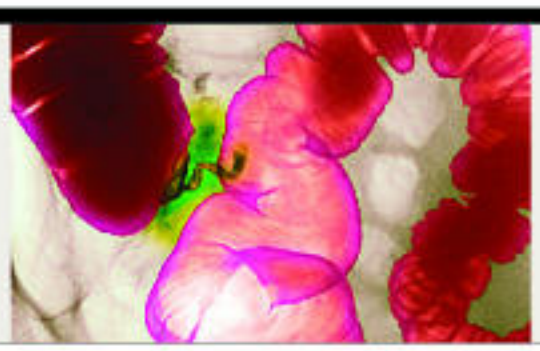

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BriefingMedia

At the heart of general practice since 1960

Choose and Book chaos as trusts cancel appointments

GPs left to face 'irate' patients after hospitals cancel appointments not confirmed within three days

EXCLUSIVE
By Madlen Davies

Overzealous hospital managers are routinely delaying or blocking Choose and Book referrals for administrative reasons, leaving GPs to deal with angry patients whose appointments have been cancelled, a Pulse investigation reveals.

Some practices are reporting up to 15 cancellations a day as hospital trusts increasingly insist that all referrals made through the controversial system are confirmed within three days.

And LMCs have also claimed that Choose and Book is listing 'phantom' slots when consultants are away or on holiday, and that GPs are not being told when appointments are cancelled.

Department of Health guidelines suggest Choose and Book appointments should be followed up with a GP referral letter within three days to ensure the appointment is 'clinically appropriate'.

But Dr Philip Fielding, chair of Gloucestershire LMC, said 'significant' numbers of appointments were being cancelled without practices being informed, and 'irate' patients were chasing up their appointments.

He said: 'A system designed to give greater choice and speedier referrals is being limited by bureaucracy and has disadvantaged patients.

'The whole idea of Choose and Book is to plan ahead. For elderly patients, it has caused more delay and angst.'

He added that GPs were also booking patients into 'phantom' appointments that were later cancelled as the system could not tell when a consultant was due to be away.

Dr Andrew Mimnagh, chair of Sefton LMC, told Pulse local practices were experiencing '14 to 15' cancellations a day, and booking of appointments when consultants were away was a particular problem.

Dr Manoj Pai, former chair of Coventry LMC, said practices in his area had also been hit: 'We have referred and it has gone through and patients have been told to ring again because the appointment is not possible.'

Eric Gatling, director of service delivery at Gloucestershire Hospitals NHS Foundation Trust, said: 'From September this year we have been taking a more robust approach to ensuring that patient appointments are confirmed by the GP within the three day period, in agreement with the PCT.'

Richard McCarthy, deputy director of performance at Southport and Ormskirk Hospital NHS Trust, said the trust 'recognises there are shortcomings in the operation of the service on both sides'.

The controversy comes at a crucial time for Choose and Book. GP usage has fallen to about 50% of referrals, but DH plans outlined in May revealed GPs may soon be forced to use Choose and Book or adopt 'labour-intensive' alternatives.

GPC negotiator Dr Chaand Nagpaul said: 'It is unacceptable for patients to be penalised this way. There is no legal requirement for a letter to be received within three days.'

A DH spokesperson said national figures on cancellations were not collected: 'We would expect local hospitals to take action so that appointments are not cancelled unnecessarily if there are any delays in receiving referral letters.'

@madlendavies

▶ CCGs warn choice agenda is 'destabilising hospitals', page 4

Hospitals are cancelling outpatient appointments that are not confirmed within three days

EDITORIAL ▶

A mockery of patient choice 18

The week in general practice

INSIDE

Dr Beth McCarron-Nash

MORE ONLINE

▶ pulsetoday.co.uk/news

CCGs should hand over commissioning budgets to the voluntary sector to commission entire pathways on their behalf, according to the NHS Future Forum's lead on choice
▶ pulsetoday.co.uk/commissioning

Resource of the week
Use our interactive timeline to trace the rocky path towards revalidation
▶ pulsetoday.co.uk/revalidation

Video of the week
Watch the Big Interview with BMA deputy chair Dr Kailash Chand
▶ pulsetoday.co.uk/the-big-interview

Revalidation rollout given DH go-ahead

Announcement comes as officials warn as many as one doctor in 20 may have concerns flagged

By Jaimie Kaffash

The Government has given the final green light for revalidation to begin by the end of this year, and warned it expects concerns to be flagged about up to 5% of all doctors.

Under new secondary legislation, due to be enacted on 5 November, GPs and other doctors will begin to be revalidated in December and the majority of doctors are expected to be revalidated by April 2016.

The announcement from health secretary Jeremy Hunt comes after the BMA backed the rollout following the agreement of a deal on funding remediation.

GMC chair Sir Peter Rubin told Pulse earlier this month that 'fewer than 10 GPs' were likely to require remediation across an area with a population of five million, which, extrapolated across the UK, would mean fewer than 125 GPs would need remediation across the five-year revalidation cycle. But new DH estimates suggest this figure could be much higher.

Alan Coffey, chief executive of the DH Revalidation Support Team, said a survey of more than 300 healthcare organisations across England found 4.1% of doctors - which would equate to 6,800 doctors across the country - were deemed to have concerns.

Mr Coffey added that the proportion of doctors with concerns might rise to 5% when revalidation begins: 'We are hoping these 5% will require low-level interventions and the environment would be much more consistent and supportive.' He also said the survey found 'high-level concerns' in 0.7% of all doctors - around 1,200 doctors across England - who would need 'significant remediation'.

Despite the higher estimates of the numbers potentially requiring remediation, the DH has insisted revalidation will be cost-neutral. It has so far refused to publish detailed costings, but will release its impact assessment on 5 November.

Mr Hunt also announced there will be one national list of GPs, dentists and ophthalmologists approved to provide primary care services, replacing performers' lists at PCT level.

BMA chair Dr Mark Porter said the association supported the rollout, as it would give patients confidence their doctors had up-to-date skills and knowledge. But he added: 'It is essential that revalidation is reviewed every step of way so that we can be sure that the system works for patients and for doctors.'

Dr Di Jelley, clinical lead for

Should the profession get behind reval

'Let's try it out, see how it goes, and be open to developing the process to provide the most benefit possible.'
Dr Johnny Marshall, interim partnership development director of NHS Clinical Commissioners

'The sticking point is this: what is the remediation for those who do not make the standard?'
Dr Andrew Mimnagh, Sefton LMC chair

Dr Di Jelley: most GPs flagged up as causing concern will not be 'new findings'

CCGs embrace advice from private firms

EXCLUSIVE

By Gareth Iacobucci

Leading private companies are already advising scores of CCGs on how to spend NHS cash, as the Government's new commissioning marketplace takes shape.

PricewaterhouseCoopers (PwC) revealed this week it is now working with around 100 CCGs, while KPMG is working with 50 CCGs and Capita around 40.

The companies are providing a mixture of short-term support to CCGs and commissioning support units on areas such as governance and authorisation, alongside longer-term advice on how to meet the daunting £20bn efficiency challenge set by the Government's QIPP agenda.

Pulse reported last year that private consultancy firm McKinsey had been enlisted by dozens of CCGs to advise on QIPP, budget-holding and governance, although McKinsey this week declined to comment.

Speaking at a Westminster Forum event last week, Tim Rideout, associate at KPMG, said the expertise provided by the private sector was vital as CCGs 'do not have the capacity and capability to commission in an effective way'. He said: 'The key message that comes from CCGs is that commissioning support is absolutely essential if they are going to succeed.'

Dr Jonathan Steel, senior clinical consultant to PwC and a GP in Uley, Gloucestershire, said: 'We're seeing the more advanced CCGs asking for help with service redesign.'

A Pulse investigation in January found four in 10 CCGs had begun to seek advice from the private sector.

Revalidation: what comes next

- NOV 12 — Secondary legislation enacted
- DEC 12 — Revalidation begins, with medical leaders in first wave
- APR 13 — Every GP to know their date of revalidation
- APR 14 — About 20% of doctors complete revalidation
- APR 16 — Most doctors complete revalidation
- APR 18 — All remaining doctors complete revalidation

GP appraisals at the North East Primary Care Services Agency and a GP in North Shields, said: 'As a GP, I am delighted. We are now ready to go ahead with the process, as we wanted. Revalidation may identify cases in areas where all doctors have not engaged in appraisals but I think the majority of doctors [who cause concern] will not be new findings.'

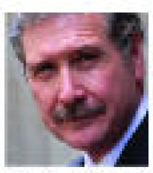
But Dr Peter Swinyard, chair of the Family Doctor Association, said: 'It is yet another added burden that is causing demoralisation in general practice. I don't think it will weed out a significant number of bad doctors. I think it will cause a lot of grief for a number of good doctors.

'But it is one of the inevitabilities of modern life that nobody trusts anyone else and no one trusts their doctor unless they have a rubber-stamp every five years saying they are up to date.'

@pulsetoday

idation?

'It is paper-heavy and bureaucratic and will just add more work for GPs. Introducing revalidation is not the answer.'
Dr Una Coales, RCGP Council member



'This was something first proposed by the profession. It is not something that has been foisted upon us.'
Dr George Rae, BMA Council member

mission remains the same

provide an easy way to collect CPD credits as you begin to tackle revalidation.

And then from January we'll be relaunching Pulse magazine in a brand-new monthly format. The new Pulse will be bigger and better – still with all your favourite clinical formats, GP columnists like Copperfield and Peverley and a comprehensive digest of the month's news, but with more space devoted to in-depth analysis and hard-hitting investigations that really get under the skin of general practice.

Throughout it all, our mission remains the same. As we have for the past 52 years, we will continue to champion and support the profession – and do whatever we can to help you do a difficult job better.

Steve Nowottny
Pulse editor

Choice 'destabilising hospitals'

Out-of-area patients cause over-capacity issues at some hospitals, while others face prospect of closure

INVESTIGATION

By Gareth Iacobucci

Evidence is emerging that the Government's patient choice agenda is destabilising secondary care, with inflated waiting lists and warnings that spare capacity could force hospital closures.

Board papers from several CCGs reveal mounting concern that patient choice may be proving unsustainable as NHS budgets tighten.

The choice agenda, first introduced by Labour in 2004 and due to be expanded into new areas by the current Government, now guarantees most patients the legal right to choose the hospital to which they are referred.

A Pulse investigation in 2009 cast doubt on the effectiveness of the policy, showing that just 6.4% of referrals in 2008–9 were for patients from outside hospitals' normal catchment areas.

But GP commissioners said patients are now increasingly exercising their choice, with influxes of out-of-area patients causing heightened activity and longer waits at hospitals for local patients.

Harrow CCG in north-west London said an audit of antenatal care at the Northwick Park Hospital showed over 40% of local patients were not seen within the set time due to an increase in out-of-area patients.

In south-east London, Lewisham Healthcare NHS Trust said it had experienced demand above the projected level in maternity and outpatient services in the past year due to patient choice.

Unintended consequences: some fear the ebb and flow of patients may lead to hospital closures

A spokesperson said: 'The trust's market share for maternity service users in Lewisham has increased by 6% in the last two years. With patient choice, many women from outside of the borough choose to give birth in Lewisham.'

'The notion of unfettered choice is a flawed one'
Dr Chaand Nagpaul

Elsewhere, councillors have warned that patient choice is leading to 'capacity issues' and the threat of closure for some hospitals.

Earlier this year, Bexley CCG reported concerns from local councillor Eileen Pallen that local patients were 'experiencing long waits for appointments'. Board papers from the CCG said 'capacity issues at hospitals resulted from patient choice'.

The NHS South West London cluster, which is currently reconfiguring its hospital services, also had warnings from a local councillor that the St Helier Hospital in Carshalton was 'likely to close' as a result of 'the anticipated adverse impact of patient choice'.

Epsom and St Helier University Hospitals NHS Trust declined to comment.

Dr Chaand Nagpaul, GPC negotiator, said: 'A full choice agenda makes it impossible for local hospitals to plan and make provision for local patients whilst at the same time being available to patients from other areas.

'It is not appropriate to the choice agenda to be applied in certain clinical areas, such as maternity. There are tensions that need to be addressed. The notion of unfettered choice is a flawed one that does meet the needs or the ethos of the NHS.'

Dr Kamran Ahmed, a GP in Wolverhampton and board member of Wolverhampton CCG, said it was important that choice was used sensibly to keep a lid on demand.

'There are lots of factors causing change. Obviously if you are a secondary care provider, increasing activity is important to your business. As a commissioner, getting a grip on the activity that's already there and trying to manage future activity is important.'

How choice is putting services under pressure

Harrow CCG Audit of antenatal care showed that 40% of local patients are not seen within the set time because of out-of-area demand

Royal Wolverhampton Hospitals NHS Trust Receiving more referrals than expected

Lewisham Healthcare NHS Trust Demand above the projected level in maternity and outpatient services

Bexley CCG Long waits for appointments reported

NHS South West London cluster Warnings hospital could close

ANALYSIS

The start of a shift in care

It is complicated, but there is a balance between patient choice, financial viability and patient safety.

From a commissioning point of view, if the local provider is performing well, we would always want to keep that going.

We are part of the wider NHS and need to work with local colleagues to ensure the whole system functions. There will be a shift from hospital care and probably a general reduction in the number of acute providers. The question is whether the driver for this will be patient choice and quality or geography and the cost per unit of that provider.

Our local trust wasn't performing terribly well so patients had said they wanted to go somewhere else. But that has been reversed and now it is performing really well.

Patients who were choosing to go elsewhere are saying 'my local hospital is the best place'.

It's about getting the right number of services locally.

Dr Helen Tattersfield is chair of NHS Lewisham CCG and a GP in Bromley

Most NICE studies 'not relevant to primary care'

By Nigel Praities

Fewer than a quarter of studies that are used to justify NICE recommendations for GPs are relevant to primary care, an independent investigation into the institute's methods has concluded.

Researchers looked at the guidelines issued over two years and found only 39% of the studies used to develop recommendations for GPs were relevant to primary care, with the relevance for some guidelines as low as 2%.

The study – independently funded by the National Institute for Health Research – examined the evidence base behind the decisions taken by NICE from January 2010 to December 2011.

Led by Professor Amanda Howe, RCGP honorary secretary and clinical senior lecturer at the University of East Anglia, and GP Dr Nicholas Steel, it looked at 32 primary care-relevant guidelines.

Two independent GPs reviewed each guideline and identified the evidence base for each recommendation aimed at primary care. Of the 555 recommendations, they found 292 specific to primary care; 21% of these were based on evidence directly relevant to primary care.

'Lack of GP representation means strange results creep in'
Dr Bill Beeby

The researchers cited guidelines that extrapolated evidence from severe disease and applied it to the mild and moderate disease commonly treated in primary care.

Presenting the study at the Society for Academic Primary Care conference in Glasgow earlier this month, they concluded: 'The important finding of this research is that the evidence is often simply not assessed for relevance to its intended audience, in this case primary care. In some guidelines the link between recommendations and any evidence base is not clear.'

Dr Steel told Pulse they planned to develop tools that NICE could use to improve the relevance of its guidelines for GPs.

He said: 'We hope that greater clarity about the relevance of guideline evidence to primary care will lead to better care.'

Dr Bill Beeby, chair of the GPC clinical and prescribing subcommittee and a GP in Middlesbrough, said the research illustrated that greater GP input was needed into NICE guidelines.

He said: 'Many working groups do not have adequate representation from primary care. So, we have strange results creeping in, such as ignoring amitriptyline for pain management and recommending pregabalin first line.'

Professor Martin Roland, chair of health services research at the University of Cambridge, said the research suggested NICE needed to indicate more clearly where a recommendation for GPs was made despite a paucity of relevant evidence.

He said: 'Where possible, NICE guidance should be based on general practice patients.

'The problem is that evidence often doesn't exist, with many of the major trials done on people in secondary care. That doesn't mean they should be ignored, but it is a weakness.'

Professor Mark Baker, director of the Centre for Clinical Practice at NICE, said it would examine the research 'in detail'.

'The lack of evidence generated in primary care is a challenge for primary care and research funders to take on.'

BMA fears trainer exodus

The BMA has warned of a potential mass exodus of GP trainers if deaneries are not granted more funding for training grants.

Four out of 10 GP trainers responding to the BMA's annual pay review survey said they would consider resigning if there was no significant uplift, while almost 60% would resist any further rise in workload.

The submission said: 'The reforms taking place in education and training will continue to increase the workload and need for GP educators, as will the introduction of revalidation and the consequent expectation of more doctors requiring remediation.'

Dr Hamed Khan, former chairman of the London Deanery GP Training Committee and a GP in Oxted, Surrey, said the number of GP trainers who would consider quitting was 'completely understandable'.

MORE ONLINE
Read the full submission
pulsetoday.co.uk/practice

GPC calls for IT cash

CCGs must not be forced to use their 'already stretched' budgets to manage the provision of general practice IT from April 2013, the GPC has urged.

The NHS Commissioning Board said in June that core GP IT spending would be included in the £12.5bn primary care commissioning budget devolved to CCGs, but the GPC is pressing it to provide additional funding.

The responsibility for handling the contractual provision of GP IT systems currently rests with PCTs, and will ultimately sit with the NHS Commissioning Board in the new system.

But GPC negotiators said the decision to include GP IT in the existing budget for CCGs was a mistake, and that the £25-per-head management allowance would not be enough to cover it.

Dr Chaand Nagpaul, GPC lead negotiator on IT, said GPC was 'in dialogue' with the NHS Commissioning Board over the issue.

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In this population or the elderly glucose monitoring should be intensified and dose adjusted accordingly. NovoMix® 30 can be used in children and adolescents aged 10 yrs and above; limited clinical data for children aged 6-9 yrs. No studies in children under the age of 6 yrs; only use in this age group under careful medical supervision. When transferring a patient from biphasic human insulin to NovoMix® 30, start with the same dose and regimen, then titrate according to individual needs. For subcutaneous administration only; not to be used in infusion pumps. NovoMix® 30 has a faster onset of action than biphasic human insulin and should generally be given immediately before a meal. When necessary it can be given soon after a meal. Penfill® designed to be used with Novo Nordisk insulin delivery systems. 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References: 1. Gumprecht J *et al.* Intensification to biphasic insulin aspart 30/70 (BIAsp 30, NovoMix® 30) can improve glycaemic control in patients treated with basal insulins: A subgroup analysis of the IMPROVE™ observational study. *Int J Clin Pract* 2009; **63**(6): 966–972. **2.** Qayyum R *et al.* Systematic Review: Comparative Effectiveness and Safety of Premixed Insulin Analogues in Type 2 Diabetes. *Ann Intern Med* 2008; **149**: 1–12. **3.** Unnikrishnan A *et al.* Practical guidance on intensification on insulin therapy with BIAsp 30: a consensus statement. *Int J Clin Pract* 2009; **63**(11): 1571–1577.

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

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LMWH: Low molecular weight heparin. VKA: Vitamin K antagonist.

1. National Institute for Health and Clinical Excellence. Technology appraisal guidance 261. July 2012. 2. National Institute for Health and Clinical Excellence. Technology appraisal guidance 256. May 2012. 3. ESC Guidelines for the management of atrial fibrillation. European Heart Journal, 2012.

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For further information on this NICE guidance please visit:
http://guidance.nice.org.uk/TA256/Guidance/pdf/English

clearance <15 ml/min; receiving concomitant systemic treatment with strong CYP3A4 and P-gp inhibitors, e.g. azole-antimycotics or HIV protease inhibitors; *Hip/knee surgery* – patients undergoing hip fracture surgery; *SPAF & DVT-t only* – with prosthetic heart valves; for treatment of acute pulmonary embolism. *Hip/knee surgery*: Take special care when neuraxial anaesthesia or spinal/epidural puncture is employed due to risk of epidural or spinal haematoma with potential neurologic complications. *SPAF & DVT-t only*: if invasive procedures or surgical intervention are required stop Xarelto use at least 24 hours beforehand, restart use as soon as possible provided adequate haemostasis has been established. Clinical surveillance in line with anticoagulant practice is recommended throughout the treatment period. See SmPC for full details. Xarelto contains lactose. **Interactions**: Concomitant use with strong inhibitors of both CYP3A4 & P-gp not recommended as increased rivaroxaban plasma concentrations to a clinically relevant degree are observed. Avoid co-administration with dronedarone. Use with caution in patients concomitantly receiving other anticoagulants, NSAIDs or platelet aggregation inhibitors due to the increased bleeding risk. Strong CYP3A4 inducers should be used concomitantly with caution as they may reduce rivaroxaban plasma concentrations. **Pregnancy & breast feeding:** Contra-indicated. **Effects on ability to drive and use machines:** Adverse reactions like syncope & dizziness are common. Patients experiencing these effects should not drive or use machines. **Undesirable effects:** Common: anaemia, dizziness, headache, syncope, eye haemorrhage, tachycardia, hypotension, haematoma, epistaxis, GI tract haemorrhage, GI & abdominal pains, dyspepsia, nausea, constipation, diarrhoea, vomiting, pruritus, rash, ecchymosis, pain in extremity, urogenital tract haemorrhage, fever, peripheral oedema, decreased general strength & energy, increase in transaminases, post-procedural haemorrhage, contusion, wound secretion. *Serious: cf. CI/ Warnings and Precautions – in addition:* thrombocythemia, allergic reactions, occult bleeding/haemorrhage from any tissue (e.g. cerebral & intracranial, cutaneous & subcutaneous, haemoptysis, haemarthrosis, muscle) which may lead to complications (incl. compartment syndrome, renal failure, fatal outcome), abnormal hepatic function, renal impairment, hyperbilirubinaemia, jaundice, pseudoaneurysm formation following percutaneous intervention. Prescribers should consult SmPC in relation to full side effect information. **Overdose:** No specific antidote is available. **Legal Category:** POM. **Package Quantities and Basic NHS Costs:** *10mg* – 10 tablets: £21.00, 30 tablets: £63.00 and 100 tablets: £210.00. *15mg* – 28 tablets: £58.80, 42 tablets: £88.20, 100 tablets: £210.00; *20mg* – 28 tablets: £58.80, 100 tablets £210.00 **MA Number(s):** EU/1/08/472/001-21 **Further information available from:** Bayer plc, Bayer House, Strawberry Hill, Newbury, Berkshire RG14 1JA, U.K. Telephone: 01635 563000. **Date of preparation:** July 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 Bayer plc. Tel.: 01635 563500, Fax.: 01635 563703, Email: phdsguk@bayer.co.uk

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Primary care urology: LUTS in men
▶ page 30

PCT assessment of 2011–12 quality and productivity indicators feeds into current round of contract talks

QIPP

NHS conducts QP post-mortem

By Madlen Davies

The future of the new quality and productivity indicators in the QOF will partly depend on the results of a survey of PCTs by NHS Employers, Pulse can reveal.

The employers' organisation has asked PCTs whether 11 QOF indicators – introduced in 2011–12 with the aim of improving prescribing, outpatient referrals and emergency admissions – were a success.

The results will inform this year's ongoing contract negotiations with the GPC. These negotiations will decide the future of the quality and productivity indicators, which have been criticised by some GPs for undermining patient trust.

The DH would not comment on potential changes to the QP indicators, but would not rule out the possibility of scrapping them altogether or introducing new indicators. The GPC also declined to comment.

The 11 indicators were amended this year, with a new indicator on reducing A&E attendance replacing the targets to improve prescribing. However, NHS Employers said it was too early to consult on the success of the new batch.

A spokesperson for NHS Employers said: 'We have recently undertaken a very small-scale survey of PCTs to ascertain their opinion on the operation of the QP indicators.

Dr Beth McCarron-Nash: A&E indicators 'beyond GPs' control'

'The outcomes of this "snapshot" survey have been fed into discussions currently taking place between NHS Employers and the GPC on what changes might be made to the 2013/14 GMS contract.'

Dr Beth McCarron-Nash, a GPC member and a former negotiator, said: 'We have heard reports from LMCs who have had varying feedback on the success of QP indicators.

'In some areas they have worked well; in other areas there are varying reasons why GPs have struggled.'

The news comes as practices struggle to meet the deadline for submitting results for the indicator QP13, which requires practices to hold an external peer review to assess A&E attendance data and agree an improvement plan to send to managers by 30 September.

Almost three quarters of practices in the 24 PCTs surveyed by Pulse submitted results by the agreed deadline and 22% required an extension.

A further 4% did not submit results or missed the deadline and are waiting for a review from their PCT as to whether they will gain the points. QP13 is worth £1,203.84 for an average practice.

Dr McCarron-Nash added: 'With regards to QP13, in some areas the data was not sent on time and wasn't accurate. A lot of doctors stated that it's beyond their control.

'The most likely reason for patients to attend A&E is their proximity and cultural reasons, which the GP can't influence.'

@pulsetoday

Progress on new A&E indicator

- **22% of practices required extension deadline for QP13**
- **4% failed to submit results or missed September deadline**
- **QP13 is worth an average £1,203.84 for practices**

Source: Pulse survey of 24 PCTs

MORE ONLINE
Read the full results: pulsetoday.co.uk/practice

CCG STAFF

Manager cull 'too far'

The NHS reforms have sparked an exodus of PCT staff and led to a worrying lack of expertise in some CCGs, the Government's leading GP adviser on commissioning has warned.

Dr James Kingsland, national clinical lead of the NHS Clinical Commissioning Community and a GP in Wallasey, Merseyside, said CCGs needed experienced managers to prevent GPs being diverted from redesigning care.

But he told delegates at a Westminster Health Forum seminar last week that the NHS management resource had probably been stripped back 'too much' and there was 'despondency' in some CCGs about the challenge ahead.

Dr Kingsland also told delegates that he provided regular 'soft intelligence' reports to the Department of Health on how CCGs are progressing on the ground, and admitted the current mood was 'mixed'.

'We have lost enough [management], probably too much, and we need to make sure that the NHS managers we have are such that their role is vital in the redesign of care.

'While GPs need to be involved in the analysis and the needs assessment of how to secure the best services, we do not expect them to do procurement and contract management.'

HEALTH ACT

NHS reforms cost rises

The cost of the Government's NHS reforms has risen by £400m, but they are due to generate savings of £5.5bn, ministers have revealed.

Health secretary Jeremy Hunt said the figure, which exceeds the initial projections of £1.2-£1.3bn, had been based on the Department of Health's annual report and accounts for 2011-12.

The BMA said the costs were 'particularly galling' in the context of the increased squeeze on NHS budgets and rationing of services, and questioned whether the savings projections were realistic.

In a written statement to the House of Commons, Mr Hunt said: 'I can now report to the House that the current estimate of costs is in the range of £1.5-£1.6bn.'

He added that annual savings 'are still expected to be £1.5bn from 2014-15 but the cumulative savings over the transition period are now forecast to be £1bn higher, at £5.5bn'.

BMA chair Dr Mark Porter said: 'The huge costs of this largely unnecessary reorganisation are particularly galling given that patient services are being rationed.'

'It is difficult to believe the changes will generate cumulative savings of £5.5bn.'

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** Measured by St George's Respiratory Questionnaire

†† Assumes use of 1 Spiriva® Handihaler® and 11 refills in 1 year or 12 EKLIRA GENUAIR® packs in 1 year

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Date of preparation: October 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 Almirall Ltd.

1. Jones PW *et al. Eur Respir J.* 2012;40(4):830-6. **2.** Kerwin EM *et al. COPD* 2012, 9(2):90–101. **3.** Data on File AB01. **4.** Data on File AB02. **5.** EKLIRA GENUAIR Summary of Product Characteristics, 2012. **6.** Chrystyn H *et al. Int J Clin Pract.* 2012;66(3):309-17. **7.** MIMS September 2012.

UKACL1332

Health Checks trial Ca screening

GPs question cost-effectiveness of including cancer questionnaire in NHS Health Checks

By David Swan

A Government-backed pilot programme trialling the inclusion of questions about cancer symptoms in the NHS Health Check scheme has identified just four patients with cancer.

The pilot – part of the Department of Health's National Awareness and Early Diagnosis Initiative and run by the NHS Tees cluster – included the questions as part of an awareness campaign in 4,251 patients at high risk of cardiovascular disease attending for health checks at GP surgeries.

The patients were sent a questionnaire about possible cancer symptoms and this was discussed with the practice nurse at the time of the health check. The nurse then examined the checklist and made specific inquiries about symptoms of possible cancer.

An evaluation of the scheme – presented by researchers at the Society for Academic Primary Care Conference in Glasgow this month – found 11% of patients were identified with a relevant cancer symptom and 6% were subsequently referred on to a GP.

Dr Greg Rubin: 'We found as many cases as we expected'

Some 80% of the group referred to a GP required no further action and the remaining 20% were sent for further investigation, with four cancer cases arising from this cohort.

NHS Tees is continuing funding for the scheme and hopes to widen its scope.

One of the study leads, Professor Greg Rubin, RCGP and Cancer Research UK clinical lead on cancer, said the findings showed that including symptom questionnaires in the NHS Health Checks scheme was viable.

He said: 'This has shown that if you raise awareness, there is an increase in use of resources, but it is manageable.

'We didn't expect to find many cases of cancer – in fact we found as many as we expected.'

But Dr Petula Chatterjee, a GP and cancer lead in Manchester, said: 'The returns on investigating large numbers of patients are small and costly.'

Diminishing returns?

4,251
Patients checked for cancer symptoms

245
Number of symptomatic patients referred to GP

4
Cancer cases identified

Source: SAPC abstract number 10.3

Dr John Ashcroft, a GP in Derbyshire and member of the Derbyshire CHD committee, said the scheme could have an adverse impact elsewhere.

He said: 'It is probably compromising the effectiveness of the health check.'

The DH said it had no plans to roll the scheme out nationally.

@pulsetoday

Tool flags drug clashes across list

A free computer download alerting GPs to prescribing contraindications across the whole practice patient population will be launched in the new year.

The tool will allow GPs to cross-reference known contraindications across the patient database automatically.

It will also allow practice staff to check whether all the patients on certain medications have had a medication review.

The software has been developed by researchers at the University of Nottingham with PRIMIS Primary Care Information Services, and is based on findings from the Department of Health-funded PINCER study.

The PINCER trial, published online by *The Lancet* in February, looked at the effect of introducing pharmacists into practices to analyse prescribing errors, agree action plans and review patients.

It found a 29% reduction at six months in the risk of prescribing errors in the pharmacist group, compared with the computerised feedback group.

The researchers said the new tool will allow practices to monitor the safety of their prescribing and recommended that GPs involve practice pharmacists when using the tool.

Professor Tony Avery, professor of primary healthcare at the University of Nottingham and a GP in the city, said: 'It takes the effort out for GPs having to do their own searches.'

IN BRIEF

Minor surgery warning

Medical defence experts have warned GPs must obtain valid consent before carrying out minor surgical procedures.

Full story ▶ pulsetoday.co.uk/practice

Antipsychotics figures

The number of patients with dementia taking antipsychotics may be 50% more than Government figures suggest, say researchers.

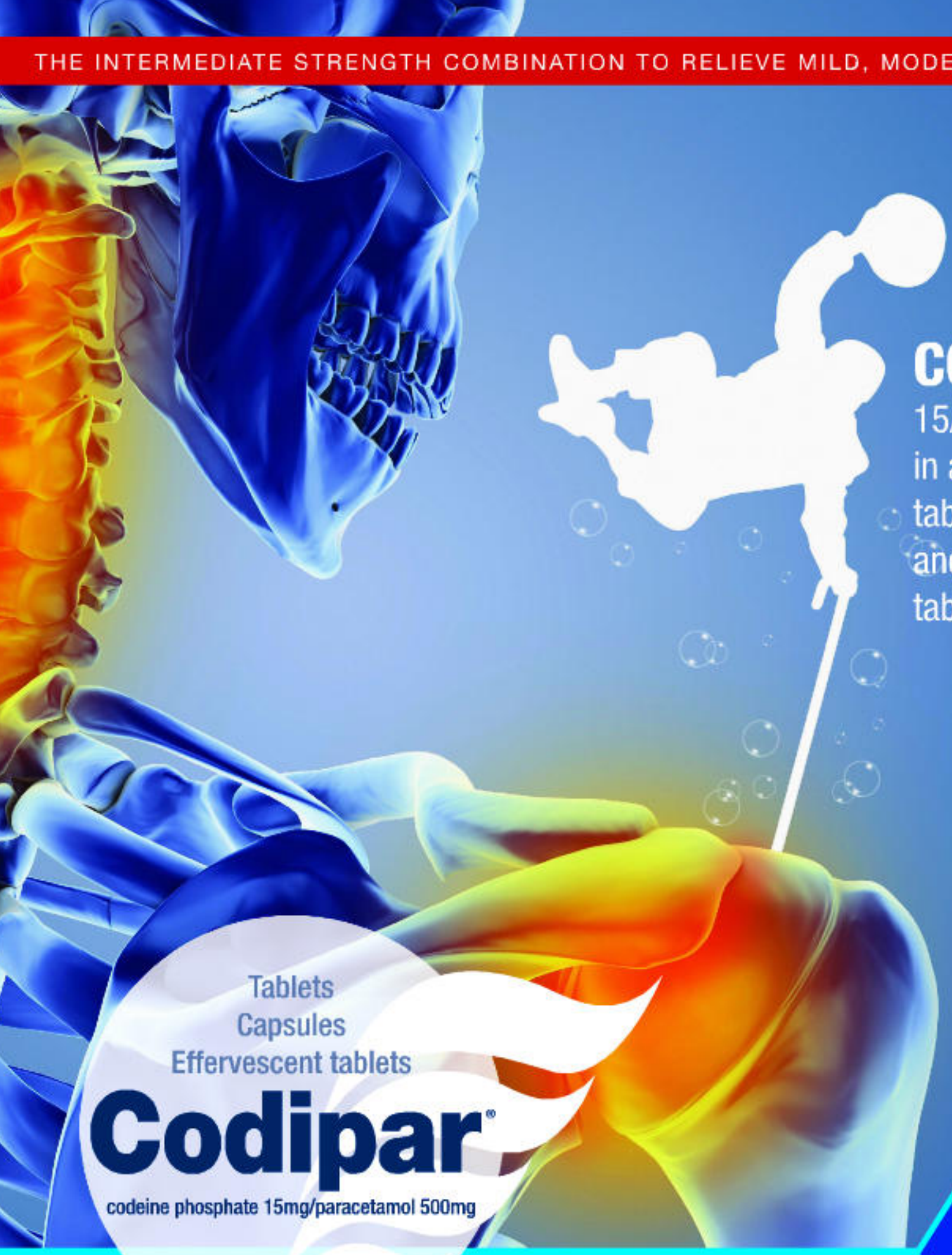
Full story ▶ pulsetoday.co.uk/clinical

NHS to go paperless

The NHS will be paperless within five years, the NHS Commissioning Board has claimed.

Full story ▶ pulsetoday.co.uk/commissioning

THE INTERMEDIATE STRENGTH COMBINATION TO RELIEVE MILD, MODERATE OR SEVERE PAIN



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Prescribing Information: Codipar Tablets. Codipar 15mg/500mg Capsules. Codipar 15mg/500mg Effervescent Tablets. Presentation: Each tablet and capsule contains paracetamol 500mg and codeine phosphate 15mg and each tablet contains paracetamol 500mg and codeine phosphate hemihydrate 15mg. Excipients in the tablets include 396mg sorbitol and 378mg sodium per tablet. **Indications:** Capsules and tablets are indicated for the relief of moderate pain while the effervescent tablets are indicated for the relief of mild to severe acute pain. **Dosage and Administration:** For oral administration. **Adults:** 1 or 2 capsules/tablets every 4 hours as required. Dissolve tablets in a glass of water and drink immediately. Do not exceed 4g of paracetamol (8 capsules or 8 tablets in a day). **Elderly:** a reduced dosage may be necessary. **Children:** Capsules and tablets are not recommended below the age of 12 years or below 18 years for the tablets. Side effects are related to dose intake. Should not be taken longer than medically directed. Long term use can lead tolerance and addiction. **Contraindications:** Hypersensitivity to either paracetamol or codeine, or any of the excipients, moderate to severe renal or hepatic impairment. Children under 12 years; patients who are contraindicated opiate medications e.g. those with acute asthma, obstructive airway disease, respiratory depression, acute alcoholism, head injuries, raised intracranial pressure, after biliary surgery, diarrhoea of any cause and in patients who have taken MAO inhibitors within 14 days. Not for breastfeeding mothers unless medically prescribed. **Warnings and Special Precautions:** Should be used with caution in patients with inflammatory or obstructive bowel disorders or with acute abdominal conditions, increased intracranial pressure or those taking CNS depressants; the elderly, debilitated, hypothyroidism, Addison's disease, impaired hepatic or renal function, prostatic hypertrophy and urethral stricture. The risk of paracetamol overdose is greater in those with all forms of alcoholic liver disease. Patients should not exceed the dose or take other products containing paracetamol or opiate derivatives while on Codipar and consult their doctor if symptoms persist. Tolerance to codeine dependence (psychological and/physical), abuse, as well as withdrawal can develop with continued use and the incidence of unwanted effects is dose related. High doses can cause respiratory depression, cough suppression, or impaired mental and physical abilities. Drug dependence and abuse is possible. Dose should be reduced for liver and kidney disease patients. Immediate medical advice should be taken after overdose especially when liver disease co-exists. Patients with hereditary fructose intolerance should not take this medicine due to the presence of sorbitol. Patients on salt restricted diets must consider the salt content of each tablet. Patients should be advised not to drive, operate machinery or perform hazardous tasks if Codipar causes dizziness, sedation or visual disturbance. Long term use for headache treatment can make them worse. **Interactions:** Antihypertensive agents, diuretics, quinine, quinidine, CNS depressants (anxiolytics, hypnotics, antidepressants, antipsychotics, alcohol), MAOI's or tricyclic antidepressants, anticholinergics, antidiarrhoeal agents, antimuscarinic drugs, metoclopramide, domperidone, cholestyramine, mexiletine, cimetidine, warfarin and other coumarins may interact with Codipar capsules or tablets when used long term. Enzyme-inducing antiepileptics (carbamazepine, phenytoin, and phenobarbital) as well as CYP2D6 inhibitors (quinidine, some selective serotonin reuptake inhibitors, some neuroleptics and ritonavir) may interact with the tablets. Opioids may interfere with results of some laboratory tests and codeine may interfere with tests for gastrointestinal function. **Pregnancy and Lactation:** Not recommended. May enter breast milk, cause withdrawal in neonates and if used during labour may cause neonatal respiratory depression. The tablets may cause increase in asthma or bronchitis in children at 18 months. **Adverse Effects:** Most common are nausea, vomiting, light headedness, dizziness, sedation, shortness of breath, constipation. In addition, meiosis, visual disturbances, headache, bradycardia, respiratory depression, difficult micturition, urinary retention and allergic reactions including hypersensitivity and skin rashes can rarely occur. Codeine can cause respiratory depression in patients with respiratory problems or with pre-existing lung disorders or in overdose situations. Codipar capsules may cause euphoria, dysphoria, abdominal pain or pruritus. Paracetamol may cause liver damage. Most often this is with chronic alcohol use. Rarely blood dyscrasias have been reported. Addiction and withdrawal are possible. Headaches can worsen with chronic use. Blood dyscrasias are rarely reported. **Overdose:** Paracetamol overdose causing liver damage can occur with over 5g ingestion if patient has risk factors (taking drugs that induce liver enzymes, excessive alcohol intake, glutathione depletion – eating disorders, cystic fibrosis, HIV, starvation, cachexia) or over 10g intake otherwise. Codeine overdose is potentiated with alcohol and psychotropic drugs. Please refer to Summary of Product Characteristics for detailed information. **Legal Category:** POM. **Basic NHS Price:** £8.25 for 100 tablets, £7.68 for 100 capsules and £8.89 for 100 Effervescent Tablets. **Marketing Authorisation Number:** Codipar Tablets: PL 12762/0050, Codipar Capsules: PL 12762/0413, Codipar Effervescent Tablets: PL 12762/0405. **Marketing Authorisation Holder:** Mercury Pharmaceuticals Ltd. NLA Tower, 12-16 Addiscombe Road, Croydon, Surrey, CR0 0XT, UK. **Date of Revision:** May 2012.

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UK/CODIPAR/1105/2012 Date of preparation: May 2012.

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Prescribing information

***flutiform*® ▼ (fluticasone propionate and formoterol fumarate) pressurised inhalation suspension**
Prescribing Information, United Kingdom
Please read the Summary of Product Characteristics before prescribing.

Presentation: Pressurised inhalation suspension, in a pressurised metered dose inhaler (pMDI), containing fluticasone propionate and formoterol fumarate dihydrate at strengths of 50 µg/5 µg, 125 µg/5 µg or 250 µg/10 µg per actuation. **Indications:** Regular treatment of asthma where the use of a combination product (inhaled corticosteroid and long-acting β_2-agonist) is appropriate: For patients not adequately controlled with inhaled corticosteroids and 'as required' inhaled short-acting β_2-agonist (SABA), or for patients already adequately controlled on both an inhaled corticosteroid and a long-acting β_2-agonist (LABA). ***flutiform*** 50 µg/5 µg and 125 µg/5 µg per actuation are indicated for use in adults and adolescents 12 years and above. ***flutiform*** 250 µg/10 µg per actuation is only indicated for use in adults. **Dosage and administration:** For inhalation use. The patient should be shown how to use the inhaler correctly by a physician or other healthcare professional. Patients should be given the strength of ***flutiform*** containing the appropriate fluticasone propionate dose for their disease severity (note that ***flutiform*** 50 µg/5 µg per actuation is not appropriate in patients with severe asthma). The appropriate strength should be taken as two inhalations, twice-daily (normally in the morning and evening) and used every day, even when asymptomatic. ***flutiform*** should not be used in children under 12 years. Prescribers should be aware that in asthmatics, fluticasone propionate is as effective as some other inhaled steroids when administered at approximately half the total daily microgram dose. Total daily dose can be increased if asthma remains poorly controlled by administering a higher strength inhaler. Appropriate doses of the β_2-agonist and inhaled corticosteroid (ICS) in separate inhalers, or the ICS alone, should be prescribed if a patient requires doses outside the recommended dose regimens. Patients should be assessed regularly and once asthma is controlled, treatment should be reviewed and stepped down to the lowest effective dose, or an ICS alone. It is extremely important to regularly review patients as their treatment is stepped down. ICSs alone are first line treatment for most patients. ***flutiform*** is not intended for initial treatment of mild asthma. For patients with severe asthma the ICS therapy should be established before prescribing a fixed-dose combination product. Patients on ***flutiform*** must not use an additional LABA. An inhaled SABA should be taken for immediate relief of asthma symptoms arising between doses. The ***AeroChamber Plus®*** spacer device is recommended in patients who find it difficult to use inhalers; re-titration should always follow the introduction of a spacer device. Patients should be advised to contact their prescriber when the ***flutiform*** dose indicator is getting near zero. **Contra-indications:** Hypersensitivity to any of the active substances or excipients. **Precautions and warnings:** ***flutiform*** should not be used for the first treatment of asthma, to treat acute asthma symptoms or for prophylaxis of exercise-induced asthma. It should not be initiated during an exacerbation, during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. Patients should use their ***flutiform*** maintenance treatment as prescribed, even when asymptomatic. If a patient experiences serious asthma-related adverse events or exacerbations, they should continue treatment but also seek medical advice. Patients should be reviewed as soon as possible if there is any indication of deteriorating asthma control. In the case of sudden and progressive deterioration, which is potentially life-threatening, an urgent medical assessment should be carried out. Use with caution in patients with: pulmonary tuberculosis; quiescent tuberculosis; fungal, viral or other infections of the airway; thyrotoxicosis; pheochromocytoma; diabetes mellitus (consider additional blood sugar controls); uncorrected hypokalaemia; predisposition to low levels of serum potassium; impaired adrenal function (monitor HPA axis function regularly); hypertrophic obstructive cardiomyopathy; idiopathic subvalvular aortic stenosis; severe hypertension; aneurysm or other severe cardiovascular disorders. There is risk of potentially serious hypokalaemia with high doses of β_2-agonists or concomitant treatment with β_2-agonists and drugs that can induce or potentiate a hypokalaemic effect. Particular caution is recommended in unstable or acute severe asthma and other conditions when the likelihood for hypokalaemia adverse effects is increased. Monitoring of serum potassium levels is recommended during these circumstances. Formoterol may induce prolongation of the QTc interval. Caution must be observed when treating patients with existing prolongation of QTc interval. ***flutiform*** should be discontinued immediately if there is evidence of paradoxical bronchospasm. Systemic effects with an ICS may occur, particularly at high doses for prolonged periods or when combined with potent CYP3A4 inhibitors, but are less likely than with oral corticosteroids. Use of a spacer device may also cause an increased systemic exposure. Increased exposure can be expected in patients with severe hepatic impairment. Prolonged treatment with high doses of corticosteroids may result in adrenal suppression and acute adrenal crisis, particularly in adolescents and children or potentially as a result of trauma, surgery, infection or rapid dose reduction. Patients should be advised that ***flutiform*** contains a small amount of ethanol; however this negligible amount does not pose a risk to patients. ***flutiform*** is not recommended in children under 12 years of age. **Interactions:** Caution is advised in long-term co-administration with strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nelfinavir, saquinavir, telaprevir and telithromycin); co-administration should be avoided if possible. Ritonavir in particular should be avoided, unless the benefits outweigh the risks of systemic side-effects. Caution is advised with use of non-potassium sparing diuretics (e.g. loop or thiazide), xanthine derivatives, glucocorticosteroids, L-dopa, L-thyroxine, oxytocin, alcohol or other adrenergic drugs. There is an increased risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Hypokalaemia may increase the risk of arrhythmias in patients being treated with digitalis glycosides. Concomitant use of β-adrenergic drugs can have a potentially additive effect. Extreme caution should be taken when using formoterol fumarate with drugs known to prolong the QTc interval, such as tricyclic antidepressants or MAOIs (and for two weeks following their discontinuation), as well as antipsychotics (including phenothiazines), quinidine, disopyramide, procainamide and antihistamines. Concomitant use of an MAOI or a similar agent, such as furazolidone or procarbazine, may precipitate hypertensive reactions. β-blockers and formoterol fumarate may inhibit the effect of each other. β-blockers may produce severe bronchospasm in asthma patients, and they should not normally be treated with β-blockers including those that are used as eye drops to treat glaucoma. Under certain circumstances, e.g. as prophylaxis after myocardial infarction, cardioselective β-blockers could be considered with caution. **Pregnancy and lactation:** ***flutiform*** is not recommended during pregnancy. It should only be considered if benefits to the mother outweigh risks to the foetus. It is not known whether fluticasone propionate or formoterol are excreted in breast milk; a risk to the breast feeding infant cannot be excluded. A decision should be made on whether to discontinue breastfeeding or discontinue/abstain from ***flutiform***. **Side-effects:** Potentially serious side-effects: hyperglycaemia; depression; aggression; behavioural changes (predominantly in children); paradoxical bronchospasm; agitation; vertigo; palpitations; ventricular extrasystoles; angina pectoris; tachycardia; hypertension; dyspnoea; peripheral oedema; Cushings Syndrome; adrenal suppression; growth retardation; cataract and glaucoma; hypersensitivity reactions and QTc interval prolongation. Please consult the SPC for details of non-serious side-effects and those reported for the individual molecules. **Legal category:** POM **Package quantities and price:** One inhaler containing 120 actuations 50 µg/5 µg - £18.00, 125 µg/5 µg - £29.26, 250 µg/10 µg - £45.56 **Marketing Authorisation numbers:** PL 16950/0167 PL 16950/0168 PL16950/0169 **Marketing Authorisation holder:** Napp Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0GW UK. Tel: 01223 424444. Member of the Napp Pharmaceutical Group. For medical information enquiries, please contact medicalinformation@napp.co.uk **Date of preparation:** August 2012

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

UK/FLUT-11019

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1. ***flutiform*® –** Summary of Product Characteristics. Napp Pharmaceuticals Limited.
2. Bordenave-Lukasiyk A et al. BMC Pulm Med 2011;11:1-29.
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flutiform cost effectiveness.

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Date of preparation: October 2012.
UK/RES-11058a

NAPP RESPIRATORY

GMC warning on notes for Dignitas

GPs face conflict between Data Protection Act requirements and new GMC guidance on assisted suicide

By Madlen Davies

GPs are facing demands from patients for copies of medical reports to support them in assisted suicide - but have been warned by the GMC that this could lead to criminal prosecution.

Dr Gareth Bryant, medical secretary at Wessex LMC, told Pulse the LMC had recently been contacted by a GP for advice after a patient had asked for a copy of their medical reports to send to Dignitas, the Swiss organisation that facilitates assisted suicide.

Doctors are required to provide access to a patient's records under the Data Protection Act 1998 if a 'subject access request' has been made.

However, new GMC draft guidance for fitness-to-practise decision-makers, due to be published later this year, advises it is a criminal offence for doctors to encourage or assist a person to commit or attempt suicide. GPs should explain this to patients when faced with demands for medical records for this purpose, the guidance says.

The GMC told Pulse that GPs are required to provide medical records under the Data Protection Act. However, if a GP suspects this will be used for the purposes of assisted dying, the GP will be contravening the 1961 Suicide Act by providing the medical records.

Dr Bryant said GPs had to be 'very cautious: the Suicide Act makes aiding suicide illegal. Although no-one has been prosecuted, the risk is there. We have to give access to medical records under the Data Protection Act, but GPs have to protect themselves against prosecution. It's a very difficult ethical position.'

A spokesperson for Dignitas said that patients required a medical report from within the past four months in order to sufficiently make the case to Swiss authorities that assisted suicide should go ahead.

He added: 'A GP denying the issue of a medical report would violate basic patient rights. I would imagine the GMC's advice is probably in conflict with human rights laws. That's something that would have to be established through a legal case.'

GPs have to be 'very cautious' when providing patient records

The Medical Protection Society said it had received around 100 member requests for advice on the issue of assisted dying over the past five years, while the Medical Defence Union said it had dealt with 20 in the past three years. An MPS spokesperson said GPs had expressed concerns about working within the law, maintaining confidentiality and protecting the GP-patient relationship at a time when the patient is most vulnerable.

There have been four GMC investigations since 2007 involving allegations that the doctor assisted a suicide. Two of these led to fitness-to-practise hearings. One resulted in the doctor being suspended while the other case was dropped because the suicide occurred in Canada, even though the doctor was registered in the UK.

@madlendavies

MORE ONLINE
The draft guidance in full
pulsetoday.co.uk/regulation

TUPE blamed for iSoft switch-off

GP IT experts have blamed employment law for the demise of three primary care software systems, which has left almost 600 practices needing to find alternative suppliers.

Earlier this month, software company CSC said it could not continue to support iSoft products Synergy, Premiere and Ganymede, meaning 582 GP practices would have to switch to other systems.

Dr John Lockley, chair of the iSoft User Group (iSUG), formerly an external medical consultant at CSC and a GP in Ampthill, Bedfordshire, said the company had tried to sell the code for the software to potential buyers or the NHS, and even considered giving it away. But interested parties were put off because they would be liable to take on the employment rights of CSC staff under TUPE employment laws. Dr Lockley told the annual iSUG conference last week: 'Never again do we want to see further situations where software used in healthcare is there but cannot legally continue to be used,' he said.

Dr Paul Cundy, chair of the GPC's IT subcommittee, said the announcement had caused 'huge disruption'. 'The TUPE laws are plain stupid,' he said. 'It would be very sensible if one of the other GP stock suppliers bought the code.'

CSC declined to comment.

Learning disability DES questioned

Call for redesigned incentives after study finds most patients with learning disabilities miss health checks

By Julia Robinson

Growing numbers of GPs are carrying out health checks in patients with learning difficulties, but most patients are still missing out on the annual assessments, say researchers.

The figures come despite a long-standing DES being in place to incentivise practices to conduct a physical and mental health review in patients with learning disabilities.

The researchers from the University of Manchester said the low level of checks meant that the Government should look at redesigning the DES – introduced in 2008 – to make it more attractive to practices.

But they also concluded from interviewing GPs and nurses that the Department of Health should continue the current funding, which they said was having an impact on the care that patients with learning difficulties receive.

The DH said it had looked at the evidence, which was presented at the Society for Academic Primary Care this month.

The researchers looked at anonymised clinical data from more than 3,600 learning disability patients registered at 166 practices in six PCTs in north-west England from April 2009 to March 2011.

Not all practices were signed up to the DES, but 120 practices in 2009/10 and 142 in 2010/11 were providing regular checks to patients with learning difficulties.

Researchers found a greater uptake of checks under the QOF

Despite this, only 31% of patients with a learning disability received an annual health check in 2009/10, although this rose to 42% of patients in 2010/11.

The study found it was often the checks that were not included in the QOF, such as visual and hearing assessments, that were not being carried out. Patients who had a health check had a 21% increased likelihood of having QOF-related checks, such as blood pressure and BMI, compared with a 19% increased likelihood of non-QOF checks.

Dr Umesh Chauhan, lead author and a GP in Brierfield, Lancashire, said: 'We need to do further research but any redesign of the health check should be in collaboration with people who have learning disability and their carers as well as health professionals.'

A spokesperson from the DH said: 'We remain committed to improving the health of people with learning disabilities and have already been in contact with Dr Chauhan to discuss his results. There are no current plans to withdraw the DES for learning disabilities.'

But Dr Richard Vautrey, GPC deputy chair, said: 'The DES is quite clear and is available for every practice to take up, but there are a number of reasons why uptake varies. Practices are already struggling under significant workload and are having to make difficult choices.'

@pulsetoday

In numbers

Proportion of patients with learning disabilities receiving checks across 166 practices

31% 2009/10 | **42%** 2010/11

Source: SAPC abstract SA.4

'Stigma' a barrier for sick doctors

The stigma felt by doctors who are signed off sick for long periods is a major obstacle to them returning to work, according to psychiatrists.

A series of interviews with 19 doctors who had been off for more than six months found most had very negative views about themselves and felt unsupported and judged.

Many found being away from work left them isolated and sad and questioning their place in the world, the study found.

The researchers, led by Dr Max Henderson, senior lecturer in epidemiological and occupational psychiatry at Kings College London, concluded in *BMJ Open* that these 'self-stigmatising' views may come from a belief that doctors should be 'invincible'. They interviewed doctors who had a mix of physical and mental illness, in some cases with GMC involvement, and called for a change in culture 'from medical school onwards' to allow doctors to recognise their vulnerabilities.

The study concluded: 'A greater willingness to accept the possibility that one might at some stage become a patient, together with greater input from colleagues as to how this might be managed, could reduce the sense of shock and bewilderment should illness strike.'

RCGP chair Dr Clare Gerada said doctors had a sense of invincibility because it helped them cope with a job where they were dealing with death and delivering devastating news.

NICE-approved drugs 'underused' in some areas

Drug companies have claimed NICE-approved drugs are being 'underused' in the NHS after an analysis by the NHS Information Centre showed use was lower than expected in half of the disease groups they looked at.

The analysis – part of a Government-backed scheme to encourage greater use of NICE-approved drugs – looked at 13 disease groups where a comparison with expected levels of prescribing was possible. They then compared this with actual prescribing rates and found use was higher than expected for six areas and lower for another six.

Drugs such as prucalopride and febuxostat showed a degree of underuse compared with predictions.

In contrast, statins, varenicline and alendronate were found to be overused.

But a spokesperson from the NHS Information Centre warned the data could not be used to definitively show drugs were being either underused or overused.

Stephen Whitehead, chief executive of the ABPI said: 'This year's report shows that many medicines still continue to be underused.'

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

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Fostair® (beclometasone dipropionate and formoterol fumarate dihydrate pressurised inhalation solution). Please refer to Summary of Product Characteristics (SmPC) before prescribing. **Prescribing Information Presentations:** Pressurised inhalation solution containing 100 micrograms of beclometasone dipropionate and 6 micrograms of formoterol fumarate dihydrate per actuation. **Indications:** Regular treatment of asthma where use of a combination product (inhaled corticosteroid and long acting beta$_2$ agonist) is appropriate: patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short acting beta$_2$ agonist; or patients already adequately controlled on both inhaled corticosteroids and long acting beta$_2$ agonists. Not appropriate for treatment of acute asthma attacks. **Dosage and Administration:** For inhalation use only. Fostair is not intended for the initial management of asthma. If an individual patient should require a combination of doses other than those available in the combination inhaler, appropriate doses of beta$_2$ agonists and/or corticosteroids by individual inhalers should be prescribed. Beclometasone dipropionate in Fostair is characterised by an extra-fine particle size distribution which results in a more potent effect than formulations of beclometasone dipropionate with a non-extra-fine particle size distribution (100 micrograms of beclometasone dipropionate extra-fine in Fostair are equivalent to 250 micrograms of beclometasone dipropionate in a non-extra-fine formulation). Therefore the total daily dose of beclometasone dipropionate administered in Fostair should be lower than the total daily dose of beclometasone dipropionate administered in a non-extra-fine beclometasone dipropionate formulation. Adults 18 years and above: one or two inhalations twice daily, maximum four inhalations daily. Children and adolescents under 18 years: The safety and efficacy of Fostair has not yet been established. No data are available with Fostair in children under 12 years of age. Only limited data are available in adolescents between 12 and 17 years of age. Therefore Fostair is not recommended for children and adolescents under 18 years until further data become available. The dose should be titrated to the lowest dose at which effective control of symptoms is maintained. Fostair may be used with the AeroChamber Plus™ spacer device. Patients should be advised in the proper use and care of their inhaler and spacer. **Contraindications:** Hypersensitivity to any of the components. **Warnings and Precautions:** Cardiovascular disorders including cardiac arrhythmias and QTc prolongation, thyrotoxicosis, diabetes mellitus, pheochromocytoma, untreated hypokalaemia, active or quiescent pulmonary tuberculosis, fungal and viral infections. 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Titrate to the lowest dose at which effective control of asthma is maintained to minimise systemic effects. Special care is needed in transferring patients from oral steroids. Fostair contains a small amount of ethanol (approximately 7mg per actuation); at normal doses the amount of ethanol is negligible and does not pose a risk to patients. Patients should rinse mouth after inhalation to minimise risk of oropharyngeal candida infection. **Interactions:** Beclometasone dipropionate undergoes a very rapid metabolism via esterase enzymes without involvement of the cytochrome p450 system. Avoid beta-blockers (including eye drops). Caution is required when theophylline or other beta$_2$-adrenergic drugs are prescribed concomitantly with formoterol. Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines, MAOIs and TCAs can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with MAOIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertensive reactions. Risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Theoretical potential for interaction in sensitive patients taking ritodrine from intravenous. **Pregnancy and Lactation:** No relevant clinical data. Should only be used during pregnancy or lactation if the expected benefits outweigh the potential risks. **Undesirable effects:** Common: pharyngitis, headache, dysphonia. Uncommon: influenza, oral fungal infection, oropharyngeal and oesophageal candidiasis, vulvovaginal candidiasis, gastroenteritis, sinusitis, rhinitis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, vasovagal syncope, arrhythmias, hypotension, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dysgeusia, dysphagia, burning sensation of the lips, nausea, dyspepsia, pruritus, rash, hyperhidrosis, muscle spasms, myalgia, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased. Rare: ventricular extrasystoles, angina pectoris, bronchospasm paradoxical, urticaria, angioedema, nephritis, blood pressure increased, blood pressure decreased, thrombocytopenia, hypersensitivity reactions, adrenal suppression, glaucoma, cataract, atrial fibrillation, dysphonia, exacerbation of asthma, growth retardation in children and adolescents, oedema peripheral, bone density decreased. Unknown: psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children). **Legal Category:** POM **Packs and Prices:** Fostair 100/6 (PL03229/0156) £29.32. Each inhaler contains 120 actuations.[1,2] denotes Trademark. AeroChamber Plus™ is a trademark of Trudell Medical International. Full prescribing information is available from the **Marketing Authorisation Holder:** Chiesi Limited, Cherwille Royal Business Park, Highfield, Chandler, SN8 3RX. **Date of preparation:** February 2012.

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

1. MIMS. September 2012. 2. De Backer W, Devolder A, Poli G et al. Lung deposition of BDP/formoterol HFA pMDI in healthy volunteers, asthmatic, and COPD patients. J Aerosol Med Pulm Drug Deliv 2008; 21(2): 137-146. **Date of preparation:** September 2012. CHFOS2012073b.

Chiesi

Key questions: ADHD
▶ page 25

One in five discharge summaries are poor or 'unacceptable', finds study

OBESITY

GPs 'left in lurch' over bariatric surgery

By Emma Wilkinson

A national audit has uncovered serious failures in the care of obese patients undergoing bariatric surgery, with more than one in five patients re-admitted within six months of the procedure.

GPs are frequently left to pick up the pieces with little or no information on how to care for the patient, the panel of independent experts concluded.

The review of the care of almost 400 patients undergoing bariatric surgery over a three-month period found 18% of patients were readmitted within the first six months of surgery.

A third did not receive adequate follow-up in the six months after their operation and 44% had their first follow-up appointment more than six weeks after surgery.

One in five discharge summaries were 'poor or unacceptable' and only 29% had received psychological testing before referral for surgery.

This was despite 8,000 people undergoing bariatric surgery in 2010/11 – an increase of more than 90% from two years ago.

The National Confidential Enquiry into Patient Outcome and Death found bariatric surgery was often seen as a 'quick fix' and carried out without proper consideration of the risks or adequate follow-up.

Around 60% of all patients reviewed had been referred by their GP but almost half had paid privately for weight loss surgery.

The authors concluded: 'Given the potential for significant metabolic change after bariatric surgery, good quality care is supported if patients have clear post-operative dietary guidance and a timely and complete discharge summary, with full clinical detail and post discharge plan to ensure safe and seamless care.

'This must be provided to the GP as soon as possible following discharge, preferably within 24 hours.'

Dr Andrew Brewster, a GPSI in obesity and diabetes lead for Berkshire, agreed surgery was an effective option, but said in the UK 'we are not doing it properly'.

He said: 'I've had patients for whom the follow-up has been pretty poor. The surgeons think you're fixed, off you go and they're left to primary care to deal with.

'Obesity surgery is about a whole package of change. As it becomes more common We are going to have a situation where GPs are just left in the lurch not knowing how to manage these patients.'

Professor David Haslam, a GP in Watton-at-Stone, Hertfordshire and one of the authors of the report, said it must be an 'absolute priority' to improve discharge communication, and this was a particular problem in the private sector.

He said patients who had diabetes were being discharged while still on insulin, even though their diabetes goes into remission in up to 80% of cases after surgery. He added: 'The GP doesn't even know the patient had gone in for surgery or had information about follow-up.'

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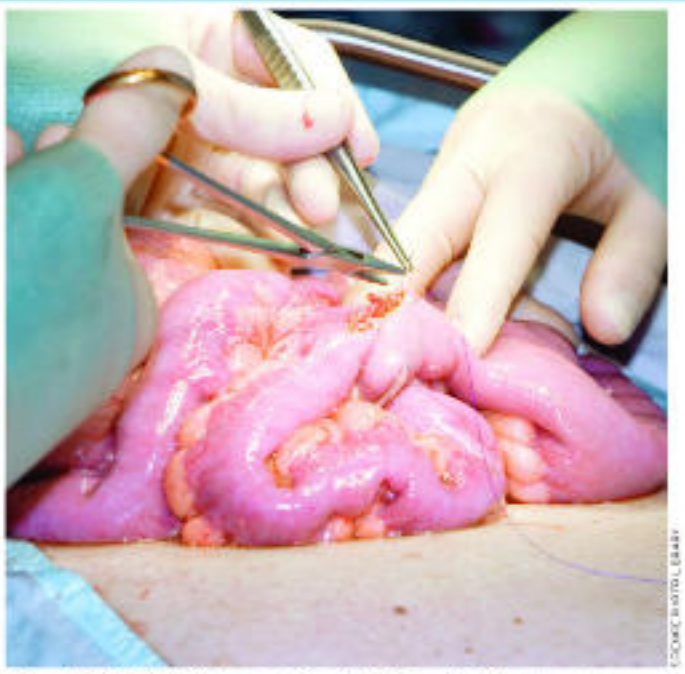
National Confidential Enquiry into Patient Outcome and Death, online 18 October



Almost half of patients pay privately for bariatric surgery

Bariatric surgery in numbers

- **90% increase in patients receiving bariatric surgery**
- **60% referred by GP**
- **29% received psychological counselling**
- **32% received adequate follow-up**

Source: National Confidential Enquiry into Patient Outcome and Death, online 18 October

PSORIASIS

Psoriasis patients have 30% higher risk of diabetes

Patients with psoriasis have a 30% increased risk of developing diabetes, according to a new analysis.

US researchers included 27 observational studies that compared the risk of diabetes in psoriasis patients with matched controls without psoriasis.

The meta-analysis of 4,942,271 patients found those with psoriasis had a 27% increased risk of developing diabetes compared with patients without psoriasis.

Psoriasis patients under 60 had a 26% increased risk compared with those without psoriasis, but those older than 60 had a 9% decrease. Mild psoriasis was associated with a 53% increase and for those with severe psoriasis the risk almost doubled.

The researchers at the University of California concluded: 'These studies suggest that psoriasis is associated with a 59% increased prevalence of diabetes and a 27% increased risk of developing diabetes among patients with psoriasis. Patients with psoriasis, especially those with severe psoriasis, should be educated about the increased risk of developing diabetes.'

***Arch Dermatol* 2012, online 15 October**

Ten top tips: anal fissure and haemorrhoids
▶ page 28

CPD TIP OF THE WEEK

Use combination therapy for migraine

Combination therapy, with an oral triptan and an NSAID or an oral triptan and paracetamol, should now be the first-line treatment option for migraine, according to a new case-based learning module.

When prescribing a triptan, start with the one that has the lowest acquisition cost, say the authors of the learning module, which covers last month's NICE guidance on headache.

It is important to remember that failure of response to a triptan is not a class effect. If one does not work, there is an 80% chance that another one will. Injectable formulations should be considered in patients where severe nausea or vomiting is a problem.

CASE-BASED LEARNING
Guideline debrief: headache
pulse-learning.co.uk

CANCER

GPs should be alert to cancer patients' anxiety

GPs should be alert to 'emotional distress' in patients with a recent diagnosis of cancer, as they are more likely to develop anxiety problems or depression, say UK researchers.

The study used data from 173 general practices in Scotland, obtained from the Primary Care Clinical Informatics Unit. Cases were at least 18 years of age with a diagnosis of cancer, matched to controls with no diagnosis of cancer, depression or anxiety. A total of 7,298 cancer cases and 14,596 controls were included.

The researchers found patients with cancer were 13 times more likely to be diagnosed with depression; 14 times more likely to develop anxiety within a year of diagnosis; four times more likely to excessively consume alcohol and were prescribed significantly more psychotropic drugs. The researchers concluded: 'All health professionals, in primary and secondary care, should be alert to emotional distress in patients with cancer and ensure psychological health is discussed and treated.'

***BJC* 2012, available online 11 October**

HIV

GP training doubles practice HIV detection rate

A GP training programme can double the number of HIV cases detected in primary care, according to UK researchers.

Their Sexual Health in Practice (SHIP) education intervention was carried out in 51 GP practices in Haringey, north London. This consisted of two afternoon sessions – one addressing clinical and communication skills and the other focusing on HIV.

Trained practices – that is practices with at least one staff member who completed the full education programme – found that diagnoses of HIV increased from 19 in the two years before training to 39 two years post-training.

The testing rate improved significantly in trained practices from 2.29 tests per 1,000 patients per year in the 24-month period before training to 6.66 tests per 1,000 patients per year in the six months after training started.

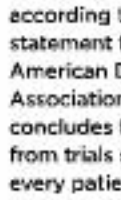
By comparison, untrained practices went from 1.54 tests per 1,000 to 1.90 tests per 1,000, a non-significant increase.

The researchers from University College London concluded: 'These findings support the conclusion that SHIP, as an educational intervention, led to changes in clinical practice and behaviour.'

***STI* 2012, online 8 October**

COELIAC DISEASE

Gluten-free diet benefits coeliac disease patients



A gluten-free diet improves multiple outcomes for patients with coeliac disease, say Swedish researchers.

Symptom questionnaires were sent to randomly selected members of the Swedish Society for Coeliacs.

They were asked to self-report symptoms and healthcare consumption for the year prior to diagnosis and the year prior to receiving the questionnaire while undergoing treatment with a gluten-free diet.

Of the 1,031 responses, significantly fewer patients reported fatigue after starting a gluten-free diet, with 22% reporting this symptom compared with 89% who reported it one year prior to diagnosis of coeliac disease.

A significant number of patients (4%) reported weight loss after commencing the diet, compared with 87% who reported the problem one year before diagnosis.

Just eight patients (0.8%) were still vomiting post-diet compared with 88% before, and 2% reported hair loss compared with 85% who complained of this pre-diagnosis.

The researchers concluded: 'Coeliac disease patients profit from being diagnosed and treated with a gluten-free diet.

'An earlier coeliac disease diagnosis is therefore of great importance.'

***BMC Gastroenterology* 2012, online 17 September**

GUIDANCE ROUND-UP

Alteplase for acute ischaemic stroke

The tissue plasminogen activator alteplase should be used to treat acute ischaemic stroke, says NICE. The institute recommended in its final guidance that treatment should be started as early as possible within four-and-a-half hours of the onset of stroke symptoms and only once bleeding in the brain has been ruled out with a brain scan.

NICE, September 2012

Set individual HbA_1c targets

Glycaemic targets for patients with type 2 diabetes should be 'individualised', according to a position statement from the American Diabetes Association. The association concludes that evidence from trials suggests not every patient benefits from aggressive glucose management. They recommended GPs consider a patient's life expectancy, disease duration, comorbidities and any risks associated with hypoglycaemia when setting HbA_1c targets. The association also recommended that the percentage of patients with an HbA_1c of less than 53mmol/mol (7%) should not be used as a quality marker for diabetes care.

American Diabetes Association, October 2012

Warning for typhoid vaccine

The UK medicines regulator has warned GPs that some patients injected with the typhoid vaccine TyphimVi may not be fully protected. The MHRA said Sanofi Pasteur MSD had recalled 16 batches of their TyphimVi and that those patients who have received the vaccine, and have returned from abroad feeling unwell should be encouraged to see their GP.

MHRA, October 2012

A mockery of patient choice

Ask politicians about the choice agenda, and it's likely that they'll wax lyrical about patient rights, competition and the benefits of a free market. Ask a GP, and they'll probably tell you about Choose and Book.

For all the NHS' ideological rhetoric, in practice the choice agenda generally boils down to a GP asking a patient where they would like to be referred, and then using Choose and Book to arrange for them to be seen at the hospital of their choice.

Or not, as the case may be. For, as Pulse reveals this week, more than seven years after it was launched Choose and Book is still plagued with operational gremlins, and patients are suffering as a result.

Hospitals are routinely cancelling appointments if GPs fail to attach referral letters within an arbitrary three-day time limit. They are failing to record when consultants have booked holiday, then cancelling appointments that clash. In some

Steve Nowottny
Editor

cases they even seem to be failing to inform practices that appointments have been cancelled – leaving GPs, as ever, to pick up the pieces with understandably angry patients.

Such behaviour is completely unacceptable in a modern health service. Unilaterally cancelling appointments makes a mockery of the notion that patients should be able to choose where and when they are seen.

But, while the issues we cover this week are the latest in a long line of Choose and Book complaints, two factors make this story particularly significant.

First, the latest revelations come on the back of a Department of Health consultation earlier this year, *Liberating the NHS: No decision about me, without me*, which outlined a series of proposals to boost patient choice.

Practices were told they would have to use Choose and Book, offer choice through 'alternative, potentially labour-intensive, methods' – perhaps even phoning around hospitals – or face as-yet-unspecified sanctions. GPs may soon no longer have any choice about offering choice.

And secondly, there are growing questions about the wider principle of offering patients choice at all. We also report this week fears among CCGs that choice is destabilising secondary care, with some hospitals struggling to cope with rising demand and others struggling with lack of it.

In one respect, this is a triumph for patient choice. As funding follows the patient, and the fortunes of hospitals wax and wane, politicians can celebrate the fact that, at last, the drive to create a demand-led market in healthcare appears to be making progress.

GPs, though, stuck with the reality of Choose and Book and battling ever-tighter funding constraints, may wonder if the choice agenda as a whole is not a little wasteful.

Pulse is changing

As you'll already have read on pages 2 and 3, Pulse is planning to improve the way it supports GPs next year.

We're improving what we offer online and, if you haven't already signed up to our upgraded website, you should do so today – it's free, quick and enables you to get daily or weekly emails rounding up the best of Pulse's content.

From January, we'll also be relaunching Pulse magazine in a new monthly format, with all your favourite features but also more space for in-depth investigations, extended analysis and long-form interviews, which will allow us to delve deeper into the issues facing general practice.

We're excited about the changes, and hope you are too. Find out more and let us know your ideas at pulsetoday.co.uk/2013.

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1 in 4

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

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

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® powder and solvent for suspension for injection [shingles (herpes zoster) vaccine (live)] *Refer to Summary of Product Characteristics for full product information.* **Presentation:** Vial containing a lyophilised preparation of live attenuated varicella-zoster virus (Oka/Merck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque-forming units) varicella-zoster virus (Oka/Merck strain). **Indications:** Active immunisation for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN) in individuals 50 years of age and older. **Dosage and administration:** A single dose should be administered by subcutaneous injection, preferably in the deltoid region. **Contraindications:** Hypersensitivity to the vaccine or any of its components (including neomycin). Individuals receiving immunosuppressive therapy (including high-dose corticosteroids) or who have a primary or acquired immunodeficiency. Individuals with active untreated tuberculosis. Pregnancy. **Warnings and precautions:** Appropriate facilities and medication should be available in the rare event of anaphylaxis. Deferral of vaccination should be considered in the presence of fever. In clinical trials with Zostavax, transmission of the vaccine virus has not been reported. However, post-marketing experience with varicella vaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varicella-zoster virus (VZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zostavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zostavax may not result in protection in all vaccine recipients. **Pregnancy and lactation:** Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Caution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. **Undesirable effects:** Very common side effects include: pain/tenderness, erythema, swelling and pruritus at the injection site. Common side effects include warmth, haematoma and induration at the injection site, pain in extremity, and headache. Post marketing use has shown hypersensitivity reactions including anaphylactic reactions, joint and muscle pain, fever, swollen glands, rash, also hives and rash at the injection site. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic cost:** Vial and pre-filled syringe with two separate needles. The cost of this vaccine is £99.96. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 Rue Jonas Salk, 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. Miller E, Marshall R, Vurdien J. Epidemiology, outcome and control of varicella-zoster infection. *Rev Med Microbiol* 1993; 4: 222-30. **2.** Bowsher D. The lifetime occurrence of Herpes zoster and prevalence of post-herpetic neuralgia: A retrospective survey in an elderly population. *Eur J Pain* 1999; 3: 335-42. **3.** ZOSTAVAX® SmPC.

* The need for a second dose is currently unknown

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

UK15206a c 06/12

sanofi pasteur MSD
vaccines for life

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

CHAMPIX vs.	4 weeks	3 months	6 months	12 months
Standard-dose NRT patch (≤22 mg)	✓ OR 2.06 (CrI 1.54–2.76)	✓ OR 1.86 (CrI 1.36–2.54)	✓ OR 1.53 (CrI 1.20–1.97)	✓ OR 1.89 (CrI 1.38–2.63)
High-dose NRT patch (>22 mg)	✓ OR 1.64 (CrI 1.22–2.20)	✓ OR 1.63 (CrI 1.07–2.50)	– OR 1.06 (CrI 0.76–1.47)	✓ OR 1.60 (CrI 1.07–2.43)
NRT patch plus another NRT formulation*	✓ OR 1.72 (CrI 1.04–2.89)	✓ OR 2.66 (CrI 1.22–5.74)	– OR 1.44 (CrI 0.94–2.23)	✓ OR 2.14 (CrI 1.32–3.48)

✓ = statistically significant – = not statistically significant

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

CrI = 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 refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should usually start 1-2 weeks before this date. Patients who are not willing or able to set the target quit date within 1-2 weeks, could be offered to start treatment and then choose their own quit date within 5 weeks. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Changes in behaviour or thinking, anxiety, psychosis, mood swings, aggressive behaviour, depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour or thinking that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. In many post-marketing cases, resolution of symptoms after discontinuation of varenicline was reported, although in some cases the symptoms persisted; therefore, ongoing follow up should be provided until symptoms resolve. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). In a trial of patients with stable cardiovascular disease (CVD) certain cardiovascular events were reported more frequently in patients treated with CHAMPIX. Patients taking CHAMPIX should be instructed to notify their doctor of new or worsening cardiovascular symptoms and to seek immediate medical attention if they experience signs and symptoms of myocardial infarction. The safety and efficacy of Champix in patients with serious psychiatric illness has not been established. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. There have been post-marketing reports of hypersensitivity reactions including angioedema and reports of rare but severe cutaneous reactions, including Stevens-Johnson Syndrome and Erythema Multiforme in patients using varenicline. Patients experiencing these symptoms should discontinue treatment with varenicline and contact a health care provider immediately. **Fertility, pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. There are no clinical data on the effects of varenicline on fertility. Non-clinical data revealed no hazard for humans based on standard male and female fertility studies in the rat. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1mg tablets Card (EU/1/06/360/003) £27.30. Pack of 28 1mg tablets Card (EU/1/06/360/004) £27.30. Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60. Pack of 56 1mg tablets HDPE Bottle (EU/1/06/360/002) £54.60. Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS **Last revised:** 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 Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

Reference:
1. Mills EJ *et al.* Comparisons of high-dose and combination nicotine replacement therapy, varenicline and bupropion for smoking cessation: a systematic review and multiple treatment meta-analysis. *Ann Med* August 2012.

CHAMPIX® varenicline tartrate

The GMC's politically correct faith ban is not in patients' best interests

Dr Richard Scott, warned by the GMC for discussing Christianity with a patient, argues the regulator's latest guidance ignores the evidence

Following its 1993 document on personal beliefs, the GMC has produced various new guidance over the years on sharing personal and religious beliefs. This guidance has been deliberately aimed at restricting the ability of doctors to discuss faith with their patients.

Back in 1993, doctors were able to discuss faith freely, as long as it was done in a gentle and sensitive manner. But in the GMC's 2008 guidance, we were warned not to introduce the subject of faith unless it was deemed directly relevant to the patient's care.

Now the GMC's revised draft of *Good Medical Practice*, due to be published next month, states we may not do so unless explicitly invited to do so by the patient, meaning when the patient directly requests a faith discussion or indicates in advance his or her willingness to approach the problem from a spiritual angle. These developments are worrying on several counts.

Firstly, over the past decade, there has been an explosion of evidence that confirms conclusively that faith is of enormous benefit to patients' health. All conditions studied thus far – whether the incidence of heart disease, recovery from surgery or response to cancer treatment – show that faith leads to better outcomes for the patient.

In my GMC case recently, I read out some of the statistics concerning mental health outcomes in relation to faith to the GMC, but the findings were essentially ignored by the panel.

A secular agenda

The GMC purports to act in the best interest of patients, yet by ignoring the evidence concerning faith and tightening its guidelines, it is acting in direct opposition to what has been proved beneficial for patients. In doing so, the regulator reveals not only a foolish disregard for the facts but its own motives.

It clearly has a secular agenda that overrides any possible benefit to patients from the Christian faith, a matter that should be of grave concern to all of its thousands of members. Essentially, political correctness is once again at the fore, with disregard for inconvenient facts.

When I take my car to a mechanic, I trust his opinion and do not expect him to act based solely on my suggestions. If he feels something is amiss with the carburettor but I direct him to the battery, how can I expect the car to improve?

In the same way, if a doctor with considerable experience in treating the spiritual health of patients feels this is an appropriate way for a consultation to proceed, but is unable to act unless a patient initiates this line of discussion, not only is the doctor hampered in his efforts but the patient is denied access to a proven benefit. All through the unhelpful intervention of the GMC.

Furthermore, if a doctor does take courage and introduce a spiritual angle, any problem arising will risk him being sanctioned by his professional body for introducing an approach without the patient's express and prior request for him to do so.

I have previously had doctors contact me who have wished to introduce a spiritual approach but who have been too scared to do so. This new guidance will only deter them further. The GMC has acted against the evidence – and against patients' best interests.

Dr Richard Scott is a GP in Margate, Kent

GPs must develop commercial skills to survive the NHS funding squeeze

Practices may be small businesses, but they will need to adapt to survive in the new NHS, writes **Dr Shane Gordon**

The decline in local enhanced service (LES) funding is a weather vane for the decline in all traditional sources of funding for general practice. Figures from the NHS Information Centre released last month show that total investment in general practice grew by only 0.3% and 0.5% in the past two years, a figure significantly below inflation.[1]

The future for overall NHS funding does not look rosy either.

Former health secretary Andrew Lansley promised above-inflation increases in health spending until the end of the current comprehensive spending review round.

But, following continued poor growth in the UK's GDP, his successor Jeremy Hunt has already started hinting that the NHS may not be protected from spending cuts after 2015.

At the same time, the commercial environment for general practice is changing rapidly.

There will certainly be increasing investment in out-of-hospital services as CCGs and the NHS Commissioning Board seek to improve the quality of patient services while reducing infrastructure costs. Only a few years ago, this would have meant increased investment in general practice through enhanced services and GPSIs – but the falling investment in LESs is partly an indication that simply passing work and funding to general practice is no longer seen as viable.

At the heart of the matter are the NHS's new duties to promote choice and competition.

The NHS Cooperation and Competition Panel publishes rules for commissioners, including obligations to ensure transparent procurement (which means they must be open to competition) and to use providers who are best placed to meet the needs of their populations.

The net result is that much of the investment going into out-of-hospital services is funnelled through open procurement processes rather than enhanced services or uncontested contracts. There are examples of GP-led companies succeeding in this environment. These successes are often in the core business of general practice, such as out-of-hours services or GP-led health centres. Much of the coming investment will be in more integrated services.

GPs as businessmen

Despite the successes of these GP-led companies, the reality is most practices have never bid for work in this new commercial environment. I often wonder why this is, given that many GPs describe themselves as businessmen as well as front-line clinicians.

We can see our 'core business' and the associated funding gradually slipping away from us as the needs of patients and the pressures on the health service change, but most practices seem strangely inert.

Our CCG recently commissioned some research to see what sort of approach practices might want to undertake to meet these challenges.

Unsurprisingly, there were a wide variety of clinical priorities but the study revealed an underlying lack of understanding of the current commercial environment. Given the crisis of funding in general practice I suspect many people would find this surprising.

However, I think there are some simple explanations for this. Although general practice does indeed have a small business model, it does not operate in the competitive environment in which most businesses find themselves. GPs' focus as 'businessmen' falls on service delivery and internal cost control, with relatively little need to attract new customers by developing innovative service models.

Current medical and postgraduate education also does little to equip the average GP with skills to survive in a competitive business environment, and many practice managers have little or no commercial experience.

As a commissioner, I find this difficult to deal with. I know that when push comes to shove, many GPs have great adaptability to adversity and the ability to deliver high-quality services come rain or shine.

But we are no longer able to spend precious NHS resources on the basis of 'trust me, I'm a doctor'. Most practices will need significant skills development to thrive in this new, challenging environment.

CCGs and the NHS Commissioning Board have a significant role to play in encouraging the development of these skills, but the onus is on the profession to adapt to survive.

Dr Shane Gordon is the chief officer of North East Essex CCG and a GP in Colchester

Reference

1 NHS Information Centre. Investment in general practice 2007/08 to 2011/12 England, Wales, Northern Ireland and Scotland, 2012

22 Copperfield

SHUTTERSTOCK/PIXELSTUDIO

A prehistoric encounter

Self-important private consultants may be dinosaurs, says **Copperfield**, but unfortunately they are far from extinct

Dinosaurs. Found only in the Natural History Museum and Steven Spielberg's imagination, right?

Wrong. Remember the coelacanth? A prehistoric fish, thought to be long gone, which was hauled up, alive and flapping, off the coast of South Africa? Well, I've found my coelacanth. Or, rather, it has found me.

'My private specialist wants me to have this,' said my patient, thrusting a handwritten note under my nose.

'My private specialist' was a neurologist she'd paid to see, who hadn't worried about courtesies like a referral from her GP.

'Me' was a lady with a long history of headaches, fibromyalgia and dissatisfaction.

And 'this' was a list of drugs comprising two types of antidepressant, a sleeping pill, an anti-convulsant, calcium supplements and vitamins. All of which replaced her current treatment regime, which was precisely nothing.

'Does he?' I replied. 'Well, he can prescribe them, then.'

There followed a lengthy discussion during which I explained that generally my philosophy is to avoid polypharmacy, especially when initiating treatment, and that specifically I would adopt a step-wise approach in her condition rather than leaping straight to the Nuclear Option.

Predictably, she flounced out and, equally predictably, I received a proper letter from her private consultant. 'Dear Dr Copperfield,' it began, 'I understand this charming lady is having problems obtaining her prescription

with consultasaurus rex

from you. I can't see why she shouldn't have her treatment under the NHS, and I would be obliged if you would do this for her.'

Hmm, I thought, as you do when you're punching a wall, this bloke's a genuine dinosaur. Probably uglier and more stupid than a coelacanth, though. I won't bore you with the detail of my response but, to paraphrase, it said, 'Dear Jurassic Prat, piss off. Yours sincerely, Dr C. PS Charming? Hilarious.'

A fortnight later, I received another, longer, letter from the pinstriped pin-pricker. It sighed at my obduracy, tut-tutted over my lack of co-operation and wagged a fat finger at my 'attitude'.

He went on to explain, as if to a retard, that medicine is 'as much art as science', and that some of my patient's problems were linked to loneliness. This, he suggested, might be resolved by a monthly house-call from her GP.

So, despite the fact that my knuckles were bleeding by now, I replied again, expanding on my previous themes: 'Dear Dino Doc, piss off, you pompous twat'.

This is what a GP's life must have been like back in the day

Oddly, though, this episode did leave a warm glow, and not just because I'd catharted a whole gallbladder's worth of bile. It made me think that this is what a GP's life must have been like back in the day: self-important consultant pillocks with obsequious patients, treating GPs as their lackeys.

True, our job can be as much fun as eating shards of glass, but, nowadays, at least our NHS consultant colleagues usually treat us with some respect – and so do most of our patients.

Plus, I can console myself with the fact that the dinosaurs eventually died out.

We don't know what did for them, exactly, but I favour the meteorite theory. In this consultant's case, I hope it's a direct hit.

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

More online

Can't wait for his next column? You can now get your regular blast of the world according to Copperfield via Twitter @doccopperfield or on his blog at pulsetoday.co.uk/copperfield

We want to hear your views

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

The GMC is wrong – faith has a crucial role to play in patient care

LETTER OF THE WEEK

From Dr Ravi Vatish
Handsworth, Birmingham
via pulsetoday.co.uk

I am responding to the GMC's revised advice on discussions of religion with patients ('GMC: Do not bring up personal beliefs', pulsetoday.co.uk/news).

Faith has a very important role in patient care, particularly when dealing with distress, anxiety, depression and coming to terms with loss.

If we approach the matter in terms of patients' beliefs, or 'generic religion', then I can see no problem.

Difficulties arise when, say, a Christian doctor speaks to Muslim patients in terms of Christian beliefs.

But we would lose a valuable tool if we did not raise the matter out of fear.

I regularly discuss religion with patients and there has never been a problem. Patients actually appreciate it. It is important to be familiar with various beliefs and faiths.

Should GPs be able to discuss religion with patients?

Can we really copy patients into everything?

From Dr Michihiro Tomonaga
Warrington
via pulsetoday.co.uk

I cannot see how copying patients in on notes 'would not be too expensive' (GPs face "huge burden" of copying patients in on all correspondence', pulsetoday.co.uk/news). Yesterday alone I had (if you include telephone contacts) over 60 consultations. Every week I have close to 200 consultations.

Even my time to copy, print and hand over notes (bearing in mind some patients will want to read the material there and then) would result in the loss of several consultations.

If it took 10 seconds per patient, multiplied by 200 consultations that is 33 minutes, which is a loss of at least three consultations, per GP, per week. So between all the GPs in my surgery, that is 17 consultations each week – or my salaried GP's morning session.

I haven't even factored in the cost of stationery – printing out this much paper would not be inexpensive.

● From Dr Rupen Kulkarni
Redditch, Worcestershire
via pulsetoday.co.uk

Making copies of letters for every trivial consultation would be irrelevant and wasteful. It would not be possible, or helpful in terms of time lost, even if patients paid for it. It would be a burden to everyone at the cost of actually seeing patients and getting some work done.

Acupuncture is effective in chronic pain

From Dr Rosemary Alexander
Pinner, Middlesex

I am writing to voice my concern after reading the article by Dr Tim Williams on chronic pain ('Key questions on chronic pain', pulsetoday.co.uk/clinical).

Although Dr Williams is obviously experienced in writing about the drug treatment of pain, he seems to have less experience with acupuncture and other modalities.

NICE guidelines in 2009 for chronic back pain recommend a structured exercise programme, acupuncture or a course of manual therapy, according to patient preference, as an alternative to drug treatment. NICE guidelines for the treatment of chronic headache 2012 state that a course of acupuncture should be offered as an alternative to gabapentin according to patient preference.

Dr Williams claims that acupuncture is extremely expensive as an outpatient procedure – approximately £200 a session – and that there are no reliable selection procedures.

In fact, most pain clinics and many physiotherapy clinics offer acupuncture for far less than £200 a session and many patients do respond.

As a GP and practising acupuncturist, I feel sad when I see patients on escalating drug treatments who come for acupuncture at a late stage when their joints have worn and muscles atrophied, rendering this treatment less effective.

Many have had no exercise regimes in their management and this is also not mentioned in the article.

A recent meta-analysis of 29 high-quality randomised controlled trials using acupuncture by Vickers et al (*Arch Intern Med* Sept 2012) showed that in chronic back and neck pain, osteoarthritis and chronic headache, acupuncture produced a significant difference in pain levels.

● From Dr David Metson
Bracknell, Berkshire

Dr Williams's article on chronic pain raised interesting points, but I felt there was insufficient emphasis on the risk of opiate addiction. Interestingly there was an article on a patient addicted to prescription drugs in the same edition!

1 Smith BH, Higgins C, Baldacchino A. Substance misuse of gabapentin. *Br J Gen Pract* 2012; 62(601): 406–7

Dr Williams replies

Thank you for your letter. Having worked in the field of chronic pain for over 10 years, I have referred a number of patients for acupuncture and some have benefited significantly.

The tariff price of secondary care acupuncture is, in my opinion, a significant barrier to its use long term and needs to be addressed. I am grateful for the additional reference to NICE guidance. However, I still think predicting who will respond is difficult as with any treatment, and reducing the price of this intervention will allow finding out to be more palatable to commissioners.

Regarding the issue of addiction, thank you for re-emphasising this important issue, which I stated should be discussed whenever initiating opiates.

Any concerns should be dealt with by referral to specialist support services.

MORE ONLINE
Read Dr Williams' full response
pulsetoday.co.uk/letters

Partnerships are not for everyone

From Dr Babak Shokouhi
Retired GP
Worthing, West Sussex

I am writing in response to Dr Libby Hodges's article on becoming a locum ('Why I quit my partnership to become a locum', pulsetoday.co.uk/opinion).

I think it's good to have insight into what suits you best in your career. Many of us only know how to be a GP partner. It takes so much to get to know your patients and get old alongside them. That's nice, but not ideal for everyone.

People like Libby enjoy variety and more balance in the work-life interface. I admire people who are brave enough to admit that the GP principal role as it is now, with all the pressures and challenges, is not for them.

What are private firms so afraid of?

From Dr Marie-Louise Irvine
BMA Council member
Lewisham, south London
via pulsetoday.co.uk

I am responding to criticism by NHS Partners Network director David Worskett of the plan for pledge cards to allow patients to opt out of privately provided NHS services ('BMA pledge card plan "divisive" ', pulsetoday.co.uk/news).

This is a voluntary scheme and if patients don't want to use it they don't have to. What are you afraid of, Mr Worskett? That if patients are able to express this choice they may opt to favour the NHS? You say the overwhelming majority of patients don't mind who provides their care. Where is your evidence?

If you are right, you should have nothing to worry about. If you are wrong, and a significant number of patients do want to show their preference for the NHS, the pledge card will help them do so.

Once I qualify, I'm emigrating

From Dr Stuart Buchanan
Lurgan, Northern Ireland
via pulsetoday.co.uk

GPs in the UK will be expected to do more and more, with less and less, and will continue to get the blame for just about everything ('GPs brace for another cut in take-home pay', pulsetoday.co.uk/news).

I'm finishing my GP training and not even applying for jobs here. I'm emigrating as soon as I've finished. I'm better off running a coffee shop and siphoning the money out of the UK instead! Perhaps as GPs we could set up a multinational and pay our taxes in Switzerland?

For the record

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

Pulse Clinical

In this issue

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Guideline debrief: headache
2 CPD hours
All you need to know about last month's practice-changing NICE guidance

Hot topics in irritable bowel syndrome
1.5 CPD hours
Includes new guidance on dietary advice

PulseToday
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Resource of the week
After reading this week's paediatric clinic, go to pulsetoday.co.uk/tools-and-resources to download a useful paediatric gait, arms, legs and spine examination guide from Arthritis Research UK.

Child and adolescent psychiatrist Dr Helen Fitzpatrick answers GP Dr Mandy Fry's questions on drugs, insomnia and psychological therapies in ADHD

KEY QUESTIONS

ADHD

1 There's been a lot of adverse publicity about stimulant drugs. What role do they play in treating ADHD? When would you choose a controlled-release preparation?

In mild and moderate ADHD, drug treatment is not recommended first line, and behavioural interventions should be tried initially. In more severe ADHD – or moderate ADHD where other interventions have been unsuccessful or declined – drug therapy should be offered. Drug treatments should always form part of a treatment package that includes psychological, behavioural and educational advice and interventions.[1,2]

If drug treatment is indicated, there are several factors to consider in deciding which to prescribe:

- whether there are co-morbid conditions, such as tic disorder, epilepsy or Tourette's syndrome
- the adverse effects of the drugs
- the individual's circumstances, for example how easy administration of a midday dose would be
- the informed choice of the child or young person and their parents
- the potential for medication to be sold or misused.

Go to the online version of this article at pulse-learning.co.uk to see a table of the recommended medications for different presentations of ADHD.

Immediate-release preparations can be used for titrating doses in the initial stages of prescribing, and for flexible dosing regimens. But a once-daily dose of a modified-release preparation tends to be more convenient and can lead to better compliance, less stigma for the children as they won't have to approach school staff for their medication, and smoother symptom control over the day.

2 How can we minimise the insomnia often associated with stimulant drugs? Is there any place for melatonin in sleep disorders associated with ADHD?

Sleep difficulties are commonly associated with ADHD – sometimes as part of the presenting difficulties before medication is initiated, or caused by stimulant drugs.

General sleep hygiene measures may be helpful in insomnia – for example establishing a predictable winding-down routine that includes quiet time before bed. Advice could be given about limiting intake of caffeinated drinks. Exposure to devices that emit light such as computers and mobile phones may also cause too much stimulation and inhibit melatonin secretion, so suggest the child avoids these before bedtime.

If the insomnia is unresponsive to these approaches, some clinicians will consider a trial of a small dose of evening or bedtime methylphenidate, which can have the paradoxical effect of calming a busy mind and body ready for a more restful sleep. Clonidine can sometimes be used at bedtime because of its sedative effects, but should be prescribed with caution as it has the potential to cause a rise in blood pressure on abrupt withdrawal.

There is limited evidence for the efficacy of melatonin in the management of sleep difficulties in children with neurodevelopmental conditions. A recent randomised control-led study concluded there was no significant increase in overall sleep time in children with sleep disturbance and neurodevelopmental conditions who were taking melatonin,[3] but earlier studies with less rigorous designs showed melatonin to be of benefit. In my experience, melatonin can be useful in some cases and is worth trying where other approaches have been unsuccessful.

3 Methylphenidate is often prescribed, at least initially, in secondary care. Should GPs be monitoring these children for adverse effects on growth or blood pressure? Are there any other adverse effects?

Absolutely – in a child taking methylphenidate, routine monitoring of their growth, pulse and blood pressure should be carried out in primary care. It is recommended that this is undertaken within a shared care arrangement with your secondary care provider. The frequency of monitoring depends on the patient's response to medication and on whether they have side-effects. You should be guided by the recommendations of your secondary care team, but reviews should usually take place at least every six months.[1,2]

Other adverse effects that can arise with methylphenidate include sleep problems, weight loss, stomach upset, headache, tics, anxiety symptoms, seizures and rarely psychotic symptoms.

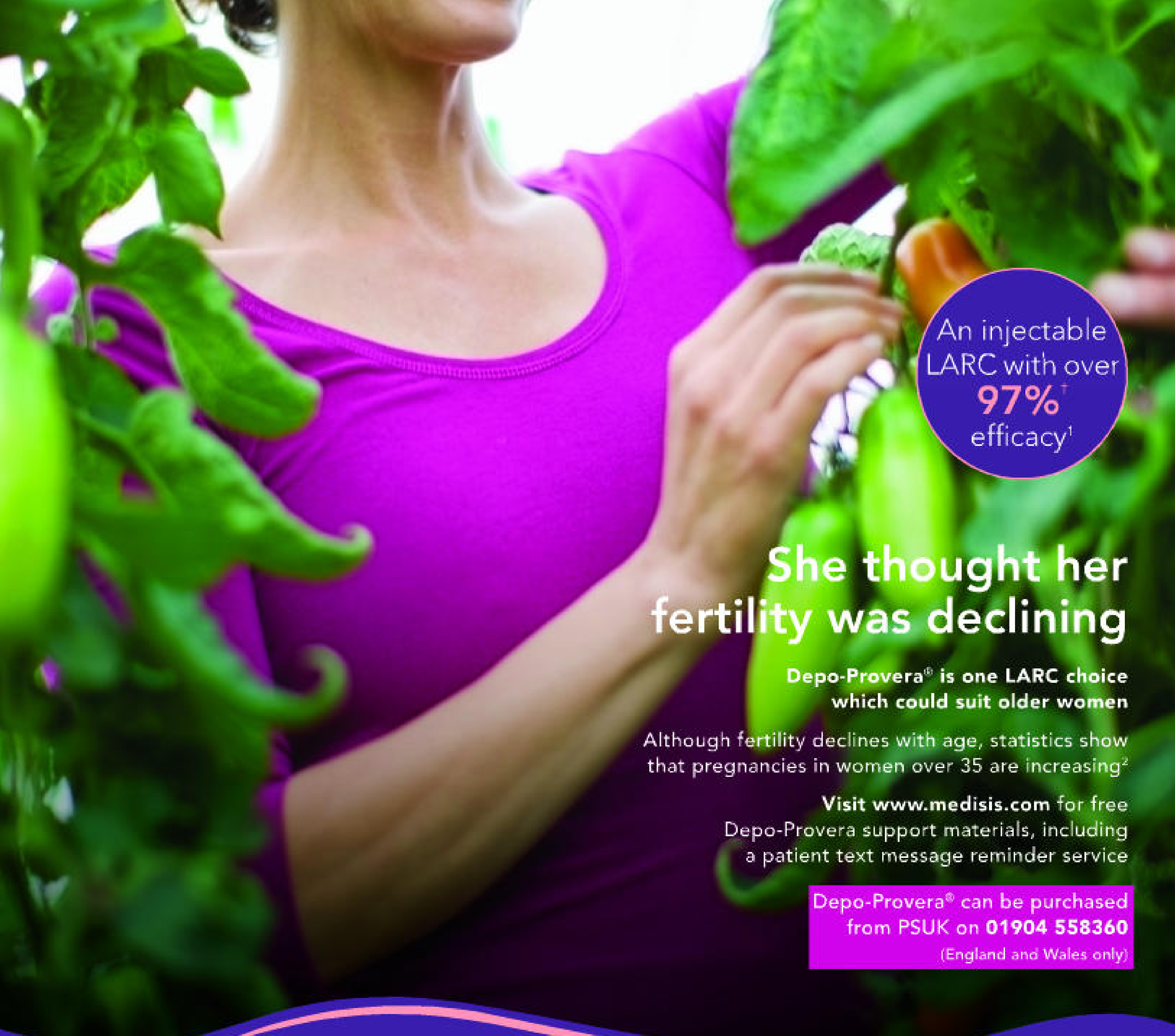
4 Is there a correlation between ADHD and substance misuse or social disorders?

Yes – people with ADHD do have an increased risk of substance misuse compared with the general population. This risk is likely to be associated with conduct disorder and social adversity, both of which have been shown to occur commonly in ADHD. Indeed ADHD is associated with adverse outcomes in many aspects of life – family, social and academic functioning, mental health and employment.

Hyperactive children with or without conduct disorder have higher rates of social problems. Children with ADHD may be rejected by peers, partly because of their increased tendency to show aggression, non-compliant and disruptive behaviour.

One prospective study found the lifetime prevalence for many types of psychopathology and mental health problems was significantly greater in

27



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medroxyprogesterone acetate

Everyday contraception - once every 12 weeks*

Pfizer

†97% with typical use, 99.7% with perfect use (if used as per SmPC)

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

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

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

Depo-Provera® 150 mg/ml [illegible]

ABBREVIATED PRESCRIBING INFORMATION (UK)

Please refer to the SmPC before prescribing Depo-Provera 150 mg/ml. **Presentation:** 1 ml Disposable syringe, containing 150 mg medroxyprogesterone acetate in a Sterile suspension for injection. **Indication:** Long-term contraceptive agent, in women who have been counselled concerning the likelihood of menstrual disturbance, potential delay in return to full fertility and risks of bone mineral density losses. Short-term contraception for the following (i) for partners of men undergoing vasectomy, until the vasectomy becomes effective, (ii) in women who are being immunised against rubella (iii) in women awaiting sterilisation. May only be used in adolescents after other methods of contraception were considered to be unsuitable. **Dosage:** *First injection:* 150mg intramuscular injection during the first 5 days of a normal menstrual cycle. *Post Partum:* Within 5 days post partum (if not breast-feeding). Women in puerperium can experience prolonged and heavy bleeding, therefore caution is required, and women should be advised accordingly. If the puerperal woman will breast-feed, the initial injection should be no sooner than 6 weeks post partum. *Further doses:* These should be given at 12 week intervals, however as long as the injection is given no later than 5 days after the 12 week interval, no additional contraceptive measures are required. For partners of men undergoing vasectomy, a second injection 12 weeks after the first may be necessary in a small proportion of patients where the partner's sperm count has not fallen to zero. If the dose repeat interval is greater than 89 days (12 weeks and 5 days) for any reason, then pregnancy should be excluded before the next injection is given and the patient should use additional contraceptive measures (e.g. barrier) for fourteen days after this subsequent injection. Elderly: Not appropriate. Children: Depo-Provera is not indicated before menarche. Data in adolescent females (12-18 years) is available, *Refer to the Summary of Product Characteristics* for further information. Other than concerns about loss of BMD, the safety and effectiveness of Depo-Provera is expected to be the same for adolescents after menarche and adult females. Depo-Provera may be poorly metabolised in patients with severe liver insufficiency. No dosage adjustment is required for renal insufficiency. **Administration:** By deep intramuscular injection. The sterile aqueous suspension should be vigorously shaken just before use to ensure the dose being given represents a uniform suspension. **Contraindications:** Known sensitivity to medroxyprogesterone acetate or any of its ingredients. Pregnancy. Known or suspected hormone-dependent malignancy of breast or genital organs. Patients with presence or a history of severe hepatic liver disease whose liver function has not returned to normal. Patients with abnormal uterine bleeding, whether administered alone or in combination with oestrogen until a definite diagnosis has been established and the possibility of genital tract malignancy eliminated. **Special Warnings and Precautions:** Use of Depo-Provera reduces serum oestrogen levels and is associated with significant loss of BMD due to the known effect of oestrogen deficiency on the bone remodelling system. Bone loss is greater with increasing duration of use, however BMD appears to increase after Depo-Provera is discontinued and ovarian oestrogen production increases. In adolescents and women with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered before using Depo-Provera. Results from a study support the conclusion that the higher observed incidence of fractures among DMPA users was principally a result of factors other than exposure to DMPA. DMPA injection can be used for 2 years as birth control method or endometrial treatment if other birth control methods or endometrial treatments are inadequate. BMD should be evaluated when a female needs to continue use of DMPA injection long-term. In adolescent females, interpretation of BMD results should take into account patient age and skeletal maturity. The administration of Depo-Provera usually causes disruption of the normal menstrual cycle. Bleeding patterns can include amenorrhoea. Women should be counselled that there is a potential for delay in return to full fertility following use of the method, regardless of the duration of use. Long-term case-controlled surveillance of Depo-Provera users found no overall increased risk of ovarian, liver, or cervical cancer and a prolonged, protective effect of reducing the risk of endometrial cancer in the population of users. *Refer to the Summary of Product Characteristics* for further information. There is a tendency for women to gain weight while on Depo-Provera therapy. Reports of anaphylactic responses (anaphylactic reactions, anaphylactic shock, anaphylactoid reactions) have been received. Should the patient experience pulmonary embolism, cerebrovascular disease or retinal thrombosis while receiving Depo-Provera, the drug should not be re-administered. Patients with a history of endogenous depression should be carefully monitored. Some patients may complain of premenstrual type depression while on Depo-Provera therapy. As with any intramuscular injection, especially if not administered correctly, there is a risk of abscess formation at the site of injection, which may require medical and/or surgical intervention. Patients with a history of the following conditions should be carefully monitored: endogenous depression (including premenstrual-type depression), migraine or unusually severe headaches, acute visual disturbances of any kind, pathological changes in liver function or hormone levels. Diabetic patients should be carefully monitored while receiving DMPA; increases and decreases in total cholesterol, triglycerides and low-density lipoprotein (LDL) cholesterol have been observed. DMPA have been associated with a 15-20% reduction in serum high density lipoprotein (HDL) cholesterol levels. Potential for an increased risk of coronary disease should be considered prior to use. Doctors should carefully consider the use of DMPA in patients with recent trophoblastic disease before levels of human chorionic gonadotrophin have returned to normal. Pathologists should be informed of the patient's use of Depo-Provera if endometrial or endocervical tissue is submitted for examination. Results of certain laboratory tests may be affected. *Refer to the Summary of Product Characteristics for further information.* **Drug Interactions:** Aminoglutethimide administered concomitantly may significantly depress bioavailability. The possibility of interaction (including oral anticoagulants) should be borne in mind in patients receiving concomitant treatment with other drugs. **Pregnancy and Lactation:** Check for pregnancy before initial injection, and also if administration of subsequent injection is delayed beyond 89 days (12 weeks and 5 days). **Side-effects:** The following adverse events were commonly reported (by more than 5% of subjects): menstrual irregularities (bleeding and/or amenorrhoea), weight changes, headache, nervousness, abdominal pain or discomfort, dizziness, asthenia (weakness or fatigue). **Further** adverse events reported (by 1% to 5% of subjects) include: decreased libido or anorgasmia, backache, leg cramps, depression, nausea, insomnia, leucorrhoea, acne, vaginitis, pelvic pain, breast pain, no hair growth or alopecia, bloating, rash, oedema, hot flushes. *Refer to the Summary of Product Characteristics* for more detailed information on side-effects. **Package Quantities and Basic NHS Cost:** Single Pre-filled Syringe pack £6.01. **Legal Category:** POM. **Marketing Authorisation Number and Holder:** PL 00057/0665, Pfizer Limited, Ramsgate Road, Sandwich, CT13 9NJ, UK. **Last Updated:** January 2012. Further information is available on request from: Medical Information at Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS, UK. Tel. +44 (0) 1304 616161. **Ref: DP 8_0**

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk.

Adverse events should also be reported to Pfizer Medical Information on 01304 616161

1. Trussell J. Summary table of contraceptive efficacy. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Stewart FH, Kowal D (eds). Contraceptive Technology (19th edition). New York, NY Ardent Media, 2007.
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UK/DPR/11/0002 Date of preparation: January 2012

young adults with ADHD than those without. This included elevated rates of antisocial, addictive, mood and anxiety disorders.[4]

5 What is the role of psychological therapies in the treatment of ADHD? Can they help educate parents as to how to best respond to difficult behaviour?

Psychological therapies have a major role to play in the management of ADHD. NICE guidelines recommend psychological interventions as the first-line management for pre-school children and school-aged children with moderate ADHD and moderate impairment.[3]

Intervention should begin with psycho-education, providing an explanation about the nature of the disorder, aimed at the child as well as their family and teachers. Other effective approaches include group and individual cognitive behavioural therapy, interpersonal psychotherapy, family therapy, school-based interventions, social skills training and parent management training to encourage positive parenting and the development of coping strategies for managing behavioural problems in ADHD.[4]

6 The diagnosis of ADHD in adults seems to be increasing. Is it possible for ADHD not to develop until adulthood? What role does methylphenidate play, as it is not licensed in adults?

ADHD does not develop in adulthood, and in order for ADHD to be diagnosed symptoms should have been present from at least the age of six years. But symptoms do persist into adulthood in many patients, and adults may have undiagnosed ADHD.

The profile of adult ADHD has been raised with the publication of national guidelines including recommendations for adult sufferers. Understanding of the life-course of ADHD has also improved in recent decades. These factors may be among the reasons for a rise in adults seeking diagnosis.

There is evidence that treatment of adult ADHD with methylphenidate can be effective and it can be used first line unless the individual prefers psychological intervention. It is an anomaly that methylphenidate, which is considered safe and effective in children, remains unlicensed in adults. This could be managed by the development of a local shared care agreement.

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Adults with suspected ADHD require careful evaluation, so specialist assessment, diagnosis and initiation of medication should be undertaken in secondary care. Unfortunately, current provision of adult services is patchy.

7 Dietary factors, such as artificial additives, are often blamed for ADHD. Is there any evidence for dietary manipulation in the treatment of ADHD?

It is commonly believed that diet can affect children's behaviour. Certain food additives, sugar, and artificial colourings are often regarded as causes of ADHD.

Epidemiological evidence points to a link between additives and preservatives in the diet and levels of hyperactivity.[5] Some children with ADHD do show reactions to certain foodstuffs – both artificial and natural – and a food diary may help to identify if there is a link between particular foods and behaviour. An elimination diet may be helpful in some children but should be used with caution and where possible with professional advice in order to avoid too many foods being excluded.

A possible link between ADHD and omega 3 fatty acids, which have an important role in brain development and functioning, has been studied and dietary supplementation with fish oils may benefit some children.[6]

Dr Helen Fitzpatrick is a consultant child and adolescent psychiatrist at the Betsi Cadwaladr University Health Board, North Wales.

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

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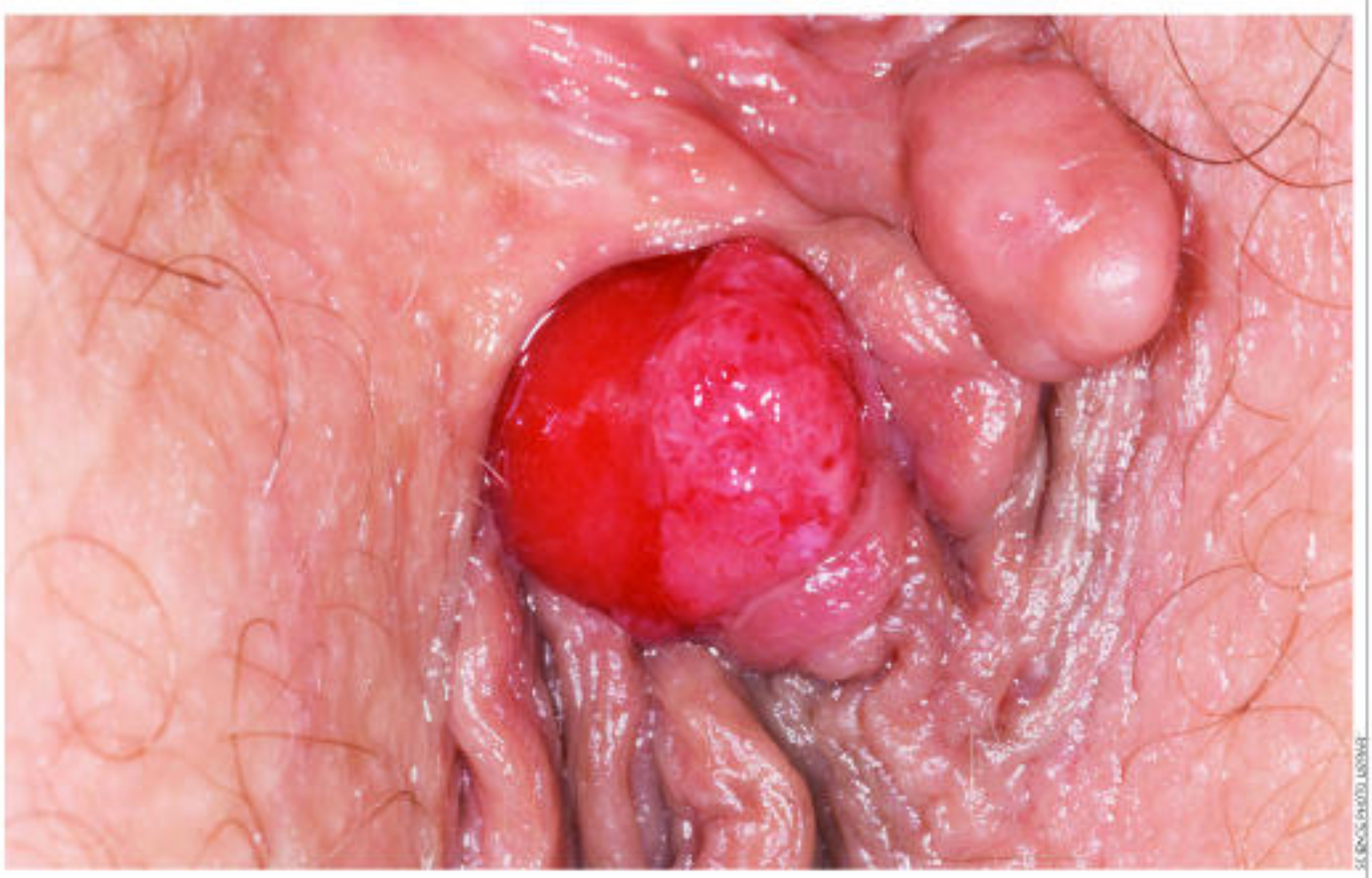
TEN TOP TIPS

Anal fissure and haemorrhoids



Professor John Scholefield, consultant colorectal surgeon, and colleague Mr Alastair Simpson offer their key tips on this common problem

1 Be aware of the presenting symptoms of a fissure

Anal fissure is a tear in the epithelium of the anal canal. It is one of the most common anorectal problems and may be caused by mechanical trauma, for example passing a large stool. The key feature is severe pain on defaecation, often described as a feeling of passing broken glass. The pain is typically shortlived – often lasting just a few minutes – compared with haemorrhoids, which can throb for hours. An anal fissure may also present with fresh bleeding and anal spasm following defaecation.

2 Have a low threshold for an anal or rectal examination

Always consider an anal or rectal examination in patients with anal symptoms because failure to examine the anus could miss a low rectal cancer.

Digital rectal examination in a patient with suspected fissure is often painful, but may reveal an elevated anal sphincter resting pressure. Examination may also show a visible split in the perianal skin on gentle retraction of the buttocks. Some 90% of fissures occur in the posterior midline. Chronic fissures are defined as those causing symptoms beyond six to eight weeks. They may exhibit a sentinel skin tag and exposed external sphincter muscle.

3 Beware concomitant diseases in atypical fissures

Atypical fissures can occur at any point on the circumference of the anal canal and tend to occur in association with other diseases such as Crohn's disease, HIV, cancer, syphilis or tuberculosis.

4 Glyceryl trinitrate will heal more than 50% of fissures

Nitric oxide relaxes the internal anal sphincter, so topical application of 0.2% glyceryl trinitrate ointment is often used as the first management step for anal fissures. Healing rates are reported to be 48% to 68% of patients, but headache is a common side-effect, occurring in up to 50% of patients.

Topical diltiazem and nifedipine also cause relaxation of the internal anal sphincter but are unlicensed for this indication and are usually only prescribed in secondary care.

Botulinum toxin may be used to paralyse the anal sphincter muscle, allowing relaxation and subsequent healing of the fissure. The effect occurs within days and lasts for two to four months.

Grade of haemorrhoid with associated symptoms and treatment options

Grade	Symptoms	Treatment
I	Bleed but do not prolapse	Stool softeners, topical creams
II	Prolapse but spontaneously reduce	Rubber band ligation, sclerotherapy, electrocoagulation, (haemorrhoidectomy)
III	Prolapse requiring manual reduction	Rubber band ligation, sclerotherapy, electrocoagulation, (haemorrhoidectomy)
IV	Irreducible prolapse	Haemorrhoidectomy

5 Reassure patients that most fissures resolve quickly

Most acute fissures resolve in a matter of days with simple perianal hygiene and a high-fibre diet. Advise the patient to avoid straining.

6 Internal and external haemorrhoids present with different symptoms

Haemorrhoids can be classified as internal or external depending on their relation to the dentate line.

External haemorrhoids are highly innervated, hence acutely painful when thrombosed. Patients with external haemorrhoids commonly present with pain, itching and fresh anal bleeding.

Internal haemorrhoids are covered by columnar epithelium and are not sensitive to pain, touch or temperature.

Haemorrhoids can be graded from I to IV (see table below). Typical presentation includes painless bleeding, mucus discharge, incomplete evacuation and tissue protrusion.

7 Increase fibre and fluid for patients with haemorrhoids

A high-fibre diet enables stools to be passed easily without straining. Increased fluid intake helps prevent constipation.

Alteration in bathroom habits, including spending less time on the toilet, may also reduce straining and minimise haemorrhoidal symptoms.

8 Identify red flag symptoms

In patients over 50 years old it is very risky to put anal symptoms down to haemorrhoids, as colorectal cancer can present in a similar manner in this age group.

Red flag symptoms for bowel cancer are:

- a change in bowel habit (particularly looser stools) which persists for more than six weeks
- unexplained anaemia
- a palpable abdominal or rectal mass
- rectal bleeding without anal symptoms.

9 Topical creams treat symptoms of haemorrhoids, not pathology

Many topical agents exist, mainly local anaesthetics, astringents and mild steroid creams, but there is limited evidence for efficacy. They tend to work by improving the symptoms rather than treating the underlying pathology. Newer agents on the horizon may be able to manipulate the local vascular supply and so treat one of the primary underlying aetiologies.

10 Warn patients what to expect before referring for haemorrhoid surgery

Only 5-10% of patients require surgical intervention involving formal excision of the haemorrhoid, ligation of the underlying vascular pedicle and closure of the overlying mucosa.

Haemorrhoid surgery is associated with significant discomfort postoperatively, often requiring a combination of local and systemic analgesics and two to four weeks off work. Patients should be warned that they will be sore and will have blood and purulent discharge for several weeks after surgery. Fortunately, serious complications such as bleeding, anal stenosis and incontinence are rare.

Professor John Scholefield is professor of surgery and consultant general and colorectal surgeon and Mr Alastair Simpson is a specialist registrar in surgery at Nottingham University Hospitals NHS Trust.

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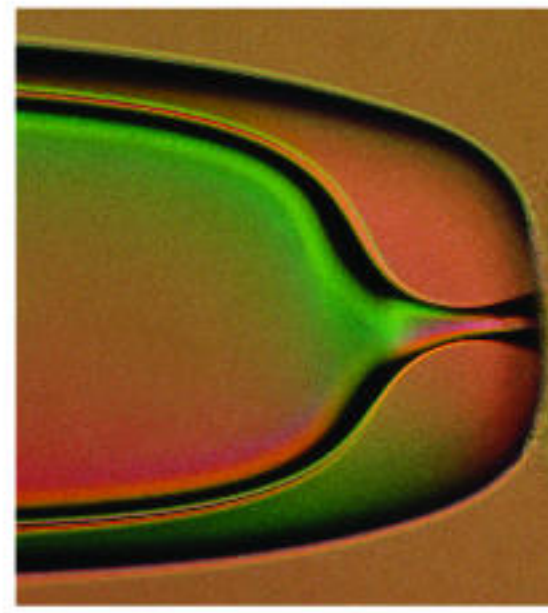
TRICKY TEN MINUTES

We've been trying to get pregnant for 18 months – what can we do now?



Gynaecologist and reproductive medicine specialist Miss Lisa Webber advises on dealing with this difficult presentation in a 10-minute consultation – with a patient leaflet to offer

A woman is born with one to two million oocytes which decline in number and quality with age – fastest from the late 30s. All fertility treatments are less successful in women over 35 years, compared with younger women, and success rates decline sharply in women over 40 years (with the exception of egg donation). On average, a woman is half as fertile aged 35-39 years as she is aged 25 years.

Infertility affects around one couple in seven and is defined as the inability to conceive after 12 months of regular unprotected sex. Basic investigations should be offered to couples after this time, ideally sooner where the woman is aged over 35 years or if she is at risk of reduced ovarian reserve for other reasons.

History

Ask the woman about:

- **Menstrual cycle length** Short menstrual cycles – less than 26 days – can indicate reduced ovarian reserve and cycles shorter than 24 days are likely to be anovulatory. Cycles over 35 days long are also likely to be anovulatory, but are commonly because of polycystic ovary syndrome and are associated with more successful fertility treatment.
- **Heavy or light periods** Heavy periods can indicate fibroids or polyps and may cause iron-deficient anaemia, which should be corrected before pregnancy. Short or light periods – especially if irregular – can be due to anovulatory bleeding. If there has been a change following Evacuation of Retained Products of Conception or a surgical termination, consider Asherman's syndrome.
- **Pelvic pain** Dysmenorrhoea and dyspareunia are associated with endometriosis.
- **Previous pregnancies** The method of conception and the outcome of previous pregnancies, including any obstetric problems, should be noted.

Patient resource

Go online to download a patient information leaflet which you can give couples to take away with them.

▶ pulsetoday.co.uk/tools-and-resources

● **Medical history** This might highlight a cause for the problems, for example a ruptured appendix may have caused pelvic adhesions, or a condition that should be optimised prior to conception, such as sub-optimally controlled diabetes. Ovarian surgery such as cystectomy or treatment for ovarian endometriosis can reduce the ovarian reserve and is associated with adhesions and tubal problems.

Ask the man about:

● **Testicular injuries** Swellings or surgeries, such as orchidopexy, can be associated with a *low* sperm count.

Ask both partners about:

● **Frequency of intercourse** Discuss this along with any difficulties either partner has, such as dyspareunia or erectile dysfunction.

● **Medication** Some drugs are contraindicated when trying to conceive, for example statins for women. Others can interfere with conception, such as anabolic steroids for men. Women should be encouraged to take folic acid (400µg daily).

● **Lifestyle** Give advice on smoking cessation and reducing alcohol consumption.

Examination

There are few benefits in routinely examining either partner – unless indicated by the history – apart from calculating the woman's BMI. A pre-pregnancy BMI of less than 19kg/m² is associated with low birth weight and so these women should be advised to increase their weight. A BMI greater than 30kg/m² is associated with low success rate for fertility treatment, and a BMI greater than 35kg/m² with low conception rate per ovulation and obstetric risks to mother and baby. Half of maternal deaths between 2006 and 2008 in the UK were related to the woman being overweight or obese[1].

Give lifestyle advice and refer for surgery those women with a BMI above 35kg/m² if they are unable to reduce their weight, and if local restrictions allow (infertility is a recognised co-morbidity). Obese women should be prescribed folic acid 5mg daily instead of the standard 400µg and should also take vitamin D 400iu daily from preconception until delivery.

Investigations

Basic fertility tests for women:

● FSH, LH and oestradiol should be measured in the early follicular phase (day two to five of the cycle) to assess ovarian reserve. If cycles are longer than 42 days, measurements can be taken on any day. FSH levels can fluctuate between cycles, but levels greater than 10iu/l are associated with declining reserve.

● Ovulation should be confirmed in women with cycle lengths less than 42 days by measuring serum progesterone in the mid-luteal phase (seven days before the next period is due). Progesterone measurements over 20nmol/l indicate ovulation has occurred.

● A pelvic ultrasound scan should look for fibroids, polyps, abnormal uterine structure, ovarian cysts and polycystic ovaries.

● Measurement of basal body temperature is generally not helpful.

● Anti-Mullerian hormone is relatively stable across cycles and is useful, especially with an ultrasound of the ovarian antral follicle counts. Anti-Mullerian hormone tests are not readily available on the NHS and antral follicle counts are best assessed by specialist ultrasonographers.

Basic fertility tests for men:

● Take a sample for semen analysis, even if the patient has fathered a pregnancy before. Repeat the test at least six weeks later if samples fall below the WHO criteria[2].

Any significant history – including if the woman is over 35 years old – or abnormality in the basic investigations should prompt referral. Local policy may dictate when a couple with normal investigations and a negative history should be referred. Couples who have been trying to conceive for a year, but have normal tests, can be reassured that they have a 50% chance of conceiving in the next year. It is difficult to quantify the effect of stress on conception, but having normal investigations reassures many couples.

General information

Urine ovulation predictor kits are of limited usefulness – false positive or negative results can cause unnecessary anxiety. They also tend to encourage intercourse only around the time of expected ovulation – this can be detrimental to the relationship and reduce the chance of conception, as abstinence for longer than seven days is associated with a decrease in sperm quality. Frequency of intercourse is an issue for many couples, sometimes for psychosexual reasons but often because working arrangements keep them apart. Advise couples to have intercourse at least two to three times a week (there is no maximum) throughout the cycle to optimise chances of success.

▶ **Now go to pulsetoday.co.uk/tools-and-resources to download the patient information leaflet**

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This article was produced in collaboration with The Centre for Reproductive and Genetic Health. Go to crgh.co.uk for more information.

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Further reading

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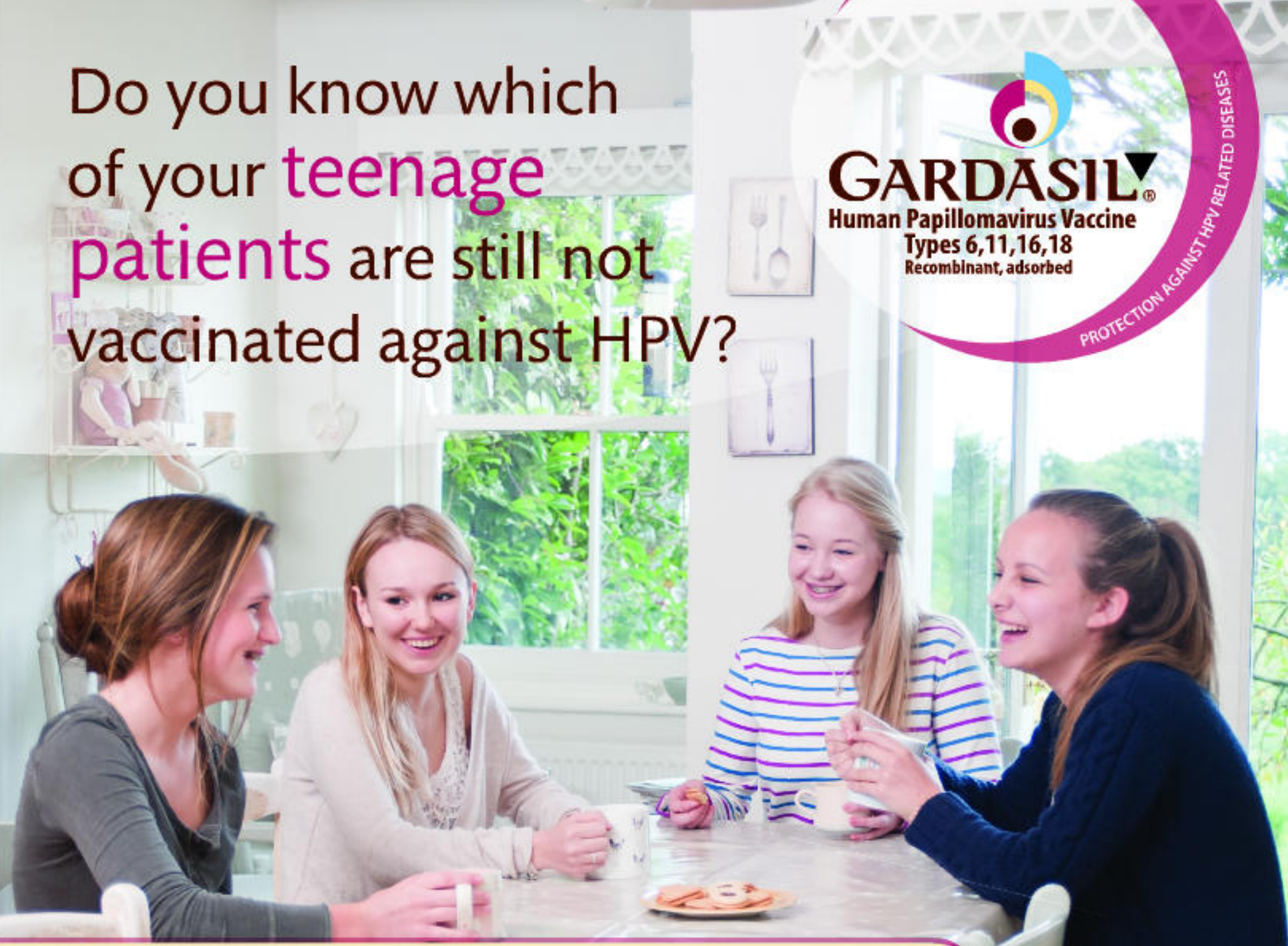

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GARDASIL® (Human Papillomavirus Vaccine [Types 6, 11, 16, 18] [Recombinant, adsorbed]).

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Presentation: Gardasil is supplied as a single dose pre-filled syringe containing 0.5 millilitre of suspension. Each dose of the quadrivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (20 µg). **Indications:** Gardasil is a vaccine for use from the age of 9 years for the prevention of premalignant genital lesions (cervical, vulvar and vaginal) and cervical cancer causally related to certain oncogenic Human Papillomavirus (HPV) types and genital warts (condyloma acuminata) causally related to specific HPV types. The indication is based on the demonstration of efficacy of Gardasil in females 16 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9- to 15-year old children and adolescents. **Dosage and administration:** The primary vaccination series consists of 3 separate 0.5 millilitre doses administered according to the following schedule: 0, 2, 6 months. If an alternate schedule is necessary the second dose 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 Gardasil. Acute severe febrile illness. **Warnings and precautions:** The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential 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 caution to individuals with thrombocytopaenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, has occurred after vaccination with Gardasil; vaccinees should be carefully observed for approximately 15 minutes after vaccination. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding 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 vaccine. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. **Undesirable effects:** Very common side effects include: headache and at the injection site, erythema, pain and swelling. Common side effects include bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Rarely urticaria and very rarely bronchospasm has been reported. Idiopathic thrombocytopaenic purpura, Guillain-Barré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single pack containing one 0.5 millilitre dose pre-filled syringe with two separate needles. **NHS cost:** £86.50 per dose. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France **Marketing authorisation number:** EU/1/06/357/007 (pre-filled syringe with two separate needles) **Legal category:** POM ® Registered trademark **Date of last review:** May 2012

References: 1. Department of Health, Third Annual Report on HPV coverage. http://immunisation.dh.gov.uk/annual-hpv-vaccine-coverage-in-england-in-201011-report/ Date accessed 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 Sanofi Pasteur MSD, telephone number 01628 785291.

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PAEDIATRIC CLINIC

Juvenile idiopathic arthritis

Paediatric rheumatologist Dr Liza McCann and colleagues on an uncommon but serious condition

THE CASE

A 15-year-old girl presents to her GP with painful joint swellings and tiredness. A history reveals she has had joint symptoms and morning stiffness for six months, and it has started to affect her daily life. On examination, she is afebrile and has multiple joint swellings involving both wrists, all proximal interphalangeal joints, and both ankles. She has low haemoglobin, high platelets and significantly raised inflammatory markers. The GP suspects juvenile idiopathic arthritis (JIA) and urgently refers her to a paediatric rheumatologist.

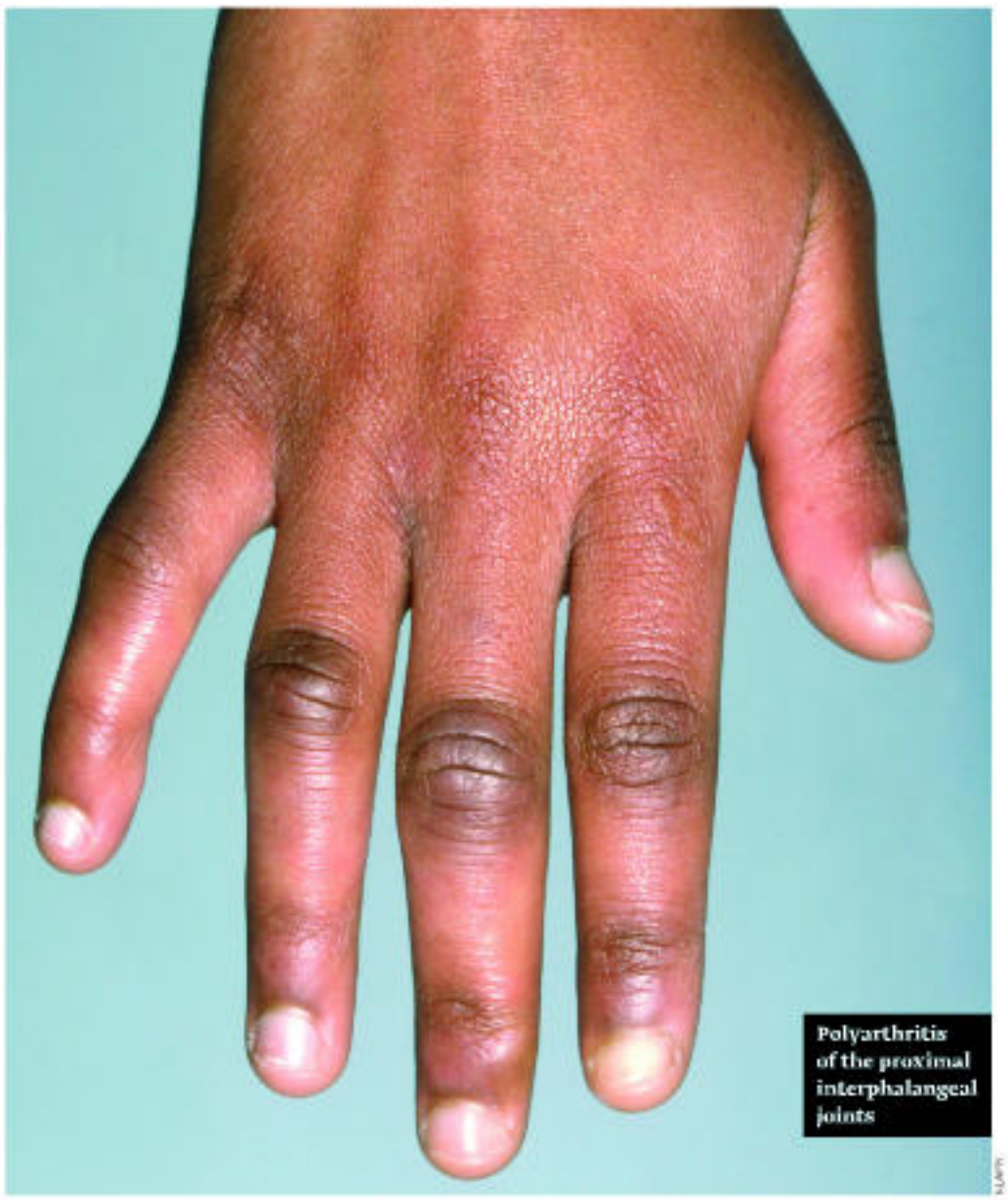
The problem

JIA is a heterogeneous group of conditions characterised by arthritis of unknown cause in children under 16 years.[1] It is the most common cause of chronic arthritis in childhood with an incidence of around one in 1,000 in the UK.[2] JIA is classified according to onset pattern:

- Oligoarthritis - four or fewer joints affected in first six months. May subsequently extend and follow a polyarthritic course.
- Polyarthritis - five or more joints affected in first six months. Subdivided by presence or absence of rheumatoid factor.
- Systemic arthritis - arthritis and quotidian fever, with at least one of:
  - evanescent rash
  - lymphadenopathy
  - serositis
  - hepatosplenomegaly.
- Psoriatic arthritis.
- Enthesitis-related arthritis - most frequent in boys and associated with HLA-B27.

Features

Often there is a history of morning stiffness with inflammatory joint pain, which improves as the day progresses. Joint pain that is worse at the end of the day is more likely to have a mechanical cause.



Polyarthritis of the proximal interphalangeal joints

Diagnosis

There are no conclusive lab tests available and diagnosis is made on clinical grounds. JIA must be considered as a diagnosis of exclusion. A careful history and examination should aim to rule out other possible causes of musculoskeletal symptoms in childhood. Differential diagnoses include infection, trauma and non-accidental injury, malignancy, connective tissue disorders and mechanical causes.

The paediatric gait, arms, legs and spine examination should be used as a screening tool. Go to pulsetoday.co.uk/tools-and-resources to view a useful guide from Arthritis Research UK. Examine all joints for pain, tenderness, swelling or restriction, noting the number and distribution of affected joints.

Perform an overall examination looking for systemic signs such as fever, lymphadenopathy, organomegaly, rashes and nail changes - this can help differentiate between JIA subtypes.

Uveitis is associated with JIA and can be sight-threatening, so all children with JIA need regular screening from an ophthalmologist.

Management

Early referral to paediatric rheumatology is essential to limit joint damage and disability. Management will be within a multidisciplinary team including specialist nurses, physiotherapists, occupational therapists, social workers, psychologists and ophthalmologists.

Pharmacological management consists of disease-modifying antirheumatic drugs, biologic agents, and intra-articular, intravenous, or oral steroids. These may make children susceptible to infections so the patient should be monitored closely.

Dr Liza McCann is a consultant paediatric rheumatologist, Dr Naomi Cable is an SHO in rheumatology, and Dr Aruna Bhat is a specialist paediatric registrar in rheumatology, at Alder Hey Children's Hospital, Liverpool.

Alder Hey is one of Europe's biggest and busiest children's hospitals providing care for over 275,000 children and young people each year. Alder Hey has a broad range of hospital and community services for direct referral from primary care. The Trust also offers more complex tertiary services - it is the designated national centre for head and face surgery and a Centre of Excellence for children with cancer, spinal and brain disease. Alder Hey has been chosen to be a national centre for heart surgery, a respiratory ECMO surgery centre and one of just four specialist centres to provide surgery for drug-resistant epilepsy. More information about Alder Hey and its services can be found at www.alderhey.nhs.uk.

References

1 Petty RE, Southwood TR, Manners P et al. International League of Associations for Rheumatology classification of juvenile idiopathic arthritis: second revision, Edmonton. *The Journal of Rheumatology* 2001;31:390-2

2 Manners PJ and Bower C. Worldwide prevalence of juvenile arthritis why does it vary so much? *The Journal of Rheumatology* 2002;29:1520-30

MORE ONLINE

Make sure you don't overlook an uncommon but serious paediatric condition. Go to pulsetoday.co.uk/clinical to view earlier articles in this series, including Meckel's diverticulm, Perthes' disease and cystic fibrosis.

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A PSA test may be performed according to national guidelines for prostate cancer detection

PRIMARY CARE UROLOGY

LUTS in men

Urologists Mr Mark Speakman and Miss Faith McMeekin discuss diagnosis and management of LUTS in primary care

Lower urinary tract symptoms (LUTS) are a major burden for the ageing male population. Bothersome LUTS can occur in up to 30% of men over 65 years old,[1] and 90% of men in their 90s have evidence of benign prostatic enlargement. This article will focus on the presenting symptoms, examination and investigation, and effective management.

Although LUTS were traditionally thought to be caused solely by an enlarged prostate, there are a number of other equally important causes (see the diagram below). The three most common urological causes are benign prostatic enlargement, overactive bladder or detrusor overactivity and nocturnal polyuria.

History

A thorough history is the most important aspect of patient assessment and should include:

- symptoms – duration, extent and most importantly impact on quality of life
- lifestyle – fluid intake and type, smoking
- medications and drugs – any current or previous medications or drugs taken
- medical history – previous pelvic surgery, trauma or neurological disorders.

When gathering information on symptoms, it is useful to establish whether symptoms are predominantly storage, voiding or post-micturition. See the table on page 37 for which category different symptoms fall under.

As well as taking a history, it is useful to ask the patient to complete a urinary frequency-volume chart – you can download a template chart from pulsetoday.co.uk/tools-and-resources. The patient should record, for a minimum of three days, time and volume of voids and include any episodes of incontinence. A urinary frequency-volume chart is the only way to diagnose nocturnal polyuria. Add up the volume of all voids overnight, including the first void of the morning, and divide this figure by the total voided volume in that 24-hour period. A figure greater than a third is diagnostic of nocturnal polyuria and a treatment such as an afternoon diuretic or desmopressin to shift the diuresis and improve the hours of undisturbed sleep can be considered.

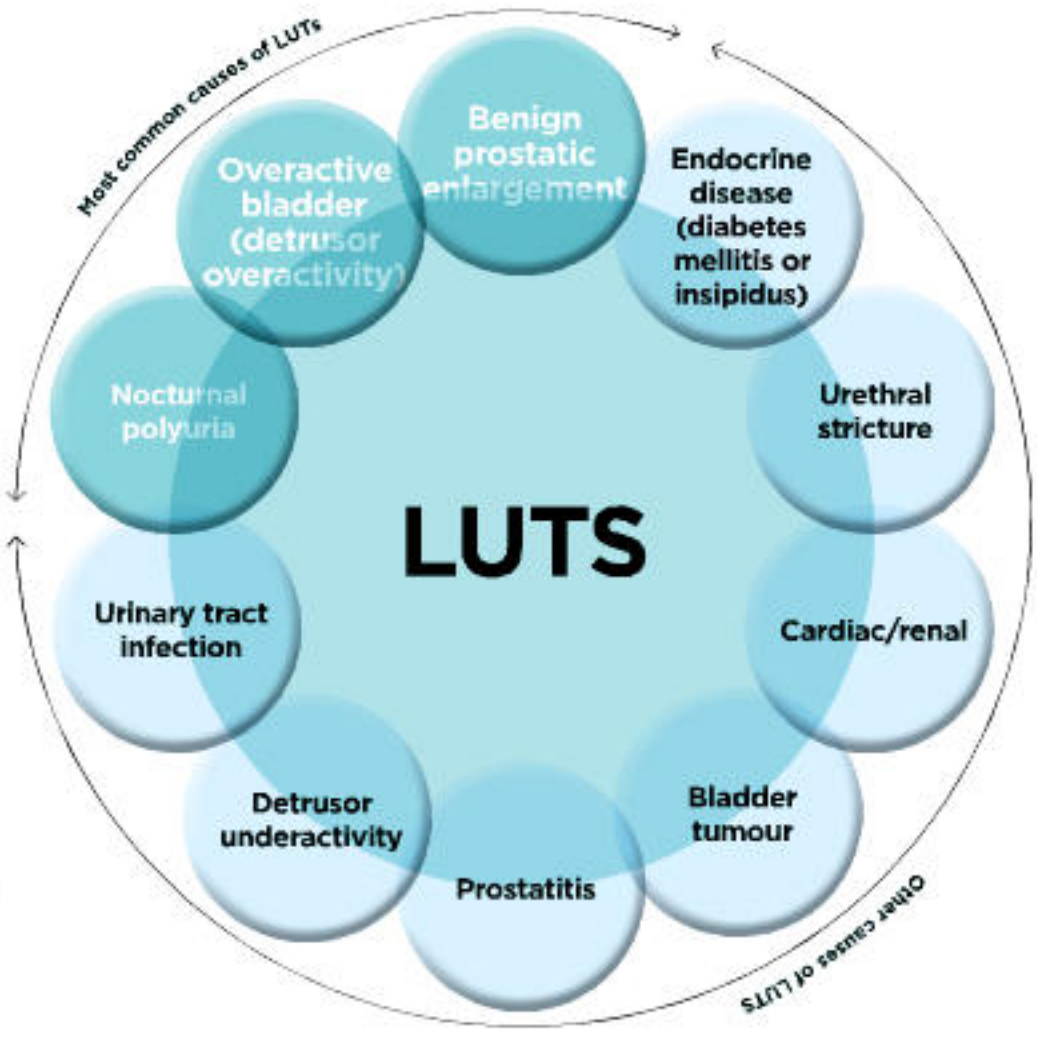
You should also do an International Prostate Scoring System (IPSS) questionnaire to classify symptoms into mild, moderate or severe LUTS, and to monitor change with time or with treatment. You can download the IPSS at pulsetoday.co.uk/tools-and-resources. This consists of seven questions based on the extent of symptoms and a single quality of life question – which is arguably the most useful.

Examination and investigation

Abdominal examination should include palpating and particularly percussing for an enlarged bladder which is indicative of chronic retention, and careful examination of the external genitalia and foreskin. Digital rectal examination is important to detect abnormalities, which could indicate prostate cancer, and to estimate prostate size and check for prostatitis. Urinanalysis should always be performed. It is a cheap and quick test to rule out infection, diabetes, proteinuria or haematuria as a causative factor in LUTS.

A PSA test may be performed according to national guidelines for prostate cancer detection, but a single PSA test may also be of value in managing LUTS in men, as men with a PSA of less than 1.4ng/ml are unlikely to have progressive LUTS or BPE and so are not likely to get retention.

Multifactorial component to LUTS[2]



Adapted from European Association of Urology guidelines [2]

Management

Conservative treatment

For many men with LUTS, the symptoms are not especially bothersome, and these men are suitable for conservative measures including education, reassurance, periodic monitoring and lifestyle advice. Often symptoms can be considerably improved by a few simple measures. You should try to identify any stimulant or irritant fluids that are being consumed, such as caffeine in coffee, fizzy drinks and tea, including green tea. Advise patients to cut out all caffeine and opt for decaffeinated drinks instead. Alcohol is also a stimulant and a diuretic and should only be drunk in moderation. A fluid intake of approximately 1.5l per day is appropriate.

If a patient has predominantly storage symptoms then guidance on bladder training and physiotherapy can be very beneficial. If the main symptom is post-micturition dribbling, techniques of urethral milking and pelvic floor physiotherapy are effective. If the predominant feature is incontinence, containment devices and referral to the local continence adviser can be useful.

Drug treatment

For men with uncomplicated but bothersome moderate to severe LUTS, where conservative management has not improved symptoms, the first-line treatment is an α-blocker. These inhibit the effect of endogenously released noradrenalin on prostatic smooth muscle cells, so reducing prostatic tone and bladder outlet obstruction. They also work on receptors outside the prostate including urinary bladder and central nervous system. Commonly used α-blockers are tamsulosin, alfuzosin and doxazosin (the latter to treat hypertension in conjunction with LUTS).

Review the patient four to six weeks

37

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Fultium-D_3 capsules: Each capsule contains colecalciferol 800 IU equivalent to 20 micrograms vitamin D_3. Also contains 124.5 mg arachis oil (peanut oil).

Indication: The prevention and treatment of vitamin D deficiency. As an adjunct to specific therapy for osteoporosis in patients with vitamin D deficiency or at risk of vitamin D insufficiency.

Dosage and administration: Vitamin D deficiency in adults and the elderly (serum levels <25nmol/l (<10ng/ml)) 1-4 capsules (800-3200IU) daily for up to 12 weeks dependent upon the severity of the disease and the patients response to treatment.

Vitamin D insufficiency in adults and the elderly (serum levels 25-50nmol/l (10-20 ng/ml) AND Long term maintenance therapy following treatment of deficiency AND Prevention of deficiency 1-2 capsules (800-1600IU) daily.

As an adjunct to specific therapy for osteoporosis 1 capsule daily.

Vitamin D deficiency or insufficiency in children over 12 years 1 capsule daily depending on the severity of the disease and the patient's response to treatment. Should only be given under medical supervision.

Fultium-D_3 should not be used by children under 12 years.

The capsules should be swallowed whole (not chewed) with water.

Contraindications: Hypersensitivity to vitamin D or any of the excipients in the product; peanut or soya allergy; hypervitaminosis D; nephrolithiasis; diseases or conditions resulting in hypercalcaemia and / or hypercalciuria; severe renal impairment.

Warnings and Precautions: Vitamin D should be used with caution in patients with impairment of renal function or sarcoidosis and the effect on calcium and phosphate levels should be monitored. In patients with severe renal insufficiency, vitamin D in the form of colecalciferol is not metabolised normally and other forms of vitamin D should be used. Close monitoring of calcium levels should be carried out under medical supervision. Caution is required in patients receiving treatment for cardiovascular disease. Consider vitamin D supplementation from other sources. Contains arachis oil (peanut oil).

Interactions: Concomitant treatment with phenytoin, barbiturates and glucocorticoids can decrease the effect of vitamin D.

Interactions have also been seen with digitalis and other glycosides, ion exchange resins, laxatives such as paraffin and cytotoxic agents.

Pregnancy and lactation: There are no or limited amounts of data for the use of Fultium-D_3 in pregnancy and lactation. Vitamin D is excreted in breast milk. It should therefore only be used under medical supervision.

Effects on ability to drive and use machines: Fultium-D_3 has no influence on the ability to drive and use machines.

Undesirable effects: Allergic reactions are possible. Uncommon disorders include metabolic and nutrition disorders; hypercalcaemia and hypercalciuria; skin and subcutaneous disorders.

Overdose: Refer to SmPC.
Legal Category: POM
Pack size: 30 capsules
NHS Price: £3.60
MA Number: 17871 / 0151

MA Holder: Jenson Pharmaceutical Services Ltd, Carradine House, 237 Regents Park Road, London N3 3LF, UK.
Full Prescribing Information available from Internis Pharmaceuticals Ltd, Carradine House, 237 Regents Park Road, London N3 3LF, UK.

Adverse events should be reported. Reporting forms and information can be found at http://yellowcard.mhra.gov.uk/ Adverse events should also be reported to Jenson on 01271 334 609.

Date of preparation: August 2012
Unique ID No: FUL-ADV-0050

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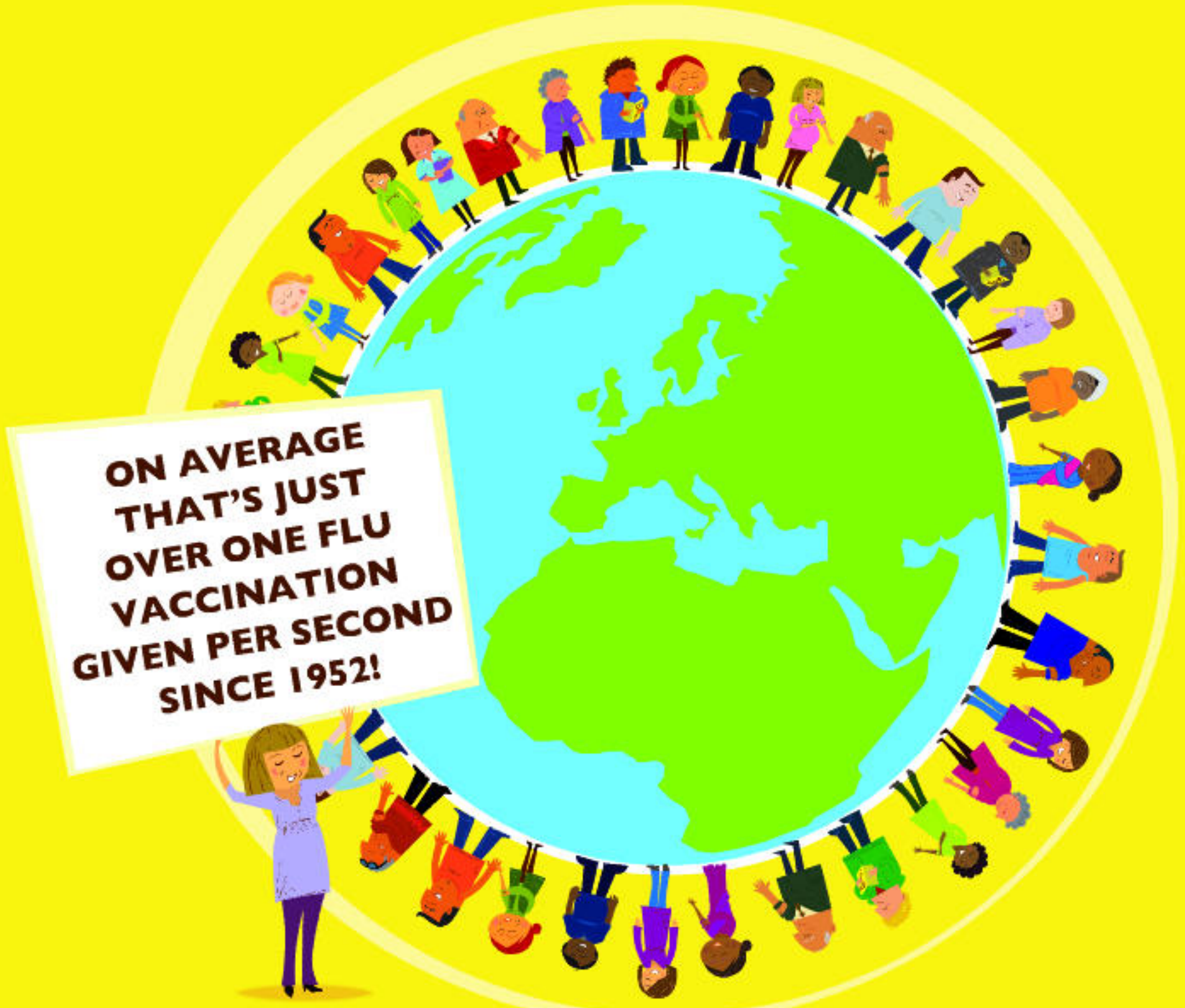

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ABRIDGED PRESCRIBING INFORMATION
Inactivated Influenza Vaccine (Split Virion) BP
Refer to Summary of Product Characteristics for full product information. **Presentation:** Inactivated Influenza Vaccine (Split Virion) BP contains 15 micrograms of antigen (per 0.5 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as single dose prefilled syringes each containing 0.5 millilitre of suspension for injection. The vaccine may contain traces of eggs, such as ovalbumin, neomycin, formaldehyde and octoxinol 9 which are used during the manufacturing process. **Indications:** Prophylaxis of influenza especially in those who run an increased risk of associated complications. Inactivated Influenza Vaccine (Split Virion) BP is indicated in adults and children from 6 months of age. **Dosage and administration:** Adults and children from 36 months should receive one 0.5 millilitre dose. In children aged 6 months to 35 months clinical data are limited and dosages of 0.25 or 0.5 millilitre have been used. Children who have not been previously vaccinated should receive a second dose of vaccine after an interval of at least 4 weeks. Doses should be administered intramuscularly or deep subcutaneously. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, neomycin, formaldehyde, and octoxinol 9. Immunisation should be postponed in patients with febrile illness or acute infection. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. **Pregnancy and lactation:** Inactivated influenza vaccines can be used in all stages of pregnancy. May be administered during lactation. **Undesirable effects:** Common side effects include: injection site reactions (redness, swelling, pain, ecchymosis, induration) and systemic reactions (fever, malaise, shivering, fatigue, headache, sweating, myalgia, arthralgia). These usually disappear within 1 to 2 days. Other serious side effects have been reported and include, allergic reactions (in rare cases leading to shock, angioedema), convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome.
For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095
Legal category: POM. Date of last review: April 2012
Reference: 1. Sanofi Pasteur MSD. Data on file 2012 UK15877

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.

UK15944 c 07/12

after initiating an α-blocker. If there has been inadequate improvement in persistent bothersome LUTS, consider dual therapy – for example if the residual symptoms are storage symptoms such as frequency and urgency, the addition of an anticholinergic drug like oxybutynin, fesoterodine, solifenacin or trospium is worth considering. If the patient has an enlarged prostate (greater than 40ml) then the addition of a 5α-reductase inhibitor, such as dutasteride or finasteride may be appropriate. This combination will reduce the risk of retention and the need for surgery by approximately 50-60%. Lack of response at this stage is an indication for secondary care referral for consideration of surgery.

Referral

Most men with LUTS can be managed in primary care, but there are a few occasions where specialist referral is required.

You should refer for cystoscopy if the patient has any of the following in their history:

- recurrent UTI or persistent sterile pyuria
- haematuria
- bladder pain in the absence of a UTI.

There are also a small group of patients who require investigation with a renal ultrasound. These include men with:

- chronic urinary retention
- haematuria
- recurrent UTI.

Also, patients with an elevated PSA – checked either at their request or after a suspicious digital rectal examination – would need referral under the two-week pathway for consideration of prostate biopsy.

Mr Mark Speakman is a consultant urologist and Miss Faith McMeekin is an STS urology registrar at Taunton and Somerset NHS Foundation Trust Hospital

References

1 NICE The Management of lower urinary tract symptoms in men. National Institute for Health and Clinical Excellence CG97. May 2010.
2 Oelke M, Bachmann A, Descazeaud A et al. European Association of Urology Guideline on Male LUTS Update February 2012. tinyurl.com/LUTSguideline. Accessed 8 October 2012.

MORE ONLINE
Go to pulse-learning.co.uk to view previous articles in this series on haematuria and testicular swellings and pain. Earn 1 CPD credit for answering assessment questions.

▶To come in this series penile conditions, ureteric colic and recurrent UTIs.

LUTS categories

Storage symptoms	Voiding symptoms	Post-micturition symptoms
Altered bladder sensation	Hesitancy	Sensation of incomplete emptying
Increased daytime frequency	Intermittency	Post-micturition dribble
Nocturia	Slow stream	
Urgency	Splitting or spraying	
Urinary incontinence	Terminal dribble	

TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

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

Key

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

C = See Yellow fever, next column

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

Vaccinations information

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

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

Yellow fever
● An international certificate of vaccination may be required for those entering from, or transiting through airports in YF endemic countries where **C**, **S**, **R** or **M** appears indicated in the yellow fever column. For details consult: http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-3-infectious-diseases-related-to-travel/yellow-fever-and-malaria-information-by-country.htm#seldyfm298

● **M** = Mandatory generally indicates that all travellers aged >12 months should carry an international certificate of vaccination. Country specific ages are indicated in the web site above.

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

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

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

Parasitic infections

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

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

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

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

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

Travel medicine update

Polio
Polio is resurgent in Nigeria, which has already reported more cases than the 62 in 2011. By late August, new wild-type virus cases, including both serotype 1 and 3, totalled 77 in 2012. Immunisation mop-up days will be held in late September and the possibility of conducting immunisation campaigns in Niger across the border from Katsina State is being explored. Transmission continues in Afghanistan, with a total of 17 cases in 2012. The World Health Organization goal of global polio eradication remains frustratingly elusive, although no cases have been reported from India this year and early indications are that the global number of cases in 2012 will be less than the 650 in 2011.

West Nile virus (WNV)
WNV has been causing problems in Europe and North America. Forty-three states in the US have reported infections, with a total of 693 human cases in 2012 including 26 deaths and 59% classified as neuro-invasive. This is the highest number of infections reported to the Centers for Disease Control and Prevention since WNV was first detected in the US in 1999. Southern states have been hit hardest and almost half the cases are from Texas.

Canada has also seen an increase in WNV, with 49 cases in Ontario, of which 60% occurred in Toronto. Smaller numbers have been reported from neighbouring provinces.

A total of 57 cases have been reported in Greece, four from Romania, and 127 with four deaths in the Russian Federation.

WNV is transmitted by daytime biting Culex mosquitoes. Most infections are asymptomatic and severe infection is rare, so reported cases represent the tip of the iceberg. WNV is rarely reported in travellers and the risk is greatest in those undertaking outdoor activities, who should take particular precautions to prevent mosquito bites during summer months. A vaccine is needed to halt human cases because the bird reservoir will remain.

Source
travax.nhs.uk
polioeradication.org/Dataandmonitoring/Poliothisweek.aspx

Specialist advice

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

PULSE

Updated: September 2012

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningitis/ACWY	Japanese enceph	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Lebanon	S	R			S		S	S	C				No			Le
Lesotho	R	R	S		S	S	S	S	C				No			Sh
Liberia	R	R	S	R	S	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Libya	S	R			S	S	S	S	C				No risk			Le
Liechtenstein		S					S					S	No			
Lithuania		S				S	S	S				S	No			
Macedonia		R					S	S				S	No			Le
Madagascar	R	R			S	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh
Madeira		S					S						No			
Malawi	R	R	S			S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Malaysia	R	R	S		S	S	S	S	C		S		Yes, high risk Sabah and deep forests of peninsular Malaysia	ME or DO or MON	PC	
Maldives	R	R				S	S	S	C				No			
Mali	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Ta
Malta and Gozo		S					S		C				No			Le
Martinique		S				S	S		C				No			Sh
Mauritania	R	R	S	R	R	S	S	S	R	S			Yes, high risk all year in south Low risk in far north	ME or DO or MON	PC	Sh Le
Mauritius		R					S		C				No	W		
Mayotte	R	R				S	S	S	C				Yes, high risk	ME or DO or MON	PC	Le
Mexico	R	R					S	S					Yes, southern rural areas only Elsewhere and tourist areas	C W	P	Tc
Moldova	S	R			S	S	S	S				S	No			
Mongolia	S	R				S	S	S				S	No			
Montenegro		R				S	S	S				S	No			Le
Montserrat		S					S		C				No			
Morocco	R	R				S	S	S					No	W		Le
Mozambique	R	R	S		R	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Myanmar (Burma)	R	R	S		R	S	S	S	C		S		Yes, Kayin and East Shan state Yes, elsewhere Low/no risk Mandalay & Rangoon	DO or MON ME or DO or MON W	PC PC	
Namibia	R	R	S		S	S	S	S	C				Yes, NE third only Elsewhere low risk	ME or DO or MON W	PC	Sh
Nepal	R	R	S	R	R	S	S	S	C		S		Yes, below 1,500m (no risk in Kathmandu)	PC	DRF	Le
Neth Antilles		S					S		C				No			
Netherlands													No			
New Caledonia	S	R					S		C				No			
New Zealand													No			
Nicaragua	R	R				S	S	S	C				Yes, variable risk in north, low risk in south	C	P	Le Tc
Niger	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Nigeria	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Norway		S										S	No			
Oman	S	R					S	S	C				Sporadic imported risk	W		Sh Le
Pakistan	R	R	S	R	R	S	S	S	C		S		Yes, significant below 2,000m	ME or DO or MON	PC	PC
Panama	R	R			S	S	S	S	R				Yes, high risk NE coast & Colombia border Variable risk east & west of Canal	ME or DO or MON C	PC P	
Papua New Guinea	R	R	S		R	S	S	S	C		S		Yes, high risk below 1,800m	ME or DO or MON	PC	
Paraguay	R	R			S	S	S	S	R				Yes, extreme eastern areas, Oct-May	C	P	Le Tc
Peru	R	R				S	S	S	R				Yes, high risk in Amazonian Loreto Dept. Variable risk SE area bordering Brazil & Bolivia, and around Tumbes & Piura	ME or DO or MON C	PC P	Le Tc
Philippines	R	R	S		S	S	S	S	C		S		Yes, many rural areas below 600m No risk – Cebu, Bohol, Catanduanes	PC W	DRF	Sh
Poland		S					S	S				S	No			
Portugal		S					S						No			
Puerto Rico		R			S		S	S					No			Sh Le
Qatar	S	R				S	S	S					No			Le
Reunion		R				S	S		C				No			Sh
Romania	S	R				S	S	S				S	No			
Russian Federation	S	R			S	S	S	S	C		S	S	No			
Rwanda	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Sabah	R	R	S		S	S	S	S	C		S		Yes, high risk inland Low risk coastal area and Kota Kinabalu	ME or DO or MON W	PC	

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningitis/ACWY	Japanese enceph	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Samoa	S	R			S		S	S	C				No			
Sao Tome	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Le
Saudi Arabia	S	R			R		S	S	C	S M			Yes, SW region, rural areas of W region Elsewhere (no risk Mecca, Medina)	ME or DO or MON W	PC	Sh Le
Senegal	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Serbia		R				S	S	S				S	No			Le
Seychelles	S	R				S	S		C				No			
Sierra Leone	R	R	S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Singapore		S					S		C		S		No			
Slovakia		S					S	S				S	No			
Slovenia		S					S	S				S	No			
Solomon Islands	R	R			S	S	S		C				Yes, high risk	ME or DO or MON	PC	
Somalia	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Le
South Africa	S	R	S		S	S	S	S	C				Yes, NE rim bordering Zimbabwe, Mozambique & Eastern Swaziland, including Kruger, Kosi Bay & [illegible]	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			Le
Sri Lanka	R	R				S	S	S	C		S		Yes, far north and NE, north of Anuradhapura & Polonnaruwa Elsewhere	PC W	ME, DO DRF	
St Helena & Ascension		S							C				No			
St Kitts & Nevis		S					S		C				No			
St Lucia		S					S		C				No			
St Vincent & Grenadines		S					S		C				No			
Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
South Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
Surinam	S	R			S	S	S	S	R				Yes (except Paramaribo and coast)	ME or DO or MON	PC	Sh Le
Swaziland	R	R	S		S	S	S	S	C				Yes, high risk, eastern areas	ME or DO or MON	PC	Sh
Sweden		S										S	No			
Switzerland		S										S	No			
Syria	S	R			S		S	S	C				No			Sh Le
Taiwan		R				S	S				S		No			
Tajikistan	R	R	S			S	S	S				S	Yes, Jun-Oct variable on NW & SW borders	PC	ME, DO or MON	
Tanzania	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Ta
Thailand	S	R	S		S	S	S	S	C		S		Yes, on extreme fringe of international borders Elsewhere	DO or MON W		
Tibet	S	R	S	R	R	S	S	S	C		S		No			
Tobago		S			S		S	S	C				No			Tc
Togo	R	R	S		S	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Trinidad		S			S		S	S	R				No			Tc
Tunisia	R	R					S	S	C				No			Le
Turkey	S	R					S	S					Yes, Syria border May-Oct Elsewhere	C W	P	Le
Turkmenistan		R			S	S	S	S				S	No			
Uganda	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Ukraine	S	R			R	S	S	S				S	No			
United Arab Emirates	S	R			S		S	S					No			Le
Uruguay		R					S	S	C				No			Tc
USA													No			
Uzbekistan	S	R				S	S	S				S	Yes, very low risk extreme SE	W		Le
Vanuatu	S	R			S	S	S						Yes, high risk	ME or DO or MON	PC	
Venezuela	S	R			S		S	S	R				Yes, high risk to south of Orinoco River Variable/low risk north of Orinoco No risk Caracas or Margarita	ME or DO or MON C W	PC P	LE Tc
Vietnam	R	R	S		S	S	S	S	C		S		Low risk in cities, coast between Ho Chi Minh & Hanoi, Mekong Delta Elsewhere	W ME or DO or MON	PC	
Virgin Islands		S					S						No			
West Papua (formerly Irian Jaya)	R	R			R	S	S	S	C		S		Yes, high risk below 1800m	ME or DO or MON	PC	Sh Ta
Yemen	R	R	S		R	S	S	S	C				Yes, but no risk in Sana'a city	PC	DRF	Sh Le
Zambia	R	R	S		S	S	S	S	S				Yes, high risk	ME or DO or MON	PC	Sh Ta
Zimbabwe	R	R	S		S	S	S	S	C				Yes, high risk Zambezi valley Yes, elsewhere below 1,200m Nov-Jun Negligible risk Harare and Bulawayo	ME or DO or MON ME or DO or MON W	PC PC	Sh Ta

Key to malaria prophylaxis regimens

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

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

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

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

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

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

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

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

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

Children's doses of antimalarial prophylactics

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

Doxycycline only above 12 years and the adult dose is given

Children's doses

Paediatric malarone for prophylaxis

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

Specialist advice

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

TIP OF THE MONTH

Hajj 2012

This year, the Hajj is expected to fall between 24 and 29 October. The World Health Organization has published the Ministry of Health of Saudi Arabia requirements for entry visas for the Hajj in 2012. A full report can be accessed in the WHO weekly epidemiological record (see URL below).

Meningococcal meningitis
Adults and children under two years must have a vaccine certificate for the meningococcal ACWY vaccine issued not more than three years and not less than 10 days prior to arrival in Saudi Arabia. For UK travellers, proof of vaccination is a visa requirement.

Yellow fever
All travellers arriving from countries known to be infected with yellow fever must carry a valid certificate. Otherwise the traveller will be vaccinated and placed under surveillance for six days or from the last date of exposure.

Polio
The recommendations are complex, but the implications are that all travellers from the UK should ensure they are up to date with the recommended combined polio/tetanus/diphtheria vaccine. A booster should be given if it is more than 10 years since the last dose.

Seasonal influenza
Recommended for Hajj attenders, especially those at increased risk.

Measles and rubella
These viral infections are resurgent. Travellers should be immune, either by previous vaccination (two doses of MMR) or natural measles infection.

Sources
travax.nhs.uk
who.int/wer/2012/wer8730/en/index.html

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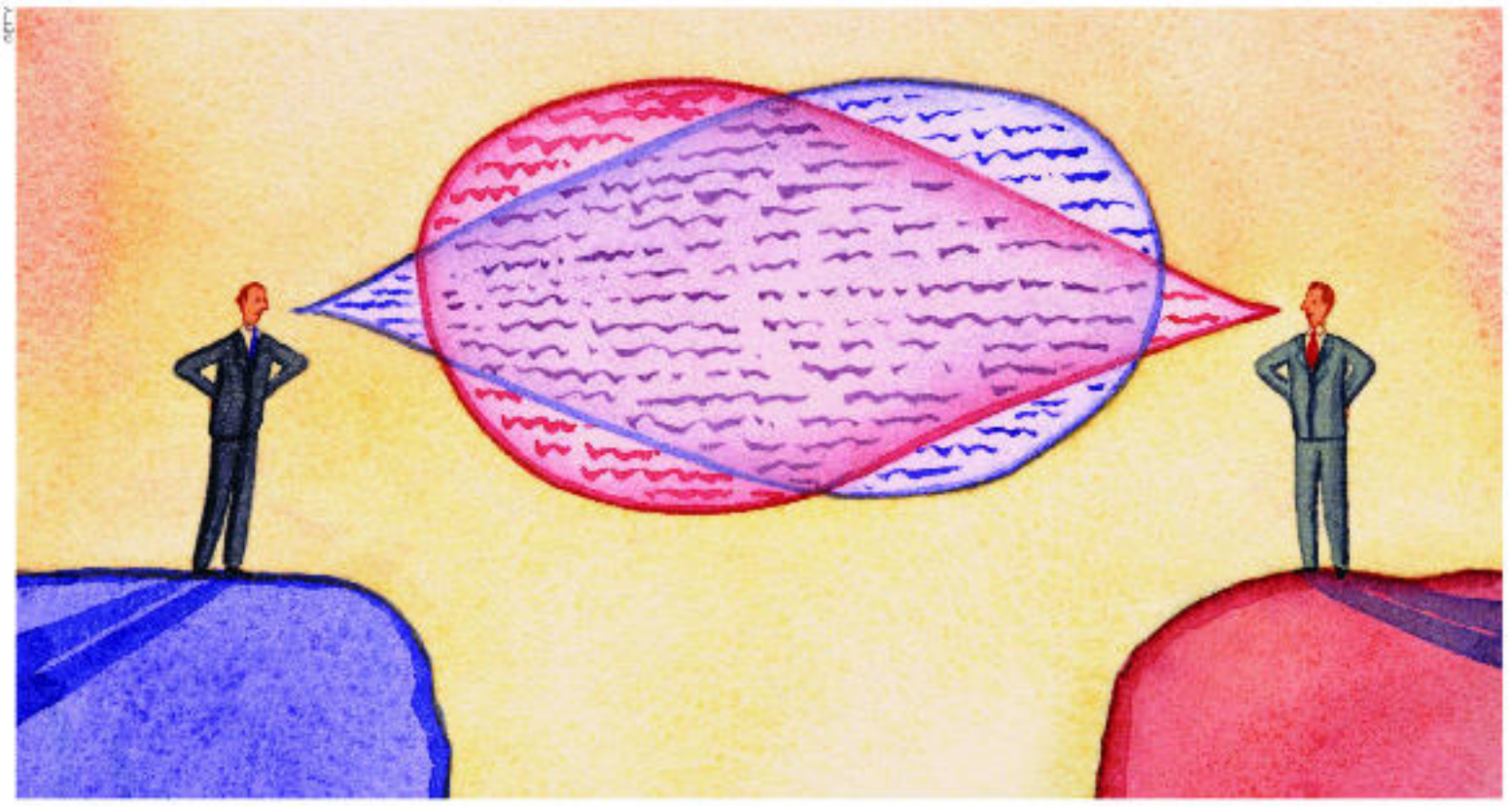
Five-Minute Digest: Procurement guidance
Rebecca Thornley explains how the latest documents will affect service provision



Five steps to mediating a practice dispute

Dr Stephen Bassett offers a quick guide to negotiating staff or partnership conflicts

As GPs, we pride ourselves on our ability to manage uncertainty, tolerate ambiguity, and think creatively. In so doing, we provide a risk sump without which the NHS would have already collapsed. The same strengths are also the keys to achieving conflict control, but because we are not always effective or efficient at translating and transferring skills from our clinical practice to other domains in life, we often need some pointers on applying existing knowledge, skills and attitudes to common GP conflicts.

In my experience both as a partner and a sessional GP, the common conflicts are:

- between partners
- partners and sessional doctors
- partners and administrative staff
- situations where a GP supports a colleague, for example a practice nurse or receptionist, in a patient-initiated complaint.

Think of how we negotiate a patient's attendance at surgery instead of a home visit, agree a delayed script, break bad news, arrange a Do Not Attempt CPR document, establish rapport with heartsinks, explain cardiovascular risk or counsel on PSA screening, all of which are complex communications and negotiations.

Doctors don't like conflict and we are not trained to deal with it. Patients want the caring cavalry, simultaneously empathetic and omnipotent, and this can train us to behave similarly outside of our medical work.

The approach I take to conflict control uses techniques that fall under the large, slightly flower power-patterned umbrella of alternative dispute resolution (ADR). ADR is potentially faster, cheaper and better than litigation for most disputes – and the judiciary is keen on it.

Before thinking about resolving a dispute, ask yourself if you're actually in one. If not, it's always worth considering just walking away or apologising. Compromise, apology and forgiveness are options. The evidence suggests apologies for medical mistakes reduce litigation, and unequivocally shows that an apology almost always reduces stress. It is now clear that an apology is not an admission of liability.[1]

Here are five steps to mediating a dispute. At all stages reflect, review, reframe, regroup and reconsider.

1 Cool off

As GPs we are used to using 'watchful waiting' or 'optimistic observation' with self-limiting clinical problems, where, for example in the management of uncomplicated fever in children, the evidence increasingly favours therapeutic minimalism and the doctor as drug. Such masterful inactivity can be deployed with potential or actual disputes.

In my ADR training sessions, I encourage out-of-hours doctors to give patients an hour to telephone family and friends to arrange transport to an out-of-hours centre, rather than feeling forced to agree or decline a visit request under pressure. This allows time for reflection and cooling off, avoids later confrontation or complaint, and often solves the transport problem.

When we enter emotionally charged conversations, such as encounters with demanding or heartsink patients, the most creative and flexible bits of our brains are at risk of disengaging. Recent psychology recasts this classic fright-flight-fight response as flight-fight-freeze-and-appease. Take time to cool off from reactive situations.

2 Gather information

After collecting your thoughts, gather and organise the evidence you need. Be dispassionate and avoid 'blaming, naming and claiming'.

Instead try taming the information – organising any papers chronologically and adding reference documents such as model contracts, partnership agreements, invoices and receipts – and framing it

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by charting a timeline of events. Again, under stress, it's reassuring to have information readily to hand and a structure to your narrative of events.

Clarify what the dispute is about. Mediators probe clients to find out what drives a dispute. GPs will be familiar with the Johari window and 'unknown unknowns'. Reflect on potential personality clashes. Productive negotiation is not horse-trading or haggling – termed positional bargaining – but finding out how to create as many options and outcomes as possible and then how to allocate these to the maximum satisfaction of all the parties.

What do you really want? Run SWOT and Johari analyses to look for hidden options and opportunities that advance your real priorities.

For example, instead of a partner negotiating dropping a session, he may wish to negotiate working from home for a session, where he could remotely deal with paperwork and administration. In return for more time for CCG involvement, part of realising managerial aspirations and potential, a salaried GP could take a lead on significant event audits, and tick a revalidation box at the same time.

Know what your ideal outcome would look like. Mediators use the technique of the 'yes' question: design a question which leads to a guaranteed affirmative answer, such as: 'Would you like to see this dispute over if an agreement could be reached?'.

Assess the relative strengths of your case and the other party's case. Use an easily available risk-analysis matrix to categorise your dispute as 'easy' or 'hard' – if it's too hard for you to deal with in the practice, seek help from a third party such as another partner or practice manager, someone at the LMC or a lawyer.

Remember this is an iterative process, like an audit spiral, and you will need to reframe and reconsider as new information becomes available, sometimes only after meeting the other party. All this reflection makes great material for your revalidation folder, and you might actually learn some surprising things about yourself.

3 Hold face-to-face meetings

Non-trivial partnership and staffing disputes can't be dealt with by letter, email or text. We recognise that face-to-face encounters are the most productive in clinical practice, because they provide crucial non-verbal as well as verbal data.

The same applies to negotiations. Get the practical details right, eliminating as many collateral sources of stress as possible. Emotionally charged meetings should be held in neutral territory to constrain mammalian territorial responses.

The most creative and flexible bits of our brain are at risk of disengaging

Arrange a neutral space, for example at LMC or CCG offices. Postgraduate centres such as deaneries may help, and many local community organisations have lists of spaces available for conflict resolution.

If a neutral chairperson is available, use one. LMCs and PCOs can help here and even if a conflict of interest prevents their direct involvement, they often have a list of third party providers.

4 Reach an agreement

Make sure that the person with whom you are dealing has the authority to settle the dispute. Mediations and negotiations often fail just when an agreement is about to be reached because one party has to confirm the agreement with a superior. In an employment dispute, for example, the practice manager may need to refer back decisions to the partners, in which case, a partner needs to be in the room.

One of the most valuable lessons I have learnt is that the idea of 'having one's day in court' is a dangerous fantasy. In negotiation or mediation, the parties are in control. Once litigation begins, you cede that control to lawyers.

If you end up in court, giving evidence is a highly structured process – structured by others – and rarely allows you to get your point across. Cross-examination can be devastatingly disempowering. You will have so much more ownership of an agreement reached through ADR.

One of the strengths of a mediator is their ability to provide reality testing by being a devil's advocate; the iterative questioning of the parties, separately and privately in what are called caucuses, helps them realise their mutual interests.

There is a DIY approach to this, developed from Gestalt therapy. Arrange two facing chairs, sit in one, imagine the other party's best arguments against your case, and deliver them aloud. Physically swap chairs and defend your position.

This exposes your weaknesses and allows you time and space free of face-to-face stress to strengthen your position. (If you do this in a public building, do draw the blinds!)

5 Review implementation

Without good implementation of the agreement, not only will little be achieved but the seeds of a new conflict will germinate. Draw up an action plan for parties involved in the conflict and create tasks, making sure each one is specific, measurable, attainable, relevant and timely. Set a timescale and meet to review task outcomes. Unlike conflicts with patients, against the costs of which you are indemnified by your medical defence body, in a non-clinical partnership or employment dispute, it's your money, or more likely the bank's, with your house as security.

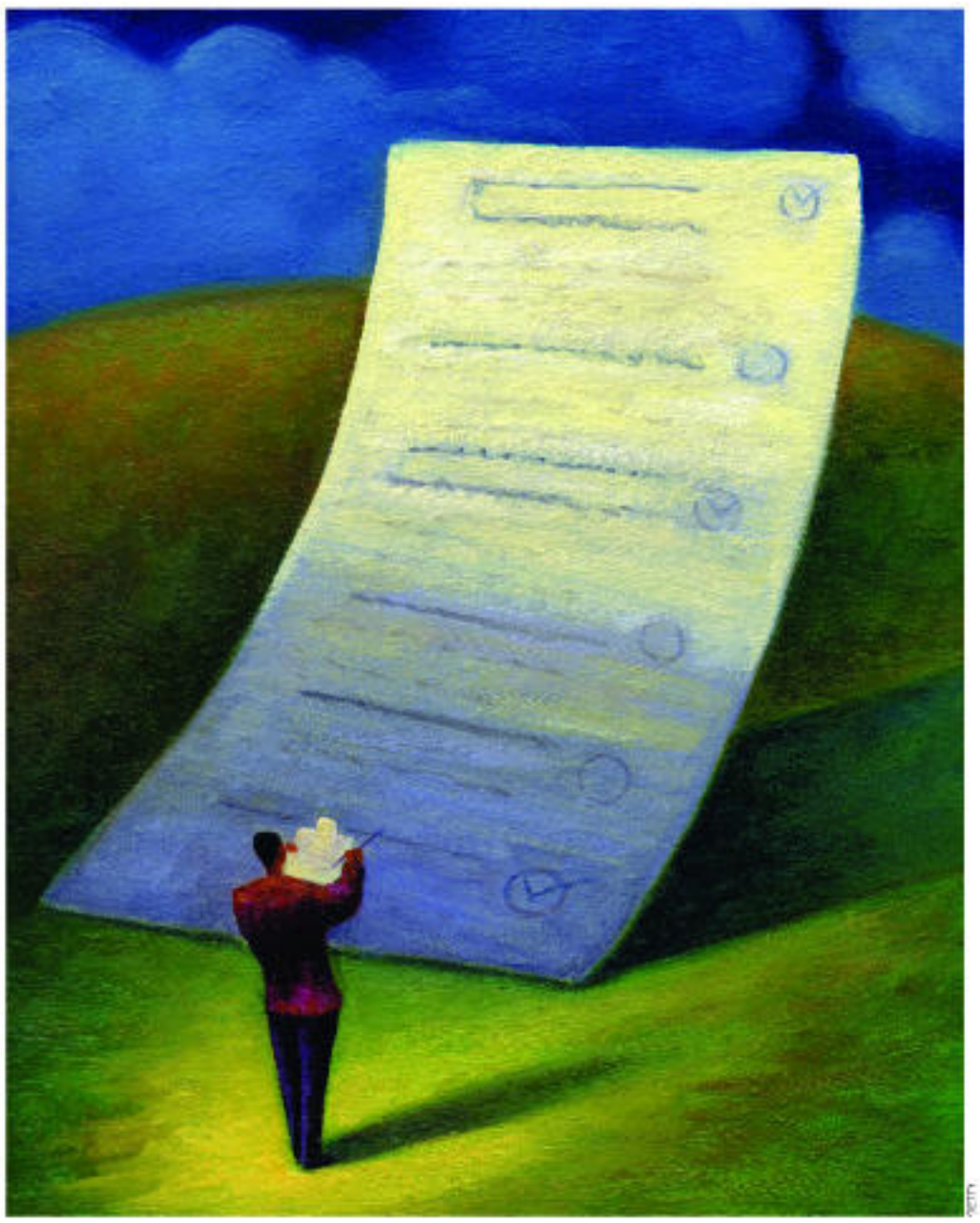
Dr Stephen Bassett is deputy chair of the BMA's sessional GP subcommittee and a GP in Swansea. He is a former GP partner.

References

1 Section2 Compensation Act 2006 (c.28) stipulates that, in the event of an accident, an apology or offer of redress is not, of itself an admission of liability – a view fully endorsed by medical defence organisations.

A legal guide to commissioning new services

Lawyer **Jonathan Hayden** offers a simple step-by-step guide to the commissioning and decommissioning process



THE AUTHORISATION PROCESS may be the main focus for many CCGs at present, but service reform is an exciting prospect for GP commissioners, and possibly a way to help meet the financial challenges ahead.

Here are four key legal steps for GPs to take when looking to decommission an existing service and commission a replacement.

1 Evaluate existing terms

The first step for a CCG will be to review the current service and the terms on which the existing provider is engaged.

In most cases, terms and conditions applicable to any clinical services should be those of the NHS standard contract (explored in more detail below). But a different form of contract may have been used, or the provider may be engaged on an oral contract.

In the latter case, applicable terms and conditions may be unclear, but where there is a written contract, it should be fairly easy to determine the CCG's rights.

The contract should specify its duration and any early termination rights. There should be rights to terminate in the event of default (and other events) and there will often be a right to terminate simply on notice at any time. That notice period may be quite long (12 months in the case of the current NHS standard contract, although contracts based on that version of the standard contract may have an expiry date of 31 March 2013).

Of course, the service being considered for decommissioning may be one of several covered by a single contract, and the CCG may be looking to partially terminate or vary the contract to remove just the one unwanted service. If the contract does not allow the CCG to do that unilaterally, it will need to be the subject of negotiation.

2 Assess needs and involve service users

CCGs will be expected to determine what their population needs and wants. Of course, one of the aims of clinical commissioning is the involvement of knowledgeable local GPs in commissioning decisions, but there are also a number of important documents you should look at before making decisions.

When considering new services the CCG should consult the joint needs assessment and joint health and wellbeing strategy prepared with the local authority. CCGs must also consider whether they have a legal duty to involve service users.

PCTs were under a duty to involve service users when considering certain service reforms and CCGs will have a similar duty (contained in section 14Z2 of the NHS Act 2006 – see the online version of this article).

The CCG is not required under this provision to involve the public on every change, but it must involve service users when developing or considering proposals (or making decisions) which would have an impact on the range of services available or the manner in which services are delivered.

It is worth noting that, when assessing the impact on 'delivery', it is the point at which the services are received that is relevant, rather than any change in delivery behind the scenes. So if a supplier changes the way it delivers a service (for example, by relocating a call centre), that change may not trigger the need to involve patients so long as the service is essentially unchanged from the patient's perspective.

Each CCG will also need to check its constitution as that must include a description of its involvement arrangements and a 'statement of the principles which it will follow in implementing those arrangements'.

If a CCG needs to involve service users in a proposal or decision it must consider the available options. Those options are beyond the scope of this article, but it is worth noting that the extract from the aforementioned NHS Act 2006 refers to service users being 'involved (whether by being consulted or provided with information or in other ways)'.

There was detailed guidance available to PCTs about the ways in which they should discharge their duty,[1] and the NHS Commissioning Board will no doubt publish similarly helpful guidance in due course. Before making any decisions, GP commissioners should consult this guidance.

The CCG is not required to involve the public on every service change

In addition to the duty to involve relevant service users, the CCG is also likely to have to undertake a more formal consultation exercise where a substantial development/variation is proposed.

3 Select a new provider

The NHS Commissioning Board released some useful guidance last month that outlines the procurement options available to CCGs, including the situations in which Any Qualified Provider (AQP) may be appropriate.[2] It also provides a useful summary of the relevant legal and policy requirements, some of which are outlined below.

For the purposes of this article we assume the CCG is looking to appoint a single provider, rather than go down the AQP route.

When determining the process it should follow, the CCG must consider the legal requirements (EU and domestic) and the requirements established through guidance and policy.

There is a financial limit of roughly £174,000 (which, broadly speaking, relates to aggregate payments under the contract) before the procurement legislation applies, but it will apply to most healthcare contracts.

Usefully, healthcare services currently fall within a category of services not subject to the full rigour of the procurement rules. However, where the contract could attract cross-border interest from overseas providers, some general principles (equal treatment, non-discrimination, mutual recognition, proportionality and transparency) will also apply.

For some contracts, the CCG will be legally required to undertake some kind of procurement process. It is worth noting that the advice here may change as the European Commission is currently negotiating a new procurement directive due to be implemented into UK law by June 2014.

Existing guidance documents (the *Principles and Rules for Co-operation and Competition*[3] and the *Procurement Guide for Commissioners of NHS-funded Services*[4]) also impose various requirements on commissioners, including that all healthcare contracts over £100,000 be advertised on the NHS Supply2health website.

4 Award the contract

When commissioning healthcare services, the CCG will usually be required to use the NHS standard contract (available from the Department of Health website).

That contract has evolved gradually over the past eight years since the creation of foundation trusts. Initially it was just a model document for acute services, but models for other services were subsequently introduced and there is now a single document covering most healthcare services (other than primary care).

That document is now a 'standard' rather than 'model' contract. Consequently, there are constraints upon how the contract can be tailored. A traffic light approach has been adopted showing where text is not mandatory but can be included (green), is mandatory but can be tailored locally (amber), or is mandatory and cannot be amended (red). The core legal terms are in one of the red sections and cannot be amended.

In recent years a new version of the standard contract has been released just before Christmas each year (for use from the following April). A new standard contract is expected to be released in the coming months for use during the 2013/14 financial year.

Jonathan Hayden is a partner in the commercial health team at national law firm Browne Jacobson LLP

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3 Department of Health. Principles and rules for cooperation and competition. 30 July 2010. tinyurl.com/DHcooperation
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- Excellent, friendly and progressive practice team

Salary negotiable. 6 weeks annual leave plus one week study leave pro rata

Start date January 2013

Please apply in writing with full CV to: Miss Lesley Hynds, Denton Medical Practice, 100 Ashton Road, Denton, Manchester, M34 3JE. Tel: 0161 337 4425.

E-mail: Lesley.hynds@nhs.net

Informal enquiries welcome
Closing date for applications: 12th November 2012

DRS N & S K NAGPAL
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SALARY:	Negotiable
HOURS:	9 sessions per week
RESPONSIBLE TO:	Lead GP

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Practice Manager Vacancy

Dr Curry & Partners, Faversham. Kent.

We are seeking to recruit an enthusiastic & motivated person to join our team due to retirement of our current manager. We are a friendly GMS practice serving a population of 6200. There are 4 GP Partners, Practice nurse & HCA. We are expecting the prospective candidate to start in March 2013. Good I.T. & organisational skills essential. Previous NHS experience is preferable but not essential.

For further information please contact:
Mrs Lin Heathfield, Assistant Practice Manager
Dr Curry & Partners, 1 Bank Street, Faversham, ME13 8PR
Tel 01795 562004 Email: lheathfield@nhs.net
Practice Website: www.drcurryandpartners.nhs.uk

Closing date: 23rd Nov 12

BEDFORD
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Please contact: Sam Paul, Practice Manager, Putnoe Medical Centre.
Tel: 01234 319990, email: sam.paul@nhs.net

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10 partner suburban Vanguard practice run from new purpose built premises.

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Please write with cv and other supporting information to David Dunlop, Firsway Health Centre, 121 Firsway, Sale, Cheshire, M334BR. Email d.dunlop@nhs.net – tel. 0161 9050312

Closing date: Nov 23rd

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- **No OOH commitment**

Please apply in writing with CV to:
Mrs Maria Malkin
Health Centre Manager
Leek Health Centre
Fountain Street
Leek
Staffordshire
ST13 6JB
Tel 01538 398658

Closing date: Friday 9th November 2012

SALARIED GP with a view to PARTNERSHIP
FAVERSHAM, KENT

Due to retirement of our Senior Partner we are looking for a Part Time or Full Time GP (6 or 8 sessions) to join our forward looking, enthusiastic team from July 2013.

We are a long-established GMS practice of 4 partners (3 wte) in a pleasant semi-rural historic market town, working from a purpose built Health Centre. We have a list size of 6,200 with high QOF achievements.

If you would like to enjoy working in a friendly and committed environment, find out more by contacting:

Ann Richardson, Practice Manager, Dr Curry & Partners, Faversham Health Centre, Bank Street, Faversham, Kent ME13 8PR.

Tel: 01795 562004, Email: annrichardson@nhs.net

Practice Website: www.drcurryandpartners.nhs.uk

Interviews will be held in Dec 2012-Jan 2013 period

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Up to 3 sessions a week
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At Bevan House we provide sensitive and responsive Primary Care services for people who are homeless, asylum seekers, refugees and hard to reach groups.

If you want to find out more about this innovative and successful service, we would love to hear from you. Please contact our Practice Business Manager, Lisa Jones-Tinsley on 01274 323764 or by e-mail at: lisa.jones-tinsley@bradford.nhs.uk

Closing date for applications is 12.00 Monday 12th November 2012.

SALARIED GP
Due to the retirement of a partner, a vacancy has arisen at Park Medical Practice, St. Anne's on Sea, Lancashire.

We are looking for an enthusiastic GP to join our busy, friendly practice. Initially 4 sessions per week with a view to increasing to full time and eventual partnership.

- List size 6,100
- High QOF achievers
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- Long established training practice
- Modern purpose build premises
- GMS practice
- Clinical support team includes Practices Nurses and Health Care Assistant
- Happy and enthusiastic admin team

Please send CV and covering letter to Practice Manager, Park Medical Practice, St. Anne's Health Centre, Durham Avenue, St. Anne's on Sea. FY8 2EP. Closing date: 9th November 2012

Salaried GP required with view to partnership

I am a single handed PMS GP looking for a replacement for my current salaried GP at 4 to 5 sessions per week, with a view to a full time partnership.

The practice is looking for an enthusiastic GP to join our small, friendly team. The practice currently has 2,679 patients and is fully computerised (Vision).

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Please apply in writing to: Mrs Margaret Clarke
Beehive Surgery 106-108 Crescent Road Bolton BL3 2JR
Tel: 01204 550 100 E-mail: Margaret.clarke2@nhs.net

SALARIED GP with possible Partnership
Bridlington East Yorkshire

Full time - eight sessions (Part time options considered)

Competitive Salary Package

Field House Surgery

Friendly semi rural dispensing practice looking for an energetic and motivated person to join our forward thinking team who is committed to developing a high quality and progressive service in Primary Care.

Enquiries, expressions of interest or for a Practice Information pack please contact:
Alyson Ritchie, Practice Manager,
Field House Surgery, 18 Victoria Road
Bridlington, East Yorkshire YO15 2AT Tel: 01262 673362

Email:alysonritchie@nhs.net

Closing date for applications: 30th November 2012

SALARIED GP with possible Partnership
Bridlington East Yorkshire

Full time - eight sessions (Part time options considered)

Competitive Salary Package

Field House Surgery

Friendly semi rural dispensing practice looking for an energetic and motivated person to join our forward thinking team who is committed to developing a high quality and progressive service in Primary Care.

Enquiries, expressions of interest or for a Practice Information pack please contact:
Alyson Ritchie, Practice Manager,
Field House Surgery, 18 Victoria Road
Bridlington, East Yorkshire YO15 2AT Tel: 01262 673362
Email:alysonritchie@nhs.net
Closing date for applications: 30th November 2012

DOCTORS/GPS REQUIRED

Associate Partners

Ridgacre Medical Centres www.ridgacremedicalcentres.com is a highly regarded group of GP surgeries based in the Quinton and Nechells areas of Birmingham offering a comprehensive range of medical services.

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Ridgacre Medical Centres, 83 Ridgacre Road, Quinton, Birmingham, B32 2TJ or via email to ian.middlemiss@nhs.net You can also call Ian on 0121 423 5028 for more information or for an informal discussion.

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Please send covering letter with full CV to Mrs Wendy Jennings, Whitehall Medical Practice, Morton Gardens, Rugby, CV21 3AQ or via email wendyjennings@nhs.net telephone: 01788 545350 website: www.whitehallmed.co.uk

Closing date for applications: 31st October 2012

3-6 month FT/PT Locum GP Required ASAP

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If you are interested in this work please telephone or send you CV and covering letter to;
Miss A Norfolk or Mrs Frances Rance,
Amwell Street Surgery,
19 Amwell Street, Hoddesdon, Herts, EN11 8TS
or email: amwell.surgery@nhs.net

PARTNER GP AND SALARIED GP VACANCY NORTH HOUSE SURGERY RIPON, NORTH YORKSHIRE

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Closing date for applications: 31st October 2012

For any further assistance, please contact Nigel Peacock, Business Manager on 01765 690666 Ext 203 or email nigel.peacock@gp-b82008.nhs.uk

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Please apply in writing with CV to: Dr Tina Archdeacon, Wheatfield Surgery, 60 Wheatfield Road, Luton, LU4 0TR. Tel: 01582 601116 or email tarchdeacon@doctors.org.uk

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- No OOH Commitment
- High QOF Achiever

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Salary negotiable depending on experience

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Hellendi Practice
Scapa Crescent
Kirkwall, Orkney
KW15 1RL

Tel 01856 872388 – Email ork-hb.hellendi@nhs.net

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yannieteuvre@nhs.net
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@pulsetoday The best of what's online this week at pulsetoday.co.uk

EDITOR'S CHOICE

Reflecting on revalidation

The new emphasis on 'reflection' in revalidation is irrelevant, onerous and unlikely to improve patient care, argues Dr Jim Sherifi

Reflection is hard-wired into our learning instincts from birth. We touch a candle flame – it hurts. We think about it and we don't do it again.

We intuitively have an audit cycle where learning is acquired and then either used, discarded or needs reinforcing. None of this is exclusive to doctors – and nor has it been invented by the GMC or RCGP.

However, until now, with revalidation, we have never had to document what is a natural occurrence. And I am still not sure why.

Is it not the height of intellectual arrogance to presume that doctors have not been engaged in such activity up until now?

All doctors complain of increased workloads, so why does our regulatory body choose to make our lives even more onerous? I am not even sure this activity will improve patient care.

If I repeatedly see something, it sticks. I see a lot of diabetes and know a lot about it. The same cannot be said for Gaucher's disease. If I see someone with Gaucher's, I look it up, but retain that knowledge for no longer than a goldfish.

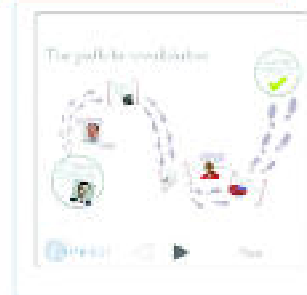
In our forthcoming appraisals, with increased emphasis on reflection, we are going to have to demonstrate an incremental growth in knowledge…

Dr Jim Sherifi: surely 'reflection' is hard-wired from birth?

Dr Jim Sherifi is a GP in East Bergholt, Suffolk

MORE ONLINE
Read the full article
pulsetoday.co.uk/revalidation

REVALIDATION



Last week, health secretary Jeremy Hunt announced that revalidation will start in December. Use our interactive 'path to revalidation' timeline to find out how the process will work and what you'll be expected to do and when.
▶ pulsetoday.co.uk/pathtorevalidation

WHAT YOU'VE BEEN SAYING
▶ pulsetoday.co.uk/forum

Not to worry because patients are going to blame GPs anyway.
… on the question of who GP commissioners will answer to

After the exodus of managers comes the exodus of GPs.
… on claims the NHS reforms have prompted too many PCT staff members to leave the health service

This is outrageous. What on earth do they think doctors smoke?
… on researchers urging GPs to be alert to 'emotional distress' in cancer patients

OPINION

Why I back a patient opt-out

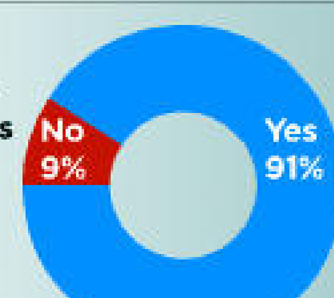
As the BMA debates whether to lead a mass patient opt-out from privately run NHS services as part of the next phase of its campaign to fight the NHS reforms, east London GP Dr Coral Jones explains why she's already offering 'patient pledge' cards in her surgery: 'We GPs must stop being conned. Do we want to be remembered as the generation that allowed the NHS to be destroyed?'

MORE ONLINE
Read Dr Jones's article
pulsetoday.co.uk/opinion

THIS WEEK'S POLL

Has offering choice improved patient care?
Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Are blanket 28-day prescription policies a false economy?



Turn inside for this week's shot of the world according to Copperfield ▶ page 22