper workshop is foreign territory as far as you are concerned.

Having said that, the majority of us will have been invited to a workshop recently. The commissioning group workshop is a standing invitation, and workshops on child abuse and prescribing policy are now a standard part of general practice.

Not only that, but we will also have been offered the use of a toolkit. Perhaps more than any other bastardisation of our language, the toolkit offends me. I've been offered and given a revalidation toolkit.

I know what a toolkit is. I've owned one, in one form or another, since I was about 16.A toolkit is a box with tools in. Mine is a blue metal job which expands and has six compartments containing, well, tools with which I can tackle most DIY jobs around my house.

It's not, frankly, a paper folder containing a number of bits of paper offering vague directions pointing me in the direction of some sort of future revalidation procedure. That's not a toolkit, not at all. And if those are tools, then I don't want to use them.

I went to a communications skills workshop recently. (I don't despise these events altogether, because hey, it's time off work. And who wouldn't want that?)

I have now been a doctor 25 years and two months. I have been talking to people all that time. If I know one thing, it's how to talk. If words were pounds, I would now be Richard Branson. Sometimes when I get home after work, my mouth is so tired that I prefer to communicate with my wife via semaphore.

However, the actress leading our workshop didn't allow us that degree of autonomy. She told us that if we wanted to talk to people, we

I've owned a toolkit since I was 16. It's blue and it's for DIY should look at them. This was news to me.

Previously I had been hanging my head out of
the window while I had been attempting to
communicate, and scratching my advice on a
wax tablet.

She told us that we should be making eye contact, and that during significant intercourses (what other type do we have?) we should be grasping the patient's hand, or shoulder.

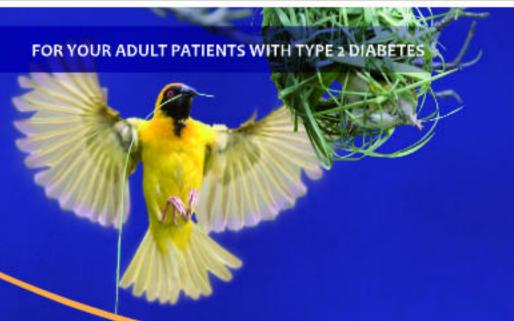
This demonstrated, if nothing else, that our actress had had no significant experience of British general practice. While I have every respect for my patients as a source of income, I have visited their houses and seen their underwear and I am not about to start touching them indiscriminately for no very good reason.

An actress is someone who basically tells lies for a living. I am not.

I am someone who tells the truth for a living, most of the time, and acting skills are inappropriate for what we do. Sincerity is not an affectation. Hand-holding is not fitting when we advise a man not to thump his wife, and a friendly grasp of the shoulder is not apt when we deliver a diagnosis, especially when that diagnosis is bicipital tendinities.

The next time I visit a workshop will be when I need a bit of welding done.

Dr Phil Peverley is a GP in Sunderland



# Improving control Improving care



Start and stay with Trajenta® (linagliptin)



#### Efficacy

- significant HbA<sub>n</sub> reductions vs placebo<sup>1-1</sup>
- HbA<sub>c</sub> reduction sustained over 102 weeks as add-on to merformin + a sulphonylurea in the completer population (319 patients out of 544 enrolled patients)<sup>c</sup>

#### Benerally well tolerated

overall incidence of adverse events that is similar to placebo<sup>a</sup>

#### Different

 the first one dose, once-daily DPP-4 inhibitor excreted primarily via the bile requiring no dose adjustment or additional renal or hepatic monitoring combined with metformin
Introducing NEW Jentadueto®

Available in 2 dosage strengths:



or



#### Significant efficacy

up to 1.7% HbA<sub>10</sub> reduction vs linagliptin or metformin monotherapy<sup>11</sup>
 up to 3.7% in patients with high baseline HbA<sub>10</sub> (×11%) in the open-label arm<sup>41</sup>

#### Added convenience

single tablet combination of linagliptin and metformin taken twice daily<sup>is</sup>

Prescribing information can be found on the adjacent page.





# MargaretMcCartney

# Catching the running bug



#### A chance encounter and small kindness helped **Margaret** make a profound lifestyle change

At first, I could do 10 minutes and I felt awful.

My shoes hurt, and I went to a shop to get new ones. I explained my needs - something comfortable that didn't make me look ridiculous. The man in the shop was reflective. My current shoes weren't really designed for running, more fashion, did I know? Nope. No wonder they weren't comfortable. So where was I running? In the gym, I explained, for 10 minutes - I couldn't manage any more. I can never quite get the grip of the treadmill.

'Hmm,' he said. 'Where do you live?'
I told him. 'Well,' he said, 'you make it
down the avenue just opposite and then run
back. That's about two kilometres. It's much
easier outside. When you can manage that, let
me know.'

At first, I was slow and horribly breathless. I would pause at the end of the avenue before running back. I went out at night, wearing dark clothes and brimming with embarrassment at how useless I was.

I kept doing it. A few weeks later, I could

get there and back - not fast, but without stopping. I told the man in the shop.

'Ah,' he said. 'Now you're ready for a "park

These are 5K runs that happen in parks all over the country on Saturday mornings. They're free - you register online and bring your barcode with you, which means you get a time on the website later that day.

The folk at the front are fast and wearing running club T-shirts. The folk at the back are friendly, smiling and some of them alternately walk and jog. I did too, at first – then I could manage to jog all the way. The next time I passed my shoe shop I gave the good news, and I was told definitely: now you need to plan a 10K.

Running is fabulous because it is so time-efficient. You can leave your door, have half an hour of music, thinking, fresh air and sweat, then return to your shower and your day.

You will feel wonderful, your thighs aching

# It's easy to forget the simple pleasure of physical activity

the potential to after renal function such as dehydration, severe

slightly, your cheeks pink and glowing, and your self-esteem dragged up a notch.

You don't need a gym. You only need comfortable shoes. Phone apps make it easy to track and enjoy your progress.

The sedentary nature of general practice can make us forget the thrill of physical exhilaration. I did my first 10K three years ago and have done every year since, getting a little bit faster each time.

In the grand scheme of things I am still slow, and not particularly athletic. In terms of my own achievements, I have surpassed what I thought I could manage and the feeling of fitness, the ability to think for a while and sleep better is ample reward.

What has it taught me? First, that it's easy to forget the pleasure of simple physical activity and the profound effects it can have on our health.

Second, that attending and paying a fortune for a gym membership wasn't as good for me as using the straightforward resources I had at my disposal already.

And lastly, that a bit of kindness, thoughtfulness and continuity of care was capable of providing long-lasting and highly effective lifestyle changes - for which I'll always be grateful to the man in the shoe shop.

Dr Margaret McCartney is a GP in Glasgow

Prescribing Information (UK)

TRAJENTA® 5 mg

Film-coated tablets containing 5 mg linaging in Indication: Trajents is indicated in the treatment of type 2 diabetes melitias to improve glycaethic control in adults: as monotherapy - in patients inacequately controlled by diet and energise alone and for whom metformin is inappropriate due to intolerance, or contraindicated due to renal impairment, as combination therapy; - in combination with mellormin when diet and exercise plus metformin alone do not previde adequate glycaetric control; - in combination with a sulphonylurea and methorn in when diet and exercise plus dual therapy with these medicinal products do not provide adequate giveaemic control. Dose and Administration: 5 mg once only. If nodes to melformin, the dose of metformin should be maintained and Irragistin administered concomitantly. When used in combination with a sulphorylurea, a lower dose of the sulphorylurea may be considered to reduce the risk of hygoglycaemia. Patients with renal impairment no sose adjustment required. Pharmacokinetic studies suggest that no dose adjustment is required for patients with hepatic impairment but ofinical experience in such patients is tacking. Elderly: no alcer adjustment is necessary based on age however, clinical experience in patients > 75 years of age is limited. The salety and efficacy of linapliptin 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 alliquid not be used in patients with type 1 diabetes or for the treatment of diabetic keloacidosis. Caution is actived when finagliptin is used in combination with a sulphonyluma; a dose reduction of the sulphorytures may be considered. Interactions: Linapliptin is a weak competitive and a weak to moderate mechanism-based inhibitor of CYP isozyme CYP3A4, but does not inhibit other CYP isozymes. It is not an inducer of CVP isozymes. Linegliptin is a P-glycoprotein substrate and inhibits P-glycoprotein mediated transport of eigevin with low potency. Based on these results and At interactions with other P-do substrates. The risk for clinically meaningful interactions by other medicinal products on linagliptin is low and in clinical studies linagliptin had no clinically relevant effect on the pharmacokinetics of metformin, plytruride, stravaitatin, warfarin, digrain or oral contraceptives (please refer to Summary of Product Characteristics for information on clinical data). Fertility, pregnancy and factation: Avoid use during prepnancy. A risk to the breast-fed child cannot be excluded. A decision must be made whether to discontinue broast-feeding or to discontinue abstain from Trajents 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 Traienta. Undesirable effects: Adverse reactions reported in patients who received finagliptin 5 mg daily as monotherapy or as add-on therapies. (pooled analysis of placebo-control ed 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  $t_0 < 1/1000$ , rare  $p_1 1/10,000$  to < 1/1,0000, or very rare [<1/10,0000], not known (carnot be estimated from the available data). Very common: hypoglycaemia (combination with/add on to metformin and sulphenylures). Uncommerc nasopharyngits (moretherapy, combination will hiadd on to metformini; hypersensitivity (combination with add on to melformin'; count improtheness; combination with: acid on to metformin). Not known; masopharying its (combination with/add on to metformin and autonomylurea); hypersensitivity

improtheragy; combination with/add on to metformin and sulpherafures; cough icombination with/add on to metformin and sulpherafures; partnerables (monotherapy; combination with/add on to metformin; combination with/add on to metformin; and sulpherafures; Prescribers should consult the Summary of Product Characteristics for further information on side effects. Pack sizes and NHS prices: 25 bibliots: 233-26. Legal category: POM. MA number: EUT-11/707/203. Marketing Authorisation Holder: Sosthinger Ingetheim Internsional GmbH, D-55216 Ingelheim an Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in September 2011.

UK Prescribing Information JENTADUETO\* (inagliptin and moffermin hydrochloride) 2.5 mg/850 mg film-scated tablets and 2.5 mg/1,000 mg film-scated tablets.

Film-coated tablets containing 2.5 mg linegiptin and 850 mg mottermin hydractionide or 2.5 mg Inegligith and 1,000 mg metformin hydrochloride. Indication: Trealment of adult patients with type 2 diabetes mellitus: as an adjunct to diet and exercise to improve plycaemic control in adult patients inadequately controlled on their maximal tolerated dose of metformin alone, or those already being treated with the combination of linegistin and methorning in combination with a sulphonylures (i.e. triple combination therapy) as an adjunct to diet and exercise in adult patients inaliquality controlled on their maximal tolerated dose of metformin and a sulphonylures. Base and Administration: The dose of Jerrisdueto about be individualised based on the patient's current regimes, effectiveness and tolerability, not exceeding the maximum recommended daily dose at 5 mg linagliptin plus 2,000 mg at metformin hydrochloride. For purients inadequately controlled onmarinal tolerated close of methornin monotherapy; the usual starting sisse of Jertaducto should provide linapliptin 2.5 mg twice daily (5 mg total daily dose) plus the current dose of metformin. For palients switching from co-administration of linegiptic and wertprovide initiate Jentaqueto at the dose of linard prin and metformin already being taken. For patients inadequately controlled on deal combination of the transitival tolerated dose of multistrain and a 2.5 mg twice daily (5 mg total daily dose) and a dose of mettormin similar to the dose already being taken. When Insolictin plus metformin hydrochloride is used in combination with a sulphonylurea, a lower dase of the sulphonylurea may be required to reduce the risk of hypoglycaemie. Elderly: As methornin is excreted by the kidney, Jentadurio should be used with caution as age increases. Mostoring of sent function is necessary. Dinical experience with patients > 90 years of age is firrited and caution should be exercised. Renal impairment: Jentadurlo must not be used in patients with moderate or severe renal imparitment (creatinine dearance < 60 million); due to mettermin. Hasselic Associativest: Jentadusto is not recommended in patients with hepatic impairment size to methymin. Clinical experience with Jentadueto in patients with hepatic impairment is lacking. Pacellatric population: The safety and efficacy of Jernaducto in children and addrescents (aged 0 to 18 years) have not been established No data are available. Jentaduete should be taken buke. daily with meals. All patients should continue their diet with an adequate distribution of carbohydrate make during the day Overweight patients should continue their energy-restricted diet If a dose is missed, it should be taken as soon as the patient remembers. However, a double dose should not be taken at the same time (the missed dose should be skipped). Contraindications: Hypersensitivity to the active substances or to any of the excipients: diabetic ketoacidosis, diabetic pro-coms; ronal failure or renal dysfunction (creatinine clearance < 60 mi/min); acute conditions with

infection, shock; agute or chronic pisease which may cause fissue hypoxia such as cardiac or respiratory failure, moent myocardial infarction, shock; hepatic impairment, asute alcohol intoxication, alcoholism. Warnings and Precautions: Jertadueto should not be used in patients with type 1 dispetes or for the treatment of dispetic ketoacidosis. Caution is advised when Jenfadueto is used in combination with a sulphonyluma due to increased incidence of hypoglycaemia. Lactic acidosis is 8 very rare, but serious (high mortality in the absence of prompt treatment), metabolic complication that can occur due to metformin hydrochloride accumulation. Renerted cases have occurred primarily in diabetic patients with significant renal failure. The incidence of lactic acidosis can and rould be reduced by also assessing other associated risk factors. As methormin hydrochloride is excreted by the kidney, serum creativine levets should be determined before initiating treatment and regularly thereafter. Decreased renal function in elderly subjects is frequent and asymptomatic. Special caution should be exercised in situations where renal function may become impaired. As Jertadueto contains methormin hydrochiloride the treatment must be discontinued 48 hours before elective surgery with general, spiral or epidural anaesthesia, or prior to, or all the time of intravascular administration of lodinated contrast agents in rapidlogic studies and therapy with Jestsducto should usually not be resumed earlier than 48 hours following surgery or teet and only after renal function has been reevaluated and found to be normal. The use of Jordadueto in combination with insulin has not been adequately studied. Caution should be exercised when treating patients 80 years and older. As Jordaducto contains metformin, a patient with proviously well controlled type 2 diabetes on Jentaduelo who develops bihoratory abnormalities or clinical litness (especially vague and poorly defined finess) should be evaluated promptly for evidence of ketospidosis or factic acidosis. If acidosis of either form occurs, Jentadueto must be dopped immediately and other appropriate corrective measures inflated. In post-marketing experience of linegliptin there have been spontaneously reported adverse reactions of acute pancreofffs. I pancrealitis is apprecied, Jertisduele should be discontinued. Interactions: Continuation requiring prescutions for and disretics. More frequent blood glucose manitoring should be performed, especially at the beginning of treatment with such medicinal products. If necessary, the ease of Jertaducts should be adjusted during therapy with the other medicinal product and on its discontinuation. Combinations not recommended: There is increased risk of facilic acleosis in acute alcohol intoxication. Consumption of alcohol and medicinal products containing alcohol. Cationic substances that are eliminated by renal tubular secretion e.g. climetidine. The intravascular administration of lodinated contrast agents in racidingical studies may lead to renal failure, resulting in methormin accomplation and a risk of factic acidosis (see above). Fertility, pregnancy and lactation: Jertadueto should not be used during programmy. If the patient plans to become program, or if pregnancy occurs, treatment with Jentadueto should be discentinued and switched to insulin treatment as soon as possible in order to lower the risk of foetal maillarmalians associated with abnormal blood plucase levels. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from Jordadueto 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 Jehtsducto. Undesirable affects: Adverse reactions reported with the fixed dose combination: Adverse reactions reported in all plinical trials with Jentacueto. Uncommon (> 1/1,000 to < 1/100); resopharyngitis; hyperseneitivity; cough; decreased appetite; diarrhoea; nausea; verniting: pruntus;

blood arrylass increased. Not known (cannot be estimated from the available dalat: pancreatitis. Adverse reactions known to occur with each active substance given singly but which have not been seen in clinical trials with Jeniadueto, may occur during treatment with this medicinal product. Adverse reactions reported when linealistic and melformin were combined with sulphonylurea: additional adverse reaction very common (a 1/10) hypophycaemia. Additional information on Auditodical components: Adverse reactions greviously reported with one of the individual active substances may be potential adverse reactions with Jentzdueto, even if not observed in clinical trials with this medicinal product. Lineariptics All identified adverse reactions of leagriptic monotherapy are also described for Jertadueto, Melforolio Keown adverse reactions that were not reported in patients who received Jentaduets. Very common (> 1/10): abdominal pain. Common (x 1/10) to < 1/10); taste disturbance. Very rare (< 1/10,000): lactic acidosis; vitamin 812 deficiency; fiver function disorders, hepatitis; skin mactions. Past-marketing experience: additional adverse reactions from post-marketing experience for linearippin: rare ( $\approx 1/10,000$  to < 1/1,000); angloederies, urticaris direquency ast mates are based on the pooled analysis of the placebo controlled trials). Prescribers should consult the Summary of Product Characteristics for further information on side effects. Pack sizes and NHS price: 2.5 mp/850 mg 56 tablets £30.26; 2.5 mg/1,000 mg 56 fabriels 233,26. Legal category: POM. MA numbers: 2.5 mg/850 mg (56 tablets) EU/1/12/790/005; 2.5 mg/1,000 mg (56 tablets) EU/1/12/780/019. Marketing Authorisation Holden Boehringer Ingelheim International GmbH. 0-55216 Ingelheler am Rhein, Germany, Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in August 2012.

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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 Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephene).

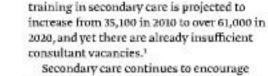
# Recruiting more GPs is the key to future-proofing the NHS

We must cut hospital training places to ensure a fundamental shift in the balance of the medical workforce, writes **Dr Sarah Wollaston** 

The Nicholson challenge was set out in 2009 as a project for the NHS to make efficiency savings of £20bn, and it is often misrepresented as a drive to cut services to do less of the same. But it is, in fact, something more challenging - the need to spend £20bn of what we have in an entirely different way.

Part of that must involve changing the balance of medical staffing. There is clear evidence that the majority of health and social care need is in long-term conditions, and yet we still run a health service designed around emergencies and elective admissions.

The number of doctors completing



Secondary care continues to encourage applications in order to fill posts, with little realism about the future. As a result, we waste millions of pounds training graduates who choose to emigrate or retraining them on high-grade salaries in lower-grade posts.

High-quality primary care and the design of effective integrated pathways reduce the need for hospital admissions, but clinical commissioning cannot function effectively without an adequate workforce.

Even in the South West, where GP vacancies were once unheard of, there is now a vacancy rate of 12% and locums are in short supply.

A combination of an ageing workforce nearing retirement, where 22% are 55 or over, and an increasing percentage of women more likely to work part time are contributing to the pressure.<sup>4</sup>

We have to persuade half of all medical students to opt for general practice. The 'carrots' should be the challenge of generalism and the opportunity for continuity of care that few secondary care posts can offer.



Alongside the increase in GP numbers, there must also be a disinvestment in specialist training posts beyond those required in the long term. Those planning rotations should not duck the workforce challenge.

Some specialists continue to portray primary care as an isolated backwater that treats only minor illnesses, but as the balance of clinical need shifts further towards the elderly with long-term conditions and as GPs take control of commissioning, medical staffing must be adapted.

General practice is an astonishingly varied field. More medical students and junior doctors should be introduced to it and encouraged to apply.

Dr Sarah Wollaston is MP for Totnes in Devon, a member of the House of Commons Health Committee and a former GP

#### References

Centre for Workforce Intelligence. Recommendation for medical specialty training, 2011, ewfi.org. uk 2 Deloitte UK Centre for Health Solutions. Primary care for today and temerow. 2012, deloitte.com

#### Give GPs a 10% pay rise

The Government must recognise the burden on GPs in the next round of contract talks and award the profession an equivalent increase in funding, writes Dr Robert Morley. Go online to pulsetoday.co.uk/opinion to read his article and leave your comments on what he and Dr Wollaston have said this week.



9/12/0067 August 2012

#### EpiPen® and EpiPen® Jr. adrenaline auto-injector

Presentation: EpiPen delivers a smale close of 0.3mg of adrenaine 8P 1:1000 (0.3ml) in a Sterile solution. EpiPen II. delivers a single close of 0.15mg adminaline BP 1:2000 (0.3ml) in a sterile solution. 1.7ml of adrenaline remains in the auto-injector after activation. Indications: For immediate self administration in the emergency treatment of allergic anaphylactic reactions. Anaphylasis may be caused by insect stings or bites, foods, drugs and other alergers as well as idiopatric or exercise-induced anaphylosis. **Dosage:** ADULIS: Self-administration of 0.3mg adrenaline (EpiPeri) intramuscularly. CHILDREN, The appropriate dosage may be 0.15mg (EpiPen Jr.) for children 15-30kg body weight and 0.3mg (EpiPen) adrenaline for children >30kg body weight, or at the discretion of the physician. EpiPen should only be injected into the anterolateral aspect of the thigh through dothing if recessary. A second injection with an additional EpiRen may be administered after about 5 - 15 minutes if indicated. As EpiPen is designed for emergency treatment, the patient should always. seek immediate medical attention even if symptoms have disappeared. Contraindications: There are no absolute contra-indications to the use of adrenatine in a life threatening situation. Warnings and precautions: Avoid the risk of inadvertent intravascular injection, DO NOT INJECT INTO THE BUTTOCKS. Accidental injection into the hands or feet may result in loss of blood flow to the affected areas. If there is an accidental injection.

into those areas, aclese the patient to go immediately to the nearest emergency room or hospital casualty department for treatment must be instructed in the proper use of EpiPen. Use with extreme caution in patients with heart disease and those taking digitals, mercurial diuretic or guindine. The effects of adrenaline may be potentiated by tricyclic antidepressants and monoamine oxidase inhibitors. Advinaine should be used in pregnancy only if the potential benefit justifies any potential risk to the foetus. Side effects: May include palpitations, tachycardia. sweating, nausea and vomiting, respiratory difficultly, pallor, dizziness. neryousness and arrivety. Cardiac arrhythmias may follow administration of adenaine. Diverdoses of adrenaine may cause cerebral haemorrhage or arrhythmias. For a complete list of warmings and side effects, you should consult the Summary of Product Characteristics. Legal category: FOM Package quantity and basic NHS price: Epifen and EpPen J are available as single unit closes at £26.45 each or as a twin pack of 2 Auto-injectors at £52.90. Product licence number: EpiPen Auto-Injector Pl. 15142/0245. EpiPon. Jr. Auto-Injector Pl. 15142/0246. Marketing authorisation holder: Meda Pharmaceuticals Ltd, Skyway House, Parsonage Road, Takeley, Bishop's Stortford, CM22 6PU. Tet 0845 4600000 Date of preparation of prescribing information: February 2012.

Prescribing Information
Macrobid\* (Witrofurantoin MR Capsules)
Macrodantin\* (Witrofurantoin Cansules)

Macrodantin<sup>®</sup> (Nitrofurantoin Capsules) Presentation: Macrobid capsules are supplied as modified release hard gelatin capsules containing 100mg nitrefurantoin in macrocrystalline and monohydrate forms. Macrodantin capsules are supplied as hard gelatin capsules containing 50mg or 100mg nitrofurantein in macrocrystalline form. Indications: Treatment and prophyloxis against acute or recurrent, uncomplicated lower urinary tract infections (UT) or pyelitis either spontaneous or following surgical procedures. Mitrofurantoin is specifically indicated for the treatment of infections due to susceptible strains of Eacherichia coli, Enterococcus ap, Staphylococcus ap, Citrobacter sp, Klabelella sp, and Enterobacter sp. Macrobid is not indicated for treatment of associated renal cortical or peri-nephric abscesses. Dosage and Administration: For oral administration taken with food or milk. Macrobid capsules. Adults and children over 12 years of age: Acute or recurrent uncomplicated UTI and pysitis — 100mg twice daily for 7 days. Surgical prophylaxis - 100mg twice daily on the day of the procedure and 3 days thereafter Elderly: unless significant renal impairment exists, dosage as for adults (See Warnings and Precautions). Children under 12 years: Macrobid is not suitable for children under 12 years of age Macrodantin capsules. Adults: Acute uncomplicated UTL 50mg four times daily for 7 days. Prophylaxis. 50mg four times daily for the duration of the procedure, and for 3 days after. In addition Macrodantin can also be used for severe chronic recurrence (UTIs): 100mg four times daily for seven days and long term suppression: 50-100mg once a day. Elderly: unless significant renal impairment exists, desage as for adults (See Warnings and Precautions). Children and infants over 3 months of age: Acute urinary tract infections: 3mg/ kg/day in four divided doses for seven days. Suppressive - 1mg/kg, once a day. For children less than 25kg body weight consideration should be given to the use of the suspension. Contraindications: Known hypersensitivity to Nitrofurantoin or other nitrofurans, or ingradients of Macrobid/Macrodantin capsules. Patients with renal dysfunction, GEPD deficiency, acute prophyria, pregnancy at term (including labour and delivery) and in infants under 3 months of ago, Warnings and Special Precautions: Use with caution in patients with pulmonary (lung) disease, hepatic (liver) dysfunction, neurological disorders, peripheral neuropathy, araemia, diabetes melitus, those with vitamin B or folste deficiency, electrolyte imbalance and allergic diathesis. May cause haemolysis in patients with deficiency of glucose-6-phosphate dehydrogenase. Patients on long term treatment should be monitored for appearance of hepatic or pulmenary symptoms and other evidence of toxicity. Taking the drug with food or milk or adjustment of dosage minimises GI reactions. Urine may be coloured yellow or brown, may cause false positive for urinary glucose. Discontinue treatment if otherwise unexplained pulmonary. hepatotoxic, haematological or neurological syndromes occur. Contains factore. Pregnancy and Lactation: Contraindicated in pregnancy at term (including labour and delivery). Mitrefurantein is detected in trace amounts in breast milk. Should be avoided if breast feeding infants suspected to have GSPD deficiency. Interactions Concurrent use with quinolones, magnesium trisilicate. uricosurio drugs such as probenecid and sulphinpyrazone, carbonic anhydrase inhibitors, urine alkalinishing agents, nestrogen, nestrogen containing contraceptives and oral typhoid vaccine is not recommended. Increased absorption with food or agents delaying gastric emptying. Adverse Effects: Nausea, shorexia, emesis, abdominal pain and diarrhosa have been reported. Less common and rare are those events that affect the respiratory system. Acute pulmonary reactions occur in first week of treatment and are reversible with cessation of therapy. Sub-acute and chronic reactions (collapse, cyanosis, fever, chills, cough and dysphosa) can occur with continuous treatment for six months or more. Hepatic (reactions including cholestatic jaundice, and chronic active hepatitis which may lead to hepatic necrosis occur rarely). Fatalities have been reported. Neurological (peripheral neuropathy and optic neuritis infrequently). Haematological (praemia's, 66PD deficiency and other rarely reported events such as leucopoenia, agranulocytosis, granuloxytopenia and thromboxytopenia resolve with cessation of therapy). Allergic reactions including rashes eczematous oruptions and pruntus. Angionourotic dedoma, anaphylaxis, Lupus-like syndrome, sialadentiis, pancreatitis. Transient alopecia and benign intracranial hypertension have been reported. Superinfections by fungi or pseudomonas may occur. Please refer to Summary of Product Characteristics for detailed information. Legal Category: POM. Basic NHS Price: Macmbid: £4.89 per pack of 14 capsules. Macrodantin: £2.49 per 30-capsules pack of 50mg, £4.81 per 30-capsules pack of 100mg. Marketing Authorisation Number: Macrobid 100mg PL 12762/0052, Macrodantin 50mg PL 12762/0048, Macrodantin 100mg PL 12762/0049 Marketing Authorisation Holder: Mercury Pharma Group, NLA Tower, 12-16 Addiscombe Road, Croydon, Surrey. CRO OKT, UK. Date of Revision April 2012.

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- Bean DC et al. Antimicrobial resistance in community and nosocomial Escherichia coli urinary tract isolates London 2005-2006. Annals of Clinical Microbiology 2008,7:13.
- Brumfitt W and Hamilton-Wiler JMT. Efficacy and safety profile of long term Nitrofurantoin in uninary infections: 18 years experience, Journal of Antimicrobial Chemotherapy 1998;42:363-371.

Adverse events should be reported to the local regulatory authority. Reporting forms and information can be found at http://yellowcard.mhra.gov.uk. Adverse events should also be reported to Mercury Pharma Medical Information at 08700 70 30 33 or via e-mail to medicalinformation@mercurypharma.com

Visit www.managinguti.com for more information.





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

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

# No wonder Peverley's ready to go part time

From Dr Paul Harris

I feel that Dr Phil Peverley perfectly captured the mood of the time and spoke for hundreds of GPs in his recent column ('The tale of a spurned lover', pulsetoday. co.uk/peverley).

He says that if the NHS had treated him right it could have had his services for life, but it hasn't. So like a spurned lover, he is leaving - or, at least, considering going part time. I too feel constantly on the verge of resigning.

I am 56 and could go at any time. I still have vocation, I still care about my patients and my excellent staff, and I still do an excellent job as attested to by just about any measure you care to look at - patient satisfaction, surveys, low A&E attendance rates, low emergency admission rates. low referral rates and high conversion of outpatient attendance to follow-up.

The demands of the job, though, are rising. As well as having to deal with an increasingly anxious and sick society, ever more is expected from us in the identification and management of chronic

It has been suggested that 15- to 20-minute appointments are more appropriate for dealing with the extent of what is expected from a consultation, but where are the time, manpower and finances coming from to allow this to happen?

The Government is constantly harping on about increasing quality in general. practice, yet is unwilling to pay for it.

How does the NHS reward me for my hard work? My takehome pay has dropped 23% in the last two years. I have had half a day off sick in 25 years.

I hardly have any holiday - I



struggle to get two weeks off a year because of the cost and unavailability of locums. And study leave? Forget it:

The Government has orchestrated a campaign to denigrate GPs in the national media. The Care Quality Commission quango will be poking its nose into my practice and no doubt demanding costly and pointless changes.

And to cap it all, there is the threat of being found unequal to revalidation, and the retirement age being pushed further backwards along with a smaller pension at

In the same issue of Pulse, RCGP chair Dr Clare Gerada

said she is anxious about undergoing the revalidation process. If she is at risk, who is safe? If a significant number of GPs fail, who is going to do their work?

Who is going to pay for locums - if they are even available - and who will pay for the retraining? Who is going to run the retraining, and will they know more than the experienced GPs they are meant to be improving?

And if a shed-load of senior doctors decide they've had enough and retire, just who is going to do their work?

There is no doctor better able to look after my patients than me, and yet after 25 years of the

prison sentence that is general practice I feel threatened with

I have looked up my pension entitlement now and at various stages until I am 65.

I predict that with the current rate of decline in my take-home pay, there will be a point in the not-too-distant future when I will actually be better off not working.

Similarly, Dr Peverley is considering going part time and I expect many older doctors will do likewise and vote with

Where will the Government's precious NHS reforms be then? In our area, only senior doctors are involved in commissioning.

When they go I can't see it remaining viable.

What will the Government do then? Bring in the private companies to run commissioning? What will that cost? More than paying a few public-spirited GPs to do it for peanuts in time squeezed between other working commitments, I'll bet.

The public love the NHS - as well they might. They trust doctors. They won't forget or forgive in a hurry the party who led to the downfall of the NHS.

GPs are notoriously bad at sticking together and fighting - look at the fiasco over the pensions dispute. So I call on young GPs to think about their future. Is your job going the way you want it to? If not, do something about it. Protest. Save the NHS, because now more than at any time in the past I feel it is in real danger.

In a sense, Phil and I are irrelevant.We've done our time. But what of your future? What sort of NH5 are you heading for?

#### From Dr Patrick Pearson

via pulsetoday.co.uk I'm with you, Phil. There was a time when the job was hard work, but enjoyable.

We actually looked at patients instead of computer screens and listened to what they wanted to say instead of quizzing them to tick a lot of largely irrelevant boxes.

There was also time to live a life and enjoy things. Our lives and profession now seem to be run by a bunch of faceless bureaucrats.

I feel burnt out and disillusioned by the QOF and am suffering from guideline fatigue. I have grabbed my pension before the Government steals it and am going part-time to help pay off my mortgage. Good luck to the Stepford

#### Saddle up and grit your teeth

#### From Dr Nick Foreman

I am sorry to read that Dr Phil Peverley is considering going part time, but I'm also concerned his clear symptoms of burnout provoke a wider

He writes wistfully of 1987, when things seemed so much easier - but those of us in general practice then will remember being on call 24/7, with a broken night's sleep followed by a busy Monday morning surgery and the consequent disruption to family life.

The demands of general practice have, no doubt, increased with an ageing, more demanding population and an increased armamentarium allied with greater scrutiny of our effectiveness.

But there are cycles in everything and we have also been lucky to have practised since 1997, while the health service has been awash with funds. GPs with historical awareness will know of the despondency in the 1960s.

The wheel is turning and GPs need to take the longer view. It is going to be tougher for a spell, as it has been before, and over a 35-year career lifecycle GPs will witness several episodes of these alterations in professional

But for now, we need to saddle up, grit our teeth and realise that it is going to be long ride back to the sunny uplands.

READ THE COLUMN Go online to read Peverley's original column pulsetoday.co.uk/peverley

#### A Scottish contract is long overdue

From Dr Sandy Sutherland LMCs conference Lauder, Berwickshire

We are all going to have to get used to the rear view of GPC Scotland chair Dr Alan McDevitt if he continues with his ostrich-like approach to a Scottish GP contract ('A Scottish contract isn't the answer', pulsetoday.co.uk/ opinien).

On the face of it, the rapid divergence of health north and south of the border and the prospect of a vote on Scotland's independence in two years' time would both seem reason enough to be at least investigating the idea.

But more compelling reasons lie in the structure of the present contract itself.



The Scottish government favours a 'tartanised' approach

The fact that 95% of Scottish practices required a correction factor when the new contract was introduced tells its own story about its suitability for Scottish general

That figure has been reduced over the following years, most recently by the expedient of using the majority of any pay rise to offset the correction factor, with the result that practice income has been stationary - or, in the case of rural areas, actually falling while expenses move ever upwards.

Practices have reacted to this in several ways, Skill mix has been taken as far as it

Enhanced services are the only source of increased income, and these are generally short-term. inadequately funded pet projects dreamed up by politicians and managers with little clinical benefit.

Meanwhile, more and more salaried GPs are being employed, creating a disenfranchised group with no prospects, which weakens the profession - something a previous generation fought long and hard to get rid of in the 1950s.

We are constantly told we can use the 'existing flexibilities' in the contract to make it more suitable for Scotland, but my question is: what are they and why on earth have they not been used already?

The basic problem with the present contract was built into it at the very beginning - the money attached to a Scottish patient was weefully inadequate.

Previously, adding 1,000 extra patients to the list was a cause for rejoiding, as the practice was funded to take an another partner.

But now it is a curse as the extra income is not remotely sufficient to take on another doctor so everyone just has to work harder.

All we hear from our leadership is the mantra 'we are stronger together', but repeating the same thing over and over again does not eventually make it true.

Are they happy that the pay gap between Scottish and English GPs currently stands at £25,000, that practices have no incentive to expand, that every GP in the land is working a lot harder for a static or falling income and that rural recruitment is falling through the floor?

I date say most of my colleagues are not.

Surely it is time GP leaders in Scotland removed their heads from the sand, accepted that the current situation is untenable over the long term and negotiated a Scottish contract that is genuinely suited to Scottish general practice.

#### 'Cottage industry' jibe unfair

#### From Dr Daryl Mullen

#### Wigan, Greater Manchest via pulsetoday.co.uk

The King's Fund has done its usual selective reading/ quoting to fit with the political masterelass with its recent report on primary care ('GP 'cottage industry' not fit for purpose, says King's Fund', pulsetoday.co.uk/news).

The report quotes a paper by Professor Ellen Nolte and Professor David McKee, which the King's Fund says shows how the NHS is poor by international standards - when the full paper says nothing of the sert.

In fact, the paper shows how much the NHS improved after 1999 and how poor the US system is.

#### From Dr Qamar Siddiqi

#### via pulsetoday.co.uk

Perhaps some of the authors of the recent King's Fund report should leave London and visit other parts of the country.

They may realise that general practice is not about über-practices with a gazillion patients. People want to know their GP personally and will travel many miles to stay with their family physician.

So I return the compliment to the King's Fund and have to question their relevance too.

#### From Dr Melanie Wynne-Jones

#### Stockport, Greater Manchester via pulsetoday.co.uk

The 'small business model of general practice' is a godsend to the Government.

We act as its risk sink, and simply cope when the model is overloaded or doesn't work - although that's currently being tested to destruction.

The King's Fund needs to be careful what it wishes for.

#### Federations could ease GP burnout

#### From Dr Malcolm Ridgway Blackburn, Lancashire

via pulsetoday.co.uk

I must say I am rather disappointed by the attitude of colleagues to what is a constructive and illuminating paper from the King's Fund.

To think that all is well with general practice is naive and shows colleagues are in denial.

We should be looking for the opportunities that closer

#### For the record

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



Could forming federations ease GP practices' workload?

working would bring rather than just pointing out the problems.

There are models of federation in which continuity and high quality are maintained or improved, yet practices retain their sovereignty - co-operatives were such organisations that mutually traded to the members' benefit, yet also improved patient care since the doctors were less tired. Do we all need practice managers and COPD-trained nurses? Couldn't we share these among a group of practices?

Similarly, GPs with more specialist interests such as dermatology could see other practices' patients on a quidpro-quo basis or even for a small payment, particularly if the budget for referrals could be devolved to groups of practices.

There is no doubt that the ever-burgeoning workload and the desire to move patients out of secondary care will drive many GPs and practices into the ground.

The issue that drove the formation of out-of-hours coops was the burnout caused by the 24/7 commitment and the ever-increasing demands from patients for out-of-hours care. We are heading this way now with in-hours care.

It is better that we come up with our own solutions rather than have something imposed by the contractual route, or being taken over by acquisitive acute trusts or commercial providers.

This could be a Win-win if we just think through the solution that works for us and our patients.

#### Choice is not just for patients

#### From Dr Hadrian Moss Kettering, Northamptonshire via pulsetoday.co.uk

I was interested to read your story on mandatory Choose and Book use (pulsetoday.co.uk/ news). Choose and Book is a tool and it is good that patients have a choice.

But I also have the right to choose if I use it.



Actimel is a probletic drinking yegurt containing the probletic strain Lactobackus case/ 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<sup>12</sup> and duration or severity <sup>3-2</sup> 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 \* WGO practice guidelines report, \*\*One study indicated that L. case/ DN-114 001 is effective in hospitalised adult patients for preventing antibiotic-associated oliarrhea and C. difficile diarrhea\*\*\*I and in the "prevention of acute diarrhea\* there is "suggestive evidence that... L. case/ DN-114 001... [is] effective in some specific settings\*\*\*I\*\*\* A number of UK hospitals have integrated Actimel into their C. difficile management plans.



Activia is a probiotic yogurt containing the probiotic strain all/lockacterium lectis DN-173 010. Activis 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."

NIGE guidelines state, "There is fair evidence to show that some probletics (single or combination) give a significantly greater improvement in global symptoms of IBS than placebo". and Map of Medicine states, "Some specific strains, such as Billidobacterium lactis DN-173 010 ... have clinical trial evidence of efficacy for bloating [and] distension"."

#### "Based on studies using two bottles/pots consumed daily

† Abdominal bleafing and disfonsion are part of elgostive discention. References: 1. Pediate CA et al. Int./ Oliv Place 2000; 54: 568-571. 2. Maranatain Diet al. Ecz. J CRv Netz 2010; 64: 659-677. 3. Fedone CA et al. on J Clin Prost 1999;53:179-164, 4, Agarwal KN et al. Ardian Pediatr 2001; 38:985-910.5. Agamis IKN et al. Eur J Clin Not. 2002:563agp14:856-59.61ficksonMeta/BMA2007:335:80-63; Guyonnet D et al. Alment Pharmacol Ther 2007;26:475–486. 8. Agranal A. et al. Aliment Phannacol Ther 2009;29:104-114. Gayernet D et al. Br J Met 2009;102(11) 1654-1656. McFarland LV. Assemble 2009;15:274-280. et all ENU 2007; 335-340, 12. Martieau P. Øyr 2010; 59: 285-286. 13. World Gastroenterology Organisation (WGO) Practice Guideline. Protiotics and Probletics: October 2011, Available online at: naww.mor/digastroenterology.org/probletics-probletics.html (accessed February 2012). 14. National Collaborating Centre for Nursing and Supportive Care (NCCNSC) on behalf of the National Inglitute for Health and Clinical Excellence (NICE), imitable bowel syndrome in adults: Dispress and management of initiable bowel syndrome in primary care (CG61). 15. Contributors representing the Royal College of Physicians 2011. Available unline at: http://eng. mapolinisdicive.com/evidence/inap/irritable\_bowel\_syndrome\_ ibs\_2.html (accessed February 2012).



D4W001 Feb 2012

# 2 different probiotics.2 different reasons.





Studies have shown Actimel may help reduce the incidence 1.2 and duration or severity 8-6 of acute and infectious diarrhoea and reduce the incidence of antibiotic-associated diarrhoea (AAD) and C. difficile-associated diarrhoea (CDAD) 8

Actimel contains the exclusive probiotic strain Lactobacillus case/ DN-114 001



Studies have shown Activia may help reduce digestive discomfort,<sup>7-9</sup> including bloating<sup>7†</sup>

Activia contains the exclusive probiotic strain Bifidobacterium lactis DN-173 010



Not all probiotics are the same. Different probiotic products contain different strains. Each has different benefits, demonstrated by clinical evidence. 10-12

For more information, please visit www.probioticsinpractice.co.uk

Scan the code to find out more about different probiotic strains

Information for Healthcare Professionals

# **PUSE Clinical Update**

#### Free-to-attend half-day seminars



# Lower GI update

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

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11 October King's Fund, London

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- Establish how to tailor first- and second-line management options to meet individual needs
- Hear expert insight on patient perspectives to maximise the effectiveness of your consultations

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



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# Pulse Clinical

#### In this issue

Key questions 1.5 CPD hours Ocular disorders page 27

NEW SERIES Paediatric clinic Meckel's diverticulum page 31



The information

Acne

page 32

#### **Guideline update**

Venous thromboembolism page 34

#### Picture quiz

Itchy skin rashes page 36

Ten top tips

Gout

page 38

### More online



Guideline debrief: assessing fracture risk 2 CPD hours

A case-based learning update on last month's NICE guidance

The information: shingles 0.5 CPD hours An update on the causes, triggers and management





#### Resource of the week

After reading this week's Ten top tips on gout, go to pulsetoday. co.uk/tools-and-resources to download patient information leaflets from the UK Gout Society

Consultant
ophthalmic surgeon
Miss Claire Daniel
answers questions
from GP Dr Melanie
Wynne-Jones
on diagnosing

on diagnosing episcleritis, managing uveitis and referring for cataract surgery

How can GPs tell the difference between scleritis and episcleritis? Distinguishing between scleritis and episcleritis can be difficult. Both present with redness and pain in the eye, but scleritis requires urgent referral as it can lead to severe pain and loss of vision if left untreated, while episcleritis does not affect vision and is

Typically, scleritis is much more painful than episcleritis and keeps the patient awake at night. Scleritis pain is described as a deep 'boring' sensation and is not settled by simple analgesia or lubricants.

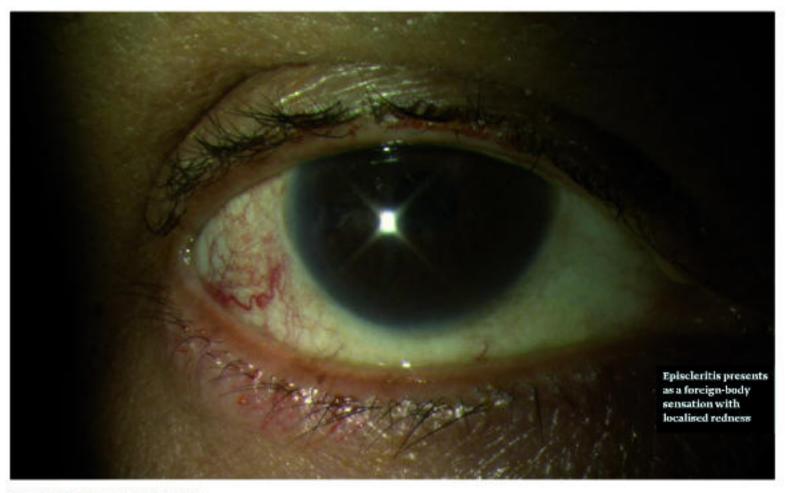
mild and self-limiting after few weeks.

A few drops of phenylephrine 2.5% or 10% will blanch episcleritis-dilated vessels after five minutes, but will not affect scleritis-dilated vessels.

Episcleritis is much more common than scleritis, and presents as a foreignbody sensation with localised redness. It usually appears when the patient is tired, stressed, has been in a dry, air-conditioned environment or has been using a computer for long periods of time.

Recurrent or persistent episcleritis can be associated with underlying systemic disease such as rheumatoid arthritis, systemic lupus erythematosis, polyarteritis nodosa or gout as well as sero-negative spondyloarthropathies such as inflammatory bowel disease, ankylosing spondylitis or reactive arthritis.

In recurrent or persistent cases of episcleritis, blood tests may be useful - FBC and differential, antinuclear antibody, rheumatoid factor, ESR, uric acid, venereal disease research laboratory test for syphilis and fluorescent treponemal antibody-



**KEY QUESTIONS** 

# Ocular disorders

**PULSE** Learning

### 1.5 CPD hours

Go online to complete this CPO module for a suggested 1.5 credits. This module will be available free to all members of Pulse Learning until 3 October 2012

► pulse-learning.co.uk

absorption test to confirm a syphilis test, if necessary - and a chest X-ray.

How would you investigate and manage uveitis? Is it reasonable for GPs to prescribe steroid eye drops for recurrences without referring?

Uveitis tends to present in patients between the ages of 20 and 40, and can be unilateral or bilateral.

It is generally not a good idea for GPs to prescribe steroid drops for uveitis. But patients with known uveitis may be on a tapering dose of steroid and if they run out of their drops, it would be beneficial for GPs to supply these patients with more – to ensure

they finish their course - as they may get rebound uveitis if they stop suddenly.

Oveitis needs to be seen by an ophthalmologist to ensure the patient's intraocular pressure has not increased as a result of the uveitis or as a secondary effect of steroid use. Patients will also need to be assessed to ensure they do not have a posterior uveitis, which often presents as an increase in floaters as well as photophobia and a red eye. Posterior uveitis may need oral steroids.

After three to four episodes of uveitis or one episode of bilateral uveitis, a chest X-ray, serum ACE and syphilis serology are requested as primary investigations.

Often the cause of uveitis is not found, but causes include HLA-B27 positive

### PULSECLINICAL

anterior uveitis, sarcoidosis, herpes zoster or simplex, syphilis, Bechet's syndrome and TB.

What are the symptoms and signs of wet age-related macular degeneration (AMD) and when are anti-vascular endothelial growth factor (VEGF) drugs indicated? Do you recommend vitamin supplements for AMD? What foods should patients eat?

Wet AMD tends to present as sudden onset of distortion over a few days. Door frames appear kinked and reading becomes difficult, or the patient may notice blurring - usually in their central vision.

Wet AMD is extremely rare in patients under 50 years old. Amlser grids are useful to document the areas of distortion and to check the other eye. Patients with suspected wet AMD should be referred as soon as possible

to the local eye department as they may need intravitreal anti-VEGF injections. Anti-VEGF drugs are indicated if a choroidal neovascular membrane has been diagnosed that threatens

High doses of vitamins A, C and E, and B-carotene and zinc may slow down the onset of macular degeneration, but the evidence is still controversial and potential harmful effects must be considered.

It has been suggested that B-carotene increases the risk of lung cancer in smokers and vitamin E may increase the risk of cardiac problems in patients with diabetes or underlying cardiovascular disorders. Dark green leafy vegetables, oily fish and fresh fruit are advisable for patients with AMD.

Cataract surgery is being capped in many areas because of cost. What criteria should we use for best-practice referrals?

Cataract is an extremely variable and notoriously difficult condition to measure. Some patients can have good vision when tested on the Snellen chart, but actually have significant glare and difficulty reading or driving at night.

In making referral decisions, we tend to rely on testing the patient's visual acuity with a Snellen test and a reading chart, and taking a detailed history on how much their vision is affected in their daily routine. If the patient is a driver or avid reader, they are often significantly debilitated by the condition.

Even though cataracts tend to be slow growing, some can come on over a period of a few weeks. These are typically posterior subcapsular cataracts as they cause scattering of light at the nodal point within the lens, which is where the majority of light rays are focused. Posterior sub-capsular cataracts are more common in patients who have had uveitis or who have used steroids.

Rapid deterioration of vision - over a few weeks - because of a cataract is rare. This would require a more urgent appointment than usual because additional eye pathology will need to be excluded, to confirm that vision deterioration is primarily due to the cataract.

#### ...... How should we manage a patient with upper facial herpes zoster?

Herpes zoster ophthalmicus may cause ocular problems in several ways - for example, vesicles close to the lid margin may cause keratoconjunctivitis or uveitis. Less commonly, herpes zoster may also cause episcleritis or scleritis, uveitis raised intraocular pressure, optic neuritis, necrotising retinitis or phlebitis.

In general, 800mg of aciclovir five times a day taken orally for seven to 10 days is prescribed - ideally within 72 hours of symptom onset. If epithelial defects are seen, ophthalmic chloramphenicol 1% qds for two weeks should be prescribed. If the patient develops any change in vision or redness in the eye, an ophthalmic opinion should be requested within a few days.

Facial palsy may also be a secondary effect, leading to ocular exposure because of incomplete closure of the eye. In these cases, prescribe an ocular lubricant four to six times a day with liquid paraffin at night and horizontal lid taping with soft tape.

#### What are the most common mistakes GPs make and how can we avoid them? In the acute painful red eye, most GPs are aware of the usual red flags, but are there more subtle signs we could look for?

The most common mistake we see in the eye casualty department is patients having been given chloramphenicol or brolene eye drops for microbial keratitis or anterior uveitis.

Microbial keratitis needs urgent referral and is much more common in a patient who wears contact lenses.

It is sometimes difficult to diagnose without a slit lamp, so if a contact lens wearer presents with red eye, suspect microbial keratitis and refer. Chloramphenicol only covers around 40% of microbial keratitis infections, whereas levofloxacin covers around 98% of microbial keratitis in the UK.

Levofloxacin hourly for five days is used for microbial keratitis in those who wear contact lenses - but this is usually prescribed by the ophthalmologist rather than the GP because the cornea will need examining with a slit lamp to ensure the keratitis is bacterial and does not have a fungal or an acanthamoeba cause. We also generally prescribe levofloxacin or ofloxacin rather than chloramphenical for one week in contact lens wearers if there is an epithelial defect from a scratch or a foreign body.

Patients with uveitis who have been prescribed chloramphenicol for a red eye will typically have no discharge and complain of photophobia. The condition is usually unilateral and they may have had uveitis before.

Any previous uveitis sufferer with red eye should be referred to make sure it is not a recurrence - this is a slit-lamp diagnosis and very difficult to exclude without ophthalmic training. Uveitis generally has no discharge or mucous, but can cause watering as a secondary reflex of tearing from the inflammation of the uveal tissue.

A mid-dilated, oval pupil and reduction in vision in a red eye should alert you to the possibility of acute angle-closure glaucoma. This needs urgent referral as soon as possible.

In general, any sudden deterioration in vision should be discussed with the on-call ophthalmologist.

Some UK hospitals are using this probiotic yogurt drink in those at risk of antibiotic-associated diarrhoea and C. diff-associated diarrhoea...



#### ... could it help your at risk antibiotic patients too?

Probletics have been shown to help restore the balance of gut bacteria disturbed by antibiotic use "Actimel is a probiotic yogurt drink, containing Lactobacillus case! DN-114 801\*, which has been shown to support the body's immune system in numerous clinical studies?. In one clinical study older hospitalised patents (over 50 years of age). drinking Actimel daily\* during a course of antibiotics and for one week after showed significantly reduced incidence of antibiotic-associated diamhoea and C. dMic/e-associated diamhoea." WGO Practice Guidelines report "Recent research has indicated that L. casef DN-114 001" is effective in hospitalised adult patients for preventing antibiotic-associated diarmosa and C. difficile diarmosa". Some hospitals near your practice have already started integrating it into their G. difficile management plans.

Visit www.probioticsinpractice.co.uk to see the evidence for yourself and register for a new RPS accredited CPD e-learning module on probiotics, the immune system and gut microbiota.

Information for Healthcare Professionals

- \* Cactobasitus casei CN 114 001/CNCN1+1818 (L. casei Durono)
- Third hottles uproumed bully

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AH029 May 2012

29

# What governs your choice of drug for lowering intraocular pressure in glaucoma? What are the common side-effects and can patients with well-controlled pressures take drugs with anticholinergic effects?

Anti-glaucoma medications include β-blockers, carbonic anhydrase inhibitors, prostaglandin analogues, α-agonists and miotics.

The choice of medication will vary according to the severity and type of glaucoma, underlying systemic illnesses and medications and individual response.

The common side-effects of different drugs are as follows:

- ß-blockers decreased cardiac output, bronchospasm, bradycardia, heart block or hypotension. Depression or anxiety and sexual dysfunction may be experienced by some patients.
- Carbonic anhydrase inhibitors superficial punctate keratitis, acidosis, paresthesias, anorexia, nausea and depression.
- Prostaglandin analogues conjunctival hyperaemia, iris pigmentation, chronic
- myalgic encephalopathy and uveitis.

  α-agonists dry mouth, fatigue and drowsiness.
- Miotics brow ache or headache, induced myopia and reduced vision in dim lighting.

In general, I would say that patients with well-controlled pressures can take drugs with anticholinergic effects, because the anticholinergic effect is only relevant for patients who have a tendency for angle-closure glaucoma.

It is very difficult to tell who is likely to develop angle-closure glaucoma without examination with a slit lamp and gonioscopy. But, if patients are deemed to be at risk of angle closure, then they would have had a YAG iridotomy or lens extraction to prevent the onset of the disease.

The most common type of glaucoma is open-angle glaucoma and these patients are not affected by anticholinergic medications.

......

### What common drugs have ocular side-effects? What are these?

Adverse ocular side-effects from systemic medications are well documented.

- Aminoquinolines may induce bull's eye maculopathy.
- Phenothiazines have a risk of phototoxic retinopathy and may also increase the risk of cataract formation.
- Tamoxifen may lead to crystalline deposits in the retina.
- Retinoids may cause decreased night vision and reduced dark-adaptation.
- Ethambutol is known to be associated with a reduced visual acuity or colour vision and visual field defects due to optic neuropathy.
- Tamsulosin has been widely shown to cause intraoperative floppy iris syndrome in patients undergoing cataract surgery.
   Cataract surgery can be more difficult in patients taking tamsulosin and so they will have a higher risk of post-operative complications. Discontinuation of the drug does not reverse the risk.
- Some sulphur-based drugs can induce angle-closure glaucoma by causing swelling of the ciliary body.
- Anticholinergic and ß-agonist medications may cause pupil dilatation and potentially acute angle-closure glaucoma in some patients with pre-existing shallow anterior chambers.
- Systemic or topical steroids are known to cause an increase in intraocular pressure in some patients. Long-term use of glucocorticoids increases the risk of developing a cataract.

- Patients on long-term treatment with linezolid may develop an optic neuropathy (swollen or pale optic disc), symmetric painless decrease of visual acuity and colour vision, and bilateral visual field defects.
- Erectile dysfunction medications can cause photophobia and blurring of vision, and affect colour perception.
- Amyl nitrate an increasingly popular recreational drug - can cause blurred central vision due to a toxic effect on the retina.

# How urgently should patients with retinal detachment symptoms be seen by an ophthalmologist? How is the condition treated?

Retinal detachment symptoms include floaters, flashing lights, a dark curtain appearing in the peripheral vision or a sudden loss of vision.

If you have a patient with suspected retinal

detachment, make an urgent referral to the ophthalmologist on call.

Retinal detachments are more common in myopic (short-sighted) patients. A retinal detachment typically occurs after a posterior vitreous detachment has occurred.

The posterior vitreous detachment can cause a tear in the retina where the vitreous is quite firmly attached to the retina. This usually occurs at the periphery of the retina. Once the retina is torn, fluid can get behind it and cause the retina to detach.

Retinal detachment usually requires an operation, but if caught early enough it can be treated with laser retinopexy around the tear before it develops into retinal detachment.

Miss Claire Daniel is a consultant ophthalmic surgeon at Moorfields Eye Hospital, London Dr Melanie Wynne-Jones is a GP trainer in

Or Melanie Wynne-Jones is a GP train Stockport, Cheshire

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#### Advertisement Feature

### Next steps in antidepressant selection

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

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

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.<sup>2</sup>

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

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. When switching antidepressants, NICE recommends considering, initially, a different SSRI or a better tolerated newer –generation antidepressant. Use of the SSRI Cipralex (escitalopram) in the care pathway, in such circumstances, is consistent with national guidelines (NICE CG90). 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.<sup>5</sup> Cipralex was also superior to citalopram (p≤0.02) in achieving acute response and remission in major depression (after 6-12 weeks) in an independent Cochrane review.<sup>6</sup>

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. 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. 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).

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



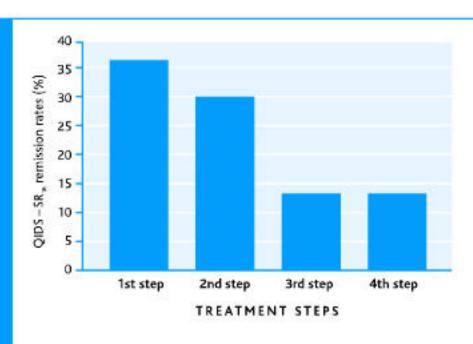
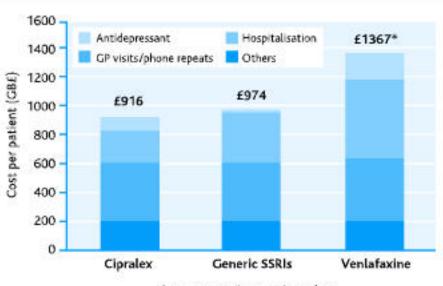


Figure 1. Acute remission rates by treatment step. Adapted from STAR\*D, Rush et al.<sup>3</sup>



\*p<0.0001 vs Cipralex GB£ = 2006 Pound Sterling

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<sup>7</sup>

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#### Abbreviated Prescribing Information.

Oprofest\* (excitatoprom) Tablets and Oral Brops, Solution
Prescribing information: Please refer to the 1ull Sommany of Product.
Characteristics before prescribing particularly in relation to ride effects, precautions and contro-indications. Presentation: Tablets containing 5, 10 or 20 mg of excitatoprom (as the colates). Oprofest and deeps, solution containing 30 mg/mal excitatoprom (as the colates). Explose or and deeps, solution containing 30 mg/mal excitatoprom (as the colates). Evaluate or containing 30 mg/mal excitatoprom (as the colates). Evaluate or containing 30 mg/mal excitatoprom (as the colates). Open depressive opposite of colates planticly, generalised anxiety disorder and obsessive computative disorder. Design: Explosion: 10 mg dealy for adult and obsessive computative disorder. Design: Depressive 10 mg dealy. Treatment, for at least 6 months is required. Penic disorder, 5 mg for the first week increasing to 10 mg dealy and, if nauchid, 20 mg dealy. Maximum of functionism is machad after about 3 months. Social amolety disorder Usual date 10 mg dealy and, if nauchid, 20 mg dealy. Treatment for 12 weeks is recommended. Testiment should be re-evaluated regularly. Cemeralised anxiety disorder initial date. 10 mg once deliy, May be increased to a maximum of 20 mg dealy. Chiestope is 5 mg ence of 20 mg if nequired. Electry (365 years) initial closage is 5 mg ence deliy. Depending on individual potient response the dose may be increased up to 10 mg dealy. Children and

idalescents (<16 years): Not recommended. **Reduced hepatic function** Sing date for the first 2 weeks in mild-moderate impairment, increasing to 10 mg, if required. Use with caution and careful done titletion in severally impaired hepatic function. Reduced renal function: Use with caution in everely reduced renal function (CLCR 30ml/min). Contra-indications: Hypersensitivity to excitatourum or excipients. Use in combination with non-selective, irreversible manaamine avidase inhibitors [MAOIs]. Use to combination with revenible MAD-As (models emidd) or line told. Use in patients with known QT interval prolongation or congenital long QT synchronic. Use teactiver with medicinal products that are known to rolong the QT interval Fertility, pregrency and lectation: Do not us in pregnancy unless dearly necessary. Reastfeeding is not recommended. SSRI use in projectory, particularly in late programs; may recrease the risk of personent multimorary ingentension in the newborn (PRHM).

Procuutions: Possible risk in ability to drive a car or operate machinery.

Alcoholic chiefs not advised Co-administration with sentomergic compounds not recommended Insulin and/or dial hypoglyczemic drough may require adjustment. Use with coation in patients at risk of hyporatraemix with a lititory of monia/hypomanix undergoing ICT. — th epilepsy [discontinue if settams begin for the first time or increase in frequency); with blending disorders or taking medicines that will affect clotting of blend or platelet function. Excitalogram has been found to

close-dependent prolongation of advised in patients with coronary heart disease, significant bradycardio, recent myocardiol, infanction or uncompanied heart foliate. 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 SCG if signs of cardiac arrhythmia eccur. Do not stop treatment abruptly. Clessly supervise patients, expecially those at high risk, for spicide-related behaviours during first few weeks of treatment, until Improvement occurs. Drug interactions: MAOIs, MAO-A and MAO-B inhibitors Potential Interaction with sendonergic medicines (e.g. triptana). Uthium, triptophen, St. John's wort, products which may lower the soliture threshold, otrepretale, exameptatole, lansopretale, flavorumine, tridopidine and dimetidine, Caution in poor metabolises of CYPEC19. Use caution with drugs metabolised by the engines CFP206 or CPP2CT9. Co-administration with medicinal products that prolong the QT interval, such as Class M and Ill antianhythmics, antipsychotics (e.g. phenothias he derivatives, pirrezida, haloperidalli, tricyclic antidepressants, certain antimicrobial agents (e.g. sparfloxeon, monificacin, erythtomycin IV, portamidine, anti-malarial treatment particularly halotantrine). certain antihistamines (asternizole, mirolastine) etc. is contraindicated Adverse events: Adverse reactions are most frequent during the first or

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#### **NEW SERIES PAEDIATRIC CLINIC**

# Meckel's diverticulum

Paediatric surgeons Ms Joanne Minford and Dr Osama Abusanad on an uncommon but serious condition

#### THE CASE

A 20-month-old boy presents with a four-day history of vomiting, abdominal distension and constipation. He is pale and tachycardic with a capillary refill of three seconds. He is revived with two boluses of 10ml per kg of 0.9% saline. Abdominal X-ray shows small bowel obstruction. A closed loop obstruction by a band associated with a Meckel's diverticulum is identified on laparotomy.

#### The problem

Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal

It occurs because of failure of regression of the vitelline duct.

The most common complications are inflammatory (bleeding and inflammation



because of ectopic gastric or pancreatic tissue) and mechanical (as a lead point in intussusception or volvulus around a Meckel's band).

Remnants of the vitelline duct can cause less common problems such as fibrous cord, umbilical fistula, vitelline cyst and umbilical sinus or polyp.

#### Features

The 'rule of twos' broadly applies. Meckel's diverticulum:

- occurs in 2% of the population
- is located two feet from the ileocecal valve
- becomes symptomatic before two years
- is 2cm in diameter and 2in long
- is twice as common in boys as in girls. Most cases are asymptomatic, but in those with symptoms, abdominal pain, rectal bleeding, vomiting and abdominal distension are features. In neonates, bowel obstruction is a typical presentation. Older infants often present with painless bleeding, and older children usually have inflammatory symptoms similar to appendicitis.

#### Diagnosis

Examination reveals lethargy, pallor, dehydration, abdominal distension and tenderness. A mass may be felt in intussusception. In a bleeding Meckel's diverticulum, the test of choice is technetium-99m isotope scan (sensitivity 85%). The isotope concentrates in the ectopic gastric mucosa lining the diverticulum. If intussusception is suspected, an ultrasound may be diagnostic.

#### Management

Urgent hospital referral is needed in cases of bleeding or obstruction. Some patients

need resuscitation, analgesia and nasogastric decompression. Haemoglobin, plasma electrolytes and inflammatory markers may be helpful.

Resection and end-to-end anastomosis is generally the preferred treatment, but diverticulectomy is also used.

Whether to treat an incidentally discovered Meckel's diverticulum is debateable because the reported incidence of complications is only around 5%. Generally, resection of the Meckel's diverticulum is recommended in children under the age of eight, or at any age if there is ectopic tissue, since this makes complications more likely.

Ms Joanne Minford is a consultant paediatric surgeon and Dr Osama Abusanad is a core surgical trainee at Alder Hey Children's Hospital, Liverpool

#### Further reading

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- Schropp K and Garey C. Meckel's Diverticulum. In: Holocomb III G, Murphy J (eds). Ashcraft's Pediatric Surgery (5th ed). Philadelphia: Saunders Elsevier, 2010
- Upcoming topics in this series include juvenile arthritis, cystic fibrosis and leukaemia

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# 32 PULSECLINICAL

#### THE INFORMATION

# Acne

Dr Shernaz
Walton, consultant
dermatologist, and
Dr Vanessa Smith,
dermatology SpR,
advise on how to
manage a case of
acne, using PUNs
and DENs



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of patients at just 2 weeks4

80% of patients, regardless of disease extent at 6 weeks – on oral therapy alones



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#### THE PATIENT'S UNMET NEEDS (PUNs)

An 18-year-old woman attends the surgery with severe acne, much of which she conceals with her hairstyle. She is obviously distressed by her condition, tossing the empty packets of antibiotics on the table with the comment: 'These are useless.' On further discussion she becomes quite tearful and seems significantly depressed. 'Nobody's helping me,' she says. 'No one has even told me what diet I should follow.' She has looked up her condition online and is keen to be referred to a dermatologist with a view to starting isotretinoin.

#### THE DOCTOR'S EDUCATIONAL NEEDS (DENs)

Which antibiotics are recommended in acne as first or second line, and what are the reasons for treatment failure?

Acne may present with a mixture of comedones, papules, pustules, nodules, cysts or scarring. The type of acne and the severity should guide treatment. Topical retinoids, rather than oral antibiotics, are the mainstay of treatment for comedonal acne. But antibiotics are indicated in patients with extensive disease – as in this case – including truncal acne and moderate to severe papulopustular acne.

Oral antibiotics should never be used as monotherapy because of the risk of antimicrobial resistance. Non-antibiotic antimicrobials, including benzoyl peroxide and azelaic acid, should be used alongside. Topical antibiotics would be used in those not on oral antibiotics.

Oral doxycycline (100-200mg daily) and lymecycline (300-600mg daily) are recommended as first-line treatment in preference to minocycline (100-200mg daily) and oxytetracycline (500mg twice daily), because doxycycline and lymecycline have a superior side-effect profile and better patient adherence. Erythromycin (500mg twice daily) is effective and should be used in

Oral

should

never be

monotherapy

used as

antibiotics

patients who cannot tolerate tetracyclines. Trimethoprim (300mg twice daily) is effective in cases where other antibiotics cannot be used. If a topical retinoid is used, adapalene should be selected in preference to tretinoin and isotretinoin.

Poor treatment response may be due to:

- the wrong diagnosis
- poor adherence to therapy
- inappropriate assessment
- of the overall acne severity
- side-effects of, or intolerance to, therapy
   bacterial resistance or underlying conditions such as congenital adrenal hyperplasia or polycystic ovary syndrome.

Non-comedogenic oil- and fragrance-free moisturisers, cleansers and creams may alleviate the side-effects of treatment and so improve adherence.

Is there any role for special diets in acne? There have only been a few published studies evaluating the role of special diets in acne, but there is no significant evidence either for or against a specific diet. In particular, no significant link has been found between the consumption of chocolate or sugar and acne.

Do hairstyles - particularly floppy, concealing fringes - have a role to play in causing or aggravating the condition? Evidence about whether fringes can have an impact on acne is limited, but case reports and

patient experience would suggest that having a fringe does aggravate acne. Whether this is through increased sebum production, lack of sunlight, use of hair products or contact and friction is not entirely clear.

#### How common is comorbid depression in

Comorbid depression is common with acne, although published estimates vary greatly and evidence is complex because the severity of psychological impact is wide ranging. Around 10% of patients with acne may have depression and the prevalence seems to be higher in females and those with more severe acne.

#### How should GPs manage patients with depression and acne - which is the priority?

Cases of acne are best managed on an individual basis. Often, acne may be one of the causative factors for the depression. It is well known that acne can limit an individual's social and work activities and negatively affect personal relationships and self-esteem.

Unless the depression is extremely severe or the acne is viewed as insignificant, it would seem reasonable to treat the acne early to prevent worsening of disease, as this would reduce the risk of scarring and any longerterm psychological impact.

#### How effective is co-cyprindiol? If this treatment is used, how long would it take for any improvement to be noticed?

All oestrogen-containing oral contraceptives have the potential to improve acne in some women. And cyproterone acetate combined with ethinylestradiol has been found to be effective - in the UK, it is not licensed as a contraceptive but as a treatment for severe acne in women.

The risk of venous thromboembolism is highest for first-time users and during the first year of use.' Careful selection and counselling is required when prescribing the combined pill for acne.

Acne treatment often takes several weeks to work, but some benefit should be seen after

#### How strong is the link between depression and isotretinoin, and would pre-existing depression be a contraindication to treatment?

Although there are reports of patients who have suffered from severe depression, serious mood change or committed suicide while taking isotretinoin, no causal relationship has been established. And mood changes are common in adolescents and young adults.

There is evidence that the risk of depression is no greater during isotretinoin therapy than during conservative acne therapy.9 In fact, treatment of severe acne with isotretinoin may often be associated with mood improvement. So depression is not a contraindication to treatment.

But as evidence is lacking, current UK guidelines on the prescription of isotretinoin' recommend enquiry about previous psychiatric health for all patients considered for isotretinoin, that all patients and their families are made aware of the potential for mood change and a direct enquiry about psychological symptoms at each clinic visit. If symptoms of depression or mood change do occur, ideally isotretinoin should be discontinued. But some patients may wish to continue because of the benefit to their skin. In these cases, specialist psychiatric support should be obtained.

What other issues should be discussed with the patient prior to referral for isotretinoin?

#### Key points

#### Cause

Acne is a disease of the pilosebaceous unit and pathophysiology includes: androgen-dependent

increase in sebum production

abnormal follicular differentiation with hyperkeratinisation

 colonisation with gram-positive anaerobic Propionibacterium acnes early peri-follicular inflammation prior to microbial colonisation

P. acnes colonisation

#### Epidemiology

 Lifetime risk is estimated to be 80%

later inflammation due to

Peak incidence is at 13-16 years in both sexes

During adolescence it is

more common in males; the opposite is true in adulthood

Clinical features

Open and closed comedones, papules, pustules, nodules, cysts and scarring

#### Management

 Depends on type and severity

 May include antiseptics, antibiotics, retinoids and hormonal therapy

Dr Shernaz Walton is a consultant dermatologist at Hull Royal Infirmary and honorary clinical reader at Hull York Medical School

Dr Vanessa Smith is a dermatology SpR at Leeds Teaching Hospitals

Conflict of Interest None declared

thromboembolism. BM/2001;323:828.4

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3 Fulton J Jr, Plewig G and Kligman A. Effect of chocolate en acne Vulgaris JAMA 1969;210:2071-4

4 Bowyer A. Fringe or pop sene. B&U 1965;25:1548-9 5 Mayor S. European evaluation concludes third-generation pills are associated with a small increase in risk of venous

6 Marqueling A and Zane L Depression and suicidal behaviour in acne patients treated with isotretinnin: a systematic review. Senio Cutan Med Strig 2007;26:210-00. 7 Goodfield M, Cox N, Bowser A et al. Advice on the safe introduction and continued use of isotreting in in sone in the UK. Br J Dermatel 2010;162:1172-9

The British Association of Dermatologists is the central association of UK dermatologists. Its aim is to improve the treatment and understanding of skin disease. Visit badlerguik for patient information leaflets, as well as up-to-date guidelines for clinicians, conferences in dermatology and information on training.

Isotretinoin is a potent teratogen, so women normally need to participate in the before isotretinoin is commenced. Pregnancy Prevention Program to receive Other side-effects of isotretinoin

for the month after finishing the course. Women are required to use two forms of contraception (one hormonal and one barrier form) while taking isotretinoin. Starting female patients on an oral contraceptive at

time of referral is helpful, as patients need to

repeated monthly prescriptions of the drug.7

The course of treatment is typically for four to

six months, and pregnancy should be avoided

be established on a hormonal contraceptive

include altered liver function, raised blood lipids, skin and mucosal dryness, muscle aches, headaches and vision problems particularly night vision - so isotretinoin is contraindicated in airline pilots.

Baseline bloods with fasting lipids may be helpful so that treatment can be started promptly when the patient is reviewed in secondary care.



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#### **GUIDELINE UPDATE**

# NICE guidance on venous thromboembolism

GP Dr Matt Hughes distils the June 2012 guideline and the dilemmas it poses

#### The guideline

NICE. Venous thromboembolic diseases: the management of venous thromboembolic diseases and the role of thrombophilia testing. NICE 2012;CG144

Venous thromboembolisms range from asymptomatic deep venous thrombosis (DVT) to fatal pulmonary embolism (PE).

Non-fatal venous thromboembolic diseases may cause serious long-term conditions such as post-thrombotic syndrome or chronic thromboembolic pulmonary hypertension.

The mortality associated with venous thromboembolism (VTE) from any cause is not known in the UK. But preventable, hospital-acquired VTE alone causes 25,000 deaths a year in the UK.<sup>1</sup>

DVT can be a challenging clinical diagnosis in primary care - where we commonly see patients with leg pain, swelling and erythema usually due to cellulitis, trauma or peripheral oedema.

This article will summarise NICE's June recommendations on the management of confirmed or suspected venous thromboembolic diseases in adults.

#### Use the Wells score in suspected DVT

In a patient with signs or symptoms of DVT, conduct an assessment of their general medical history and a physical examination to exclude other causes.

If DVT is suspected, use the two-level DVT Wells score to estimate the clinical probability of DVT as 'likely' or 'unlikely' (see

NICE recommends the Wells score as the most widely validated clinical decision rule, although some GPs may be more familiar with others, such as the Oudega rule.<sup>2</sup> But the two-level Wells score is a useful tool (more so than the older three-level Wells score which separated patients into low, moderate and high risk).

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This change has also been communicated to the major patient support groups in the UK. Should patients be concerned with the switch, there is a freephone helpline available on **0800 077 8566**, through which patients can receive information on local stockists of the identical product.

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PHY/ADV/12/0142 - September 2012

#### Advice on when to use proximal leg scans

DVT 'likely' on the Wells score

For patients who score 'DVT likely':

offer a proximal leg vein ultrasound within

four hours and - if negative - a D-dimer test

 if a proximal leg vein ultrasound scan cannot be done within four hours, arrange a D-dimer test and an interim 24-hour dose of a parenteral anticoagulant, with a proximal leg wein ultrasound scan within 24 hours.

The proximal leg vein ultrasound scan should be repeated six to eight days later for anyone with a positive D-dimer test and a negative proximal leg vein ultrasound scan.

#### DVT 'unlikely' on the Wells score

For patients who score 'DVT unlikely', offer a D-dimer test. If the result is positive:

- offer a proximal leg vein ultrasound scan within four hours
- if a proximal leg vein ultrasound scan cannot be done within four hours, offer an interim 24-hour dose of a parenteral anticoagulant - usually low-molecular-weight heparin (LMWH) - with a proximal leg vein ultrasound scan within 24 hours

#### A greater role for D-dimer testing

The guideline implies a D-dimer test should be done as soon as a DVT is suspected – simple in hospital, but more challenging in primary care where we typically have a 24-hour turnaround for a serum sample. NICE suggests waiting this long would lead to an unacceptable risk of propagation of a clot, potentially leading to a PE. This presents a dilemma for GPs, most of whom won't be able to implement this guidance as it stands until CCGs reorganise services to make rapid D-dimer testing available.

Point-of-care D-dimer tests have been developed which give an accurate result within 10 to 15 minutes from a finger-prick blood sample, which makes them useful for

#### The two-level DVT Wells score Clinical features Active cancer - treatment ongoing, within previous six months or palliative 1 Paralysis, paresis or recent plaster immobilisation of the lower extremities 1 Recently bedridden for three days or more, or major surgery within 12 weeks requiring general or regional anaesthesia Localised tenderness along the distribution of the deep venous system Entire leg swollen Calf swelling at least 3cm larger than asymptomatic side Pitting oedema confined to the symptomatic leg Collateral (distended) superficial veins (non-varicose) Previously documented DVT An alternative diagnosis is at least as likely as DVT Clinical probability simplified score **DVT likely** 2 points or more total **DVT** unlikely 1 point or less total

#### Two-level PE Wells score **Points** Clinical feature Clinical signs and symptoms of DVT - minimum of leg swelling and pain with palpation of the deep veins 3 An alternative diagnosis is less likely than PE 3 Heart rate >100bpm 1.5 Immobilisation for >three days or surgery in the previous four weeks 1.5 Previous DVT/PE 1.5 Haemoptysis Malignancy (on treatment, treated in the previous six months or palliative) 1 Clinical probability simplified scores PE likely More than 4 total 4 point or less total PE unlikely



or until the INR is normal (at least two) for at least 24 hours with warfarinisation, whichever is longer.

#### Continue anticoagulation for three months

Patients with a confirmed proximal DVT or PE should be started on an oral anticoagulant within 24 hours of diagnosis. At three months, assess the risks and benefits of continuing treatment.

Patients with an unprovoked PE or previous DVT should be offered oral anticoagulation beyond three months, taking into account the risk of recurrence and risk of bleeding. Patients with active cancer and confirmed proximal DVT or PE should be given LMWH for six months. At six months, assess the risks and benefits of continuing.

#### Advice on compression stockings

Offer below-knee, graduated compression stockings with an ankle pressure greater than 23mmHg (class II stockings) to patients with proximal DVT a week after diagnosis or when swelling is reduced sufficiently and there are no contraindications.

Advise patients to continue wearing them for at least two years - and ensure they are replaced two or three times a year or according to the manufacturer's instructions.

Make sure patients know they only need to be worn on the affected leg or legs.

#### Recommendations on cancer investigations

Any patient with an unprovoked DVT or unprovoked PE - not already known to have cancer - should be offered a physical examination (guided by the patient's history), chest X-ray, FBC, serum calcium, LFTs and urine analysis.

Consider an abdominopelvic CT scan (and mammography for women) in all patients aged over 40 years with a first unprovoked DVT or PE who do not have signs or symptoms of cancer, based on the above initial assessment.

#### When to do thrombophilia investigations

Don't offer thrombophilia testing to patients who are continuing anticoagulation treatment, or to those who have had 'provoked' DVT or PE in the previous three

months - for instance surgery, trauma, prolonged immobility, pregnancy or puerperium - or women on HRT or the

Consider testing for antiphospholipid antibodies in patients who have had unprovoked DVT or PE if stopping anticoagulation treatment is planned.

Consider testing for hereditary thrombophilia in patients who have had unprovoked DVT or PE and who have a first-degree relative who has had DVT or PE if stopping anticoagulation treatment is

Do not routinely offer thrombophilia testing to first-degree relatives of people with a history of DVT or PE and thrombophilia.

#### Dr Matt Hughes is a GP and hospital practitioner in cardiology in Cardiff

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# NICE Venous thromboembolic disease. June 2012; **CG144** 

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Calf swelling of at least 3cm is suggestive of DVF on the Wells

primary care. Some GPs may already be using them in a DVT LES.

A 2010 study in the British Journal of General Practice showed that use of a clinical decision rule with point-of-care D-dimer testing reduced unnecessary referrals and missed very few DVTs.

#### Use the Wells score in suspected PE

In a patient with signs or symptoms of PE, a full assessment should be carried out, including: general medical history, a physical examination and a chest X-ray to exclude other causes. The two-level PE Wells score should then be used and a full assessment is crucial for an accurate result (see table, left).

Again, this poses a dilemma for GPs who are unlikely to have access to rapid chest X-ray reporting. But, of course, if the PE Well's score means a PE is 'likely', refer immediately.

Patients with a suspected PE and a Wells score above four ('PE likely') should be referred for immediate CT pulmonary angiography. If this isn't possible, offer immediate interim parenteral anticoagulant treatment followed by CT pulmonary angiography. Consider a proximal legvein ultrasound scan if the CT pulmonary angiography is negative and DVT is suspected.

For patients with 'PE unlikely' on the Wells score, offer a D-dimer test. If positive, then follow the algorithm above for a Wells score over four. If negative, advise patients they are not likely to have a PE, discuss symptoms and signs of PE and when to seek medical review

#### Update on use of LMWH or fondaparinux

Anticoagulation will almost always be initiated in secondary care. LMWH or fondaparinux is usually the preferred option, but unfractionated heparin is preferable in severe renal impairment or patients who have a high risk of bleeding or are haemodynamically unstable.

This initial anticoagulant is started as soon as possible and continued for five days ADVERTISEMENT

#### Treating earache in babies and young children

Earache is common in babies and children, particularly between the ages of 6 and 15 months. The usual cause is a viral or sometimes bacterial infection of the middle ear. The pain, due to inflammation and a build up of fluid and pressure behind the eardrum, and the accompanying fever, can be uncomfortable and distressing - often resulting in inconsolable crying, Irritability and restlessness. The symptoms usually begin to subside within 2 to 3 days as the child's immune system fights the infection, but parents naturally want to relieve their child's discomfort as quickly as possible. Medicines are not always necessary, but when they are, parents need to know which medicines they can use and which medicine is likely to work. So what advice can you, the community practitioner give?

Many cases of earache (particularly those accompanied by respiratory | Ibuprofen or paracetamol? symptoms) are viral, but parents mistakenly assume that their child. Both medicines are effective for the treatment of pain and fever in will need antibiotics. It is important to reinforce the message that because earaches are often due to viruses and not bacteria antibiotics won't necessarily help. You should reassure parents that more effective than paracetamol at reducing fever from 4 hours their child's immune system should defeat the infection within 4 days without their child having to take antibiotics. And explain that, as antibiotics make little difference to symptoms and can cause adverse effects, a doctor will only consider using them to treat a bacterial cause in children who are less able to fight infections, such as Nurofen for Children. Paediatric ibuprofen suspensions (100 mg. as those who are:

- under 3 months of age,
- · systemically very unwell, or
- · at risk of serious complications (due to chronic disease, reduced immunity, cystic fibrosis or premature birth).

#### What should parents do?

For most simple cases, you can reassure the parent that they can treat their child's symptoms at home. If the child has a fever, you should advise the parent to keep their child cool and hydrated. You should also advise them to check their child regularly for any worrying symptoms and to seek further advice if they are concerned or if their child gets worse. If the child's earache appears to cause discomfort or distress, you can advise the parent to give a suitable analgesic, such as paediatric ibuprofen or paracetamol. Both these medicines are licensed for the relief of fever and pain and are proven to relieve the pain associated with children's earaches.1

children and have a good safety profile. However, ibuprofen starts to relieve a fever in just 15 minutes (with a 10 mg/kg dose) and is post dose. Fever relief is clinically proven to last longer than with paracetamol. 23 Ibuprofen also has anti-inflammatory properties. So when earache symptoms cause discomfort or distress, provided there are no contraindications, you may recommend that parents try giving a paediatric paracetamol or ibuprofen suspension, such / 5 ml) are available for children who are at least 3 months of age and weigh over 5 kg.

For further expert advice about relieving children's earaches and other types of pain and fever, refer to January's Educational Supplement on common childhood ailments.

#### Nurofen for Children

- · For fast, effective relief of fever and pain
- Starts to reduce a fever in just 15 minutes
- More effective than paracetamol at reducing fever - from 4 hours post dose
- Lasts longer than paracetamol for fever relief
- Anti-inflammatory properties
- Suitable for children from 3 months and weighing over 5 kg
- · Easy-dosing device for accurate, mess-free dosing



ESSENTIAL INFORMATION: NUROFEN FOR CHILDREN ORANGE 3 MONTHS TO 12 YEARS: NUROFEN FOR CHILDREN STRAWBERRY 3 MONTHS TO 12 YEARS: Suspension of ibuprater 100 mg/5 ml.

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Legal Category: F.MRRP: 15.49 (200 ml.) Data of preparation: August 2011.

Adverse events should be reported. Reporting forms and information can be found at warminhers govincity ellowcard. Adverse events should also be reported to Recklist Renckliser Healthcare (UR) Ltd on: 8500 455 456.

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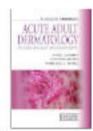
#### **PICTURE QUIZ**

# Itchy skin rashes



This 28-year-old man complained that his itchy rash was so severe it was waking him from sleep. It had been present for two weeks and comprised widespread excoriated papules.

These five patients all presented with itchy rashes – can you diagnose the condition in each case? Answers are at the bottom of the page



These cases are taken from Acute Actult Dermatology - A Colour Handbook by Daniel Creamer, Jonathan Barker and Francisco A. Kerdel, ISBN 9781840761023 (Manson Publishing), available from: www. mansonpublishing.com/colour\_handbooks and all good booksellers priced £29.95



This teenage girl's mum was concerned that her daughter was developing chicken pox. These lesions had appeared on just one leg over the preceding few days and were very itchy but not painful.



These very irritating papules had first appeared on this young, man's arms some weeks ago and seemed to be spreading. He recalled similar, though milder, episodes in the past.



This 40-year-old woman presented with this excoriated rash on both elbows, which had been present for a couple of months. She described it as unbearably itchy, and she had similar lesions on her buttocks.



This middle-aged-man had a number of itchy, circular patches symmetrically distributed on his legs. He'd tried moisturisers for some weeks before he presented.

#### ANSWERS

cobicej queuebly se appover essential. Relaptee can be treated with e auto una expudoudde di equaleupe peduojosid Aguenbesupo pue esundo piudulo e uni oj spuej eulezbe pioblijo Vep herapy and steroid cintment, twice per Juettome Meneg flyw a Juemegenem by an impeliginised on at immediate but become dry with time, often covered Adees, ere suorse; eur Ageniuj suue pue agelierti no eserwezie seegge yam anoisel biggue. Thereafter several similar, discord ruceusety richy, disc-shaped patch or he confluent and evolve into an starts as a cluster of timy papules which moisel eff. get end to toeget rewal eft. no adoleveb gliebini siptemneb to sew presentation, in discoid eczema a localisad develope and denity precipitating an acute The enuption is very itchy and often more commonly they are multiple. pourenties a solitairy lesion will occur: discrete, round patches of dermabble. Discoid eczerna is characterised by

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# COMING



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## 38 PULSECLINICAL

#### TEN TOP TIPS

## Gout

## Consultant rheumatologist Dr Alastair Hepburn offers some practical advice on how to manage this common form of arthritis

1

#### Look for sudden severe pain, swelling, warmth and erythema.

Gout can be confidently diagnosed on clinical grounds when there are classical features, such as rapid-onset, severe symptoms, tophi or podagra. Desquamation is a common, though non-specific, sign. The most commonly affected joint is the first metatarsophalangeal joint. Others include the tarsus, ankle, knee and wrist. Repeated and uncontrolled attacks may lead to chronic tophaceous gout, which often involves the small joints of the hands - particularly those affected by nodal osteoarthritis.



Assume an acute hot joint is infected until proven otherwise.

Pseudogout, septic arthritis and palindromic



rheumatism are the key differential diagnoses. Always consider urgent referral for arthrocentesis to confirm the diagnosis. Synovial fluid will be examined for crystals, and culture performed to exclude infection. The latter should always be performed in secondary care in an acute hot joint.



#### Measure serum urate between acute

The serum uric acid may be normal during an acute attack of gout, so a normal serum urate does not exclude the diagnosis. It is better to measure serum urate between acute attacks - hyperuricaemia is likely to be found. Hyperuricaemia is the main risk factor for developing gout, but the diagnosis of gout can only be made with certainty by confirming

the presence of monosodium urate crystals in synovial fluid. If the diagnosis is uncertain and you are not confident in doing arthrocentesis, refer the patient to secondary care for joint aspiration to allow polarised microscopy for MSU crystals.



#### Commence short-acting NSAIDs as soon as possible.

Use NSAIDs as a first-line treatment for acute gout, unless there are definite contraindications - for example, allergy, warfarin therapy, renal impairment, active peptic ulcer disease or asthma that is sensitive to NSAIDs. Try diclofenac 50mg tds, indomethacin 50mg tds, naproxen 500mg bd or ibuprofen 800mg tds. Continue NSAIDs for five to seven days. Consider co-prescription

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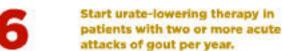
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of a PPI in patients at increased risk of peptic ulceration and gastrointestinal bleeding.

5

#### Only use colchicine in low doses.

Colchicine is an effective alternative to NSAIDs in acute gout, but tolerability issues mean it should only be used in low doses - for example, 0.5mg bd to qds for three days. Oral prednisolone 25-35mg once daily for five to seven days is a suitable third-line treatment, as are IM methylprednisolone 120mg or intra-articular steroids. However, septic arthritis must have been excluded before prescribing these. Both colchicine and steroids can be used in patients on warfarin, but IM and joint injections are probably best avoided if the INR is greater than 2.5.



Other indications for urate-lowering therapy include chronic tophaceous gout, recurrent urate stones, erosive change in radiographs, renal impairment and a continued need for diuretics - for example, in congestive cardiac failure. Delay starting urate-lowering therapy for two weeks after an acute attack has settled. Initial long-term urate-lowering therapy should be with allopurinol 100mg once daily. Increase the dose in 100mg increments every two to three weeks according to tolerability and serum urate. The typical maintenance dose of allopurinol is 300mg daily, the maximum daily dose is 900mg. Febuxostat 80-120mg once daily is an alternative to allopurinol and has been approved by NICE for patients with hyperuricaemia and gout who can't tolerate or are resistant to allopurinol.

Uricosuric drugs such as probenecid, sulphinpyrazone and benzbromarone are alternative second-line drugs.

#### Urate-lowering therapy can be used with renal impairment.

Allopurinol can be used safely in patients with renal impairment, but the dose should rarely exceed 300mg daily and renal function should be closely monitored. The dose may have to be reduced considerably in patients with more advanced renal failure - for example, to 100mg on alternate days. Februsostat and benzbromarone may also be used in renal impairment, down to a GFR of 30ml/min and 20ml/min respectively.

Aim for a serum urate level under 0.36mmol/l in patients on uratelowering therapy.

Measure serum urate every two to three weeks until the target level is consistent. In patients with severe disease such as those with chronic tophaceous gout or polyarticular flares, a target serum urate of less than 0.30mmol/l is better.

Advise patients on weight loss and alcohol consumption.

Patients with gout should be actively encouraged to modify their diet and reduce their intake of alcohol. Avoid crash diets and diets that are high in protein. Restrict intake of foods high in purines such as offal, shellfish, nuts and yeast extract, and avoid carbonated soft drinks containing fructose. Skimmed milk, low-fat yogurt, vitamin C supplements, soybeans and cherries may help. Go to pulsetoday.co.uk/tools-and-resources to

download a factsheet on diet and treatment in gout from the UK Gout Society. Restrict alcohol consumption to fewer than 21 units per week in men and 14 units per week in women. The risk of gout is highest with beer - particularly bitter and stout - port and fortified wines, and is lowest with spirits.

10

#### Screen patients for metabolic syndrome.

Patients presenting with gout should be screened for metabolic syndrome. This includes blood pressure measurement (off NSAIDs), weight or BMI, fasting lipid profile and fasting glucose or HbA.c. If diuretics are being used for hypertension, alternatives should be considered. Losartan has a mild uricosuric effect and can counteract the effect of thiazides on serum urate. In patients with hypertriglyceridaemia, consider using fenofibrate. This too has a mild uricosuric effect. However, statins are still likely to be more appropriate in patients with both gout and hyperlipidaemia, and fenofibrate should only be used in patients already receiving a statin on specialist advice.

Dr Alastair Hepburn is a consultant rheumatologist at Western Sussex Hospitals NHS Trust and a trustee of the UK Gout Society

Competing interests None declared

The UK Gout Society (ukgoutsociety.org) is a registered charity that aims to promote greater public awareness of this common metabolic arthropathy. It provides information for patients on the causes, treatment and prevention of gout. Patient information leaflets on the treatment of gout, dietary modification and the links between gout and the metabolic syndrome are available to download on its website.







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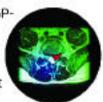
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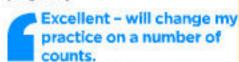
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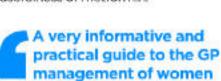
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# Pulse Business & Commissioning

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#### IN THIS ISSUE

#### How we set up virtual wards

One GP explains how he helped cut hospital admissions page 43



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Download Primary Care Commissioning's guidance on designing and commissioning services

#### 'Traffic light' test for liver problems

How commissioners can develop a tool for early diagnosis

## Ask the experts: flexible working

Three leading GPs and a health employment lawyer tackle three scenarios in which a request by a salaried GP or a member of staff for a change of hours might affect capacity at the surgery

One of your salaried GPs wants to cut her hours, but you don't want her to work any less. Are you obliged to allow her to do this? What might she do if you refuse?

Dr Fiona Cornish (FC) In our practice, we'd probably agree that the GP could cut her hours down and negotiate with her. If there's a reason for her decision, we'd be flexible and accommodate. I think the whole basis you operate on in general practice is that everyone has to be happy about the

Dr Richard Fieldhouse (RF) There's no choice but to go for the win-win solution. Find out from her not so much what she wants to do - in this case, reduce her hours - but why she wants to do this. You may well have a solution to her problem that she may otherwise not have foreseen.

And of course, explain the situation from your perspective too, and what a reduction in capacity as you perceive it may mean to you. Dr John Canning (JC) As I understand it, there is no obligation to change a salaried doctor's hours - but any decision should follow a period of discussion and consultation with the doctor concerned. If you refuse, the doctor may leave and pursue a case for unfair dismissal. To defend your position, full, accurate and contemporaneous records must be available of all discussions, correspondence and consultations so as to demonstrate that the decision is not unfair.

Doctors are rarely specialists in employment arrangements and it is vital that advice is taken from employment specialists - for members, advice is available from the

Alexandra Robinson (AR) There is no right for the GP to change her hours of work, and where a request is made, there is no obligation on you as the employer to agree. However, there are traps for the unwary.



Blake Lapthorn LLP

Your options will depend on the reasons for the GP's request. Parents, guardians or foster carers of children under 17 - or children under 18 where the child has disabilities - and certain carers of adults have a right to request flexible working and there is a statutory procedure to follow. As an employer, you do not have to agree to this request, but a refusal would have to be justified on specified

If the GP considers that you have failed to comply with the procedure, that you cannot show that one of the specified grounds applies or that you have refused a request based on incorrect facts, she will be able to bring a claim in an employment tribunal. Where a claim succeeds, the tribunal may make an order that the application be reconsidered and an award of compensation made.

You should consider exploring whether an alternative arrangement can be agreed or whether you could agree to the reduction of hours on a trial basis.

You have just adapted one salaried GP's hours for flexible work, but you're concerned he's not working the hours you agreed. How do you approach the issue, and if nothing changes what recourse do you

FC Discuss with the doctor why he's not doing the hours. If there was some personal or family reason, we'd reduce the hours and simply pay them for what they do. One or two of the partners would sit down in the surgery with the GP and have a formal discussion with the practice manager present as well.

At our surgery, there's a lot of flexibility, but arguably it's more difficult for smaller practices. If a lot of your salaried doctors want to work a minimal number of sessions, it can create fragmentation and loss of continuity of care.

#### **PULSEBUSINESS & COMMISSIONING**

RF Sit down with the GP and ask him how the new arrangement is going. Are there any problems? Is it all working out okay?

Chances are you'll find your answer in a mutually conducive, non-confrontational way. You'll be able to pick up on any misunderstandings and support your colleague to reach the targets you'd both initially agreed to.

JC Although you will have a disciplinary process as part of your employment contracts, it may be better to consider the situation as part of an employee appraisal - not to be confused with professional appraisal.

If this fails, the disciplinary process may be the only way forward. Take advice, keep documentation and ensure any decision is fair, rational and justifiable.

AR It will be important to find out from the GP why he is not working the hours agreed. An explanation should be sought and the reasons given should be checked.

Generally speaking, lateness without good reason or absenteeism without authorisation are conduct issues and give grounds for disciplinary action against the GP. You should always follow your disciplinary procedure and the ACAS Code of practice when considering taking disciplinary action.

In most cases, a first offence would not merit dismissal. It may be that a formal warning is more appropriate.

A warning would be issued after a disciplinary hearing at which the GP would be given an opportunity to explain his actions.

If the situation does not improve, it is

#### In all cases, requests should be given due consideration

likely that further disciplinary action would be appropriate and that this could lead to a decision to dismiss.

However, there may be situations where disciplinary action is not appropriate. For example, where the GP's actions are caused by an underlying medical condition, care should be taken as any disciplinary action or dismissal could result in a claim of discrimination under the Equality Act 2010.

If the medical condition amounts to a disability within the definition of the Equality Act, consideration should be given as to whether any adjustments should be made to the GP's working arrangements.

As a further example, if the GP's actions are caused by temporary problems relating to dependants, the GP may be entitled to time

There may be some situations where the consequences of the GP failing to work the hours agreed are so serious that they justify dismissal without prior warnings, for example, if the GP's actions are putting the safety of patients at risk. A decision to

dismiss should only be taken after full consideration of the circumstances within the context of a formal disciplinary procedure, including an investigation and disciplinary hearing.

It is important to deal with this type of issue promptly, firmly and consistently. It is also good practice to ensure that any discussions and disciplinary procedures are well documented.

Two practice nurses approach you for a jobshare. How is it best to negotiate a jobshare agreement? How do you designate new workload, decision-making powers and annual leave?

FC Set up a 'team' system between the two employees whereby they try to maintain continuity of care and help each other out for instance, by looking at each other's patients' results when they come in.

If you have two employees who fall pregnant at the same time, this can be a good

RF A really important area for each party and the employer is to understand the other jobsharer's life outside work - kids' ages and schooling, life-partner's work commitments, caring commitments for family members or friends, their faith and what commitments that may entail, if any, where they live and their transportation and their health.

The biggest two reasons for falling out would be pay and workload, so wherever possible try and set those in stone. JC Contracts will need amending to reflect the arrangement if the two employees already work for the practice, and if they are new employees treat them as two part-timers with two contracts. If one leaves the other can stay, leaving the employer to determine what to do with the vacancy. For example, you could offer it to the remaining person as a full-time position or recruit a new part-timer.

AR Most of the issues for setting up a jobshare will be the same as those for a parttime employee.

It will be important to establish how you and the employees envisage that the job will work on a shared basis, including how the two employees will communicate with each other and with you, workload management and distribution, whether there will be any overlap between them during which they can discuss their work, how handovers will take place, how they will co-ordinate annual leave and training, how periods of absence due to illness or annual leave will be covered and what will happen if one of them leaves.

You should also review and monitor the arrangement periodically to ensure it is working for all parties, and keep a record of meetings where the conditions of the arrangement are negotiated.

#### Do you have a practice business dilemma you'd like to solve?

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#### The model

In 2007, I attended a presentation by Dr Geraint Lewis, now a senior fellow at the Nuffield Trust, outlining the virtual ward concept and the principles of predictive modelling that he had piloted in Croydon, south London.

While the name 'virtual ward' has appeared in several areas since, including in secondary care, the original principle remains the combined use of two components – a predictive model to identify those at risk of admission and the use of a community-based, multidisciplinary team (MDT) providing secondary-level care at home to prevent admissions.

This seemed like an ideal model to adapt to our area, to help address the rise in patients with complex needs who were frequently admitted. We found to our frustration when we reviewed cases it was often clear that a co-ordinated intervention several months earlier might have prevented many of the admissions for that individual.

#### What we did

In 2008, we got the agreement of two other local practices and set out a business case to obtain a small amount of funding. We then set up a local 'virtual ward' in North Devon. This coincided with the development of 23 complex care teams (CCTs) across Devon, as part of a Department of Health-funded project.

Our core community services were developed into a multidisciplinary, multiprovider model by restructuring the existing workforce and employing a co-ordinator for each CCT. The teams scheduled weekly MDT meetings that included social workers, volunteers and community nurses.

Their remit was to provide co-ordinated community care to a local population. The inclusion of extra community matrons also increased capacity.

The virtual ward was a formal structure for the CCT's case-management function to work within, and it helped identify and 'admit' individual patients. Practices received copies of the at-risk patient list and discussed these patients with the CCT to agree who should be admitted to the ward. Contact was made with the patient, consent gained, information gathered and goals for the period of admission set. This then led on to timely discharge from the service on achievement of those goals and space for a new admission.

We evolved a new way of risk-scoring patients, based on the Patients At Risk of Readmission (PARR) score but including patient data as in the Combined Predictive Model (CPM). Local analysts published a variation of the system known as the Devon Predictive Model (DPM) - scores from this model are now shared with practices monthly using a secure website.

The pilots appeared to have a clear impact on outcomes, with reduced visit requests, consultations and admissions for the highrisk group.

In 2010, the need to tackle a rise in admissions across the whole of Devon was significant enough that NHS Devon made the decision to roll out both the DPM and virtual wards to all practices and CCTs in the area.

NHS Devon incentivised this rollout through a LES. This required practices to complete a data-sharing agreement, establish monthly extracts, review the DPM lists and refer patients with the highest risk scores whose situation was deemed amenable to intervention. Practices were paid £120 per virtual ward bed per annum.

Subsequent versions of the LES have evolved to be more specific and focus on reducing the rate of bed occupancy, rate of patients admitted from the highest-risk DPM



## How we set up virtual wards

Dr Paul Lovell explains how improving care co-ordination helped to cut admissions for patients with complex needs

score group and supplying an out-of-hours care plan for each patient managed on the virtual wards.

In 2011, NHS Devon was divided into three localities, all of which had a slightly different approach to running the virtual wards.

Although this affected the ability to ensure standardisation, it also provided us with some insights into what makes the intervention work.

One locality

#### Challenges

While we were initially
using the CPM to identify
patients, we also asked GPs
to nominate patients they
thought would benefit from a
'proactive approach'. Once both
lists were ready, we compared them
and found significant differences. There was
some overlap, but the 'clinician knows best'
default was challenged by the listings and
some doctors were encouraged to take a leap
of faith as we relied on the risk stratification
tool when we rolled the service out.

During the roll-out it became clear we could only standardise to a point. The important parts were to ensure the right people were being seen, the turnover was occurring and the process flow happening. We had to adapt the wards on a teamby-team basis - for example, noting the differences between rural (moorland and coastal) and urban areas when we rolled the programme out across the county. This included challenges such as covering large areas, providing accommodation for the CCT members and introducing more mobile solutions into the IT system.

#### Results

Measuring the impact of admission avoidance schemes is difficult and open to many confounding factors.

We've been looking at the effects on the target population - namely, the top 0.5% stratified by DPM risk score. We have then observed each monthly cohort

over time, comparing rolling growth and outcomes to the cohorts of the corresponding months in previous years. Since the inception of the virtual wards just over two years ago, we have case-managed nearly 6,000 individuals from these cohorts across Devonapproximately 45% of the available capacity.

In terms of the outcomes seen, it's important to note that there were no other specific proactive admission avoidance interventions targeting this group over the same period. As the table below shows, the Exeter and East Devon and North and Mid Devon localities had very high occupancy in the virtual wards, reduced admissions for the top 0.5% risk group and saved payment by results costs. They also had over 40% achievement in the 2011 LES.

The results show an impact proportional to the intervention provided, which suggests a positive link. There appears to be a strong correlation between the responsiveness of the service to rising risk scores and duration of stay, with an optimum duration being around five or six months. If we achieved this length of stay more often, the improved turnover would also increase the capacity of the service further.

The results from the three localities also show the opportunity for improvement in each area, with some practices currently not hitting the full targets of the LES in terms of occupancy and profile and a few not participating. This reflects the difficulties of making changes on such a large scale and the challenges in changing attitudes, perceptions and working practices.

The Exeter and East Devon locality has demonstrated the greatest impact, with a 22% reduction in admissions and a minimum payment by results saving of £845,310. From comparing the different profiles of the service, it became clear that the role of the commissioner was key – they were the ones to actively support the project on the ground and troubleshoot.

It was also clear, after the removal of the LES by one of the localities for a period, that this had a significant impact on the success of the intervention.

Having local GP champions in each cluster or in every practice also helped to bridge the gap between the theory and effective local implementation.

Ideally, as in the original Croydon model, a patient's GP should be available to discuss their care at the weekly MDT meetings. But we've found that to be impractical in terms of cost, time and geography. Communication between clinicians is vital to keep the process moving effectively, with monthly bed-state meetings with practices to review the lists plus weekly and ad hoc contact with case managers for clinical discussions encouraged.

#### The future

The challenge in Devon is to take the service to the next level by encouraging its full adoption. This will include an increased focus on identifying and proactively responding to patients identified as at high risk.

The evidence nationally and internationally for the success of virtual wards, predictive modelling and case management has to date not encouraged large-scale uptake. From our experiences, however, this approach can deliver the savings needed and change the emphasis of care to a proactive, community-based approach.

Dr Paul Lovell is a GP in South Molton, Devon, and an urgent care clinical lead for NHS Devon

#### Results by locality

Locality	Average virtual ward (VW) occupancy (%)	Average VW occupancy from top 0.5% risk group (%)	Average VW occupancy from low-risk group (DPM score <19) (%)	Percentage of practices hitting 2011 LES targets (%)	Q1 net admission change 2009 to 2011 for top 0.5% cohort (%)	Change in actual payment by results cost associated with net admission change
Exeter and East Devon	107	45	16	66	-22	-£845,310
North and Mid Devon	99	38	22	43	-14	-£210,758
South and West Devon	90.3	28.7	26.4	19.2	3.91	£151,742



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Mrs Nicky Goulter (Practice Manager) Dr Kate Laws & Partners Shadbolt Park House Surgery Salisbury Road, Worcester Park, Surrey, KT4 7BX.

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#### RCGP Core Skills in Musculoskeletal Care Trainer

Approx. 6 sessions (TBC) Oct 2012 - Mar 2013, with potential for role to continue

The Royal College of General Practitioners are seeking nine trainers to deliver workshops for a pilot being developed with Arthritis Research UK. Experience of managing MSK

problems in primary care is essential. Three workshops will be delivered in Feb/Mar 2013.

with a training day in Nov 2012.

Contact msk@rcgp.org.uk Application deadline 25 Sep 2012

### COURSES/CONFERENCES



CONFERENCES TO COME:

**PREMESIS** 

relea Status 20th | Stat Ectober 2012 2nd -9th Feb 2015

Seriffe à Granada

October 2012

BOOK ONLINE AT: www.conferenceplus.co.uk 

**BABTA** 

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THURSO, HIGHLANDS, SCOTLAND (www.thursohalkirkmp.co.uk) ADDITIONAL PARTNER REQUIRED

Call 020 7498 7999

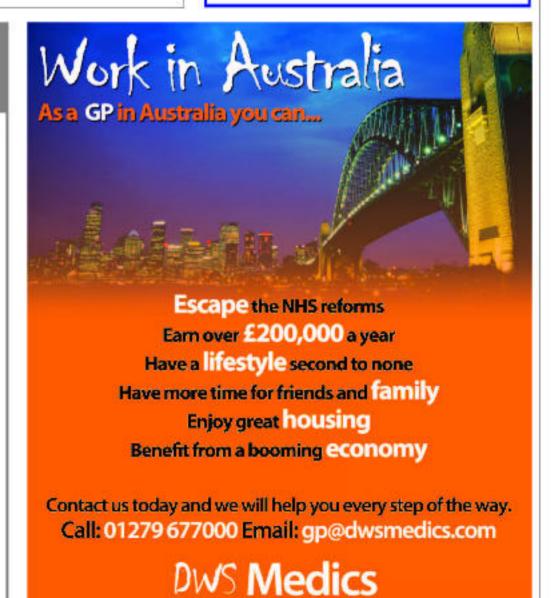
gp@drlocums.com

We are looking for an additional partner to join our innovative GMS practice in an area of outstanding local beauty in the North of Scotland. We require an enthu-slastic, hardworking and committed GP who will play an active role within the practice to maintain our values and help develop patient services for the future. We are committed to providing high quality leath care with a wide range of services tailored to meet the needs of our patients.

- 6 9 sessions (but could be flexible).
- · Non Equity or Equity Partner position · List size approximately 6,000 (currently
- four partner practice) · Dispensing branch surgery (six miles
- from town)
- · Established Training Practice Specialist Registrars and Undergraduate teaching, Practice Based Small Learning Group (PBSLG)
- · High patient satisfaction survey scores
- Clinical support team includes Practice Nurses and Health Care Assistant
- In the final stages of recruiting a Nurse Practitionery Prescriber
- · GP led community hospital next door
- IT IMPS (Vision), FrontDesk and Docman clinical systems with on site VC facility for training / meeting purposes and telemedicine
- · Well equipped premises
- · Enhanced services and extended hours offered
- · No out of hours commitment (although opportunities exist locally)
- · Olinics provided by visiting Midwife and Physiotherapist
- · Generous annual leave plus 5 public holidays (includes 5 days study leave) · Maternity/paternity pay written into contract
- · Excellent local facilities, housing and schools, low crime rate
- · Twenty miles from nearest airport · Vacancy available new but willing to wait for the right person.
- · Applications welcome from current ST3s, newly qualified and experienced GPs

Further information, including Practice Profile, GP/Logury testimentals and the results of our patient satisfaction survey are available on our newly updated practice website at www.thursohalkirkmp.co.uk. Information together with a promotional video on the town of Thurso and the surrounding area can be found at www.thursotown.co.uk.

If you would be interested in joining our friendly, forward thinking and high quality practice team in this beautiful part of Scotland, please write (enclosing CV) to: Christine Tait, Management Partner, Thurso & Halkirk Medical Practice, 69 Princes Street, Thurso, Caithness KW14 7DH. For more information or for informal enquiries please contact Christine on 01847 895495 or c.tait@nhs.net.



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

**EDITOR'S CHOICE** 

## My diet to tackle fibromyalgia

When Hampshire GP Dr Clare Morrison started experiencing all the symptoms of fibromyalgia, she came up with a somewhat controversial solution...

I recently wrote a couple of articles for the Daily Mail describing my experience of dietary management of fibromy algia - headlined as 'the GP who gave up fruit and veg to cure her aches and pains'.

During my career, I had sometimes met middle-aged, female patients suffering from a combination of widespread muscle aches and stiffness, chronic fatigue, poor sleep, restless or 'tingly' legs, 'brain fog, increased urinary frequency, irritable bowels and cold intolerance.

As a 46-year-old, I also experienced all these symptoms for about two years - the fatigue and pain were so debilitating I thought I might have to quit work.

However, I discovered that I could eliminate all my symptoms by cutting out foods containing a little-known chemical called oxalate.



Dr Clare Morrison cut out foods containing oxalate

Oxalate is present in most plants, to a variable extent. Spinach, for example, contains 750mg per 100g.

My decision led to a certain degree of ridicule and bemusement from fellow doctors - but since writing for the Daily Mail people from all over the country have responded...

Dr Clare Morrison is a GP in Havant, Hampshire

MORE ONLINE
Read more at
pulsetoday.co.uk/off-duty



Pulse's newest blogger Dr Nick Ramscar explains how reading other doctors' notes gives him a window into their working worlds - and their choice of words can be very revealing...

▶ pulsetoday.co.uk/blogs







Calogen° Extra Shots

#### WHAT YOU'VE BEEN SAYING

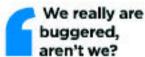
> pulsetodav.co.uk/forum

The time that was wasted on this paper exercise could have been used to see patients.

... on practices losing QOF income attached to the new A&E indicators

There is no way I would agree to this as a patient.

... on GPs being asked to vet consultant-to-consultant referrals



... in response to Peverley announcing he is considering going part time



#### Next up,

Dr Mark Porter

Next month, we're interviewing Dr Mark Porter, the new chair of the BMA, as part of our Big Interview series - and we'd like your help.

What should the BMA do next on pensions? How would you like him to campaign on the Government's NHS teforms?

Send us your questions and we'll put the best to Dr Porter.



Email feedback@pulsetoday. co.uk with 'Mark Porter Interview' in the subject line

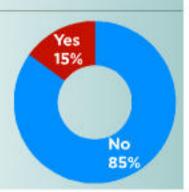
#### THIS WEEK'S POLL

## Should the BMA boycott commissioning?

Vote at ▶ pulsetoday.co.uk/polls

#### Last week's poll

Are you happy with Jeremy Hunt as the new health secretary?



Turn inside for this week's Phil Peverley and Margaret McCartney columns page 20-21

"Containing selections." \*PM for make 350 years (except No. K. O);

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