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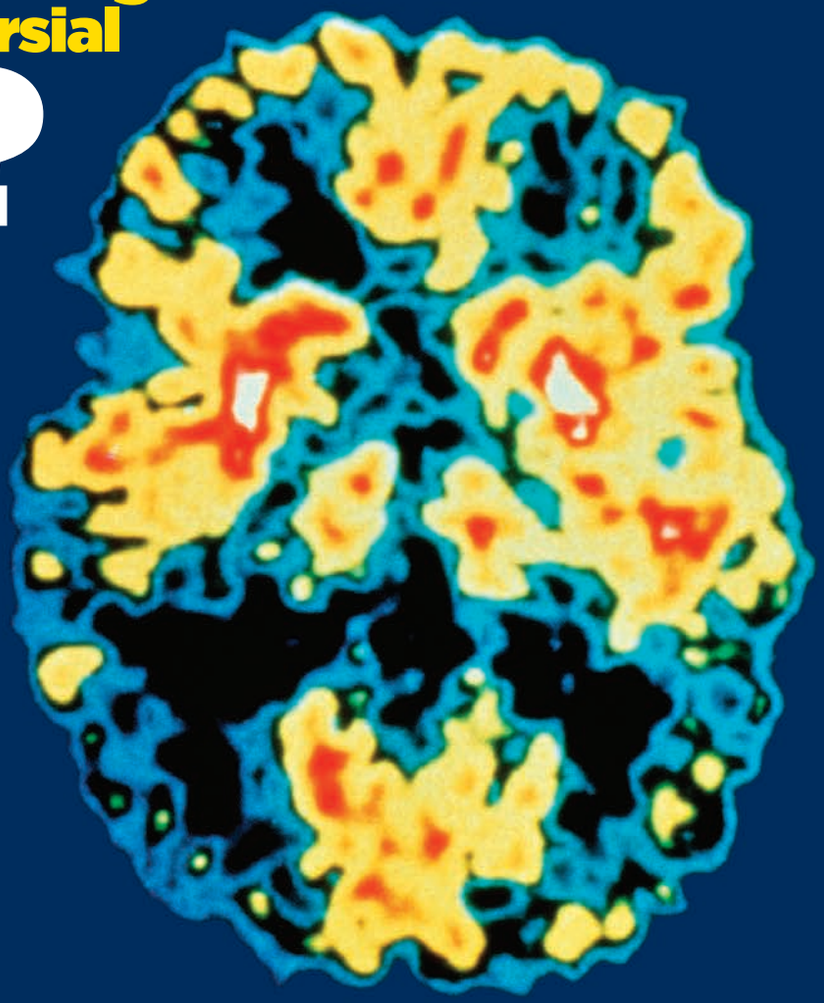
DEMENTIA SCREENING: CRUEL OR KIND?

Why the planned DES is proving so controversial



Plus
Key questions on type 2 diabetes
Why has it become so hard to recruit GPs?
Ten things you need to do before April
Peverley on sticking it to the malingerers

IN THIS ISSUE
2.5 CPD HOURS

Relax, Urgency controlled

Vesicare®
solifenacin

PRESCRIBING INFORMATION

Presentation: Vesicare® film-coated tablets containing 5 mg or 10 mg solifenacin succinate. **Indication:** Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder syndrome. **Dosage:** *Adults:* Recommended dose: 5 mg once daily. If needed, the dose may be increased to 10 mg once daily. *Children and adolescents:* Should not be used. **Contraindications:** Urinary retention, severe gastrointestinal condition (including toxic megacolon), myasthenia gravis or narrow-angle glaucoma and in patients at risk for these conditions. Patients hypersensitive to the active substance or to any of the excipients, or undergoing haemodialysis, or with severe hepatic impairment, or with severe renal or moderate hepatic impairment and on treatment with a potent CYP3A4 inhibitor. **Warnings and Precautions:** No clinical data are available from women who became pregnant while taking solifenacin. Caution should be exercised when prescribing to pregnant women. The use of Vesicare® should be avoided during breast-feeding. Assess other causes of frequent urination before prescribing. Use with caution in patients with clinically significant bladder outflow obstruction at risk of urinary retention, gastrointestinal obstructive disorders, risk of decreased gastrointestinal motility, severe renal or moderate hepatic impairment (doses not to exceed 5 mg), concomitant use of a potent CYP3A4 inhibitor, hiatus hernia/gastroesophageal reflux and/or patients currently taking medicines that can cause or exacerbate oesophagitis, autonomic neuropathy. QT prolongation and Torsades de Pointes have been observed in patients with risk factors, such as pre-existing long QT syndrome and hypokalaemia. Safety and efficacy have not yet been established in patients with a neurogenic cause for detrusor overactivity. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. Angioedema with airway obstruction and anaphylactic reaction have been reported with some patients on Vesicare®. **Interactions:** Concomitant medication with other medicinal products with anticholinergic properties may result in more pronounced therapeutic effects and undesirable effects. Allow one week after stopping Vesicare® before commencing other anticholinergic therapy. Therapeutic effect may be reduced by concomitant administration of cholinergic receptor agonists. Can reduce effects of stimulators of gastrointestinal tract motility. If used concomitantly with ketoconazole or other CYP3A4 potent inhibitor, maximum dose should be 5 mg due to 2-3 fold increase in AUC of Vesicare®. Pharmacokinetic interactions are possible with other CYP3A4 substrates with higher affinity and CYP3A4 inducers. **Adverse Effects:** Dry mouth, blurred vision, constipation, nausea, dyspepsia, abdominal pain, urinary tract infection, peripheral oedema, colonic obstruction, rash, urinary retention, hallucinations, confusional state, angioedema, anaphylactic reaction, delirium, Torsade de Pointes, electrocardiogram QT prolonged. *Prescribers should consult the Summary of Product Characteristics in relation to other side effects.* **Basic NHS Cost:** Vesicare® 5 mg blister packs of 30 tablets £27.62; Vesicare® 10 mg blister packs of 30 tablets £35.91. **Legal Category:** POM. **Product Licence Number:** Vesicare® 5 mg PL 00166/0197; Vesicare® 10 mg PL 00166/0198. **Date of Revision:** January 2013. **Further information available from:** Astellas Pharma Ltd, 2000 Hillswood Drive, Chertsey, KT16 0RS. Vesicare® is a Registered Trademark. For full prescribing information please refer to the Summary of Product Characteristics. **For medical information phone 0800 783 5018.**

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 Astellas Pharma Ltd. Please contact 0800 783 5018.

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VES12484UK(1)

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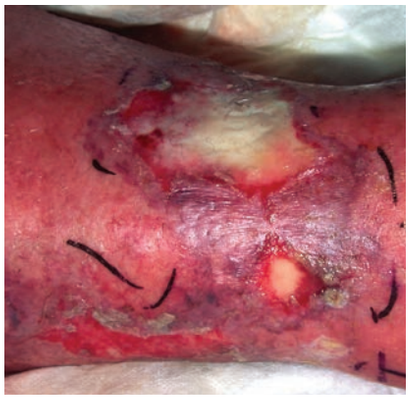
MARCH 2013

'We are paid less than our salaried GP'
Page 22



How not to miss necrotising fasciitis
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A GP's day in photos
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COVER PICTURE: DR ROBERT FRIEDLAND, SCIENCE PHOTO LIBRARY/ GIOVANNI TAIT/AMANDA OAKLEY/JOE D MILES

THIS MONTH

VIEWS

CLINICAL

YOUR PRACTICE

ONLINE-ONLY HIGHLIGHTS

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GP contract latest

Follow the very latest developments in the GP contract talks
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How not to miss type 1 diabetes in children

The key signs and pitfalls in diagnosing the condition
pulsetoday.co.uk/hntm-diabetes

Paper of the day

The best of the latest research, plus its implications for GPs
pulsetoday.co.uk/paper-of-the-day

Dr Tom Gillham

Meet Pulse's brand-new blogger
pulsetoday.co.uk/blogs

Paediatric clinic: Intussusception

A nine-month-old boy presents to his GP with a two-day history of non-bilious vomiting and crying
pulsetoday.co.uk/paediatric-clinic

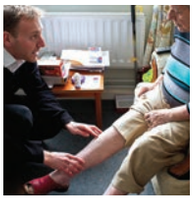

Photo essay: Dr David Weinstein

View the full gallery of images from a day in the life of one GP
pulsetoday.co.uk/weinstein

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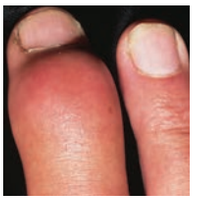
This month's most popular modules



Key questions on gout

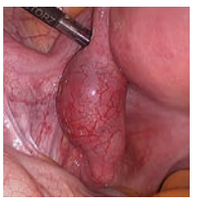
1.5 CPD HOURS
'Excellent module, clear with good evidence-based references'
Dr Nigel Chatwin

Clinical casebook: addiction

1.5 CPD HOURS
'Excellent and very relevant to practice'
Dr Maajida Ahmad

Key questions on asthma

1.5 CPD HOURS
'An excellent educational module with precise guidance for GPs'
Dr Bhasker Patel



Guideline debrief: ectopic pregnancy and miscarriage

1.5 CPD HOURS
'Interesting and highly applicable'
Dr Kathleen Turner

The information: plantar fasciitis

0.5 CPD HOURS
'Very helpful – clear and straightforward'
Dr Amanda Brown

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You can now read Pulse on your iPad

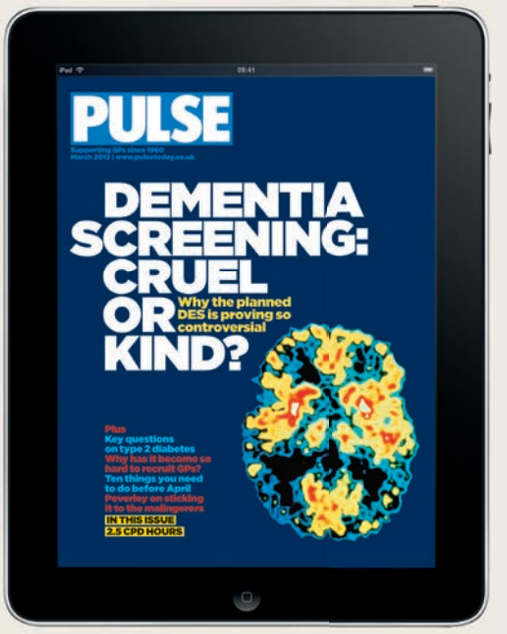
Steve Nowottny
Editor

Over the past couple of months we've had a fantastic response from GPs to the new-look Pulse magazine – and one repeated question: 'When are you launching an iPad app?'

I'm pleased to say that we have now done just that. Our new interactive app enables you to read all our trademark investigations, analyses and clinical features as they appear in print, but you'll be able to do much more besides – watch embedded videos, access further information directly online and link up your reading with CPD on Pulse Learning.

The app is completely free, and as a bonus you'll get each month's Pulse as soon as it's published, before your print copy arrives by post.

To find out more and download the app, go to pulsetoday.co.uk/iPad – and as with the magazine, please do let me know what you think and how it can be improved at editor@pulsetoday.co.uk



Prescribing information

Presentation: Betmiga™ prolonged-release film-coated tablets containing 25mg or 50mg mirabegron. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Dosage:** *Adults (including the elderly):* Recommended dose: 50mg once daily. *Children and adolescents:* Should not be used. **Contraindications:** Hypersensitivity to active substance or any of the excipients. **Warnings and Precautions:** Should not be used in patients with end stage renal disease (or patients requiring haemodialysis), severe hepatic impairment and severe uncontrolled hypertension. Not recommended in patients with severe renal impairment and/or moderate hepatic impairment concomitantly receiving strong CYP3A inhibitors. Dose adjustment to 25mg is recommended in patients with; mild/moderate renal and/or mild hepatic impairment receiving strong CYP3A inhibitor concomitantly and in patients with severe renal and/or moderate hepatic impairment. Caution in patients with a known history of QT prolongation or in patients taking medicines known to prolong the QT interval. Not recommended during pregnancy and in women of childbearing potential not using contraception. Not recommended during breastfeeding. **Interactions:** Clinically relevant drug interactions between Betmiga™ and medicinal products that inhibit, induce or are a substrate for one of the CYP isozymes or transporters are not expected, except for inhibitory effect on the metabolism of CYP2D6 substrates. Betmiga™ is a moderate and time-dependent inhibitor of CYP2D6 and weak inhibitor of CYP3A. No dose adjustment needed when administered with CYP2D6 inhibitors or CYP2D6 poor metabolisers. Caution if co-administered with medicines with a narrow therapeutic index and significantly metabolised by CYP2D6. When initiating in combination with digoxin, the lowest dose for digoxin should be prescribed and serum digoxin should be monitored and used for titration of digoxin dose. Substances that are inducers of CYP3A or P-gp decrease the plasma concentrations of Betmiga™. No dose adjustment is needed for Betmiga™ when administered with therapeutic doses for rifampicin or other CYP3A or P-gp inducers. The potential for inhibition of P-gp by Betmiga™ should be considered when combined with sensitive P-gp substrates. Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. **Adverse Effects:** Urinary tract infection, tachycardia, vaginal infection, cystitis, palpitation, atrial fibrillation, dyspepsia, gastritis, urticaria, rash, rash macular, rash papular, pruritus, joint swelling, vulvovaginal pruritus, blood pressure increase, liver enzymes increase, eyelid oedema, lip oedema, leukocytoclastic vasculitis and purpura. *Prescribers should consult the Summary of Product Characteristics in relation to other side effects.* **Pack and prices:** Betmiga™ 25mg and Betmiga™ 50mg pack of 30 tablets £29.00. **Legal Category:** POM. **Product Licence Number:** Betmiga™ 25mg EU/1/12/809/001 - 007; Betmiga™ 50mg EU/1/12/809/008 - 014. **Date of Preparation:** January 2013. **Further information available from:** Astellas Pharma Ltd, 2000 Hillswood Drive, Chertsey, Surrey, KT16 0RS, UK. Betmiga™ is a Registered Trademark. For full prescribing information please refer to the Summary of Product Characteristics. **For Medical Information phone 0800 783 5018.**

Adverse events should be reported.
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Adverse events should also be reported to Astellas Pharma Ltd.
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Date of preparation: February 2013 BET13068UK

Reference:
1. Gras J. *Drugs of Today* 2012;**48**(1):25–32.

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COVER STORY

Will earlier dementia diagnosis harm patients?

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As practices prepare to take on the new dementia case-finding DES from April, Michael Woodhead investigates claims widespread screening will do more harm than good

When he launched his 'challenge on dementia' a year ago, Prime Minister David Cameron fired the starting gun on a frantic stream of activity at the DH.

To the delight of dementia charities, he said diagnosis and awareness levels were 'shocking' and accused the NHS of 'collective denial' over the true prevalence of the disease.

He then tasked civil servants with raising diagnosis rates for the condition by 2015, with GPs at the forefront of the plan. Now practices face a potential £3,600 cut in income if they do not sign up to a new dementia case-finding DES from April, funded by the retirement of QOF indicators.

But GPs are questioning the basis of the DES, and weighing up the pros and cons of labelling thousands of patients as having dementia when the services to support them may not be in place and the diagnosis could have far-reaching consequences for their daily lives.

As controversy over the programme grows, Pulse asks if the Government's plans for dementia case-finding could cause more harm than good.

Variation

The drive to increase diagnosis rates is based on figures showing that only 42% of people with dementia in England have a formal diagnosis.

The Alzheimer's Society estimates were based on age-specific rates determined in a review of evidence by King's College London and the London School of Economics in 2007. They show wide regional variation, with as few as 34% of the true number of cases diagnosed in North Wales and as many as 70% in Glasgow (see map, page 8).

A spokesperson for the charity says the variation is due to a lack of 'joined-up' services: 'GPs want to know that there are places they can refer to and that there are services in place, so there's no reason to have a nihilistic attitude.'

But health secretary Jeremy Hunt has gone much further, accusing GPs of being unable or unwilling to diagnose dementia, and showing a 'grim fatalism' that denies patients access to treatment.

In a recent article in the *Daily Telegraph*, he claimed: 'Some even believe that without an effective cure there's no point putting people through the anxiety of a memory test – even though drugs can help stave off the condition for several years.'

In the *Spectator*, Conservative commentator Richard Marsh claims this emphasis on dementia is a sign of a canny minister who knows it is important to be seen to take action on a disease of great public concern.

The move may be good politics, but is it good medicine? The most recent NICE appraisal of anticholinesterase inhibitors concluded that they offer only small clinical benefits for cognitive function and have uncertain benefits for behaviour, and there was little evidence to support anecdotal claims they reduce progression of dementia and delay time to institutionalisation.

The drugs are now recommended by NICE as options for managing mild as well as moderate Alzheimer's disease, but as author and Alzheimer's patient Sir Terry Pratchett says, drugs for dementia are like 'sandbags in the stream' – they slow its progress but don't stop it.

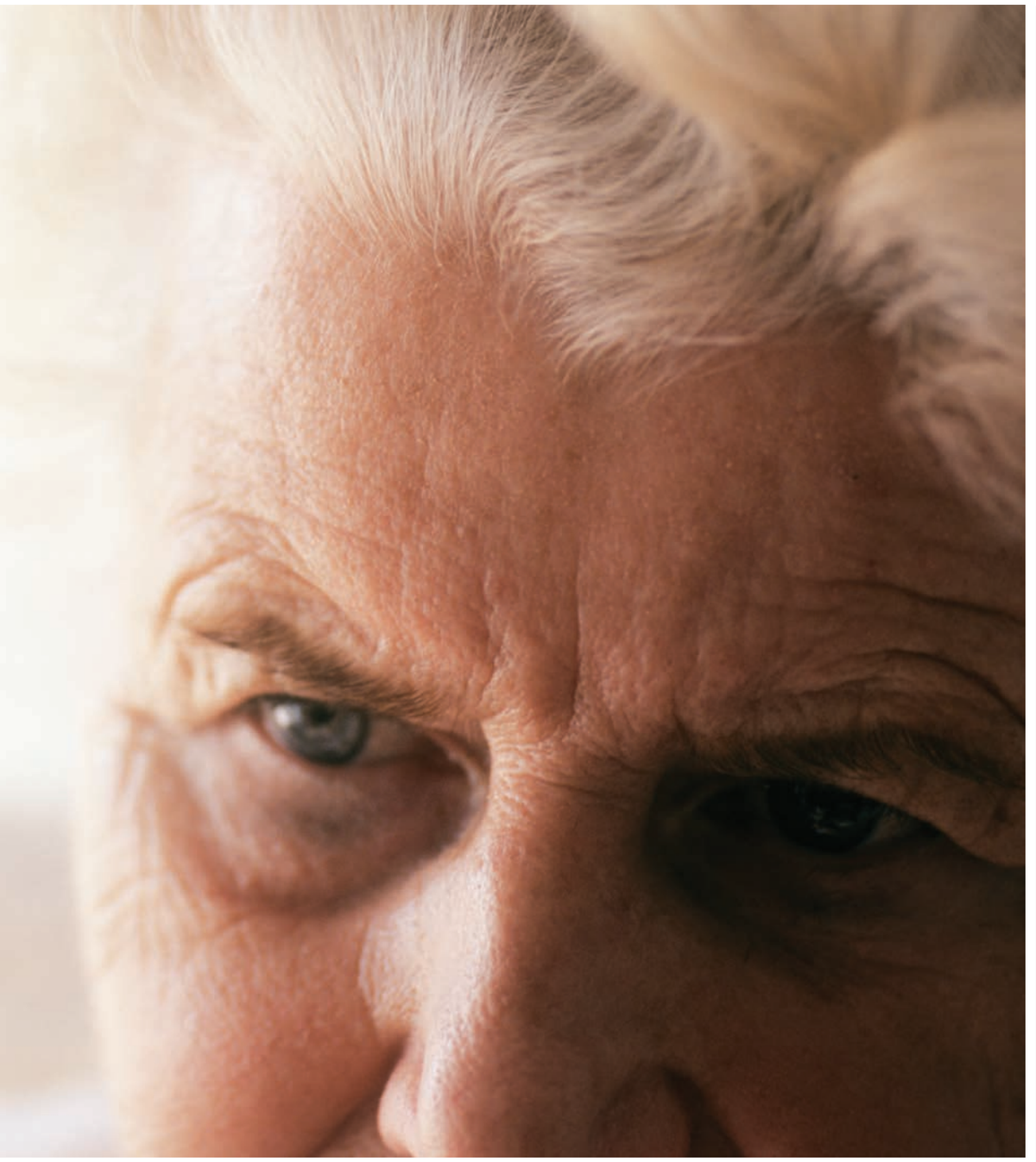
DES specifications

Since last March, targets to increase diagnosis rates have been included in the NHS outcomes framework, 'dementia champions' have been placed on hospital wards and an audit of prescribing in dementia has been launched.

But the biggest change will be in

EXTRA ONLINE

Read the draft specifications for the DES pulsetoday.co.uk/dementia-spec



Who is likely to be screened under the DES?

- Patients aged 60 and over with CVD, stroke, peripheral vascular disease and diabetes
- Patients with learning disabilities
- Patients with long-term neurological conditions, such as Parkinson's disease
- All other patients aged 75 and over

Source: Department of Health

general practice, which will be tasked by the new DES with screening all patients aged 75 and over, those aged 60 and over with risk factors, and all patients with learning disabilities or long-term neurological problems.

The DH's proposed specifications for the DES – due to be finalised in the next few weeks by the NHS Commissioning Board – suggest patients should be questioned 'to establish if they are concerned about memory'; then a specific test, such as GPCog, should be used to detect any early signs.

If a patient has suspected dementia, GPs will be mandated to refer them to specialist services, such as a memory clinic, to confirm the diagnosis, then provide treatment if necessary and give advice and support to the patient's carer.

The DH says the DES is designed to promote early diagnosis, and insists it is not a screening scheme.

'We are suggesting GPs could deliver a proactive approach to assessing patients known to be at risk as a way of improving diagnosis and care.'

Controversy

The DES has proved controversial so far, with a group of doctors, including former RCGP president Dr Iona Heath, setting up a petition opposing it.

They claim the DES case-finding programme is being introduced without any evidence of benefit and that it could harm patients through misdiagnosis and overtreatment, as well as distressing patients and their families.

Dr Martin Brunet, a GP in Guildford, Surrey, and one of the doctors leading the petition – which has 300 signatures – says the DES could confuse patients. He says: 'There's no consent, no prior warning, which makes it quite unethical. I think the Government and the people promoting this are being paternalistic and not respecting patient consent, choices and autonomy.'

The group has been invited by dementia tsar Professor Alistair Burns to propose an alternative way of boosting diagnosis rates but has yet to agree on the possible solution.

Dr Brunet says current services need improvement, as waiting times at memory clinics are too long and patients with dementia don't receive adequate help, for instance with advanced care planning or power of attorney. He says: 'People

Expert view
Professor Steve Iliffe

'GPs are right to be wary'

I am not sure the scale of the problem is as big as the Government thinks it is. In our EVIDEM study of GP dementia diagnosis, we are not finding large numbers of patients you have to do anything with. The idea that there is some massive unmet need is probably not right.

I suspect some [prevalence] figures have been inflated over time.

We are finding a tendency to under-document dementia in the QOF. GPs are cautious over labelling patients with dementia – this is understandable and may be right.

The patient may respond negatively and it might be the last thing they want on their records. It does close the door to some things, particularly rehabilitation services, for instance, post-stroke.

There is a lot of GP bashing over dementia that is not warranted.

Professor Steve Iliffe, professor of primary care for older people at University College London and a GP in Kilburn, north west London, is leading the unpublished EVIDEM study

> We're just giving someone a label of dementia
>
> *Dr Martin Brunet*

COVER STORY

promote early diagnosis to say we can help patients plan for the future, but we don't help them do that – we're just giving someone a label of dementia and leaving them to get on with it. Having a diagnostic label of dementia without support is probably worse than not having it at all.'

Dr Eamonn Jessup is a GP in Prestatyn in North Wales, an area often dubbed 'the geriatric coast' because of the number of retired people, but which also has some of the lowest rates of dementia diagnosis in the country.

He has doubts about how case-finding will work because of the grey area between mild cognitive impairment and Alzheimer's disease.

He says: 'We have difficulty with knowing the threshold for diagnosis – at the end of the day what can we actually do for people with dementia? We can put a good team around them to support the family, but the medications are not great.'

But not all GPs agree. Dr Ian Greaves, a dementia GPSI in Gnosall, Staffordshire, warns that late diagnosis often leads to catastrophic consequences.

He says: 'People are admitted with an acute presentation and diagnosis is occurring in a hospital setting.

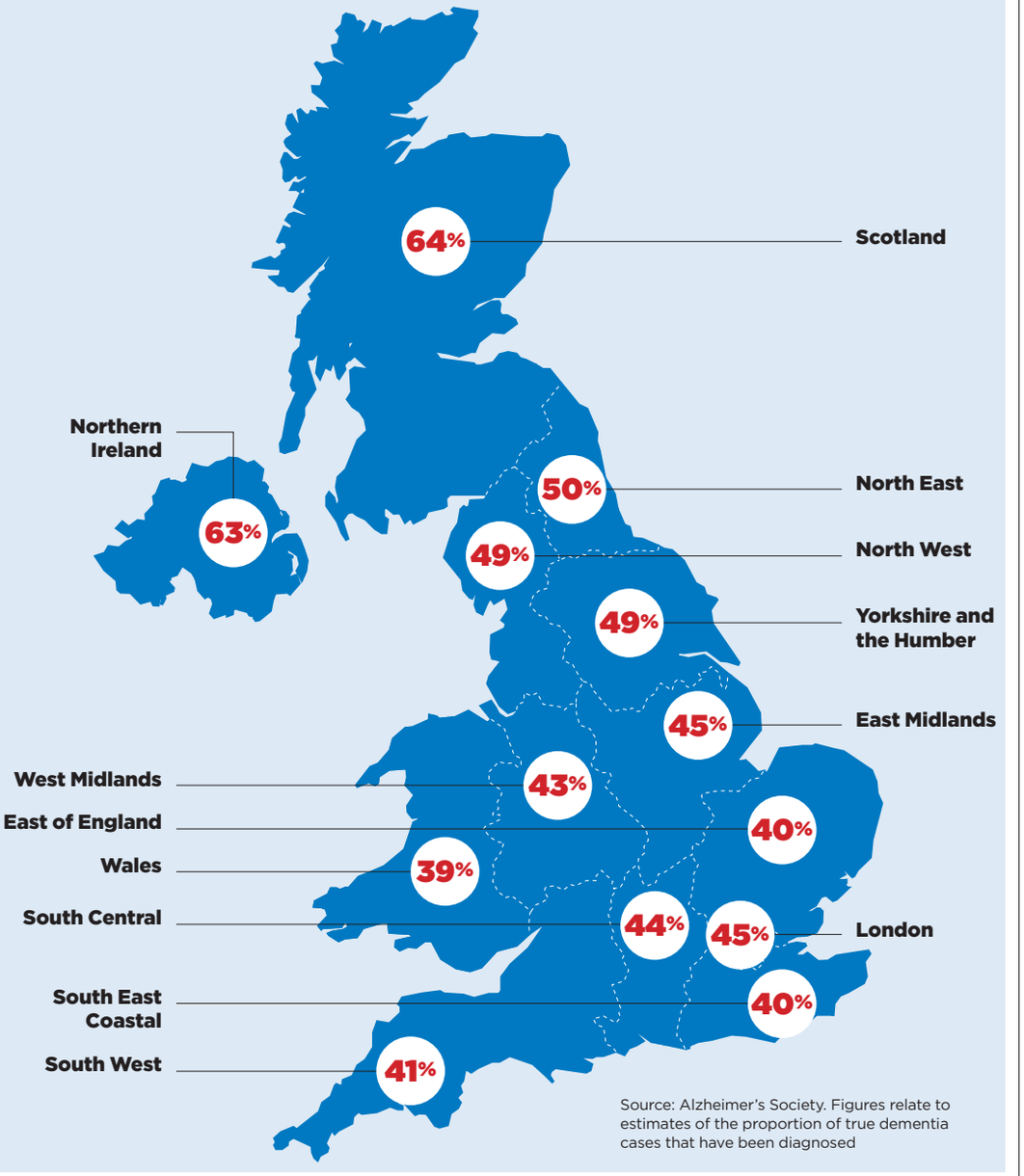
'That leads to an extended hospital stay and the only option then is for them to go into a care home. It would make a lot of sense if people got a diagnosis at the appropriate time and had a care plan that went in with them to the hospital.'

According to Dr Greaves, there are many positive examples of GP practices providing better care for dementia patients. He argues: 'I would like to see our profession value [early diagnosis] because of the value it offers patients, not just because it's put into the QOF or a DES.'

Dr Nick Cartmell, a GP in Ashburton, Devon, and clinical lead for dementia at NHS Devon and the South West Dementia Partnership, says: 'We should not be pursuing early diagnosis purely for the sake of increasing prevalence figures, but rather ensuring timely diagnosis for people who will benefit from that diagnosis.'

He suggests the DES should be narrowed to cover screening solely of those on QOF registers with a previous stroke, TIA or ischaemic heart disease, as they are more likely to have dementia. He adds: 'The current emphasis on increased prevalence should be matched by an equal emphasis on the provision of high-quality post-diagnosis services across the UK, so we don't simply diagnose more people only for them to fall into a "care vacuum".'

How dementia diagnosis rates vary across the UK



Source: Alzheimer's Society. Figures relate to estimates of the proportion of true dementia cases that have been diagnosed

Evidence base

The National Screening Committee's assessment for Alzheimer's in June 2010 concluded there was not enough evidence to warrant population screening, although another review is due to report this year.

There is also some evidence to support the claim that patients commonly experience anxiety and distress while waiting for a definite diagnosis. A small study published in the *British Journal of General Practice* recently looked at the experiences of 27 patients referred by GPs to memory clinics in England, and found they felt 'abandoned and ignored' while awaiting a diagnosis. The authors recommended policymakers should act 'cautiously' before urging more rapid diagnosis'.

And Professor Steve Iliffe, professor of primary care for older people at University College London, says unpublished data from his EVIDEM study on GP dementia diagnosis suggests the Government is exaggerating the potential benefits of the DES (Expert view, page 7).

Memory clinics

Access to memory clinics is another significant issue, with a report by MPs last year finding waiting times of up to a year.

CCGs are to be measured from April on memory clinic waiting times, but it is unlikely they will be given additional funding and GPs fear these services will be swamped.

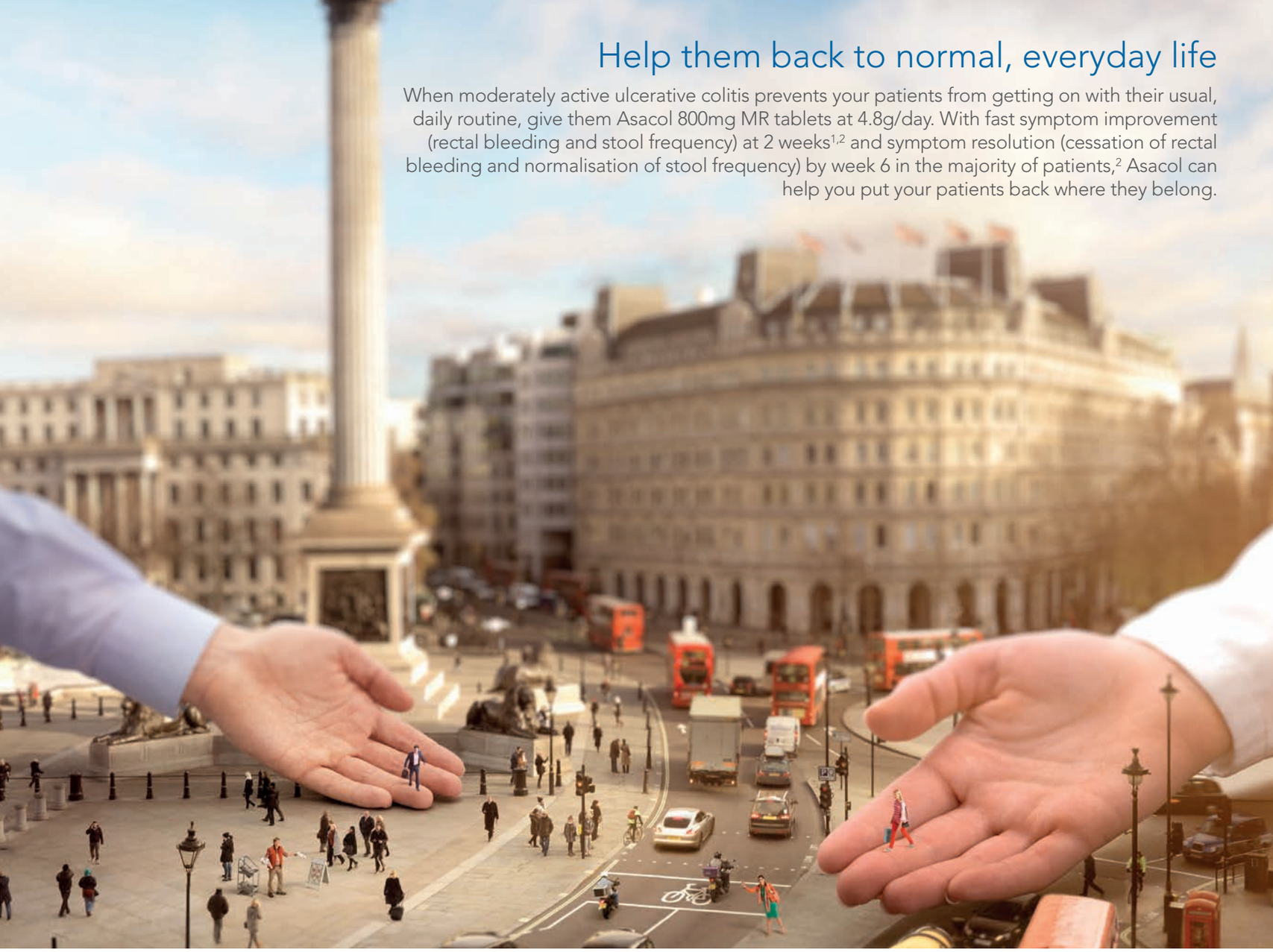
Dr Lindsay Hadley, a GP in Bexhill on Sea, East Sussex, has set up her own primary care memory clinic after becoming frustrated at delays in her area, and says it has been 'overwhelmed'.

She says: 'Where we are, about a third have been diagnosed with dementia and this DES is going to push it up to 70% or 80%. But there aren't the services.

'The answer is to develop primary care memory services. It would be more important to have a LES for helping with diagnosing and looking after people with dementia.'

Help them back to normal, everyday life

When moderately active ulcerative colitis prevents your patients from getting on with their usual, daily routine, give them Asacol 800mg MR tablets at 4.8g/day. With fast symptom improvement (rectal bleeding and stool frequency) at 2 weeks[1,2] and symptom resolution (cessation of rectal bleeding and normalisation of stool frequency) by week 6 in the majority of patients,[2] Asacol can help you put your patients back where they belong.



Combined Abbreviated Prescribing Information: **Asacol 400mg MR Tablet, Asacol 800mg MR Tablet, Asacol 250mg and 500mg Suppositories and Asacol Foam Enema** ***Presentation:*** **Asacol 400mg MR Tablets**, PL 10947/0011; each modified release tablet contains 400mg mesalazine (5-aminosalicylic acid). Bottles of 120, £39.21. Bottles of 90, £29.41. **Asacol 800mg MR Tablets**, PL 10947/0012; each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Bottles of 180, £117.62. **Asacol 250mg Suppositories**, PL 10947/0013, each containing 250mg mesalazine. Packs of 20, £4.82. **Asacol 500mg Suppositories**, PL 10947/0014, each containing 500mg mesalazine. Packs of 10, £4.82. **Asacol Foam Enema**, PL 10947/0015, 1g mesalazine per metered dose. Carton containing can of 14 metered doses, 14 disposable applicators and 14 disposable plastic bags, £26.72 ***Indications:*** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. Maintenance of remission. Suppositories particularly appropriate for distal disease, Foam Enema for distal colon disease only. **400mg Tablets, 800mg Tablets, Suppositories**: Maintenance of remission. **400mg Tablets and 800mg Tablets only:** Crohn's ileo-colitis: Maintenance of remission. ***Dosage and administration:*** **ADULTS: 400mg Tablets:** Acute disease: 6 tablets a day, in divided doses, with concomitant corticosteroid therapy where clinically indicated. Maintenance therapy: 3 to 6 tablets a day, in divided doses. **800mg Tablets:** Mild acute exacerbations: 3 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Suppositories:** *250mg:* 3 to 6 a day, in divided doses, with the last dose at bedtime. *500mg:* A maximum of 3 a day, in divided doses, with the last dose at bedtime. **Foam Enema:** 1 (disease of rectosigmoid region) or 2 (disease of descending colon) metered doses as single daily dose for 4-6 weeks. **ELDERLY:** The normal adult dosage may be used unless renal function is impaired. **CHILDREN: 800mg Tablets:** Not recommended. **400mg Tablets, Suppositories, Foam Enema:** No dosage recommendation. ***Contra-indications:*** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR <20ml/min). **400mg Tablets, Suppositories and Foam Enema only:** Children under 2 years of age. **800mg Tablets only:** Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency. ***Precautions:*** Use in the elderly should be cautious and subject to patients having a normal renal function. Asacol should be used with extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to start of treatment, and periodically during treatment, taking into account individual history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation, during therapy, and are required immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Concurrent use of other known nephrotoxic agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. **400mg Tablets and 800mg Tablets:** Lactulose or similar preparations which lower stool pH should not be concomitantly administered. **400mg tablets, Suppositories, Foam Enema:** Only use during pregnancy if benefits outweigh the risk. Avoid during lactation unless essential. **800mg Tablets only:** Mesalazine should be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. ***Undesirable Effects:*** **Common:** Nausea, diarrhoea, abdominal pain, headache. Rare reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, peripheral neuropathy, pancreatitis, abnormalities of hepatic function and hepatitis, myocarditis, pericarditis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), drug fever, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment, usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients developing renal dysfunction. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis, Stevens Johnson syndrome & erythema multiforme. **400mg Tablets, Suppositories, Foam Enema:** Rare reports of allergic and fibrotic lung reactions. **800mg Tablets only:** Common: vomiting, arthralgia / myalgia. Rare reports of vertigo, bronchospasm, eosinophilic pneumonia, bullous skin reactions. Very rarely, interstitial pneumonitis. **Suppositories, Foam Enema:** Rarely, local irritation may occur after use of rectal dosage forms of mesalazine. ***Legal category:*** POM. ***Marketing Authorisation Holder:*** Warner Chilcott UK Ltd, Old Belfast Road, Millbrook, Larne, County Antrim, BT40 2SH, UK. Asacol is a trademark. Refer to Summary of Product Characteristics before prescribing. Date of preparation Feb 2012. AS8478a.

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 0800 0328701

References:

1. Orchard T *et al. Aliment Pharmacol Ther* 2011; **33**(9): 1028–1035.

2. Data on file: UK/AS/0125/08-11b(1).

Date of preparation: December 2012

UK/AS/0175/12-12b

Asacol®

800mg MR tablets

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DIGEST

Your essential round-up of all the political, financial and business news relevant to your practice. For full stories and analysis go to pulsetoday.co.uk/news

Sainsbury's to expand in-store GP surgeries

Sainsbury's is planning an expansion of the primary care services in its stores, with a further seven GP surgeries due to open across the country this year.

Premises will be offered rent-free and will not be run or funded by Sainsbury's.

Read the full story at pulsetoday.co.uk/sainsburys

GPs press ministers on health tourism

GPs should be able to charge overseas visitors if there is any doubt over their eligibility for healthcare in order to prevent 'health tourism', LMC leaders have urged ministers.

Bedfordshire and Hertfordshire LMC has written to the Department of Health and the Home Office to urge them to tackle the 'difficulties' faced by GP practices, which have to treat visitors even if think they may not be eligible for care.

In the letters, the LMC urged the Government to ensure visitors entering the country had their eligibility stamped on their passport.

Read the full story at pulsetoday.co.uk/health-tourism

Quote of the month

'This is about the safety and care of patients: sort it out'

Dr Paul Roblin on the 'lengthy and obscure' summaries used by the new NHS 111 service
pulsetoday.co.uk/111-summaries

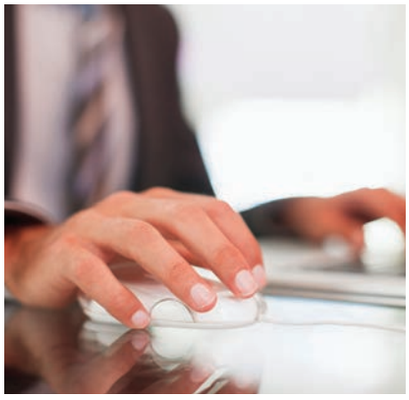
Doubts over online access to records

Fewer than a third of doctors think giving patients online access to their full records is a good idea, a medical defence body survey has found.

The poll of 850 members of the Medical Protection Society and 1,766 members of the public also found 66% of doctors and 73% of the public believe particularly sensitive information should never be accessible online.

A spokesperson for the MPS said the survey showed the Government's plans to give patients full access by 2015 should be reconsidered, with some information automatically redacted from records unless patients requested it.

Read the full story at pulsetoday.co.uk/records-access



GMC tightens rules on self-prescribing

The number of doctors hauled in front of the GMC for self-prescribing has trebled in two years, according to figures released by the regulator.

The GMC said the number of closed fitness-to-practise cases featuring allegations of self-prescribing, self-treatment or informal treatment of family and colleagues had increased from 36 in 2010 to 82 in 2011 and 98 in 2012.

The rise in cases was revealed as GMC guidance on self-prescribing and treatment of close family or friends was tightened up.

Talking point of the month

What does the Francis Inquiry mean for GPs?

What did the Francis Inquiry find?
Robert Francis QC's damning report into the failings at Mid Staffordshire NHS Foundation Trust found appalling standards of hospital care and made 290 recommendations for 'fundamental change'.

What did it recommend for GPs?
It said GPs should have an independent 'monitoring role' to ensure hospitals provide high-quality care. It said the failures in care at the hospital went unnoticed because local GPs only expressed 'substantive concern' after they were specifically asked by investigators.

What will this mean for GPs?
The Government has yet to issue a formal response to the enquiry, but the Prime Minister has already said GPs must be 'more enquiring' about hospital care. Health secretary Jeremy Hunt has also said he is considering plans for a new 'chief inspector of primary care' to identify failing practices and a revamp of CQC inspections.

Read the full story at pulsetoday.co.uk/francis-inspector

The latest guidance from the GMC, *Good practice in prescribing and managing medicines and devices* (2013), says GPs 'must' avoid prescribing for themselves or 'anyone with whom they have a close personal relationship'.
Read the full story at pulsetoday.co.uk/self-prescribing

GPs told £300k refit needed for CQC

A GP practice has been told by NHS managers its surgery must have a £300,000 refurbishment in order to prepare for CQC inspection.

The Monkspath Surgery in Solihull, built in 1985, has been told it is non-compliant with infection control rules and must be completely refurbished.

The PCT said it was simply trying to provide a 'safe environment for patients', but the CQC has criticised the work as unnecessary, and urged any practice faced with PCT demands to refurbish their premises to contact it.
Read the full story at pulsetoday.co.uk/300k-refit

A good month for...

Would-be GP troubleshooters
A CCG has asked GPs to help urgently assess every patient on one hospital's wards to see if they can be discharged, in a bid to ease 'unusually high' levels of demand.

An email from Basildon and Brentwood CCG interim chair Dr Anil Chopra, sent to local GPs, said Basildon Hospital had over the past few months 'struggled to achieve even the minimum waiting times in A&E and this has worsened to crisis point over the past couple of weeks'.
Read the full story at pulsetoday.co.uk/gp-troubleshooters

Home visits
Changes to dog laws will give greater legal protection to doctors and healthcare staff facing dangerous dogs on private property.

Under proposals put forward by NHS Protect's legal protection unit, current legislation on dog attacks in public places will be extended to cover visiting private residences.

The changes mean that dog-owning patients will be held to account for the behaviour of their pets if they cause injuries on private property.
Read the full story at pulsetoday.co.uk/dog-bites

Professor Clare Gerada
The RCGP chair has been voted one of the 100 most powerful women in the UK by Radio 4's *Woman's Hour*. Other prominent women who made the list included Chief Medical Officer Dame Sally Davies – and the Queen.
Read the full story at pulsetoday.co.uk/gerada-100

A bad month for...

Locum cost reimbursement
Practices are set to be paid an average of £1,500 to cover locum superannuation costs from April, regardless of whether they use locums or not.

The BMA has criticised the Government's plan for GP practices to pay the superannuation themselves and be reimbursed by the flat payment into the global sum, warning GPs may find it 'impossible' to take on CCG work if locum superannuation costs are not fully covered.

GPC negotiator Dr David Bailey said: 'It won't be based on use, it will be based on patient numbers.'
Read the full story at pulsetoday.co.uk/locum-costs

Case-management DES
There is no evidence case management can reduce unplanned hospital admissions, casting doubt over one of the Government's new DESs from April, an analysis has concluded.

The meta-analysis of 11 trials concluded case-management in older people should not be promoted as a mechanism for reducing unplanned admissions.
Read the full story at pulsetoday.co.uk/case-management

Sir David Nicholson
Campaigners have been calling for the resignation of NHS chief executive Sir David Nicholson in the wake of the Mid Staffordshire scandal, because he acted as interim chief executive of the health authority that oversaw Stafford hospital. But GP leaders have refused to join the calls for him to quit. GPC chair Dr Laurence Buckman said: 'I don't think it's useful to blame leaders.'
Read more at pulsetoday.co.uk/leaders-nicholson

CONTRACT UPDATE

BMA fights back on contract imposition

The BMA has fought back against the Government's planned imposition of changes to the GP contract in England with a 31-page analysis detailing how practices and patients will be affected.

The official response to the consultation published as Pulse went to press included the results of a survey of 8,000 GPs that found nearly 90% believe they will be less able to provide high-quality care as a result of the Government's proposed contract deal for 2013/14. It also showed nearly two-thirds of practices in England are planning to make changes to current services available to patients.

Overall, 30% said their practice would have to reduce access for patients.

The BMA's analysis also said key aspects of the contract proposal should be delayed, including the plan to give practices the job of paying locum superannuation and the reduction in the timeframe for QOF indicators from 15 to 12 months.

It argued the proposed changes 'work against the thrust' of the Francis Inquiry's recommendations by introducing increasingly challenging targets for 'box-ticking rather than core, holistic patient care'.

But the Department of Health was quick to insist the changes would focus time and money upon patient care and 'have the potential to save more lives'.

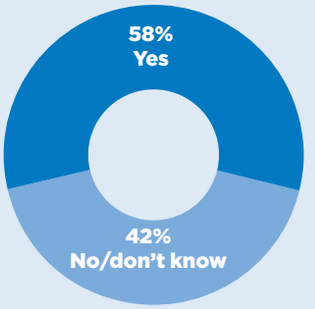
Read the full story at pulsetoday.co.uk/gpcontract

ONLINE

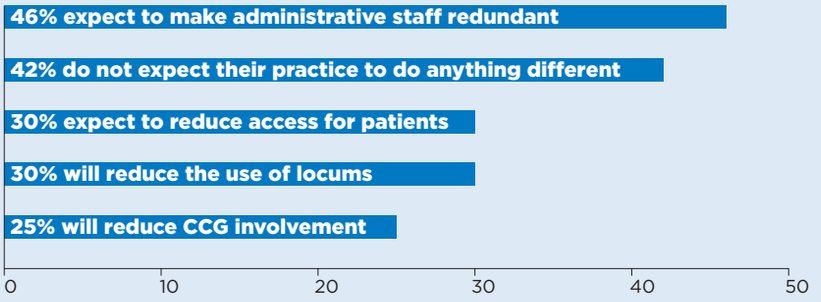
Follow all the latest contract developments as they happen pulsetoday.co.uk/gpcontract

How the changes will hit GPs

If the Government does impose the proposals in their entirety with no changes, do you expect your practice to do anything differently?



What will you do?



Source: BMA survey of 6,600 partners and salaried GPs

Main points of the BMA submission

- Changes to more equitable funding between GMS and PMS practices should not reduce the overall level of investment and should be approved by GPs 'through an opinion survey or special conference'
- QOF exception-reporting guidance should be revised, because rates are likely to rise
- Superannuation changes will have a 'distorting effect' on locums
- The dementia DES is not supported by evidence and 'contradicts NICE'
- There is 'great potential for unintended negative consequences' with plans for making full patient records, including test results, available online
- The case-management DES 'will reduce time available for routine patients'
- The changes will have a 'real impact' on recruitment and retention in general practice

Where do you turn when a sulphonylurea won't do?

For your type 2 diabetes patients vulnerable to hypos, there's Onglyza as an early add-on to metformin:

- ✓ Less hypoglycaemia with comparable reduction in HbA1c to a sulphonylurea at 1 year*[1]
- ✓ Onglyza 5 mg can be taken **once a day**, at any time, with or without food. No need for dose titration.

Onglyza 2.5 mg is suitable for patients with moderate or severe renal impairment. Caution in use with severe renal impairment. Not recommended in ESRD requiring dialysis.[2]

*Non-inferiority study comparing metformin and saxagliptin vs. metformin and glipizide

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ONGLYZA™ 2.5MG & 5MG FILM-COATED TABLETS (saxagliptin)
PRESCRIBING INFORMATION. Consult Summary of Product Characteristics before prescribing.
Presentation: 2.5mg or 5mg saxagliptin (as hydrochloride) film-coated tablets. **Indications: Adults 18 and older:** For Type 2 diabetes mellitus patients to improve glycaemic control in combination with diet, exercise: and metformin, when metformin alone, does not provide adequate glycaemic control; and sulphonylurea, when sulphonylurea alone does not provide adequate glycaemic control, where metformin is considered inappropriate; and thiazolidinedione, when thiazolidinedione alone does not provide adequate glycaemic control and thiazolidinedione is considered appropriate; and in combination with insulin (with or without metformin), when this regimen alone, with diet and exercise, does not provide adequate glycaemic control **Dosage:** *Adults:* 5mg once daily as add-on therapy with or without food at any time of the day. Use in combination with a sulphonylurea and insulin, consider a lower dose of sulphonylurea or insulin to reduce the risk of hypoglycaemia. *Children and Adolescents:* < 18 years old: Safety and efficacy not yet established. *Moderate Hepatic Impairment:* Use with caution. *Severe Hepatic Impairment*: Not recommended. *Moderate & Severe renal impairment:* 2.5mg once daily, caution in patients with severe renal impairment. Assessment of renal function is recommended prior to initiation of Onglyza, and, in keeping with routine care, renal assessment should be done periodically thereafter. *End stage renal disease:* Not recommended. *Elderly:* ≥75 years: Use with caution. **Contraindications:** Hypersensitivity to saxagliptin, any of the excipients or history of a serious hypersensitivity reaction, including anaphylactic reaction, anaphylactic shock, and angioedema, to any dipeptidyl peptidase 4 inhibitor. **Warnings and precautions:** Not for the treatment of Type 1 diabetes mellitus or diabetic ketoacidosis. Onglyza is not a substitute for insulin in insulin-requiring patients. Inform patients of the characteristic symptom of acute pancreatitis: persistent, severe abdominal pain. If suspected discontinue use of Onglyza and other potentially suspect medicinal products. If a serious hypersensitivity reaction to saxagliptin is suspected, discontinue use, assess for other potential causes, and institute alternative treatment. Not recommended in patients with rare hereditary galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption. Limited experience in NYHA class I-II. No experience in cardiac failure (NYHA class III-IV) or immunocompromised patients. In keeping with routine care, monitoring for skin disorders is recommended. **Drug interactions:** Clinical data suggest low risk for clinically meaningful interactions with co-administered medicinal products. Caution with CYP3A4/5 inducers as glycaemic effect may be lowered. **Pregnancy and lactation:** Avoid use unless clearly necessary. **Undesirable events:** *Common adverse reactions reported across add-on trials:* Upper respiratory infection; urinary tract infection; gastroenteritis; sinusitis; headache; and vomiting. *Add-on to metformin:* Nasopharyngitis (common) *Add-on to sulphonylurea:* Hypoglycaemia (very common) *Add-on to thiazolidinedione:* Peripheral oedema (common). *Adverse reactions reported in at least two more patients treated with Onglyza compared to control:* **Add-on to metformin:** *Common:* Dyspepsia and myalgia. **Add-on to sulphonylurea:** *Uncommon:* dyslipidaemia and hypertriglyceridaemia. Adverse reactions reported in post-marketing experience: Nausea (common); pancreatitis (uncommon); hypersensitivity reactions (uncommon); anaphylactic reactions including anaphylactic shock (rare); angioedema (rare) and rash (common). Key: Very common (≥ 1/10), common (≥ 1/100 to <1/10), uncommon (≥ 1/1,000 to <1/100) and rare (≥ 1/10,000 to <1/1,000). Refer to SmPC for complete information on side effects. **Legal Category:** POM. **Marketing authorisation number:** EU/1/09/545/012 & EU/1/09/545/006. **Presentation & basic NHS price:** Onglyza 2.5mg film-coated tablets 28: £31.60; Onglyza 5mg film-coated tablets 28: £31.60. **Further information is available from:** Bristol-Myers Squibb / AstraZeneca EEIG, Bristol-Myers Squibb House, Uxbridge Business Park, Sanderson Road, Uxbridge, Middlesex, UB8 1DH, UK. [ONGLYZA] is a trademark of the Bristol-Myers Squibb / AstraZeneca group of companies. **Date of PI preparation:** 09 2012 **Approval code:** 422UK12PM139
CV 12 0143

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 Bristol-Myers Squibb Pharmaceuticals Ltd. Medical Information on 0800 731 1736 or medical.information@bms.com

References:
1. Göke B *et al. Int J Clin Pract* 2010; **64:** 1691-1631
2. Onglyza Summary of Product Characteristics

Date of preparation: January 2013
422UK13PR00414 2348001

Bristol-Myers Squibb AstraZeneca

onglyza® (saxagliptin)

Nicorette Invisi Patch Prescribing Information:
Presentation: Transdermal delivery system available in 3 sizes (22.5, 13.5 and 9cm²) releasing 25mg, 15mg and 10mg of nicotine respectively over 16 hours. **Uses:** Nicorette Invisi Patch relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. Nicorette Invisi Patch is indicated in pregnant and lactating women making a quit attempt. If possible, Nicorette Invisi Patch should be used in conjunction with a behavioural support programme. **Dosage:** It is intended that the patch is worn through the waking hours (approximately 16 hours) being applied on waking and removed at bedtime. ***Smoking Cessation: Adults (over 18 years of age):*** For best results, most smokers are recommended to start on 25 mg / 16 hours patch (Step 1) and use one patch daily for 8 weeks. Gradual weaning from the patch should then be initiated. One 15 mg/16 hours patch (Step 2) should be used daily for 2 weeks followed by one 10 mg/16 hours patch (Step 3) daily for 2 weeks. Lighter smokers (i.e. those who smoke less than 10 cigarettes per day) are recommended to start at Step 2 (15 mg) for 8 weeks and decrease the dose to 10 mg for the final 4 weeks. Those who experience excessive side effects with the 25 mg patch (Step 1), which do not resolve within a few days, should change to a 15 mg patch (Step 2). This should be continued for the remainder of the 8 week course, before stepping down to the 10 mg patch (Step 3) for 4 weeks. If symptoms persist the advice of a healthcare professional should be sought. ***Adolescents (12 to 18 years):*** Dose and method of use are as for adults however, recommended treatment duration is 12 weeks. If longer treatment is required, advice from a healthcare professional should be sought. ***Smoking Reduction/Pre-Quit:*** Smokers are recommended to use the patch to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. Starting dose should follow the smoking cessation instructions above i.e. 25mg (Step 1) is suitable for those who smoke 10 or more cigarettes per day and for lighter smokers are recommended to start at Step 2 (15 mg). Smokers starting on 25mg patch should transfer to 15mg patch as soon as cigarette consumption reduces to less than 10 cigarettes per day. A quit attempt should be made as soon as the smoker feels ready. When making a quit attempt smokers who have reduced to less than 10 cigarettes per day are recommended to continue at Step 2 (15 mg) for 8 weeks and decrease the dose to 10 mg (Step 3) for the final 4 weeks. ***Temporary Abstinence:*** Use a Nicorette Invisi Patch in those situations when you can't or do not want to smoke for prolonged periods (greater than 16 hours). For shorter periods then an alternative intermittent dose form would be more suitable (e.g. Nicorette inhalator or gum). Smokers of 10 or more cigarettes per day are recommended to use 25mg patch and lighter smokers are recommended to use 15mg patch. **Contraindications:** Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, renal or hepatic impairment, phaeochromocytoma or uncontrolled hyperthyroidism, generalised dermatological disorders. Angioedema and urticaria have been reported. Erythema may occur. If severe or persistent, discontinue treatment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** *Very common:* itching. *Common:* headache, dizziness, nausea, vomiting, GI discomfort; Erythema. *Uncommon:* palpitations, urticaria. *Very rare:* reversible atrial fibrillation. See SPC for further details. **NHS Costs:** 25mg packs of 7: (£9.97); 25mg packs of 14: (£16.35); 15mg packs of 7: (£9.97); 10mg packs of 7: (£9.97). **Legal category:** GSL. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL numbers:** 15513/0161; 15513/0160; 15513/0159. **Date of preparation:** Feb 2012.

McNeil Products Ltd.

DISCOVER A LOGICAL COMBINATION TO UNLOCK A SMOKE-FREE FUTURE

℞ NICORETTE® INVISI 25mg PATCH™ + nicotine QuickMist Mouthspray

With sustained 16-hour background support[1] from NICORETTE® INVISIPATCH™ and fast craving relief[2] from NICORETTE® QUICKMIST mouthspray, discover an NRT combination that applies logic to the quitting needs of smokers.

"The combination that appears to make most sense is patch plus an acute delivery form…"[3] – ASH Guidance

Nicorette QuickMist Prescribing Information:
Presentation: oromucosal spray containing 13.2ml solution. Each 0.07 ml contains 1 mg nicotine, corresponding to 1 mg nicotine/spray dose. **Uses:** Relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. It is indicated in pregnant and lactating women making a quit attempt. **Dosage:** ***Adults and Children over 12 years of age:*** The patient should make every effort to stop smoking completely during treatment with Nicorette QuickMist. One or two sprays to be used when cigarettes normally would have been smoked or if cravings emerge. If after the first spray cravings are not controlled within a few minutes, a second spray should be used. If 2 sprays are required, future doses may be delivered as 2 consecutive sprays. Most smokers will require 1-2 sprays every 30 minutes to 1 hour. Up to 4 sprays per hour may be used; not exceeding 2 sprays per dosing episode and 64 sprays in any 24-hour period. Nicorette QuickMist should be used whenever the urge to smoke is felt or to prevent cravings in situations where these are likely to occur. Smokers willing or able to stop smoking immediately should initially replace all their cigarettes with the Nicorette QuickMist and as soon as they are able, reduce the number of sprays used until they have stopped completely. When making a quit attempt behavioural therapy, advice and support will normally improve the success rate. Smokers aiming to reduce cigarettes should use the Mouthspray, as needed, between smoking episodes to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. **Contraindications:** Children under 12 years and Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, G.I disease, uncontrolled hyperthyroidism, phaeochromocytoma, hepatic or renal impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and both less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** ***Very common:*** dysgeusia, headache, hiccups, nausea and vomiting symptoms, dyspepsia, oral soft tissue pain and paraesthesia, stomatitis, salivary hypersecretion, burning lips, dry mouth. ***Common:*** dizziness, paraesthesia, palpitations, cough, aphthous stomatitis, gingival bleeding, toothache, pharyngeal hypoaesthesia. ***Other:*** chest pain, atrial fibrillation, dyspnoea. See SPC for further details. **NHS Cost:** 1 dispenser pack £11.48 2 dispenser pack £18.50. **Legal category:** GSL. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL number:** 15513/0357. **Date of preparation:** Sept 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 McNeil Products Limited on 01344 864 042.

References:
1. Nicorette® Invisi 25mg Patch Summary of Product Characteristics.
2. Nicorette® QuickMist Summary of Product Characteristics.
3. Guidance for health professionals on changes in the licensing arrangements for nicotine replacement therapy. ASH, London. Dec 2005.

Date of preparation: February 2013 UK/NI/13-1241

nicorette

www.nicorette.co.uk

For every cigarette, there's a nicorette®

CLINICAL ROUND-UP

All the new guidelines, journal papers and clinical policy developments with practice-changing implications

Alert over stepping down ICS in asthma

Patients with stable asthma who stop taking low-dose inhaled steroids more than double their risk of an exacerbation over the following six months, a meta-analysis has found.

The finding casts doubt on the BTS/SIGN guideline recommendation to consider a reduction in ICS dose every three months in those with stable asthma.

For every five patients with stable asthma who stop taking inhaled steroids, one will suffer an exacerbation as a result, the study concluded. There was also a mean decrease in FEV1 of 130ml in those who gave up inhaled steroids.

The US researchers analysed data from seven randomised controlled trials involving 1,040 patients with stable asthma. They found patients whose ICS treatment was stopped were 2.3 times more likely than those who continued on ICS to suffer an exacerbation over the following six months.

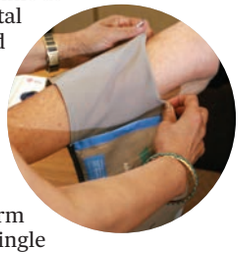
Professor Mike Thomas, chief medical adviser for Asthma UK and a GP in Minchinhampton, Gloucestershire, said: 'Sometimes people are so well controlled, they are tempted to stop treatment. Some may be able to, but they need to be informed about the risk of asthma attacks and withdrawal of inhaled steroids should be carefully monitored.'

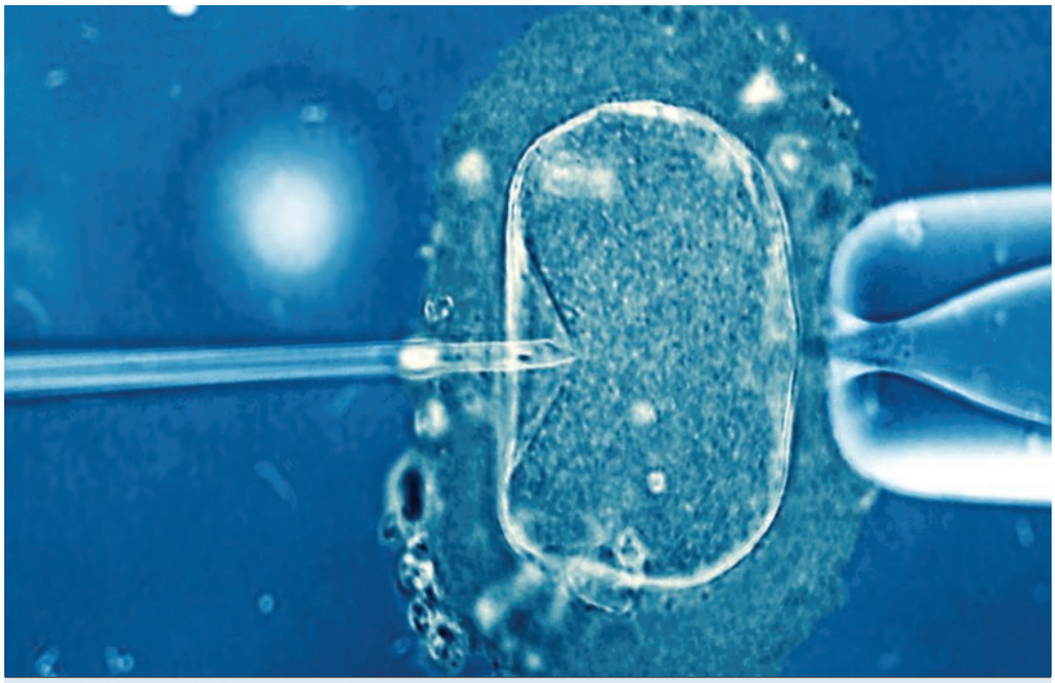
J Allergy Clin Immunol 2013, online 14 Jan

Measure BP in both arms, GPs advised

Single blood pressure readings are 'not accurate', a study has concluded.

Researchers who checked the BP in both arms of 710 patients attending a hypertension clinic at University Hospital Birmingham, and then compared the readings with 24-hour ambulatory blood pressure, found systolic pressure in the arm with the higher single reading was on average 25.1 mmHg higher than the ABPM, compared with





Guideline of the month

NICE: Fertility

Scope of the guideline

Infertility is estimated to affect one in seven couples in the UK. The leading causes are male factors (30%), ovulatory disorders (25%), tubal damage (20%) and unexplained infertility (25%). This update of 2004 guidance covers investigations and treatment options once a diagnosis has been established.

Key points for GPs

- A couple who have not conceived after a year of unprotected intercourse should be offered assessment and investigation. Consider an early referral if the woman is over 35 or if there is a known clinical cause or predisposing factors.
- GP initial assessment should include semen analysis using the 2010 WHO reference values – if the first sample is abnormal, repeat three months later.
- A menstrual history should be taken to assess ovulation – possibly confirmed with a mid-luteal progesterone.
- Women with irregular cycles should have FSH and LH measured.
- Women aged under 40 should be offered three full cycles of IVF funded by the NHS and those aged 40-42 should be offered one cycle.
- Women with no known comorbidities (such as pelvic inflammatory disease or endometriosis) should be offered hysterosalpingography (HSG) or hysterosalpingo-contrast-sonography to assess for tubal damage.

EXTRA ONLINE

Guideline debrief: In our CPD module, *Guideline debrief: fertility*, Dr Wilkes uses six case histories to outline the GP implications of the new NICE guidance.

2 CPD HOURS

pulse-learning.co.uk

For the full guideline and GP reaction go to pulsetoday.co.uk/NICE-fertility

Expert comment

Dr Scott Wilkes, a GP in Amble, Northumberland and associate editor of the *Journal of Family Planning and Reproductive Health Care*: 'The focus is on the need to perform an initial assessment to ensure efficient management and appropriate referral. But the prevalence of obesity is increasing and with it ovulatory dysfunction – so GPs have a significant role to play in weight reduction, which is the first-line treatment for this cohort.'

Practical issues

- The recommendation to offer women aged 40–42 one cycle of IVF may be difficult to implement in areas where IVF is not offered to women over 40.
- Open access to HSG is not widely available.
- The increased emphasis on weight loss in both men and women to improve the chances of ovulation and successful treatment may prove challenging in primary care.
- The guidance excludes interventions – including ovulation prediction kits, temperature charting and clomifene for ovulation induction – which couples might have previously found useful.

The guideline

CG156. Fertility: assessment and treatment for people with fertility problems. NICE 2013.

SCIENCE PHOTO LIBRARY/ALAN HARRIS

a mean difference of 15.5mmHg between the arm with the lower BP and the ABPM. This reinforced the importance of NICE advice to measure BP in both arms and repeat this if the difference between arms is more than 20mmHg, the researchers said.

Dr Terry McCormack, a GP in Whitby and member of the NICE guideline development group for hypertension, said: 'Unless you are using equipment which simultaneously takes BP in both arms, you need to do a series of tests to be accurate.'

BJGP 2013, online 28 Jan

New drug options for urinary incontinence

Draft NICE guidelines for urinary incontinence recommend a wider range of antimuscarinic drugs for use first-line.

Women with overactive bladder syndrome or mixed urinary incontinence should be offered a choice of oxybutynin, tolterodine or immediate-release propiverine, according to the draft released for consultation last month.

Current NICE guidance, from 2006, recommends only oxybutynin first line, with other antimuscarinics reserved for women unable to tolerate oxybutynin.

Under the updated draft, extended-release formulations of trospium, oxybutynin and tolterodine may be offered as second-line treatments, as well as darifenacin.

Dr Julian Spinks, a GP in Rochester, Kent, and member of the 2006 guideline development group, said: 'The basic outline of how to treat has not really changed.

'The overall thrust is still to start with lifestyle modification, pelvic floor training for urge incontinence and management of overactive bladder with bladder training.'

pulsetoday.co.uk/urinary-incontinence

Beta-blocker benefits reduced in AF

Patients with heart failure who also have atrial fibrillation gain less benefit from β-blockers than those who are in sinus rhythm, a meta-analysis has found.

The review of four trials of β-blockers in heart failure found patients with AF had 14% lower mortality than those taking placebo whereas β-blocker use was associated with 37% lower mortality than placebo among patients in sinus rhythm.

The UK and Dutch researchers concluded that the effect of β-blockers is 'significantly different' among heart failure patients who also have AF.

But they did note that carvedilol had a 'relatively favourable effect in the analysis in AF patients' in the one study that examined it, although those patients had milder disease than those in other studies.

JACC Heart Failure 2013; 1: 21-8

GPs refer most cancer after one or two visits

More than 80% of patients presenting to their GP with symptomatic cancers are referred after one or two visits, a new study shows.

Data from more than 13,000 cancer patients analysed by the National Audit of Cancer Diagnosis in Primary Care found 58% were referred on their first GP visit and a further 25% on their second.

The researchers said encouraging GPs to refer patients with non-specific symptoms may improve the timeliness of diagnosis but at the cost of more false positives, patient anxiety and overinvestigation.

B J Cancer 2013, online 7 Feb

'Avoid injections in tennis elbow'

Corticosteroid injections should be avoided in patients with tennis elbow as they are associated with worse outcomes, researchers warn.

The randomised trial compared steroid injection, placebo injection and either injection plus physiotherapy.

Those who received steroid injections were 14% less likely to experience complete recovery at a year than those who had a placebo. Steroid injection was also associated with a 77% higher risk of recurrence than placebo. Physio had no significant impact on either recovery or recurrence rates at a year.

Dr Louise Warburton, a musculoskeletal medicine GPSI in Shrewsbury, said: 'Previous work showed corticosteroids produce only short-term benefits. Physio seemed better. Now with a high recurrence rate from injections and physio effects wearing off after a year, we are left with a management plan of short-term physiotherapy.'

JAMA 2013, online 6 Feb

Paper of the month

NICE traffic light system for childhood fever misses infections

The study

In what is claimed to be the first major validation study of the 2007 NICE guidelines for assessing feverish illness in children, Australian researchers used the recommended traffic light assessment tool in almost 16,000 children aged under five presenting to a paediatric A&E.

The findings

The NICE traffic light tool missed 20% of UTIs, 14% of cases of bacteraemia and 8% of pneumonia cases, all of which were classified as 'green' rather than red or amber risk.

Combining the red and amber risk categories, the NICE tool had a sensitivity of 86% and a specificity of 29% for detection of serious bacterial infection. The addition of routine urinalysis would have improved sensitivity to 92%.

What does it mean for GPs?

The researchers said the missed UTIs were of greatest concern as occult bacteraemia had become much rarer in febrile children following the introduction of pneumococcal vaccination.

They suggested urine analysis should be routinely performed in children with fever and suspected bacterial infection, pointing out that NICE recommended it in children with fever without apparent source yet did not include it in the traffic light assessment tool.

However, they added that the low specificity of the traffic light test meant clinical judgment was still important to avoid overinvestigation.

Expert comment

Dr Kathryn O'Brien, clinical lecturer in primary care at Cardiff University and a GP in the city: 'Taking urine samples from loads of children isn't really feasible in general practice. It's difficult to obtain urine samples from children.

'Dipsticks have been found to be unreliable for diagnosing UTI in young children and are not recommended by NICE for use in children under three years old. So we're not even sure that the UTIs missed by the traffic light system were actually UTIs.'

The paper

BMJ, 2013; 346: f866

To read the full story and Dr O'Brien's expert analysis, go to pulsetoday.co.uk/NICE-traffic-lights

INVESTIGATION

GETTY

Why has recruiting GPs become so hard?

With the GP vacancy rate quadrupling in two years, practices are facing a recruitment crisis just as they prepare to take on more work, finds Jaimie Kaffash

Four years ago it would have seemed ludicrous to predict a shortage of GPs to fill partnerships and salaried posts.

Deaneries were warning GPs to expect unemployment after training, with reports of 50–80 applicants for every full-time role in some areas. Pulse even launched a 'One Voice' campaign calling for contractual changes and incentives to make it easier for practices to take on extra partners.

But fast-forward to 2013 and the profession is facing a very different jobs market. Many GPs are now complaining of a 'dramatic' reduction in the quality and number of candidates for vacant partnerships and of rising locum costs.

As practices struggle to cope with rising expenses, below-inflation funding awards and a huge shift in workload from hospitals into primary care, they are finding it harder to recruit GPs to share the load.

Rising vacancies

A Pulse snapshot survey of 220 practices, covering around 950 full-time positions, reveals the full extent of the problem.

The results show an average vacancy rate for all full-time-equivalent GP posts in the practice of 7.9% in January 2013 – almost double the 4.2% figure found in a similar Pulse survey in January 2012, which itself was twice the official figure of 2.1% at the start of 2011.

There's no doubt that, for practices looking to take on GPs, the quadrupling of the vacancy rate in just two years is causing real problems. Dr Peter Swinyard, chair of the Family Doctor Association and a GP in Swindon, says: 'It is immensely hard to recruit. This is the experience of a lot of the doctors I have talked to. We are on our second firm of headhunters now, at significant expense, to fill our vacancy.'

Dr Anne Crampton, a GP partner in Crowthorne, Berkshire, says there were 30 applicants when her practice advertised a partner post three years ago, but only five for a similar post this year. She says: 'I don't know why general practice seems to be so unpopular. This difficulty in recruiting came as a complete surprise.'

Dr Malcolm Kendrick, a member of the GPC's sessional executive committee and a salaried GP in Cheshire, says there has been an 'absolute' turnaround from the situation five years ago.

> General practice is looking less attractive as a career
> *Dr Peter Swinyard*

'It is becoming more difficult to recruit partners. There is definitely less appetite for partner roles.'

Recruitment is not such an issue in Scotland, Dr Kendrick adds, but rural practices in Wales are struggling to take on partners.

GPC deputy chair Dr Richard Vautrey says the problem has been a big concern at the BMA contract roadshows: 'Wherever we have been, GPs have been telling us there is a recruitment and retention crisis. It is starting to happen now.'

The recruitment crisis comes at a particularly difficult time for practices, with CCGs taking over commissioning responsibilities and the new GP contract hiking up practice workload from April.

The GPC argued in response to the Government's contract imposition that 'practices have reached a point of workload saturation', while LMCs have reported a 'shocking' rise in requests for pastoral care – partly as a result of excessive workload.

The difficulties practices are having in

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Contra-indications, warnings, side-effects etc: Please refer to SPC for full details before prescribing. Do not use if sensitive to any of the ingredients. In the unlikely event of a reaction stop treatment. Keep away from the eyes. Take care not to slip in the bath or shower. **Package quantities, NHS prices and MA numbers:** Dermol Wash: 200ml pump dispenser £3.55, PL00173/0407. Dermol 200 Shower Emollient: 200ml shower pack £3.55, PL00173/0156. Dermol 500 Lotion: 500ml pump dispenser £6.04, PL00173/0051. Dermol Cream: 100g tube £2.86, 500g pump dispenser £6.63, PL00173/0171. Dermol 600 Bath Emollient: 600ml bottle £7.55, PL00173/0155. **Legal category:** P **MA holder:** Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR. **Date of preparation:** February 2012. 'Dermol' is a registered trademark.

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 Dermal.

References:

1. Gallagher J. *et al.* Poster presented at EADV Congress 2009.
2. Dermol Range – Total Unit Sales since launch. Dermal Laboratories Ltd. Data on file.

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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 thrombocytopaenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, can occur before or after vaccination with Gardasil as a psychogenic response to the needle injection. Vaccinees should be observed for approximately 15 minutes after vaccination; procedures should be in place to avoid injury from faints. 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: Nov 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.

Reference: 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 January 2013.

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INVESTIGATION

'It has become an arms race to get an applicant'

I have found it difficult to fill vacancies recently. The quality of applicants and the number has definitely fallen.

It had been declining for a while but it dropped dramatically in the past year.

It is a sellers' market. There have been instances where applicants have been offered another job at the same time elsewhere and it has become an arms race to get that applicant in the post by offering as attractive a proposition as possible.

There are more people taking up locum posts and working out of hours in APMS providers than previously. I don't think people want to be tied into long-term contracts.

I think it will get worse if you want to recruit a partner when no one knows what is happening in three years' time, let alone five.

Dr Richard van Mellaerts is a GP in Kingston, Surrey

filling vacancies are also having a financial impact. In the Pulse survey, practices reported an average increase in locum costs of 9.5% over the past 12 months, on top of the further 9% increase seen in 2011.

Portfolio careers

So why are so few GPs applying for jobs? Official figures from the NHS Information Centre show there was a slight fall in the number of GP partners in 2011 – 27,218 – compared to 2001, when there were 27,938. By contrast, the number of consultants rose sharply from 27,782 in 2001 to 39,088 in 2011.

However, the total number of practising GPs has increased by an average of 2.3% annually since 2001, from 31,835 to 39,780. In other words, fewer GPs are taking the route into partnership, instead remaining salaried or locums. However, unlike in 2009, when competition for partnership vacancies was fierce, this now seems to be through choice.

A shift towards portfolio careers and a steadily rising number of women choosing to work part time are both having an impact, GPs say.

Dr Crampton says: 'Nobody wants to work full time. Initially, we wanted a nine-session partner.

'What most GPs seem to want to do now is part-time general practice and part-time GPSI work – clinical assistants, out-of-hours work, that type of thing.'

Dr Kendrick agrees partnerships are widely seen as unattractive: 'There is a lot of uncertainty about the contract imposition, falling income and people seeing partners working ridiculous hours.

'GPs doing other roles are now saying: "This does not look like such an attractive option".'

At the other end of the scale, GPs are increasingly considering early retirement as the demands of the job pile up. Exactly half of the respondents to Pulse's survey said they were thinking of retiring early. Many cited workload as a key reason for considering early retirement.

Dr Swinyard says: 'We're seeing more and more principals saying: "Sod this, I'm going early". Some take roles working as locums for the last few years of their practice lives. It's a shame to lose the wisdom of senior people – you cannot replace that.'

Looking to the future

The Department of Health has recognised that more GPs are needed for the NHS to function, with former health secretary Andrew Lansley last year setting out a plan to boost the number of GP trainees by 20% by 2015 in England so that GP registrars would make up 50% of the specialty training places (up from 41%).

But this drive is floundering. Figures from the GP National Recruitment Office (GPNRO) last summer showed there were 2,693 GP training places accepted in England in 2012, which actually represented a net decrease of three compared with the previous year.

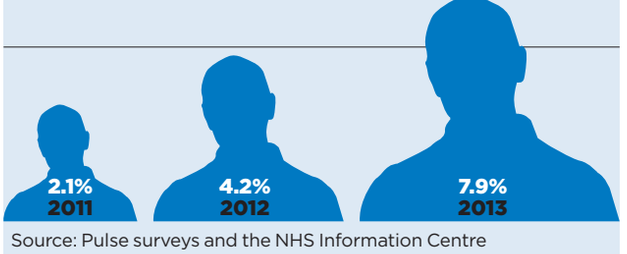
EXTRA ONLINE

'GPs are in a recruitment crisis'

Watch the Big Interview with Dr Bill Irish, chair of the GP National Recruitment Office

pulsetoday.co.uk/tbi-irish

How GP vacancy rates have risen



Source: Pulse surveys and the NHS Information Centre

This compares with a rise of almost 700 in hospital training places in England, with 4,725 places accepted, up from 4,034 in 2011. The proportion of GP trainees fell from 40% in 2011 to 36% in 2012.

A DH spokesman says: 'The DH and Health Education England are currently working with key stakeholders to support the increase of training numbers in general practice.

'A national GP taskforce has been established to support this work and make recommendations for increasing training posts to 3,250 each year.'

An unattractive proposition

According to the Committee of General Practice Education Directors, the struggle to recruit new GPs is down to an excess of hospital training places, rather than a dearth of GP ones. Chair Dr Barry Lewis, a GP in Rochdale, says: 'We have expanded training steadily and have an expansion target for the next three years – there is no shortage of training places. We have empty slots in programmes, except in London and the South East.

'There are not enough applicants because an excess of hospital specialty posts is still in the system.

'There is a significant imbalance in the workforce at junior level that has and continues to produce too many "-ologists" and too few generalists, especially GPs.'

Research published last month showed that only 28% of medical graduates cite general practice as their first-choice career, compared with 71% who opt for secondary-care specialties.

Study leader Professor Michael Goldacre, a professor of public health at the University of Oxford, says there is 'some cause for concern' about this relative lack of interest in general practice from newly qualified doctors.

He says: 'A much smaller percentage express a preference for a career in general practice than the NHS actually needs.'

Rising medical school fees and the proposed four-year training for GPs, which could begin as soon as 2014, are also likely to have an effect on the numbers entering the profession.

The reluctance of many medical graduates to opt for general practice is not new. However, the Government is doing a poor job of encouraging people into the profession, says Dr Vautrey.

'There is a feeling there are better opportunities for them in hospital or abroad,' he says.

Dr Swinyard – still looking to fill his practice's outstanding vacancy – says more must be done to encourage the next generation into the profession.

'General practice as a whole is looking less attractive as a long-term career option,' he says. 'I still think this is the best job in the world, but it is becoming bloody hard to do it.'

● *Editorial: 'A profession fast losing its appeal', page 29*

INVESTIGATION

PMS practices squeezed as funding reviews bite

One PMS practice in three has had its contract changed in the past two years and many are switching back to GMS. Does PMS have a future? Sofia Lind investigates

In the waxing and waning fortunes of PMS GPs, 2013 may come to be seen as a watershed. Over the past two years, a Pulse investigation reveals, half of such practices have had their contracts reviewed by managers, in the biggest reappraisal of their funding since the alternative GP contract was introduced.

Some report losing tens of thousands of pounds in funding, sending GP drawings plummeting and putting staff at risk of redundancy. Others have gained from the review. But most agree the overarching purpose of the PMS contract – to provide local services – has been 'dumbed down' by managers seeking easy 'efficiency' savings.

Some practices have reverted to the GMS contract, a few have closed, but many have had to come to terms with new contract terms – and the uncertainty looks set to continue as the NHS Commissioning Board begins a root-and-branch overhaul of practice funding from 2014.

Two-tier funding

Established as a pilot scheme in the 1997 Act for Primary Care, PMS was the first opportunity for GPs in England to negotiate their own contracts locally with PCTs, based on the health needs of their local population.

Over time, PMS contracts became ▶

ONLINE

Dr Derek Hopper explains how PMS GPs in his area secured their deal pulsetoday.co.uk/pms-negs

JOE D MILES

'We are paid less than our salaried GP'

We switched to a PMS contract in 2001 and our original objectives closely matched Lambeth's health needs at that time. But last year, we were called to a meeting.

We were given a presentation and at the end of the meeting we were given an envelope telling us how much we were going to lose.

Ours was £179,000. It was a huge chunk of our funding.

The funds cut were spent on clinical staff and now we and our patient access and services are hurting. We are the second-largest practice in our borough, with some of the highest needs in the UK.

We have extremely high consultation rates due to the high disease prevalence rates, particularly mental health issues.

We are still providing these services, but we are having to fund it with different methods. The clinical need doesn't go away just because the money goes away.

We [the partners] are now being paid less than our salaried GP, and I know that is not unusual because I am part of a peer support group and it is the same across the board.

We didn't cut the nurses' pay. These two outreach nurses were paid for by the PMS funding, which then disappeared. They were doing work with frail, elderly people with long-term conditions, just the services that are needed now that more hospital work is shifting to be carried out in the community.

We are having another pay cut this month – it is going to be a reduction of around 40%.

We do good things, but we now have our arms tied behind our backs. *Dr Di Aitken is a GP in Lambeth, south London*

In a statement issued to Pulse, NHS Lambeth said: 'Our review has given us the opportunity to refocus and better incentivise the provision of primary care contracts to be more closely aligned towards our priority health goals which seek to address the highest health needs in Lambeth, as prioritised by local people and health professionals.'

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Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.
Adverse events should also be reported to Pfizer Medical Information on 01304 616161

Date of preparation: April 2012 UK/MED/12/0006

INVESTIGATION

very popular – with a third of GPs practising under one by 2002 – providing a wider range of primary care services. But the PMS revolution also drove a wedge between GPs, with fears of a 'two-tiered' profession developing as PMS practices commanded higher funding per head than many GMS GPs could ever have dreamt of.

Those rising earnings also caught the eye of the national media, which decried drawings of up to £150,000 a year.

The backlash began in 2006. The Government sent out a notice to all PCT chief executives in England saying they must conduct a 'value for money' review of all PMS contracts, ensuring they were equitable and fair in relation to GMS.

A further blow followed in 2010, when the DH added a clause to PMS regulations giving PCTs the right to terminate contracts 'without grounds'. The NAPC warned that PMS GPs faced 'unilateral' variation to PMS contracts rather than genuine negotiations. In some cases, those fears have been realised.

'Hypocrisy'

Six months ago Dr Tom Frewin, a single-handed GP in Bristol, was subject to a PCT-wide review of PMS contracts that resulted in his practice losing about £67,000 a year. Dr Frewin has taken a big hit to his pay rather than reduce the services he provides, but he warns that this is not sustainable over the long term.

He says: 'For a single hander that is a lot. It was a PCT-wide review of the outliers only. If you just looked at capitation, I might have been 5% over the average. But weighted capitation changes this. With weighted capitation it is fine if you go across a large group, but when you pick out individuals you get some bizarre results.'

He says redistributing funds is not always wrong or unfair, but says he feels he was not listened to by NHS managers.

'There were no negotiations. They said they would negotiate and there were a lot of meetings, but what a complete waste of time that was. It is an entire hypocrisy.'

In a statement to Pulse, a spokesperson for NHS Bristol insisted it had followed an 'extremely robust' process in renegotiating PMS contracts.

But Dr Frewin is not alone in feeling hard done by. Dr Di Aitken's practice in Lambeth, south London, lost £179,000 of its annual funding, leaving the partners on lower pay than their salaried GP (case study, page 22).

In fact, Pulse can reveal that in the past two years, over half (55%) of PMS contracts have been subject to review.

The data – obtained under the Freedom of Information Act – covers 1,278 PMS contracts held by PCTs on 1 April 2011. More than a third of practices (37%) have seen their contract terms varied as a result of review, while 4% have had their contracts terminated, resulting in practice closure, merger or – in most cases – reversion to a GMS contract. In total, 30 of the 1,278 practices reverted to GMS.

> *For a single hander, £67,000 is a lot*
> *Dr Tom Frewin*

In some areas, the changes to PMS contracts have been dramatic. NHS Derby City has retained just two of the 16 PMS contracts it held two years ago after 14 practices decided to revert to GMS. A spokesperson said the reviews were 'an opportunity for the PCT to standardise and simplify primary care contracts' and that practices now had 'the additional security' of a GMS contract.

But such changes have led to the first reduction in the number of PMS GPs since the introduction of the new contract. Figures from the NHS Information Centre show that in 2011, the most recent year for which figures are available, 44.4% of GPs worked in PMS practices – the lowest proportion since 2005.

Dumbed down

Not all reviews end in cuts, however. Dr James Kingsland, national clinical lead of the NHS Clinical

The rise and fall of PMS

1998	Pilots of PMS contracts begin with 83 practices in England
2003	The DH announces that it will end the PMS pilot and give the contract permanent status
2004	The new GMS contract comes into force and PMS contracts are established
2006	DH directs PCTs to carry out 'value for money' reviews of all PMS contracts
2010	DH adds clause to PMS regulations giving PCTs the right to terminate contracts 'without grounds'
2011	A group of 20 PMS practices lose their High Court case against PCTs, with the court upholding trusts' right to unilaterally cancel PMS contracts so long as they give six months' notice
March 2012	Workforce figures show a fall in the number of PMS GPs after six years of consecutive rises
October 2013	DH announces plans for 'more equitable' funding for all practices

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astellas

*Protopic is for use in patients with moderate-to-severe AD who have failed to adequately respond to[2,3] or are intolerant of conventional therapies, such as topical corticosteroids[2]

References:

1. Reitamo S and Allsopp R. *J Dermatol Treat* 2010; **21**: 34–44.
2. Protopic 0.1% Summary of Product Characteristics, August 2012.
3. Protopic 0.03% Summary of Product Characteristics, August 2012.

Prescribing information can be found on the adjacent page

PRO12106UK December 2012

Protopic®
tacrolimus 0.03, 0.1% ointment

Help your patients outsmart eczema

INVESTIGATION

Over time, PMS has been dumbed down, without the real flexibility it had when we first started
Dr James Kingsland

As of April, PMS renegotiations will be conducted with rigour
Dr Charles Alessi

Commissioning Community and a PMS GP in Wallasey, Merseyside, says his PCT has just topped up his practice funding by £4,000 for carrying out additional vaccinations. But, while he says his contract has been managed well, he has heard from colleagues that not all PCTs have been as understanding.

'My practice was one of the first-wave PMS sites in the country. We were pioneers, very enthusiastic, but over time [PMS] has been dumbed down, without the real flexibility it had when we first started. It is a shame. There are PCTs that just don't understand the nature of PMS contracts and just look at basic information like costs-per-patient baseline and say: "There is a difference and therefore we want our money back" – which is an incredibly rudimentary process.'

NAPC chair Dr Charles Alessi also says many of the reviews have started with a 'misconception' that PMS is better remunerated: 'Of course we all have to change what we are doing. We are all in the same situation at the moment, in terms of the fiscal environment. But what is important is that we do [this] in a way that is ordered well, and that we are not just making assumptions and proceeding on those assumptions.'

GPC deputy chair Dr Richard Vautrey says that reviews of contracts by PCTs over recent years have been destabilising for PMS practices, particularly when done for financial reasons.

He says: 'There have been a lot of reviews, and quite vigorous reviews taking place, some inappropriate.'

An uncertain future

Pressure on PMS funding is not likely to ease any time soon, although practices may see a more consistent application of the reviews from April.

Starting next year, PMS-funded practices are facing a contract overhaul that will last for seven years. The Government claims this will result in a 'more equitable' funding structure for GPs that bases GMS and PMS funding around the same principles. The NAPC has said a further round of changes is causing 'increasing anxiety' among GPs, but Dr Alessi says he has been encouraged by recent discussions with the NHS Commissioning Board.

He says: 'As of April, renegotiations are going to be conducted with rigour. There is going to be a single process and that is encouraging, because that is what we have been asking for. We will also be intimately involved in the detail of that process.'

The GPC has also cautiously welcomed the move. Dr Vautrey says: 'I think moving to one arrangement, one process, led by the board should be helpful as long as it is done in a measured and understanding way.

'[PCT] reviews are very variable, approached in different ways. Practices want stability. They want to be treated fairly.'

JON ENOCH/PAUL STUART

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 comprising asthma, aggravated asthma or dyspnoea, purpura, angioedema, bullous dermatoses (including epidermal 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. **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.

MercuryPharma

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/TRA/ADV/194/2012 Date of preparation: July 2012.

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VIEWS

EDITORIAL

A profession fast losing its appeal

It's been widely accepted for some time now that general practice needs more GPs. The shift of work from secondary to primary care is an ongoing trend, the 'retirement time bomb' seems to have been ticking for years – and the small matter of GPs taking on commissioning responsibility, now just four weeks away, has been on the horizon since 2010. But our investigation this month suggests long-standing fears of a recruitment crisis have finally been realised, with the average vacancy rate for GP posts at practices quadrupling in just two years.

It is important, of course, not to overstate the case. An average vacancy rate is a crude measure which masks regional variation, and there have always been cyclical fluctuations in the jobs market. Just a few years ago, we were talking about a recruitment crisis in general practice which consisted of there being too few jobs for GPs, rather than the other way round.

It's also worth acknowledging the shortages are partly due to general practice's rapidly changing demographics. 2013 is supposed to be the year when women will for the first time make up the majority of the GP workforce, but it's not just female GPs who are increasingly keen on a better work-life balance. Portfolio careers, meanwhile, are fast becoming the norm. Dr David Weinstein, for instance, the Brighton GP featured in our Working Life photo essay this month (page 64), works every Friday in A&E and says the variety makes him a better doctor.

Whatever the causes, both CCGs and the Department of Health must do more to ensure practices can plug the gaps. Adequate backfill for partners taking on commissioning work and including sessional GPs in CCG work will help somewhat; asking practices to pay locums' superannuation and then reimbursing them according to list size rather than locum use, as is currently the plan, will probably not.

But beyond the immediate difficulties in filling vacancies, the jobs crisis raises fundamental questions about the future of the profession, and how it can attract the new blood it desperately needs.

General practice has always been a hard sell to medical graduates tempted by the glamour of hospital medicine, but in the years after the introduction of the 2004 contract, healthy earnings, acceptable hours and a degree of independence made it an attractive alternative. Yet, despite the DH boldly declaring that GP registrars should account for 50% of specialty training places by 2015 and opening up more training slots as a result, deaneries are struggling to fill the ones they have.

> If ministers really do value GPs, they have a funny way of showing it

If ministers are serious about increasing the number of GPs, they must make it an enticing career option once again. GPs cite an unmanageable workload and 'box-ticking' clinical culture as off-putting factors for would-be trainees, while increasing bureaucracy and contractual uncertainty are dissuading many from the financial commitment of partnership. In the past few months alone, ministers have brought in revalidation, ripped up the GP contract and gone to war over pensions. If they really do value general practice, they have a funny way of showing it.

For an older generation general practice will always be, as Dr Peter Swinyard puts it, 'the best job in the world'. But that generation is a retiring breed. Their successors need to know it will still be the best job in the world in 20 years' time.

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FEEDBACK

Email: letters@pulsetoday.co.uk

Letter of the month

Could GPs learn business lessons from Tesco?

GPs must consider new ways of working in order to survive

From Dr Malcolm Ridgway, Blackburn
I think all GPs are aware of the extra stress on practices and the likely further increases in demand and reductions in income ('"Shocking" numbers of GPs seeking pastoral support, say LMCs', pulsetoday.co.uk/news).

For me, we are trying to utilise a general practice model that was invented before the inception of the NHS to deliver 21st-century care. Many commentators (such as the King's Fund) are now calling for the cottage industry/corner shop organisational model of general practice to be updated. The RCGP has talked about federation. The Government, I think, is piling on the pressure to enforce structural changes voluntarily – or GPs will have to surrender and succumb to an enforced salaried model, vertical integration or whatever scheme seems politically beneficial at the time.

I always feel we should be in control of our own destiny, yet all I see from GP colleagues is a head-in-the-sand, 'hope it all goes away or I retire' attitude. When will we wake up and smell the coffee? There are possible models that maintain continuity of care, improve quality and reduce variation, maintain practice sovereignty, expand and improve services, bring more expertise and care out into the community and yet improve work-life balance and maintain incomes.

> We must find alternative models for general practice

Successful businesses generally expand and diversify (like Google and Tesco) and, at the end of the day, GP practices are businesses – at least for now. Yet the vast majority of GPs won't even consider alternative models of working.

I think Pulse should start a campaign that debates innovative solutions to do what I have said above, and at least gets GPs thinking outside the box. I am close to retirement, so none of this will really affect me, but I am getting fed up with the increasingly intense demands from clinical work. Also, I have seen lots of GPs of my age or younger retiring – not because they feel able to financially, but because they can no longer cope with how general practice has become. These are people at the height of their experience and knowledge and they will be sadly missed by their patients, and indeed the NHS.

● *From Dr Ivan Camphor, secretary of Mid Mersey LMC, via pulsetoday.co.uk*
General practice is going through exceptionally challenging times. Morale is at an all-time low, and we are all suffering from overload. I work 12-hour days in the week and spend all Sunday, like colleagues, doing paperwork. We're only human, and we need to see our families and friends to survive emotionally. At the moment GPs are maxed out – many of my colleagues in their 50s are retiring simply to get away from the workload. General practice isn't sustainable at the moment – which makes the failure of the latest contract negotiations all the more painful to watch.

Let's call ministers' bluff and resign from CCGs en masse

From Dr Anthony O'Brien, Silverton, Devon
Why is the GPC not suggesting co-ordinated action in response to the contract imposition? We have a powerful negotiating weapon that we seem to be ignoring. A co-ordinated resignation of practices from CCGs would have no effect on patients or doctors but would cause apoplexy in Government and Whitehall.

It is surprising that GPs who have been coerced into commissioning are not now questioning whether we wish to continue our involvement. Why should we help the Government with its NHS rationing difficulties? The Government cannot allow its commissioning 'project' to fail. But CCGs are membership organisations. The statutory duty to belong to a CCG may be part of the new contract – but it is not in the old one.

If we resign from our CCGs, political chaos will follow. The Government will be forced back to the negotiating table. The public will not be affected and will have no understanding of what is happening. We will not be seen to be complaining about money – just reconsidering the flawed health bill proposals. Commissioning enthusiasts might have to twiddle their thumbs for a bit, but we have survived without fully functioning PCTs for many months. A few more will not sink the NHS.

If practices want to leave CCGs, they do not have to justify themselves. If the Government wishes to use the courts to impose the contract and commissioning, we should challenge them to do so. It is important to emphasise this is not a debate about money or pros and cons of commissioning. It is a point of principle. We have negotiated in good faith and do not wish to be treated in this way.

Shame on the GPC for being so despondent. We should all stand up, stop moaning and call for a boycott of commissioning if negotiations are not reopened.

Common sense approach to CSA must stay

From Dr Hamish Duncan, Exeter, via pulsetoday.co.uk
While it is laudable to ensure the CSA exam is rigorous and non-discriminatory, let's not create a two-tier pass rate ('Lawyers give RCGP three weeks to sort CSA, or face legal action', pulsetoday.co.uk/news).

ALAMY X2

Being a good doctor includes a certain level of understanding of the cultural and linguistic norms of the society you serve, the systems to deliver the service and the ability to work within a different cultural context. If someone is not good enough to do this, they should fail regardless of background. Multiple failings should lead to removal from training. There is nothing politically incorrect, racially motivated or immoral about this, it's just good common sense.

In the same vein, let's ensure this challenge is rigorous and sensible and the outcome does not succumb to political correctness. If the verdict goes against the plaintiffs, they must accept it and move on. If it finds in favour, the RCGP needs to answer serious questions about its impartiality and conduct.

How many GPs does it take to change a lightbulb?

From Dr Gavin Jamie, Swindon, via pulsetoday.co.uk

Your story ('CCG calls GPs into "crisis point" hospital to help assess every

patient for discharge', pulsetoday.co.uk/news), reminded me of a joke on Twitter a few weeks ago: 'Q: How many National Rifle Association members does it take to change a lightbulb? A: More guns!'

It sometimes seems the reflex answer to any issue in health is 'More GPs!' While this faith in our omnipotence is touching, it may be seen by others as arrogance or even pomposity. Hospitals are full of excellent doctors capable of making good assessments of their patients. Could they benefit from more knowledge of community care? Quite possibly. But let's respect them, let them do their job and fund decent and prompt community care.

ONLINE

Join the debate
Have your say on the big GP issues of the moment at **pulsetoday.co.uk/forum**

What you're saying about the Francis Inquiry

'We do not need GPs to be given the role of assessing care standards. We need to use existing processes properly'

'The concept of a primary care-led NHS was always just wishful thinking – easily said but never done'

'And there was me thinking the CQC actually had a purpose'

Join the debate at pulsetoday.co.uk/your-comments

THE BIG INTERVIEW

Dr Paul Cundy

‘It’s time to pull the plug on Summary Care Records’

Does the NHS IT programme promise genuine progress – or just change for its own sake? Madlen Davies talks to the GPC’s IT lead Dr Paul Cundy

‘In this practice we have a disproportionate number of nuns,’ begins Dr Paul Cundy, in answer to a question about concerns over data requests from the new General Practice Extraction Service (GPES), the Government-run system that is set to make patient records more accessible to NHS managers, researchers and private companies.

‘We have concerns that some queries might not be appropriate for those patients.’

It is a typically clear-headed response, sensitive to the real-world concerns of patients, to a question about the use of IT, for which he has been a GPC spokesperson for nearly 12 years.

Sitting in his – surprisingly low-tech – practice in Wimbledon, south-west London, Dr Cundy appears relaxed, despite the continual stream of new-technology projects clogging up his in-tray as they float downstream from the Department of Health.

A member of the GPC for 18 years and a GP since 1982, Dr Cundy has seen his fair share of politicians promising whizz-bang technology solutions that turn out to be duds.

And this Government, he says, is no different.

‘It’s a continuing disappointment that successive governments have introduced policy that is not based on evidence,’ he says with an air of weariness.

‘That’s the political world, it’s not the scientific world we live in. The GPC will point out the evidence; it’s up to the Government to decide whether to listen.’

EXTRA ONLINE

‘Choose and Book is an absolute nightmare’
Watch the full interview with Dr Paul Cundy
pulsetoday.co.uk/tbi-cundy

Online records

Dr Cundy is leading the GPC’s IT subcommittee at a time when historic decisions are being made about the future of NHS IT. Health secretary Jeremy Hunt – who has promised a ‘paperless NHS’ by 2018 – has made technology a top priority, with the Government’s information strategy aiming to enable patients to book GP appointments, access their records and contact their GP online by 2015.

Dr Cundy says these proposals for GPs are ‘self-evidently very sensible’ but need to be carefully managed: ‘The net effect will lower the threshold at which patients will communicate with health services; that will inevitably result in an increase in workload.

‘If general practice suffers what has happened in the States, where there’s a 25% across-the-board increase in work, primary care will fall apart because it cannot sustain that level of increase.’

Summary Care Records

He is even more strident on the long-running Summary Care Record (SCR)

CV

- Chair of the GPC IT subcommittee since 1999 (bar two years)
- GP in Wimbledon, south-west London, since 1982
- Ran a GP out-of-hours commissioning group for 10 years
- Ran an IT company for 15 years
- Lists motor racing, flying planes and anything mechanical as his hobbies

THE BIG INTERVIEW

Dr Cundy on...

...online access to GPs
If general practice suffers what has happened in the States, primary care will fall apart

...Choose and Book
The patient and GP can only choose from the appointments offered by the trust. There's no choice there – you are given what you're given

...the SCR programme
The system is a disgrace; the plug should be pulled as soon as possible

...the GPES
We're on the verge of a public information campaign saying: 'When you go to see your GP, the information that's been taken will not be used just for your personal care'

programme. According to the latest NHS Connecting for Health bulletin, almost 23 million people in England – more than one in three – now have an SCR, and their records have been accessed a combined total of 242,341 times since their creation.

But Dr Cundy is unimpressed by the stats, and offers some calculations of his own: 'If you look at that in terms of utilisation rate, it means that each time an SCR has been accessed for a patient, it has cost £1,200 for that access.

'The system is an absolute disgrace and the plug should be pulled as soon as possible,' he adds, though he later stresses that he is speaking in a personal capacity on this issue and that official BMA policy remains that the SCR programme should 'stand on its merits'.

Dr Cundy supports LMC leaders who have called for patient information campaigns on the SCR to be restarted, as most patients are blissfully unaware any record has been created in their name.

'The information programme was run several years ago,' he says. 'These records are now being created and patients are not aware of what's going on.'

GPES

Dr Cundy is also highly critical of the DH programme to make data from GP records more accessible to NHS managers and others through the new GPES system.

ONLINE

New this month
Go online to watch our Big Interview with Dr John Canning on the CQC, GP contract and work capability assessments
pulsetoday.co.uk/tbi-canning

The Government is keen to stamp on any suggestion that it is creating a 'super-database', but Dr Cundy says the initiative marks a sea-change in attitudes to the use of patient data.

He says: 'There's a great move at the moment to say that patient data in the NHS is there for use by the NHS, but that's not the way data has been used for the past 60 years. That's a fundamental change and patients need to understand that.'

The GPES system enables data – both patient-identifiable and anonymous – to be extracted from GP systems and sent to the Health and Social Care Information Centre, which can send it on to customers in the NHS and potentially also private companies.

The GPC negotiated some important protections, namely that GPs must agree to the extract being taken and requests for data must go before the GPES Independent Advisory Group, which will conduct an information governance assessment.

The NHS Commissioning Board recently announced it planned regular extractions of anonymised data on demographics, diseases, events and referrals from GP systems.

Dr Cundy says: 'Most patients do not understand that their information may be used to police CCGs, trusts and GPs. If we're going to be moving to an area where it's being used to routinely manage what's going on in the NHS – which is a legitimate aspiration – then patients need to understand that.'

He advocates a public information campaign on the GPES to inform patients that 'when you go to see your GP or go to A&E or hospital, the information that's been taken will not be used just for your personal care but for other things too'.

Telehealth

Dr Cundy is also critical of another of the Government's big ideas, questioning whether GPs can cope with leading the drive on telehealth.

'There's no doubt there are a few niche areas where the use of telehealth can be very valuable,' he says.

'But for the average patient who lives half a mile from their practice, and who has conditions that are not terribly urgent and is mobile, telehealth is of no value whatsoever.

'You go from a situation where you take someone's blood pressure once every six months to 24 every day. That overwhelms systems.'

He concludes with an observation that might apply not just to telehealth but to the wider NHS IT strategy: 'We have to be careful not to do things just because they can be done.'

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Palexia only: vomiting. *Common (≥1/100, <1/10):* decreased appetite, anxiety, sleep disorder, tremor, flushing, diarrhoea, dyspepsia, pruritus, hyperhidrosis, rash, asthenia, fatigue, feeling of body temperature change. Palexia SR only: depressed mood, nervousness, restlessness, disturbance in attention, involuntary muscle contractions, dyspnoea, vomiting, mucosal dryness, oedema. Palexia only: confusional state, hallucinations, dry mouth, muscle spasms, constipation, abnormal dreams. Other important undesirable effects: Palexia SR only: drug hypersensitivity *(uncommon ≥1/1000, <1/100)*, respiratory depression *(rare ≥1/10,000, <1/1000);* Palexia only: respiratory depression *(uncommon ≥1/1000, <1/100)*, hypersensitivity *(rare ≥1/10,000, <1/1000).* No evidence of increased risk of suicidal ideation or suicide with Palexia SR/Palexia. 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Adverse events should be reported. Reporting forms and information can be found at http://www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Grünenthal Ltd (telephone 0870 351 8960).

References
1. Tzschentke, T.M., *et al.* Drugs Today (Barc), 2009; 45(7): 483-96.
2. Palexia SR, Summary of Product Characteristics. February 2011.

UK/P13 0009. Date of preparation: February 2013.

GRÜNENTHAL

DEBATE

Can GPs monitor hospital care?

YES

Dr Robert Varnam says GPs are well placed to take on the Francis Inquiry recommendation to monitor the quality of secondary care

Most of the recommendations from the Francis Inquiry in the wake of the Mid Staffordshire scandal were aimed at national regulators and local hospitals. However, there are some significant implications for general practice, including the proposed 'duty of candour' legislation and the reminder that both CCGs and GPs share a responsibility for improving patient safety.

GPs are well placed to pick up on some safety issues within hospitals. This is not about spying on our hospital colleagues but rather being vigilant for opportunities to improve patient care.

Two major barriers, though, are time and confidence in the system. We need to ensure the forms for recording safety issues are easy to access and quick to complete for GPs and our teams. And we also need to be confident that our safety reports result in improvement for patients. There's no point in taking time out of a busy day to complete a form if it doesn't end up benefiting patients.

Evidence shows that people will report safety concerns if they receive rapid feedback and can see that effective action is taken.

> CCGs will create a more cooperative culture between primary and secondary care

These changes are likely to require a massive increase in the responsiveness of local commissioners and national agencies. I'm optimistic CCGs will create a much more cooperative and clinically led culture between primary and secondary care. One challenge for many CCGs will be breaking some of the traditions in NHS commissioning. In many areas, commissioning has revolved around contracts – CCGs are in a good position to take a fresh approach, which begins with clinical collaboration.

As far as I can see, none of the lessons from the Mid-Staffs tragedy are new. The challenge for CCGs and the national regulators is to put the old lessons into practice.

Dr Robert Varnam is a GP in Manchester and clinical lead for primary care at the NHS Institute for Innovation and Improvement

NO

Professor Aneez Esmail says the recommendations are unresourced and unrealistic

I understand where Robert Francis QC is coming from, but I don't think it is feasible.

GPs do look at what happens to their patients when they are admitted. I, for example, have frequently raised issues when things have not been done properly, or raised complaints about poor care where appropriate.

But he is asking us to do this in a much more systematic way. This requires a whole new stream of work and we don't have any mechanisms with which to identify these concerns.

This is another example where lots of work is being put at the door of GPs without any resources. At the moment there are no such systems at all in GP practices. We are totally dependent on, and only see, the patient's discharge letter.

I don't have a problem with rethinking how GPs define their role – maybe it is something that we need to be concerned about. But could GP monitoring prevent another Mid Staffs? That's just conjecture, really. The point about Mid Staffs is that no one questioned it, and the issue is who is best to do that.

> This is another example of work being put at the door of GPs

It is possible that CCGs should have that responsiblity, and perhaps could set up systems to do this. The logical thing when you talk about monitoring patterns is that it is going to be the commissioning groups that need to develop that.

If patients are going to do an 'exit interview', which hospitals say they will, then you might argue that is something commissoners need to look at when they make decisions about the hospital.

I would not write the idea off, but it requires a level of analysis and sophistication that is quite complex. We have already got enough to do with planning and commissioning services, let alone monitoring them.

Professor Aneez Esmail is a professor of general practice at the University of Manchester. His research has focused on patient safety, including the Shipman Inquiry

More opinions online

'Book prescriptions' won't work without guided support from GPs
Dr Martin Brunet says many GPs are already offering 'book prescriptions', but argues that the campaign still lacks the practical detail it needs to take off
pulsetoday.co.uk/brunet

Debate: will the dementia DES benefit patients?
Dr Alec Turnbull says the proposed dementia DES will improve patients' quality of life, but Dr John Cosgrove argues that case finding is not enough
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The profession must face up to the reality of GP burnout
GPs must be honest about the stess and mounting workload they face, and should be taught coping strategies, writes Dr Sara Khan
pulsetoday.co.uk/khan

McCARTNEY

When listening matters most

The Mid Staffordshire scandal was an object lesson in the danger of relying too heavily on data and box-ticking, writes Margaret

Dr Margaret McCartney is a GP in Glasgow

How did it happen? The Francis report on the Mid Staffordshire hospital scandal is at best uncomfortable reading, at worst, horrendous. People died needlessly because of poor care. Why?

There has been debate recently about how useful hospital standardised mortality ratios (HSMRs) really are. But it is clear that the rates at Mid Staffordshire were higher than expected as far back as 2001.

There are multiple problems in pulling reliable data from existing coding systems. The trust spent time and money investigating mortality statistics and wrongly identified coding errors rather than substandard care as responsible for the apparently high mortality rates. Making changes to coding practice was considered to be the best solution. It wasn't until 2008 that the Healthcare Commission launched a full investigation.

But look again and the warning signs were all there. In 2001, the chief executive of South Western Staffordshire PCT warned the hospital leadership was not competent. In January 2002, a clinical governance review recommended urgent action over a range of concerns. In 2003, another review noted inadequate medical and nursing staffing. Junior doctors had been removed from position because of concerns over training. Staff were 'utterly demoralised' and 'facing a chronic lack of manpower'. The medical director told the inquiry 'a quick walk around the wards would have shown... there was cause for concern'.

Evidence-based medicine is in my blood. I like numbers. I like robust proof. But no matter what the HSMR had been, the story on the ground was there to be heard. If patients are left to soil themselves or go unfed, if staff are demoralised and distressed, this is what we should have been hearing. That evidence was there. But who was listening?

People tend to go into medicine or nursing because they have a desire to do something useful. So what happens when the professional culture goes sour? I was thinking about this today when I caught myself worrying about all the contract indicators I was missing. I was torn between what would tick boxes and what would be best for my patients.

> A quick walk around the wards would have shown there was cause for concern

What would happen if we ditched the QOF and made appointments 15 minutes long? What if we collected the data we thought clinically useful, and peer reviewed each other, supporting ourselves and our colleagues? What if we asked our patients to help us do what we said we wanted to do in our interview at medical school – deliver our work as a vocation?

As the QOF drives its fingernails under the skin of the consultation, we get further away from centring what we do on patients. We look at the computer instead. I hate it. We have less time to listen, and less time to hear. This was at least part of the problem in Mid Staffordshire: numbers mattered more.

The skill of GPs is being squeezed out by the demands of the contract. We are being pushed harder to meet tighter targets. But what are we doing? And who is it for?

ONLINE

Read more of Dr McCartney's columns at pulsetoday.co.uk/mccartney

COPPERFIELD

I'm with Stupid, unfortunately

After a quarter of a century in general practice, Copperfield has given up hope that patients will develop any common sense

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

I'll come straight to the point. Patients: they're a bit stupid, aren't they? I've spent more than 25 years in general practice waiting for them to up their game. But I'm starting to think it's hopeless.

True, just occasionally they can be something other than stupid. Take today, for example. I saw one patient who was quick and one who was honest. The quick one was a young woman who, I pointed out, had now attended twice claiming that her dihydrocodeine-containing handbag had been stolen. 'And yet,' I said smugly, 'I've never seen you with a handbag.' 'That's because they've all been nicked,' she shot back, which is smarter and less expletive-riddled than you'd expect from a junkie.

The honest one? A middle-aged man who phoned about his Viagra. 'I'm afraid there's a problem at your end,' he said. No, I thought, there's a problem at your end, that's why you're taking a phosphodiesterase type-5 inhibitor, but carry on. It turned out we'd forgotten to tick the 'private prescription' box on the computer, so his last few FP10s had been free on the NHS. 'Actually,' he said, 'it was my wife who made me phone,' which put a different slant on the situation, while rendering him even more honest. And a bit poorer.

So, some are quick and honest. But mostly, as I survey the wreckage of the day, they are stupid. There is, of course, the low-grade stupidity of glazed-eyed punters who need me to explain what the combination of sore throat, runny nose and cough might possibly add up to, and who also presumably need reminding not to stick their moistened fingers in the plug socket.

And there's the acute-on-chronic stupids, whose denseness deserves wider dissemination for posterity. Hence:

Patient 1, a 70-year-old man who's had a stiff and creaking neck for nine – yes nine – months. No prizes for guessing he has cervical spondylosis. But a gold medal in moronalysis if you realised his underlying concern, as MRCGP hopefuls call it, is – no kidding – meningitis.

Patient 2, a 28-year-old bloke who's had a clicky and painful jaw intermittently for a year. Self-diagnosis? Tetanus. My diagnosis? Slack-jaw.

> Presumably they also need reminding not to stick wet fingers in a plug socket

Where would you rate these examples, stupidity-wise, on a scale of one to monumental? I don't mean to be unkind. I know they don't have medical degrees. But I'm not a mechanic, and yet if my car won't start in the morning, I don't automatically assume it's been written off by a truck, do I?

It's possible, of course, that my perception's distorted. Maybe GP attenders are skewed towards the stupid end of the spectrum. Perhaps we don't see the sensible ones who piece together their symptoms intelligently and decide they don't need to bother a doctor. Then again, maybe they really are all a bunch of malingering, neurotic stupids.

And if my appraiser is reading this, a) See you soon and b) Don't worry that I'm showing signs of burn-out. I've always been like this.

ONLINE

Read Copperfield's blog at pulsetoday.co.uk/copperfield or follow him on Twitter @DocCopperfield

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1. Jones PW *et al.* Aclidinium Bromide in Patients with Chronic Obstructive Pulmonary Disease: Improvement in Symptoms and Health Status in the ATTAIN Study. Poster presented at the American College of Chest Physicians Annual Congress, Honolulu, Hawaii, USA, October 22-26, 2011. **2.** Kerwin EM *et al.* COPD 2012, 9(2):90–101. **3.** EKLIRA GENUAIR Summary of Product Characteristics 2012. **4.** Beier J *et al.* Thorax 2012, 67: A26-A27. **5.** Karabis A *et al.* Poster presented at ISPOR 15th Annual European Congress, Berlin, Germany, 3-7 November 2012. **6.** Chrystyn H *et al. Int J Clin Pract.* 2012;66(3):309-17. **7.** MIMS September 2012.

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Date of preparation: January 2013

CLINICAL

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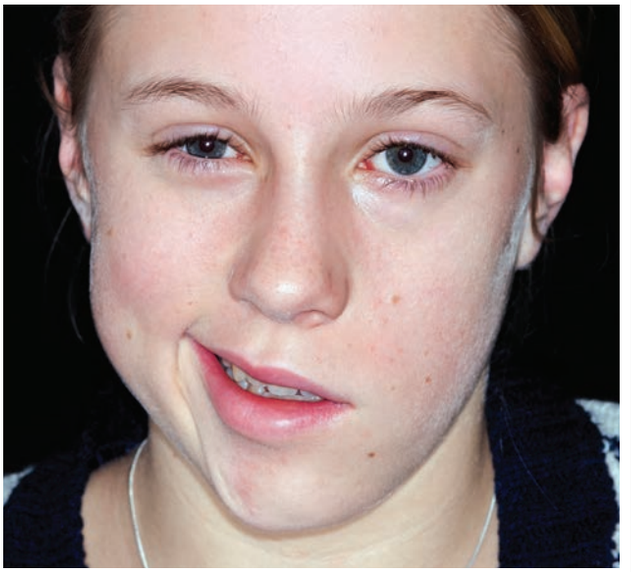

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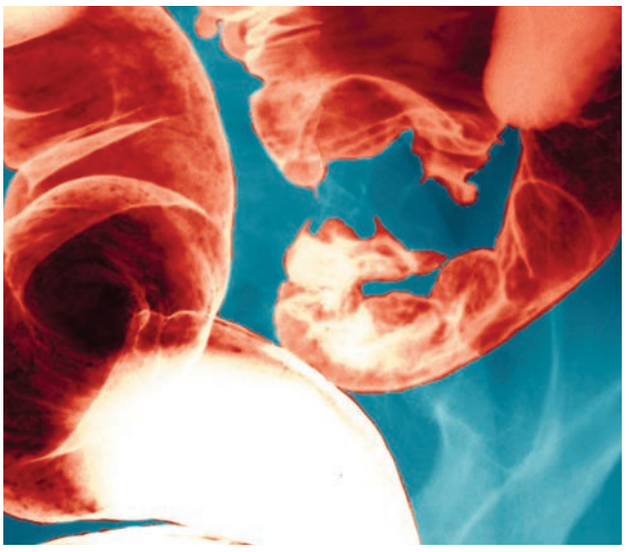

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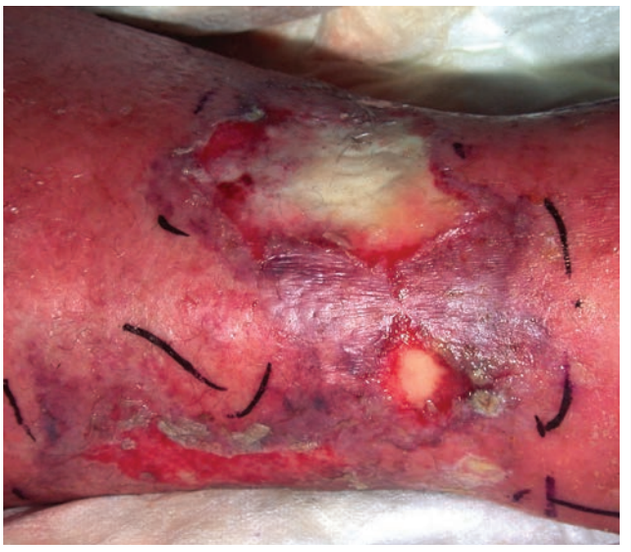

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KEY QUESTIONS

Type 2 diabetes

Professor Roger Gadsby answers GP Dr David Russell's questions on prescribing aspirin, metformin, and human and analogue insulin

Q What is the current evidence on prescribing aspirin 75mg daily in patients with type 2 diabetes for primary prevention?

A The latest evidence and guidance does not support the use of aspirin for primary prevention in people with diabetes.

NICE 2008 guidelines[1] suggested that aspirin 75mg should be offered to patients with diabetes aged over 50 with a blood pressure above 145/90mmHg, and to those younger than 50 with other significant risk factors. But the evidence base has changed since this guidance was published – new evidence has shown the benefits of low-dose aspirin in primary prevention in people with diabetes do not exceed the risks, for example gastrointestinal bleeding.

SIGN guidance published in March 2010[2] says that aspirin should not be used in primary prevention.

Q Which class of antihypertensive drugs should be used first line in patients with type 2 diabetes aged over 55 years – ACE inhibitors or calcium channel blockers?

A ACE inhibitors should be used first line in patients with type 2 diabetes aged over 55 years. The NICE guideline update on type 2 diabetes[3] recommends that an ACE inhibitor (or ARB, if ACE inhibitor is not tolerated) should be the first-line therapy. These agents lower blood pressure and there is evidence that they give renal protection. Patients with diabetes on an ACE inhibitor (or ARB) are less likely than patients taking either nothing, or calcium channel blockers to develop microalbuminuria – or if they already have it, this is less likely to progress to frank proteinuria or end-stage renal failure.

NICE diabetes recommendations do not make any distinction between patients over or under the age of 55 years. This age recommendation comes from the general NICE hypertension guidelines which do not specifically cover people with diabetes.

Q NICE advocates human rather than analogue insulins first line in those with poor glycaemic control on oral drugs, but many GPs are less comfortable with human insulin than analogue. Also, I understand that insulin glargine is coming off patent soon. Could you offer any pragmatic advice on this?

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A NICE[3] recommends that for most people with type 2 diabetes who require insulin:
- insulin therapy should be initiated from a choice of a number of insulin types and regimens
- treatment should preferably begin with human NPH insulin taken at bed-time or twice daily according to need.

NICE[3] also recommends that long-acting insulin analogues can be considered as an alternative for patients:
- who require assistance from a carer or healthcare professional to administer their insulin injections (NPH often needs to be administered twice daily)
- whose lifestyle is significantly restricted by recurrent symptomatic hypoglycaemia
- who would otherwise need twice daily basal insulin injections.

So, there are circumstances where starting with an analogue basal insulin is recommended, although NICE must have felt that the evidence of benefit for basal analogue insulin over NPH did not justify the cost difference in most patients.

Insulin glargine is due to come off patent in the next couple of years. We will have to wait until generic long-acting basal analogue insulins are launched to see if their cost becomes similar to the current NPH insulins.

Remember that NICE guidelines are advisory, so if an individual prescriber feels that their experience and expertise is in initiating one type of basal insulin, and that that insulin is the best one for their patient, they have a reason and defence for that clinical action.

Q Given the rarity of lactic acidosis, at what level of renal impairment should metformin be withdrawn? Our local nephrologists have suggested rather higher levels of creatinine – and lower eGFR – than usually suggested.

A Metformin is safe down to an eGFR of 30 ml/min/1.73m², but probably with a dose reduction when the eGFR is below 50.

The balance has to be drawn between not denying people with mild to moderate renal impairment the benefits of taking metformin, and the perceived increased risk of lactic acidosis if metformin accumulates in patients with severe renal impairment.

Research I've been involved with – due to be published soon – suggests that it is fine to use metformin at full dose with an eGFR at or above 50. It is safe to use it

down to an eGFR of 30 but with a maximum dose of 1g daily.

Metformin should only be used where eGFR is below 30 with the agreement of a specialist and where the risks and benefits have been assessed and agreed to be in favour of its use.

Q What factors would make you consider that a patient may not have type 2 diabetes but may have type 1 diabetes or maturity onset diabetes of the young? How can we make these alternative diagnoses?

A In most cases, it is possible to distinguish between type 1 and type 2 diabetes by the age at first presentation, the symptoms at presentation, the presence of ketonuria and the need for insulin to control hyperglycaemia.

It can be difficult to differentiate between type 1 and type 2 when diabetes presents acutely but without ketosis in adults.

It is wise to always consider the possibility that such an individual might have type 1 diabetes, and to follow them very closely until it becomes clear that they do have type 2 diabetes.

The genetic forms of diabetes (which include maturity onset diabetes of the young) tend to have a very strong multigenerational family history.

Some people with maturity onset diabetes of the young who present in young adulthood may be wrongly diagnosed as having type 1 diabetes. Others may present under the age of 45 with apparent having type 2 diabetes, but without features of insulin resistance.

The diagnosis is made by sending samples for molecular genetic testing. It is important to make the diagnosis of maturity onset diabetes of the young as sulfonylurea therapy is the effective treatment for the most common forms, and if the patient is using insulin therapy it can be stopped.[4]

Q When should bariatric surgery be considered in patients with type 2 diabetes? Patients who've had successful bariatric surgery sometimes appear to have their diabetes 'cured' – their sugars normalise to the extent that they can stop their treatment. Are they still 'diabetic'?

A The role of bariatric surgery as a treatment for type 2 diabetes requires more research and no definitive consensus about its role has yet been reached.

Obese people with type 2 diabetes who have undergone bariatric surgery, and who lose a lot of weight, may be able to stop glucose-lowering medications and may have HbA_{1c} levels in the normal range.

This can also happen after very significant weight loss through dieting.

'Diabetes in remission' is the preferred term, rather than 'cured', as diabetes is likely to recur if the person regains enough weight.

References

1 NICE. Type 2 Diabetes. 2008.CG66

2 SIGN. Management of diabetes. 2010. SIGN 116

3 NICE. Type 2 diabetes (rapid update of glycaemic lowering section of CG66). 2009. CG87

4 Thanabalasingham G and Owen KR. Diagnosis and management of maturity onset diabetes of the young (MODY). *BMJ*, 2011;343:837-842

5 Holman RR, Paul SK, Bethel MA et al. 10-year follow up of intensive glucose control in type 2 diabetes. *N Engl J Med*, 2008;359:1577-1789

EXTRA ONLINE

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It is important to ensure that these patients are still offered annual screening for diabetes macrovascular and microvascular complications as they will continue to be at risk from these.

Q Should glitazones ever be initiated now in the UK given their withdrawal for safety reasons in other parts of the world?

A NICE[3] recommends that glitazones (pioglitazone is the only one available in the UK) be considered as second-line agents, with a DPP4 agent as the other possible choice, to be added to metformin where there is a significant risk of hypoglycaemia or its consequences.

This guideline also recommends that a glitazone be considered as a possible third-line agent to be added to metformin plus sulfonylurea.

Rosiglitazone – which was the other glitazone launched in the UK – was withdrawn worldwide in 2010 because of an increased risk of cardiovascular ischaemic events.

There is evidence from a randomised controlled trial and a number of observational studies that pioglitazone reduces the risk of cardiovascular ischaemic events.

Evidence has emerged that there is an association between pioglitazone use and increased risk of bladder cancer.

A warning to this effect has been issued by the regulatory authorities in Europe, but they considered that pioglitazone still had a place in therapy and did not order its removal from the market. Though it has been withdrawn in France.

Pioglitazone came off patent nearly 12 months ago and its price has dropped significantly, helping to support cost-effectiveness discussions.

Q How important is it to achieve early good glycaemic control in diabetes?

A It is important to achieve early good glycaemic control in patients who are newly diagnosed with diabetes.

The follow-up evidence from the UK Prospective Diabetes Study[5] suggests that getting patients to an HbA_{1c} of 7% and keeping them there for as long as possible reduces cardiovascular disease events in the long term.

There is no benefit in getting people with diabetes for 10 years or more down from an HbA_{1c} of 7.5% to 6.5% – and it may cause harm.

In observational studies the best outcomes are obtained when people have HbA_{1c} levels in the 7% to 7.5% range.

Professor Roger Gadsby is a GP and associate clinical professor at the University of Warwick. Professor Gadsby is GP lead for National Diabetes Audit and primary care lead for NHS diabetes. He was on the guideline development group for the 2008 NICE diabetes guideline. Dr David Russell is a GP in Darlington

THE INFORMATION

Bell's palsy

Mr Christopher Skilbeck and Mr Rupert Obholzer

advise on a case using PUNs and DENs

The patient's unmet needs (PUNs)
A 20-year-old woman who is otherwise well and on no medication, presents with a two-day history of weakness on the left side of her face. She has self-diagnosed Bell's palsy – which you confirm on examination. Her eye on the affected side is sore, though vision is normal. She has discovered that some doctors advise aciclovir because the palsy may be caused by *Herpes simplex* virus. She wants to know your view – and whether she should have a course of steroids.

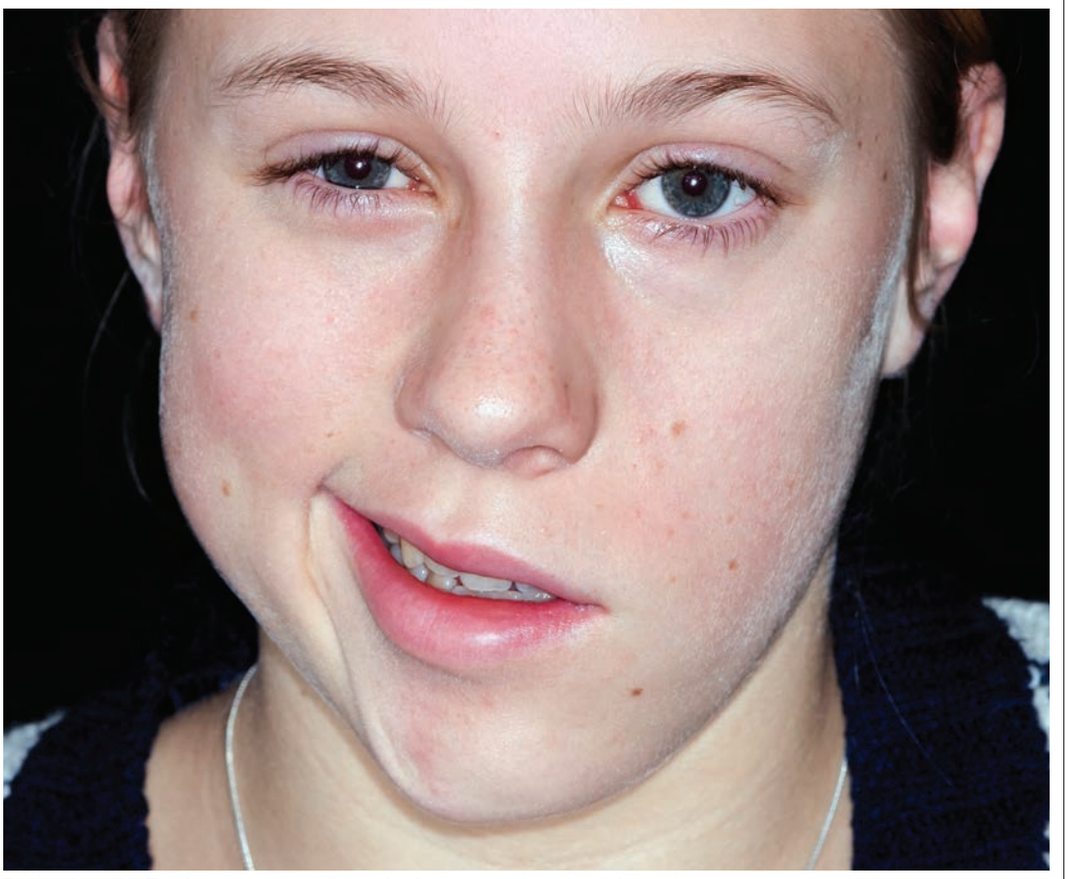
The doctor's educational needs (DENs)

How common is Bell's palsy and what are the current theories of causation?
Bell's palsy – a partial or complete idiopathic lower motor neurone facial paralysis – has an incidence of between 11 and 40 per 100,000 per year. Around two-thirds of cases of acute facial weakness are truly idiopathic. The peak incidence is between 30 and 50 years of age, with an equal male-to-female ratio.

The aetiology is unclear, but an infectious origin is most likely, triggering an immunological response which leads to neuronal injury. HSV has been implicated, but HSV type 1 can be isolated from 86% of human geniculate ganglion cells with no history of facial palsy.

How can the GP confidently exclude other causes for this type of symptom?
The classical Bell's palsy history is of a short duration. Patients report pain on the affected side, which may be post-auricular. Subsequently, they develop weakness that peaks within 48 hours. Slower onset, or progressive weakness, suggests a more sinister cause.

Clinical examination should confirm the lower motor neurone weakness. The ears and neck, including the parotid gland and facial skin, should be carefully examined. An assessment of the patient's eye closure is mandatory. Finish with a full cranial nerve examination. If this reveals no other abnormalities, the diagnosis is very likely to be Bell's palsy.



Patients with Bell's palsy should be started on oral corticosteroids as soon as possible

ONLINE

Hot topics in headache
2 CPD HOURS
pulse-learning.co.uk

References
1 Sullivan FM, Swan IRC, Donnan PT et al. Early treatment with prednsiolone or aciclovir in Bell's palsy. *N Engl J Med* 2007; 357:1598-1607

Further reading
- Davenport RJ, McKinstry B, Morrison JM et al. Bell's palsy: new evidence provides a definitive drug therapy strategy. *Br J Gen Pract* 2009;59:569-70
- Salinas RA, Alvarez G, Daly F and Ferreira J. Corticosteroids for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. 2010
- Lockhart P, Daly F, Pitkethly M et al. Antiviral treatment for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. 2009

What treatment should be offered? How time-sensitive are these treatments?
Patients with clear or suspected Bell's palsy should be started on oral corticosteroids as soon as possible after onset, ideally within 72 hours. This treatment improves outcomes, but there is no additional benefit from antiviral regimens, according to a trial that compared antivirals with corticosteriods, and we would not recommend them[1]. The treatment arm of the study used prednisolone as a single 25mg tablet, taken twice daily for 10 days. There is no evidence of benefit of steroids initiated later than 72 hours, but we would consider trying them up to two weeks.

Antiviral medication is mandated in Ramsay-Hunt syndrome – suggested by vesicles around the pinna or in the mouth, on the tongue or on the palate.

What potential ocular complications are there? How can GPs prevent or treat them?
Patients with severe weakness and incomplete eye closure may experience corneal exposure, leading to drying and trauma, and irreversible ulceration can occur. So, in addition to pharmacological treatment, eye care with lubrication is appropriate – taping at night and daytime eye protection are advised.

What is the prognosis of Bell's palsy, and do certain patient groups have a worse outlook than others? What are the possible long-term complications?
Most patients with Bell's palsy will recover well, but up to 30% will have a poor outcome with persistent facial weakness and associated psychological distress. One study showed 72% of those treated with prednislone returned to normal movement at 12 months. Those who do not receive steriods can expect a resolution rate of less than 60%.

Sometimes reinnervation of the target muscles occurs in a haphazard way, and synkinesis – the involuntary movement of one part of the face while attempting to move another, for example the mouth moving on tight eye closure – may result.

Pregnancy appears to protect women from Bell's palsy, although pregnant women who are affected seem to have a worse prognosis. Poor prognosis is also associated with complete paralysis, slow recovery and older age. Idiopathic facial palsy is recurrent in up to 15% of cases. Care should be taken to exclude a middle ear or skull base cause. Referral is recommended for any patient where clinical examination suggests another cause, those with incomplete recovery and when the palsy is recurrent.

Mr Christopher Skilbeck is an ENT/skull base fellow and Mr Rupert Obholzer is a consultant ENT/skull base surgeon at Guy's & St Thomas' Hospitals, London

- *This article was produced with Facial Palsy UK – a new charity dedicated to providing information and supporting patients and their families. For more information visit: facialpalsy.org.uk*

SCIENCE PHOTO LIBRARY

Your VTE patients might be home but they may not be dry

Fragmin® is the only LMWH licensed for extended treatment of symptomatic VTE and prevention of its recurrence in solid tumour patients[1]

In addition, Fragmin® has a broad range of indications with approved licences for:

- Treatment of VTE[2]
- Surgical and medical thromboprophylaxis[3]
- Unstable angina and NSTEMI[4]
- Haemodialysis and haemofiltration[5]

Recurrent VTE is three times more frequent in patients with cancer versus patients without cancer[6]

VTE can complicate the management of patients with cancer and increase morbidity[7–9]

Fragmin®
dalteparin sodium

Extended treatment of VTE with Fragmin® halves the relative risk of recurrent DVT/PE versus VKA* in patients with solid tumours at 6 months[10†]

* Warfarin was used in all but two countries in the Fragmin® CLOT study.[10]
† HR: 0.48; 95% CI: 0.30–0.77; P=0.002; ARR: 8%.[10]
ARR: absolute risk reduction. LMWH: low molecular weight heparin. NSTEMI: Non-ST elevation myocardial infarction. VKA: vitamin K antagonists. VTE: venous thromboembolism, including deep vein thrombosis (DVT) and pulmonary embolism (PE).

Date of preparation: November 2012. UK/FRA/12/0058. Page 1 of 2

Pfizer

Prescribing information, adverse event reporting information and references can be found overleaf.

FRAGMIN® ▼ (dalteparin sodium) ABBREVIATED PRESCRIBING INFORMATION ALL PRESENTATIONS AND INDICATIONS (See Fragmin Summary of Product Characteristics for full Prescribing Information). Treatment of VTE Fragmin 7,500 IU, 10,000 IU, 12,500 IU, 15,000 IU, 18,000 IU single-dose syringes containing dalteparin sodium 7,500 IU in 0.3 ml; 10,000 IU in 0.4 ml; 12,500 IU in 0.5 ml; 15,000 IU in 0.6 ml; 18,000 IU in 0.72 ml. **Indication:** Treatment of venous thromboembolism (VTE) presenting clinically as deep vein thrombosis (DVT), pulmonary embolism (PE) or both. **Dosage and Administration:** By subcutaneous (s.c.) injection. *Normal risk of bleeding:* single daily dose to match bodyweight: <46 kg — 7,500 IU; 46-56 kg — 10,000 IU; 57-68 kg — 12,500 IU; 69-82 kg — 15,000 IU; ≥83 kg — 18,000 IU. Single daily dose should not exceed 18,000 IU. **Fragmin 10,000 IU/1 ml Ampoules** containing 10,000 IU dalteparin sodium in 1 ml. **Fragmin 100,000 IU/4 ml Multidose Vial** containing 100,000 IU dalteparin sodium in 4 ml with benzyl alcohol. **Indication:** Treatment of venous thromboembolism (VTE) presenting clinically as deep vein thrombosis (DVT), pulmonary embolism (PE) or both. **Dosage and Administration:** By s.c. injection. *Normal risk of bleeding:* Fragmin 200 IU/kg s.c. once daily. Single daily dose should not exceed 18,000 IU. *Increased risk of bleeding:* Fragmin 100 IU/kg s.c. twice daily, up to a maximum total daily dose of 18,000 IU. For VTE treatment, anticoagulant monitoring is generally not necessary. Simultaneous anticoagulation with oral vitamin K antagonists can start immediately. Continue Fragmin until prothrombin complex levels have decreased to a therapeutic level – usually at least 5 days of combined treatment. **Legal Category:** POM. **Basic NHS Prices:** *10 prefilled syringes:* 7,500 IU/0.3 ml £42.34; *5 prefilled syringes*: 10,000 IU/0.4 ml £28.23; 12,500 IU/0.5 ml £35.29; 15,000 IU/0.6 ml £42.34; 18,000 IU/0.72 ml £50.82. *For 10 ampoules:* 10,000 IU/1 ml £51.22. *For 1 Multidose Vial:* 100,000 IU/4 ml £48.66. **PL Numbers:** 7,500 IU/0.3 ml 00057/0985. 10,000 IU/0.4 ml 00057/0976. 12,500 IU/0.5 ml 00057/0980. 15,000 IU/0.6 ml 00057/0981. 18,000 IU/0.72 ml 00057/0982. 10,000 IU/1 ml Ampoules 00057/0977. 100,000 IU/4 ml Multidose Vial 00057/0979. **Surgical Thromboprophylaxis Fragmin 2,500 IU/0.2 ml** or **Fragmin 5,000 IU/ 0.2 ml single-dose syringes** containing dalteparin sodium. **Indication:** Peri- and post-operative surgical thromboprophylaxis. **Dosage and Administration:** By s.c. injection. *Moderate risk of thrombosis:* Fragmin 2,500 IU s.c. 1-2 hours before surgery; thereafter 2,500 IU s.c. once daily in morning until full ambulation (usually 5-7 days). *High risk of thrombosis:* Fragmin 2,500 IU s.c. 1-2 hours before surgery; then again 8-12 hours later. Thereafter, 5,000 IU s.c. once daily in morning until full ambulation (usually 5-7 days). Alternatively, 5,000 IU Fragmin s.c. on evening before surgery, then 5,000 IU s.c. on each subsequent evening. Prolonged thromboprophylaxis in hip replacement surgery: 5,000 IU Fragmin s.c. on evening before surgery, then 5,000 IU s.c. on each subsequent evening up to 5 weeks post-operatively. If Fragmin is to be commenced post-operatively the first dose of Fragmin (2,500 IU) should be administered as soon as the perceived risk of bleeding is no longer present. **Legal Category:** POM. **Basic NHS Prices:** *10 prefilled syringes:* 2,500 IU/0.2 ml £18.58; 5,000 IU/0.2 ml £28.23. **PL Numbers:** 2,500 IU/0.2 ml 00057/0983; 5,000 IU/0.2 ml 00057/0984. **Medical Thromboprophylaxis Fragmin 5,000 IU/0.2 ml single-dose syringes** containing dalteparin sodium. **Indication:** The prophylaxis of proximal DVT in patients bedridden due to a medical condition, including, but not limited to: congestive cardiac failure (NYHA class III or IV), acute respiratory failure or acute infection, who also have a predisposing risk factor for venous thromboembolism such as age over 75 years, obesity, cancer or previous history of VTE. **Dosage and Administration:** 5,000 IU s.c. once daily prescribed for up to 14 days. **Legal Category:** POM. **Basic NHS Prices:** *10 prefilled syringes* 5,000 IU/0.2 ml: £28.23. **PL Number:** 00057/0984. **Haemodialysis or Haemofiltration Fragmin 10,000 IU/ 1 ml or Fragmin 10,000 IU/4 ml Ampoules** containing dalteparin sodium 10,000 IU in 1 ml and 10,000 IU in 4 ml. **Indication:** Prevention of clotting in the extracorporeal circulation during haemodialysis or haemofiltration, in patients with chronic renal insufficiency or acute renal failure. **Dosage and Administration:** In chronic renal insufficiency with no known additional bleeding risk: *Long-term haemodialysis or haemofiltration (more than 4 hours):* Fragmin intravenous (i.v.) bolus injection 30-40 IU/ kg body weight, followed by an infusion of 10-15 IU/kg body weight/hour. *Short-term haemodialysis or haemofiltration (less than 4 hours):* as above, or a single i.v. bolus injection of Fragmin 5,000 IU. For both long and short-term haemodialysis and haemofiltration the plasma anti-Factor Xa levels should be within the range 0.5-1.0 IU/ml. *In acute renal failure, or patients at high risk of bleeding:* i.v. bolus injection of Fragmin 5-10 IU/ kg body weight, followed by an infusion of 4-5 IU/kg body weight/hour and plasma anti-Factor Xa levels should be within the range 0.2-0.4 IU/ ml. **Legal Category:** POM. **Basic NHS Prices:** *For 10 ampoules:* 10,000 IU/1 ml £51.22. 10,000 IU/4 ml £51.22. **PL Numbers:** 10,000 IU/1 ml 00057/0977. 10,000 IU/4 ml 00057/0978. **Unstable Angina Fragmin Graduated Syringe 10,000 IU/ml Solution for Injection single-dose syringe** containing dalteparin sodium 10,000 IU in 1 ml. **Fragmin 10,000 IU/1 ml Ampoules** containing 10,000 IU dalteparin sodium in 1 ml. **Fragmin 7,500 IU single-dose syringes** containing 7,500 IU in 0.3 ml. **Indication:** Unstable angina and non Q-wave myocardial infarction administered concurrently with aspirin. Extended Use – beyond 8 days in patients awaiting angiography/revascularisation. **Dosage and Administration:** Duration of therapy; acute phase: 120 IU/kg body weight administered s.c. 12 hourly for up to 8 days. Maximum dose is 10,000 IU/12 hours. Extended phase: beyond 8 days, for those awaiting revascularisation, treatment is recommended to be given until the day of the invasive procedure in a fixed dose of 5,000 IU (women <80 kg and men <70 kg) or 7,500 IU (women ≥80 kg and men ≥70 kg) 12 hourly. Treatment until the revascularisation procedure but not for more than 45 days. Maximum dose 10,000 IU/ 12 hours. **Legal Category:** POM. **Basic NHS Prices:** *For 5 single-dose graduated syringes:* 10,000 IU/1 ml £28.23. *For 10 ampoules:* 10,000 IU/1 ml £51.22. *For 10 prefilled syringes:* 7,500 IU/0.3 ml £42.34. **PL Numbers:** Graduated Syringe 10,000 IU/ml Solution for Injection single-dose syringe 00057/0986. 10,000 IU/1 ml Ampoules 00057/0977, 7,500 IU single-dose syringes 00057/0985. **Extended treatment of Symptomatic Venous Thromboembolism in patients with Solid Tumours ▼ Fragmin 5,000 IU, 7,500 IU, 10,000 IU, 12,500 IU, 15,000 IU, 18,000 IU single-dose syringes** containing dalteparin sodium 5,000 IU in 0.2 ml; 7,500 IU in 0.3 ml; 10,000 IU in 0.4 ml; 12,500 IU in 0.5 ml; 15,000 IU in 0.6 ml; 18,000 IU in 0.72 ml. **Indication:** Patients with solid tumours: Extended treatment of symptomatic VTE and prevention of its recurrence. **Dosage and Administration:** Administer Fragmin 200 IU/kg total body weight s.c. once daily for month 1 (first 30 days of treatment), followed by a Fragmin dose of approximately 150 IU/kg, s.c., once daily for months 2-6 using fixed-dose syringes. Maximum daily dose should not exceed 18,000 IU. In cancer patients with body weight <40 kg at time of venous thromboembolic event, Fragmin should not be used for extended treatment of symptomatic VTE and prevention of its recurrences due to lack of data (refer to SPC for dosing tables). *Renal failure:* In the case of significant renal failure, defined as a creatinine clearance <30 ml/min, the dose of Fragmin should be adjusted based on anti-Factor Xa activity (refer to SPC for further information). In the case of chemotherapy-induced thrombocytopenia, the Fragmin dose should be interrupted/ reduced (refer to SPC for further information). **Legal Category:** POM. **Basic NHS Prices:** *10 prefilled syringes:* 5,000 IU/0.2 ml £28.23; 7,500 IU/0.3 ml £42.34; *5 prefilled syringes:* 10,000 IU/0.4 ml £28.23; 12,500 IU/0.5 ml £35.29; 15,000 IU/0.6 ml £42.34; 18,000 IU/0.72 ml £50.82. **PL Numbers:** 5,000 IU/0.2 ml 00057/0984. 7,500 IU/0.3 ml 00057/0985. 10,000 IU/0.4 ml 00057/0976. 12,500 IU/0.5 ml 00057/0980. 15,000 IU/0.6 ml 00057/0981. 18,000 IU/0.72 ml 00057/0982. **All Presentations Use in Children:** Safety and efficacy not established. **Use in Elderly:** No dose adjustment needed. **Contraindications:** Known hypersensitivity to Fragmin or other low molecular weight heparins and/or heparins; history of confirmed or suspected immunologically mediated heparin induced thrombocytopenia (Type II); acute gastroduodenal ulcer; cerebral haemorrhage; known haemorrhagic diathesis; serious coagulation disorders, septic endocarditis; injuries to and operations on the central nervous system, eyes or ears. Known hypersensitivity to benzyl alcohol for Multidose Vial presentation. In patients receiving Fragmin for treatment rather than prophylaxis, local and/or regional anaesthesia in elective surgical procedures is contra-indicated with the higher treatment doses of dalteparin. Dalteparin should not be used in patients who have suffered a recent (within 3 months) stroke unless due to systemic emboli. In cancer patients with body weight <40 kg at time of venous thromboembolic event, Fragmin should not be used for extended treatment of symptomatic VTE and prevention of its recurrences due to lack of data. **Warnings and Precautions:** Do not administer by intramuscular (i.m.) route. Due to risk of haematoma, other medicines given i.m. should be avoided for 24 hours if the dose of dalteparin exceeds 5,000 IU. Caution in conditions with increased risk of bleeding; e.g. following surgery or trauma, haemorrhagic stroke, severe liver or renal failure, thrombocytopenia or defective platelet function, uncontrolled hypertension, hypertensive or diabetic retinopathy, patients receiving concurrent anticoagulant/antiplatelet agents and in elderly patients ≥80 years may be at an increased risk of bleeding complications within therapeutic dosage ranges where careful clinical monitoring is required. Caution should also be observed at high dose treatment with dalteparin especially in patients treated for acute DVT, PE or unstable coronary artery disease. Monitoring of anti-Xa levels is not usually required but should be considered for certain special patient populations such as paediatrics, those with renal failure, those who are very thin or morbidly obese, pregnant or at increased risk for bleeding or rethrombosis. Close monitoring is recommended in the case of low and changing physiologic renal function e.g. neonates. If a transmural myocardial infarction occurs in patients where thrombolytic treatment might be appropriate, this does not necessitate discontinuation of treatment with Fragmin but might increase the risk of bleeding. Monitor plasma potassium before and during Fragmin if risk of hyperkalaemia. Careful observation and care needed for patients having spinal or epidural anaesthesia. Not recommended for use in the prevention of valve thrombosis in patients with prosthetic heart valves. Limited data are available regarding the safety and efficacy of antithrombotic therapy in patients with primary or metastatic tumours of the brain who develop concurrent thromboembolic events. There is a risk of fatal intracranial bleeding with use of anticoagulation in this category of patients. Therefore, if treatment with Fragmin is considered it should be monitored closely with regular re-assessment of the status of tumour involvement of the brain and other individual risks. Thrombocytopenia, should it occur, usually appears within 3 weeks following the beginning of therapy. It is therefore recommended that the platelet counts are measured before starting treatment with Fragmin and monitored closely in the first 3 weeks and regularly thereafter during treatment (refer to SPC for more information). Patients with severely disturbed hepatic function, significant renal failure or chemotherapy-induced thrombocytopenia may need a dosage reduction and should be monitored accordingly. Dalteparin cannot be used interchangeably (unit for unit) with unfractionated heparin, other low molecular weight heparins, or synthetic polysaccharides. The 100,000 IU/4 ml Multidose Vial contains benzyl alcohol so must not be used in premature or newborn babies. Benzyl alcohol may cause toxic reactions in infants and children up to 3 years old. Other formulations without benzyl alcohol are available. **Drug Interactions:** Care with agents affecting coagulation/platelets and NSAIDs (refer to SPC for more information). **Pregnancy and Lactation:** Dalteparin should be used during pregnancy only if clearly needed, and caution should be exercised when prescribing to pregnant women (refer to SPC for more information). *The Multidose Vial contains benzyl alcohol therefore should not be used in pregnancy.* Epidural anaesthesia during childbirth is absolutely contraindicated in women who are being treated with high dose anticoagulants. Not recommended for use in pregnant women with prosthetic heart valves. Limited data are available for excretion of dalteparin in human milk. A risk to the suckling child cannot be excluded. A decision on whether to continue/discontinue breast-feeding or to continue/discontinue therapy with Fragmin should be made taking into account the benefit of breast-feeding to the child and the benefit of Fragmin therapy to the woman. **Side Effects:** Commonly reported side effects include reversible non-immunologically-mediated thrombocytopenia (Type I), haemorrhage (bleeding at any site), subcutaneous haematoma at injection site, transient elevation of liver transaminases (ASAT, ALAT). Other side effects include: hyperkalaemia, allergic reactions, urticaria, pruritus, skin necrosis, transient alopecia, pain at injection site, immunologically mediated heparin-induced thrombocytopenia (Type II, with or without associated thrombotic complications-arterial and/or venous thrombosis or thromboembolism). (Refer to SPC for information on other side effects and post-marketing experience). **Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich KENT, CT13 9NJ, United Kingdom. Further information is available on request: Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS, United Kingdom. Date of preparation: October 2012. Company Ref: FR 6_3

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

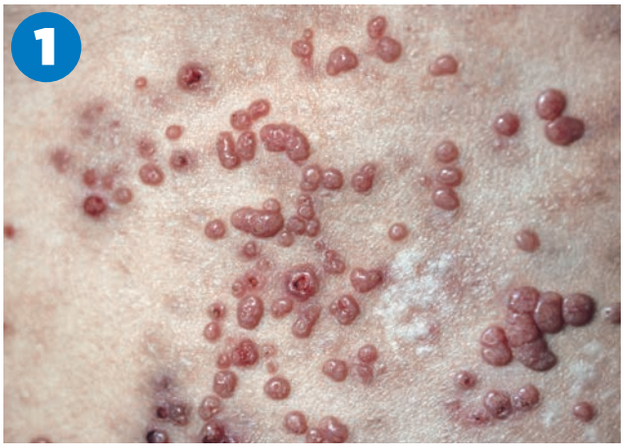
References: 1. Fragmin SmPC [Extended Treatment in Oncology (5000/18,000 IU syringes), October 2012]. **2.** Fragmin SmPC [Treatment of VTE (7500/18,000 IU syringes, 10,000 IU/1ml ampoules, 100,000 IU/4ml Multidose Vial), October 2012]. **3.** Fragmin SmPC [Medical and Surgical Thromboprophylaxis (2500 IU and 5000 IU syringes), October 2012]. **4.** Fragmin SmPC [Unstable Angina (Graduated syringe 10,000 IU/ml solution for injection, 10,000 IU/1ml ampoule, 7500 IU), October 2012]. **5.** Fragmin SmPC [Haemodialysis/Haemofiltration (10,000 IU/1ml & 10,000 IU/4ml ampoules), October 2012]. **6.** Prandoni P *et al.* Blood. 2002;100:3484–3488. **7.** Debourdeau P *et al.* Support Care Cancer. 2008;16:1333–1341. **8.** Khorana AA *et al.* Blood. 2008;111:4902–4907. **9.** Levitan N *et al.* Medicine. 1999;78:285–291. **10.** Lee AY *et al.* N Engl J Med. 2003;349: 146–153. Please refer to the eMC website for full details of Fragmin SmPCs.

Fragmin® dalteparin sodium

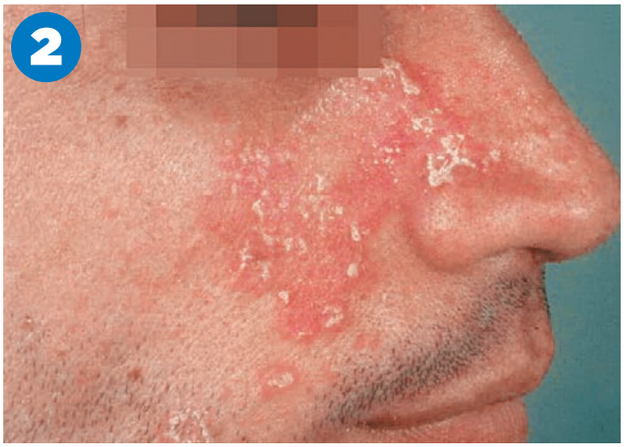
PICTURE QUIZ

Cutaneous manifestations of HIV

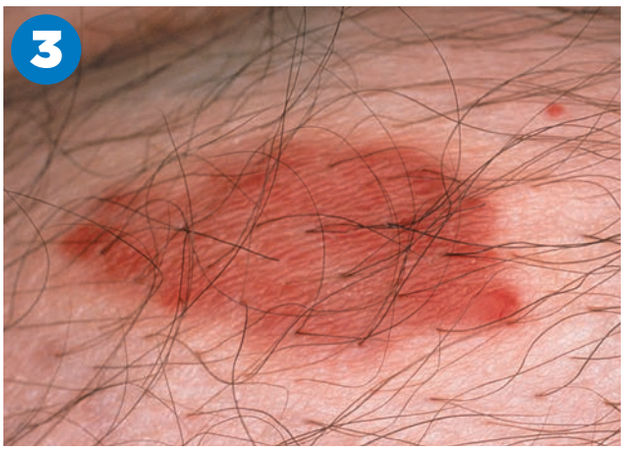
These four patients with HIV presented with cutaneous complaints – can you make the diagnoses from the pictures and case histories below?



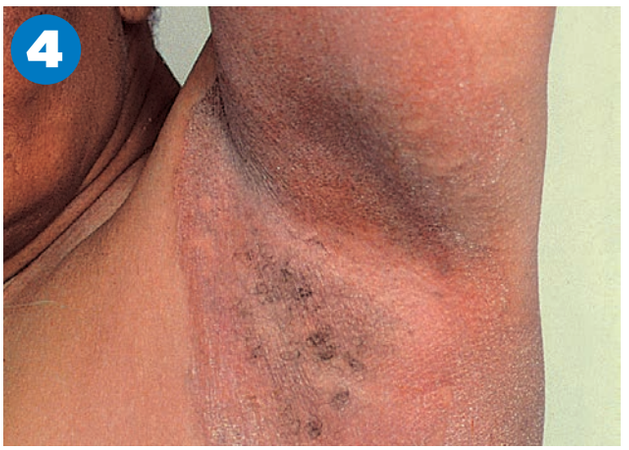
This patient has noticed the gradual development of these papular lesions on his flank over the last few months.



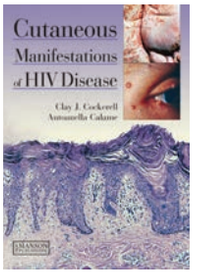
Despite using moisturisers and a mild steroid cream, this man has been unable to cure this scaly rash on his face. There is a similar rash on his scalp and behind his ears.



This bluish-red lesion has been slowly enlarging on this man's upper abdomen over the last month or two. A couple of other lesions – similar but smaller – seem to be developing on his back.



This man has been aware of this non-itchy unilateral rash in his left axilla for many weeks. A combination steroid/antifungal cream prescribed by his GP has made no difference.



These cases are taken from Cutaneous Manifestations of HIV Disease by Clay J Cockerell and Antoanella Calame. ISBN 9781840761429 (Manson Publishing); available from: www.mansonpublishing.com/colour_handbooks and all good booksellers priced £115.00

ONLINE

Key questions on HIV
1.5 CPD HOURS
pulsetoday.co.uk/kq-hiv

Answers

1 Molluscum contagiosum
Molluscum contagiosum is a viral infection almost universally encountered in sexually active people with HIV. Most lesions are self-limiting – typically white, pink, or skin-coloured umbilicated, raised papules. HIV-positive patients may develop giant lesions. Molluscum contagiosum in HIV patients is hard to treat – the most widely used methods are curettage and cryosurgery.

2 Seborrhoeic dermatitis
Seborrhoeic dermatitis consists of slightly indurated erythematous patches usually with abundant greasy scale. It usually causes moderate discomfort, but in HIV-infected patients has a propensity to be more severe with thicker scale. Therapy centres around topical antifungal and corticosteroid preparations. Treatment of HIV-associated seborrhoeic dermatitis mirrors that of ordinary seborrhoeic dermatitis.

3 Kaposi's sarcoma
Kaposi's sarcoma is the most frequent neoplastic disorder in HIV-infected patients – and is an AIDS-defining condition. Early lesions appear as violaceous or yellowish-green ecchymotic macules and patches that may simulate trauma, insect bite reactions, or dermatofibromas. In time, these enlarge or become confluent.

4 Erythrasma
Erythrasma is a cutaneous bacterial infection – generally presenting as a red, scaly plaque with well demarcated borders. The lesion may advance and change from red to brown with an area of central clearing. It is usually not self-limiting and may last weeks or months. Erythromycin is usually effective.

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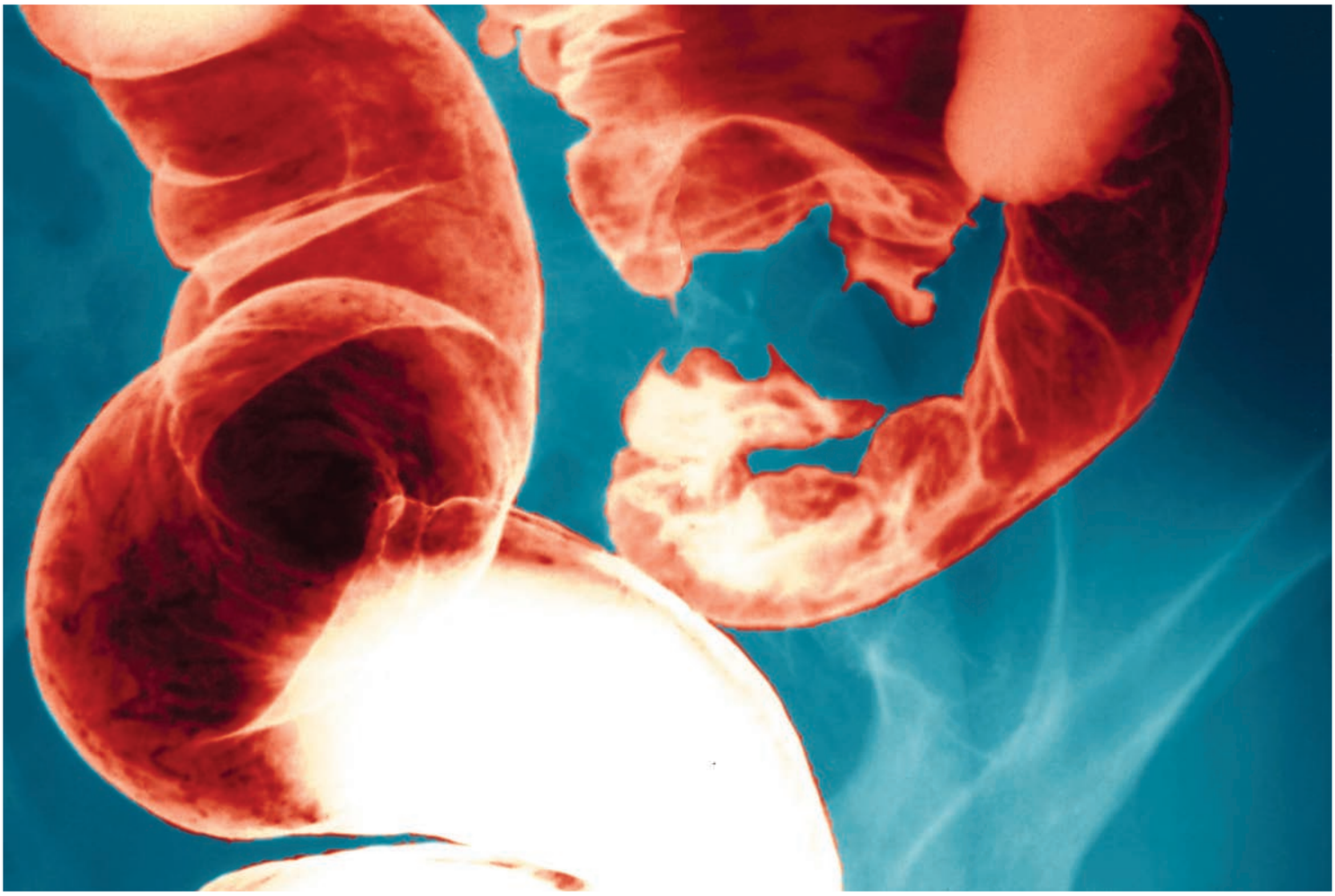
PRACTICAL GENETICS



Cancer genetics

Genetics GPSI Dr Judith Hayward advises on how to manage patients with a family history of bowel and other cancers – the rest of her series will follow online

Increasing public awareness of a genetic predisposition to some cancers is leading to family history being frequently raised with GPs.

This article discusses two patients with a family history of bowel and other cancers – including risk assessment and management of those in different risk categories.

The next article in this series will consider family history of breast and ovarian cancer – this will be published on pulsetoday.co.uk on 8 March.

Case one

Mrs H attends soon after her mother's death. Her mother had been diagnosed with bowel cancer several years earlier at the age of 62. Mrs H is concerned about her risk.

Most cancers are sporadic, resulting mainly from environmental factors – such as smoking and HPV – or due to chance. Hereditary cancer syndromes, which usually follow an autosomal dominant inheritance pattern, only account for around 5-10% of cancers. Family history is the main tool in identifying families at high risk – young age, multiple cancers of the same site, and multiple family members affected are suggestive of an underlying cancer syndrome.

The British Society of Gastroenterology (BSG) guidelines[1] outline identification and surveillance of those at above-population risk of colorectal cancer, and local guidelines may also exist. Because Mrs H only has one relative affected at over 50 years of age, and there is no family history of associated cancers (see table opposite, top), then she is likely to be at normal population risk.

Give Mrs H reassurance and information – specifically about red flag symptoms for colorectal cancer.

- If the family history alters, risk may alter and the patient should return to seek further advice.
- Advise patients to return if they develop red flag symptoms.
- Encourage patients to take part in the NHS Bowel Cancer Screening Programme – every two years from the age of 60-69.
- Offer lifestyle advice about weight, smoking, alcohol intake and exercise.

1 CPD HOUR

Go online to complete this article as a CPD module
This module will be available free to all members of Pulse Learning until 14 March
pulse-learning.co.uk

SCIENCE PHOTO LIBRARY

Above-population risk of colorectal cancer

Number of family members affected	Cancer type	Minimum degree of relationship	Average age of diagnosis
1	Colorectal	First-degree relative	Over 50
2	Colorectal	First-degree relatives (includes both parents)	Any age
3	Colorectal (although up to two may be related cancers*)	First- or second-degree relatives (at least one must be first-degree)	Any age

*Related cancers include endometrial, ovarian, small bowel, renal or bladder, biliary tract, thyroid, or sebaceous adenoma or bowel polyps.

Risks and surveillance in patients with HNPCC

Cancer type	Approximate lifetime risk	Suggested surveillance
Colorectal cancer	80% (men) 40% (women)	colonoscopy every one to two years from age 25
Gastric cancer	10%	gastroscopy every two to three years from age 50-75
Endometrial cancer	50% (women)	none – symptom awareness and vigilance
Ovarian cancer	10% (women)	currently not recommended
Urinary tract cancer	1-4%	No current consensus: an example may be annual surveillance from age 40 via renal ultrasound, intravenous urogram +/- cystoscopy.

Reducing intake of red meat – particularly processed – will lower risk.
- Signpost to further support and information, for example Macmillan: macmillan.org.uk/cancerinformation and Cancer Research UK: cancerresearchuk.org.uk.

Mrs H reattends a few months later because her brother had rectal bleeding shortly after her mother died, and has now been diagnosed with bowel cancer at the age of 42.
Mrs H now has two first-degree relatives affected and is at above-population risk. She should be referred to a regional genetics service, local gastroenterology unit or a community family history clinic, depending on what's available locally.

Surveillance would be offered with regular colonoscopies. The age at which they start and their frequency would depend on risk category.

The BSG guidelines[1] suggest that individuals at low to moderate risk are offered a colonoscopy at age 55, or as soon as they present after the age of 55. Those at high to moderate risk are usually offered colonoscopies every five years from the age of 50-75.

Mrs H then returns again, having found out that her mother's sister died of endometrial cancer.
Mrs H now has three relatives affected by colorectal and related cancers. Any patient in this situation should be offered referral to the regional genetics service.

Ovarian and endometrial cancer can occur within another cancer syndrome – hereditary non-polyposis colorectal cancer (HNPCC). The same management principles apply to HNPCC as to other hereditary cancer syndromes – increased surveillance, and prophylactic oophorectomy and hysterectomy as HNPCC carries a 10% and 50% lifetime risk of ovarian and endometrial cancer respectively. The table above outlines the risks of specific cancers and suggested surveillance.

Diagnostic testing is often possible if there is a living family member affected with cancer – if a mutation is found in an HNPCC-related gene then predictive testing can be offered to family members who are currently unaffected.

Mrs H's brother attends his regional genetics service for diagnostic testing to identify any mutation in HNPCC-related genes. Before he is seen, Mrs H, now aged 38, returns with abdominal bloating and intermittent loose stools. Although her symptoms are clinically more suggestive of IBS, a fast-track referral is made in view of the family history. Colonoscopy reveals a malignant tumour of the ascending colon.
This case highlights that patients with significant family histories are at increased risk of developing cancer, even if symptoms suggest a non-malignant cause. It is important to ask about family history in patients with symptoms which aren't red flags – a significant family history lowers the threshold for further investigation.

Reference
1 Cairns SR, Scholefield JH, Steele RJ et al, on behalf of the British Society of Gastroenterology, and the Association of Coloproctology for Great Britain and Ireland. Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002). *Gut* 2010;59:666-90

Further reading
- NICE . Familial Breast Cancer. October 2006. CG41
- Rafi I and Spicer J. Genetics and Primary Care. Chapter 5: Cancer Genetics Radcliffe Publishing, 2007

ONLINE

Coming up online
Each week, a new article in the practical genetics series will be published online.
Look out for:
- **Cancer genetics: breast and ovarian cancers**
- **Ethical issues in genetics**
- **Antenatal screening**
- **Discussing family history**

pulsetoday.co.uk/clinical

Case two

Mr C – aged 28 – was referred routinely to general surgery with painless rectal bleeding suggestive of haemorrhoids. His symptoms appeared typical, but the GP was concerned about his risk of polyps after asking about family history. Mr C's mother had multiple colorectal polyps and had a preventative colectomy in her 40s. His sigmoidoscopy revealed a colorectal polyp, so a full colonoscopy is performed. This reveals several further colorectal polyps.
A family history of colorectal polyps may be significant – some types of polyp can undergo malignant change. There are several hereditary polyposes, the most significant being familial adenomatous polyposis. Untreated, this carries virtually a 100% lifetime risk of colorectal cancer. Individuals may not have a family history of cancer, but identifying them is crucial in view of their elevated risk, and they should be offered referral to regional genetics services. Annual colonoscopy should be initiated from puberty, with prophylactic colectomy indicated, usually before the age of 30.

This article has summarised management of patients with a family history of some common cancers. But, many other cancer types can occur within cancer syndromes, and discussion of these is beyond the scope of this article. Have a high index of suspicion of any family history where cancers occur at a young age, or several relatives are affected – particularly with the same type of cancer.

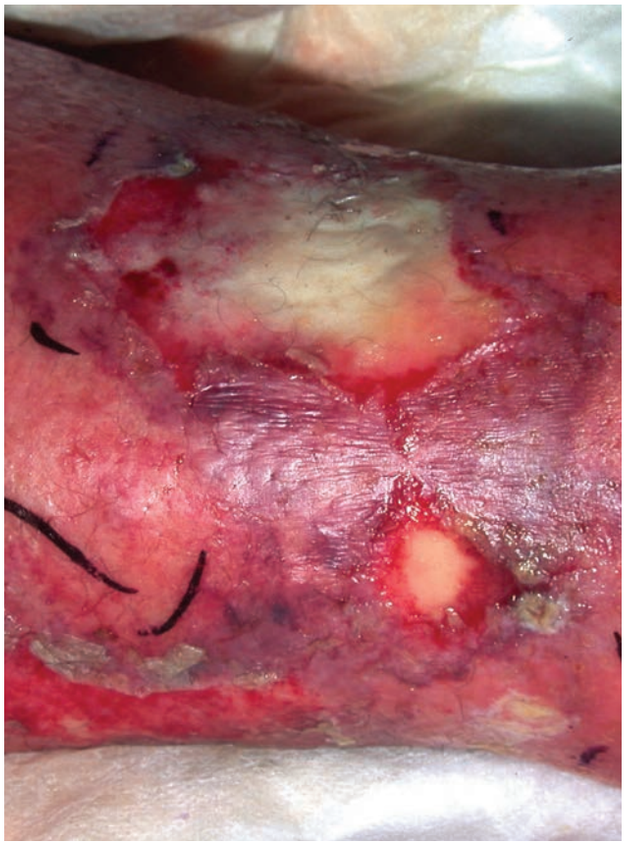
Dr Judith Hayward is a GPSI in genetics in Bradford, and works with the Yorkshire Regional Genetics Service

- *This article has been written with the help of Dr Julian Adlard, consultant in cancer genetics at Yorkshire Regional Genetics Service.*

HOW NOT TO MISS

Necrotising fasciitis

Emergency medicine consultant Dr Adrian Boyle discusses the signs, and pitfalls in diagnosing necrotising fasciitis



AMANDA OAKLEY

Worst outcomes if missed

- Death – between 20 and 40% of people with necrotising fasciitis die, despite surgery.
- Disfigurement – early diagnosis and treatment reduces mortality and the disfigurement from surgery. Delays to surgery increase the risk of amputation.

Epidemiology

- There are about 500 cases of necrotising fasciitis in the UK each year.
- Necrotising fasciitis is more common in patients with diabetes, chronic hepatitis and malignancy – particularly leukaemia – people who inject drugs and those who are immunosuppressed.
- Necrotising fasciitis can occur because of infected pressure sores.
- It is rare in childhood, but there is an association with varicella infection.
- A GP should expect to see at least one case in their career.
- Diagnosis is frequently made late, after multiple presentations.

Symptoms and signs

The classic symptoms of necrotising fasciitis are rarely present initially so distinguishing necrotising fasciitis from

Five key questions to ask

1 Can you walk or use the limb? Inability to use the limb is suggestive of necrotising fasciitis.

2 Are there any patches of numbness? This would indicate whether any sensory nerves have been infarcted.

3 Where exactly is the pain worst? Pain which is greatest slightly distant to an area of cellulitis is suggestive of necrotising fasciitis.

4 Is the pain around a wound? Uncomplicated wound infections are not usually very painful.

5 Are you feverish and unwell? Patients are usually toxic.

Five red herrings

1 Patients may attribute limb pain to a minor or non-existent injury.

2 The skin signs may be relatively mild at first.

3 Patients who inject drugs often present without systemic signs.

4 Patients may look well in the initial stages of the disease, which can last a few days.

5 Lymphangitis is unusual in necrotising fasciitis – this usually suggests a different diagnosis.

cellulitis can be difficult in the early phases of the disease. Early symptoms are non-specific:

- fever
- pain out of proportion to the clinical findings
- inability to use the affected limb.

The limbs are most commonly affected and the perineum is also a common site, but any part of the body can develop necrotising fasciitis.

In patients with fever, clinical suspicion may be aroused by something being 'not quite right' for a diagnosis of cellulitis. The classic cyanotic and bullous skin changes may only appear late in the process, but the site of infection may appear unusual. The pain may seem too severe for cellulitis, despite relatively mild skin signs, or there may be overlying sensory loss. Pain is caused by tissue necrosis, but the nerves can also be infarcted as perforating vessels to the tissues are thrombosed by the necrotic process. This can cause exquisite pain and tenderness, but also sensory loss to the overlying skin. The patient may seem disproportionately unwell for the degree of skin involvement. The progression of the illness can suggest the diagnosis – the patient may seem relatively well initially, but will deteriorate despite antibiotic therapy. Crepitus and haemorrhagic blisters are a late sign.

In patients presenting with pain alone, the severity of pain and absence of trauma may suggest the diagnosis.

Differential diagnosis

Symptoms of necrotising fasciitis are initially similar to the much more common and benign cellulitis. Patients with severe musculoskeletal pain may suggest that their pain is caused by an assumed or trivial injury.

Investigations

There are no useful investigations that can be done in primary care – necrotising fasciitis is mainly a clinical diagnosis. Where there is doubt, prompt surgical exploration at hospital is probably best, though MRI or CT scans can be used.

If necrotising fasciitis is suspected, the patient should be referred as an emergency. Patients are usually initially cared for by general surgeons or plastic surgeons, depending on local services.

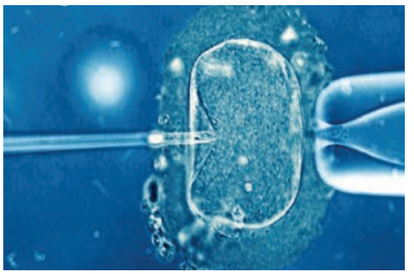
Dr Adrian Boyle is a consultant in emergency medicine at Addenbrookes Hospital in Cambridge and an honorary senior research fellow at Cambridge University.

Further reading

Sultan HY, Boyle AA and Shepherd N. Necrotising fasciitis. *BMJ*, 2012;345:e4274

pulse-learning.co.uk

Latest modules

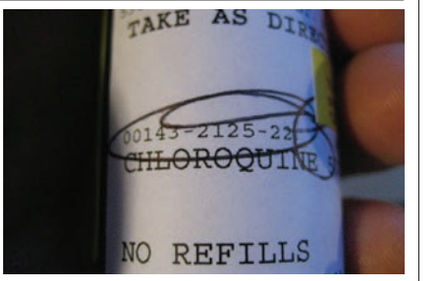


Guideline debrief

Fertility
2 CPD HOURS
This case-based learning module uses primary care case histories to update you on the GP-relevant sections of the new NICE guideline

The information

Patellofemoral pain syndrome
0.5 CPD HOURS
A concise, practical guide to the pathophysiology, underlying causes, diagnosis and management of this 'catch-all' label for knee pain



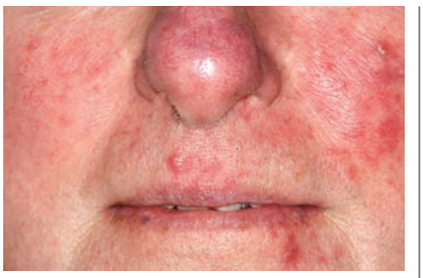
Key questions

Pre-travel advice
1.5 CPD HOURS
A travel health specialist answers a GP's questions including advice on last-minute vaccines, altitude sickness and malaria prophylaxis

Also new this month

CKD in primary care

When renal function takes a dip
1 CPD HOUR
'A simple and useful guide to management of sudden deterioration of eGFR'
Dr Tarun Sharma



The information

Rosacea
0.5 CPD HOURS
'Very good, practical tips useful in primary care'
Dr Krishna Jamuna

Hot topics

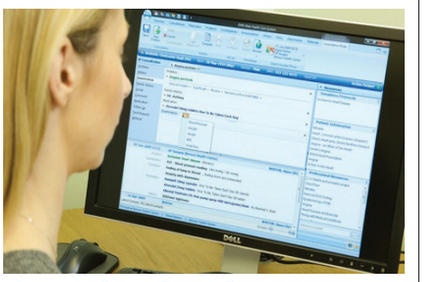
End-of-life care
2 CPD HOURS
'Incredibly useful round-up of the palliative care developments relevant to us in primary care'
Dr Matthew Hughes

Key questions

Asthma
1.5 CPD HOURS
'Very useful module with lots of practical tips to improve asthma management'
Dr Andreas Photiou

Clinical casebook

Addiction
1.5 CPD HOURS
'Crisp, clear and concise advice for front-line use'
Dr David Oram



Practice business

Managing an online appointment service
1 CPD HOUR
'Very informative, it's an eye opener'
Dr Maurice Williams

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pulsetoday.co.uk/emails

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1. Scheltens P, *et al.* J Alzheimers Dis, 2012
2. Scheltens P, *et al.* Alzheimers Dement. 2010 Jan;6(1):1-10.e1.
3. Kennedy EP Weiss SB (1956) J Biol Chem 222(1):193-214

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Contra-indications, warnings, side effects etc: Please refer to SPC for full details before prescribing. Do not use if sensitive to any of the ingredients. In the unlikely event of a reaction stop treatment. **Package quantities, NHS prices and MA numbers:** Doublebase Gel: 100g tube £2.65, 500g pump dispenser £5.83, PL00173/0183. Doublebase Dayleve Gel: 100g tube £2.65, 500g pump dispenser £6.29, PL00173/0199. **Legal category:** P

MA holder: Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR. **Date of preparation:** November 2012. 'Doublebase' and 'Dayleve' are trademarks.

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TOPICAL INNOVATION

PULSE LIVE 2013

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

Your one-stop annual update

Pulse Live is a new must-attend event offering an annual update for all GPs – covering your practice, your clinical work, and your career

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You can debate the big issues around clinical care and the future of your profession, put your questions to the experts, or appear on our soapbox to share a gripe or a success with your peers.

Pulse Live will help you make the most of your working hours and cope with this year's QOF and contract challenges. Do come and join us, we'd love to see you there. Book now through the Pulse Live website pulse-live.co.uk

'It's your event'

Professor David Haslam, former chair and president of the RCGP and chair designate of NICE, will chair both days of Pulse Live.

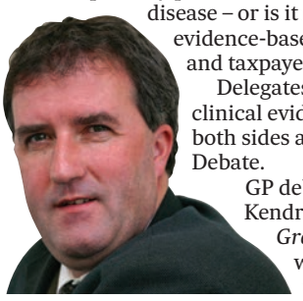
He will open the conference with a talk entitled 'At the heart of the NHS', looking at where general practice fits into the new NHS.

About Pulse Live, he says: 'The most important people there will be the delegates themselves, GPs who are working at the coalface. The programme has been built around their real world.'

Is the NHS wasting millions on statins?

Is the NHS wasting precious funds on primary prevention of cardiovascular disease – or is it making good, evidence-based use of GPs' time and taxpayers' money?

Delegates will vote on clinical evidence presented on both sides at the Pulse Live Big Debate.



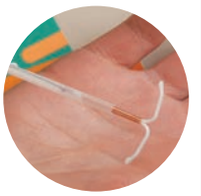
GP debater Dr Malcolm Kendrick, author of *The Great Cholesterol Con*, will go head to head with Dr Terry McCormack, a GP in Whitby with a special interest in cardiology, who will put the case in favour of using statins for primary prevention.

Which way will your vote go?

A comprehensive clinical update

Clinical sessions at Pulse Live will update you on key areas of practice, summarising new research, helping with common dilemmas and giving you tips to put into practice straight away.

On day one, the clinical stream will include recognising dementia, reducing gastroenterology referrals, the coil in emergency contraception, dermatology treatment and referral and key areas to get right in end-of-life care.



On the second day, clinical sessions will include what's new in diabetes, 10 tips on serious mental illness, four ways to make a difference in ENT, musculoskeletal update, 10 tips for better care of multimorbidity, and what's new in COPD.

How to cope with 2013 QOF changes

Proposed QOF changes from April 2013 mean that GP practices are going to have to take a more selective approach.

Dr Gavin Jamie, a GP in Swindon and founder of the QOF Database, will advise you on the law of diminishing returns and how to cope with the new world of the QOF.

His session will cover new indicators and changes to thresholds and timings. He will also look at the business case – which targets should your practice prioritise and which are not worth chasing?

Highlights from the Pulse Live programme

Day 1
30 April

Plenary sessions

- **Pulse Live Big Debate** Are GPs all heading for burnout?
- **Pulse Live Clinical Debate** Is the NHS wasting millions on primary prevention?

YOUR PRACTICE

- **Six key threats** to practices from April 2013 and how to avoid them
- **Maximising revenue** Optimising your income and keeping an eye on your cashflow
- **Reducing emergency admissions** Mission impossible or an achievable goal for the average practice?

YOUR PATIENTS

- **Dementia** Case finding and meeting the new DES
- **Dermatology** 10 key points on treatment and referral
- **Gastroenterology** Five ways to reduce your referrals
- **Emergency contraception** The case for the coil
- **Cardiovascular** Update on key challenges
- **End-of-life care** Three key areas to get right

YOUR FUTURE

- **Legal panel** How to avoid a career-ending complaint
- **Commissioning** What's in it for you and your practice?
- **Competitor or colleague?** How practices should work together to benefit themselves and their patients
- **Burnout and stress** Prevention and how to cope

Sessional GP stream

- How to set up and survive as a locum
- Chambers – a real alternative to partnership

Day 2
1 May

Plenary sessions

- **Pulse Live Big Discussion** Where does general practice fit into the NHS of the future?
- **Pulse Live Big Interview** Editor Steve Nowottny puts your questions to Professor Malcolm Grant, chair of the NHS Commissioning Board

- **QOF** How the new world of the QOF affects you and which targets to prioritise
- **Nursing homes** Improving the way that GPs and homes work together
- **Practice team dilemmas** Managing human resources effectively in straitened times

- **Diabetes** What's new in screening and therapeutic agents?
- **Musculoskeletal** Quick wins for common problems and new QOF indicators
- **Serious mental illness** 10 tips including crisis management
- **ENT** Four ways to make a difference
- **Multimorbidity** 10 tips for better care
- **COPD** What's new, including telehealth

- **Traditional general practice** Is the 'cottage industry' model fit for the future?
- **Where to go next?** How to develop your career in the new NHS
- **Digital health** Technology and social media tips and pitfalls for GPs
- **Efficiency** How to make better use of your time

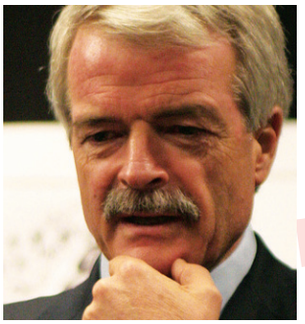
Additional programme topics are being confirmed all the time – see updates at pulse-live.co.uk/programme

Plus in the Pulse Live Hub Skills workshops, Soapbox, speakers' area, refreshments and exhibition

Pulse Live key speakers

Dr Richard Vautrey
GP in Leeds and deputy chair of the GPC

Rt Hon Stephen Dorrell MP
Chair of the House of Commons health select committee



Professor Malcolm Grant
Chair, NHS Commissioning Board

Dr Richard Fieldhouse
GP in Chichester and chief executive of the National Association of Sessional GPs (NASGP)

Dr Pauline Brimblecombe
GP and GPSI in community gynaecology, Cambridge

Dr Kartik Modha
GP in London and founder of Tiko's GP Group

Professor Stewart Mercer
GP and professor of primary care research, Institute of Health and Well-being, University of Glasgow

Dr David Carson
Director, Primary Care Foundation, and former GP and DH adviser on emergency care

Dr Hilary Pinnock
Reader with the Allergy and Respiratory Research Group, University of Edinburgh, and GP in Whitstable, Kent

Richard Apps
Partner, RSM Tenon accountants

Dr Elizabeth England
GP in Birmingham with a special interest in mental health, and senior clinical lecturer in primary care mental health, University of Birmingham

Dr Stephen Brown
GP in Buckinghamshire and GPSI in ENT

For the full list of speakers see the Pulse Live website pulse-live.co.uk

Pulse Live is your event
Here's how you can get involved...

Dr Penny Newman will use the Soapbox to talk about women in medicine

Apply for a place on the Pulse Live Soapbox

If there's an issue related to your work as a GP that you want to get off your chest, we want to hear from you.

The issue you raise might be a gripe about clinical guidelines, prescribing policy, the financial squeeze on GPs or the future of clinical commissioning. Or maybe you have a nugget of advice that's worked for you that you want to celebrate and share with colleagues.

The GPs who submit the best ideas will get a slot on the Pulse Live Soapbox, and everyone who applies will get a free place to attend the event.

Email your ideas to pat.anderson@pulsetoday.co.uk

Steve Nowottny, editor of Pulse, wants to hear your ideas and opinions

Come and meet the Pulse editorial team

Group editor Jo Haynes and Pulse editor Steve Nowottny will be at the event and ready to chat about Pulse's online, print and live content.

We want to hear what matters to you, so we can ensure we meet your needs through our websites, magazine and events.

Professor Malcolm Grant will face questions from GPs

Send in your questions for the Pulse Big Interview

Pulse editor Steve Nowottny will put your questions to Professor Malcolm Grant, chair of the NHS Commissioning Board in the final session of Pulse Live.

Perhaps you are wondering how much power GPs will really have in the new world of clinical commissioning. You might want to quiz him on the Francis Inquiry's call for GPs to police the quality of hospital care. Or maybe you're upset about the prospect of your local CCG constitution being imposed on your practice.

Email your questions and the best will be put to Professor Grant on the Pulse Live stage. steve.nowottny@pulsetoday.co.uk

How to book: see the insert in this edition of Pulse or go online to pulse-live.co.uk

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1. Attar A *et al*. Gut 1999; **44**: 226-230.

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NORGINE

TEN TOP TIPS

Preparing for April 2013

Our expert panel of GPs advises on how to get ready for the contract changes, CQC registration and the CCG handover

Identify and reduce excessive workload

1 All NHS providers of care are suffering from rising workload and financial restrictions – and to manage this, many are offloading work onto GPs. Many practices have reached saturation point and are struggling to meet the needs of their registered population. With major changes to the GMS contract planned for April, partners need to audit their existing workload to discover sources that they feel might be inappropriate or excessive. Identify the work that you are not funded to undertake and then discuss whether this can be stopped – always remembering your professional responsibilities to your patients.

Dr Nigel Watson is chair of the GPC's commissioning and service development subcommittee, chief executive of Wessex LMCs and a GP in the New Forest

Prepare for a tougher QOF

2 There are radical changes proposed for the QOF in the 2013/4 contract. It will become much more difficult to achieve QOF points and achieving the top quartile will be very challenging. Practices will have to prioritise work.

We have done two things at my practice. We took a detailed look at the proposed changes and discussed how best to achieve QOF points when the new contract is finalised. We plan to aim for a broad spread of QOF points without aiming for the top quartile in most cases. We also bought an automated blood-pressure monitor for the waiting room, which has reduced the burden on staff time in terms of blood pressure readings needed for the QOF. We expect it to have paid for itself in the next year or two.

Dr Adam Jenkins is vice-chair of Ealing, Hammersmith and Hounslow LMC and a GP in Greenford, west London

Draw up a 12-month financial plan and put a freeze on hiring new staff

3 Practices should aim to sustain themselves financially. Before April, partners and practice managers should check cash-flow arrangements. Keep cash in reserve if you can, and anticipate any impact from the loss of the MPIG from 2014 onwards. Staffing is every practice's major outgoing, so don't recruit any new staff or partners until April. Long-term commitments leave practices lumbered if income goes down – it is better to be short-staffed for a few months.

Dr Sella Shanmugadasan is chair of Tower Hamlets LMC and a GP in Shoreditch, east London

> Identify the work you are not funded to undertake
> *Dr Nigel Watson*

Negotiate a lease agreement to fix your service charges

4 In north-east London, a large number of practices operate out of healthcare centres, don't have a contract with the PCT and have disputed their service charge. Many partnerships have fallen behind on payments. It's hard to calculate the service charge but even harder to challenge invoices if there's no agreement. We don't know how NHS Property Services (PropCo) is going to operate or calculate service charges, but we can't wait around to find out.

Dr Sella Shanmugadasan

Review all practice policies ahead of CQC visits

5 GPC guidance on CQC compliance, which we have been following at my practice, suggests you review policies. Then make sure all GPs and staff know the policies and use them. Our practice manager takes the lead but we've also appointed people as leads in different areas – for example, the nurses lead on infection control. We have also set up an intranet site so that the policies and procedures are in one place. We explained to staff that CQC inspections are part of an ongoing process. Keep reviewing policies regularly and give staff the confidence they'll need when the inspector knocks.

Dr Richard Vautrey is deputy chair of the GPC and a GP in Leeds

Ensure compliance with CQC standards

6 By all means take forward your plans for the CQC by updating policies and procedures, training staff, setting up systems for ongoing notifications to the CQC, and so on. But concentrate mainly on ensuring you meet the necessary standards. If you are

GETTY

struggling with some of them, prepare plans to tackle problem areas, with a realistic timescale and implementation plan. This will prove to your CQC inspector you are taking any issues seriously.
Dr Sobhi Sadek is a GP in Northampton

Ensure your CCG resources GPs for key work

7 If local commissioners want to run a new service, GPs should help them plan resources. In our area the CCG wanted to run a new records service for palliative care patients, so we suggested ways it could be run and resourced by the CCG through general practice. Communication and engagement are key to the success of new initiatives, and the capacity of partners to commit to services outside core work.
Dr Deborah Colvin is chair of City and Hackney LMC and a GP in Hackney, east London

Research how your practice will be affected by local cuts and rationing

8 General practice, as ever, will be expected to pick up the slack – and the bill – when cuts are made. We need to learn to trust what we know and be prepared to fight hard for it.

This means keeping in touch with local commissioning strategies, paying attention to CCG communications and reading commentaries from other agencies. We need to be able to respond to top-down impositions through lobbying, petitioning the public and learning about platforms for public communication. Developing relationships with local, trade and national media and employing PR experts will be key skills. We need also to forge alliances with local councils – as highlighted in the Lewisham hospital campaign where the mayor waded in.
Dr Andy Field is a GP in York

> GPs should help CCGs to plan resources for new services
> *Dr Deborah Colvin*

Prepare for cuts to local enhanced services

9 Keep an eye on what is happening to local enhanced services. Most will fall under the control of CCGs, but some will be commissioned (or paid for) by the local authority, with CCGs or the NHS Commissioning Board involved in their detail. The risk is that funding for some LESs will be stopped. If that is the case, stop doing the work and raise the issue with your CCG and LMC. They may relaunch a LES, or make interim payments for you to continue the work while they decide whether to sustain it.

There is a clear opportunity to renegotiate LESs where they have been poorly funded or run under onerous conditions. But if practices are not robust in their approach to delivery and pricing, they could find themselves delivering more and more for less and less. Do your research and plan which services to launch, lobby for and pitch for.
Dr John Ashcroft is a vice-chair of Derbyshire LMC and a GP in Ilkeston

Get to grips with the Any Qualified Provider model

10 From April 2013 it will be up to CCGs to decide when and where to use AQP as a commissioning tool. Some practices will want to bid for new AQP contracts, but they must be fully aware of the terms.

AQP contracts are based on competition, not price. The award for a successful contract is based on the national tariff. These contracts vary from the LESs. AQP funding is paid retrospectively based on the number of referrals. Even if it's a good service, if it's not used there might be less return on your investment. In that respect, they're unlike LESs where you can plan the finance you'll get for undertaking them.

Preparing a pitch takes 40-50 hours or longer. You will need to invest in staff, equipment and other resources. You may also need to rely on co-operation with secondary and community care. I'd recommend partners look at what AQP contracts will be available in future, and research the opportunities and risks.
Dr George Rae is a GPC member and a GP in Newcastle-upon-Tyne

ONLINE

Go online to complete CPD modules on AQP contracts, managing your cash flow and revalidation pulse-learning.co.uk

FINANCE DIARY: MARCH

How to avoid becoming a dysfunctional practice

With tough times ahead, it is vital practices pull together and partners delegate effectively. Bob Senior advises on the warning signs of problems in store

Tough times lie ahead and teamwork will be essential if practices are to ride out the storm. Dysfunctional practices, where GPs fail to delegate effectively or where partners fall out, will only make a bad situation worse.

Unfortunately I have noted an increasing number of practices where solicitors have been called in to sort out partnership disputes (usually at great expense) or where profits have fallen so much that partners are deserting the ship.

I have noticed three common signs of trouble, so if your practice is showing them, now is the time to change.

GPs who micromanage

Although responsibility for patient care ultimately rests with the doctors, GPs have to work as part of a team. Clear expectations must be established of what will be done by each team member, training given, and robust processes established to ensure work is completed.

GPs should not be permanently checking up on staff. Nurses need to be trusted to operate within their remit and practice managers should be allowed to get on with running the practice.

Partners not talking to each other

In a busy practice it is not uncommon for partners to comment that they have no time to talk to colleagues. This can be overcome with effort, perhaps by moving practice meetings occasionally from the traditional lunchtime slot to first thing in the morning or in the evening. Unless partners devote time to the practice they could find it collapses around them.

But if partners are not talking to each other because they have fallen out, this must be resolved. If it isn't, things go downhill quickly and all partners feel the effects. In my experience, if partners are unable to patch things up, one of them needs to leave the practice promptly. Allowing the situation to drag on will mean solicitors have to get involved further down the line.

No succession planning

Many GPs are struggling to cope with what is happening now, let alone plan for the future. But with many now in their 50s and young doctors changing their attitudes to partnership, practices need to tackle succession planning now.

ONLINE

Go online to read previous Bob Senior columns including advice on managing premises costs and preparing for next year's tax return pulsetoday.co.uk/financediary

Bob Senior is chair of the Association of Independent Specialist Medical Accountants and head of medical services at RSM Tenon

Setting up a new business entity

Valerie Martin-Long on how GPs bidding to run services can best organise their business

As commissioning begins to take shape ahead of the handover to CCGs in April, there are increasing opportunities for GPs to tender for services across a locality and to bid to run other practices. It is important to consider the type of organisation you want to constitute for the business from the outset.

Tax considerations

Where a business is run through a limited company or community-interest company (CIC), the company's profits are subject to corporation tax at 20% on profits below £300,000 and currently 24% at the full rate (although this will be reduced to 21% from April 2014). This is favourable compared to a partnership or limited liability partnership (LLP), where the income coming in as the top slice of a GP's personal income is subject to income tax at 45% above £150,000 and 60% on taxable income between £100,000 and £118,410 in 2013/14.

However, if the profits from a limited company are going to be drawn out as dividends, then higher-income tax rates will apply to shareholders who are higher-rate taxpayers. Income tax and employer's and employee's National Insurance contributions will apply to directors' salaries, making the total tax charge much higher than would be paid by a partner or self-employed individual.

Where any spouses or partners who are basic-rate or non-taxpayers are to be brought in as shareholders, they should subscribe for shares from the outset. Dividends covered by the personal allowance or basic rate tax are then not subject to any additional income tax.

Commercial considerations

A limited company, CIC or LLP can be seen to be more independent than putting the new business through the main medical partnership and can provide a joint venture vehicle if two partnerships are launching a combined bid. However, with any new entity, the pre-qualification questionnaire will require evidence of financial support and it may be necessary to introduce capital, whereas an existing partnership would already have a financial track record and capital base.

An LLP is effectively a hybrid being, treated for accounting purposes as an independent entity, in the same way as a company with accounts that have to be on public record at Companies House. For tax purposes, its members are taxed as individuals on the profits earned, regardless of whether they are distributed or not, in the same way as partners in a partnership. An LLP does give limited liability, which can be attractive in a riskier business.

A CIC is a limited company but it is also a social enterprise with restrictions on the profits that can be withdrawn by the shareholders. This does not prevent directors' remuneration being fully paid for the services provided by the directors. Given the reinvestment in the business of the surpluses for the benefit of patients, this can give an advantage over a profit-making company in a tender.

If any shareholders are not doctors, nurses, practice managers or other members of the NHS family, then the company will not qualify as an employing authority, in which case employees' income would not be superannuable. This may be advantageous for GPs who are concerned about the pension cap, but could be a disincentive for staff. Similarly an LLP cannot have NHS employing-authority status.

Valerie Martin-Long is a partner at the specialist medical accountants PKF, and can be contacted on 01483 564646 or valerie.martin-long@uk.pkf.com

DILEMMA

A conflict of interest between partners

One GP is on the CCG board, the other runs a provider. Three experts advise on how to avoid a damaging rift within the practice

One of the GP partners at your practice sits on the CCG board, while another fronts a local GP provider organisation that is planning to bid for contracts. You are concerned that the practice's internal relationships might be put under strain during the bidding process and particularly if the board does not award contracts to the partner's organisation. How should you manage this?

Dr Mark Gaffney

The CCG board partner cannot have any say in decisions about the provider

How to deal with this will depend on the individual characters, but the provider organisation partner needs to understand the CCG board partner cannot have any say in board decisions in relation to the provider. I would have an open discussion with the provider partner and explain my concerns and expectations.

All GPs on CCGs are potentially conflicted, simply by their independent contractor status and ability to develop outside interests. It becomes more complex when board members belong to an external commercial enterprise. That person may have expert knowledge, which would be foolish to ignore, but how do you ensure impartiality?

There are only so many GPs in the UK. Those with the drive to be entrepreneurs are likely to be the same people who will make the boards a success. How do we harness that? The Committee for Standards in Public Life published the seven Nolan Principles as core working values for anyone who serves the public: selflessness, integrity, objectivity, accountability, openness, honesty and leadership. I would add another principle for conflicted CCG board members: absence. They should be excluded from conflicted items at board meetings but asked for input at seminar level where no decisions are taken.

Dr Mark Gaffney is a co-founder and joint managing director of East Sussex Out Patient Services and a GP in Eastbourne

ALAMY

Dr Ken Aswani

Recognise that GPs will be involved in different areas of work

The partners should have a full discussion in the practice to ensure any adverse fallout is minimised.

The CCG board member would have to declare a conflict of interest in any procurement where their partner's organisation is bidding. This means they are likely to be excluded from the process.

The partner who leads the provider organisation will need to accept the CCG's decision without worrying it was influenced by their partner. They should not apply influence to the CCG board member or other CCG board members that may be interpreted as unfair.

The other partners will need to understand the CCG board member must act on behalf of all its population and practices, and cannot favour an individual practice. The lay member of the CCG, on behalf of the board, will need to have governance systems to ensure conflicts of interest do not compromise decision-making.

ONLINE

Now go online to read this month's other practice dilemmas:

- **A Muslim patient presents after her brother threatens her with honour-based violence pulsetoday.co.uk/HBV-dilemma**
- **Should you offer NHS treatment to self-funding IVF patients? pulsetoday.co.uk/IVF-dilemma**

As the two partners have conflicts of interest it is important to have appropriate partnership agreements, particularly if there are any financial arrangements. This would include the extent to which a partner can have other provider interests and how these may financially affect the practice. Additional time partners spend on outside provider interests has to be negotiated. CCG governance and the individual's professional duty to maintain probity should be respected, but GPs will be involved in different areas of work, and this should not discourage innovation.

Dr Ken Aswani is the medical director at Waltham Forest Federated GP Consortium and a GP in Leytonstone

Lynne Abbess

The decision lies outside the practice – it is for the board to take

Management of conflicts will become an essential part of the new NHS. However in the present situation, there is nothing for the practice itself to 'manage'.

The decision is for the CCG board to take. If there is discussion about the award of the contract to the GP provider organisation of which the fellow partner is a member, the CCG board member should remove themselves while the decision is taken.

It is important to distinguish the role a partner plays outside the practice from the partnership business. In this case, the decision has nothing to do with the partnership. If it is understood the CCG board member/partner is unable to influence the decision, that should prevent difficulties within the practice.

It is also important that partners appreciate their responsibility lies with the partnership. If an external activity presents a conflict, then they will need to decide which way to jump. It is not reasonable to expect the other partners to put up with the challenges from one GP's external interest.

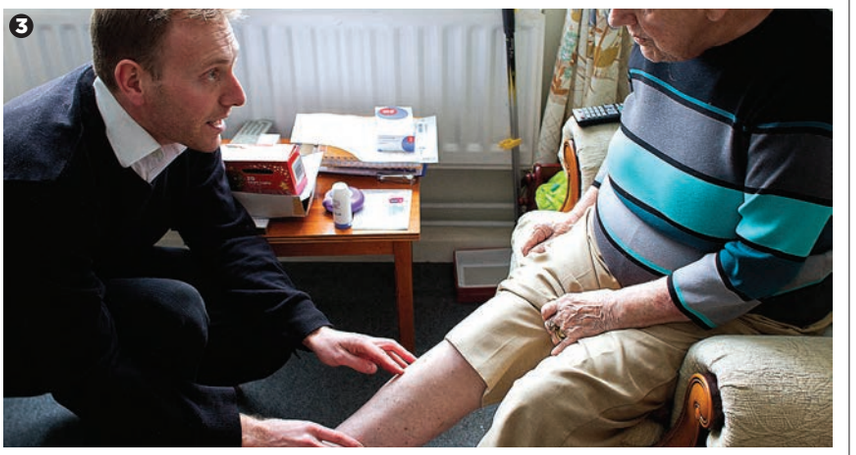
Lynne Abbess is a partner at Hempsons solicitors

PHOTO ESSAY

1 Surgery opening. Normally a 7.30am start, reviewing the morning appointments.
2 First vaccinations for this baby at eight weeks old.
3 Home visit. This patient's carer had been worried about a sore leg, but the patient just needed reassurance.
4 Arriving for an A&E shift.
5 The patient on the trolley needed a log roll to clear her c-spine.
6 Trying to establish why this patient had collapsed at home.
7 Having a badly needed five-minute break.

EXTRA ONLINE

View the full series
See all 32 pictures from this photo essay online
pulsetoday.co.uk/weinstein



Dr David Weinstein

A GP and photographer explain the idea behind their remake of an iconic photo essay that followed a family doctor in the 1940s

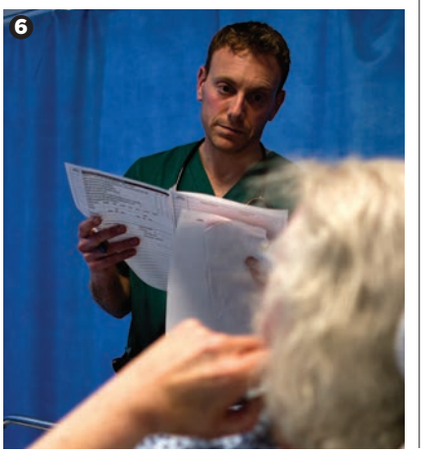
In the documentary photo series 'Country Doctor', published in *Life* magazine in 1948, photojournalist W Eugene Smith captured the working life of a family doctor in Colorado.

Six decades later, photographer Giovanni Tait and Dr David Weinstein undertook a similar exercise.

Dr Weinstein works most of the week as a GP in Brighton, but spends Friday afternoons as an A&E middle-grade doctor. 'I was beginning to feel burnt out in primary care,' he explains. 'The balance keeps me sane.'

Mr Tait was struck by how his photo essay echoed the original: 'Fundamentally the job has hardly changed.'

▶ **pulsetoday.co.uk/weinstein**



ONLINE

Editor's choice From the latest practice business and working life articles online

Better end-of-life care

Dr Damian Patterson on how his practice got gold-standard accreditation
pulsetoday.co.uk/GSF-casestudy

Online appointments

1 CPD HOUR Dr Osman Bhatti explains how to enable online booking
pulsetoday.co.uk/onlineappointments

Last-minute QOF tips

Dr Simon Clay covers exception coding to help practices gain maximum points
pulsetoday.co.uk/lastminute-qof

A GP for the homeless

Dr Nigel Hewett explains why he chose to work with this vulnerable group
pulsetoday.co.uk/nigel-hewett

Reducing workload

Dr Masood Nazir makes 10 suggestions to save time on admin and meetings
pulsetoday.co.uk/saving-time

Software to cut errors

Dr Sarah Rodgers' guide to a new plug-in to cut script errors
pulsetoday.co.uk/PINCER-guide

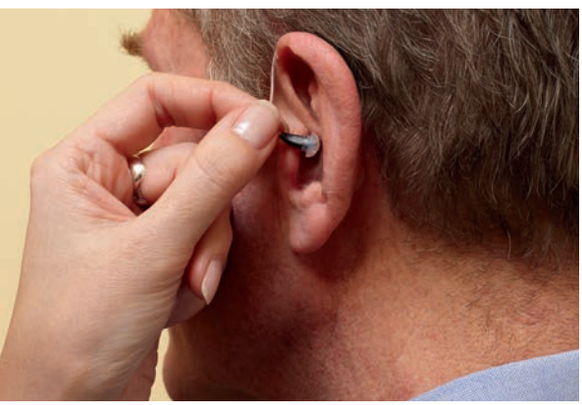
ALAMY X2/GETTY/JULIAN CLAXTON X2

AQP OFFERS YOUR PATIENTS ADULT AUDIOLOGY SERVICES ON THE HIGH STREET

What is the scale of adult hearing loss in the UK?
More than 10 million people in the UK have some form of hearing loss,[1] and an estimated two million of them have hearing aids. But at least four million people who don't have hearing aids would benefit from using them.[1] Furthermore, only about 1.4 million of the two million who have hearing aids use them regularly.[1]

The introduction of the Any Qualified Provider (AQP) initiative in audiology has been designed not only to broaden patient choice and improve the patient experience, but also to ensure that more people who need treatment are able to access it in a timely fashion.

Why has AQP been introduced in England?
Patient choice has been at the heart of NHS reforms for the past 60 years. The introduction of the AQP model last year aims to extend patient choice even further by giving patients a choice of qualified provider to whom they can be referred for treatment.



Since April 2012 adult audiology services have been included as part of AQP. Up to the end of February 2013, Specsavers Hearcare has been accredited by the NHS to provide adult audiology exams and hearing aids under 20 contracts across England[2], with others expected to follow.

What are Specsavers' credentials?
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:
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- 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
- Under the terms of the agreement, providers are not permitted to sell additional items to patients
- Services pass and exceed the rigorous, standardised qualification process and must be maintained

Specsavers offers a high standard of clinical expertise to its patients and flexibility of service including:
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How can your practice benefit?
- A quick and easy referral process through the established Choose and Book system
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How can you refer patients with hearing loss to a local Specsavers Hearing Centre?
To see whether your practice is one of the many now able to refer audiology patients under AQP, visit supply2health.nhs.uk or contact the Specsavers NHS service team by emailing nhsservices@specsavers.com or phoning **0800 077 8603**.

Once your PCT has gone live with AQP, you can refer your patients through Choose and Book, or use Audiology Referral forms provided by your PCT. If you have any questions, contact the Specsavers NHS service team.

For more information, see our special feature at: pulsetoday.co.uk/specsavers-hearcare and our CPD accredited learning module at: pulse-learning.co.uk/clinical-modules/care-of-the-elderly/key-questions-on-adult-hearing-problems

Specsavers® Hearing Centres

References 1. Action on Hearing Loss, actiononhearingloss.org.uk/ last accessed November 2012. 2. Since February 2013, contracts are live in: Brighton and Hove, West Devon and Cornwall, Berkshire, County Durham and Darlington, Tees, Kirklees (Calderdale, Kirklees and Wakefield), Birmingham (Arden, Birmingham and Solihull, Black Country, West Mercia and Staffordshire), Manchester, Tameside and Glossop, Merseyside, Lancashire, NHS South of Tyne, South East London, North West London, and Hampshire.

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PEVERLEY

Sticking it to the malingerers

Every now and then a scrounger of the first order shambles into Phil's consulting room, and he's not afraid to give them both barrels

Dr Phil Peverley is a GP in Sunderland and was PPA and BSME columnist of the year in 2012.
Read more Peverley columns at pulsetoday.co.uk/peverley

Back in the day, we used to be an all-male practice, and consequently I was as *au fait* with the complexities of the menstrual cycle as any GP in the country. I'm not saying I enjoyed dealing with these endless problems (who does?) but I could handle it fairly well and even managed to look as if I cared, quite a lot of the time.

Now the demographics of general practice have changed for the better. Pretty much every practice, including ours, has a couple of Nice Lady Doctors to deal with all this tedium.

My total freedom from exposure to the menstrual diary comes at a price, however. The reception staff have identified another type of patient who they think might best be dealt with by me. Every time some swivel-eyed, sweating sociopath with benzo-hunger in his eyes rocks up to the front desk at ten to six, they say: 'Aha! Another one for Dr Peverley.'

The reason for this (apart from me being six foot three) is that I tend to judge people, and act on those judgments. We're not supposed to do this; non-judgmentalism is a touchstone of our times. But if someone's behaviour is in my opinion self-destructive, anti-social or detrimental to other individuals or society in general, I will generally tell them. Of course, these days, you can't write 'worthless parasite' in the medical records, so my notes are littered with phrases such as 'this patient is disabled by inherent moral perplexity'. Well, I know what it means.

One such prize specimen joined our practice and handed in his repeat prescription to be filled. When he came in, it was immediately obvious that his walking stick was more of a badge of entitlement than a mobility aid.

'My old doctor wasn't giving me what I needed,' he explained. That may or may not have been true, but after looking at his prescription, it was certainly the case that his old doctor had been giving him what he *didn't* need. 'Shampoo?' I asked sweetly. 'I've got a scalp condition.' I had a quick look. 'No you haven't,' I pointed out, and the black line went through that one.

> Of course, these days, you can't write 'worthless parasite' in the medical records

'I don't want to know why you were getting toothpaste on prescription, but you're not getting it from us.' Another black line.

'Have you got gluten intolerance?' 'What's gluten intolerance?' 'Never mind that just now. But you'll not be needing all this bread, pasta and biscuits from now on.'

Then we (well, I say 'we'...) decided that the morphine, tramadol and diazepam weren't really appropriate for a 23-year-old with a bad back (investigations all normal) so they went too. So did the protein drinks, because by now I was on a roll.

'I need a sick note for the disability,' was his next try. 'What diagnosis shall I put on it?' 'Oh anything, I don't mind.' 'I think I'll wait for your records before I issue anything of that nature.' I handed him his new repeat prescription, now comfortably fitting on one side of paper, and he looked at it with disbelief: 'Where's all me gear? I'm gonna f*ckin' complain about you!'

He got up to storm out. 'You've forgotten your stick,' I told him.

DERMAL 50 1963-2013

LIFT OFF FOR SCALY SCALPS

Lift and clear with DermaX® Therapeutic Shampoo

benzalkonium chloride

NOVEL ACTION OF LIFTING SCALE

ACTIVE AGAINST MALASSEZIA FURFUR

Dermax® Therapeutic Shampoo. Benzalkonium chloride 0.5% w/w. **Uses:** For the topical treatment of pityriasis capitis and other seborrhoeic scalp conditions, where there is scaling and dandruff. **Directions:** Adults, children and the elderly: Wet the hair. Apply a liberal quantity of the shampoo to the scalp and, with the tips of the fingers, rub in thoroughly. Rinse. Repeat the application and massage to produce a rich lather. Remove as much lather as possible with the hands, before rinsing thoroughly under running water. **Contra-indications, warnings, side-effects etc:** Please refer to SPC for full details before prescribing. Do not use if sensitive to any of the ingredients. Keep away from the eyes. No known side-effects. **Package quantity, NHS price and MA number:** 250ml bottle £5.69, PL 00173/0198. **Legal Category:** P **MA holder:** Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR. **Date of preparation:** February 2012. 'Dermax' is a registered trademark.

dermax.co.uk

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 Dermal.

DERMAL™
TOPICAL INNOVATION

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

SPIRIVA®
(tiotropium)
Founded on a decade of proven success

LAMA = long-acting muscarinic antagonist.

References: 1. SPIRIVA® 18 µg Summary of Product Characteristics. http://medicines.org.uk/emc. Accessed August 2012. **2.** Tashkin DP *et al.* for the UPLIFT Study Investigators. A 4-year trial of tiotropium in chronic obstructive pulmonary disease. *N Engl J Med* 2008;359:1543–1554.

Prescribing Information (UK) SPIRIVA® (tiotropium)
Inhalation powder, hard capsules containing 18 microgram tiotropium (as bromide monohydrate). **Indication:** Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). **Dose and Administration:** Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler® device. **Contraindications:** Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein. **Warnings and Precautions:** Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the drug powder into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. **Interactions:** Although no formal drug interaction studies have been performed, tiotropium bromide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Fertility, Pregnancy and Lactation:** No documented clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Tiotropium bromide should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of tiotropium bromide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tiotropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotropium bromide therapy to the woman. Clinical data on fertility are not available for tiotropium. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness, blurred vision, or headache may influence the ability to drive and use machinery. **Undesirable effects:** Common (≥ 1/100 to <1/10) Dry mouth. Uncommon (≥ 1/1000 to <1/100) Dizziness, headache, taste disorders, vision blurred, atrial fibrillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, oropharyngeal candidiasis, rash, dysuria, urinary retention. Serious undesirable effects consistent with anticholinergic effects include glaucoma, constipation and intestinal obstruction including ileus paralytic as well as urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** Combopack HandiHaler device and 30 capsules (3 blister strips) £34.87 Refill Pack 30 capsules (3 blister strips) £33.50. **Legal category:** POM. **MA Number:** PL 14598/0062. **Marketing Authorisation 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** August 2012.

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

Date of preparation: August 2012 UK/SPI-121384