Key questions on eczema
'Very good – it will change my practice'
Dr Lorraine Ekong
▶ pulse-learning.co.uk

Successful Practice Management
Take action to secure the future of your practice
29 November, Birmingham
▶ pulsetoday.co.uk/events

pulsetoday.co.uk

PULSE

07.11.12
Issue 36 | Volume 72

BriefingMedia

At the heart of general practice since 1960

GPC rejects contract deal

Negotiators will wait on DDRB report in February as DH prepares to impose 'unsustainable' changes

EXCLUSIVE
By Sofia Lind

The GPC will reject ministers' proposals for sweeping reforms to the GP contract and instead wait for an independent assessment of GP pay – even though the Government has warned it may impose a worse deal as a result.

The Department of Health has offered a 1.5% funding uplift if GPs agree to an unprecedented series of changes to the contract, including a raft of new QOF work next year and from April 2014 the phasing out of the MPIG and a rewrite of the Carr-Hill formula.

Although ministers said the proposed changes were not 'set in stone', the DH is pressing ahead with preparations to impose a deal and warned waiting for the Review Body on Doctors' and Dentists' Remuneration's report in February could land GPs with a smaller funding uplift than is currently on the table.

The DH will begin a formal consultation on its plans this month, after which it can impose them without further negotiation.

The GPC has been tight-lipped on how it will respond, and is assessing the full impact of the changes. But its chair Dr Laurence Buckman told Pulse the additional workload involved was 'unsustainable'.

'We would have to agree to absolutely everything [to get the 1.5% uplift] and we said we will go to the DDRB, as we were going to anyway,' he said. 'We will continue to talk to the Government, to the profession and we will take any steps necessary to preserve general practice in the UK.'

GPC negotiator Dr Chaand Nagpaul added: 'We are in an impasse at the moment. Ultimately the Government has got powers to make unilateral changes – but that doesn't make it a wise thing to do.'

He added: 'We are not negotiating with the Government on those proposals.'

The proposed deal would hit practices with 22 new QOF indicators, raise QOF thresholds and shift around £19,000 from the organisational QOF domain into new DESs covering dementia, online access and chronic long-term conditions.

It also includes a commitment to move towards more 'equitable' practice funding by abolishing MPIG over seven years from 2014 and revamping the Carr-Hill formula to favour practices in deprived areas.

Dr Asad Mubarik, a GP in Oldham, said there was 'a feeling of anger among grassroots GPs'.

'Loss of the MPIG will destabilise many practices,' he said. 'The proposed QOF changes do not follow good clinical care but are simply a cost-cutting exercise. We are relying on the BMA to fight our corner but after past conflicts such as pensions I have little faith.'

A DH spokesperson told Pulse the DDRB would be asked to make a recommendation if the GPC did not agree to the deal.

She added: '[The DDRB] could actually come out and recommend less than a 1.5% uplift, so that is a risk they could take.'

@sofialind_pulse

Dr Asad Mubarik: proposed QOF changes 'are simply a cost-cutting exercise'

EDITORIAL ▶
The GPC must consult the profession 18

What next in the contract row?

- **15 NOV** – GPC next meets to discuss way forward
- **NOV** – DH launches its formal consultation on the proposed deal
- **FEB** – The DDRB will publish its recommendations for GP pay
- **APR** – The 2013/14 GP contract changes will come into effect

GP contract special

- MPIG plan will cause 'bloodbath' page 4
- Triple blow to QOF page 7
- Scottish GPs in separate contract talks page 7
- The deal in full page 7
- Dr Laurence Buckman: these draconian contract changes will hurt patients page 21

MORE ONLINE
Full analysis and reaction to the contract deal
pulsetoday.co.uk/gpcontract

News
2 Trusts book 'shadow' Choose and Book appointments
8 Doubt over benefits of NHS 111

Views
20 **Debate** Charging when patients DNA
24 **Letters** Revalidation will drive GPs into early retirement

Special report: Revalidation
26 **Your guide to surviving revalidation**
30 **Lessons from the pilots**

PulsePlus
32-41
Cardiology
Our monthly CPD section will update you in a clinical area, giving you the chance to earn credits for revalidation
32 **Key questions** Atrial fibrillation
34 **Hypertension**
35 **Ten top tips** Heart failure
38 **Cardiovascular causes of syncope**
40 **CV controversies**

CPD in this issue: 3 hours
Earn CPD for this PulsePlus on cardiology

The week in general practice

INSIDE

MPIG phase-out will cause 'bloodbath', accountants warn
page 4

Independent report raises doubt over benefits of NHS 111
page 8

NICE guidance on stroke branded 'illogical' by the RCP
page 11

Earlier HRT associated with reduced mortality risk
page 17

MORE ONLINE
▶ pulsetoday.co.uk/news

The Prime Minister is to launch a pilot project looking at speeding up diagnosis times for dementia
▶ pulsetoday.co.uk/clinical-news

Unpicking the QOF changes
Read Dr Gavin Jamie's expert analysis of the proposed contract deal
▶ pulsetoday.co.uk/gpcontract

The Big Interview
Watch our interview with RCGP revalidation lead Professor Nigel Sparrow
▶ pulsetoday.co.uk/videos

Hospitals book urgent referrals in 'shadow' slots

DH intervenes after Pulse investigation reveals 'highly dangerous' use of Choose and Book

EXCLUSIVE
By Madlen Davies

Hospital trusts are booking urgent GP referrals made through Choose and Book into non-existent 'shadow' slots before rearranging a real appointment, a Pulse investigation reveals.

The practice, which in some areas affects patients with suspected cancer, was described by the GPC as 'highly dangerous' and the Department of Health has already intervened in one trust to ensure its procedures are improved.

The latest concerns about Choose and Book come after Pulse revealed last month that appointments made through the contraversial electronic booking system were being routinely cancelled due to administrative reasons, leaving GPs to cope with angry patients.

University Hospitals Coventry and Warwickshire NHS Trust told Pulse it routinely booked urgent Choose and Book referrals, including two-week cancer referrals, into non-existent Sunday clinics, and then later rebooked the appointment.

A spokesperson said: 'These types of appointments are booked as a shadow appointment so that the Patient Access Team can easily identify an urgent appointment booking and make contact with the patient to agree a suitable time.'

The trust said its patient administration system could not transfer the site of any suspected cancer from Choose and Book. The spokesperson added: 'It is imperative the trust has this information in order to report and track two-week-wait patients.'

A number of other trusts also said they used 'shadow' appointments. A spokesperson from the Royal Surrey County Hospital said all appointments were booked 'provisionally' and patients informed, but they were not accepted until a consultant had reviewed the referral.

Central Manchester University Hospitals NHS Foundation

How 'shadow' appointments work

GP makes an urgent referral through Choose and Book

Trust books patient into a dummy appointment – for example, on Sunday

Trust re-books patient into a real appointment

Green light for NHS shingles jab

The Department of Health has given approval for GPs to vaccinate against shingles on the NHS for the first time.

The latest DH advice says that GPs can vaccinate anyone against shingles if they make a judgment that it is clinically indicated and would be 'beneficial for an individual patient'.

The decision paves the way for a much-delayed national vaccination programme in older people and comes after GPC concern that the shingles vaccine would only be made available privately.

Shortages of supply held up any decision over whether to proceed with the programme, but Pulse revealed in May that this had been resolved and ministers were considering whether the programme would be cost effective.

The latest *Vaccine Update* from the DH said: 'If a GP makes a judgment that vaccination against shingles would be clinically indicated and beneficial for an individual patient, then Zostavax can be prescribed on the NHS.'

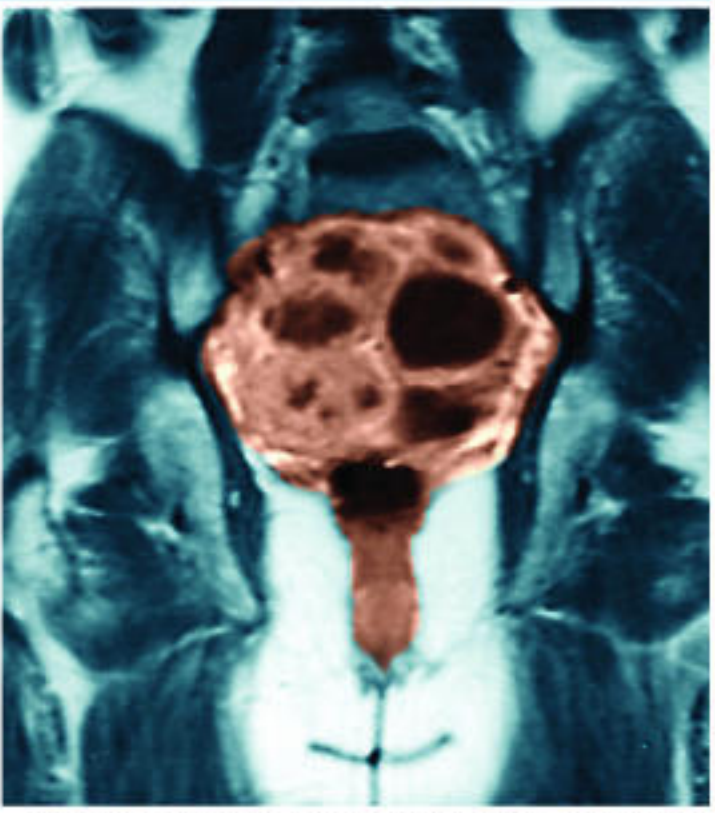
The DH also said it will issue a statement 'shortly' on whether to go ahead with a national programme for adults aged 70 to 79 years, as recommended by the Government's independent vaccine advisory committee.

The latest edition of *GPC News* said the advice had come after the GPC wrote to the DH outlining its concerns.

Dr Douglas Fleming, the director of the RCGP's Research and Surveillance Centre, said he was 'strongly in favour' of a national programme.

'It will certainly happen but I don't know when it will happen,' he said.

BIG Question Should the MPIG be phased out? ▶ pulsetoday.co.uk



One trust is booking 'shadow' appointments for cancer referrals

Trust said that for some of its Choose and Book services, including urgent referrals, shadow booking was used to 'ensure that patients are seen in the correct consultant clinic'.

A spokesperson said: 'In such cases patients can book a time slot which will subsequently be confirmed or otherwise direct with the patient by the relevant hospital.'

Dr Manoj Pai, a GP in Coventry, said he was concerned because practices could not track urgent referrals.

He said: 'We won't know if they have been seen. If something goes wrong patients could slip through the net.'

Dr Paul Cundy, chair of the GPC's IT subcommittee, said the arrangements were 'highly dangerous'.

He said: 'For an urgent referral you need confirmation and action at the other end. Choose and Book doesn't provide that.

'If the Government wants doctors in general to use this system for urgent referrals then they need to be offering an indemnity for doctors should the system fail.'

Dr Nigel Watson, chief executive of Wessex LMCs and a GP in the New Forest, said he had raised concerns with a local trust after the LMC discovered patients were being booked into 'non-existent clinics'.

He said: 'When we called the trust out on it, they refused to say it happened.'

A Department of Health spokesperson said it would raise the matter with University Hospitals Coventry and Warwickshire NHS Trust: 'Choose and Book does allow patients who need to be seen urgently or within two weeks to be booked directly into appointments.

'We have offered to work with the trust concerned and will continue to work with local organisations to help them improve their local Choose and Book processes.'

@madlendavies

GPs told to tackle lifestyle

By Alex Wellman

GPs will be mandated to 'make every contact count' to ensure their patients are leading healthier lives, under proposed changes to the NHS Constitution.

In proposals announced by the Department of Health this week, NHS staff will have a duty to ensure they take 'every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing'.

This follows a call from the NHS Future Forum earlier this year for GPs to routinely ask patients about their diet, smoking and drinking habits.

The proposal was called 'muddled' by RCGP chair Dr Clare Gerada at the time, and GPs have criticised it now being included as a responsibility in the NHS Constitution.

Dr Mary Hawking, a GP in Dunstable, Bedfordshire, said the proposal was 'absolutely insane': 'If a patient comes in to talk about a complex problem, are you supposed to sit them on the scales, take blood pressure and then give them a lengthy lecture about what to do with their lifestyle? If you do, then you have one minute to deal with their initial problem.'

Dr Grant Ingrams, a GP in Coventry, said: 'It could increase tension between GPs and patients. It is not do-able to always ask these questions, unless we increase the time we have with patients and that means doubling the number of GPs.'

The consultation was unveiled by health minister Norman Lamb and also includes pledges to make it easier for pharmaceutical companies to gain access to GP records to ensure families of patients are fully involved in decisions over end-of-life care.

Mr Lamb said: 'We are strengthening this constitution, which enshrines the right of everyone to have first-class care, now and in the future.'

Pulse revealed in August that Prime Minister David Cameron was investigating changing the constitution to allow pharmaceutical companies access to anonymised GP records 'on a scale never seen before'.

The consultation says a change to the constitution should read that the NHS commits 'to anonymise the data collected during the course of your treatment and use it to support research and improve care for others'. It promises 'where identifiable data has to be used, to give you the chance to object wherever possible'.

Campaign to boost flu vaccinations

The Department of Health will run an advertising campaign from this week in an attempt to boost flagging flu vaccination rates this year.

The latest uptake figures show just 28.5% of patients aged under 65 in at-risk groups, excluding pregnant women, have been vaccinated so far against flu, compared with 32.3% in the same period last year.

By the end of October only 48.9% of patients aged over 65 had received a flu vaccination, compared with 54.8% in the same period in 2011/12.

The DH will now run an advertising campaign encouraging people in at-risk groups to get vaccinated.

Public health minister Anna Soubry said: 'Our campaign aims to encourage people who are most at risk from flu, who have put it off, or who don't think it is important, to get the vaccine. If pregnant women are vaccinated, they not only protect themselves but also protect their newborn babies from catching flu.'

The intervention comes after problems with vaccine supply in some areas. The UK drugs regulator has asked Novartis to recall two batches of flu vaccine after the company reported 'quality defects'.

It means the removal of around 160,000 doses from the supply chain, which the MHRA said would have minimal impact on flu vaccine supplies in the UK, but was a 'worrying' development according to GP experts.

RCGP immunisation lead Dr George Kassianos, a GP in Bracknell, Berkshire, said: 'Any reduction in flu vaccine available is a problem.'

WHEN OA STARTS MAKING EVERY DAY A PAIN

BuTrans patches, for moderate OA pain, may help make everyday activities more manageable again. Prescribe your patients *BuTrans* patches for continuous pain relief from early OA.

BuTrans

Buprenorphine Matrix Patch
5µg/h, 10µg/h, 20µg/h
OA pain relief 24/7

BuTrans patches contain an opioid analgesic.

BuTrans® 5 µg/h, 10 µg/h and 20 µg/h Transdermal Patch
Prescribing Information, United Kingdom. Please read the Summary of Product Characteristics before prescribing. Presentation: *BuTrans* 5 µg/h, 10 µg/h, 20 µg/h. Transdermal beige patches containing buprenorphine. **Indications:** Treatment of non-malignant pain of moderate intensity when an opioid is necessary for obtaining adequate analgesia. *BuTrans* is not suitable for the treatment of acute pain. **Dosage and administration:** *BuTrans* should be administered every 7 days. Elderly and adults over 18 years only: Use the 5 µg/h patch for at least the first 3 days of treatment, before increasing the dose if necessary. Do not use more than two patches at a time. **Contra-indications:** Known buprenorphine or excipient hypersensitivity, opioid-dependent patients, narcotic withdrawal treatment, respiratory depression, use of monoamine oxidase inhibitors (MAOIs) within the past 2 weeks, myasthenia gravis, delirium tremens. **Precautions and warnings:** Convulsive disorders, head injury, shock, reduced consciousness of uncertain origin, intracranial lesions or increased intracranial pressure, severe hepatic impairment, history of drug abuse. Not recommended immediately postoperatively or for situations characterised by a narrow therapeutic index or for rapidly varying analgesic requirements. May affect ability to drive or use machinery. **Interactions:** MAOIs, CNS depressants (e.g. benzodiazepines, opioid derivatives, antidepressants, sedatives, alcohol, anxiolytics, neuroleptics, clonidine), CYP 3A4 inhibitors and inducers, products reducing hepatic blood flow (e.g. halothane). **Pregnancy and lactation:** *BuTrans* should not be used during pregnancy or in women of childbearing potential who are not using effective contraception. The use of *BuTrans* during lactation should be avoided. **Side-effects:** Very common (≥1/10) and common (≥1/100, <1/10) side-effects are anorexia, confusion, depression, insomnia, nervousness, headache, dizziness, somnolence, paraesthesia, vasodilation, dyspnoea, constipation, dry mouth, nausea, vomiting, abdominal pain, diarrhoea, dyspepsia, pruritus, erythema, rash, sweating, exanthema, tiredness, application site reaction, asthenia, pain, peripheral oedema, chest pain. Uncommon (<1/100) but potentially serious side-effects are respiratory depression, anaphylactic reaction, anaphylactoid reaction, hypersensitivity, blurred vision, affect lability, agitation, depersonalisation, drug dependence, euphoric mood, hallucinations, mood swings, psychotic disorder, restlessness, balance disorder, migraine, sedation, speech disorder, dysarthria, syncope, eyelid oedema, visual disturbance, vertigo, angina pectoris, palpitations, tachycardia, circulatory collapse, hypertension, hypotension, asthma aggravated, wheezing, hyperventilation, hypoxia, respiratory failure, diverticulitis, dysphagia, ileus, biliary colic, face oedema, urticaria, muscular weakness, urinary retention, micturition disorder, decreased libido, erectile dysfunction, sexual dysfunction, drug withdrawal syndrome, oedema, alanine aminotransferase increased, accidental injury, fall. Please consult the SPC for details of other side-effects. **Legal category:** CD (Sch3) POM. **Package quantities and price:** 4 individually sealed patches: 5 µg/h transdermal patch £17.60, 10 µg/h transdermal patch £31.46, 20 µg/h transdermal patch £57.34. **Marketing Authorisation numbers:** PL 16960/136-138. **Marketing Authorisation holder:** Napp Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0GW UK. Tel: 01223 424444. Member of the Napp Pharmaceutical Group. For medical information enquiries, please contact medicalinformationuk@napp.co.uk. **Date effective:** February 2012. ® *BuTrans* and the NAPP device (logo) are Registered Trade Marks. © 2011 - 2012 Napp Pharmaceuticals Limited.

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 Napp Pharmaceuticals Limited on 01223 424444.

For medical information enquiries, please contact medicalinformationuk@napp.co.uk

Scan here to access butrans.co.uk

NAPP NAPP PHARMACEUTICALS

Date of preparation: June 2012 UK/BUTR-1106fa

Draconian contract changes will hurt practices and patients
▶ page 21

MPIG plan will cause 'bloodbath'

Accountants and GP leaders warn removal of MPIG and deprivation weighting will cause practice closures

By Sofia Lind

Government plans to make radical changes to primary care funding will lead to practice closures, GP leaders and medical accountants have warned.

Ministers said they wanted to make practice funding more 'equitable' by removing the MPIG and weighting practice funding for deprivation as part of wide-ranging changes to the GP contract, but they have been accused of orchestrating a 'bloodbath'.

The changes – over a seven-year period and due to begin in April 2014 – would move all practices to a common capitation price, based on current average expenditure on the global sum, correction factor payments under MPIG, and basic elements of PMS funding.

The announcement was branded 'destabilising' by the GPC and prompted a rare intervention from the RCGP into contract negotiations, with chair Dr Clare Gerada warning it could put patient care at risk.

Dr Laurence Buckman: changes 'unnecessary and destabilising'

In a letter to PCTs and SHAs, commissioning tsar Dame Barbara Hakin said the Government was seeking to take forward work started by the GPC and NHS Employers to phase out the MPIG.

She said: 'This would mean moving in a controlled and phased way towards equitable funding for all GP practices, based on the numbers of patients they serve with an appropriate weighting for demographic factors that affect relative patient needs and practice workload.'

Negotiators said the plans would also involve altering the Carr-Hill formula to give greater weight to deprivation factors.

GPC chair Dr Laurence Buckman said: 'The GPC believes there are better ways to improve the health of patients in deprived areas than changing the funding formula, especially as there is little published evidence to suggest a link between population deprivation and practice workload.

'We sincerely hope that the Government will think very carefully about what it is doing to avoid un-evidenced, unnecessary and destabilising changes.'

RCGP chair Dr Clare Gerada also raised concern over the planned phase-out.

She said: 'The practical implications of such a change are significant beyond the GPs who will be driven out of business by it: the replacement providers are likely to be insurance companies or outsourcing companies about whose services quality concerns have already been raised.'

Bob Senior, head of medical services at RSM Tenon accountants, warned the proposals would alter the landscape of general practice, with the gradual disappearance of small and multi-site practices.

Winners and losers

Practices that will gain
Those with high retired populations, which will often have had the correction factor wiped out already; practices with a more or less average age profile, operating from a single site with 8,000+ patients and in deprived areas

Practices that will lose
Small practices with lists of 3–4,000 or fewer; practices in affluent areas and those running from split sites; those with heavy workloads from worried well

Little change
Larger (10,000+ patients) single-site practice with no deprivation issues – those whose population age means they are unlikely to have much of a correction factor

Source: RSM Tenon

He told Pulse: 'I wouldn't be astonished if you had a number of single-handers who give up, make their staff redundant and hand their list back and say "I'm done". It is going to be a bloodbath.'

But Dr Peter Swinyard, chair of the Family Doctor Association, said some practices would welcome the changes: 'There is no justice in the same town for one practice being on £55 a head and another on £120 a head and expected to offer the same service to patients.'

@sofialind-Pulse

Prescribing Information (UK) TRAJENTA® 5 mg film-coated tablets
Film-coated tablets containing 5 mg linagliptin. Indication: Trajenta is indicated for the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as monotherapy – in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to intolerance, or contraindicated due to renal impairment, as combination therapy: – in combination with metformin when diet and exercise plus metformin alone do not provide adequate glycaemic control, – in combination with a sulphonylurea and metformin when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control. Dose and Administration: 5 mg once daily. If added to metformin, the dose of metformin should be maintained and linagliptin administered concomitantly. When used in combination with a sulphonylurea, a lower dose of the sulphonylurea may be considered to reduce the risk of hypoglycaemia. Patients with renal impairment: no dose adjustment required. Pharmacokinetic studies suggest that no dose adjustment is required for patients with hepatic impairment but clinical experience in such patients is lacking. Exactly: no dose adjustment is necessary based on age; however, clinical experience in patients > 75 years of age is limited. The safety and efficacy of linagliptin in children and adolescents has not yet been established. No data are available. Trajenta can be taken with or without a meal at any time of the day. If a dose is missed, it should be taken as soon as possible but a double dose should not be taken on the same day. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and Precautions: Trajenta should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Caution is advised when linagliptin is used in combination with a sulphonylurea: a dose reduction of the sulphonylurea may be considered. Interactions: Linagliptin is a weak competitive and a weak to moderate mechanism-based inhibitor of CYP isoenzyme CYP3A4 but does not inhibit other CYP isoenzymes. It is not an inducer of CYP isoenzymes. Linagliptin is a P-glycoprotein substrate and inhibitor. P-glycoprotein mediated transport of digoxin with low patients. Based on these results and in vitro interaction studies, linagliptin is considered unlikely to cause interactions with other P-gp substrates. The risk for clinically meaningful interactions by other medicinal products on linagliptin is low and in vivo studies linagliptin has no clinically relevant effect on the pharmacokinetics of metformin, glyburide, simvastatin, warfarin, digoxin or oral contraceptives (please refer to Summary of Product Characteristics for information on clinical data). Fertility, pregnancy and lactation: Avoid use during pregnancy. A risk to the breast fed child cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from Trajenta therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. No studies on the effect on human fertility have been conducted. Trajenta. Undesirable effects: Adverse reactions reported in patients who received linagliptin 5 mg daily as monotherapy or as add-on therapy: pooled analysis of placebo-controlled studies. The adverse reactions are listed by absolute frequency. Frequencies are defined as very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), very rare (<1/10,000), not known (cannot be estimated from the available data). Very common: hypoglycaemia (combination with add-on to metformin and sulphonylurea). Uncommon: nasopharyngitis (monotherapy; combination with/add on to metformin); hypersensitivity (combination with/add on to metformin); cough (monotherapy; combination with/add on to metformin); pancreatitis (combination with/add on to metformin and sulphonylurea); hepatic enzyme elevations (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylurea). Not known: nasopharyngitis (combination with/add on to metformin and sulphonylurea); hypersensitivity reactions (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylurea); pancreatitis (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylurea). Prescribers should consult the Summary of Product Characteristics for further information on side effects. Pack sizes and RRS price: 28 tablets £33.26. Legal category: POM. MA number: EU/1/11/700/002. Marketing Authorisation Holder: Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in September 2011.

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

References: 1. Trajenta® Summary of Product Characteristics. August 2011. 2. Barnett A H, et al. Poster No. 933-P and abstract. The European Association for the Study of Diabetes, 46th Annual Meeting, 20–24 September 2010, Stockholm, Sweden. 3. Tajvidyea M-R, et al. Diabetes Obes Metab 2011;13:65–74. 4. Owens DR, et al. Diabet Med 2011;28:1620–61. 5. Boehringer Ingelheim data on file 1.M11-02a. 6. Vilsboll T, et al. Drug Metab Dispos 2009;37:25,522–8. 7. Janumet (sitagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/15610/SPC/Janumet+50+1000mg+film+coated+tablets/ (accessed August 2012). 8. Galvus (vildagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/20734/SPC/Galvus+50+mg+Tablets/ (accessed August 2012). 9. Onglyza (saxagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22315/SPC/Onglyza+2.5mg+%28+5mg+film+coated+tablets/ (accessed August 2012). 10. Duncan DF. Diabetes Obes Metab 2011;13:7–18. 11. Resch S, et al. Drug Metab Dispos 2010;38:667–78.

UK/TRJ/00076 Date of preparation: August 2012

Boehringer Ingelheim

Lilly

Grant to speak at Pulse Live

Professor Malcolm Grant, chair of the NHS Commissioning Board, is part of a high-profile line-up of speakers at Pulse Live who you will be able to challenge about your future.

This is your opportunity to get clarity about what clinical commissioning will mean for your practice and what opportunities are in it for you. Submit your questions for Professor Grant by emailing lisa.thomlinson@briefingmedia.com or via Twitter @LisaThomlinson.

Other speakers at Pulse Live include RCGP chair Dr Clare Gerada and Dr Malcolm Kendrick, a GP, author and challenger of the widespread use of statins.

Debates will cover: has there ever been a better time to work in general practice; is the traditional model of general practice broken; and has the medicalisation of patients gone too far?

Go to www.pulse-live.co.uk for regular programme and speaker updates and to book your free* place at Pulse Live in Birmingham on 30 April and 1 May

*Pulse Live is for GPs and practice managers who are registered users of PulseToday/Pulse Learning who book before the end of December and £49 per day thereafter. Book now and decide which day(s) to attend when the full programme is published in the New Year

PULSE LIVE 2013

NovoMix® 30 Biphasic insulin aspart.
NovoMix® 30 Penfill®
NovoMix® 30 FlexPen®
All presentations contain soluble insulin aspart/protamine-crystallised insulin aspart 100 U/ml in the ratio 30/70.
Indication: Treatment of diabetes mellitus in adults, adolescents and children aged 10 to 17 years. **Posology and administration:** Potency of insulin analogues is expressed in units (U). In patients with type 2 diabetes, NovoMix® 30 can be given in monotherapy or in combination with oral antidiabetic drugs (OADs) when blood glucose is inadequately controlled with OADs alone. The recommended starting dose is 6 U at breakfast and 6 U at the evening meal. Titration is according to pre-meal blood glucose levels (pre-breakfast glucose for adjustment of evening dose and pre-evening meal glucose for adjustment of breakfast dose). NovoMix® 30 can also be initiated once daily with 12 U at the evening meal and it is generally recommended to move to twice daily when the daily dose reaches 30 U; this can be done by splitting the dose into equal breakfast and dinner doses. If twice daily dosing results in recurrent daytime hypoglycaemic reactions the morning dose can be split into morning and lunchtime doses and thrice daily dosing instituted. Only consider combination of NovoMix® 30 with pioglitazone following clinical evaluation of the patient's risk of developing signs and symptoms of fluid related adverse reactions. Initiate NovoMix® 30 cautiously, titrating to the lowest dose required to obtain glycaemic control. In patients with type 1 diabetes the individual insulin requirement is usually between 0.5 and 1.0 U/kg/day and may be fully or partially supplied with NovoMix® 30. Dose adjustment may be necessary with increased physical activity, changes in diet or during concomitant illness. NovoMix® 30 can be used in the elderly; limited experience of NovoMix® 30 in combination with OADs in patients older than 75 yrs. Renal or hepatic impairment may reduce insulin requirements. In this population or the elderly glucose monitoring should be intensified and dose adjusted accordingly. NovoMix® 30 can be used in children and adolescents aged 10 yrs and above; limited clinical data for children aged 6-9 yrs. No studies in children under the age of 6 yrs; only use in this age group under careful medical supervision. When transferring a patient from biphasic human insulin to NovoMix® 30, start with the same dose and regimen, then titrate according to individual needs. For subcutaneous administration only; not to be used in infusion pumps. NovoMix® 30 has a faster onset of action than biphasic human insulin and should generally be given immediately before a meal. When necessary it can be given soon after a meal. Penfill® designed to be used with Novo Nordisk insulin delivery systems. Penfill® and FlexPen® are designed to be used with NovoFine® and NovoTwist® needles. **Contraindications:** Hypersensitivity to active substance/excipients. **Special warnings and precautions for use:** Use of inadequate doses or discontinuation of treatment may lead to hyperglycaemia and ketoacidosis which are potentially lethal. Travelling between time zones may require change in the insulin regimen. Too much insulin, omission of a meal or strenuous exercise may lead to hypoglycaemia. Compared with biphasic human insulin NovoMix® 30 may have a more pronounced glucose-lowering effect up to 6 hours after injection. This may need to be compensated for through adjustment of dose and/or food intake. Reduction of early warning symptoms of hypoglycaemia may be seen upon tightening control and symptoms may disappear with longstanding diabetes. Tighter control of glucose levels can increase the potential for hypoglycaemic episodes and therefore require special attention during dose intensification. The fast onset of action should be considered in patients where a delayed absorption of food might be expected. Concomitant disease in kidney, liver, adrenal, pituitary or thyroid gland may require change in dose. Transferring to a new type or brand of insulin should be done under strict medical supervision; may require changes in dose/number of injections. Injection site reactions, usually transitory, may occur; rotation of injection sites may help reduce or prevent these reactions; rarely they may require discontinuation of NovoMix® 30. Cases of cardiac failure were reported when pioglitazone was used in combination with insulin, especially in patients with risk factors for development of cardiac heart failure; if the combination is used, patients should be observed for signs and symptoms of heart failure, weight gain and oedema. Pioglitazone should be discontinued if any deterioration in cardiac symptoms occurs. Hypoglycaemia may constitute a risk when driving or operating machinery. **Fertility, pregnancy and lactation:** Limited clinical experience in pregnancy. No restrictions on use during breast-feeding. No differences in animal studies between insulin aspart and human insulin regarding fertility. **Undesirable effects:** Very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000); not known (cannot be estimated from the available data). Very common: hypoglycaemia; Uncommon: urticaria, rash, eruptions; refraction anomalies, oedema and local hypersensitivity reactions on instituting therapy and are usually of transitory nature; diabetic retinopathy with intensification may result in temporary worsening; lipodystrophy; Rare: peripheral neuropathy – acute painful neuropathy, usually reversible, may occur with rapid improvement in glycaemic control; Very rare: anaphylactic reactions - generalised hypersensitivity reactions are potentially life-threatening. The Summary of Product Characteristics should be consulted for a full list of side effects. **MA numbers:** NovoMix® 30 Penfill® EU/1/00/142/004 NovoMix® 30 FlexPen® EU/1/00/142/009 **Legal Category:** POM **Basic NHS Price:** 5 x 3 ml Penfill® £28.84 5 x 3 ml FlexPen® £29.99 **Further prescribing information can be obtained from:** Novo Nordisk Limited, Broadfield Park, Brighton Road, Crawley, West Sussex, RH11 9RT.
Date created/last revised: March 2012
NovoMix®, FlexPen®, Penfill®, NovoFine® and NovoTwist® are trademarks owned by Novo Nordisk A/S.
References: 1. Gumprecht J *et al.* Intensification to biphasic insulin aspart 30/70 (BIAsp 30, NovoMix® 30) can improve glycaemic control in patients treated with basal insulins: A subgroup analysis of the IMPROVE™ observational study. *Int J Clin Pract* 2009; **63**(6): 966–972. **2.** Qayyum R *et al.* Systematic Review: Comparative Effectiveness and Safety of Premixed Insulin Analogues in Type 2 Diabetes. *Ann Intern Med* 2008; **149**: 1–12. **3.** Unnikrishnan A *et al.* Practical guidance on intensification on insulin therapy with BIAsp 30: a consensus statement. *Int J Clin Pract* 2009; **63**(11): 1571–1577.

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

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Novo Nordisk Limited. (Telephone Novo Nordisk Customer Care Centre 0845 6005055). Calls may be monitored for training purposes.

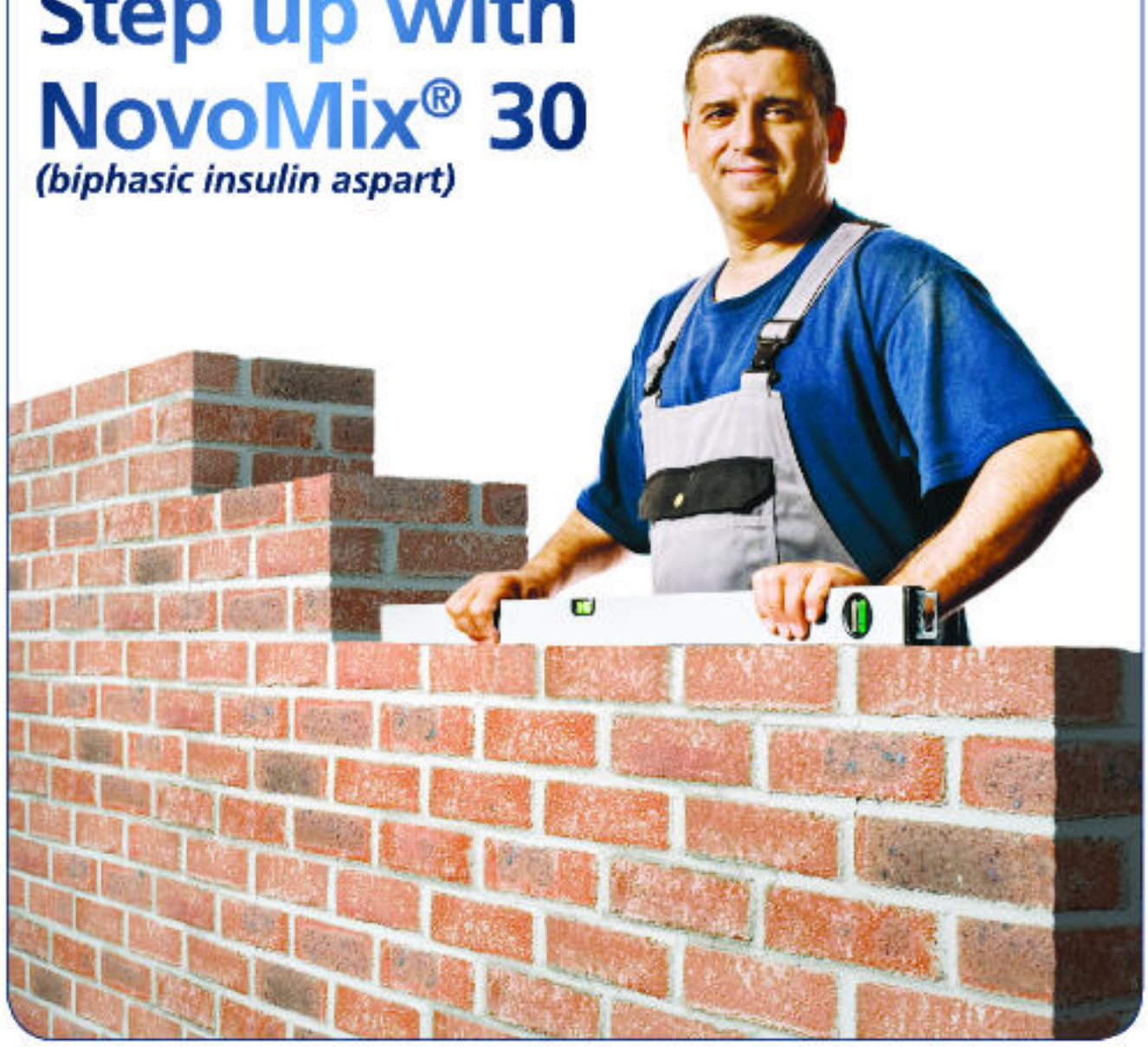
The Apis bull logo is a trademark of Novo Nordisk A/S

novo nordisk®

In type 2 diabetes, when basal insulin is no longer enough

Step up with NovoMix® 30

(biphasic insulin aspart)



Observational study results show[1]:

(p<0.0001)

-1.8%

mean reduction in HbA1c (baseline 9.3%)

at 6 months after switching from basal analogue to NovoMix® 30[1]

55%

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

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

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.

© Pfizer 2012 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 of 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: CI 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.uki@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

QOF

GPs face triple blow to QOF work and income

GPC warns some proposed new indicators could be 'unworkable'

By Nigel Praities

GPs will have large amounts of their income tied to 'unworkable' QOF indicators under the Government's plans to drastically change the work required under the framework from April 2013, the GPC has claimed.

Under the deal tabled by ministers, practices face the triple whammy of a hike in upper thresholds, removal of incentives for the organisational domain and a raft of new indicators.

To changes the GPC attacked as 'unsustainable' the Department of Health proposed accepting all the changes to the QOF considered by NICE this year - including those that were not even put forward for negotiation.

This would mean 22 new QOF indicators, changes to four indicators and the retirement of 14 indicators worth 109 QOF points.

Ministers also plan to retire all the indicators in the organisational domain except the quality and productivity indicators and those covering public health, meaning an additional 153 QOF points will be lost.

This would result in practices having to cope with the removal of indicators representing 26% of the points currently in the QOF. The GPC told Pulse some of the points will be returned to QOF with the 22 new indicators but overall the size of the framework could shrink by 14%.

The estimated £18,659 this will cut from the QOF - based on the 2012/13 allocation of £133.76 per point - will be reallocated to new enhanced services encouraging better dementia diagnosis, care for frail or seriously ill patients, helping patients with long-term conditions monitor their health and an expansion in online access to GP services.

The plans could shrink the overall size of the QOF by 14%

'The time has come for GPs to say that we can't do any more work'
Dr Laurence Buckman

The DH said the plans were designed to 'focus on better care' and stop rewarding practices for administrative tasks.

But the GPC said the move could be dangerous for patients and would introduce QOF indicators which required referrals to services that were not universally available, or which would be too work intensive for practices to deliver.

GPC chair Dr Laurence Buckman said: 'They want us to accept all of the NICE proposals for QOF changes - even the ones that are not safe for patients.

'It is not sustainable. The time has come for GPs to say that we can't do any more work. It doesn't make me less knackered if you pay me more.'

A DH spokesperson said: 'We don't think practices should be rewarded for good organisation but for good clinical care, like reducing mortality rates and improving patients' lives.'

@nigelpraities

ANALYSIS

The offer in full

1.5% funding uplift
DH says this will allow an average pay increase of up to 1% for GPs and practice staff, but the BMA fears it may not cover rising expenses.

NICE proposals accepted
Introduction of 22 new QOF indicators, changes to four indicators and the retirement of 14 indicators worth 109 QOF points.

Removal of QOF organisational domain
Loss of indicators worth a further 153 QOF points. Quality and productivity indicators and those for public health would be retained.

Reduction of QOF by 14%
The GPC says QOF would be cut overall by approximately 139 points. This equates to around £19,000 of QOF funding at 2012/13 prices.

New DESs
Savings from QOF to fund new enhanced sevices on dementia, long-term conditions, care for frail patients and online access.

MORE ONLINE
Follow the latest developments with the GP contract deal and read our in-depth analysis
pulsetoday.co.uk/gpcontract

DEVOLVED NATIONS

Scotland to negotiate separate deal

GP leaders have been invited to negotiate a separate contract deal in Scotland for next year as the impact of events south of the border threatens to speed the break-up of the UK GP contract.

The Scottish Government said it was committed to working with the BMA in Scotland to come up with a contract that 'works for both parties' and that it would be 'taking a different approach' to the UK Government.

Scottish health secretary Alex Neil said: 'Given the impasse in the UK negotiations on the GP contract, we have invited the BMA for talks on arrangements in Scotland which would better suit both patients and GPs.'

Dr Alan McDevitt, Scottish GPC chair, said the move was 'helpful'.

He said: 'This willingness to enter into discussions is a positive first step by the Scottish Government and I hope that we can reach a negotiated settlement in Scotland.'

Meanwhile, GP leaders have rejected a proposed contract deal from the Welsh Government modelled on the deal announced by the Department of Health in England.

The Welsh GPC told ministers in Wales there was 'absolutely no chance' it would accept a deal similar to the one on offer in England with a 1.5% uplift in priority funding in return for a raft of new work.

@pulsetoday

PAY

DH offers 1.5% funding uplift to boost pay 'by 1%'

The Department of Health deal offers GP practices a 1.5% uplift to the GMS contract in 2013/14, which it says would translate to an average pay increase for GPs of up to 1%.

This would enable ministers to claim to have met the Treasury's target for an average 1% uplift across the public sector next year.

In its official submission to the Review Body on Doctors' and Dentists' Remuneration earlier this year, the BMA argued the formula for calculating a good funding uplift should be revised as inflation and additional expenses next year would put an extra burden on practices and would not guarantee a 1% pay rise for GPs.

But the DH rejected this plea, saying it had no plans to review the formula.

But speaking at the NAPC Annual Conference last week, Earl Howe told delegates the Government's proposals offered GPs a fair deal.

He said: 'We want the BMA to work with us making this happen. But I should say we won't back away from making changes that will deliver better care for patients.'

PULSE LIVE 2013
THE NATIONAL CONFERENCE FOR GENERAL PRACTICE

PULSE IS GOING LIVE AND WE WANT YOUR HELP

Pulse has reached a key moment in its 52-year history. Your magazine will be going live with a two-day conference for GPs and practice managers. The event will be taking place in Birmingham 30 April – 1 May 2013.

The Pulse Live team is putting the programme together and we want to get you involved in the process! Follow the link below and tell us how you want the event to look. Help us choose the topics and issues most relevant to you and your practice.

Our mission is to meet your needs – this is your chance to get involved and help shape the event. Simply log on to pulse-live.co.uk and register your interest. You will be able to submit your suggestions as part of the registration form.

www.pulse-live.co.uk

Get Involved

GET INVOLVED

Top ten tips: heart failure
▶ page 35

Researchers predict roll-out of telephone line will cost more than current urgent care arrangements

URGENT CARE

Doubt over benefits of NHS 111

By Gareth Iacobucci

An independent evaluation of the Government's national NHS 111 pilots says the new service may never deliver the reduction in emergency care activity it was designed to achieve.

The report from researchers at the University of Sheffield said the service – designed to simplify access to non-emergency care – had 'not delivered the expected benefits' in improving patient satisfaction or stemming the flow of patients being directed to emergency care.

It also warned it 'cannot be assumed' the scheme will produce the expected benefits given more time and it will be more costly than current arrangements.

NHS 111 has not changed GP out-of-hours attendances

The report analysed the first year of operation of NHS 111 across four pilot sites and compared it with other matched control sites. It found 'no statistically significant change' in emergency ambulance calls, emergency department attendances or GP out-of-hours and walk-in attendances in pilot sites.

There was a statistically significant reduction in the use of NHS Direct – of 193 calls per 1,000 NHS 111 triaged calls per month – but emergency ambulance service incidents where a call is categorised and an ambulance dispatched increased by 29 per 1,000 triaged calls per month.

The Government had claimed the introduction of the three-digit urgent care number would help to reduce the number of unnecessary ambulance journeys, avoidable A&E attendances and unscheduled admissions, and reduce the number of 999 calls for non-emergency issues.

Impact of 111 on other services

GP out-of-hours/walk-in centres	No change
NHS Direct	-193 calls per month
Ambulance calls	No change
Ambulance incidents	+29 calls per month

Source: University of Sheffield, online October 2012

But the researchers identified a 'low probability of cost savings to the emergency and urgent care system', estimating the service would cost an extra £307,000 per month in all the pilot sites combined.

The Government has already pre-empted the publication of the report by scheduling a national roll-out of the new telephone-based service by October 2013 at the latest, despite calls from the GPC for ministers to wait for the full findings before proceeding. The service is already up and running in 13 locations across England.

The report found overall satisfaction with the service was good, with 73% of respondents to a survey of users reporting they were very satisfied, and 19% quite satisfied. But it highlighted that 'there was no evidence that NHS 111 improved satisfaction with urgent care generally'.

Health minister Earl Howe said: 'We expect to see NHS 111 have a greater impact as more areas go live.'

Dr Shane Gordon, clinical chief officer for North East Essex CCG and a GP in Tiptree, Essex, said the 'jury was still out' on the scheme.

'The thing that struck me was that the likelihood of saving money was 21%. I don't have a good feel about whether it will increase demand on GP services and what the cost will be.'

@pulsetoday

MORE ONLINE
Download full report
pulsetoday.co.uk/pilotsites

PRIVATE SECTOR

GPs exit Virgin ventures

Virgin Care is to end its joint venture partnerships with 329 GPs and focus on providing services directly, to allay fears that the establishment of CCGs could lead to conflicts of interest.

The move means that the company will assume sole control of its 25 joint venture provider groups with GPs, known as GPCos, which the company said would remove GPs from 'potential conflicts of interest'.

The 50/50 provider companies, established under Virgin's former guise of Assura Medical, operate dozens of contracts to provide primary and community care services across the country, often employing salaried staff.

But fears have been mounting over possible conflicts of interest for GPs involved since the Government's white paper first set out the new commissioning responsibilities for GPs.

A joint investigation by Pulse and The Bureau of Investigative Journalism last year revealed that at least half of board members on some shadow CCGs had links with the company.

As a result of the move, Virgin will take full control of services run by GPCos once the GPs in the joint partnerships relinquish their stake in the companies.

Dr Ian MacDonald, former chair of the Assura Coventry GPCo, said: 'Despite no conflict ever having arisen, we want to avoid any perception that a conflict exists by leaving the partnership prior to GPs taking control of commissioning in April 2013.'

SECONDARY CARE

Plan for larger CQUIN

A greater proportion of hospital income will be tied to national performance targets under plans revealed by the chief executive of the NHS.

Sir David Nicholson, chief executive of the NHS Commissioning Board, told delegates at the NAPC Annual Conference that he wanted to see an increase in the proportion of hospital income tied to the CQUIN scheme.

Sir David responded to a question about incentives for hospital trusts by describing how he has ambitions to put more money into CQUIN.

He said: 'One of the things about CQUIN is that the purpose is to reward the people who do the something exceptional and extra.

'Over the past two or three years we have increased the amount that goes to CQUIN by about 3%. My own ambition is 4% or 5%.'

He also told delegates in Birmingham that the CCGs should be given more 'flexibility' to performance manage GP practices.

He said: 'It is clear the balance between national and local is not quite right.'

PULSE VIDEO
Watch the full speech at
pulsetoday.co.uk/naoc2012

PNEUMOCOCCAL DISEASE IS A MAJOR CAUSE OF ILLNESS AND DEATH IN ADULTS[1]

THE INCIDENCE OF INVASIVE PNEUMOCOCCAL DISEASE IN ADULTS INCREASES MORE RAPIDLY FROM 50 YEARS OF AGE[2]

PREVENAR 13®▼

The first and only pneumococcal conjugate vaccine licensed for adults 50 years and older[3]

ADULT INDICATION[3]

PREVENAR 13® is indicated for active immunisation for the prevention of invasive disease caused by *Streptococcus pneumoniae* in adults aged 50 years and older.

VACCINATE YOUR ADULT PATIENTS 50+ WITH PREVENAR 13® FOR THE PREVENTION OF INVASIVE PNEUMOCOCCAL DISEASE

APPROVED FOR ADULTS 50+

*Prevenar 13**

Pneumococcal polysaccharide conjugate vaccine (13-valent, adsorbed)

ABBREVIATED PRESCRIBING INFORMATION

Prevenar 13® suspension for injection. Pneumococcal polysaccharide conjugate vaccine (13-valent, adsorbed). Presentation: Each 0.5ml dose of Prevenar 13 contains 2.2 micrograms of each of the following polysaccharide serotypes: 1, 3, 4, 5, 6A, 7F, 9V, 14, 18C, 19A, 19F, 23F and 4.4 micrograms of polysaccharide serotype 6B. Each polysaccharide is conjugated to the CRM$_{197}$ carrier protein and adsorbed on aluminium phosphate (0.125mg aluminium). **Indications:** Active immunisation for the prevention of invasive disease, pneumonia and acute otitis media caused by *Streptococcus pneumoniae* in infants and children from 6 weeks to 5 years of age. Active immunisation for the prevention of invasive disease caused by *Streptococcus pneumoniae* in adults aged 50 years and older. The use of Prevenar 13 should be determined on the basis of local recommendations taking into consideration the impact of invasive disease in these age groups as well as the variability of serotype epidemiology in different geographical areas. **Dosage and Administration:** For intramuscular injection. It is recommended that infants who receive a first dose of Prevenar 13 complete the vaccination course with Prevenar 13. **Infants aged 6 weeks-6 months:** *Three dose primary series* The recommended immunisation series consists of four doses. The primary infant series consists of three doses, with the first dose usually given at 2 months of age and with an interval of at least 1 month between doses. The first dose may be given as early as six weeks of age. The fourth (booster) dose is recommended between 11 and 15 months of age. *Two dose primary series* After intrinsically when Prevenar 13 is given as part of a routine infant immunisation programme, a series consisting of three doses may be given. The first dose may be administered from the age of 2 months, with a second dose 2 months later. The third (booster) dose is recommended between 11 and 15 months of age. **Unvaccinated infants and children > 7 months of age:** *Infants aged 7-11 months* Two doses, with an interval of at least 1 month between doses. A third dose is recommended in the second year of life. *Children aged 12-23 months* Two doses, with an interval of at least 2 months between doses. *Children aged 2-5 years* One single dose. **Prevenar 13 vaccine schedule for infants and children previously vaccinated with Prevenar (7-valent) (*Streptococcus pneumoniae* serotypes 4, 6B, 9V, 14, 18C, 19F, and 23F).** Infants and children who have begun immunisation with Prevenar may switch to Prevenar 13 at any point in the schedule. *Children aged 12-23 months* Children who have not received two doses of Prevenar 13 during the infant series should receive two doses of the vaccine (with an interval of at least 2 months between doses) to complete the immunisation series for the six additional serotypes. Alternatively, complete the immunisation series according to official recommendations. *Children aged 2-5 years* One single dose. *Adults aged 50 years and older* One single dose. The need for revaccination with a subsequent dose of Prevenar 13 has not been established. Regardless of prior pneumococcal vaccination status, if the use of 23-valent polysaccharide vaccine is considered appropriate, Prevenar 13 should be given first. **Contra-indications:** Hypersensitivity to the active substances, to any of the excipients, or to diphtheria toxoid. As with other vaccines, the administration of Prevenar 13 should be postponed in subjects suffering from acute, severe febrile illness. However, the presence of a minor infection, such as a cold, should not result in the deferral of vaccination. **Warnings and Precautions:** Do not administer intravascularly. Appropriate medical treatment and supervision must be available in case of anaphylaxis. It should not be given to individuals with thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injection, but may be given subcutaneously if the potential benefit clearly outweighs the risks. Prevenar 13 will only protect against *Streptococcus pneumoniae* serotypes included in the vaccine, and will not protect against other microorganisms that cause invasive disease, pneumonia, or otitis media. As with any vaccine, Prevenar 13 may not protect all individuals receiving the vaccine from pneumococcal disease. Individuals with impaired immune responsiveness, whether due to the use of immunosuppressive therapy, a genetic defect, human immunodeficiency virus (HIV) infection, or other causes, may have reduced antibody response to active immunisation. Safety and immunogenicity data for Prevenar 13 are not available for individuals in specific immunocompromised groups (e.g., congenital or acquired spleen dysfunction, HIV infected, malignancy, haematopoietic stem cell transplant, nephrotic syndrome) and vaccination should be considered on an individual basis. **Infants and children aged 6 weeks to 5 years:** Limited data have demonstrated that Prevenar 7 when three dose primary series induces an acceptable immune response in infants with sickle cell disease with a safety profile similar to that observed in non-high-risk groups. Children younger than 2 years old should receive the appropriate for age Prevenar 13 vaccination series. The use of pneumococcal conjugate vaccine does not replace 23-valent polysaccharide vaccine in at risk children ≥2 years of age. Children ≥2 years of age at high risk, previously immunised with Prevenar 13 should receive 23-valent pneumococcal polysaccharide vaccine whenever recommended. The potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunisation series to very premature infants (born ≥28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. Antipyretic treatment should be started according to local treatment guidelines for children with seizure disorders or a prior history of febrile seizures, or when vaccinating simultaneously with whole cell pertussis vaccines. **Fertility, Pregnancy & Lactation:** There are no data from the use of pneumococcal 13-valent conjugate in pregnant women. It is unknown whether pneumococcal 13-valent conjugate is excreted in human milk. **Side Effects:** Adverse reactions reported in clinical studies or from the post-marketing experience for all age groups are listed in this section per system organ class, in decreasing order of frequency and seriousness. The frequency is defined as follows: *Very common* (≥1/10), *common* (≥1/100 to < 1/10), *uncommon* (≥1/1,000 to < 1/100), *rare* (≥1/10,000 to < 1/1,000), *very rare* (<1/10,000), *not known* (cannot be estimated from available data). **Infants and children aged 6 weeks to 5 years:** *Very common* (≥1/10): Decreased appetite, fever, pyrexia, irritability, any injection-site reactions (including erythema, induration/swelling ≥2.5cm – 7.0cm after booster dose and under children aged 2 to 5 years for pain/tenderness), drowsiness, restless sleep. *Common* (≥1/100 to < 1/10): Fever over 39°C, injection-site movement impairment due to pain, injection-site erythema or induration/swelling ≥2.5cm – 7.0cm after Infant series. *Uncommon* (≥1/1,000 to < 1/100): Vomiting, diarrhoea, injection-site erythema, injection-site swelling > 7.0cm, crying. *Rare* (≥1/10,000 to < 1/1,000): Hypersensitivity reaction including face oedema, dyspnoea, bronchospasm, convulsions (including febrile convulsions), hypotonic-hyporesponsive episode, rash, urticaria or urticaria-like rash, anaphylactic/anaphylactoid reaction including shock, eye oedema, injection-site urticaria, injection-site dermatitis, injection-site pruritis, flushing. *Very rare* (≤1/10,000): Lymphadenopathy (localised to the region of the injection site), erythema multiforme. *Additional information in special populations:* Apnoea in very premature infants (≥28 weeks of gestation). **Adults aged 50 years and older:** *Very common* (≥1/10): Decreased appetite, headaches, diarrhoea, rash, chills, fatigue, injection-site erythema, injection-site induration/swelling, injection-site pain/tenderness, limitation of arm movement, arthralgia, myalgia. *Common* (≥1/100 to <1/10): Vomiting, pyrexia. *Uncommon* (≥1/1,000 to < 1/100): Nausea, hypersensitivity reaction including face oedema, dyspnoea, bronchospasm, lymphadenopathy (localised to the region of the injection site). **Legal Category:** POM. **Package Quantities:** Pack of 1 single-dose pre-filled syringe (with separate needle) or pack of 10 single-dose pre-filled syringes. **Cost:** There is no cost to immunisers supplied under the UK routine childhood immunisation programme. Cost for supply outside the UK routine childhood immunisation programme: Single-dose pre-filled syringe (with separate needle) pack of 1: £68.10; single-dose pre-filled syringe pack of 10: £681. **Marketing Authorisation Numbers:** Single-dose pre-filled syringe (with separate needle) pack of 1: EU/1/09/520/002; single-dose pre-filled syringe pack of 10: EU/1/09/520/003. **Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent CT13 9NJ United Kingdom. **For full prescribing information and details of other side effects see Summary of Product Characteristics.** Further information is available on request from Medical Information Department at Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS, UK. **Date of Prescribing Information:** July 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 Pfizer Medical Information on 01304 616161

Reference: 1. World Health Organisation. 23-valent pneumococcal polysaccharide vaccine: WHO position paper. Wkly Epidemiol Rec. 2008;83:373-384. **2.** Centers for Disease Control and Prevention. 2011. Active Bacterial Core Surveillance Report, Emerging Infections Program Network, Streptococcus pneumoniae, 2010. Available via the Internet: http://www.cdc.gov/abcs/reports-findings/survreports/spneu10.pdf. **3.** Prevenar 13 Summary of Product Characteristics July 2012.

Pfizer Vaccines

www.pfizervaccines.co.uk

PREV0066a Date of Preparation October 2012 *Trademark

1 in 4

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

ZOSTAVAX®▼

Shingles (herpes zoster) vaccine (live)

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

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® powder and solvent for suspension for injection [shingles (herpes zoster) vaccine (live)] *Refer to Summary of Product Characteristics for full product information.* **Presentation:** Vial containing a lyophilised preparation of live attenuated varicella-zoster virus (Oka/Merck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque-forming units) varicella-zoster virus (Oka/Merck strain). **Indications:** Active immunisation for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN) in individuals 50 years of age and older. **Dosage and administration:** A single dose should be administered by subcutaneous injection, preferably in the deltoid region. **Contraindications:** Hypersensitivity to the vaccine or any of its components (including neomycin). Individuals receiving immunosuppressive therapy (including high-dose corticosteroids) or who have a primary or acquired immunodeficiency. Individuals with active untreated tuberculosis. Pregnancy. **Warnings and precautions:** Appropriate facilities and medication should be available in the rare event of anaphylaxis. Deferral of vaccination should be considered in the presence of fever. In clinical trials with Zostavax, transmission of the vaccine virus has not been reported. However, post-marketing experience with varicella vaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varicella-zoster virus (VZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zostavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zostavax may not result in protection in all vaccine recipients. **Pregnancy and lactation:** Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Caution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. **Undesirable effects:** Very common side effects include: pain/tenderness, erythema, 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

Debate: should patients who DNA be charged?
▶ page 20

STROKE

NICE 'illogical' on stroke, says RCP

Royal College says TIA and stroke are the same disease process so should both be treated with clopidogrel

By Mark Gould

GPs have been advised to prescribe the antiplatelet treatment clopidogrel after a transient ischaemic attack, even though it is not licensed for this indication and is not recommended in NICE guidelines.

The advice comes in new guidance from the Royal College of Physicians that recommends the management of patients after stroke and a TIA should be the same. It advises GPs to ignore 'illogical' 2008 NICE guidelines that recommend dipyridamole plus aspirin for TIA and clopidogrel after a stroke.

Published last month, the RCP guidelines said a 'unified approach' was needed in the treatment of TIA and stroke.

'Clinicians have tended to treat TIA and ischaemic stroke as different manifestations of the same disease so it is illogical to have different treatment strategies for the two,' they said.

'While clopidogrel does not have a licence for use after TIA, as the more cost-effective and better-tolerated option it was felt that the benefits of recommending this drug as a first line outweigh any disadvantages.'

Professor Tony Rudd, professor of stroke medicine at Kings College London and co-author of the RCP guideline, said: 'The reason why we have deviated from NICE is because we consider stroke and TIA to be the same condition, just differing in severity, and therefore it is illogical to treat them differently.

'The combination of aspirin and dipyridamole is certainly no better than clopidogrel alone and is often not well tolerated. It also has to be given twice a day rather than once a day.'

Dr Kathryn Griffith, a GPSI in cardiology in York, welcomed the guidance.

She said: 'When a patient is discharged from hospital after a TIA we prescribe clopidogrel – it's cheaper and it's better tolerated, and it's a once-a-day dose so you get better compliance.'

A NICE spokesperson responded: 'Unless the Department of Health indicates otherwise, NICE will not publish guidance on the use of a technology for indications for which regulatory approval has not been granted in the UK.'

'Because clopidogrel is not licensed for the treatment of transient ischaemic attack, no recommendations could be made in the 2010 NICE technology appraisal.'

@pulsetoday

Clopidogrel does not have a licence for use after a TIA

NICE vs RCP TIA guidance

	NICE	RCP
First choice	Dipyridamole + aspirin	Clopidogrel
Second choice	Dipyridamole	Dipyridamole + aspirin

Source: NICE CG 153, October 2012; RCP National Guidelines for Stroke, 4th edition, September 2012

PULSE CPD
Stroke and transient ischaemic attack
pulse-learning.co.uk

SMOKING

NICE backs wider use of NRT

GPs should prescribe nicotine replacement therapy to patients who want to smoke less rather than quit, according to new NICE draft guidance.

Currently, NICE recommends GPs only provide NRT for patients who have set a date to quit smoking. But new draft guidelines advise GPs to broaden the range of patients they consider for NRT, and include those who wish to cut down prior to quitting, smoke fewer cigarettes or temporarily abstain.

It comes after a study published by UK researchers last year recommended GPs should offer treatment to all smokers whether or not they have expressed an interest in quitting.

Professor Mike Kelly, director of the NICE Public Health Centre, said: 'Smoking less is an option for those who are not interested in quitting, although the health benefits are not clear.

'However, for some this can kick-start a gradual change in behaviour that eventually leads them to quit smoking.'

But Dr Alex Bobak, a GP in south London and smoking cessation adviser at Wandsworth PCT, criticised the guidance for focussing solely on NRT.

He said: 'The goal has to be to get people to stop smoking. We must offer all available therapies as well as support.'

PSORIASIS

Ask about well-being in psoriasis, GPs told

GPs should ensure the psychological and social well-being of patients with psoriasis as well as managing their skin, NICE guidance has recommended.

NICE said the guideline – published last month – would ensure that the mental health of patients with psoriasis was not 'overlooked'.

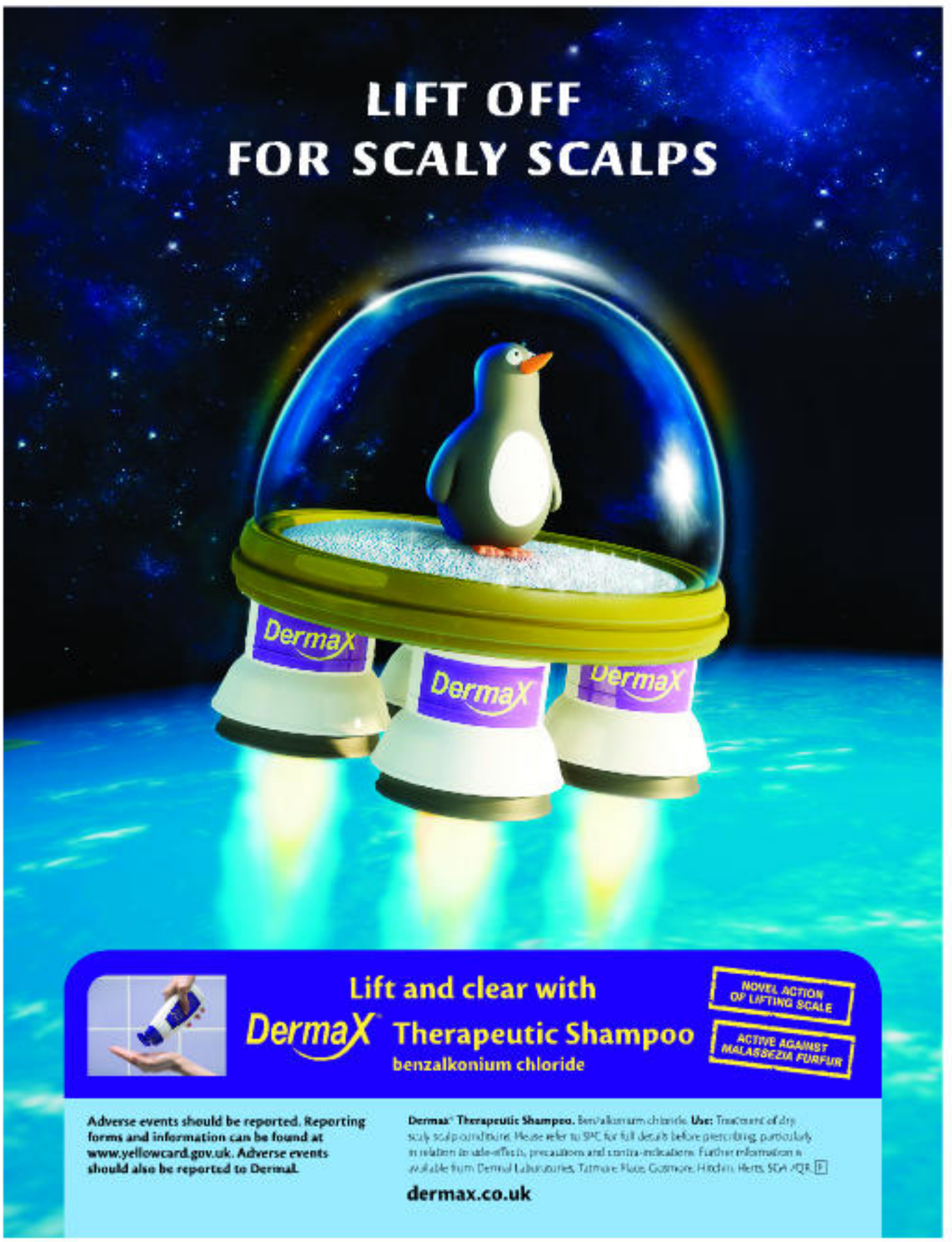
The advisory body recommends new checks for anxiety and depression in patients with psoriasis, and an assessment of how the condition affects the patient's participation in social and physical activities, employment and education.

Professor Mark Baker, director of the Centre for Clinical Practice at NICE, said: 'Clinical practice for the treatment of psoriasis is variable across the NHS. This guideline provides clear advice to improve comfort and minimise its effects.'

Dr Stephen Hayes, a GPSI in dermatology in Southampton, welcomed measures to improve care for psoriasis patients as the condition is 'underestimated and undertreated'.

He said: 'It's a rotten, lifelong, incurable disease that makes people depressed and is given a very low priority in the NHS.'

PULSE CPD
Key questions on psoriasis
pulse-learning.co.uk



Myalgia on his initi
Switch to CRESTOR 5mg before exe

Prescribing Information CRESTOR®
Consult Summary of Product Characteristics (SmPC) before prescribing
Use In patients unresponsive to diet and other non-pharmacological measures, CRESTOR is indicated in adults, adolescents and children aged 10 years or older for primary hypercholesterolaemia (including heterozygous familial hypercholesterolaemia), homozygous familial hypercholesterolaemia, or mixed dyslipidaemia. CRESTOR is also indicated for prevention of cardiovascular events in patients who are estimated to have a high risk for a first cardiovascular event, as an adjunct to correction of other risk factors. **Presentation** CRESTOR is supplied as film-coated tablets containing 5mg, 10mg, 20mg, or 40mg of rosuvastatin. **Dosage and administration** *Treatment of hypercholesterolaemia:* The recommended starting dose for all patients (including those being switched from other statins) is CRESTOR 5 or 10mg once daily. The choice of start dose should take into account the patient's cholesterol level and future cardiovascular risk as well as the potential risk for adverse reactions. A dose adjustment to the next dose level can be made after 4 weeks, if necessary. When titrating to the maximum dose of 40mg, specialist supervision is recommended and should only be considered in patients with severe hypercholesterolaemia at high cardiovascular risk. Doses may be given at any time of the day with or without food. Paediatric use should only be carried out by specialists. *Children and adolescents 10 to 17 years of age:* the usual start dose is 5mg daily. The usual dose range is 5-20mg orally once daily. The 40mg dose is not suitable for use in paediatric patients. *Children under 10 years:* Safety and efficacy have not been established in children younger than 10 years. *Elderly:* A start dose of 5mg is recommended in patients >70 years. *Asian patients:* 5mg recommended start dose. *Renal impairment:* 5mg recommended start dose in patients with moderate renal impairment (creatinine clearance <60 ml/min). *Patients with pre-disposing factors to myopathy:* 5mg recommended start dose. *Prevention of cardiovascular events:* the dose used in the cardiovascular events risk reduction study was 20 mg. However, use a lower dose if you have any of the factors mentioned above. **Contraindications** Hypersensitivity to any of the ingredients; active liver disease or unexplained persistent elevations in serum transaminases; severe renal impairment; myopathy; concomitant ciclosporin; pregnancy and breastfeeding; women of child-bearing potential not using contraception. In addition, CRESTOR 40mg is contraindicated with concomitant fibrates, in patients with predisposing factors for developing myopathy/rhabdomyolysis and patients of Asian origin. **Precautions** *Renal effects:* Proteinuria seen in patients treated with higher doses of CRESTOR, in particular 40mg, where it was usually transient or intermittent. An assessment of renal function should be considered during routine follow-up of patients treated with CRESTOR 40mg. *Muscle effects:* Patients with signs and symptoms of myopathy should have their creatine kinase (CK) levels monitored. CRESTOR should be discontinued if CK levels are markedly elevated or, if muscle symptoms are severe and cause daily discomfort. Risk of myositis and myopathy may increase when administered with certain other drugs, combination of CRESTOR with gemfibrozil is not recommended and other fibrates should be used with caution with CRESTOR 5, 10 and 20mg. As with other HMG-CoA reductase inhibitors CRESTOR should be prescribed with caution in patients with pre-disposing factors for myopathy and rhabdomyolysis. CRESTOR should not be used in patients with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis. Rarely, rhabdomyolysis, occasionally associated with impairment of renal function, has been reported with all doses and in particular with doses >20mg. Very rare cases of immune-mediated necrotising myopathy have been reported during treatment or after discontinuation of CRESTOR. Neuromuscular and serologic testing and treatment with immunosuppressive agents may be required. *Liver effects:* CRESTOR should be used with caution in patients with a history of liver disease and/or alcoholism. Liver function tests should be carried out, prior to, and 3 months following the initiation of treatment. CRESTOR should be discontinued or the dose reduced if the level of serum transaminases is greater than 3-times the upper limit of normal. *Race:* Increased systemic exposure has been seen in Asian subjects. CRESTOR 40mg is contraindicated and caution should be used when making other dose decisions in such patients. *Interstitial lung disease:* Exceptional cases have been reported with some statins. If it is suspected that a patient has developed interstitial lung disease, statin therapy should be discontinued. *Diabetes Mellitus:* In patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI>30kg/m², raised triglycerides, hypertension) treatment with CRESTOR has been associated with an increased risk of diabetes mellitus. *Paediatric population:* Long-term effects of CRESTOR on puberty are unknown. Muscle symptoms following exercise or increased physical activity was observed more frequently than in adults. *Pregnancy and lactation:* CRESTOR is contraindicated in pregnancy and lactation. *Drug interactions:* CRESTOR is neither an inhibitor nor inducer of cytochrome P450 isoenzymes. CRESTOR may potentiate the anticoagulant effect of Vitamin K antagonists, monitor International Normalised Ratio (INR) upon initiation, dose adjustment and discontinuation of CRESTOR therapy. Caution should be exercised with concomitant use of CRESTOR and ezetimibe. Decrease in CRESTOR levels seen when co-administered with erythromycin or antacids containing aluminium and magnesium hydroxide. Increase in oral contraceptive level seen when co-administered with CRESTOR. Concomitant use of CRESTOR with protease inhibitors is not recommended. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Undesirable events: (refer to the SmPC for a full list of side effects)** Side effects most frequently reported in controlled clinical studies and post marketing experience: headache, dizziness, constipation, nausea, abdominal pain, myalgia, asthenia and diabetes mellitus in patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI>30 kg/m², raised triglycerides, hypertension). Rarely: myopathy (including myositis), rhabdomyolysis with and without acute renal failure, hypersensitivity reactions including angioedema, pancreatitis. Very rarely: arthralgia, jaundice, hepatitis, polyneuropathy, haematuria, memory loss, gynaecomastia. Unknown frequency: cough, dyspnoea, diarrhoea, Stevens-Johnson syndrome, immunemediated necrotising myopathy, oedema. Other usually transient side effects: elevations in transaminases and CK levels, proteinuria. The following side effects have been reported with some statins: depression, sleep disturbances, sexual dysfunction, in exceptional cases, interstitial lung disease and tendon disorders. **Legal Category** POM. **Marketing Authorisation numbers** CRESTOR 5mg PL 17901/0243; CRESTOR 10mg PL 17901/0201; CRESTOR 20mg PL 17901/0202; CRESTOR 40mg PL 17901/0203. **Basic NHS price** CRESTOR 5mg (28 tablets), £18.03; CRESTOR 10mg (28 tablets), £18.03; CRESTOR 20mg (28 tablets), £26.02; CRESTOR 40mg (28 tablets) £29.68. **Further information is available from the Marketing Authorisation Holder** AstraZeneca UK Ltd, 600 Capability Green, Luton, LU1 3LU, UK.

'CRESTOR' is a trademark of the AstraZeneca group of companies.
Licensed from Shionogi & Co Ltd, Osaka, Japan.

Date of preparation 08/2012 CV 12 0134

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 AstraZeneca on 0800 783 0033.

References:
1. www.gpcontract.co.uk (accessed October 2012).
2. CRESTOR Summary of Product Characteristics. Available at: www.emc.medicines.org.uk (accessed October 2012).

2212205 November 2012

The recommended start dose for CRESTOR (including patients being switched from other statins) is 5 or 10mg once daily. If necessary, titrate up to either 10 or 20mg after 4 weeks[2]

Key questions on atrial fibrillation ▶ page 32

Putting women on HRT soon after menopause halves risk of death or major CVD events, study finds

WOMEN'S HEALTH

Early HRT 'boosts health benefits'

By David Swan

GPs should initiate HRT as early as possible after menopause, as it can halve a woman's risk of death or a serious cardiovascular event, say researchers.

The 10-year study found that initiating HRT less than two years after women have stopped menstruating resulted in a significant 52% reduction in a combined endpoint of death, heart failure or myocardial infarction, compared to women not receiving treatment. The study adds support to the 'timing hypothesis' for HRT, which states that differences in cardiovascular outcomes are explained by the time between menopause onset and the start of HRT.

Danish researchers followed 502 women aged 45 to 58 years whose last menstrual bleed was three to 24 months prior to being given HRT or who had perimenopausal symptoms in combination with recorded postmenopausal serum FSH values.

Ten-year follow up data was compared with 504 controls who did not take HRT.

Although the 52% reduction in the composite endpoint was significant, a 43% reduced risk of death, an 86% decrease in heart failure risk and a 75% reduced likelihood of myocardial infarction in the HRT group were not.

There was no significant difference between the groups for cancer occurrence (36 cases in the HRT group and 39 in the control group). Breast cancer rates were also non-significant between the groups (10 in the intervention arm, 17 in the controls).

These results from the Danish Osteoporosis Prevention Study conflict with the Women's Health Initiative (WHI) study in 2010. That found combined HRT was associated with a 25% increase risk of invasive breast cancer in a group of women aged 50 to 79 years, compared with those not taking HRT, but it involved elderly women who had been post-menopausal for a number of years before receiving HRT.

This new study was supposed to last for 20 years but was stopped early because of the WHI data.

Study lead Dr Louise Lind Schierbeck, registrar in endocrinology at Hvidovre Hospital in Denmark, said: 'Our findings suggest that initiation of HRT in women early after menopause significantly reduces the risk of the combined endpoint of mortality, MI or heart failure.

'Importantly, early initiation and prolonged HRT did not result in an increased risk of breast cancer or stroke.'

Dr Fiona Cornish, president of the Medical Women's Federation and a GP in Cambridge, said the study was good news for GPs.

She said: 'HRT is so effective for treating menopausal symptoms, yet we have felt apprehensive about promoting it because of the perceived risks of cardiovascular events.

'I have always been baffled by its apparent change of position from beneficial to risky, and this study looking at the specific issues of starting time and age seems to clarify the situation and allow us to make use of HRT to the great benefit of women.'

But Dr Sally Hope, honorary research fellow in women's health at Oxford University and a retired GP, felt the study needed a larger cohort.

She said: 'This is an interesting study. However, it is too small to make any firm conclusions either way. I wish they'd done a several-orders-of-magnitude-bigger study.'

BMJ 2012, online 9 October

Initiating HRT within two years of menopause was linked to a significant reduction in mortality

Early use of HRT

Death, heart failure or MI	52%↓
Risk of stroke	no increase
Risk of any cancer	no increase
Risk of breast cancer	no increase

Source: BMJ online 9 October

Online CPD

PulsePlus on women's health

pulse-learning.co.uk

SORE THROAT

Relief for sore throats

A single dose of oral steroids may help increase the rate of recovery in patients with painful sore throats, a new analysis concludes.

The Cochrane analysis summarised the results of eight randomised trials covering almost 750 adults and children, and showed those taking oral or intramuscular steroids were three times more likely to have no pain 24 hours later, compared with placebo or standard care.

Fewer than four people needed to be treated to prevent one person still having pain from a sore throat 24 hours after taking the drugs.

The steroid also reduced the mean time to onset of pain relief and the mean time to complete resolution of pain by six and 14 hours respectively.

The UK and Australian researchers admitted antibiotics were used in most of the studies, so evidence was 'lacking' for the benefit of steroids alone.

Study author Dr Matthew Thompson, a GP in Oxford and a clinical researcher at the University of Oxford, told Pulse: 'The take-home message for GPs is that using a single dose of steroids in patients with sore throat seems to provide some therapeutic benefit.'

Cochrane Collaboration, online, 17 October

HYPERTENSION

Diastolic BP warning

Transiently raised diastolic blood pressure is linked with a raised risk of death, especially in women, say researchers.

They looked at more than 20,000 patients whose records were flagged for long-term follow up in the early 1970s to look at the long-term effects of diastolic hypertension.

Initial results after an average follow-up of 29 years showed that those with diastolic hypertension and transiently raised high diastolic pressure were at increased risk of death and death from cardiovascular causes. But when the researchers from Imperial College London looked in more detail they saw that the link was only significant in women.

Transient diastolic hypertension was linked with a 57% increased risk of total and cardiovascular mortality in women and sustained diastolic hypertension was found to increase this risk by 39%.

The researchers concluded: 'Transient diastolic hypertension does not seem to be benign, particularly in women and may point to those at higher cardiovascular risk when seen in a general practice population.'

Journal of Hypertension, online 17 October

STROKE

Elderly missing out on warfarin therapy

Elderly patients are missing out on warfarin therapy, even after taking into account that their age puts them at higher risk of bleeding, UK researchers have warned.

Reluctance to anticoagulate this group seems to be based on age, rather than stroke or bleeding risk, suggests the analysis of the General Practice Research Database.

The data from more than 81,000 patients with atrial fibrillation diagnosed between 2000 and 2009 found only a third of patients aged over 80 were put on warfarin compared with 57% of those in their sixties, and 55% of those in their seventies.

Categorising patients by bleeding risk showed that the very elderly were significantly less likely to be prescribed warfarin regardless of whether the benefits outweighed the risks.

The University of Cambridge researchers also showed that women and those with a low basal metabolic index, dementia, and higher bleeding risk scores were less likely to be started on the anticoagulant.

The researchers concluded: 'The low use of warfarin in people aged 80 years is not explained by increased comorbidity or increased bleeding risk.'

Heart, online 19 October

NEW LAMA FOR COPD

Eklira® Genuair® ▼

aclidinium bromide inhalation powder

18% less initiation cost vs. tiotropium HandiHaler®7*

Around-the-clock COPD symptom control, making a real difference to patients' lives[1,2]

- Comparable efficacy to traditional LAMA treatment with twice daily dosing[3-5†]
- Sustained bronchodilation from day 1[1]
- Improves patients' breathlessness and health status**(vs. control)[1]
- Simple and easy-to-use device[3,5-7]
- 15% annual cost saving vs. tiotropium[7††]

* Based on the cost of 1 Spiriva® HandiHaler® vs. Eklira® Genuair® initiation at month 1

† Network meta-analysis and phase III study evaluation of aclidinium vs. tiotropium

** 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

Eklira® Genuair® ▼
322 micrograms inhalation powder aclidinium bromide

Active Ingredient: Each delivered dose contains 375 µg aclidinium bromide equivalent to 322 µg of aclidinium. Each metered dose contains 12.6 mg lactose monohydrate. **Indication:** As a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD). **Dosage and Administration:** The recommended dose is one inhalation of 322 µg aclidinium twice daily. *Consult SmPC and package leaflet for method of administration.* **Contraindications, Warnings, etc:** *Contraindications:* Hypersensitivity to aclidinium bromide, atropine or its derivatives, including ipratropium, oxitropium or tiotropium, or to the excipient lactose monohydrate. *Precautions:* Should not be used to treat asthma or for relief of acute episodes of bronchospasm, i.e. rescue therapy. May cause paradoxical bronchospasm. Re-evaluation of the treatment regimen should be conducted if there is a change in COPD intensity. Use with caution in patients with a myocardial infarction during the previous 6 months, unstable angina, newly diagnosed arrhythmia within the previous 3 months, or hospitalisation within the previous 12 months for heart failure functional classes III and IV as per the "New York Heart Association". Consistent with its anticholinergic activity, dry mouth has been observed and may in the long term be associated with dental caries. Also, use with caution in patients with symptomatic prostatic hyperplasia or bladder-neck obstruction or with narrow-angle glaucoma. Patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. *Interactions:* Although co-administration with other anticholinergic- containing medicinal products is not recommended and has not been studied; no clinical evidence of interactions when taking the therapeutic dose has been observed. *Pregnancy and lactation:* Aclidinium bromide should only be used during pregnancy if the expected benefits outweigh the potential risks. It is unknown whether aclidinium bromide and/or its metabolites are excreted in human milk. The benefit for the breast-feeding child and long-term benefit of therapy for the mother should be considered when making a decision whether to discontinue therapy. *Ability to drive and use machines:* The effects on the ability to drive and use machines are negligible. The occurrence of headache or blurred vision may influence the ability to drive or use machinery. **Adverse Effects:** *Common:* sinusitis, nasopharyngitis, headache, cough, diarrhoea. *Consult SmPC in relation to other side-effects.* **Legal Category:** POM **Marketing Authorisation Number(s):** EU/1/12/778/002 – *Carton containing 1 inhaler with 60 unit doses.* **NHS Cost:** £28.60 (excluding VAT) **Marketing Authorisation Holder:** Almirall S.A. General Mitre, 151 08022 Barcelona Spain. **Further information is available from:** Almirall Limited, 1 The Square, Stockley Park, Uxbridge, Middlesex UB11 1TD, UK. Tel: (0) 207 160 2500. Fax: (0) 208 7563 888. Email: almirallprofessionalinformation.co.uk

Date of Revision: 09/2012 **Item code:** UKACL1352 Eklira and Genuair are both registered trademarks.

Almirall

Solutions with you in mind

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.

Date of preparation: October 2012

UKACL1332

At their age you'd think they'd know better...

...fortunately for them there's

TRAXAM® GEL

FELBINAC

Relieves pain and inflammation

Prescribing Information
Traxam® Gel (Felbinac)
Presentation: Traxam Gel 3% w/w is a clear, non-greasy, non-staining gel containing 30mg felbinac in each gram. **Indication:** Topical anti-inflammatory and analgesic for the relief of rheumatic pain, pain of non-serious arthritic conditions and soft tissue injuries such as sprains, strains and contusions. **Dosage and Administration:** Cutaneous administration. **In adults and elderly:** Rub 1g Traxam Gel (approximately 1 inch/2.5cm of gel) lightly into the affected area(s) 2 to 4 times a day. Do not exceed total daily dose of 25g regardless of the size or number of affected areas. **Children:** Not recommended. Wash hands following application unless they are the site of treatment. **Contraindications:** Hypersensitivity to the ingredients. Patients in whom attacks of asthma, urticaria or acute rhinitis are precipitated by aspirin or other non-steroidal anti-inflammatory drugs. **Special Precautions and Warnings:** Use of Traxam should be limited to intact and non-diseased skin and it should not be applied with occlusive dressings, or simultaneously to the same site as other topical preparations. Discontinue if rash develops. Contact with mucous membranes and the eyes should be avoided. Topical application of large amounts may result in systemic effects, such as hypersensitivity, asthma and renal disease. To avoid the possibility of photosensitivity, patients should be advised against excessive exposure of treated areas to sunlight. **Pregnancy and Lactation:** Not recommended. **Interactions:** Serum levels following topical application are extremely low and therefore clinical drug interactions are unlikely. Concurrent use of aspirin or other NSAIDs may result in increased incidence of adverse reactions. **Adverse Effects:** The overall incidence of side effects reported with Traxam Gel is low (less than 2%). Anaphylaxis, respiratory reactivity (including asthma, aspirin-induced asthma or dyspnoea, purpura, angioedema, bullous dermatoses (including conjunctival necrolysis and erythema multiforme) and skin photosensitivity have been reported. Local reactions such as mild erythema, irritation, dermatitis, pruritus and paraesthesia which recover upon cessation of treatment may be seen with Traxam Gel/Foam. Whilst systemic side effects are rare, gastrointestinal disturbances and hypersensitivity reactions such as rashes and bronchospasm have been reported. **Please refer Summary of Product Characteristics for detailed information. Legal Category:** POM.

MercuryPharma

Basic NHS Cost: 100gm gel £8.03. **Marketing Authorisation Numbers:** PL 12762/0085. **Marketing Authorisation Holder:** Mercury Pharmaceuticals Ltd., NLA Tower, 12-16 Addiscombe Road, Croydon, Surrey, CR0 0XT, UK. **Date of preparation:** July 2012.

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

Visit **www.managingpain.co.uk** for more information.
UK/TRAXDW/1204/2012. Date of preparation: July 2012.

Revalidation will drive GPs into early retirement
▶ page 24

Breast screening 'overdiagnoses'

Report finds for every death delayed, breast cancer screening prompts unnecessary treatment for three women

By Madlen Davies

The Department of Health has said it will rewrite the advice it gives to women before breast cancer screening, following a report showing the programme prevents deaths, but also results in overdiagnosis.

The meta-analysis of evidence found women who were invited for breast cancer screening had a 20% reduced relative risk of dying from breast cancer compared with women who weren't invited.

But it also suggested just over 1% of the roughly 307,000 women invited for screening every year are being treated for cancers that would not have caused problems in their lifetime.

Jointly commissioned by Cancer Research UK and the DH, the panel concluded the benefits of early detection and treatment with screening outweighed the harms, but added that women should be made aware of the risks so they could make an informed decision.

The panel conducted a meta-analysis of 11 randomised controlled trials assessing whether breast cancer screening resulted in fewer deaths and the evidence for over-diagnosis, compared with no screening.

Although it acknowledged there were limitations to the studies - all of which took place more than 20 years ago - it found the current breast cancer screening programme prevented about 1,300 deaths from breast cancer a year. It also found around 4,000 cases were overdiagnosed each year, with women receiving surgery, radiotherapy and medication for cancers that may not have come to clinical attention in the woman's lifetime were it not for screening.

Study author Sir Michael Marmot, director of the Institute of Health Equity at University College, London, concluded: 'On the positive side, screening confers a reduction in the risk of mortality of breast cancer. On the negative side, there is perhaps a 1% chance of having a cancer diagnosed and treated that would never have caused problems.'

Breast cancer screening is thought to save 1,300 deaths annually

Impact of breast cancer screening

For 10,000 UK women invited to screening from the age of 50 years, for 20 years

681 cancers discovered

129 represent overdiagnosis

43 deaths will be prevented

Source: *Lancet* 2012, online, 30 Oct

Dr Phil Sawyer, a GP in St Albans, Hertfordshire, and Mount Vernon Cancer Network primary care lead, said: 'The breast cancer screening programme will need to review its communications to ensure a full understanding of the risks and benefits.'

Professor Mike Richards, national cancer director at the DH, said it was looking at how to best revise the information women receive before screening in the light of the review.

▶ Margaret McCartney, page 23

Public faith in NHS reforms falls

The public is becoming more pessimistic over the impact of the Government's changes to the NHS, with 43% saying they think things would get worse under the reforms, a DH-commissioned poll reveals.

The Ipsos Mori poll of 1,015 people found 69% were happy with the running of the NHS, but a quarter said they thought the NHS reforms would mean cuts to services and 15% said they thought more services would be provided by the private sector.

Seven in 10 who mentioned either of these changes thought services would get worse.

Some 43% said they expected the Government's reforms to make things worse, compared with 38% surveyed last December. The number of people who thought the changes would provide a good service in the future dropped from 50% in December last year to 44% this year.

Most people (67%) admitted they knew little or nothing about the way the NHS was changing, although their knowledge of commissioning was increasing.

One respondent in five spontaneously mentioned the role of GPs and other healthcare professionals in commissioning, up from 13% in December 2011.

The involvement of GPs and other healthcare professionals in commissioning would improve things in the NHS, said 42%, down 5% on the December survey.

IN BRIEF

Health checks panned

General health checks by GPs are of little use and should be scrapped, a review has found

Full story ▶ pulsetoday.co.uk/clinical

CCGs 'must join up care'

CCGs have been urged to address 'wide variations' in the urgent care system

Full story ▶ pulsetoday.co.uk/commissioning

'Amorous' email warning

Patients are increasingly using texts, emails and social networking sites to make romantic advances to doctors, the MDU has warned

Full story ▶ pulsetoday.co.uk/practice

Safe Breath for 12 hours![1]

Developed by dentists, CB12's clinically proven formulation doesn't just mask bad breath – it neutralises and prevents the cause of the problem for 12 hours with just one use.[1-2]

Scientifically proven[4-5]

In clinical trials, CB12 proved to be more effective in neutralising bad breath than 18 other leading mouthwash products.[2-3,5]

- **Unique patented formulation** – neutralises all 3 of the VSCs (Volatile Sulphur Compounds) that cause bad breath[1-2]
- **Chlorhexidine diacetate** breaks down even complex VSC gases, and adheres to mouth surfaces for a lasting effect[1-2,4-5]
- **Zinc acetate** works in synergy with Chlorhexidine to effectively neutralise bad breath-causing sulphur compounds[2-5]

The result?

Bad breath is safely under control for up to 12 hours.[1]

So, if you have patients who are worried about bad breath, recommend CB12.

www.cb12.com

References 1. Thrane PS et al, Dental Health, 2009;48(2):8-12. 2. Thrane PS et al, Dental Health, 2010;49(1):5-10. 3. Young A et al, International Dental Journal, 2003;53:237-242. 4. Thrane PS et al, The Journal of Clinical Dentistry, 2007;18(3):92-96. 5. Saad S et al, Oral Diseases, 2011;17:180-186.

MEDA

CB12/025/Sep/2012

The GPC must consult the profession

Changes to the GP contract are supposed to be the result of considered negotiation. Of late, despite intense funding pressures, the process has been remarkably smooth. But, two weeks ago, months of relatively positive contract talks – the GPC even claims a deal was close – came to a shuddering halt.

Instead of negotiation, the new health secretary issued a series of diktats. QOF thresholds would be raised and up to a quarter of indicators withdrawn. The MPIG would be phased out, the Carr-Hill formula adjusted. The only negotiation ministers appeared willing to countenance was over whether the GPC would accept this imposed deal or reject it in favour of one that will probably be worse.

Steve Nowottny
Editor

GPC chair Dr Laurence Buckman hit back, claiming GPs were 'stunned and angered', and has since mounted a PR offensive decrying 'draconian' changes. But, while the GPC's bark has been ample, its capacity to bite is unclear. We report this week it will wait for the DDRB's recommendations on GP pay in February, rather than accept the deal on the table. The hope is that in the meantime something – no one can say quite what – will alter the Government's approach.

It is understandable that the GPC does not wish to capitulate, and important that it has time to crunch the numbers. But it must engage the wider profession in decisions that affect every practice in the country.

Negotiators have always been secretive about contract negotiations, even with their own membership, while talks are under way. But continuing to be so once talks have broken down is harder to justify.

In his letter to the profession, Dr Buckman hinted darkly about the possible effect of the changes on GPs' ability to engage with commissioning, but he refuses to be drawn on exactly what that might mean. The GPC has refused even to confirm how it will formulate its response, and, crucially, whether grassroots GPs will be consulted.

Meanwhile, it is making important executive decisions. Rejecting the Government's deal out of hand, while likely to be popular, is not without risk, given that ministers could end up imposing the deal anyway but without the modest 1.5% funding uplift. Nor will there be universal support for the GPC resisting a plan to phase out the MPIG. There will be winners as well as losers from a revision of global sum funding.

The truth is the GPC has few options. The 2008 extended hours dispute proved contractual changes can be imposed. Winning over public opinion on anything to do with GP pay is a real challenge. And the BMA's flawed opposition to pension reforms – over which, again, many grassroots GPs feel they were not adequately consulted – means ministers probably consider the threat of industrial action an empty one.

What the GPC does next is crucial, not only in terms of practice funding, but in determining the balance of power between GPs and ministers in future contract deliberations. It is a decision the whole profession should have a say in.

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

When your patients suffer from severe sore throat pain

Recommend **Strefen.**

The **ONLY** anti-inflammatory lozenge for relief from throat pain, swelling and difficulty swallowing.

- Flurbiprofen for ANTI-INFLAMMATORY action
- Fast acting relief from 15 MINUTES[1]
- Long lasting for up to 4 HOURS[1]

Strefen® Flurbiprofen 8.75mg. Honey & Lemon. anti-inflammatory action. 16 lozenges

PRESCRIBING INFORMATION STREFEN HONEY & LEMON™
Contains Flurbiprofen BP 8.75 mg per lozenge Indication: Symptomatic relief of sore throat Dosage and administration: Adults and children over the age of 12 years: One lozenge sucked/dissolved slowly in the mouth every 3 - 6 hours as required. Maximum 5 lozenges in a 24 hour period. The lowest effective dose should be used for the shortest duration necessary to relieve symptoms. The patient should consult a doctor if symptoms persist or worsen, or if the product is required for more than 3 days. It is recommended that this product should be used for a maximum of three days. Children: Not indicated for children under 12 years. Elderly: No dose modification is required. As with all lozenges, to avoid local irritation, Strefen Honey and Lemon should be moved around the mouth whilst sucking. Contraindications: Hypersensitivity to flurbiprofen or any of the excipients in the product. Patients who have previously shown hypersensitivity reactions e.g. asthma, rhinitis, angioedema, or urticaria in response to aspirin or other non-steroidal anti-inflammatory drugs. Active or history of recurrent peptic ulcer/haemorrhage (two or more distinct episodes of proven ulceration or bleeding). History of gastrointestinal bleeding or perforation, related to previous NSAIDS therapy. Severe heart failure, renal failure or hepatic failure. Last trimester of pregnancy. Special warnings and precautions for use: Pregnancy and lactation: Whilst no teratogenic effects have been demonstrated in animal experiments, the use of Strefen Honey and Lemon should, if possible, be avoided during the first 6 months of pregnancy. During the 3rd trimester, flurbiprofen is contraindicated as there is a risk of premature closure of the foetal ductus arteriosus with possible persistent pulmonary hypertension. The onset of labour may be delayed and the duration increased with an increased bleeding tendency in both mother and child. Flurbiprofen appears in the breast milk in very low concentration and is unlikely to affect the breast-fed infant adversely. Undesirable effects: Strefen Honey and Lemon have the potential for inducing transient local irritation of the buccal mucosa. The most frequently reported adverse event, in clinical trials, was taste perversion. Hypersensitivity reactions have been reported and these may consist of: (a) non-specific allergic reactions and anaphylaxis; (b) respiratory tract reactivity e.g. asthma, aggravated asthma, bronchospasm, dyspnoea; (c) various skin reactions e.g. pruritus, urticaria, angioedema and more rarely exfoliative and bullous dermatoses (including epidermal necrolysis and erythema multiforme). The list of the following adverse effects relates to those experienced with NSAIDS at doses available over the counter for short-term use. In the treatment of chronic conditions, under long-term treatment, additional adverse effects may occur. Hypersensitivity reactions: Uncommon: Hypersensitivity reactions with urticaria and pruritus. Very rare: severe hypersensitivity reactions. Symptoms could be facial, tongue and laryngeal swelling, dyspnoea, tachycardia, hypotension (anaphylaxis, angioedema or severe shock). Exacerbation of asthma and bronchospasm. Gastrointestinal: The most commonly observed adverse events are gastrointestinal in nature. Uncommon: abdominal pain, nausea, dyspepsia. Rare: Diarrhoea, flatulence, constipation and vomiting. Very rare: peptic ulcer, perforation or gastrointestinal haemorrhage, melaena, haematemesis, sometimes fatal, particularly in the elderly. Ulcerative stomatitis, gastritis. Exacerbation of colitis and Crohn's disease (section 4.4). Nervous System: Uncommon: Headache. Very rare: Aseptic meningitis – single cases have been reported very rarely. Renal: Very rare: Acute renal failure, papillary necrosis, especially in long-term use, associated with increased serum urea and oedema. Hepatic: Very rare: liver disorders. Haematological: Very rare: Haematopoietic disorder (anaemia, leucopenia, thrombocytopenia, pancytopenia, agranulocytosis). Flu-like symptoms, severe exhaustion, unexplained bleeding and bruising. Dermatological: Uncommon: Various skin rashes. Very rare: Severe forms of skin reactions such as bullous reactions including Stevens-Johnson syndrome, erythema multiforme and toxic epidermal necrolysis can occur. Immune System: In patients with existing auto-immune disorders (such as systemic lupus erythematosus, mixed connective tissue disease) during treatment with ibuprofen, single cases of symptoms of aseptic meningitis, such as stiff neck, headache, nausea, vomiting, fever or disorientation have been observed (see section 4.4). Cardiovascular and Cerebrovascular Oedema, hypertension and cardiac failure, have been reported in association with NSAID treatment. Clinical trial and epidemiological data suggest that the use of NSAIDs (particularly at high doses 2400 mg daily) and in long-term treatment may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke). VMRP: £2.99 for 16s lozenges. Drug Tariff Price: £2.99. Product licence number: 0087/0135. Product Licence Holder: Crookes Healthcare Ltd, Nottingham NG2 3AA. Legal category: P. Date of preparation: 08/09/2012

All 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 Reckitt Benckiser Healthcare UK Ltd on 0500 455 456

UK/STF/0912/0007

1. Bonnimoj SI et al. Clin Drug Invest 2001; 21:183-93

How to contact Pulse

General editorial enquiries 020 7332 2904
News desk 020 7332 2904
Classified advertising 020 7332 2924
Display advertising 020 7332 2928
pulsetoday.co.uk 020 7332 2938
Email pulse@pulsetoday.co.uk

Address (editorial) Pulse, Briefing Media, 3rd Floor Mermaid House, 2 Puddle Dock, London EC4V 3DB
Delivery and subscription Medical Reader, c/o BHP, 2-3 Commercial Way, Christy Close, Southfields, Basildon SS15 6EF. Free circulation: Call 0845 1369316 or email medicalreader@binleys.com. Paid subscription: Call 01858 438805

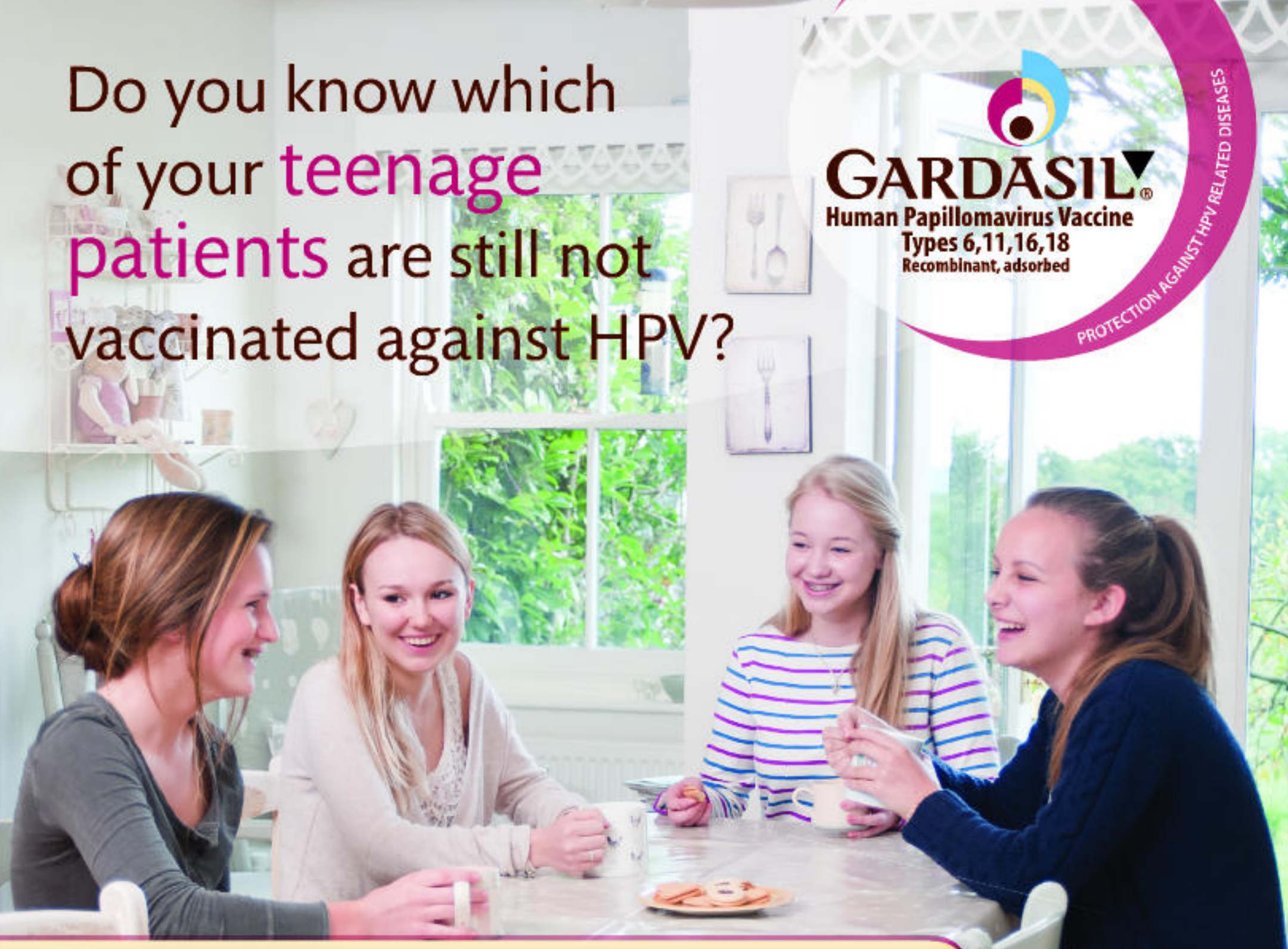
Group editor Jo Haynes
Editor Steve Nowottny
Group clinical editor Adam Legge
Deputy editor Nigel Prattas
Reporter Sofia Lind
News intern Madlen Davies
Online producer Jessica Barch
Online intern Hannah Bass
Deputy clinical editor Rhiannon Smith
Assistant clinical editor David Swan
Assistant features editor Ellie Broughton
Art director Ravi Nadoo
Art editor James Depree

Events editors Lisa Thomlinson, Kerry Holmes
Editorial adviser Dr Keith Hopcroft
General practice adviser Dr Alistair Moulds
Production controller Justine Sumner
Advertising executive Cliff Brown
Head of events Stephen Knowles
Projects director Paul Bernessem
Associate publisher Sanjay Chudasama
CEO, Briefing Media Neil Thackray
CMO, Briefing Media Rory Brown

PULSE
BriefingMedia
recycle

Registered office: Briefing Media, 3rd Floor Mermaid House, 2 Puddle Dock, London EC4V 3DB. © Briefing Media 2012. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or any information storage and retrieval system without the express consent of the publisher. The contents of Pulse are subject to reproduction in other media unless clear notice to the contrary is given. Pulse is available on subscription at £199 per year (single copy £10). Prices exclude VAT, including Europe, £327 per year (single copy £18). Refunds on unused subscriptions will be made by request at the Publisher's discretion, unless specifically agreed and in the terms of a subscription offer. Briefing Media may add suitable readers' subscriptions to other related titles. If outside the UK, to income tax at the rate applicable from time to time, please write to Pulse, Briefing Media, 3rd Floor Mermaid House, 2 Puddle Dock, London EC4V 3DB. Printed by TNT Publitheo Services, London. Printed by Polestar. ISSN 0308-5910

Do you know which of your teenage patients are still not vaccinated against HPV?



In 2010/11, over 10% of eligible girls did not start their course of HPV vaccination.[1]

You have an opportunity to change this. Gardasil® is available at no cost for GP practices through Movianto UK Ltd, for all previously unvaccinated girls aged 12-17.

Identify them, then help protect them.

For further information, contact your local Sanofi Pasteur MSD representative or visit www.123againstHPV.co.uk

ABRIDGED PRESCRIBING INFORMATION

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

Refer to Summary of Product Characteristics for full product information.

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 thrombocytopenia 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 thrombocytopenic 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.

sanofi pasteur MSD
vaccines for life

UK15592 a 08/12

If patients DNA, they should pay

Charging for no-shows is the most straightforward way to make patients understand the economics of missed appointments, argues **Dr Richard van Mallaerts**

I have a love/hate relationship with patients who do not attend their appointments.

I love the fact I can catch up when running behind, grab a quick cup of coffee, or make a start on my ever-growing in-tray. But I hate the fact that patients then complain that they can't get an appointment quickly enough, and we are always only just coping with the demand.

About one in 20 GP appointments is missed by the patient, costing the NHS approximately £162 million per year. That's a lot of money wasted at a time when NHS purse strings are getting tighter and tighter.

Like most practices we've tried various things to stop patients from failing to turn up. One practice I worked in had a 'three strikes and you're out' policy – miss three booked appointments in six months and it was time for you to find a new GP. While this might seem a little harsh, it did have the desired effect to some extent – probably by moving the worst offenders on to other practices who then had to deal with them.

When I make an appointment to see my dentist or solicitor, I am often informed that I will be charged a cancellation fee if I fail to turn up without adequate prior notification. Surely it is time to consider a similar scheme in the NHS to stem the tide of wasted appointments?

By not arriving for their appointment, the patient has prevented another patient from being seen, as well as leaving me twiddling my thumbs wondering if they'll turn up. The cost of a GP appointment is £10–£20, I estimate, and a monetary fine to the patient of this value would remind them that there is actually a cost to a service that is provided free at the point of use, as well as acting as a disincentive to them doing the same in future.

Taking responsibility

If the NHS is seen as having no monetary value, it appears worthless and is treated as such.

A trial a few years ago presented patients on discharge from hospital with a faux bill detailing their treatment and the costs of it. In a society where few can remember there being no free medical care, all the patients studied were amazed at the cost of their care.

With the ongoing negative press regarding doctors' salaries and pensions, few patients have much sympathy for wasted GP time, and not many seem bothered about the inconvenience and potential harm their fellow patients are put to either. By reminding them in a way that hits them in the wallet, they are likely to be more considerate next time – just as my car parking behaviour certainly changed after a fine.

If the fine were pitched so as to cover the cost of the appointment, no GP could be accused of seeking to profit from sick patients, and an appeal scheme could be used when there was a genuine reason for failing to attend (though I'm fairly sure of my dentist's response if I were to appeal to their cuddly side after having wasted their time).

To make a small charge in the event of a patient failing to attend their booked GP appointment will not bring about the privatisation of the NHS. It will not herald the onslaught of co-payments and a myriad of other charges for services. It will not be the end of the NHS as free at the point of use.

It will, however, encourage patients to think about the value the NHS has and realise that wasting their appointment comes at a cost. And it may even help prevent further privatisation, as patients wake up to the real worth and value of the NHS.

Dr Richard van Mallaerts is a GP in Kingston in Surrey

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

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

Probiotics have been shown to help restore the balance of gut bacteria disturbed by antibiotic use.[1,2] Actimel is a probiotic yogurt drink, containing **Lactobacillus casei DN-114 001***, which has been **shown to support the body's immune system in numerous clinical studies**[3]. In one clinical study older hospitalised patients (over 50 years of age) drinking Actimel daily[†] during a course of antibiotics and for one week after showed significantly reduced incidence of antibiotic-associated diarrhoea and C. difficile-associated diarrhoea.[4] **WGO Practice Guidelines** report "Recent research has indicated that L. casei DN-114 001* is effective in hospitalised adult patients for preventing antibiotic-associated diarrhoea and C. difficile diarrhoea".[5] Some hospitals near your practice have already started integrating it into their C. difficile management plans.

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

Information for Healthcare Professionals

* Lactobacillus casei DN-114 001/CNCM I-1518 (L. casei Danone)
† Two bottles consumed daily

References: 1. De La Cochetiere MF et al. Microb Ecol 2008;56:395–402. 2. O'Toole PW and Cooney JC. Interdisc Perspect Infect Dis 2008; 175–485. 3. Danone Research. Clinical studies – Actimel publications. Available online at: www.studies.danone.com (accessed August 2011). 4. Hickson M et al. BMJ 2007;335:80. 5. World Gastroenterology Organisation Practice Guidelines. Probiotics and Prebiotics; May 2008. Available online at: www.worldgastroenterology.org/probiotics-prebiotics.html (accessed August 2011).

AH029 May 2012

DANONE HEALTH AFFAIRS

The debate continues online

Charging for DNAs is inhumane

Hackney GP Dr Jonny Tomlinson argues fining patients who fail to attend is a 'zombie' policy – one of those proposed NHS policies that is repeatedly killed and resurrected

Go online to www.pulsetoday.co.uk/comment to read the other side of the debate and give us your verdict on whether GPs should charge for DNAs

These draconian contract changes will hurt practices and patients

An imposed deal could significantly damage GP funding, writes **Dr Laurence Buckman**

The GP contract negotiations are the most important part of the calendar for our profession, and much of the UK's primary care system relies on us getting it right. Good negotiations are not about 'winning' or 'losing'. They are about reaching agreement.

However, the Government's stance this year has made it difficult for us to reach a sensible settlement. The new health secretary Jeremy Hunt intends to impose a set of draconian new changes to the GP contract despite the fact the BMA and NHS Employers had been within sight of an agreement.

In my 16 years as a negotiator, I have been threatened by governments twice – in the case of extended hours, which were imposed, it was a decision that changed general practice dramatically.

We don't yet know in detail the terms the Government wants to impose. However, the suggestion that the MPIG will be phased out over seven years is worrying. The implication is that practices that are perceived to be 'overfunded' – that is, many PMS practices and (usually) larger GMS practices, which rely heavily on correction factor payments – would be squeezed.

The GPC negotiators' original plans for reducing funding variation between practices would have included detailed modelling of the changes for each practice, and we would have put these to the profession. Each practice would have had a chance to see its own seven-year trajectory, meaning no nasty surprises.

A grand project requires majority support, and to get support you need detail so that every GP can work out the implications of new contractual terms for themselves. I couldn't support a scheme if I thought GPs wouldn't support it.

The argument that every practice should get roughly the same funding for the same work is fundamental for our profession. It fits with the policy discussed at many LMCs conferences and has been in the pipeline for years. But if PMS GPs were to feel that they were being targeted by the project to reduce variation, we would damage the excellent work that they do. There should be changes to per capita funding, but without destabilising any practice.

The Government's proposed changes to the financial calculation for the funding of global sum risk interfering with the formula that keeps practices afloat. Under these never-discussed and undefined changes, GPs will fall victim to being funded for the population they look after, rather than how hard they work to look after those patients. Given that this has not been part of any negotiation, I have not been privy to the detail of how the Government proposes to write this into our contracts.

Changes next year

The DH suggests reducing the number of points in QOF next year by removing the entire organisational domain, bar the QP indicators and some public health indicators. It also plans to raise thresholds and reduce the time limit to achieve those points. Then it is trying to offset this enormous loss of funding by offering a number of yet-to-be-defined DESs.

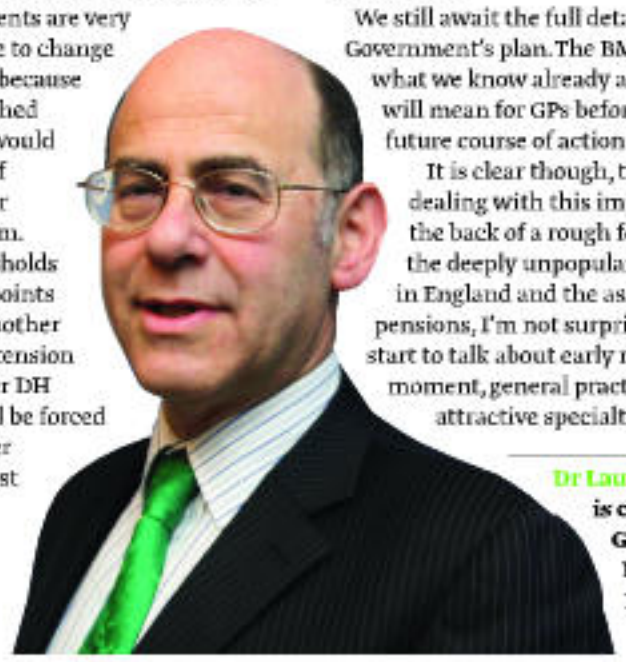
Changing thresholds and cutting QOF points is defunding

Under these proposals, most practices would lose much of the funding attached to the 139 points to be taken out of the QOF. We expect some practices would be able to maintain some of this funding, but those that struggle to achieve current thresholds because their patients are very sick or are not able to change their lifestyles, or because workload has reached saturation point, would lose big swathes of funding from their QOF income stream.

Changing thresholds and cutting QOF points is defunding by another name. Take hypertension for example: under DH proposals, GPs will be forced to chase up a larger number of the most hard-to-reach cases, and asked to recommend treatments such as anti-hypertensive drugs for elderly patients that they wouldn't normally. The evidence shows how over-tight control of certain conditions, such as diabetes, actually harms patients, but the DH is still promoting this approach. When you have accountants and politicians deciding what GPs should do, it's never as effective as asking GPs themselves.

We still await the full details of the Government's plan. The BMA is examining what we know already and what this will mean for GPs before we decide our future course of action.

It is clear though, that GPs are dealing with this imposition off the back of a rough few years. Given the deeply unpopular NHS reforms in England and the assault on our pensions, I'm not surprised when people start to talk about early retirement. At the moment, general practice isn't a terribly attractive specialty.



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

THE ELIDEL® STEROID FREE ZONE

ELIDEL®
Pimecrolimus Cream 10 mg/g
For delicate skin areas when more than a mild steroid is needed

skincareful

www.meda-psm.com

ELIDEL® is indicated for patients aged from 2 years with mild-to-moderate atopic eczema when steroids are ineffective or contraindicated.
Information about this product, including adverse reactions, precautions, contra-indications and method of use can be found in the product SPC or at www.medicines.org.uk/emc
Legal category: POM. Further information is available from the Marketing Authorisation Holder: Meda Pharmaceuticals Ltd, Skyway House, Parsonage Road, Takeley, Bishops Stortford CM22 6PU.

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 Meda Pharmaceuticals Ltd.

UK/ELI/12/0046 September 2012

MEDA

sanofi pasteur MSD
vaccines for life

We've supplied over 2.5 BILLION DOSES of flu vaccine worldwide in the last 60 years[1]...

www.flu-protect.co.uk

Visit www.flu-protect.co.uk for more information about flu and flu vaccination

FLU & YOU
A Sanofi Pasteur MSD initiative

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, Maidenhead 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

PhilPeverley

PPA COLUMNIST OF THE YEAR 2012

Ready for revalidation? I am...

The prospect of revalidation fills **Phil** with dread. But when it comes to reflection, he's already in a league of his own

It's no secret that I'm not exactly finding general practice a breeze at the moment. The daily misery, the relentless increase in workload (much of which I believe is in no way in the interests of the patient), the approach of revalidation, the fact that after five static years we've had to give ourselves a 10% pay cut this month, and the fact that my blood pressure doggedly refuses to come down to a sensible level, all means that – even after going part time recently – I am not having much fun here.

Revalidation? I am just not facing up to it at the moment. I get emails, which I don't open. There was a letter in the post this morning from the GMC, and I quote from the outside of the unopened envelope: 'Ready For Revalidation -> Starts 3 December 2012.' That's in a couple of weeks! I don't intend to open the letter until I'm a fair bit drunker than this. Maybe later tonight.

I am struggling to see the point of either annual appraisal or revalidation, for one main reason; it seems obvious to me that bad, incompetent or even frankly criminal doctors (of which there are undoubtedly more than a few) would barely break their stride in hurdling the obstacles that these processes would put in their way. It is an oft-repeated canard that Harold Shipman would have sailed through not only annual appraisal but 360-degree patient and colleague feedback. And if these processes are not designed to find people like him then what are they for? What are they actually for?

'Kafkaesque menace'

I will concede that it is marginally more sensible for our profession to organise these hoop-jumping exercises ourselves, rather than allow some outside agency to have an aggressive poke at us at random, but I'm not impressed by our efforts so far.

I'd like to quote the medical intellectual giant Dr Theodore Dalrymple at this point: 'In obeying directives not because they are right but because they are directives, doctors lose their self-respect, their probity and their intellectual honesty. Gogolian absurdity can result – with a hint of Kafkaesque menace and Orwellian linguistic dishonesty.'

I've had a somewhat arm's-length elationship with annual appraisal

And he wasn't only talking about revalidation.

I've had a somewhat arm's-length relationship with annual appraisal so far, since I discovered it wasn't a legal requirement, but revalidation is different; it *is* a legal requirement, or what passes for legal in GMC-world, so I'll have to play the game.

My impression is that appraisal and revalidation are all about reflection; the constant re-evaluation of how we practise and what we know.

And here's the rub; that's exactly what I do. I live and breathe general practice, I bore myself to death with the amount of time I spend thinking about this vocation and those patients directly under my care. I wish I could bloody well stop, but all I can do in reality is to divert my obsession into these fortnightly articles. I genuinely doubt that there are more than a few GPs more obsessively reflective than I am.

So that's my plan. When it's my turn for revalidation, I'll walk into the room, tell them that I've not had a clinical complaint in 15 years, and lay 20 photocopied Pulse articles on the table. That should be enough, shouldn't it? And if not, why not?

Dr Phil Peverley is a GP in Sunderland

MargaretMcCartney

A sea change for screening?

Last week's review of breast screening must prompt a rethink of how we assess risk, says **Margaret**

The Marmot review is in. Breast screening has now been officially recognised in the UK to be a mixed bag, with the potential for benefit but also the risk of harm through overdiagnosis and overtreatment.

This is nothing new; it's been available via Cochrane for years.[1] But now it is on the front pages of the tabloids – screening can cause harm.

From antibiotics to statins and the last stages of life, GPs deal in uncertainty. We are versed in the weighing of unknowns against each other.

Yet the immediate response of Breakthrough Breast Cancer, the Breast Cancer Campaign and Breast Cancer Care was to join together and say the review had brought 'much needed clarity – screening can save lives'.

They added: 'This is good news for women as they can now be assured that breast screening can be beneficial... however, some women who attend screening may be diagnosed and treated for a cancer that may not have caused them harm in their lifetime... We encourage all women to attend their screening appointments.'[2]

I find this amazing, in a sad way. The cancer charities are making a value judgment that women should take part in a programme that, the review found, gives a 43 in 10,000 chance over 20 years of delaying your death due to breast cancer – and that will overdiagnose 129 women over the same period, thus exposing them to treatment they cannot benefit from.[3] The chance of being harmed by unnecessary treatment is far more than the chance of extending life due to the screening; for every death delayed from breast cancer, three women are treated unnecessarily.

So what should women do? If we really mean what we say by informed choice, we must allow women the autonomy to decide for themselves.

Despite the enormous amount of 'awareness' about breast cancer, most women do not know age is a large risk factor and most overestimate the benefit of mammography.[4,5] We have to stop focussing on the throwaway advertising lines that awareness campaigns ride on, and concentrate on evidence-based knowledge. Some women will have rotten bad luck and develop breast cancer despite no apparent risk factors. But how many other women know about the effects of being overweight or excess alcohol on cancer risk; and how much investment is going into reducing population risks through evidence-based legislation on food or alcohol? We have been 'pinkwashed' by screening, which has been oversold to the extent that we are overlooking interventions that could be less harmful and more beneficial.

Now it's on the front pages – screening can cause harm

It is now up to the UK National Screening Committee to evaluate the cost effectiveness of breast screening. They will no doubt bear in mind the review was clear its numbers were best estimates, not proven facts; that it focussed on breast cancer rather than all-cause mortality, which can overestimate screening benefit; and they will also know the trials focussed on are up to two decades old, which means the effect of newer breast cancer treatments isn't going to be visible.

The Informed Choice about Cancer Screening consultation is to report in November and is likely to herald a sea change in how we describe risk and benefit to patients, via new, evidence-based information leaflets. And I predict then GPs will be busy doing what they do best: helping people deal with uncertainty as best, and as independently, as we can.

Dr Margaret McCartney is a GP in Glasgow

ILLUSTRATIONS: MARK ELLIOTT

References

1 Gøtzsche P C and Nielsen M. Screening for breast cancer with mammography. Cochrane Database of Systematic Reviews 2011; CD001877

2 The Breast Cancer Campaign. Breast screening review. www.breastcancercampaign.org/articles

3 Independent UK Panel on Breast Cancer Screening. The benefits and harms of breast cancer screening: an independent review. *Lancet* 2012: published online 30 October

4 Moser K, Patnick J and Beral V. Do women know that the risk of breast cancer increases with age? *Br J Gen Pract.* 2007; 57 (538): 404–406

5 Domenighetti G, D'Avanzo B, Egger M et al. Women's perception of the benefits of mammography screening: population-based survey in four countries. *Int J Epidemiol.* (2003) 32 (5): 816–821

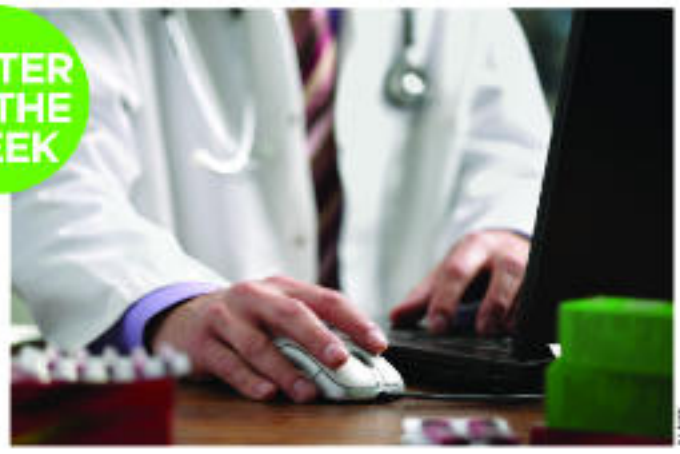
We want to hear your views

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

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

Revalidation will drive GPs into early retirement

LETTER OF THE WEEK



From Dr Phil Clarke
Southampton

I am writing this open letter to Professor Peter Rubin in his role as chair of the GMC to express my concerns over revalidation.

I have loved my 31 years' work as a GP and count it a privilege to have served my patients for so long. I am 59 and plan to retire in 2013. I would have continued in practice but I will not, because of the huge increase in unnecessary work that has been dumped on GPs by successive governments, with the collusion of the GMC and RCGP, and with the spineless response of the BMA.

I do not resent the need to work hard; what I resent is the needless work required of me simply to jump through hoops and tick boxes for the sake of political expediency.

Revalidation as it stands is an insult to the profession, and our governing and representative bodies should be ashamed of the extra pressure it is putting on GPs.

I am not against appraisal and CPD – quite the reverse, as evidenced by my involvement in training. But the prescriptive demands of revalidation are unacceptable. I have to take a week of my holiday to prepare for my appraisal – and at my last one I was told that I was not 'reflecting' and documenting enough.

One evening two weeks ago, I sent an email to every GP in Southampton expressing my sentiments. By 7.30am the next day there were seven replies, and since then my inbox has been flooded. There have even been contributions from appraisers who don't believe in the system. Only one GP tried to defend revalidation, and he had to as part of his job.

Here is a small sample of the emails I received:

- 'I probably have another 20 years left in my GP career but I don't feel that the next few years are going to be easy. I dread the whole appraisal/revalidation process. I don't have time set aside to do this. There has to be a better system to catch the Shipmans in this world.'
- 'I couldn't agree more with you. It is clear to me that the whole thing has got out of hand.'
- 'I suspect your views echo the feelings of the majority of rank-and-file GPs in their late 50s/early 60s, who are still working but talking about when rather than if they'll retire.'
- 'I am not going to work after the age of 60, for the reasons you mentioned.'
- 'I am an appraiser and I have met many doctors in their 50s who are counting the days till they retire. They still enjoy the clinical work but are going to retire because they're fed up with endless non-clinical work of limited benefit.'
- 'At 62, I have decided to retire at the end of the year, not because of the job, but because of all the tick-boxing and ennui that comes over me at every new directive.'
- 'Like you, I love the job, and have probably got better at it over the years. I do not intend going on past 60 and, while I would love to keep doing occasional sessions, the nonsense of revalidation will ensure that does not happen. I feel very sad about the way things are going'.
- 'I am now in my 68th year, working part time since age 65. I entirely agree that revalidation is complete nonsense and an insult to our professionalism. It puts a huge burden on us, on top of all the challenges heaped on us every year.'
- 'I went to a GMC/RCGP meeting on revalidation yesterday. As someone in their middle years, yesterday left me wanting to retire and hang up my stethoscope.'

I haven't sent you all the responses but I think you get the picture – it seems I am not alone.

Perhaps a full-blown manpower crisis will be what is needed to shake the GMC out of its arrogant certainty of the merits of revalidation.

The generic replacement for Predfoam®

Better patient acceptance and tolerability than equivalent liquid enemas[1,2]

PREDNISOLONE RECTAL FOAM

Please see Prednisolone 20 mg/dose Rectal Foam Summary of Product Characteristics before prescribing, particularly in relation to side effects, precautions and contra-indications.
Market Authorisation Holder: Chemidex Pharma Limited, 7 Epsom Business Village, Crabtree Road, Epsom, Surrey KT20 8RB, UK.
Legal Category: POM.

References:
1. Gupta RB, Siegel CA. Foam Preparations for the Treatment of Ulcerative Colitis. Current Drug Delivery. 2012 Jan 24.
2. Ingham JR, Rhodes J, Evans BK, Novembre RG, Thomas GA. Comparative study of enema retention and preference in ulcerative colitis. Postgraduate Medical Journal. 2005 Sept. 81(959):604-8.

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 Essential Generics on 01784 477167.

ESSENTIAL GENERICS

For further information, please contact: Essential Generics, 7 Epsom Business Village, Crabtree Road, Epsom, Surrey KT20 8RB, UK

PIP: 116-3872
MOVIANTO: PREDRF20
AAH: PRE1290T
UNICHEM: 8439937

No faith in Carr-Hill – or the GPC

From Dr Roger Boyle
Glasgow
via pulsetoday.co.uk

I thought the original Carr-Hill formula was to fund the extra expenses of a practice area with higher-than-average mortality and morbidity ('Government to press ahead with 'destabilising' Carr-Hill formula changes', pulsetoday.co.uk/news) But this didn't really work. Then the GPC's tinkering with disease prevalence by square-rooting it again had a negative effect on high-prevalence areas – generally speaking, I think it fair to say high morbidity and prevalence correlate with deprivation. I have no faith this new plan will deliver, but I have no faith in the GPC either.

From Dr Stephen McCarthy
Ipswich, Suffolk
via pulsetoday.co.uk

Unless expectations are changed then it will be very destabilising. I have worked in a deprived area for 13 years. Before the 'new contract', I earned more than in the new 'affluent' area. I now work flat out and there is no opportunity for private practice. Thank God it's not long until early retirement.

Private sector can't match our efforts

From Dr Kevin Winkle
Leeds
via pulsetoday.co.uk

I agree with the editor Steve Nowottny's blog ('GPs were promised a future of 'blood, sweat and tears' – and now it's here', pulsetoday.co.uk/blogs). You don't know what you've got till it's gone. If HM Government thinks primary care will be provided cheaper to the same quality in the hands of private companies, then they will be very surprised. Who does all these little tasks for free? GPs, receptionists and practice nurses, that's who.

Where is the evidence on religion?

From Dr Andrew Clarke
Newton Aycliffe, Co Durham

I agree wholeheartedly with Dr Ravi Vatish's letter ('The GMC is wrong; faith has a crucial role to play in patient care', pulsetoday.co.uk/letters) and disagree with Dr Richard Scott's opinion piece ('The GMC's politically correct faith ban is not in patients' best interests', pulsetoday.co.uk/opinion). Dr Scott appears to be advocating faith in the consultation room, while Dr Vatish advocates common sense.

I am an atheist but have used the patient's faith in the consultation narrative when the patient initiates it. Once a female patient actually called me 'Father', before correcting herself. I can understand how having a faith can give comfort to a patient but please, Dr Scott, where is this evidence you allude to? Was it in the *BMJ* or was it anecdotal 'evidence'? I have an open mind and would seriously like to review the research.

Lastly, to use Dr Scott's analogy, when I take my car to the mechanic, I do not ask him about my kitchen boiler! Doctors are doctors, while vicars, imams and others are there for our pastoral needs.

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

eggs

how advice has changed

It is now generally acknowledged that cholesterol in foods such as eggs does not have a significant effect on blood cholesterol in most people.[1] All major UK heart and health advisory bodies, including the British Heart Foundation, have already removed the previous limits on egg consumption linked to their cholesterol content.

And now official new data from the Department of Health[2] shows that today's eggs also contain higher levels of certain nutrients: more than 70% more vitamin D and double the amount of selenium than when previous analyses were carried out 30 years ago,[3] as well as less fat and fewer calories. This news adds to the growing evidence of the health benefits of eating eggs, so is it time to take a fresh look at eggs and the nutritional benefits they can offer to patients?

Eggs have long been recognised as a good source of high quality protein, but the new survey shows there are higher levels of nutrients than previously thought lying beneath their shells...

Vitamin D

The new analysis found that two medium eggs can provide around two thirds of the EU labelling RDA for vitamin D. The finding that eggs make a more important contribution to vitamin D intake than previously thought is particularly significant given concerns that around 20% of UK adults and 18% of children have inadequate levels of vitamin D[4] and because there is emerging evidence that low vitamin D status may be linked to increased risk of heart disease and some cancers as well as to poor bone health.[5]

Selenium

Two medium eggs now provide 42% of the RDA of selenium, meaning eggs qualify as a rich selenium source. Selenium is a mineral that is involved in the body's antioxidant defences and thyroid hormone metabolism. Recent Government data[4] indicate that low intakes are widespread, especially amongst women, so eggs could make an important contribution to selenium intake in the UK.

Choline

There are also new data for choline, which is an important component of cell membranes and is involved in fat metabolism. Eggs contain significant amounts of this nutrient - two medium eggs would provide about 50-65% of the US AI (Adequate Intake) for choline.

Omega 3

The omega 3 fatty acid content of eggs was analysed for the first time and the results indicate that, according to EC nutrition claims regulations, UK eggs qualify as a source of the fatty acid DHA. DHA is involved in maintaining normal brain and heart function.

Fat, cholesterol and weight management

The levels of total fat, fatty acids, cholesterol and energy have decreased in eggs with a medium egg now containing 66 calories, 4.6g of fat, 1.3g of saturated fat and around 177mg of cholesterol.

There is increasing evidence to suggest that eggs can help with weight management due to their satiating qualities. Several studies have shown that meals containing eggs can reduce hunger, the desire to eat, and subsequent short-term energy intake.[7] One study also showed that when an egg breakfast was consumed as part of a calorie-controlled diet, there was significantly greater weight loss and reduction in waist circumference.[8]

References

1 Grundy & Griffin. B (2009). Eggs and dietary cholesterol – dispelling the myth. Nutr Bull 36: 199-211. **2** Data produced by the UK Foodcomp project consortium funded by the Department of Health as part of their rolling programme of nutrient analysis surveys, led by the Institute of Food Research and comprising partners including British Nutrition Foundation, Royal Society of Chemistry, Laboratory of the Government Chemist and Eurofins Laboratories. **3** The changes are believed to be the result of improvements to hens' feed, an increase in the ratio of white yolk in an average egg, and improved analytical methods since the last official Government analyses were carried out: in the 1980s, vegetable oils replaced meat and bonemeal in UK hens' feed in the 1980s and it is believed that better quality oils, together with other enhancements to hens' feed, have improved the hens' absorption of fat-soluble vitamins and the take-up of nutrients. **4** Bates B et al. (2011) National Diet and Nutrition Survey: Headline results from Years 1, 2 and 3 (combined) of the Rolling Programme (2008/2009–2010/11). http://transparency.dh.gov.uk/2012/03/03/ndns-3-years-report/ **5** Ruston CHS and Derbyshire E. (2011) Health impacts of Vitamin D: are we getting enough? Nutrition Bulletin 34, 185-193. **6** Bates B et al. (2011) National Diet and Nutrition Survey: Headline results from Years 1 and 2 (combined) of the Rolling Programme (2008/2009–2009/10). Department of Health and Food Standards Agency. **7** Ruxton C (2011) Eggs and satiety. Network Health Dietitians Issue 37. **8** Van der Wal E et al. (2008) Egg breakfast enhances weight loss. Int. J. Obesity 32, 1545-51.

Pulse Special report Revalidation

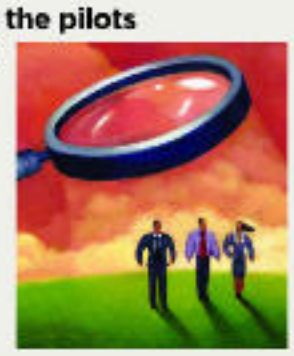
In this issue

Your guide to surviving revalidation
The GMC, RCGP and defence bodies help Pulse tackle GPs' questions
page 26

Revalidation dilemmas
The MDU and MDDUS deal with three difficult cases for GPs
page 28

How revalidation works
Our flowchart explains the process
page 29

Lessons from the pilots
GPs who took part in the revalidation pilots offer their top tips
page 30



More online

pulsetoday.co.uk/revalidation

Preparing for revalidation
1 CPD hour
What you need to know to get ready

Clinical audit: a GP guide
1 CPD hour
Choosing, planning and carrying out an effective audit

Significant event auditing
1 CPD hour
Developing an embedded SEA process

Five steps to achieving 360-degree feedback The RCGP offers a guide

Video Watch our interview with RCGP revalidation lead Professor Nigel Sparrow

Your guide to surviving revalidation

With less than a month to go until the start of revalidation, Pulse tackles GPs' most frequently asked questions

When will my revalidation take place?
The GMC will start writing to all doctors from 3 December to give them their revalidation date, and by March 2013 all doctors will have received their date. The GMC has worked with responsible officers to agree these dates, which are based on when responsible officers anticipate the doctors they oversee will be ready.

The three minimum requirements the GMC has set for a GP to be 'ready' are:

- participation in an annual appraisal process that covers all of the doctor's medical practice and has *Good Medical Practice* as its focus.
- completion of at least one appraisal, as above, which has been signed off by the doctor and their appraiser.
- demonstration through appraisal that the GP has collected and reflected on the six key pieces of evidence stipulated by the GMC (see flowchart on p29).

Any doctor who becomes fully registered with a licence to practise after 3 December will be given their revalidation date at the point of registration. Their revalidation date will almost always be set five years from the point when they became fully registered with the GMC.

How much formal notice will I get?
All doctors will be given formal notice of their revalidation date at least three months before the GMC expects to receive a recommendation from their responsible officer. Doctors will also be able to check their revalidation date via 'GMC Online', part of the GMC website.

Revalidation timetable

3 December 2012	First cycle of revalidation begins
March 2013	The majority of responsible officers and other selected medical leaders complete the process
April 2014	One fifth of licensed doctors complete revalidation
April 2016	The majority of doctors complete revalidation
January 2018	All doctors will now have been through their first cycle of revalidation

Is there any flexibility to reschedule the date of my revalidation if I am on a career break, such as maternity leave or a sabbatical?
Yes. A doctor's revalidation date can be deferred if they are on sabbatical, maternity leave or otherwise on a career break. Doctors should discuss the possibility of deferral with their responsible officer in the first instance, who can defer revalidation by up to 12 months. Primary care organisations should not expect GPs to collect supporting information and participate in an appraisal when they are on a career break. A GP can be out of practice for up to two years and continue with the normal revalidation cycle - longer than that and they will be required to take part in a return-to-practice programme.

The RCGP recommends that GPs taking a break from practice contact the organisation through which they receive their appraisal. Maternity leave should be recorded as an 'exceptional circumstance' on a doctor's portfolio so that her responsible officer can take this into account when making their recommendation.

I haven't been told who my responsible officer or my designated body are. How do I find out?
For GPs on a performers list, the designated body is the primary care organisation that manages that list. You will have one named responsible officer from that organisation. The GMC has a tool to help find your designated body on its website, which you can access via tinyurl.com/DesignatedBody.

What information will I have to supply during my next appraisal?
Annual appraisals organised by your designated body will play a crucial role in revalidation. GPs will be expected to prepare a portfolio of supporting information from every area of their practice, including any work they do for organisations other than their designated body. The GMC has stipulated six types of supporting evidence that doctors will be expected to provide at least once in each five-year revalidation cycle:

- quality improvement activity (such as clinical audits)

28

ADVERTISEMENT FEATURE

General practitioner and RCGP 'Clinical Commissioning Champion' Dr Nicholas Summerton says: 'The NHS AQP scheme has the potential to deliver substantial benefits to patients and healthcare professionals.'

ADULT AUDIOLOGY AVAILABLE ON THE HIGH STREET WITH SPECSAVERS HEARCARE

Patient choice on the NHS

Patient choice has been at the heart of NHS reforms for the past 60 years. Since the early 1990s, patients – and their healthcare professionals – have had an ever-increasing choice of where to go to receive care and treatment as part of the NHS.

The introduction this year of the Any Qualified Provider (AQP) model aims to extend patient choice even further by giving patients the choice from a number of qualified providers when they are referred for treatment.

Partnering with the NHS: acceptance of Specsavers Hearcare into the AQP initiative

Since April 2012, adult audiology services have been included as part of the AQP initiative.

Specsavers Hearcare has so far been accredited by the NHS to provide adult audiology exams and hearing aids under 23 contracts across England, with others expected to follow.

General practitioner and RCGP 'Clinical Commissioning Champion' Dr Nicholas Summerton says: 'The NHS Any Qualified Provider scheme has the potential to deliver substantial benefits to patients and healthcare professionals. From the patient's perspective, being able to access a free, high quality service "on the high street" – which is being delivered in conjunction with the NHS – is very appealing as it enhances both choice and convenience – for example, locality, opening times and the availability of appointments.'

Specsavers' commitment to delivering excellence for the NHS

Since 2006, Specsavers has delivered audiology services in partnership with leading PCTs and cared for over 100,000 NHS patient journeys. Specsavers therefore has the experience and capability to deliver a high quality service while maintaining the highest standard of patient care under AQP.

Under AQP contracts:

- All hearing tests and treatment is entirely free for the patient
- 'Competition' is judged on quality of the patient journey and the clinical outcome achieved, not on price (providers are paid the same tariff price)
- Specsavers is committed to delivering a service based on NHS core principles: free at the point of delivery and based on clinical need and not the ability to pay. There will be no attempts made encouraging patients to trade-up or purchase additional items from Specsavers
- Services pass and exceed the rigorous and standardised qualification process. These standards will be maintained moving forward

Specsavers offers a high standard of clinical expertise to its patients and flexibility of service including:

- Accessible, community-based service on the high street
- Appointments at flexible times – including weekends
- A maximum 16-day referral to treatment service
- Replacement hearing aid batteries available locally – and uniquely, a batteries-by-post delivery service
- Referral process through established Choose and Book system
- Feedback provided to GPs following consultation and recommendations for further treatment/investigation as necessary

Darius Rejali, Consultant ENT Surgeon from University Hospitals Coventry and Warwickshire, has been referring appropriate patients to Specsavers Hearcare for the last year. He says: 'Specsavers is committed to delivering excellence in clinical standards and patient care. My patients are seen quickly and tell me they're happy with the level of service they receive. I, in turn, have been impressed at the speed and standard at which I have received a follow-up communication from Specsavers detailing my patients' diagnosis and treatment plan.'

Measuring success

The Department of Health has recommended that a review of patient outcomes will be available from 2013. Specsavers will be collecting its own patient outcome and satisfaction data to share with its partner GP practices quarterly.

For more information on how Specsavers Hearing Centres can meet your AQP requirements, see our special feature at: pulsetoday.co.uk/specsavers-hearcare and our CPD accredited learning module at: pulse-learning.co.uk/commissioning-modules/commissioning/any-qualified-provider

To contact us, call 0800 077 8603 or email nhsservices@specsavers.com

Specsavers Hearing Centres

26

- feedback from patients (at least 34, if using the GMC questionnaire, once every five years)
- feedback from colleagues (at least 15, if using the GMC questionnaire, once every five years)
- continuing professional development (CPD)
- significant event audits
- a review of complaints and compliments.

Dr Caroline Fryar, medico-legal adviser at the Medical Defence Uniont (MDU), says: 'Your ability to revalidate largely depends on the success of the yearly appraisals. Failure to engage with the process could mean your responsible officer notifies the GMC and you will not be able to revalidate.

'During your appraisal discussion, you will be expected to demonstrate, with reference to the supporting information, that you are up to date and fit to practise, and that you have reflected on your practice and identified any area for improvement.

You may find it useful to review the GMC's appraisal framework, which sets out 12 professional attributes against which doctors' practice should be considered during appraisals.

'Following your appraisal, you should have a new personal development plan setting out your objectives for the following year, such as further training. It will then be up to you to meet these objectives and update your portfolio before your next appraisal.'

What are the possible outcomes of revalidation?

A responsible officer can make one of three recommendations about a GP. They can:

- make a positive recommendation that the GP is up to date and fit to practise, and should be revalidated
- request a deferral because more information is required to make a recommendation (for example, in the event of a career break)
- notify the GMC that the GP has failed to engage with any of the local systems or processes (such as appraisal) that support revalidation.

However the recommendation, deferral, or notice of failure to engage is not the final decision on a GP's revalidation. The responsible officer can only submit their decision to the GMC; the GMC makes the ultimate decision.

What will happen to my licence to practise if a decision about me is deferred, or my responsible officer says I have not participated in revalidation?

If a responsible officer requests a deferral of a doctor's revalidation date, the GMC will consider their request and decide if it is appropriate to defer. A deferral of a doctor's revalidation date is an administrative process and has no impact on a doctor's licence to practise.

All licensed doctors must participate in revalidation to maintain a licence to practise. This is a legal requirement. Doctors must also participate in local processes that underpin any revalidation recommendation. Doctors will put their licence at risk if they fail to engage, despite being given ample opportunity to do so. All local efforts to deal with the problem should be exhausted before the doctor's non-engagement is reported to the GMC.

If I feel I've been unfairly treated. Can I appeal?

The GMC says that it has put in place a number of safeguards to ensure revalidation is delivered in a way that is fair for all doctors, including clear guidance for responsible officers on assessing evidence, flexibility for doctors who are absent from work for long periods and guarantees that doctors will not be penalised for any failures by their employers or responsible officers.

GPs will have a right of appeal in respect of any decision that affects their registration or licence to practise. If the GMC becomes aware that a doctor has failed to engage with revalidation, it will contact the doctor directly and give them an opportunity to engage. If a doctor's licence is withdrawn by the GMC because of a failure to engage, the doctor can appeal to a GMC registration appeals panel.

The GMC is also conducting a programme of evaluation, supported by independent research, to assess the impact of revalidation, including the impact on different groups of doctors. Alongside this, a separate quality assurance programme will collect and analyse data about responsible officers' recommendations to ensure they are consistent and fair.

If I'm remediated, does that process defer the revalidation cycle?

Not necessarily. Local remediation may be appropriate to support a doctor if problems with their practice are identified. A responsible officer may request that a doctor's revalidation date be deferred until a period of remediation has concluded.

In some cases, a deferral may not be necessary, if the concern is a low-level one and the responsible officer is satisfied that the doctor is fit to practise and that there are no risks to patients.

How will remediation, or cover for GPs undergoing remediation, be funded?

The BMA says that this has yet to be fully determined - there is now an agreement that funding will be provided but the details are being looked at by an NHS Commissioning Board working group.

Is collecting 50 CPD credits a year mandatory?

No, it is not. RCGP revalidation lead Professor Nigel Sparrow says: 'The GMC simply states that a doctor needs to keep up to date. All

the royal colleges are using a credit system for measuring CPD with 50 credits a year required. All the other colleges use a time-based credit system, where one hour of learning plus a reflective record equals one credit.

'However, the RCGP recognises the value of implementation of learning in practice and so the time-based credit can be doubled if the GP can demonstrate how the learning has been used in practice.

'If the credit system is not used, the GP has to decide how they will show their appraiser that they are keeping up to date.'

Dr John Holden, senior medical adviser at the Medical and Dental Defence Union of Scotland (MDDUS), adds: 'Revalidation should not simply be seen as a test you either pass or fail. It is designed to help doctors meet the required standards and is a continuous process.

'You will have the opportunity to discuss any exceptional circumstances with the appraiser and then make plans to address the shortfall in CPD. The doctor and appraiser should agree how the appraisal is summarised and what steps the doctor will take to address any issues.'

Appraisal and revalidation management

Revalidation management system with integrated colleague and patient feedback tool

- Fully developed and in use by over 50 trusts
- Primary, secondary and independent healthcare versions
- All inclusive pricing - no set up fees
- MAG compliance guaranteed
- Client led development plan

revalidation.premierit.com

premierIT

Revalidation dile

Dr Caroline Fryar, medico-legal adviser with the MDU and Dr John Holden, senior medical adviser with the MDDUS, answer three revalidation dilemmas

I am a locum GP and cover sessions at a variety of GP practices. I still don't know my designated body or responsible officer. What should I do?

Dr Fryar says 'If you are a locum on a performers' list, your designated body will be the primary care organisation that manages this list.

'You should contact the responsible officer at the relevant PCO and check if you are already on their list of doctors to be scheduled for revalidation.

'The GMC has an online tool to help doctors in doubt find their designated body, which is accessible from the revalidation section on its website. If you discover you are one of the small minority of doctors who do not have a designated body to connect to, you should inform the GMC by logging onto your GMC Online account, selecting the "My Revalidation" tab and clicking on the "I don't have a designated body" button. You will be asked for further information so that the GMC can advise you.'

My primary care organisation is investigating my performance. Will this prevent me from revalidating?

Dr Fryar says 'If the matter is still being investigated when your revalidation is scheduled, it is likely your responsible officer will request that your date be deferred.

'In its protocol for responsible officers, the GMC says that deferral requests apply to doctors "participating in ongoing local HR or disciplinary processes, the outcome of which you will need to consider prior to making your recommendation". Your responsible officer will be asked to specify the length of the deferral, which can be up to a year.

'Once the investigation is complete, you will still be able to revalidate, provided the findings do not cast doubt on your fitness to practise. It will be important to demonstrate that you have reflected on what happened and any lessons you have

What is the minimum number of sessions I need to document to meet the supporting information criteria?

If you do not work full time in general practice, you will still need to provide the same amount of supporting information as your full-time peers in order to demonstrate that you are up to date and fit to practise.

Professor Sparrow says: 'The RCGP recommends that responsible officers should be willing to consider a standard portfolio so long as it meets the requirement to document 200 half-day clinical sessions, of which 100 are from the two years prior to revalidation.

'A half-day is defined as four hours, of which 2.5 hours are face-to-face clinical contact. If a GP believes they cannot meet the minimum criteria for supporting information, they should discuss this with their responsible officer who will consider their individual circumstances.'

I work in a remote practice and it is difficult and costly for me to access CPD activities and to get feedback from colleagues. Are my circumstances likely to be taken into account?

Dr Holden says: 'There is likely to be consideration given to a GP's circumstances and if you don't have many colleagues, you may have to agree with your appraiser another way of demonstrating the attributes required by exploring alternative forms of evidence. GPs in remote areas might, where appropriate, consider using alternative evidence-based methods which may better satisfy the requirements. For example, it may be more valid for GPs who have fewer contacts to opt for a smaller, detailed sample of contacts than a larger sample of people who have limited knowledge of the GP.'

Will revalidation affect where I am registered as a patient?

It is likely to, yes. The GMC's *Good Medical Practice Framework for Appraisal and Revalidation* states that doctors should make arrangements for accessing independent medical advice when necessary. It says 'Ensure that you have access to independent and objective medical care'.

MORE ONLINE
To read more FAQs and pose your own, go online to pulsetoday.co.uk/revalidation

How revalidation works

The GP must collect six types of supporting information for their appraisal and revalidation (see panel, right).

This supporting information feeds into an annual appraisal. Your appraiser may request to see other evidence beyond this, but these six are all the GMC requires the GP to have.

↓

The appraiser (another GP or someone working at the local PCT/CCG) provides an appraisal statement to the GP's responsible officer. The statement verifies three things:
- that the appraisal has taken place
- that the appropriate supporting information has been provided
- that there are no concerns about the doctor's practice.

↓

The responsible officer makes one of three recommendations about the GP, usually once every five years. They can:

- Recommend that the GP be revalidated.
- Request a deferral, for instance if they need more information.
- Report the GP's failure to engage with revalidation.

↓

The GMC makes a decision based on the responsible officer's recommendation.

Types of supporting information:

1 Feedback from at least 34 patients if using the GMC questionnaire (at least once every revalidation cycle)

2 Feedback from at least 15 colleagues if using the GMC questionnaire (at least once every revalidation cycle)

3 Quality improvement activity (such as clinical audits)

4 Continuing professional development – the RCGP specifies a minimum of 50 credits a year for its members (every appraisal)

5 Significant event audits (every appraisal)

6 Review of complaints and compliments (every appraisal)

mmas

learnt and be prepared to discuss this during your next appraisal.'

A complaint was made against me which I feel was unfounded. The patient concerned was eventually removed from the practice list. Will this breakdown of relationship with a patient will count against me in my appraisal?

Dr Holden says 'In order to recommend you for revalidation, the responsible officer will need to be satisfied that there are no unresolved concerns about your performance as a doctor.

'Details of the complaint should be provided as part of your supporting information during your appraisal, including a description of events that resulted in the complaint and the actions and outcomes that followed – all supported with proper notes. The supporting information should show how you are meeting the principles and values set out in the GMC's *Good Medical Practice*.

'If there are no unresolved concerns about your performance and the complaint made against you didn't lead to any further actions at the time (for example, a complaint to the GMC), then the appraiser may be satisfied the issue is resolved.

'If, however, your appraiser or responsible officer believes this incident raises serious concerns about your fitness to practise, the responsible officer may be unable to recommend you for revalidation or may defer the decision.'

For moderately active ulcerative colitis (UC): Rx Asacol 800mg MR tablets – 4.8g/day (2.4g BD)

Help your newly diagnosed patients and those that flare get **back to normal everyday life**

Asacol 800mg MR tablets at 4.8g/day were studied in three clinical trials (ASCEND I, II & III) with primary efficacy endpoints at 6 weeks and post-hoc analysis (ASCEND I & II) including efficacy evaluation at 2 weeks[4]

Fast symptom improvement (decrease in symptom score from baseline of ≥1 point) **in 73% of patients at just 2 weeks**[4]

Mucosal healing (endoscopy subscore of 0 or 1) **in 80% of patients, regardless of disease extent at 6 weeks – on oral therapy alone**[5]

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 Warner Chilcott UK Ltd on 0845 0220181

References:
1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

Warner Chilcott

Asacol 800mg MR tablets (MESALAZINE)

Lessons from the pilots

GPs who participated in the revalidation pilots offer their top tips on how to prepare

Keep the GMC's requirements in mind

Dr Stephen Scott is a GP in Dorchester, Dorset, and an appraisal lead. He took part in the original pathfinder pilots

Bear in mind that the GMC bar is what you will be revalidated against, and that bar is much lower than the one set by the RCGP. The college's bar is what you might wish to aim for, but the GMC requirements are ones that most GPs should be able to demonstrate.

For example, the college expects you to do 50 hours of CPD in a year and two significant event analyses, whereas the GMC refers to CPD appropriate to your work, and quality and improvement activity every year. This quality and improvement activity could be case-based discussion about what you are doing.

Don't worry about the IT and workload

I was involved in the pathfinder pilot of revalidation in Dorset in 2010, and it was appalling, because the IT requirements weren't right. But the pilot did what it was meant to do and enabled change, and what is happening now is much better. To prepare for your appraisal shouldn't take more than one session – that is, three to four hours.

If you are a locum, you don't have to take a week off to update – it has to be proportionate to your work.

Try not to think of appraisal as a hurdle

Make appraisal useful – use it as time to stop and think. It is not about ticking a box, but about talking things through, and that should be helpful. In my area, appraisal has helped to retain GPs who were considering leaving. It can also prompt people to retire or reduce their working hours because they are burning out. It is not a huge hurdle and you can't fail. The appraiser is simply there to appraise you and make a recommendation to the responsible officer. The appraiser is not judge, jury and executioner – that role belongs to the GMC, as it always has.

Focus on the positive

Dr Seema Jani is a GP in Denham, Buckinghamshire. She was involved with the pilot of the *Medical Appraisal Guide* last year

Appraisal can be seen as a chore and there can be a lot of negativity about it. However there are benefits, in improving care and improving your confidence. It's definitely helped me, and I think it will improve the standing of the profession and public confidence in us.

Keep a regular learning log

I have got into the habit of keeping a learning log, just in a notebook, but you could keep one on a computer. This has helped me address PUNs and DENs – patients' unmet needs and doctors' educational needs. I don't put in any patient-identifiable information, just a note about the condition and the outcome and what action I took. It can be difficult to keep those interesting cases in your head, so if you jot them down, you won't forget. This shows you are reflecting on cases and changing your practice, and is the type of thing that the appraiser will want to see.

Constantly look for gaps in your knowledge

Dr Graham Edlin is a GP locum in London, and took part in a revalidation pilot last year

For revalidation, you need to review your education, look for gaps in your knowledge and fill them. This is not a one-off exercise; over the whole year you have to be focusing your mind on it. This does represent a change in the way we work, from how it used to be 10 years ago. We have to do this consciously – and have to be seen to do it.

Be up-front about complaints and mistakes

We all make mistakes and we have got to be honest about it. It's a whole process, asking whether we are practising in a way that is helpful to patients, in our attitude and practice.

You need to put mistakes and complaints into the evidence you present and say what you are doing about them.

Get feedback from your patients

Feedback from patients is a key part of revalidation. Even if you are a locum, there are ways to get patient feedback. I have used the American Medical Association's tool for allowing the patient to rate you. If you just do one session at a practice it could be more difficult, but I might do a run for a period of time and can collect feedback.

Use an audit appropriate to the way you practise

As a locum you can do a small-scale audit of your work. Practices will help as they will see the logic in it. I have audited my referrals, going back to the practice and asking for the outcome of referrals to see if I am working in a sensible way. You don't refer unless you can't deal with the problem or don't know what it is, so you get a bit of education. It is a learning experience.

Remember, dramatic consequences are unlikely

Revalidation is nothing really terrifying. If the appraisal is done to standard, any concerns should have come up with the responsible officer before revalidation and revalidation is the final stop.

I think practice has changed because revalidation is taking place. If you start looking at something, you change it.

There are already structures in place for remediation, such as being mentored – I have mentored an individual to help ensure that their practice was up to standard. Remediation is there on paper but whether it will work in practice is another matter.

I don't think we have anything new coming in, we have had a steady build-up that has put these checks in place. It won't be a dramatic result because everyone has moved in anticipation.

Don't worry about your appraisal...

Dr Funmi Chirnside is a GP and principal medical officer at Northwood HQ in Hertfordshire. She took part in a revalidation pilot last year

Before the pilot I was really worried; you can read and read about something but still you don't know what it is going to be like. Having done it, I now think 'Wow, how easy was that?'

It is nothing to be frightened of at all. Most doctors are good doctors and try to improve their practice, because they want to do the best for their patients. The appraisal process just proves that you have done it.

...but don't leave it till the last minute

You will have to bring along evidence to your appraisal, such as certificates of attendance for courses. The key thing to it is keep collecting evidence all year long. Don't leave it all to the last minute.

Put everything into your file as you go and you will have more than enough evidence.

Keep everything in the right order

Keep all your documentation in date order. Otherwise you can spend 10 minutes trying to find things during your appraisal. So, if you went to a meeting, file your notes under the right month. You need some sort of system for knowing where everything is. Put key documents that the appraiser will want to see where you can easily get them.

Don't overload your PDP – and consider putting in something fun!

When I started having appraisals I would put too many things in my personal development plan and my appraiser pointed out that it might be better to focus on just a few. I've also been recommended to put in a fun thing – we all have lives outside work.

MORE ONLINE
Go online to read more tips from the pilots, and discuss your expectations of the revalidation process
pulsetoday.co.uk/revalidation

... And finally, will revalidation be worth it?

Professor Nigel Sparrow argues that while revalidation won't stop criminal doctors, it will prove that 99% of GPs are safe and trustworthy

Dr Peter Tyerman says there is still time to put the brakes on an unnecessary process – and save the NHS millions in doing so

▶ Go online to pulsetoday.co.uk/opinion to read and comment on both articles

NEW FIXED-DOSE COMBINATION FOR ASTHMA MANAGEMENT GO

Your search had ONE result:

NEW

flutiform®

fluticasone propionate/formoterol

50/5 µg 125/5 µg 250/10 µg

- Combined for the first time for asthma maintenance therapy[1]
- Rapid bronchodilation and long-lasting (12 month) efficacy delivered in a MDI[1-3]
- Offers a cost-effective treatment for the NHS[4]

NEW

flutiform®

fluticasone propionate/formoterol

TOGETHER AT LAST

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 anaesthetic 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 PL 16950/0169 **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
*FLUTIFORM is a registered trademark of Jagotec AG, and is used under licence.
*AEROCHAMBER and AEROCHAMBER PLUS are registered trade marks of Trudell Medical International. *©2012 Napp Pharmaceuticals Limited.

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

References

1. ***flutiform*® –** Summary of Product Characteristics. Napp Pharmaceuticals Limited.
2. Bordenave-Lokeshyk A et al. BMC Pulm Med 2011;11:1-29.
3. Mansur A. Eur Respir J 2008;32:6345 [abstract P3625].
4. Napp Pharmaceuticals Limited. Data on file.

flutiform cost effectiveness.

*The 'lung' device (logo) is a registered trade mark of Mundipharma AG.

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

NAPP RESPIRATORY

Pulse Plus

Our monthly CPD section provides an in-depth update on a clinical area, allowing you to earn credits for appraisal by answering questions online

In this issue

Cardiology 3 CPD hours

Key questions
Atrial fibrillation
page 32

Hypertension
One year on from NICE
page 34

Ten top tips
Heart failure
page 35

Cardiovascular causes of syncope
page 38

Controversies in CV medicine
page 40

More online

Pulse Learning
▶ pulse-learning.co.uk

Diagnosing heart failure
1 CPD hour
Cardiology GPSI Dr Ahmet Fuat presents on diagnosing heart failure in primary care

Photofile: itchy skin lesions
1.5 CPD hours
Test your diagnostic skills with six cases of itchy rashes

PulseToday
▶ pulsetoday.co.uk

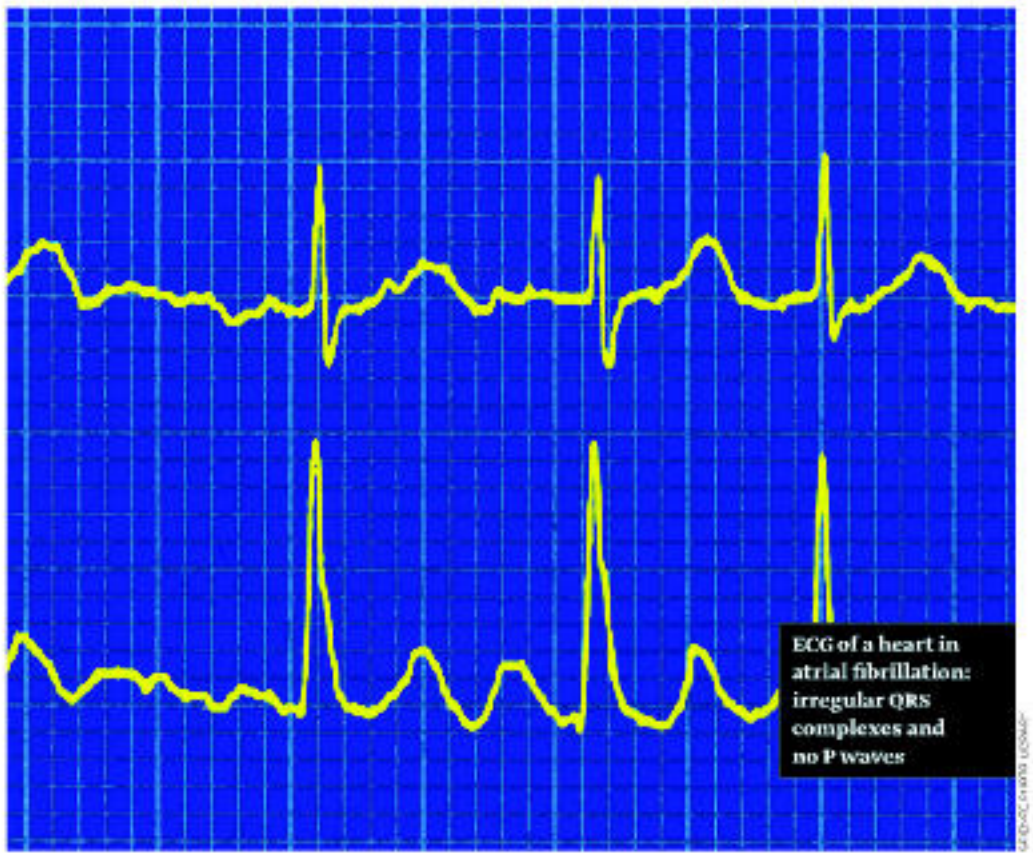
Resource of the week Go to Pulsetoday.co.uk/clinical to see our new ten top tips article on sleep apnoea – full of practical advice for GPs

Cardiology

Key questions

Atrial fibrillation

Dr Matthew Fay, cardiology GPSI, tackles questions from GP **Dr Mandy Fry** on atrial fibrillation, in the first of our two-part update on cardiac arrhythmias



ECG of a heart in atrial fibrillation: irregular QRS complexes and no P waves

1 Given how common atrial fibrillation (AF) is, which patients should we be referring for specialist assessment? Which patients require an echocardiogram?

AF is the most common sustained cardiac arrhythmia, affecting between 1.3-1.7% of the population. Prevalence increases with age and with other cardiovascular issues such as diabetes or heart failure. The most notable consequence of AF is stroke, but patients with AF can also have a poorer prognosis and quality of life than the general population.

When a patient presents with AF, it is important to exclude other cardiovascular disease as this is often overlooked and can cause problems.

All patients with AF – whether paroxysmal, persistent or permanent – should be assessed for stroke risk, and this is discussed further in question three.

When assessing a patient who has been newly diagnosed with AF, perform a cardiovascular risk assessment, exclude diabetes and assess for symptoms of ischemic heart disease or left ventricular systolic dysfunction (LVSD). If any of these conditions are identified they should be evaluated as appropriate, according to local protocols.

I usually arrange an echo for all new AF patients, but locally we have easy access to echo – NICE guidelines are a bit more restrictive[1], but I'd suggest arranging echo for all AF patients if possible given your local availability. I feel that in the older patient it would be appropriate to only arrange echo where you suspect valvular disease or LVSD.

It is my view that basic management is the remit of the GP – the stroke risk assessment and the decision to use anticoagulation should be made with the patient and their GP.

When the patient has cardiac compromise, urgent advice is required from an expert. If you feel that a rate control strategy is appropriate then referral beyond primary care may not be necessary. I have produced a flow chart to guide your choice of anticoagulation in AF and this can be downloaded from pulsetoday.co.uk/tools-and-resources.

2 It is often hard to know whether AF is of recent onset or not. How can we determine which patients might benefit from cardioversion? If we suspect that the AF is of recent origin how hard should we search for a precipitating cause, such as an MI?

The classical symptoms of AF are sudden breathlessness or palpitations, but as we so often see in primary care, few patients actually present this way.

In people who have AF, the minimum investigations include blood tests, electrolytes, liver function tests, cholesterol/lipids (for the CVD risk assessment), glucose (to exclude diabetes) and thyroid function. Even if you suspect heart failure, BNP is not of value in patients with AF, so an echo would be indicated. Other investigations should always include a 12-lead ECG. I usually also perform a chest X-ray in patients with a smoking history, as AF is more prevalent in those with pulmonary pathology.

If the patient is asymptomatic and no clear precipitating cause can be identified then cardioversion is unnecessary. If the patient is asymptomatic and a clear precipitating cause can be identified, you may wish to take advice on cardioversion as a return to sinus rhythm may be achievable[4]. The patient should be made aware that this is unlikely to be a permanent solution.

If a patient is symptomatic despite rate control then refer – preferably to an electrophysiologist – for consideration of rhythm management.

3 Can you tell me the difference between $CHADS_2$ and CHA_2DS_2-VAS_c in deciding which patients with AF require formal anticoagulation? How do you recommend counter-balancing

PULSE Learning

3 CPD hours

The five articles that make up this PulsePlus CPD module, worth 3 credits, will be available free to all members of Pulse Learning until 21 November 2012
▶ pulse-learning.co.uk

this with assessing risk of bleeding? What antithrombotic therapy should we give to those who are not suitable for formal anticoagulation?

Patients with AF are at increased risk of stroke and this risk can be mitigated by the use of anticoagulants. Aspirin should not be considered to be an alternative.[1,4,5] By far the best-known risk-assessment tool is $CHADS_2$ which looks at age over 75 years and comorbidities of congestive heart disease, hypertension, diabetes and prior stroke.

This scoring system has now been adopted into QOF for AF. Traditionally the tipping point for intervention was a score of two or greater (an annual adjusted stroke risk of 4%), but increasingly clinicians have been intervening at a score of one or greater (an annual adjusted stroke risk of 2.8%).

Some argue that $CHADS_2$ has a limited role because, even with a score of 0, there is an annual adjusted stroke risk of 1.9%, which still seems very high. If we are discussing CVD risk assessment, a 10-year risk of 20% is regarded as high risk, where the stroke risk with a $CHADS_2$ score of 0 would be almost as high as that.

An alternative view, considering that the stroke risk in AF is so severe and the bleeding risks of aspirin and anticoagulants are the same, is that we should be looking for those at low risk and then tending to anticoagulate the rest.

If a patient is under 65 with no other cardiovascular risk, they should be considered truly low risk and should receive no anti-thrombotic therapy (including aspirin)[6].

If the patient is over 65, they should undergo the CHA_2DS_2-VAS_c score. This is similar in mnemonic to $CHADS_2$ except that it now would give one point at age 65 or two points if over 75, and includes an extra point for vascular disease and for female gender. If you have a score of zero, you remain truly low risk. If you have a score of one, you should be considered for anticoagulation. With a score of two or more anticoagulation should be actively discussed and recommended. Visit pulsetoday.co.uk/tools-and-resources to access an online version of both $CHADS_2$ and CHA2DS2-VASc.

4 What is the role of dabigatran in AF? It is currently restricted locally – do you think this will change or will warfarin remain the anticoagulant of choice?

Dabigatran is a direct thrombin inhibitor and is the first of a group of agents being described as the novel oral anticoagulants. These new agents have been shown to be non-inferior to warfarin in large multicentre trials, and in the case of dabigatran – at 150mg bd – are mildly superior to warfarin. Direct thrombin inhibitors also have an advantage in that they have fewer drug interactions or lifestyle-restricting issues than warfarin and so do not require such frequent monitoring.

But, currently there is no way to easily monitor the effects of these drugs and they are irreversible in an emergency. This raises understandable concerns with some clinicians. They all also need dose adjustment in poor renal function.

Both dabigatran and rivaroxaban have been assessed and approved by NICE so they are now available to be prescribed. They are currently black-triangle medications and we need to develop experience in clinical practice to appropriately position them in pathways of care. Keeping close to the limited populations of the clinical studies would seem prudent. I would advise caution with their use in the elderly with multiple comorbidities, when warfarin would remain the first-line medication, due to the experience in use and the ability to sensitively monitor its effects.

Both medications have been deemed cost-effective in the prevention of AF-related stroke by NICE, but GPs and local CCGs may still want to consider their affordability.

5 Which patients benefit from a 'pill in the pocket' regimen? Do all such patients need an echo to ensure that their hearts are structurally normal? Which drugs are most commonly used?

Some patients have very symptomatic but episodic AF. In these cases, daily intervention may seem inappropriate and they could be considered for a 'pill in a pocket' approach. In the UK this tends to be done using flecainide.

All anti-arrhythmics can also be pro-arrhythmic, and flecainide is no different. It should be only be initiated by a specialist, and many suggest the first dose should be given in a hospital setting.

Assessment in these patients would always include an echo as the use of flecainide is not recommended in those with left ventricular dysfunction or left ventricular hypertrophy.

6 I understand that you can approach AF in two ways – controlling the rate or trying to modify the underlying rhythm. How do you decide which approach to take? Does the cerebrovascular accident risk return to baseline if you achieve sinus rhythm?

The AFFIRM study[2] showed that prognostically there was little to choose between rate and rhythm control. This has lead to the attitude that if a patient is asymptomatic, a return to sinus rhythm is not necessarily a priority. To achieve rhythm management there is almost always a need for anti-arrhythmic medication, with the issues discussed above.

A return to sinus rhythm does not reduce stroke risk, and this should always be considered in the management of a patient with AF and revisited regularly, because risk is not static and increases with age. If someone is at risk of a stroke with AF, a return to sinus rhythm should not seen as an indication to discontinue their anticoagulation.

If, despite good rate management, the patient remains symptomatic, consider rhythm management. This should be discussed with an expert in AF who can consider all modalities of rhythm management, including ablation.

Dr Matthew Fay is a GP in Shipley, West Yorkshire, and a cardiology GPSI at the Westcliffe Cardiology Service

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

Dr Fay is national clinical lead for NHS improvement, heart and stroke. For more information, go to improvement.nhs.net

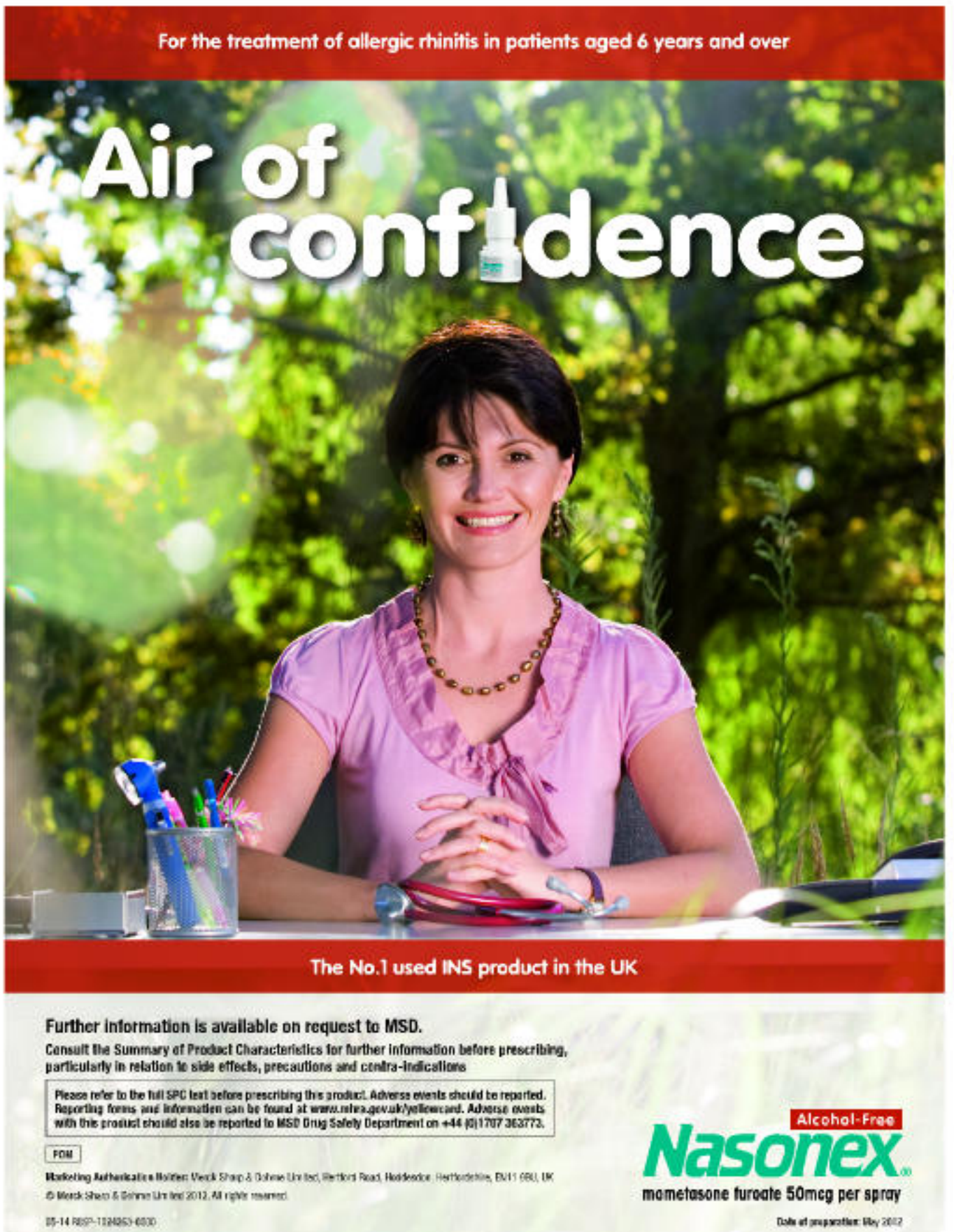
▶ Still to come **Look out for the second part of this update, on non-AF arrhythmias, next week**

Four more Q&As online

▶ pulse-learning.co.uk

View the online version of this article for four extra questions, covering:
- AF as part of an intercurrent illness
- Who might benefit from radio-ablation
- Factors affecting the recurrence rate after cardioversion
- Whether digoxin still has a role to play

1 NICE. Atrial Fibrillation. June 2006. CG36
2 Flaker G C, Belew K, Beckman K, et al; AFFIRM Investigators. Asymptomatic Atrial Fibrillation: demographic features and prognostic information from the Atrial Fibrillation Follow-up Investigation of Rhythm Management (AFFIRM) study. *Am Heart J* 2005; 149: 657-63
3 Hart R G, Pearce L A, Aguilar M I. Meta-analysis: antithrombotic therapy to prevent stroke in patients who have nonvalvular Atrial Fibrillation. *Ann Intern Med* 2007; 146: 857-67
4 Mant J, Hobbs F D R, Fletcher K, et al. Warfarin versus aspirin for stroke prevention in an elderly community population with Atrial Fibrillation (the Birmingham Atrial Fibrillation Treatment of the Aged Study, BAFTA): a randomised controlled trial. *Lancet* 2007; 370: 493-503
5 Stroke Prevention in Atrial Fibrillation Investigators. A differential effect of aspirin in prevention of stroke on Atrial Fibrillation. *J Stroke Cerebrovasc Dis* 1993; 3: 181-88
6 Camm A J, Lip G Y H, De Caterina R et al. 2012 Focused update of the ESC Guidelines for the management of atrial fibrillation. *European Heart Journal*, 2012; 33: 2,719–47



PULSE Supporting you with CPD
Go to pulse-learning.co.uk

Hypertension – one year on from the NICE guidance

Now that the dust has settled on the 2011 NICE hypertension guidance, Cardiology GPSI **Dr Kathryn Griffith** discusses how the guidance is being implemented in primary care, and the challenges that remain

In August 2011, NICE published guidance on the clinical management of primary hypertension in adults.[1] This article will look at the impact this guidance has had on primary care management of hypertension, which recommendations have been taken up and what issues have arisen.

How has the guidance affected GPs?

Diagnosis of hypertension

An important change for GPs in the guidance was in the method of making a diagnosis. In the past, GPs were encouraged to bring patients back to surgery to have multiple blood pressure measurements before starting treatment. In practice, patients usually found the process stressful and developed higher blood pressure as a result, or they gave up before reaching the mandated third measurement and so missed out on treatment and preventive measures.

The guideline encouraged GPs to use 24-hour ABPM as the gold standard. Although few practices have yet brought this in house, remember the price of these devices has come down greatly since the NICE guideline was published, and that you can get good deals when buying in quantity, for a cluster of practices for example.

Many GPs have automatic monitors to lend to patients to take home measurements. NICE recommends taking two readings, twice a day over seven days, but I tend to ask patients to take three readings at rest twice a day over a couple of weeks, and then to bring the readings in to me. This system is effective, although in my experience the results of home measurements rarely allow me to actually hold-off treatment, since most of the patients I manage are at high cardiovascular risk and need therapy.

Once a patient has been diagnosed, they may want to consider buying a monitor. I print the list of approved devices from the British Hypertension Society website[2] and encourage patients to shop around. The best deals seem to be for mains-powered devices or those with rechargeable batteries, saving patients money in the long run.

Cardiovascular risk

I don't believe this guideline emphasised strongly enough that management of the blood pressure risk is only one part of cardiovascular risk reduction. If the patient is at high cardiovascular risk we should offer treatment. If the patient has high blood pressure but their cardiovascular risk is otherwise low, there is time and scope to consider lifestyle measures - particularly weight reduction and limitation of salt and alcohol intake - before starting treatment. GPs should remember that in most of our patients with high blood pressure, this is just one of many cardiovascular risk factors, both modifiable and non-modifiable. In a patient at high cardiovascular risk, you should have a lower threshold than normal, in terms of blood pressure levels, for treatment.

Managing older patients

The guideline did make a very helpful suggestion that treatment targets for people aged over 80 should be higher at 150/90mmHg, compared with a target of 140/90mmHg for patients younger than 80. This fits in with evidence that shows the benefits of treating to higher targets and remembering that older people are more likely to experience side effects from antihypertensive therapy.

Another important consideration for primary care is the high prevalence of postural hypotension in the elderly. Older patients on treatment should have both seated and standing blood pressure to identify those who are at risk of postural hypotension and falls. It is no good reducing the number of strokes but increasing the risk of fractured femurs. A fall in blood pressure of 20mmHg between seated and standing blood pressure is a sign of postural hypotension and should prompt you to review the medication, particularly drugs which are associated with this side effect.

Clinic and home readings to assess control

The guideline recommended doing clinic readings to assess control. But it also includes values for home readings, which is very helpful for patients who have a significant element of white coat hypertension, with a difference in blood pressure of at least 20/10mmHg. I encourage my patients to bring their home device into the surgery from time to time and check their reading with our calibrated device and then use their home readings.

Calcium channel blockers, ACE inhibitors and ARBs

The 2011 guidance recommended that GPs use an ACE inhibitor or ARB first line in patients under 55 and a calcium channel blocker in patients over 55. I don't think that this recommendation made much difference in primary care, because many GPs were doing this already.

Thiazide-like diuretics

The guideline recommended using a thiazide-like diuretic, such as indapamide, rather than a conventional thiazide diuretic, such as bendroflumethiazide. This recommendation doesn't seem to have been well taken up in primary care, and bendroflumethiazide is still often used at the diuretic of choice. The evidence for this is virtually non-existent, but it was very cheap when the last guideline was published.

In contrast, the evidence for indapamide is robust. It has come off patent so it is cost effective too. I find it useful to switch patients with poor blood pressure control over to indapamide, and I also would use it as my thiazide of choice for new patients. In our practice, though, we have not yet changed the hundreds of patients we already have on bendroflumethiazide to indapamide.

Resistant hypertension

The guideline included advice about how to manage resistant hypertension. Potassium-sparing diuretics such as spironolactone can produce dramatic blood pressure falls, but can also cause deterioration in renal function. GPs have become more confident in using these agents in patients with heart failure since the NICE guidance. It is important that we monitor renal function with dose changes for all drugs that affect the renin-angiotensin-aldosterone system, including the aldosterone antagonist spironolactone.

The guideline recommends referral for patients with resistant hypertension, but I think that we should consider modifiable causes, for example the effects of salt, alcohol and therapeutic agents. Also consider issues with compliance - remember that patients may have problems paying for their medications, particularly since we are encouraged to offer monthly prescriptions. Encouraging patients to monitor their own blood pressure may also improve their adherence to therapy.

Challenges for the future

I am concerned that there are still too many differences between NICE and QOF diagnostic thresholds on treatment targets. And of course the numbers will be different if the patient also has diabetes, chronic kidney disease or proteinuria. Although QOF is now under the wing of NICE the numbers for QOF seem to take some time to catch up, and the numbers used as treatment targets are not the same as those used as audit standards. It will be interesting to see if different management of older patients is included in QOF in future.

Dr Kathryn Griffith is a cardiology GPSI in York

References

1 NICE. Hypertension: Clinical management of hypertension in adults. August 2011. CG127
2 British Hypertension Society. bhsoc.org. Accessed 23/10/12

Ten Top Tips

Heart failure

Dr Clare Taylor, GP and cardiovascular disease specialist, offers her advice on diagnosing and managing heart failure in primary care

1 Be aware of patients at highest risk

Around 68,000 new cases of heart failure are diagnosed each year in the UK. The general population prevalence is around 1%. Heart failure occurs predominantly in the elderly, in patients with cardiovascular risk factors such as hypertension or diabetes and is particularly prevalent in those with a history of MI. Bear it in mind that the symptom profile of co-morbid conditions, such as COPD, can overlap. CKD is also prevalent and can limit heart failure treatments. Patients with heart failure and other co-morbidities require close monitoring and holistic care.

2 Suspect heart failure in patients with signs and symptoms, and a history of MI

In patients with symptoms and signs suggestive of heart failure, a history of MI makes a diagnosis of heart failure extremely likely, so refer directly for an echocardiogram. According to the European Society of Cardiology, heart failure is a clinical syndrome in which the patient has symptoms, signs and objective evidence of a structural or functional abnormality of the heart.

Echocardiography is the most commonly used investigation to establish 'objective evidence' of cardiac dysfunction in routine clinical practice. You could also measure natriuretic peptides to determine if an echo is indicated. B-type natriuretic peptide (BNP) and NT-pro BNP (the inactive cleaved fragment of the pro-BNP molecule) are released in response to volume and pressure overload and are raised in heart failure. BNP relaxes vascular smooth muscle to reduce ventricular pre-load and also acts on the kidney to increase sodium excretion and induce diuresis.

4 Remember that 'heart failure' can be a scary phrase for patients

'Heart failure' can be a frightening term for patients so it is crucial to explain what the diagnosis means and the treatment options available. It is also important to address and, where appropriate, modify cardiovascular risk factors.

5 ACE inhibitors and ß-blockers should be used in left ventricular systolic dysfunction (LVSD)

LVSD is the most common cause of heart failure. Evidence supports the use of ACE inhibitors and ß-blockers in the treatment of heart failure because of LVSD. Trials showed these agents improve quality of life and reduce mortality.

6 Diuretics are helpful for symptom control in LVSD

Diuretics are helpful for symptom control in LVSD but evidence for an effect on survival is lacking. Regular monitoring of pulse, blood pressure and renal function is important. Guidelines suggest specialist advice should be sought if further management with medical agents is needed.

7 Risk-factor modification is crucial in heart failure with preserved ejection fraction (HFPEF)

HFPEF occurs because of abnormal cardiac muscle relaxation, which results in reduced left ventricular filling. Trials of ACE inhibitors and ß-blockers have been disappointing and guidance suggests modification of risk factors – particularly blood pressure and diabetes control – is the mainstay of treatment.

8 Refer patients with moderate or severe valvular disease

A surgical opinion is indicated in moderate-to-severe valvular disease. Once the valve lesion or rhythm problem is resolved heart function may improve.

9 Heart failure has a worse prognosis than many types of cancer

Recent data from an English population study suggests the 10-year survival rate for patients with a diagnosis of heart failure is around 30%. Use of ACE inhibitors and ß-blockers should be optimised to improve outcomes.

10 Discuss palliative care early

Given the poor prognosis of heart failure, palliative care provision is vital – but regional approaches vary. The point where active treatment should be changed to palliative can be difficult for clinicians to gauge. Patients can deteriorate suddenly, but equally a few days of intravenous diuretic in hospital can make a dramatic difference. Discussions at an early stage with the patient and their family can ensure the patient's wishes are met.

Dr Clare Taylor is a GP in Birmingham and a clinical research fellow in cardiovascular disease at the University of Birmingham

Dr Taylor is involved with delivering a four-day course on heart failure management in primary care at the University of Birmingham in February 2013. For more information go to: tinyurl.com/heartbirmingham

Further reading

- NICE. Chronic heart failure: management of chronic heart failure in adults in primary and secondary care. August 2010, CG108
- Dickstein K, Cohen-Solal A, Filippatos G et al. European Society of Cardiology guidelines for the diagnosis and treatment of acute and chronic heart failure. *European Heart Journal* 2008; 29: 2,388-442

More online

▶ pulse-learning.co.uk

Go to pulse-learning.co.uk to view two new video modules on heart failure (diagnosis and treatment), from cardiology GP Dr Ahmet Fuat

Did you know that the whole Stérimar™ range is now available on prescription?

Stérimar nasal sprays can help your patients to breathe easier by rebalancing nasal functions and provide relief from rhinitis, sinusitis, congestion and chronic conditions. Packed with beneficial sea minerals and 100% natural, Stérimar has three products that are already recommended by many ENT specialists and GPs across the UK:

- Stérimar Congestion Relief (Hypertonic)
- Stérimar Nasal Hygiene (Isotonic)
- Stérimar Baby (Isotonic)

Find out more about how Stérimar works at www.sterimaracademy.co.uk

Stérimar is a trademark of SOFIBEL SAS. Ref: CP-12.

STÉRIMAR®
Natural Sea Water Nasal Spray

Pulse is changing – but our

Throughout Pulse's 52-year history our aim has been to provide news, education, analysis, opinion and resources to support you, the GP. Those core values will never change.

But the way you want to receive all that Pulse offers is changing. We've listened to what you told us in a recent reader survey and we're responding.

In 2013 we intend to offer you more content than ever before. We're committed to supporting you with:

- our comprehensive breaking news and clinical update service – with rolling updates on **pulsetoday.co.uk**
- more in-depth analysis and expert opinion – setting the key developments in context and explaining what they mean for you and your practice
- investigations and exposés on the issues close to your heart
- clinical education and CPD – with more than 360 learning modules now live on **pulse-learning.co.uk**
- practice business and finance tips, advice and resources
- compulsive debate and thought-provoking views on the topics that matter to you – and of course our must-read columnists Peverley and Copperfield

Make sure you are signed up to our email newsletters via **pulsetoday.co.uk/emails** and look out for your new monthly Pulse magazine from January 2013.

Sign up to our free email newsletters for your chance to win an iPad

All GPs will be in with a chance of winning. The more newsletters you're signed up to, the better your chance. The prize draw will take place on 17 December 2012.

Enter now at **pulsetoday.co.uk/win**

Don't miss out, sign up now

mission remains the same...

How Pulse will deliver the information you need

pulsetoday.co.uk PULSE

PULSE Supporting you with CPD
Go to pulse-learning.co.uk

An implantation loop recorder can be used to investigate infrequent syncope

Cardiovascular causes of syncope

Syncope specialists **Dr Steve Parry** and **Dr Iain Matthews** advise on how to diagnose the underlying cause of syncope and best management

Syncope is defined as transient loss of consciousness secondary to global cerebral hypoperfusion, characterised by rapid onset, short duration and spontaneous complete recovery.[1]

Syncope can be classified as reflex (neurally-mediated) syncope, syncope because of orthostatic hypotension and primary cardiovascular syncope - including pulmonary embolism.[1]

Identifying the cause

The initial history and examination should include clues to the underlying diagnosis. Ask about prolonged standing, medication changes and family history of premature unexplained or cardiac death. It is also useful to get a witness account if possible. Do a 12-lead ECG in all patients. Also measure lying and standing blood pressure if you suspect orthostatic hypotension.[2] A normal ECG and the absence of heart disease effectively rules out a cardiac cause of syncope in nearly all cases.[1]

Neurally mediated syncope

Neurally mediated syncope is the most common cause – accounting for between 65% and 95% of cases[3,4] and is most common in teenagers and in patients aged over 65. Neurally mediated syncope can be categorised as a simple faint (vasovagal syncope) or situational syncope (for example, cough syncope, micturition syncope). Correctly diagnosing vasovagal syncope minimises unnecessary investigation and referral and, more importantly, allows you to reassure patients about its predominantly benign nature. NICE guidance identifies the three 'P's in the history as hallmarks of vasovagal syncope:[4]

- **Posture** - prolonged standing or prior episodes aborted by sitting or lying
- **Provoking** factors - for example, pain, blood phobia
- **Prodrome** - light-headedness, cold sweat, heat, nausea, yawning, visual disturbance.

In addition, there should be no evidence of structural heart disease.

Carotid sinus syndrome is a less common cause of neutrally mediated syncope and is seen in older patients. Clues to diagnosis - which is made during carotid sinus massage with appropriate symptom reproduction[1,5] - include syncope with head turning or looking up. Rapid-onset syncope in older patients should prompt consideration of this condition.

COMMON CAUSES OF PRIMARY CARDIOVASCULAR SYNCOPE

Arrhythmia	Structural heart disease
Bradycardia ● Sinus node disease ● Atrioventricular block	**Valvular heart disease**
Tachycardia ● Supraventricular ● Ventricular - Structural heart disease - Inherited ion channel disorders	**Hypertrophic cardiomyopathy** **Cardiac masses** **Pericardial disease**

Neurally mediated syncope is best managed conservatively, but it is important to review medications and give advice on how to abort and prevent further episodes. Patients with simple faints should be encouraged to drink plenty of fluids - 1.5l before midday - avoid prolonged standing and try to counter prodromal symptoms as soon as they start, for example with immediate leg crossing. If syncope is recurrent and intrusive, consider referral to a specialist syncope service. Suggest that patients with situational syncope minimise exposure to the situation, for example by stopping smoking in cough syncope, or minimise orthostatic stress, for example sitting to pass urine for men with micturition syncope.

Syncope secondary to orthostatic hypotension

A diagnosis of syncope secondary to orthostatic hypotension requires the demonstration of a fall in blood pressure on standing of greater than or equal to 20mmHg with reproduction of the presenting symptoms. Syncope secondary to orthostatic hypotension is frequently associated with polypharmacy, especially in the elderly, and may be an early precursor of Parkinson's disease and the Parkinson's plus syndromes. Addisonism is a rare but important cause.

Conservative therapy is the mainstay of treatment, with a reduction in the dose or cessation of culpable drugs, along with advice to avoid sudden changes in posture and to drink plenty in the first few hours of the day.

Primary cardiovascular syncope

Primary cardiovascular syncope can be subdivided into primary arrhythmia and structural heart disease (see table below).

Features in the history that point to a cardiovascular cause of syncope include:

- Unheralded event
- Syncope during exertion
- Syncope associated with breathlessness, chest pain or palpitations
- Family history of inherited cardiac conditions or sudden cardiac death, particularly at a young age
- Known structural heart disease.

Signs elicited on examination that should prompt consideration of specialist assessment include:

- Signs of heart failure
- A new - or known but not previously investigated - murmur
- Heart rate lower than 50bpm (in the absence of rate limiting drugs) or higher than 120bpm
- Abnormal 12-lead ECG - see the table opposite for different abnormalities and their ECG appearance.

NICE recommends that assessments should be made within 24 hours,[4] but in practice this is dependent on availability of local services.

A complete cardiovascular examination is important to screen for the physical signs of structural heart disease. Identification of a new murmur should prompt an urgent transthoracic echocardiogram and specialist referral. Syncope in the presence of ischaemic heart disease - particularly left ventricular systolic dysfunction - raises the possibility of ventricular arrhythmia, and should prompt specialist referral.

An arrhythmia on a 12-lead ECG clearly points toward this as the cause of syncope and should prompt specialist referral. Evidence of conducting system disease on the 12-lead ECG suggests an arrhythmic cause of syncope. Bi- or tri-fascicular block in the context of syncope are indications for permanent pacing. Left- or right-axis

deviation, bundle branch block and – to a lesser extent – first-degree heart block with a very prolonged PR interval point towards an arrhythmic cause.

The demonstration of ST or T wave abnormalities in the chest leads, or prolongation of the QT interval, raise the possibility of a cardiomyopathy such as hypertrophic cardiomyopathy or an inherited ion channel disorder, such as long QT syndrome. This should prompt specialist referral within 24 hours[3] – particularly if there is a family history of cardiomyopathy or sudden cardiac death at a young age.

Where you suspect arrhythmia, a period of ambulatory monitoring is needed. Unless syncope is recurring several times per week there is little value in 24- or 48-hour monitoring and a prolonged external event recorder is advised. For syncope occurring less than once a fortnight, an implantable loop recorder is most appropriate.[4] Although these devices are expensive and need formal surgical implant, their diagnostic yield in correctly selected patients is impressive.

✚ ABNORMAL ECG FINDINGS SUGGESTIVE OF AN ARRHYTHMIC CAUSE OF SYNCOPE

Abnormality	ECG appearance	Practical tips
First-degree atrioventricular block	PR interval >200msecs	
Left-axis deviation	Cardiac axis beyond between -30° and -90°	Positive QRS lead I and Negative QRS lead aVF and Negative QRS lead II
Right-axis deviation	Cardiac axis beyond between +90° and -180°	Negative QRS in lead 1 and Positive QRS in lead aVF
Right-bundle branch block	QRS width >120msecs with positive R wave in lead V1	
Left-bundle branch block	QRS width >120msecs with negative R wave in lean V1	
Bi-fascicular block	Right-bundle branch block and left-axis deviation	
Tri-fascicular block	First-degree atrioventricular block and left-axis deviation and right-bundle branch block	
Prolonged corrected QT interval (QTc – on most modern print-outs)	QTc >450msecs in men QTc >470msecs in women	
Pre-excitation	PR interval <120msecs Slurred onset to QRS (δ wave)	

Fitness to drive

For ordinary licence holders, a diagnosis of vasovagal syncope has no implication for driving, provided the DVLA's own three Ps are fulfilled:

- **Provocation:** provoking factors are consistent with vasovagal syncope
- **Prodrome:** there must be prodromal symptoms to allow evasive action to be taken
- **Postural:** syncope occurred upright, not seated or supine.

Syncope demonstrated or suspected to be cardiovascular in origin or syncope which occurred while sitting or without warning can result in the revoking of a licence for six months. Driving can resume one month after diagnosis and the institution of treatment, but must be discussed with the DVLA. If in doubt, the DVLA's medical advisors can assist. The DVLA guidance in the UK is regularly updated to reflect current practice and can be found at pulsetoday.co.uk/tools-and-resources.

Dr Steve Parry is a consultant physician with a special interest in syncope and Dr Iain Matthews is a cardiology SpR at the Falls and Syncope Service, Royal Victoria Infirmary, Newcastle upon Tyne and Institute for Ageing and Heath, Newcastle University

References

1 Moya A, Sutton R, Ammirati F et al. Guidelines for the diagnosis and management of syncope (version 2009). Task Force for the diagnosis and management of syncope of the European Society of Cardiology. Eur Heart J 2009;30: 2,631-71
2 NICE. Transient loss of consciousness ('blackouts') in adults and young people. 2010. CG109
3 Tan MP and Parry SW. An approach to the evaluation and management of syncope in adults. BMJ 2010; 340: c880
4 van Dijk N, Boer KR, Colman N et al. High diagnostic yield and accuracy of history, physical examination and ECG in patients with transient loss of consciousness in FAST: the Fainting Assessment Study. J Cardiovasc Electrophysiol 2008, 19(1): 48-55
5 Parry SW, Reeve P, Lawson J et al. The Newcastle protocols 2008: an update on head-up tilt table testing and the management of vasovagal syncope and related disorders. Heart 2009; 95: 416-420

Useful links

Syncope Trust and Reflex anoxic Seizures. STARS. stars.org.uk. Accessed 19/10/12.

PULSE Learning

Our most popular CPD modules over the past week

Key questions 1.5 CPD hours
Erectile dysfunction

Key questions 1.5 CPD hours
Chronic pain

Writing a business plan to develop your premises 1 CPD hour

▶ pulse-learning.co.uk

PULSE Medical Store

Powered by Williams Medical

Providing you with the widest range of medical goods & services

1 GP Registrar Set

The Registrar Set is the perfect combination of essential surgery equipment in one fantastic value, easy-to-order kit.

24% OFF

Kit includes:
- Griffiths lightweight padded Canvas Bag with numerous compartments and zipped pockets
- 3M Littmann Classic II SE Stethoscope
- Keeler Jazz LED Diagnostic Set
- Omron M6 BP Monitor
- Merlin M-pulse finger pulse oximeter
- KaWe Dialight XL LED pen torch

Now £359.94 Includes VAT
Was £478.80 Code PW7950 (contents and colours may vary)

2 Nonin 9590 Onyx® Vantage Finger Oximeter

The Onyx is the only finger pulse oximeter with scientifically proven accuracy in motion and low perfusion, and it is tested for use on fingers, thumbs, or toes.

19% OFF

- Accurate - Scientifically proven performance in the widest range of patient populations and settings
- Durable - Protects against dropping and water spills
- Efficient - Up to 6,000 spot checks or 36 hours of continual operation
- Safe - Built in the USA with lead-free and latex-free construction
- Cost Effective - Proven accuracy, quality and durability
- Available in black, blue, red and purple

Now £144.00 Includes VAT
Was £178.80 Code PW9590* (please state colour choice)

3 Brandon Coolview MT6008 Mobile Lamp

Versatile examination light with double wall head construction to ensure coolness and good Lux brightness. MT6008 provides a cool, white light with a low temperature output. Its flexible arm allows the practitioner to precisely position the light where it is needed.

15% OFF

- Lux at 0.5m: 18,000
- Degrees Kelvin: 3,200
- Reach: 0.75m
- Guarantee: 3 year

Now £406.98 Includes VAT
Was £478.80 Code PW3962M

November Special - 25% off ALL Doctors Bags

All bags, cases from a variety of colours options - Quote 'November Special' when ordering

How to order

Call 0800 212 855 E-mail sales@pulsemedicalstore.co.uk
Online www.pulsemedicalstore.co.uk (To find more products and offers)

Order now Free delivery on orders over £100

Advertised deals cannot be used in conjunction with any other promotions unless otherwise agreed. Offers valid for 4 weeks.

PULSE Supporting you with CPD
Go to pulse-learning.co.uk

Controversies in CV medicine

Dr Matt Hughes, GP and clinical assistant in cardiology, discusses five recent controversies facing GPs

ARBs should rarely be prescribed with ACE inhibitors in primary care

1 When should ACE inhibitors and ARBs be used together?

The simple answer to when ACE inhibitors and ARBs should be used together in primary care is very rarely - and normally then only after initiation by a specialist.[1,2] See the table below for ACE inhibitor/ARB combinations in different patient groups.

Both drug classes work at different stages in the renin-angiotensin system and it was thought the combination might block it more effectively than either drug alone. In theory, this could particularly benefit patients with CKD and diabetes. But the ONTARGET study[3] - of over 25,000 patients aged over 55 with coronary heart disease or diabetes, plus additional risk factors, treated with ramipril, telmisartan or a combination of both - showed that this wasn't the case in practice.

A key finding of this study was that combination therapy was no more effective than ramipril alone, but was associated with significantly more discontinuations because of hypotension, syncope, diarrhoea and renal impairment. Safety concerns were then raised when a second ONTARGET analysis, suggested that, far from being beneficial, combination therapy worsened renal outcomes.[4]

In patients with heart failure, the most useful data comes from an arm of the CHARM study and the Valsartan Heart Failure Trial, which suggest that adding an ARB to patients already on an ACE inhibitor or ß-blocker significantly reduced admissions and cardiovascular mortality.[5]

This is reflected in NICE guidance, which suggests ARBs only be added to already-optimised ACE inhibitor or ß-blocker treatment. This shouldn't be routine and the risk of renal dysfunction and hyperkalaemia means patients need to be carefully monitored.[2]

✚ OUTCOMES WITH ACE INHIBITOR AND ARB COMBINATIONS

Patient Groups	Outcomes
Hypertension	No benefit, worse outcomes when compared with an ACE inhibitor alone.
Post-MI	No evidence of benefit and not recommended in NICE post-MI guidance.
Heart failure	An option after treatment with ACE inhibitor and ß-blocker is optimised but needs careful monitoring of renal function.
Diabetes and CKD	No benefit, worse outcomes when compared with an ACE inhibitor alone. No specific recommendation in NICE CKD guidance but it states that there is no evidence to suggest benefit over ACE inhibitor alone. May have a specialist use in high-risk renal patients.

2 When should clopidogrel be used, and for how long?

The major recent change to the way GPs should use clopidogrel came in a 2010 NICE technology appraisal, commissioned because the drug had become cheaper.[6] The guidance brought clopidogrel above aspirin as first-line antiplatelet therapy for all cardiovascular events except TIA and MI, and it also lifted the two-year time limit on the use of clopidogrel in most instances.

After an ischaemic stroke:

- Clopidogrel monotherapy is now first choice with no specified limit on duration of treatment.
- Modified-release dipyridamole plus aspirin is now recommended after an ischaemic stroke only if clopidogrel is contraindicated or not tolerated, with no time limit.
- Modified-release dipyridamole alone is recommended after an ischaemic stroke only if aspirin or clopidogrel cannot be used, with no time limit.

After a TIA:

- Treatment with modified-release dipyridamole plus aspirin is still recommended for people who have had a TIA, but now there is no recommended limit on the duration of treatment.
- Modified-release dipyridamole monotherapy is recommended after TIA only if aspirin is contraindicated or not tolerated, again with no limit on duration of treatment.
- No recommendations are made about clopidogrel after a TIA because it is not licensed for this indication.

After an MI

- Clopidogrel is recommended after an MI only if aspirin is contraindicated or not tolerated.

There is lingering controversy over the recommendations for patients after a TIA. The guidance states that clopidogrel does not have a licence for use in patients who have had a TIA, so it can't be recommended. But many stroke specialists have argued that because the pathophysiology behind a stroke and a TIA is identical, this is irrational. NICE certainly have not shied away from recommending other unlicensed indications - most recently metformin for impaired glucose tolerance - and I certainly have patients referred back to me after a TIA who are on clopidogrel, so I see no reason to query its use.

Another controversy surrounding clopidogrel has recently appeared. This summer, researchers published an analysis that suggests that the beneficial effects of clopidogrel do not extend to non-smokers.[7] Non-smokers in the clopidogrel-treatment arm saw no reduction in the primary end point of ischemic stroke, MI, or vascular death compared with the aspirin-treated non-smoking group. But clopidogrel-treated current smokers had a 24% reduction in the primary end point, compared with the aspirin-treated current smokers. Of course the usual warnings about drawing conclusions from sub-group analyses of large trials need to be emphasised, but there are early signs that other large clopidogrel data sets are showing a similar effect and it will be interesting to see how this plays out.

3 What is the current view on co-prescribing PPIs with clopidogrel?

In 2008, the first paper was published which suggested that PPIs may interfere with clopidogrel through inhibition of the CYP2C19 cytochrome pathway - necessary for activation of clopidogrel.[8] This was followed by observational studies suggesting that PPIs were associated with an increased risk of adverse cardiac outcomes in patients taking clopidogrel and aspirin.[9]

The importance of this debate shouldn't be underestimated - the number of patients starting clopidogrel increases each year and, after the NICE guidance was amended in 2010, patients will be taking it for longer[6]. No GP needs to be reminded about how ubiquitous PPI prescribing is - and not all of it initiated (or even understood) by us GPs.

In the years since 2008 a consensus seems to have emerged - that PPIs probably do have an effect on clopidogrel, but that the benefits outweigh the risks.

The most recent reassuring study comes from researchers who used the UK General Practice Research Database to assess the risk of recurrent MI in people who were receiving aspirin and clopidogrel and who did or did

not use PPIs. They found that use of PPIs was associated with a significant increased risk of MI (35%). But people who are prescribed a PPI are probably at high underlying risk of MI anyway, for example, obese people may be at high risk of MI but also of gastro-oesophageal reflux disease. So researchers compared the MI rate in patients taking aspirin and clopidogrel in the periods when they were also taking a PPI with when they weren't and found no significant difference. Of course this approach comes with limitations but it does seem to suggest that the benefits of taking clopidogrel with a PPI outweigh the risks.

4 Where are we now with the polypill concept?

The concept of a polypill - consisting of a combination of drugs to reduce multiple cardiovascular risk factors - first came to widespread attention almost a decade ago.

The initial composition of the pill was aspirin, a statin, three antihypertensives at half the standard dose - a thiazide, an ACE inhibitor and a calcium-channel blocker - and folic acid. Since then, several formulations have been manufactured and tested which have shown the approach to be feasible and safe in lowering blood pressure and LDL cholesterol in people with one or more cardiovascular disease risk factors, although these effects were generally less than predicted in early research.

Earlier this year one of the most important studies yet on this topic was published - a randomised, double-blind, placebo-controlled, crossover study which was designed to estimate risk reductions more accurately than the parallel-group designs of earlier trials.[10] The polypill in this study consisted of amlodipine 2.5mg, losartan 25mg, hydrochlorothiazide 12.5mg, and simvastatin 40mg. The only criteria for inclusion were age (50 years or over) and no history of cardiovascular disease, with 86 participants taking the polypill for 12 weeks and a placebo for 12 weeks in random sequence.

Compared with placebo, the polypill reduced mean systolic blood pressure by 17.9mmHg (12%) and diastolic blood pressure by 9.8mmHg (11%), and LDL cholesterol by 1.4mmol/l (39%) - greater than those in earlier trials, and almost identical to those predicted for the polypill from meta-analyses of the individual components. The researchers estimate this would result in reductions of 72% for ischemic heart disease events and 64% for strokes.

The other important aspect of this study is that the formulation used here will be the one that is to be submitted for regulatory approval, with one difference - the dose of simvastatin will be reduced from 40mg to 20mg, following MHRA advice that this lower dose should be used in patients also taking amlodipine.

But I believe there are still areas of confusion that need clarifying before a regulatory-approved polypill can be used:

- Adherence in these trials is much better than usually seen with long-term drugs, which may be expected as the low doses used are less likely to cause side effects. But we need to see rates from longer trials.
- There is no data on clinical outcomes, although there is ongoing debate over whether it's needed before the approach can be put into practice.
- It's arguable whether the approach is feasible in practice without the large-scale research and development and marketing push a large pharmaceutical company could provide. Currently, polypills are made by small, generic companies without these resources.

5 What is the new NICE guidance on ivabradine in heart failure?

Ivabradine is licensed for the treatment of chronic heart failure (NYHA class II to IV) with systolic dysfunction, in patients in sinus rhythm and whose heart rate is 75bpm or more, in combination with standard therapy including ß-blockers or when ß-blockers are contraindicated or not tolerated.

The key data on the role of ivabradine comes from the SHIFT trial of 6,505 adult patients with chronic heart failure NYHA class II to IV who had been stable for at least four weeks.[11] After almost two years' follow-up, cardiovascular death or admission with heart failure was reported in 24% of those taking ivabradine compared with 29% of placebo patients - an 18% relative risk reduction and a 4.2% absolute risk reduction. In patients with a heart rate greater than or equal to 75bpm (64% of the patients) these outcomes were seen in 27% on ivabradine and 33% on placebo - a 24% relative risk reduction and a 6.2% absolute risk reduction.

At the end of last month, NICE published its draft guidance on ivabradine, supporting its use in treating chronic heart failure for people:[12]

- with NYHA class II to IV stable chronic heart failure with systolic dysfunction and
- who are in sinus rhythm with a heart rate of 75bpm or more and
- with a left ventricular ejection fraction of less than or equal to 35% and
- who are already on standard therapy of ß-blocker, ACE inhibitors and aldosterone antagonists, or when ß-blocker therapy is contraindicated or not tolerated.

Ivabradine should only be initiated after a stabilisation period of four weeks on optimised standard therapy with an ACE inhibitor, a ß-blocker and an aldosterone antagonists. It should be initiated by a heart failure specialist. Dose titration and monitoring should be carried out by a heart failure specialist, or in primary care by either a GP with a special interest in heart failure or a heart failure specialist nurse.

Dr Matt Hughes is a GP and clinical assistant in cardiology in Cardiff

References

1 NICE. Hypertension - clinical management of primary hypertension in adults. August 2011. CG127
2 NICE. Chronic heart failure: management of chronic heart failure in adults in primary and secondary care. August 2010. CG108
3 The ONTARGET investigators. Telmisartan, ramipril or both in patients at high risk for vascular events. *N Engl J Med* 2008; 358: 1,547-59
4 Mann JF, Schmieder RE, McQueen M et al. Renal outcomes with telmisartan, ramipril, or both, in people at high vascular risk (the ONTARGET study): a multicentre, randomised, double-blind, controlled trial. *Lancet* 2008; 372: 547-53
5 Lakhdar R, Al-Mallah MH, Lanfear DE et al. Safety and tolerability of angiotensin-converting enzyme inhibitor versus the combination of angiotensin-converting enzyme inhibitor and angiotensin receptor blocker in patients with left ventricular dysfunction: a systematic review and meta-analysis of randomized controlled trials. *J Card Fail* 2008; 14: 181-88
6 NICE. Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events. December 2010. TA210.
7 Gurbel PA, Nolin TD and Tantry US. Clopidogrel efficacy and cigarette smoking status. *JAMA* 2012; 307: 2495-96
8 Gilard M, Arnaud B, Cornily JC et al. Influence of omeprazole on the antiplatelet action of clopidogrel associated with aspirin: the randomised, double-blind OCLA (Omeprazole CLopidogrel Aspirin) study. *J Am Coll Cardiol* 2008; 51: 256-60
9 Juurlink DN, Gomes T, Ko DT et al. A population-based study of the drug interaction between proton pump inhibitors and clopidogrel. *CMAJ* 2009; 180: 713-8
10 Wald DS, Morris JK and Wald NJ. Randomised polypill crossover trial in people aged 50 and over. PLoS ONE 2012; 7(7): e41287.
11 Swedberg K, Komajda M, Böhm M et al, on behalf of the SHIFT investigators. Ivabradine and outcomes in chronic heart failure (SHIFT): a randomised placebo-controlled study. *Lancet* 2010; 376: 875-85
12 NICE. Heart failure (chronic) - ivabradine: final appraisal determination. NICE October 2012

PlusPlus Cardiology

Key learning points

Key questions on atrial fibrillation page 30

- AF affects between 1.3-1.7% of the population.
- All patients with AF - whether paroxysmal, persistent or permanent - should be assessed for stroke risk.
- Basic investigations in AF include blood tests, electrolytes, liver function tests, cholesterol/lipids, glucose and thyroid function.
- Patients with symptomatic but episodic AF could be considered for a 'pill in the pocket' regimen.

Hypertension - one year on from the NICE guidance page 32

- The 2011 guideline encouraged GPs to use 24-hour ABPM as the gold standard investigation.
- Treatment targets for people aged over 80 should be 150/90, compared with 140/90 for younger patients.
- GPs should use an ACE inhibitor or ARB first-line in patients under 55 and a calcium channel blocker in patients over 55.

Ten Top Tips: Heart failure page 33

- Around 68,000 new cases of heart failure are diagnosed each year in the UK.
- Diuretics are helpful for symptom control in left ventricular systolic dysfunction but evidence for effect on survival is lacking.
- The 10-year survival rate for patients with a diagnosis of heart failure is around 30%.
- Co-morbidities such as COPD can overlap symptom profile with heart failure.

Cardiovascular causes of syncope page 36

- Do a 12-lead ECG in all patients with syncope.
- A normal ECG and the absence of heart disease effectively rules out a cardiac cause of syncope.
- Syncope secondary to orthostatic hypotension may be an early precursor of Parkinson's disease.
- Neurally-mediated syncope accounts for between 65% and 95% of cases.

Controversies in CV medicine page 38

- Clopidogrel is first-line antiplatelet therapy for all cardiovascular events except TIA and MI
- PPIs probably do have an effect on clopidogrel, but the benefits outweigh the risks.
- Research into the polypill estimated it could reduce ischemic heart disease events by 72% and strokes by 64%.

After reading these articles and referring to the associated guidelines and studies, go to pulse-learning.co.uk and answer 20 questions to earn 3 CPD credits. This module is available free to all members of Pulse Learning until 21 November 2012

More than 20,000 GPs are already receiving the Pulse education weekly email newsletter

Be the first to find out about:

- New CPD modules
- Online-only clinical articles
- Clinical videos

Don't miss out - sign up now at:
pulsetoday.co.uk/email-sign-up

42 PULSESERVICES TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningococcal ACWY	Japanese encephalitis	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Abu Dhabi	S	R				S		S	S					No		Le
Afghanistan	R	R		S	R	R	S	S	S	C				Yes, below 2,000m, May-Nov	ME or Do or VKN	PC	Le
Albania	S	R						S	S	C			S	No		Le
Algeria	R	R					S	S	S	C				Yes, low risk West in South	W		Sh Le
Angola	R	R		S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Antigua & Barbuda		S						S		C				No			
Argentina	S	R						S	S	S				Yes, rural areas near 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 Jan-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	ME or DO or MON W	PC	Le
Barbados		S				S		S		C				No			
Belarus		R				S	S	S	S				S	No			
Belize	S	R					S	S	S	C				Variable risk in south, low risk Belize City	C	P	
Benin Republic	R	R		S	R	S	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Le
Bermuda		S						S						No			
Bhutan	R	R		S			S	S	S	C		S		Yes, southern districts	ME or DO or MON	DFF	Le
Bolivia	R	R				R	S	S	S	R				Yes, high risk in Amazon basin. Variable risk on Paraguayan and Argentine borders	ME or DO or MON PC	PC DFF	
Borneo	R	R		S		S	S	S	S	C		S		Low risk, coastal areas of Malaysian Sarawak and Sabah. Indonesian Kalimantan, high risk all areas	W ME or DO or MON PC	PC PC	
Bosnia		R				S	S	S	S				S	No			Le
Botswana	R	R		S		S	S	S	S	C				Yes, northern half only Nov-June	ME or DO or MON	PC	Sh Ta
Brazil	S	R				S	S	S	S	R				High risk in NW half in Amazonia states. Elsewhere, very low	ME or DO or MON W	PC	Sh Le Tc
Brunei		R					S	S	S	C		S		No			
Bulgaria		R					S	S	S				S	No			
Burkina Faso	R	R		S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Le Ta
Burundi	R	R		S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Cambodia	R	R		S		R	S	S	S	C		S		Yes Yes, significant risk elsewhere. Minimal risk Phnom Penh, Angkor Wat, Siem Reap	DO or MON ME or DO or MON W	PC PC	
Cameroon	R	R		S		R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Canada														No			
Cape Verde Islands	R	R				S	S	S	S	C				Yes, very low risk Aug-Nov	W		Le
Cayman Islands		S						S						No			
Central African Rep.	R	R		S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Chad	R	R		S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Chile	S	R						S	S					No			Tc
China (Mainland)	S	R		S	R		S	S	S	C		S	S	Yes, in Yunnan and inland Hainan. Elsewhere, very low/no risk	ME or DO or MON W	PC	Sh
China (Hong Kong)		R					S	S						No			
China (Macao)		R					S	S	S			S		No			
Colombia	S	R						S	S	R				Yes, high Eastern half Variable risk elsewhere <1,800m Very low around Medellin, Bogota & Cartagena	ME or DO or MON PC W	PC DFF	Le Ta
Comoros	R	R		S		S	S	S	S					Yes, high risk	ME or DO or MON	PC	Le
Congo	R	R		S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Congo-Dem. Rep.	R	R		S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Cook Islands		R						S						No			
Costa Rica		R				S		S	S	C				Small variable risk area on East coast. Rest of country, low risk	C W	P	Le Tc
Croatia		S						S	S				S	No			Le
Cuba		R						S	S					No			
Cyprus		S												No			Le
Czech Republic		S						S					S	No			
Djibouti	R	R		S		S	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Le
Dominican Republic	R	R		S		R	S	S	S					Yes, high risk along Haitian border, variable risk elsewhere	C	P	Sh Le
Dubai	S	R				R		S	S					No			Le
East Timor (Timor Leste)	R	R				S	S	S	S	C		S		Yes, high risk	ME or DO or MON	PC	Le
Ecuador	R	R					S	S	S	R				Yes, moderate risk coastal provinces, substantial on Peru and Colombian border. Elsewhere low risk	ME or DO or MON W	PC	Tc
Egypt	R	R						S	S	C				No			
El Salvador	R	R						S	S	C				Yes, low risk	W		
Equatorial Guinea	R	R		S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Ta
Eritrea	R	R		S		R	S	S	S	C	S			Yes, high risk (no risk in Asmara)	ME or DO or MON	PC	Sh Le
Estonia		S						S	S				S	No			
Ethiopia	R	R		S		R	S	S	S	R	S			Yes, high risk below 2,000m (No risk in Addis Ababa)	ME or DO or MON	PC	Sh
Falklands (Tristan da C.)														No			
Fiji	S	R				R		S		C				No			
Finland													S	No			
France													S	No			Le
French Guiana	S	R				S	S	S	S	M				High risk inland and border areas, coast and islands, low/no risk	ME 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	ME or DO or MON	PC	Sh
Gambia	R	R					S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Georgia	S	R					S	S	S				S	Yes, v. low risk SE villages July-Oct	W		
Germany													S	No			
Ghana	R	R		S		R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Goa	R	R			R	R	S	S	S	C		S		Yes, variable risk	PC	DFF	Le
Greece and Islands		S						S					S	No			Le
Greenland		R				S		S	S					No			
Grenada		S						S	S	C				No			
Guadeloupe		S					S	S		C				No			
Guam		R					S	S						No			
Guatemala	S	R					S	S	S	C				Yes, some risk below 1,500m	C	P	
Guinea	R	R		S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Guinea Bissau	R	R		S		S	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Guyana	S	R					S	S	S	R				Yes, high risk at areas except coastal strip	ME or DO or MON	PC	Sh
Haiti	R	R		S		R	S	S	S	C				Yes, high risk throughout country	ME or DO or MON	PC	
Hawaii								S						No			
Honduras	R	R					S	S	S	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	ME or DO or MON W PC	PC DFF	Le
Indonesia	R	R		S		R	S	S	S	C		S		Yes, high in Lombok Very low in Bali and cities Yes, variable elsewhere	ME or DO or MON W PC	PC DFF	Sh
Iran	S	R		S		S		S	S	C				Yes, most SE provinces Mar-Nov	ME or Do or MON	PC	Sh Le
Iraq	R	R		S		R	S	S	S	C				Yes, v. low risk rural north May-Nov	W	P	Sh Le
Israel		R						S	S					No			Le
Italy		S						S					S	No			Le
Ivory Coast	R	R		S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Ta
Jamaica		R				S		S		C				No			
Japan								S				S	S	No			Sh
Jordan	S	R						S	S	C				No			Le
Kazakhstan		R				R	S	S	S	C			S	No			Le
Kenya	R	R		S	R	R	S	S	S	R	S			Yes, high risk (Nairobi and highlands low risk)	ME or 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 south	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)	ME 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://www.nc.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

Specialist advice

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

Parasitic infections

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

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

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

Tc = South American trypanosomiasis (Chagas' disease). Transmitted by 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 695 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
policeradication.org/Dataandmonitoring/Poliothisweek.aspx

PULSE

Although every effort is made to ensure that information in these pages is correct, the compilers and Pulse cannot accept responsibility for the consequences of errors. © PULSE 2012

Updated: September 2012

Malaria

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningococcal ACWY	Japanese encephalitis	Tick-borne encephalitis	Risk areas and seasons	Recommended regimen	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			Li
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 low risk 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			Li
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 states 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, N E third only Elsewhere low risk	ME or DO or MON W	PC	Sh
Nepal	R	R	S	R	R	S	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 forests Dept. Variable risk SE area bordering Brazil & Bolivia, and around Tambos & Pisco	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 areas and Kota Kinabalu	ME or DO or MON W	PC	
Samoa	S	R				S		S	S	C			No			
Sao Tome	R	R	S				S	S	S	M			Yes, high risk	ME or DO or MON	PC	Sh Le
Saudi Arabia	S	R				R		S	S	C	S M		Yes, SW region, rural areas of Mecca Elsewhere (no risk Mecca, Medina)	ME or DO or MON W	PC	Sh Le
Senegal	R	R	S	R	R	S	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, Bos Bay & Jozini	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			No
Sri Lanka	R	R				S	S	S	C		S		Yes, for 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
Suriname	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	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			Li
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	LET
Vietnam	R	R	S		S	S	S	S	C		S		Low risk in cities, most 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-Jan Negligible risk Harare and Bulawayo	ME or DO or MON ME or DO or MON W	PC PC	Sh Ta

Key to malaria prophylaxis regimens

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

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

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

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

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

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

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

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

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

Children's doses of antimalarial prophylactics

Weight in kg	Chloroquine Proguanil	Mefloquine	Age
Under 6.0	0.125 adult dose ¼ tablet	not recommended	term to 12 weeks
6.0 to 9.9	0.25 adult dose ½ tablet	0.25 adult dose ¼ tablet	3 months to 11 months
10.0 to 15.9	0.375 adult dose ½ 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 ½ 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

Although every effort is made to ensure that information in these pages is correct, the compilers and Pulse cannot accept responsibility for the consequences of errors. © PULSE 2012

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

PULSE LIVE 2013

YOUR PRACTICE
YOUR PATIENTS
YOUR FUTURE

THE NATIONAL CONFERENCE FOR GENERAL PRACTICE | 30 APRIL – 1 MAY | BIRMINGHAM

PULSE IS GOING LIVE AND WE WANT YOUR HELP

Pulse has reached a key moment in its 52-year history. Your magazine will be going live with a two-day conference for GPs and practice managers. The event will be taking place in Birmingham 30 April – 1 May 2013.

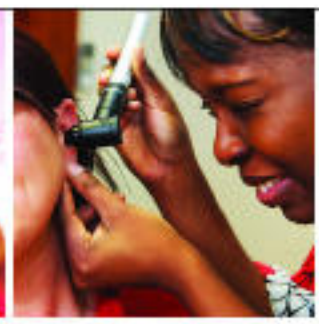
The Pulse Live team is putting the programme together and we want to get you involved in the process! Follow the link below and tell us how you want the event to look. Help us choose the topics and issues most relevant to you and your practice.

Our mission is to meet your needs – this is your chance to get involved and help shape the event. Simply log on to pulse-live.co.uk and register your interest. You will be able to submit your suggestions as part of the registration form.

www.pulse-live.co.uk

Get Involved

GET INVOLVED



Register today
Online pulse-seminars.com/successful-practice-management
Call 020 7332 2934

6 CPD hours

PULSE Business Seminars

Successful practice management 2012

Thursday 29 November, Birmingham

Develop the skills and the strategy to ensure your practice is standing on solid financial ground

In just one day, you will learn how to:

- Protect your income and ensure you don't lose out in QOF changes
- Face tough decisions on staffing and structure
- Set up and maintain a good relationship with your CCG
- Stay ahead of changes to contracts and patient care models

Hear from experts with real experience at the coalface of general practice:

Dr Charles Zuckerman GP and medical secretary at Birmingham LMC
Dr Peter Patel Chair of South Birmingham Commissioners Local Network
Dr Jeff Stoker GP partner, The Bermuda Practice, Hampshire

Seminar chair
Dr Simon Clay

Dr Simon Clay is senior partner and QOF lead at the Poplars GP surgery in Erdington, Birmingham. He has written a number of educational articles on how to optimise QOF coding and organisation.

PULSESERVICES RECRUITMENT

Contact
Cliff Brown
Advertisement executive
020 7332 2924
For a quote send adverts to:
clifford.brown@briefingmedia.com

Rates
£18.00 – £26.00 per single column centimetre.
Colour rates available on request

Issue date/Copy deadline
Publication date Wednesday.
Booking deadline Thursday 4pm preceeding publication date.
Copy deadline Friday noon preceeding publication date

By post
Briefing Media
3rd Floor, Mermaid House
Puddle Dock
London, EC4V 3DB

Website
pulsetoday.co.uk

DOCTORS/GPS REQUIRED

SALARIED GP – UP TO 9 SESSIONS

Situated on the beautiful Cambridgeshire / Norfolk / Lincolnshire border, The North Brink Practice is looking to recruit an enthusiastic GP to join our friendly, innovative and award-winning team.

We are the largest practice in Wisbech, committed to providing high quality, compassionate care through an effective team approach and full engagement within our local commissioning group.

- An expanding list of 18,000 patients
- SystmOne with remote and WIFI access
- RCGP Quality Practice accreditation since 2005
- Training practice
- On-site Dispensary and practice-owned retail Pharmacy
- Exceptional QoF Achievement
- Commitment to CPD
- Extensive range of Enhanced Services
- Easy access to good schools, housing and unspoilt countryside.
- Competitive salary

Closing date for applications: 16th November 2012
Interview date: 23rd November 2012
Download an information pack: www.northbrink.com
To apply, please send a CV and covering letter to Carol Shailes at: northbrink.vacancies@nhs.net

Welcome to North Brink!

Abbey Medical Practice Evesham, Worcestershire

PART TIME SALARIED GP – 6 SESSIONS (3 DAYS) PER WEEK

We are a friendly, growing 4-Partner semi-rural Practice looking for an enthusiastic and forward-thinking doctor to join our team, initially for a period of 12 months.

- GMS Practice with 7,250 patients
- High QOF/enhanced service achievement
- Dispensing to approx 43% of list
- Excellent supporting team
- Paperlight (EMIS PCS computer system)
- Modern, purpose-built premises
- Competitive salary

Please send your CV with covering letter to Mr R Allen, Business Manager, Abbey Medical Practice, Evesham Medical Centre, Abbey Lane, Evesham WR11 4BS. Tel 01386 761111. Email rallen3@nhs.net

Informal enquiries welcome.
Closing date: 30th November 2012

GP VACCANCY

Liverpool

Full / Part Time Salaried GP with View of Partnership

DR. Sapre & Partners
Maghull

Are you looking to work in a well organised, friendly and forward thinking practice with an opportunity for further development in your career?
Look no further and contact us immediately.

Location	Maghull
List size	5000
Contract	PMS/GMS
Positions	2 GP Posts
Operating System	EMIS WEB; Paperlite
Services Provided	All the usual GMS Contract services
Support	Good Clinical and Administrative support provided
Availability of Position	Immediate

Please send CV and references or for further details, please contact -
Mrs. Liz Rigby
0151 520 2487/0151 526 5453
lizandbrianuk@yahoo.com

TORQUAY, SOUTH DEVON PARTNERSHIP

Due to planned retirement, a rare opportunity arises to join this stable, enthusiastic GMS practice in our sunny seaside town. We are 4.75 WTE with 8000 patients, looking for a salaried GP with the intention of parity partnership after 12 months. We are flexible about start date, ideally, March 2013, and will consider part-time as well as full time (8 sessions).

We offer you 8 weeks leave, a wonderful extended PHCT, attached independent pharmacy, a full nursing team and marvellous admin. support including you own personal secretary. There is no OOH commitment unless you choose to offer your services to Devon Doctors, our local provider.

Apply in writing with CV to Mrs. P. Vooght, Practice Manager, Croft Hall Medical Practice, 19 Croft Road, Torquay. TQ2 5UA
Closing Date 28 November 2012

For an informal chat and further details please contact: Dr. Ellie Rowe 01803 298441

We are a friendly, rural 3 partner practice seeking a well motivated experienced doctor who is willing to be involved in medical student training.

- 3730 Patients
- GMS: High QOF achievers
- Dispensing
- GP Training practice to year 4 students
- Emis LV (Emis Web from February 2013)
- No extended hours

Salaried position 2-4 sessions from January 2013 with the prospect of increase of hours at the end of 2013 when one of our GP Partners retires. Family planning training desirable. Job share applications will also be considered.

Applications by CV with a covering handwritten letter to:
Mrs Susan Mellor-Palmer
Practice Manager
Craven Arms Medical Practice
Craven Arms
Shropshire SY7 9PY

01588 672309 or cravenarms.practicemanager@nhs.net
Closing date 22nd November 2012

SALARIED GP
Coventry

(Possible Future Partnership)

We are looking for 2 Part Time or 1 Full Time
Highly motivated and enthusiastic Salaried GP(s) to join our friendly inner city practice.

Emis Web Clinical System
GMS Practice with approximately 4000 patients
High QOF achievement
Actively engaged in commissioning
Situated in newly built City of Coventry Health Centre
Enthusiastic, friendly team
No OOH commitment

Please apply in writing with a CV to
Jas Bhogal, Business Manager
Dr Sani & Partners, City of Coventry Health Centre,
2 Stoney Stanton Road, Coventry, CV1 4FS
Or email jas.bhogal@nhs.net Tel: 02476 661321

PARTNER REQUIRED
Withnell - Rural Chorley

We are seeking to replace our long serving retiring senior partner commencing beginning of June 2013.

Our three partner practice is based in a picturesque rural location on the edge of West Pennine Moors only five minutes from Chorley and the motorway network.

We are proud to continue to practice traditional family medicine out of a Health Centre so little capital outlay is required. The health centre has a full compliment of practice staff with two practice nurses and district nurses, health visitors and parenting team on site.

An ideal candidate would value the traditional doctor patient relationship and continuity of care and ideally would have an interest in female medicine, family planning and child health. There is scope for further development of the practice, and a desire to drive the practice forward would also be welcomed.

The practice is highly valued within the local community and offers a partner the opportunity to obtain an adequate remuneration with a good work life balance.

Enquiries to Nicola Phillipson/Ethel Vickers 01772 777770
Applications to Mrs Nicola Phillipson by 30th November
Withnell Health Centre
Railway Road
Withnell
Chorley
PR6 8UA.
Interviews January 2013

SALARIED GP (s)

A vacancy has arisen for 1 or 2 salaried GP's to provide cover for 6 to 7 sessions per week.

- EMIS LV
- No out of hours
- List size over 4000
- High QOF achievement
- Actively engaged in Commissioning
- Purpose built premises
- Candidate to be able to perform 6 to 8 week CHS checks
- Salary negotiable

If you are interested, please apply by email to anita.verma@nhs.net or you may send your CV to:
Thatched House Medical Centre,
136 High Rd, Leytonstone, E15 1UA

Woking, Surrey
Salaried GP
Up to 8 sessions per week

We are looking for an enthusiastic and highly motivated GP to join our busy team of 3 Partners & 4 salaried GP's. A special interest would be welcome.

- GMS practice shortly migrating to EMIS Web
- 12200 list size
- High QOF points achieved
- Efficient, friendly, motivated team

For applications or further details please contact: Jill Keen, Practice Manager, The Family Practice, St John's Health Centre, Hermitage Rd, St John's, Woking, GU21 8TD
Jill.keen@nhs.net
01483 227064

Closing Date: 30th November 2012

Dynamic teaching practice seeks maternity locum cover to start asap for 5-8 sessions per week in the SW17 area.

We also need up to 4 sessions per week cover, initially as a locum, at our Clapham surgery in SW4.
Please send CV to Penelope.smith@nhs.net or
Tel: Fiona Hughes on 020-8254-8036.

DOCTORS/GPS REQUIRED

SUMMERHILL SURGERY

SALARIED GP REQUIRED

We are a medium sized practice with approximately 6,000 patients and we operate under the Dudley local enhanced service providing primary care services for half of Dudley's care home residents (Approx 1,000 patients). This currently includes providing out of hours care.

We are looking for an experienced GP (at least 6 sessions) who is flexible and works well in a team. The post will be for a salaried GP with a view to possible partnership in the future.

The post involves routine & emergency visits to patients in Care Homes, undertaking all normal duties associated with primary care. The work is clinically interesting and varied; experience in end of life care and caring for patients with multiple co-morbidities would be beneficial.

We are:

Synergy and Docman practice
Consistently high QOF achievers
3 Full time and 3 part time GP's, Nurse Practitioner.
2 practice nurses and a part time HCA. all with full administrative support
Active participants in the local Dudley CCG.

Applications / enquiries to Carol Jones, Practice Manager.

Summerhill Surgery, Summerhill, Kingswinford, West Midlands. DY6 9JG

Tel: (01384 273275)

Closing Date is November 23rd 2012

Wheatfield Surgery
Part-time Partner

We are looking for a part-time partner as part of a job share. Working 4 sessions over 2 days covering Monday plus either Tuesday or Wednesday. We are interested in an enthusiastic GP to join our busy and friendly practice team.

- Long established 7 Partner practice (currently 6 ¾ wte)
- List size 13,500
- PMS
- Purpose built leased premises
- Fully computerised (Synergy)
- High QoF achievers
- 7 week annual leave includes 1 week study leave (pro rata)
- 3.5 Practice nurses, including nurse prescribers and 2 HCA
- On site counsellor, midwife, 100hr pharmacy
- Actively involved in CCG
- Excellent road links, easy to access close to junction 11 M1

Informal enquires and visits welcome.

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

Closing date: 14th November 2012

SALARIED GP REQUIRED
(POSSIBLE FUTURE PARTNERSHIP)
FOR SOUTH EAST LONDON PRACTICE CLOSE TO THE THAMES.

We are a well established practice
with 6000 plus patients occupying brand new state of the art premises
looking for a committed enthusiastic doctor.
No out of hours
Supportive friendly administration team
We welcome a doctor who specializes in obstetrics, gynaecology and sexual health

For informal discussion and further details please contact:
Dr Y Lefeuvre 020 8654 0356
yannlefeuvre@nhs.net
Closing date: 11 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).

- Purpose adapted premises
- High QOF points achieved
- Dedicated Staff
- Local Holiday Cover Scheme

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

HARLEY STREET DOCTORS LTD.

Doctors required UK-wide for mobile insurance medicals, especially in the following areas:
London, Bournemouth, Southend, Chelmsford, Reading, Southampton, Leics., Lincs., Cambs., Herts., Dorset, Dundee, Aberdeen & Dublin
Please email your CV to: peter@harleystreetgroup.co.uk
or call on 020 7224 0030

DRS N & S K NAGPAL

THE SURGERY, WILLIAM HOPWOOD STREET, BLACKBURN, BB1 1LX

VACANCY:	Salaried GP
SALARY:	Negotiable
HOURS:	9 sessions per week
RESPONSIBLE TO:	Lead GP

We are looking for an enthusiastic GP to join our friendly patient centred team. A combination of outstanding clinical skills with a forward thinking and innovative approach to patient care are essential:

- PMS Practice providing a wide rang of NHS services.
- Approximately 5855 patients
- Enthusiastic and supportive team
- High QoF achievement
- Excellent administration and support teams
- Extended Hours provider
- EMIS WEB System

Job Description available on request

All applications in writing please enclosing Curriculum Vitae and the names of two referees to: Dr N Nagpal at the above address or by email: nirmala.nagpal@nhs.net

Firsway Health Centre
Sale, Cheshire

Full Time Partner (8 sessions)

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

- High QOF achiever
- Training Practice
- Vision System
- List size 16,000+
- Enhanced services offered
- No out of hours commitment
- A number of ancillary services e.g. dieticians, ENT and cardiology clinics and podiatry run from the centre

We are looking for enthusiasm, dedication, experience and commitment to high quality patient care.

Please write with cv and other supporting information to David Dunlop, Firsway Health Centre, 121 Firsway, Sale, Cheshire, M33 4BR. Email d.dunlop@nhs.net – tel. 0161 9050312

Closing date: Nov 23rd

DOCTORS/GPS REQUIRED

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

FULL TIME PARTNER REQUIRED

West Wickham, Kent

Friendly practice of 7 Partners (12,500 pts), seeks enthusiastic doctor to replace retiring Partner in April 2013.

- 8 sessions a week over 5 days (including on-call rota)
- Paperlight, Emis web, high QOF achievers
- Undergraduate teaching practice
- Good local schools and easy access to central London

Contact Pauline O'Dwyer, Practice Manager, Station Road Surgery, on 020 8916 8027, or email pauline.odwyer@nhs.net.

Doctors required UK-Wide for Insurance medicals.

dc life

...is growing. Join our panel of doctors who provide Insurance Medicals.

- Adhoc or sessional work
- Training provided
- Excellent remuneration
- Full administrative support

This is a unique opportunity to be part of our team. If you are interested please send a copy of your CV to:

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

Staffordshire Salaried GP

Friendly five Doctor, well managed practice situated in the attractive market town of Leek in Staffordshire, looking to employ a 5/6 session (negotiable) Salaried GP for twelve months with a view to partnership.

- **Full complement of primary care staff**
- **8,200 patients**
- **4 GP WTE**
- **GMS**
- **InPS Vision system**
- **Paperlight**
- **High Q&OF achievement**
- **Actively involved in CCG**
- **Well established training practice**
- **No OOH commitment**

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

Closing date: Friday 9th November 2012

2 Salaried GP(s) required for Minster Medical Group

Minster Medical Centre, Minster on Sea, Sheerness, Kent, ME12 3LT

We are a 4 partner APMS practice based in a modern community hospital looking for two enthusiastic GPs to join our busy multidisciplinary team on the Isle of Sheppey, Kent.

The two full time salaried GP roles will include interesting work within local prisons and general practice.

Experience of EMIS PCS and SystmOne desirable

Salary negotiable according to experience

If you are interested in joining our team please submit your cv to the Practice Manager elaine.rosenthal@nhs.net or for more information please call 01795 877714

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
- Emis Web
- 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

LOCUM AGENCIES

Locum Staffing

Finding work doesn't have to be time consuming. Let the work come to you.

- Earn up to £100 p/hour
- Placements nationwide
- Newly qualified/experienced welcome
- Free e-mail and sms job alerts
- Excellent referral bonuses

Ongoing locum and salaried positions throughout the UK

We are providers of GPs to:

- PCTs
- Hospitals
- GP Practices
- Walk In Centres
- HM Prisons
- Out of Hours Services
- Medico - Legal

t. 08450 562 867 | f. 01582 345 355

info@locumstaffing.co.uk | www.locumstaffing.co.uk

dr-locums

Earn £1000* per day

Recruiting across the UK :-

London * Sussex * Essex * Suffolk * Midlands * North England * Wales

Walk In Centres
Out of Hours
Prisons (RCGP1 trained)
GP surgeries

Call 020 7498 7999
www.drlocums.com
gp@drlocums.com

LOCUM AGENCIES

Escape to New Zealand!

Alarmed at the drastic NHS proposals?

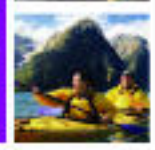
Make the move to New Zealand with our friendly communities, sandy beaches, and rolling vineyards, now is the time!

We are New Zealand's only not-for-profit, government funded medical recruitment specialists, and will provide you with:

- Free end-to-end recruitment service
- Wide choice of short-term, long-term and permanent GP positions
- Immigration assistance
- GMC accredited three-day orientation course

Contact us today!

enquiries@nzlocums.com | Freecall 0800 246 7653 | www.nzlocums.com



NZLocums

Cimarron

Established and unique GP Locum Agency, offering a professional, efficient service for all GPs.

URGENTLY REQUIRED

Primary Care and Substance Misuse GPs required for prison work in; Chelmsford, Manchester, Peterborough and Middlesex

Contact us today and see the Difference!
Phone 01206 274174
Email: enquiries@cimarron-uk.com

REC Recruitment & Employment Confederation

COURSES/CONFERENCES

CONFERENCE PLUS

2nd - 9th February 2013

Oman

Oman is an exotic and beguiling destination. Though historically one of the most important trading ports on the Arabian Peninsular and the centre of the East African Slave Trade, Oman's interior, its mountains and valleys, spectacular forts, sand dunes and most of all its relaxed desert culture has remained undiscovered.

Join us on a week of discovery as we enjoy the magnificent Arab welcome from the Shangri-La 5* hotel with its wonderful restaurants and bars, beaches, stunning coral reefs, diving school and turtle sanctuary - all set in 124 acres of dramatic landscape, encompassing both the beauty of the sea and the rocky terrain protecting it. Enjoy an overnight trip in the desert and even an evening of Ballet at the spectacular Muscat Opera House. Combine all this with our excellent academic programme and you will see why Oman is a perfect winter destination for Conference Plus.

ACADEMIC FACULTY

- Dr Joel David - Rheumatology
- Dr Bevan Patel - Cardiology
- Mr Rash Fachan-Hejal - Orthopaedics
- Mrs Sally Bekier - Ophthalmic

CONFERENCES TO COME:

St Tropez	18th - 26th January 2013	Cappadocia & Bodrum	29th May - 1st June 2013
Sevilla & Granada	8th - 12th October 2013	Peru & The Amazon	14th - 20th October 2013

BOOK ONLINE AT: www.conferenceplus.co.uk
OR EMAIL: info@conferenceplus.co.uk
Tel: 01923 859363 Fax: 01923 469363

ABTA

Visit www.pulsetoday.co.uk/jobs for all the latest job listings!

Please contact Clifford Brown on 0207 332 2924 for more information on how to advertise

PULSE

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

EDITOR'S CHOICE

General practice behind bars

Dr Jenny Schaefer is a prison GP. She describes her working week looking after prisoners in Bristol – and reveals how even the hardest of criminals suffers from man-flu...

How long have you been a prison GP?
I started at HMP Bristol in May 2009. It's an all-male, category B prison built in Victorian times, housing about 600 prisoners.

Do you need to do any extra training?
There is a rigorous security clearance procedure involving lots of form-filling.

I was required to have the RCGP certificate in substance misuse (part two).

There is also specific training that the prison itself requires each staff member to undertake. For instance: personal protection, key training (there are a lot of locks), challenging bullying behaviour, prevention of suicide and self harm and computer training.

How does prison care work?
I almost always have a nurse with me in the room, for security but also as a witness to the proceedings. I write more copious notes than I would do in usual practice, as the client group has a tendency to take advantage of even the slightest lack of clarity.

The patients are all men over the age of 18, so there is no paediatrics, obs and gynae or family planning. Their problems are asthma, chest infections (almost everybody smokes roll-ups), hypertension, epilepsy, diabetes, skin infections and infestations, musculoskeletal disorders and of course man flu, just like any other practice.

There is a lot of mental illness, as well as insomnia, anxiety and depression.

The biggest challenge is discerning whether a condition is genuine or not; substance misuse is always on the agenda.

Sum up being a prison GP in three words
Fair but firm.

Dr Jenny Schaefer is a GP at HMP Bristol

MORE ONLINE
Read the full article at pulsetoday.co.uk/careers

BLOGS

'There is a feeling that full-time general practice is virtually impossible to sustain. In my patch it is becoming rare for a GP to be over 60, full-time and happy...'

▶ Read more on why Jobbing Doctor is retiring
pulsetoday.co.uk/blogs

GP ADVERTISEMENT FEATURE

How many of *your* patients will be relieved when they have an appointment with *acute pain?*

- A survey revealed that **four** out of **five** respondents had taken a painkiller at some point that had **not offered sufficient** relief[1]
- **Nuromol** (200mg ibuprofen + 500mg paracetamol) is a unique combination of clinically proven pain relievers that provides synergistic effects[2]
- **Nuromol** provides **stronger pain relief** than standard ibuprofen,[2] paracetamol[3] or co-codamol[3*]
- A meta-analysis has shown that **Nuromol** works in **more patients** than other OTC analgesics studied[4]

For effective pain relief recommend Nuromol

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

Advice to students thinking about a medical career: do something else
... in response to Jobbing Doctor's blog 'Why I'm retiring'

No, it's down to the NHS to deal with NHS debt
... on whether GPs should take on responsibility for PCT debt

Can I please just do the job I spent nine years training to do?
... on GPs being asked to promote healthier lifestyles

NAPC 2012

Conference videos

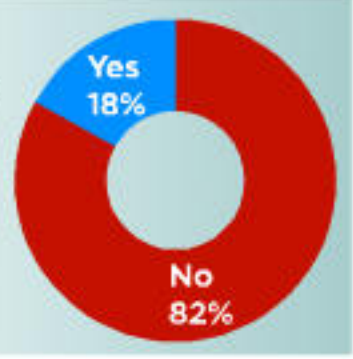
At last week's NAPC conference in Birmingham, Pulse caught up with Dr Simon Poole and Dr Rajendra Praysad – and you can also watch Sir David Nicholson's keynote speech

NAPC 2012
Watch all the videos online at pulsetoday.co.uk/NAPC2012

THIS WEEK'S POLL

Should the MPIG be phased out?
Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Has offering choice improved patient care?



Turn inside for this week's Phil Peverley and Margaret McCartney columns
▶ page 23